LIGHT BEYOND THE HORIZON:
A MINDFUL COUNSELLING EXPERIENCE AT FAMILY SERVICE REGINA

A Field Practicum Report
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Abstract
This report outlines my clinical counselling experience at Family Service Regina (FSR) within the Counselling Unit and the Thrive Walk-in Counselling Clinic. Within this report, there are two therapeutic approaches that are of primary focus: 1) trauma-focused cognitive behavioural therapy with both adults and children, and the use of 2) solution-focused therapy in both brief walk-in and extended counselling sessions. Both approaches were utilized in conjunction with mindfulness-based cognitive therapy and mindfulness-based stress reduction activities. The theme of mindfulness emerged consistently, both professionally and personally, throughout this practicum setting. The benefits of being attachment focused, trauma-informed and anti-oppressive, and placing emphasis on the therapeutic relationship, were instrumental for my growth and development both personally and professionally throughout my time at Family Service Regina. A discussion about the prevention of burnout with the use of self-care strategies will also be included in this report, as this phenomenon becomes a reality for many counselling practitioners new to the field of social work. As a student counselling practitioner, my experiences with Family Service Regina will be highlighted and woven into this report to illustrate the therapeutic approaches noted above as I navigated working with clients and family systems during the practicum placement for my Master of Social Work degree.
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The pursuit and accomplishment of my Master of Social Work degree would not have been possible without the help and guidance of many: I would like to thank my professional associate, Linda Routledge, and Family Service Regina for welcoming me to their team as well as for the opportunity to learn and develop under their guidance. Linda, you have been an inspiring mentor throughout my journey at Family Service Regina; thank-you for all you have taught me. Thank-you goes to the staff at Family Service Regina as well for not only accepting me, but also providing me with a safe space to learn, grow and ask as many questions as needed. I also wish to thank Dr. Nuelle Novik for her commitment to my continued learning and growth throughout my practicum.

This practicum has afforded me the privilege of hearing the stories of clients who sought support and a listening ear. I wish to thank all of them for allowing me the immense opportunity to be a part of their journey through life in some of their most vulnerable moments and biggest triumphs; I am forever grateful to have shared in a small portion of each of their life stories. I would also like to thank my parents for their guidance, support and encouragement as I navigated my way through my educational goals. As well, my husband, Darrel – you have provided me endless encouragement and motivation daily. To my children, Lily, Olivia and Jack – you light up my life, and are my motivation for everything I do. I hope to instill in you the drive to never give up on your dreams, believe in the power of change, develop empathy towards the most vulnerable, and always help those who need it most.
Dedication

This practicum report is dedicated to the many children, youth, adults and families that I have had the incredible privilege of serving during my career so far as a social worker. Your vulnerability, hope for change, resilience, and strength shown in even the most difficult of situations has inspired me to be the professional and human being that I am today.
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Chapter One: Introduction

This first chapter will detail the reasons that went into choosing my practicum placement and will describe the important work that Family Service Regina does within the community. It will highlight the objectives I proposed to accomplish throughout my practicum experience, provide a reflection of my experience in utilizing my chosen therapeutic approaches, and will discuss how my own ideologies and values coincided with those of the Agency I chose to work at. This chapter will also discuss the importance of using the therapeutic relationship as an agent of change, and how I was able to pull growth and learning out of the obstacles and challenges I faced while in the practicum placement.

Family Service Regina Agency

While employed as a child protection worker at the Ministry of Social Services, I was initially introduced to Family Service Regina (FSR) and the Domestic Violence Unit and made referrals for individual counselling through their counselling unit. Furthermore, as I moved into my role as a clinical caseworker at Ranch Ehrlo Society, I regularly referred clients and their family members to the various groups offered at FSR, including ‘Art for the Heart’ and the Domestic Violence Walk-in Groups. Thus, as I searched for a practicum placement, it was brought to my attention by fellow colleagues and professionals that this Agency was an excellent choice for consideration for a clinical practicum placement.

After speaking to my academic advisor, I was convinced a counselling practicum at FSR would be an incredible opportunity and would only further enhance my counselling abilities. I was first introduced to the Agency mission statement which states: “Family Service Regina strengthens individuals, families and communities through responsive leadership and innovative programs and services” (Family Service Regina, 2018, p. 2). This mission statement is one that I
connect with and believe in as a social work practitioner; by providing members of the community with an outlet for constructive support, counselling and change through the employment of social work practitioners, FSR empowers its clients to be leaders of growth in their own lives.

**Practicum Proposal**

My counselling practicum at Family Service Regina consisted of 450 hours on a full-time basis, beginning May 6, 2019 and ending August 9, 2019. During this time, I had four objectives outlined in my practicum proposal to accomplish; the first of which was to develop an advanced level of understanding and skills in the theory and use of solution-focused therapy (SFT) and cognitive behavioural therapy (CBT). These two therapeutic models will be explained in greater detail in chapter three. To work through this first objective, I was provided the opportunity to carry a clinically supervised caseload and used the counselling sessions related to my caseload to practice these aforementioned therapies/approaches. Within these sessions, I was provided consent by multiple clients to video record the sessions to be later reviewed by my professional associate and myself, in order to learn and develop insight into my practical counselling competencies.

My next identified objective for the practicum was to develop an advanced level of understanding and skills in the theory and use of mindfulness strategies, and to implement these strategies during counselling sessions with my clients. Mindfulness and how it was implemented within my practicum will be further explained in chapter three as well. I was first able to observe my professional associate utilize mindfulness strategies during an individual counselling session which I was given permission to observe. I then went on to practice these strategies with my own caseload of clients during both ongoing and walk-in counselling sessions at the Agency. As part
of this practicum placement, I also completed a literature review on mindfulness-based cognitive therapy and mindfulness-based stress reduction strategies. Many of these strategies and practices were used in my sessions with adult clients who were struggling with anxiety, depression and post-traumatic stress disorder (PTSD) symptoms. These strategies were also utilized in my practice with children, youth and teens who were experiencing trauma symptoms or were diagnosed with attention deficit hyperactivity disorder (ADHD), anxiety and/or depression. As a result, mindfulness turned out to be a strategy I was able to implement with every single client on my supervised caseload.

My third and fourth learning objectives included attending to relevant and available training opportunities during the practicum placement, and to increase my experience and competencies in working with children and families. These objectives were achieved by engaging in professional development opportunities to enhance my theoretical knowledge, understanding and skill set as a counsellor. This included the opportunity to attend a two-day training session on solution-focused therapy as well as watching a number of live webinars that focused on a variety of important topics related to working with children and families (Appendix C).

Since my previous professional experience was in the area of practice with children and families, it was also a goal of mine to work individually with adults to ensure I was stretching and growing my professional abilities. I was able to practice my counselling skills through Family Service Regina’s walk-in counselling clinic which was not only run out of the Agency’s facility, but also out of the Regina Public Library main branch, and the Mâmawêyatitân Centre.

To start, I completed a comprehensive literature review in order to seek to understand the solution-focused therapeutic approach to ensure I was providing clients with adequate support in
a brief and efficient manner. Prior to meeting with individual clients at the Agency’s walk-in counselling clinic, I was afforded the opportunity to observe two walk-in counselling sessions at the Regina Public Library prior to engaging in my own individual counselling sessions. Throughout the full duration of my practicum, I was privileged enough to meet and engage in over 40 counselling sessions with adults through the walk-in counselling clinic.

**Report Outline**

Within this report, I have included a reflection on my student counselling experience at Family Service Regina as well as an analysis of the therapeutic approaches utilized within the practicum including cognitive behavioural therapy (CBT), solution-focused therapy (SFT) and mindfulness-based practice. Along with a literature-based discussion of these therapeutic approaches, I will also include a review of the theoretical frameworks that influenced my application of these therapeutic approaches. This review will include a discussion of trauma-informed care, anti-oppressive practice and attachment theory. Case studies and different interventions that were utilized during sessions will be woven into the document to provide practical understanding of these therapeutic frameworks and approaches in action. This report will conclude with a discussion of the implications of practice on social work counsellors, along with recommendations for budding practitioners to consider in the areas of burnout prevention, self-care, and the recognition and resolution of ethical dilemmas.

**Ideologies and Values**

In choosing an agency that would suit my professional goals and personal values, I had to ensure my ideologies and values aligned with those of the agency. Family Service Regina is an Agency that adopts an anti-oppressive framework, a client-centered and family-centered approach, and acknowledges systemic barriers within the community. The Agency’s values do
not only align with my beliefs, but also correspond to the values of the Canadian Association of Social Workers’ Code of Ethics (2005) and the Saskatchewan Association of Social Workers’ Standards of Practice for Registered Social Workers in Saskatchewan (2020).

Family Service Regina: Ideologies and Values

FSR is an Agency that promotes a client-centered, trauma-informed and anti-oppressive environment. According to their mission statement, the Agency’s goal is to “strengthen individuals, families and communities through responsive leadership and innovative programs” (Family Service Regina, 2014). Family Service Regina’s mission is to support people through changes, aid them in healing from past traumas, strengthen familial and community relationships, and develop the necessary skills to meet their future goals (Englot, 2014). As a social work counselling student, I was able to observe the staff and management at FSR give focus to their clients’ individual circumstances and traumas, and believe in the power of change as they aided their clients with their counselling needs. They continually demonstrated equitable treatment regardless of ethnicity, language, age, ability, gender, sexual orientation, income, or political and religious affiliations; and appreciated the diversity everyone had to offer within all operations of the Agency (Family Service Regina, 2014). This type of client-centered practice allows practitioners at FSR to be able to adapt to meet the needs of clients as they learn about each individual’s traumas, regardless of their circumstances. Having this client-centered approach allows people who come to FSR to not feel oppressed due to their backgrounds, but rather, to be able to feel accepted and understood for who they are.

Supplementary to this, Family Service Regina further supports having an anti-oppressive environment as policies have been put into place to ensure equal opportunity is provided throughout all aspects of their operations. According to Robbins et al. (1999), it is important that
agencies take a proactive response to personal and societal forces that oppress and restrict human potential and wellbeing. In kind, FSR has designed their programs to be centered on eliminating barriers so that all members of society have the opportunity to participate and be served. Having their walk-in counselling clinics offered throughout the City and within central neighborhoods, allows for vulnerable populations to have access to these important services. They have also re-focused their office space to reflect a trauma-informed environment, including training front reception on what it means to be trauma-informed. However, while they aim to provide community acceptance to everyone who seeks services, they do acknowledge that systemic barriers (attitudinal, organizational and physical) exist within society which may prevent opportunities for many clients. Because of this, FSR strives to grow and develop their knowledge and understanding to overcome such barriers for their clients.

Family Service Regina uses a strength-based perspective as they believe in the idea that humans are strong, resilient and courageous when faced with adversity. The Agency also uses ingenuity in accessing and creating resources that will aid individuals in forming their own aspirations and definitions of their situations. FSR also recognizes the incredible role that the community has in supporting and influencing the success of an individual and understands that communities have a social responsibility to improve the welfare of its members. Inversely, when personal issues are kept private, existing issues of power and privilege and the idea that individuals are meant to struggle alone only become more reinforced (Parker, 2003). By working to enhance community awareness of mental illness and domestic violence, and by providing free counselling services through the Thrive Walk-In Counselling Program, Family Service Regina promotes a society that is open and willing to seek help rather than encouraging individuals and families to suffer in silence.
**Personal Ideologies and Values**

My personal ideologies have had an incredible impact on my practice as a clinician. At a young age, I had an intense desire to help others, but lacked the skills and knowledge to do so. When I was first employed at Ranch Ehrlo Society as a youth care worker, I began gathering and building skills to use in my interactions with vulnerable populations which allowed me to focus on the needs and personal growth of clients. Still not fully understanding the underlying values that were influencing my approaches to the work, I felt an intense desire to continue to learn and better understand how to help others.

I returned to school in 2010 to pursue my degree in social work and began understanding, through formal education, the values and principles I utilized in my previous work experiences. I began to develop knowledge of trauma-informed theory, anti-oppressive practice, and to learn how attachment plays an integral role in people’s lives. These terms will be further described in chapter two. Understanding these perspectives allowed me to fully embrace the stories of others, and to advocate, collaborate, and work alongside individuals to provide them with the support they needed throughout their journeys of change.

After obtaining my Bachelor’s degree in social work, I began working as a child protection worker with the Ministry of Social Services. In this role, it was imperative that I be clear that the well-being of children was my responsibility, as the job entailed protecting children from physical, sexual, verbal, emotional or psychological abuse. At the Ministry, I worked cooperatively with parents to help ensure children stayed in their homes; however, I often found myself in a position of power as I had to show up unexpectedly for home check-ups, perform unannounced visits at schools, and ask very personal questions to decipher whether a child was at risk. As I worked in this position, I found myself feeling as though I was not supporting
families as I had previously when I worked at Ranch Ehrlo but, instead, was managing crises and reacting to events that often led to children being removed from their homes. I began to understand that child protection was a reactive approach to social issues instead of an approach that proactively focuses on clients’ needs to change their situations for the better. With over 30 different families to see on a monthly basis, my time at the Ministry seemed to be spent diffusing explosive family circumstances, investigating concerns and interrogating families based on information provided by secondary sources. I found I was no longer a collaborator, nor a support person involved in the needs of a client, but instead, an authority figure left in charge to try to resolve unrelenting, often volatile, family situations.

The job duties I had to perform while working at the Ministry of Social Services allowed me to change my views and start to look at the ideologies and values that are supposed to inform the field of social work: the importance of attachment history with family, the impact of a child’s move to multiple placements throughout life, developmental milestones missed due to trauma or neglect, intergenerational and epigenetic impacts of colonization, stress within relationships, lack of support, and the disparaging of mental health in our society. All of these factors play a role in a person’s outlook and relate to how a social work practitioner should take care in understanding the situations of their clients in order to collaboratively work with them to overcome the barriers/problems each one faces. I began looking at broader systemic oppressive structures that existed within each individual’s life, how their trauma and attachment history played a role in their personal capacities, and took the time to truly listen to personal stories without any judgment or preconceived notions. When problems became externalized, I was able to identify other systemic oppressions that may have been contributing to their struggles (Long & Young, 2007). The focus shifted to the problem and how to work to find a solution, as opposed to
reacting to the events taking place in the person’s life.

As I moved into the role of being a clinical caseworker at Ranch Ehrlo Society, I experienced a remarkable change in my attitude, ideologies and values. I began to fully identify and align myself with the Canadian Association of Social Workers’ Code of Ethics in believing that all individuals were deserving of “inherent dignity and individual worth” (CASW, 2005, p. 4). I also developed understanding in the areas of trauma, attachment and oppression. Every story that was shared with me, and every moment of triumph and tribulation, showed me the resilience that each person is capable of. Every individual, at their own pace and rate, has the tools within themselves to facilitate change and healing.

**Personal Ideologies and Therapeutic Approaches**

Cognitive behavioural therapy (CBT), solution-focused therapy (SFT) and mindfulness were counselling approaches that I chose to focus on in my social work practicum. These approaches appeared to be appropriate strategies based on their client-centeredness and an anti-oppressive lens. These approaches treat each individual as the expert in their lives, view them through a strength-based perspective, and adhere to the notion that individuals have the capacity for change. In my role as a student counsellor at Family Service Regina I was able to fully embrace and witness how change can help a person and their healing when a safe space is provided. Bloom (1997) suggested that instead of taking the approach ‘what’s wrong with you?’, we need to ask, ‘what happened to you?’ and ‘how can we help?’. Shifting to this paradigm has allowed me to connect with people on a level that fully embraces the client’s story. There is an immense privilege in being close to people as they experience growth from traumatic circumstances, and being able to provide those individuals with a compassionate, trusting relationship to allow for change.
Believing is Healing

As a student counsellor at Family Service Regina, I often received referrals from the Ministry of Social Services or from concerned parents, wanting me to do “something” to “fix” a client within a certain timeframe. This left me with an anxious feeling of having to embrace the most popular evidence-based practice or formulate a six-session therapeutic plan to fast-track the healing of yet another client who needed to be “fixed.” What I subsequently learned is that when we rush towards different innovative, therapeutic approaches as one-solution quick fixes, we can lose an understanding and closeness in the relationships with our clients. In doing so, we no longer look at them as clients with their own individual needs to be met, but rather as a statistic in our caseload.

For example, when I was working with a client who struggled with anxiety, I theorized that cognitive behavioural therapy (CBT), a highly useful and proven approach, would be the most effective therapeutic intervention to utilize. However, after multiple sessions of trying to implement relevant strategies, I hit a roadblock and our therapeutic relationship suffered despite my best efforts to utilize CBT. After self-reflection and discussion with my professional associate, I realized that the healing that takes place during a session is not dependent on the strategies or operative ingredients used, but rather is based on the interactions which exist moment-to-moment between the counsellor and client. Being present with the client in their pain, believing their story and understanding their anxiety, provided a far more essential and meaningful intervention than just providing a quick fix of educating the client on CBT and its strategies.

What I have also learned during my time as a clinician and student counsellor is that all human beings seem to have an intense desire to be understood by someone else. This connection
allows an individual to not feel alone in their pain and suffering, and validates their feelings. No matter what we bring to the session in our skills, knowledge, insights, and interpretations as practitioners, if the client feels that we do not believe in their ability to change, then hope for change in their lives can feel far away and healing often becomes stunted. According to Kottler (2017), one of the major elements of healing takes place when hope is instilled among those who feel only despair. As practitioners, it is pertinent to provide clients with an environment that allows for understanding and hope so that the healing process is facilitated. Simply throwing a strategy at a client as a “quick fix” does not help; practitioners need to be present and empathetic listeners who incorporate meaningful strategies based on their understanding of an individual and their needs.

Family Service Regina has no doubt played an instrumental role in my development as a counsellor. Focusing on solution-focused therapy and cognitive behavioural therapy throughout my practicum, and incorporating mindfulness strategies, provided me with opportunities to develop my skillset and implement strategies that not only aided in my personal clinical growth, but also benefited my clients. Having the ideologies and values of FSR align so closely to my own personal beliefs, allowed for a seamless transition into the role as a student counsellor at the Agency. This student counselling experience gave me the opportunity to connect to parts of myself that I had been afraid to previously acknowledge as a clinician. The following chapter will outline how my chosen theoretical perspectives influenced my practicum experience.
Chapter Two: Theory

This chapter will focus on the trauma-informed perspective, anti-oppressive work, and attachment theory. Discussion will include an examination of how these theoretical perspectives guided the interventions and therapeutic methods utilized during my clinical practicum.

Theories are an essential component in social work practice as they aid a clinician in their approaches with individuals, groups, communities and society. A theory can help a clinician predict, explain and assess different situations and behaviours exhibited by their clients (Lundy, 2008). By expanding our practice to include multiple models of practice or theory, a deeper understanding of a client’s world, including their strengths, limitations and their familial and interpersonal relationships, is facilitated (Lundy, 2008). Integrating multiple approaches based on a variety of theoretical perspectives and models, such as creating a safe environment, supporting a client’s self-determination, and using a bio-psycho-social conceptualization, helps one to develop a comprehensive understanding of clients and assess multiple situations and experiences that may influence their behaviours (Lundy, 2008). By understanding theoretical perspectives, clinicians are provided with rationale for how to intervene and respond to clients whose behaviours are driven by their histories or by their future vision (Lundy, 2008). Clinicians have an ethical and professional responsibility to have knowledge about established and researched theories that are grounded in social work values.

Trauma-Informed Perspective

An integral part of social work practice involves utilizing theories and implementing the most appropriate and effective methods for clients in their lives/situations. Throughout the duration of my counselling experience at Family Service Regina (FSR), I often utilized a trauma-informed perspective and approach when working with clients as this method effectively applied
to many of my clients’ situations. Being trauma-informed, and trauma-focused in general, requires a clinician to first have a comprehensive understanding of trauma and how it impacts individuals, families, communities and generations (Knight, 2015). It also requires a clinician to consider how safe the client feels, whether they are receiving community, familial or peer support, and whether they are experiencing any gender, cultural or historical issues. It also requires that the clinician create a space that is trustworthy, honest, transparent, and collaborative; and one which provides the client with a voice and autonomy over their life. This approach focuses on the question: "What do you need to support your development and recovery?" (DeCandia & Guarino, 2015). Framed in this way, this ultimately will help to reduce shame attached to trauma and shifts the blame and responsibility away from being squarely focused on the individual.

The Impact of Trauma

When a human being is confronted with an emotional, psychological or physiological threat, they often find it difficult to adapt and, in turn, trauma develops (Canadian Centre on Substance Abuse and Addiction, 2014). Trauma itself is described as a wound that injures us emotionally, psychologically, physiologically and spiritually (Canadian Centre on Substance Abuse and Addiction, 2014). Unlike the typical stresses of our daily lives, trauma occurs when a person experiences an event that is perceived as overwhelming, possibly life-threatening, terrifying or horrifying, and which leaves them feeling vulnerable (Bloom & Farragher, 2013). Trauma will develop under various circumstances and it is important to consider that something which may be seen as a typical stress for one person may not be considered typical when experienced by another person. In other words, something that may be typical for one individual, may be experienced as traumatic by another individual.
Under trauma-inducing circumstances, the primitive fight, flight or freeze responses can take over the body, shifting the balance of our brain activity to subcortical areas to heighten our senses and prepare for threats (Courtois, 2008). In most cases, these primitive responses have survival value; however, when an individual is exposed to chronic or pervasive threatening situations, their system becomes oversensitive and often produces dysfunctional symptoms which manifest in the individual’s behaviours (Perry & Szalavitz, 2006). Even a few minutes of a stressful experience that has occurred early on in life, can change a person's stress response and behaviours forever (Levine, 2010). Under these circumstances, the fight, flight or freeze responses – all of which have survival value – are utilized unsuccessfully and the individual is unable to resist or escape the danger (Courtois, 2008). These circumstances can either occur as a single experience or as enduring, repeated experiences that upset the individual's ability to cope or come to terms with the ideas and emotions which are part of that experience (Klinic Community Health Centre, 2013). How an individual is impacted depends on the individual themselves. High levels of stress during a person’s early and formative years activates the stress response and the individual can stay in a permanent state of arousal even when there is no threat in their present reality.

A person is susceptible to trauma when they are exposed to actual or threatened death, injury or sexual violence through direct exposure, direct witnessing or indirect exposure by learning of a threat or injury to a loved one, or perhaps by being exposed to threatening and traumatic details over time (Canadian Centre on Substance Abuse and Addiction, 2014). It is important to note that trauma is not the event that occurs, but rather, the reaction to how the event is perceived by an individual within their own nervous system (Canadian Centre on Substance Abuse and Addiction, 2014). Since everyone is their own individual and thinks, feels
and perceives reality in their own way, how they react to an event dictates the severity of trauma to be experienced. Events such as poverty, racism, neglect, family discord and drug exposure can further create vulnerability to stressful situations.

For example, several people may experience the same car accident; however, the incident will impact everyone to a different degree. How each individual is impacted by such an event has a lot to do with their developmental history. It has been shown that many individuals, especially those who have naturally-effective coping styles and/or strong support systems, are resilient to even the most traumatic events (Cohen et al., 2012). Be that as it may, research also shows that those who have experienced childhood trauma are more likely to develop maladaptive emotional and behavioural reactions to common events which disrupts their psychosocial adjustment (Cohen et al., 2012). When young children are exposed to stress that is beyond their young systems’ capacity to carry, their system becomes overloaded and the result can create incredible dysfunction in their lives.

**Trauma-Informed Care**

Harris and Fallot (2006) discussed the idea of trauma-informed care quite early in the development of this area of practice. Since then, significant effort has been made to define and clarify a trauma-informed approach and incorporate this framework into policies, practices, and workforce development in the field of social work. Hopper et al. (2010) define trauma-informed care as a strengths-based framework that is grounded in an understanding of, and responsiveness to, the impact of trauma. There is an emphasis on physical, psychological, and emotional safety for both the providers and survivors (Hopper et al., 2010). In providing this safe space, there are opportunities for survivors to rebuild a sense of control, autonomy and empowerment over their lives (Hopper et al., 2010). If the trauma and its effects in a survivor's life are focused on and
given importance, it becomes easier for care providers to identify a successful approach to support provision which allows the client to grow psychologically and emotionally.

According to the CASW Code of Ethics (2005), the social work profession has an important “interest in the needs and empowerment of people who are vulnerable, oppressed, and/or living in poverty” (p. 3). There is an emphasis on counselling services and an understanding that when they are successful, they help clients build strong relationships, heal from trauma and improve their ability to meet the challenges life may bring (CASW, 2005). Many of the individuals who attend Family Service Regina for support and services, are those who have been labelled as vulnerable and oppressed due to the trauma and experiences they have been exposed to. As such, FSR’s approach is to focus their services and facility locations on those populations.

Initially, a first counselling session is often the most important for the individual as it tends to cause the greatest anxiety for clients, and therefore, it becomes important for counsellors to create an environment where clients feel safe to comfortably share their traumas (Yalom, 2002). However, what I learned throughout my practicum was that although someone may have experienced a lifetime of trauma, they may not feel comfortable nor ready to share that story with their counsellor during their first session (Knight, 2015). As counsellors meet with their clients, they make decisions about what problems need to be addressed and what interventions to attempt, and therefore, use assessments in different aspects of the counselling session.

Assessments are used across all counselling settings in a variety of ways and are an integral part of the clinical interview (Cohen & Swerdlik, 2002). Although an experienced counsellor may know not to ask invasive questions during the first session and instead may make those assessments as they move through the counselling process, a new or student counsellor who does not have years of experience may feel inclined to ask such intrusive questions for the sake of
filling out a form. Having the tools to assist new counsellors in asking appropriate questions during initial and subsequent sessions, is essential when training clinicians to practice using a trauma-informed approach.

Family Service Regina has committed to implementing a trauma-informed approach in all aspects of their work with clients, families and communities. Their approach to becoming trauma-informed includes focusing on the initial contact which reception staff have with clients, the waiting area clients sit in, and the initial self-assessment form clients complete upon attending for services. However, while FSR focuses on creating a trauma-informed counselling environment, my observation of their use of assessment forms during my practicum seemed to go against the essence of what a trauma-informed approach aims to do. Near the end of my practicum, I was provided the opportunity to work on a project that centered on reviewing the sensitivity of the assessment checklist completed by counsellors during the first session with a client. While at FSR, I often questioned the sensitivity of these initial assessments and whether they could be re-worded in a way that embodied trauma-informed care and solution-focused language. For example, including questions on the initial assessment form that inquired about whether a history of family violence or traumatic events had occurred can be overwhelming to clients who had no intention of sharing that information during their first session. The initial work that I completed in drafting a revision to the initial assessment form completed by clients attending to counselling will hopefully assist the Agency in moving towards using language within their assessment forms that is more trauma-informed, strength-based and solution-focused.
Anti-Oppressive Approach

Iris Marion Young (1990) explains that oppression can be understood as the vast and deep injustices that some groups suffer as a consequence of often unconscious assumptions and reactions of well-meaning people in ordinary interactions, media, and cultural stereotypes; and are structural features of bureaucratic hierarchies and market mechanisms. Counsellors who practice using an anti-oppressive lens believe that all individuals should be regarded with the same equality and compassion as everyone else (Young, 1990). However, as Young (1990) points out, oppression is not always overt, and social workers must be knowledgeable and have insight into how social structures operate in everyday life as well as how to visualize and work against such injustices that exist within these structures. Family Service Regina strives to be inclusive of all individuals regardless of their race, age, sex or religious affiliation; the Agency embodies an anti-oppressive approach throughout all of its programming by offering the same care and attention to everyone who attends to seek their services.

Allan et al. (2003) state that one common principle of engaging in anti-oppressive social work practice includes a commitment to the transformation of processes that perpetuate exploitation. Social workers need to be aware of the circumstances and situations that cause oppression in a client’s life and work with them to help change those realities. As advocates for social change, it is important for practitioners to remember that social work practice is not determined by the organizational context in which they work, but by the community and the reality their clients are a part of (Allan et al., 2003). If social workers experience an environment as being hostile or uncomfortable, then part of their work responsibility is to change that environment for their clients.
Another common principle within anti-oppressive social work practice is the importance of working alongside the populations that are oppressed (Allan et al., 2003). When a practitioner accompanies an individual on their journey of transformation, they need to challenge oppression and barriers, advocate for the mental and physical well-being of the individual, provide education and resources, create contexts of support, and provide planning, empowerment and motivation to follow through with creating change in the individual’s life (Finn & Jacobson, 2008). Social work practitioners must take on a lot of responsibility and develop relevant understanding in order to properly aid a client in their journey of change.

During my practicum, I was able to witness the use of anti-oppressive practice when I attended the domestic violence support group held at Family Service Regina. This group serves to meet the needs of oppressed and marginalized women and men who have suffered intimate partner and/or family violence. If there was ever a group that epitomizes a trauma-informed, anti-oppressive and client-centered lens, it would be this group. Finn and Jacobson (2008) speak of engagement as being one of the main factors that go into being an anti-oppressive practitioner. This includes interpersonal communication, anticipatory empathy, observation, noticing and bearing witness to pain/trauma, body consciousness, listening, open dialogue, understanding and respecting resistance, group work, education, and honoring differences (Finn & Jacobson, 2008). The facilitator of this support group did just that by thoughtfully and respectfully giving each attendee space to feel strength and autonomy as they shared their experiences.

The facilitator of the group also spoke intently about trusting one’s own “gut instincts” and allowed people to come as they were, and to share stories as messy as they may be; with no intent to fix or solve, but to support and acknowledge without judgment or criticism. One takeaway I gained from watching the facilitator in action was that each person learns and grows
at their own pace, and that each person’s journey looks different from the journey of others. The only person who can determine what the best decision will be is the person who is experiencing it. Therefore, the individual’s perspectives, thoughts, feelings and interpretations of their situations and traumas cannot afford to be oppressed or cast aside; focus must be given to each individual and their story. Anti-oppressive social work practice theorizes “that a better social world is possible, and that the achievement of a better social world requires a qualitative change in current social relations” (Hick & Pozzuto, 2005, p. xi). It is the role of a social worker to engage in the difficult, creative and rewarding work of assisting others in imagining and then building a better social world for themselves.

Although, Family Service Regina does not have a specific policy regarding anti-oppressive practice there is a policy that identifies a commitment to equality of services regardless of ethnicity, language, race, age, ability, gender, sexual orientation, income, and political or religious affiliation (Family Service Regina, 2014). These anti-oppressive perspectives are evident in the Agency’s floating fee structure through the provision of free Thrive Walk-in counselling sessions, and the nominal fee for follow-up sessions that is based on a sliding scale in accordance to the client’s income. By providing these options, the Agency ensures that counselling services and supports are accessible to all members of the community, regardless of their ability to pay for such services.

**Attachment Theory**

When I began to read, comprehend and eventually implement cognitive behavioural therapy (CBT) and solution-focused therapy (SFT) during my counselling practicum, I noticed that integrating attachment theory as a fundamental cornerstone was essential to my developing practice. The need for every human being to feel safe and connected to another person is
fundamental to attachment theory (Johnson, 2013). Bowlby (1988) conceptualized attachment as being essential throughout a person’s life span. His work considered the tendency for humans to form attachment relationships as representing survival value (Bowlby, 1988). He talked about the attachment behavioral system as being a biologically based system oriented toward seeking protection and maintaining proximity to an attachment figure in response to a real or perceived threat (Muller, 2011). By forming attachments, humans are able to survive their realities; however, not all attachments are facilitating of positive growth and development in an individual’s life.

Theories, in general, assist social workers in understanding, explaining or making sense of situations or behaviours, and provide insight into what might have occurred in the past, or what might occur in the future (Bowlby, 1988). As clinicians working with clients, we often build our interventions around how clients have interacted in relationships throughout their lives (Johnson, 2013). In the 1980’s attachment theory branched out and the focus shifted to include looking at attachment styles from childhood and how they relate to attachment styles in adult relationships (Perry & Szalavitz, 2006). Children who did not receive consistent, physical affection or the chance to build loving bonds, simply do not receive the patterned and repetitive stimulation necessary to properly build the systems in the brain that connect reward, pleasure, and human to human interactions (Perry & Szalavitz, 2006). In other words, if an individual does not build positive, loving attachments early on in life, they may become emotionally distant as adults.

Scholars suggest that treatment for traumatized children must start by creating an atmosphere of safety and by providing predictable and respectful relationships for the child (Perry & Szalavitz, 2006). According to Bowlby (1988), clients can change the way their
attachment system functions by using the counsellor as a secure base for exploring past and present attachment-related memories, feelings or interactions. He suggests that when clients can examine these experiences, they form meaning around their behaviours and gain perspective on negative attachment experiences (Bowlby, 1988). This connection appears to reveal predictable patterns based on childhood experiences and in turn often provides insight into managing distressing attachment interactions as an adult (Johnson, 2013). Therefore, even though a child may have developed negative attachments early on, given the right support, understanding and insight, the possibility of developing more productive attachment styles, approaches that are positive and loving, can result in more healthy attachment relations in the future.

Clinicians can often help clients look at the attachment styles they have been exposed to as children, and how they relate to their attachment styles in their adult relationships. When we help our clients recognize these patterns of behaviours, it aids them in developing an understanding behind the driving forces of their behaviours. When we consider attachment theory and that our emotional well-being is connected to relationships in our life, we begin to develop an empathetic understanding of our choices and behaviours and understand more about how we adapt to relationships and different life experiences (Johnson, 2013).

While cognitive behavioural therapy (CBT) and solution-focused therapy (SFT) were my chosen therapeutic approaches for this practicum, Bowlby (1988) states that the most important element of practice should be to ensure that the therapist acts as a secure base during the therapeutic process. Because most clients display symptoms of disorganized or insecure attachments, therapists have the important role of aiding these individuals in exploring their world, and reframing their internal dialogue (Bowlby, 1988). Regardless of the type of therapy an individual is engaged in, Bowlby argued that many clients will still display symptoms of
disorganized or insecure attachment (Bowlby, 1988). Thus, therapists can serve as a secure base from which the individual explores the world and begins to reframe their internal dialogue and the way they relate to others (Holden, 2009). To play a small part in the healing journey of another human being is an opportunity that I did not, and still do not, take lightly. Creating an atmosphere in which another human being can feel safe enough to explore their world and rebuild secure attachments is an incredible privilege.

Just as theory acts as a driving force behind how we understand our clients, therapeutic models provide us with strategies to implement when we are engaging with our clients. When we can begin to understand how our client’s story has shaped their worldview, we can better predict how our models of practice will fit into their healing journey. Our understanding helps to shape our intervention. The following chapter will outline the therapeutic models that I chose to focus on throughout the duration of my counselling practicum.
Chapter Three: Therapy Models

As has been argued in the previous chapter, *theory* is what informs the practitioner on how to interact with and understand their clients. However, theory also gives body to the development of a therapeutic model to help address a client’s needs and allow them to grow from their traumas or circumstances. This chapter will outline the two chosen therapeutic models I focused on throughout my practicum – cognitive behavioural therapy (CBT) and solution-focused therapy (SFT); and will explore the reasons why these methods were chosen. I will also weave into this chapter a discussion on the use of mindfulness practice and how this was implemented during the therapy sessions I was a part of as a student practitioner.

**Cognitive Behavioural Therapy (CBT)**

Cognitive behavioural therapy (CBT) is based on the cognitive model which proposes that people’s behaviors, emotions and physiology are influenced by their perception of events (Beck, 2011). When people learn how to evaluate their thinking in a more realistic and adaptive way, they begin to experience enhancement in their emotional state and outward behaviours (Beck, 2011). CBT can also be an effective therapeutic strategy used for individuals who have experienced a variety of life stressors or traumas (Beck, 2011). These experiences and stressors can vary considerably in quality, frequency, intensity, and impact, but all are still important in defining an individual’s behaviour (Beck, 2011). Because of these reasons, I chose to implement CBT as it appeared to fit with every age and every population due its adaptable and flexible strategies (Beck, 2011).

CBT is widely accepted and utilized in the clinical field as it is one of the most researched forms of treatment for depression and anxiety (Sudak, 2012). It is one of the most commonly used psychotherapeutic approaches amongst social work professionals, not only
“because it is proven to reduce people’s suffering quickly and move them towards a state of remission, but because it helps them stay well” (Beck, 2011, p. 8). Furthermore, CBT has been found to be applicable to a variety of individuals regardless of their education level, income, culture, or age and has been implemented in a variety of contexts including schools, medical offices, and prisons (Beck, 2011). Throughout my clinical practicum, CBT was therefore often utilized as a treatment strategy with different clients, including children, adolescents, teenagers and adults who had experienced traumatic life events because of its applicability to many different situations and individuals, and its effectiveness as a therapy model.

Cognitive behavioural therapy is an approach that is proven to be highly successful in treating both anxiety and depression (Beck, 2011). The focus of CBT is to help develop realistic thoughts in order to minimize the experience of upsetting emotions (Beck, 2011). By helping clients develop a deeper understanding of themselves, their world and the other people that surround them, there is often a lasting improvement in their moods and behaviours (Beck, 2011). When clients begin to identify and evaluate their negative thought processes and how they view their world and their future, they begin to see solutions to the problems in their lives and, therefore, show improvement in behaviour and emotion.

Many of the clients that utilized the walk-in counselling clinic at Family Service Regina (FSR), along with ongoing counselling services, struggled with symptoms of anxiety and depression. During individual sessions with clients, I was able to utilize multiple CBT techniques, including thought challenging, mood logs, stressors and strengths identifiers, feeling identification, thinking traps, understanding reactions, probability, thought records and psychoeducation on cognitive distortions. Case examples of how CBT was implemented during individual sessions will be described in detail in chapter five.
Mindfulness Practice in Cognitive Behavioural Therapy (CBT)

As noted previously in this document, utilizing mindfulness practice was a learning objective included in my practicum proposal, and it is an approach I chose to focus on in sessions where I utilized CBT. The integration of mindfulness practice into CBT teaches clients how to relate to emotional pain in a different way. When an individual can acknowledge and accept their pain and suffering, they are able to move through the emotions that are uncovered during this process in a much more manageable way (Cayoun, 2015). When the client becomes aware of their entire body and how their body reacts to the different thoughts they are experiencing, they are able to acknowledge this and begin the process of healing through self-compassion and the changing of their thought patterns (Cayoun, 2015). Mindfulness approaches are understood to result in improved self-regulation which emerges from increased acceptance of feelings and self-awareness (Segal et al., 2002). When engaging in a mindful attentional stance, a person becomes more focused and present in the here-and-now, allowing for their dorsal and regulatory systems to take affect and decrease emotional reactivity (Segal et al., 2002).

Oli Doyle (2014) explains that “it is not what happens to us that causes our suffering [but that] our suffering is caused by believing the stories our minds tell us about what happened to us” (p. 6). Just as CBT teaches clients how to challenge their thought distortions, mindfulness aids us in focusing our mind on the present moment and to move away from painful thoughts and memories. When we become more aware and focused on the present moment, our past experiences and worries lose their power because the stories that we tell ourselves about events can no longer be substantiated (Doyle, 2014). As I practiced mindfulness during individual sessions, I noticed that I began to pay attention to my thoughts without getting lost in them. This was an incredible asset as I was able to be fully present for the client and their story.
Solution-Focused Therapy (SFT)

The second therapeutic approach I applied during my counselling practicum was solution-focused therapy (SFT). I chose to focus on SFT as it differs from other traditional treatment strategies which typically center on exploring problematic feelings, behaviours and/or interactions, as well as distorted cognitions and how to interpret and confront these circumstances (Corey, 1985). In contrast, SFT aims at helping clients develop a desired vision of the future, wherein the problem does not exist, and it explores and amplifies the client’s strengths and resources to co-construct a trajectory of future solutions that can be applied to their reality (Trepper et al., 2014). The objective thus becomes having the client take the lead in defining the nature of their problem-solving abilities and learning how each of their identified resources would be useful in bettering their situations (Trepper et al., 2014). As such, the client is aided by the practitioner in identifying goals, strategies, strengths, and other internal and external resources to facilitate growth.

Although solution-focused brief therapy (SFBT) is used in a majority of walk-in counselling centres, I chose to focus on the solution-focused aspect of the therapy, rather than the notion of it being brief. Many of the clients that I saw on an ongoing basis, benefited from the solution-focused questions and techniques, and therefore, solution-focused therapy was utilized during both walk-in and ongoing sessions. One major component of my counselling practicum was to offer individuals solution-focused therapy at walk-in clinics every Tuesday and Thursday at Family Service Regina, the Regina Public Library and the Mâmawêyatitân Centre which is a community facility that brings people together to connect, learn, play, develop skills, and celebrate culture; including the library space, a school, as well as a number of other organizations. In using this approach, I was able to see the incredible impact a one-hour session
can have on a person’s ability to reframe their current struggles, focus on their strengths and
times of success, develop hope, and plan for their future. SFT emphasizes understanding how the
client views their current concern or situation, and focuses on what the client wants to see
differently (Trepper et al., 2014). In this respect, it is an approach that is entirely client-centered
and anti-oppressive in that it embraces the characteristics in clinicians that are empathetic and
understanding, naturally supportive, positive, open-minded, flexible, and solution-oriented
(Trepper et al., 2014). Due to these many characteristics that solution-focused therapy requires
from its clinicians, this approach fits well with my personal values and ideologies.

**Mindfulness Practice in Solution-Focused Therapy (SFT)**

John Kabat-Zinn, the foremost pioneer in the therapeutic application of mindfulness,
defines the approach as awareness that emerges when we pay attention, on purpose, in the
present moment, and without judgement to each experience moment-to-moment (Kabat-Zinn,
1994). SFT emphasizes people’s internal resources and resilience and how these can be used in
the pursuit of powerful, positive change. It embodies a style of thinking that rejects excessive
focus on problems and their causes, and focuses instead on identifying goals and using unnoticed
resources or pathways to achieve those goals. When we embody a solution-focused style of
thinking, it can be expected that we associate this with well-being and positive affect since we
are seeing the potential the future has to offer us as we aim to achieve our goals.

When we reflect on our goals and how we can obtain those goals, we begin to feel a
sense of self-efficacy and our overall ability to succeed (Bandura, 1995). The more we explore
our capabilities in achieving our goals, the more hope we feel in being successful. When we
focus on solutions it brings us into an awareness of the here-and-now, instead of making the
solutions to problems far-reaching and out-of-scope for the present time. Furthermore, research
indicates that the healing mechanisms behind successful therapy are not about trying to uproot negative experiences, but instead is the process of establishing a new relationship or perspective with our thoughts and feelings that makes a difference (Germer, 2009). In other words, SFT has proven to be an effective therapy model as the approach focuses on solutions to our traumas and how we understand those traumas instead of just casting them aside. We become less avoidant and entangled, and more accepting, compassionate, and aware as we lean into our troubles with understanding and compassion.

Mindfulness also encourages the clinician to fully accept the story of someone else, thus providing the client with a space that is safe and which acknowledges their pain and suffering (Germer, 2009). With the addition of mindfulness in the application of SFT, the practice allows people to experience their sensations, feelings, and thoughts, just as they are, moment-to-moment, without fear of judgment or retribution. When I incorporated mindfulness into my SFT sessions, it allowed me to be fully present with a client when they retold their painful story. When I was able to be present in the midst of a client’s suffering, and acknowledge the depth of their struggles, I could feel their hearts softening for themselves as they re-discovered empathy for their own circumstances. This brought forth the client’s desire to want to care for their inner self.

By being a naturally empathetic person, I found this to be an incredible strength during my sessions with clients. I was able to recognize when someone was in pain, abandon any fear associated with that pain, and allow a natural feeling of kindness and compassion to flow towards that individual. I allowed myself to become vulnerable with my clients, fully accepting their pain and my own reactions to their pain. I was able to see that when a client recognized my empathetic and compassionate response to their story, this elicited self-compassion for their own
story in that they became more inclined to allow themselves to see past their pain and look into solutions for the sake of their own emotional healing.

**Comparing and Contrasting CBT and SFT**

Just as cognitive behavioural therapy and solution-focused therapy are different, similarities also exist between the two. For example, both therapeutic approaches focus on cognitions and behaviours as they relate to the client’s presenting issue. Although both CBT and SFT have a great deal to offer the field of clinical practice, each approach is actually very different. One of the most significant differences between the two is that CBT views clients as having unhealthy or faulty cognitions which lead to problematic behaviours (Beck et al., 1979). Whereas, SFT does not try to find or describe faulty thinking, but instead attempts to help clients identify and recognize their own capacity for change and articulate the details of their desired future (Trepper et al., 2014). While one approach centers on the fact that an individual has flaws in their perceptions, the other focuses on an individual’s potential to re-create their own perspective.

Based on these two different assumptions, clinicians may deliver each of these therapeutic approaches in different ways. CBT therapists may be inclined to take on an expert stance and challenge different cognitions, whereas the SFT therapist takes on an unknowing stance, asking questions to elicit a client’s own resources and identify exceptions to their problems (Anderson, 1997). SFT believes that there is no need to describe in great detail the current problem but instead, focus is placed on determining a reasonable plan to address that problem or situation. Using CBT, a person may be asked to dive into these unhelpful cognitions so that they may begin to understand where they are coming from.
Unlike CBT, solution-focused thinking has emerged from a postmodern, social constructivist approach, which is concerned with how individuals and families view solutions to their problems (Sharf, 2012). There is less focus on why or how the problem arose, but rather an interest in possible solutions (Sharf, 2012). CBT on the other hand, specializes in multiple orientations and approaches, such as behaviour therapy, cognitive therapy, dialectical behaviour therapy, rational emotive behaviour therapy, and mindfulness-based cognitive therapy – each with its own theory of behaviour (Kuehlwein, 1993). Due to this multitude of orientations and approaches, there is potential for a heterogeneous practice, meaning that, depending on the therapist, each therapeutic approach and delivery method may look very different (Kuehlwein, 1993). In contrast, Steve de Shazer, the creator of solution-focused therapy, tailored the approach to have distinct interventions, using a particular set of communication skills that enables SFT therapists to deliver therapy in a homogenous, similar and sequenced manner (de Shazer, 1988). In other words, while CBT draws on many perspectives, SFT is more regimented and uniform in terms of how the approach should unfold when put it into practice.

Another major difference between the two models is the polarity that exists between solution building in SFT and problem solving in CBT. In cognitive behavioural therapy, the therapist seeks to identify problems and then develop a “best response” collaboratively with their clients to fit the situation. This approach enables clients to be able to select the most effective response to their problem (Beck et al., 1979). When problem solving, therapists will look for the best solution for the presenting problem and seek the client’s response. In contrast, solution building in solution-focused therapy involves generating ideas of how things could be better in the future, despite the presence of the current problem (de Shazer et al., 1986). In other words, the emphasis is on how the client could be doing something different in order to feel more
satisfied with their life. Eliminating the problem is not the goal but, instead, the goal is to
reconstruct the client’s idea of what their future looks like, despite the present circumstances (de
Shazer et al., 1986). Although each model’s aim is to move away from the problem at hand, CBT
and SFT accomplish this intent very differently.

Despite the many differences in therapeutic approaches, both CBT and SFT have
similarities. Both can be brief, as they deal with the presenting topic rather than aiming to alter
the personality of the client. They also both use similar techniques such as goal setting, scaling
questions and providing homework to clients. When used together, there is an opportunity to
gather information about specific problematic thoughts and/or behaviours as well as asking
questions to introduce new possibilities and construct new meanings for troubling thoughts or
behaviours (de Shazer, 1988). I found that my best therapy came when I incorporated elements
of both therapies into each individual session. The next chapter will discuss how the
aforementioned therapeutic strategies were used to aid in the achievement of my goals and
objectives that I had outlined in my practicum proposal.
Chapter Four: Objectives and Goals

This chapter will discuss the objectives outlined in my practicum proposal, and how each objective was achieved within the practicum by discussing the activities that were associated with each. For my practicum proposal there were four main learning objectives identified: 1) to develop an advanced level of understanding and skill in solution-focused therapy (SFT) and cognitive behavioural therapy (CBT), 2) to develop an advanced level of understanding and skill in mindfulness strategies, 3) to attend relevant training opportunities and workshops as they became available during the time of the practicum placement and, 4) to increase my experience and competence in working with children and families.

Goal One

Developing an advanced level of understanding and skill in the use of, and theory behind, SFT and CBT was achieved through several different specific activities. Each of those activities will be discussed in the subsections below.

Activity One

My first activity was to complete a literature review of both solution-focused therapy and cognitive behavioural therapy as therapeutic approaches. There is a considerable amount of literature available on SFT and CBT, making it difficult to determine which information to review and study. Choosing which published books, articles and literature to focus on and help to inform my practice at Family Service Regina, as well as my report, was important. Therefore, I centered my attention on research that was evidenced-based, had historical provenance and was objective. Keywords that I implemented throughout my search included trauma-focused cognitive behavioural therapy (TF-CBT); SFT; SFT with ongoing clients; integrating SFT and
CBT with mindfulness practice; CBT and SFT with children and youth; CBT and SFT with adults; SFT with couples; and creative outlets with CBT and SFT.

I utilized the University of Regina’s online library to conduct my searches, as this provided me with accessibility to published journals, peer-reviewed articles and full online texts. I also focused on including recent publication dates to ensure I was reviewing the most up to date, published information. Furthermore, since there is a countless number of journal articles centered on cognitive behavioural therapy and solution-focused therapy, I focused my attention on a number of specific and recognized academic journals including: *Behavior Therapy Journal, Canadian Journal of Psychiatry, Child Abuse and Neglect, Journal of Mental Health Counselling, and Clinical Psychology Review*.

**Activity Two**

My second activity was to observe counselling sessions led by my professional associate and other counsellors within Family Service Regina (FSR). During these sessions, I was able to observe the use of a variety of approaches and skills that my professional associate utilized with their clients, including narrative therapy, CBT, and SFT techniques. My professional associate had a holistic way of being present with the client during the telling of their story and had a gentle way of navigating the client in different directions. During one session, my professional associate provided me the opportunity to participate and ask questions of the client. This allowed for a constructive transition for myself into the world of sessions with clients which provided the opportunity to interject my thoughts into the conversation in a helpful manner that left the client feeling heard and supported by two professionals.

Providing walk-in, solution-focused brief therapy counselling was a major focal point of my practicum placement. Prior to meeting with clients individually, I was able to act as an
observer and co-therapist with another counsellor at FSR during two walk-in counselling sessions. During these sessions, the senior counsellor and I supported one another by sharing different reflections, viewpoints and ideas with the clients. This experience had a positive impact on the clients as they felt as though they had two people to hear and validate their experiences.

It is often said that “two heads are better than one”, and when a second therapist is added to a session, it can provide the client with additional resources, knowledge and treatment avenues (De Luca et al., 1992). For example, in the case of one client, one senior therapist at FSR was experiencing some resistance from the client during a counselling session. Being the second therapist involved, I was able to introduce a second voice with an additional vision and a fresh perspective for the client. The client was then able to focus their energy on my inquiries and observations which allowed the senior therapist a chance to gather their thoughts and rejoin the session in a constructive manner.

During my time at Family Service Regina, I was not able to sit in and observe other counsellors in sessions with clients even though I tried everything possible to make this a reality. Many of the therapists providing counselling services to clients at FSR are funded by the Family Service Employee Assistance Program (FSEAP) and therefore, due to insurance restrictions, are not allowed to have students sit in on their sessions. Additionally, many clients coming to FSR for help were not comfortable having a student sit in on their sessions. As such, these circumstances limited the number of times I was able to shadow therapists during their regular sessions. To counterbalance this, I made it a point throughout my practicum to speak with the clinicians at FSR about their theoretical frameworks and how they integrate theory into their practice. Attending weekly peer supervision with the counselling staff also provided me with
opportunities to hear different case examples, learn about multiple therapeutic approaches utilized, and then practice these strategies with different clients on my caseload.

**Activity Three**

The third activity was to participate in a minimum of 6 – 8 walk-in counselling sessions offered Tuesday and Thursday afternoons. The Thrive Walk-in Counselling Clinic at FSR offers counselling designed with a brief, solution-focused model of therapy in mind. It is meant to be a “total experience” for a client in one session; having a beginning, a middle and an end (Hoyt, 2002). Although it is typical to engage in only one session using this approach to therapy, it is not uncommon to see a client attend these single sessions multiple times.

Although walk-in counselling is intended to be a single session, with the first session being the most therapeutic and having the greatest influence on the client, there are times when a second, third or even fourth session may be required (de Shazer, 1985). Subsequent sessions open up dialogue for the client to explore what is going better for them since their initial session. These sessions are useful as they provide the client with opportunities to express ways they have elicited positive changes in their lives and how much closer they are to their initial goal (De Jong & Berg, 1998). Additional sessions also allow for inflection and reflection on what has transpired and what the next steps in growing might be.

Throughout the duration of my practicum, I was able to meet with over 40 clients through walk-in counselling sessions which well-exceeded my goal. Although initially fearful of walk-in counselling, as the needs of people coming in are so incredibly diverse, it did not take long to become comfortable with the solution-focused process. Walk-in counselling gave me a tremendous amount of experience in working on a variety of issues with a diverse client base. Most weeks I was able to see 4 – 5 clients for walk-in sessions and there were multiple times I
was able to see the same client for a second and third walk-in session. The flexibility the clinic offers an understanding that every individual has diverse needs and that some may require more than one session in order to process and problem solve, is a driving force behind its popularity at FSR. When clinicians maintain an ‘open door’ approach to clients, it leads to optimal long-term outcomes as we are acknowledging that some clients may require additional psychotherapeutic support in the future (Campbell, 2013). Clients are encouraged to return for single session therapy if they begin to experience difficulties out of the realm of their comfort and when they need the support.

Activity Four

Another major component of my practicum was to attend relevant training offered at FSR as well as training offered by other counselling agencies. As social workers, it is our responsibility to maintain professional proficiency and to continually strive to increase professional knowledge and practical skills so that the application of these skills will be competent in practice (CASW, 2005). The emphasis on training opportunities was to assist in enhancing my growth, knowledge and skill set as a counsellor by learning from other professionals in the field. I was able to achieve this by attending two days of training on solution-focused counselling, participating in 13 online webinars over the course of my practicum, and by utilizing various counselling techniques in sessions with clients as well as debriefing with my professional associate afterwards. I was also able to present to my peer group on my training in SFT and participate weekly in individual supervision and peer consultation groups throughout the practicum to further enhance my abilities.

Having the opportunity to further participate in the development of my skill set through consultation with my professional associate was an invaluable opportunity throughout this
practicum experience. During individual supervision, I was able to participate in a role-play activity in which my professional associate counselled me from the perspective of one of my challenging clients. This provided me with valuable insight into what the client may be feeling, needing or wanting, and how to engage the client from a strength-based perspective. I was also able to sit with my professional associate and watch myself during video-recorded therapy sessions with four different clients. In doing so, I was able to watch my progression as a counsellor from the start of my practicum, all the way into the final weeks of my counselling experience.

Being able to witness my growth as a counsellor was an incredible experience as I was able to observe the skills and theory learned and then implement them into practice. Moreover, videotaping is widely acknowledged as a valuable tool to improve the effectiveness of clinical training and supervision across a wide range of psychotherapy models (Friedlander et al., 2011). Prior to videotaping a session, consent was required from each client, and I was able to obtain permission from each client by explaining that my goal for my development as a counsellor was to continuously gain feedback from other clinical experts, such as my clinical supervisor (Appendix A and Appendix B). Getting feedback on my counselling skills through videotaping, helped me to identify my blind spots and provided me with opportunities to continuously grow in my practice.

**Goal Two**

The second goal for my counselling practicum placement was to learn and implement mindfulness strategies to practice throughout my sessions with clients seeking both ongoing and walk-in counselling support.
**Activity One**

The first activity identified as part of this goal was to complete a literature review focused on mindfulness strategies to aid in my development as a clinician and in the completion of my final paper. Mindfulness has grown in popularity over recent years, making it easy to locate relevant information; however, with an abundance of readily available information, it becomes challenging to narrow down research to certain studies. Prior to starting my practicum, I had gathered an extensive amount of resources related to mindfulness, meditation, progressive relaxation, visualization, coping skills, and other relaxation and stress reduction strategies. Keywords that I implemented throughout my literature search on this topic included mindfulness; mindfulness CBT; mindfulness SFT; mindfulness-based stress reduction; and mindfulness with youth, families, and adults.

Once again, I utilized the University of Regina’s online library to conduct my searches relating to mindfulness. Much of my information came from published books on incorporating mindfulness in everyday life. The use of mindfulness was not only a practice I meant to learn and implement during individual and family sessions I helped conduct or conducted, but was also intended as a method to practice personally during and outside of client sessions. Mindfulness is a relatively new technique utilized in therapy; therefore, much of the published information is recent. I focused my attention on academic journals which included: *Mindfulness, Behaviour Research and Therapy, Complementary Therapies in Clinical Practice,* and *Frontiers in Psychology.*

**Activity Two**

I was able to utilize mindfulness strategies in both ongoing and walk-in counselling sessions which was identified as my second activity designed to achieve my goal of practicing
and implementing mindfulness strategies. I incorporated mindfulness in every session with each of my clients whether it was mindfulness practiced with the client, or mindfulness of my own presence and how I was responding to the story being shared. By incorporating mindfulness into practice, it acted as an insulating factor which encouraged a feeling of safety, security, openness and tranquility during sessions with clients.

One of the most notable mindfulness strategies utilized during my practicum experience came from the research of Davis et al. (2008) who focused on reducing stress and increasing relaxation. The strategy was designed to help people recognize physical sensation and tension felt in their body, and how to let go of this tension by practicing body inventory with clients through the use of grounding techniques (Davis et al., 2008). First, the goal is to help the client focus on their external stimuli by listing five things they can see, four things they can touch, three things they can hear, two things they can smell, and one thing they can taste (Davis et al., 2008). Next, after the client is aware of what is going on around them, focus is shifted to their body and physical sensations by identifying things such as “I am aware of feeling hot, stomach [being] tight, throat [being] sore, heart beating, nose tickling, soreness in legs, [etc.]” (Davis et al., 2008). This practice was highly effective with almost all of my clients as it helped them to separate and appreciate the real differences between their inner and outer worlds.

Additionally, Christopher Germer (2009) illustrates a 20-minute exercise referred to as “Body Sensations”, which I utilized frequently during sessions with those who struggled with staying in the present moment, and were over-run with intense emotions and experiences from the past (Germer, 2009). Body scanning was also utilized on a regular basis during my counselling practice as well as having clients keep a stress-awareness diary to help them notice times during which a stressful event occurred outside the clinic and to take note of what physical
or emotional symptoms they noticed related to the stress (Davis et al., 2008). One client was able to identify that she held tension in her neck. As she began using exercises that promoted body awareness, she was able to increase her awareness of her triggers and sensations which allowed her to let go of the tension and find a renewed sense of energy. Working with clients during individual sessions to practice these strategies encouraged them to feel confident to find success with these relaxation exercises away from therapy.

**Activity Three**

Activity three focused on attending professional development opportunities which centered on mindfulness theory and practice. I was able to attend a trauma-sensitive yoga session with one of FSR’s trained clinicians who specializes in psychotherapy and is a registered Death Doula who practices Buddhist and Contemporary Psychology. The clinician, as the yoga instructor, was able to facilitate the session and provide us with practical skills to use with clients in a mindful and trauma-sensitive way. One of the strategies practiced during this session was called “Breath of Joy” (Neese, 2019). Through synchronized breath and arm movements, the practice awakens your whole-body system, increasing the oxygen levels in the bloodstream, which acts to stimulate the sympathetic nervous system (Neese, 2019). As you breathe deeply, you increase your energy levels (Neese, 2019). This activity is an excellent strategy to use with clients who come into sessions in a state of hypo-arousal by where they may disassociate or shut down emotionally (Germer & Siegel, 2012).

During the same yoga training session, we also practiced “Mountain Meditation,” a practice that was developed by John Kabat-Zinn. It is meant to cultivate inner strength and stability in order to find peace of mind, contentment, well-being and joy amidst the constantly changing conditions of life (Kabat-Zinn, 1994). While experiencing this meditation, participants
begin to develop the qualities of a mountain, including stillness, rootedness and stability (Kabat-Zinn, 1994). The different thoughts and feelings that we experience – the storms and crises, along with periods of joy and excitement – are all like weather on the mountain (Baer, 2014). I was able to utilize this script in session with a client who had experienced domestic violence and felt overwhelmed by her experiences. Using this guided meditation, the client was able to pick out moments during which she had experienced joy and stability, and the strength that it took to withstand the trauma that she had experienced. Seeing herself as a mountain, still standing after all the pain and suffering that she had endured, provided her with a framework which she continued to utilize throughout the remainder of our sessions together.

I was also afforded the opportunity to participate in an online webinar that focused on mindfulness and self-regulation strategies for children with attention deficit hyperactivity disorder (ADHD). I also learned about the use of mindfulness strategies from my professional associate during regular supervision sessions, and from other senior clinicians at FSR during consultation. Participating in these types of professional development opportunities opened my eyes to knowledge about mindfulness and how it is utilized and practiced in therapy sessions. Listening to other clinicians talk about their experiences with how mindfulness helps with emotion-driven behaviour was an important element in my practice as a student counsellor.

Mindfulness was not something I utilized in my practice prior to my practicum placement, so initially there were moments of discomfort that came from learning about and implementing this approach. My professional associate was incredibly encouraging throughout this process though as I was provided with resources to read as well as different strategies to try with clients of all ages. For example, I was able to witness my professional associate use a mindfulness therapeutic approach referred to as “Cookie Breathing” which is a diagrammatic
breathing exercise that helps to decrease stress, anxiety and anger (Lowenstein, 2016). This type of strategy can be applied to clients of all ages, as it encompasses a playful way to engage clients who are a bit resistant to breathing strategies.

When there were days where I would feel incompetent or vulnerable due to my lack of experience with mindfulness, my professional associate normalized these experiences and provided me with moments of success where I was able to reflect on and appreciate the knowledge and competencies I had developed up to that point. As research shows, the taboo associated with feelings of incompetence as a novice practitioner is greatly reduced when there is the opportunity to engage in an empathetic dialogue with colleagues and supervisors (Theriault et al., 2009). By having a one-hour meeting each week with my professional associate to receive guidance and feedback, the time became invaluable to my growth and overall learning experience. Learning about different psychological thought traps, identifying values and goals, observing thoughts, and being continuously curious with clients was experiential learning that I would not have been exposed to without a hands-on practicum experience.

The following chapter will outline how my objectives and goals were achieved through the use of therapeutic interventions, practical skills and strategies as outlined in a number of case examples.
Chapter Five: Case Examples of Practical Skills

Throughout my practicum, I continuously looked back at the objectives outlined in my proposal to ensure I was being accountable to my commitment. By completing the activities identified in the previous chapter as part of each of my outlined objectives, the result was remarkable growth and learning as a student counsellor. Having the opportunity to meet with my academic advisor and professional associate for my midterm and final evaluations provided me with the opportunity to reflect on my growth and respond to areas that needed improvement. Being able to critically reflect and receive professional guidance and feedback, aided me in my personal and professional growth and contributed to my development as a counsellor utilizing cognitive behavioural therapy (CBT), solution-focused therapy (SFT) and mindfulness-based strategies. This chapter will highlight how I utilized my chosen therapeutic techniques, including case examples of clients that I had the privilege of working with.

The Convergence of Cognitive Behavioural Therapy (CBT) and Mindfulness in Practice

Integrating CBT into practice was a major focus of my practicum placement. While implementing CBT, I learned how to confidently incorporate mindfulness strategies within counselling sessions. I will be highlighting this work and learning with experiences I had with two different clients within this chapter. Please note that all identifying information has been removed to protect the identity of the individuals I worked with. Verbal and written consent were obtained from each client discussed in this report in order to focus on aspects of their counselling sessions and highlight the counselling process with my professional associate which was crucial to my learning and development as a clinician.

Cognitive Behavioural Therapy (CBT), Mindfulness and Anxiety

This first case example involves a young adolescent who struggled with anxiety that led
to depressive symptoms. Before meeting with the client, I first requested a meeting with their mother. Beck (2011) indicates that it is desirable to collect as much information as possible before you see the client for the first time. The client’s mother provided me with important information pertaining to their child’s family and social history as well as their own thoughts on their child’s behavioural difficulties. I also connected with the client’s father on the telephone to receive his interpretation of the events going on in his child’s life. Because the client had sought out counselling from Family Service Regina (FSR) in the past, I was additionally able to review their historical file and read relevant notes, insights and reports from previous clinicians.

Providing caregivers with psychoeducation, or information and support about mental disabilities/illnesses, is critical at the start of counselling sessions in terms of enhancing therapeutic engagement and outlining the general procedure or therapies for treatment when working with children and youth. The client’s father signed up for a 6-week parenting course focused on children with attention deficit hyperactivity disorder (ADHD) and how to manage behaviours and symptoms. There is a critical role for the parents when their children are engaged in treatment; how involved and supportive they are is the single most important influence on the child’s healing (Cohen et al., 2012). By having the client’s father participate in aspects of their treatment, the client felt more supported in their therapeutic journey.

This client’s anxiety and depression symptoms manifested themselves during school hours as they had perceived rejection from their peers. These negative thoughts would stay with the client throughout the day, forming a narrative in their mind that they brought home from school and carried with them into evening activities. As Beck (2011) suggests, how the client interprets situations at school impacts how they feel emotionally as well as their externalizing behaviours. In this case, the client felt that their peers were only spending time with them out of
habit and that nobody enjoyed any time spent with them. They regarded this idea as the absolute truth, and would often state, “I just know” when asked about their proof of knowledge regarding their friends’ thoughts.

Their core belief seemed to be that they were unlikable, and every time they were presented with a situation that triggered this schema or thought pattern, they would become activated and this core belief was then reconfirmed (Beck, 2011). Each time I would try to present the client with positive data, they would automatically discount it and construe the situation as negative instead (Beck, 2011). After meeting with the client for three sessions, I determined that their beliefs about themselves were entrenched in their identity. Beck (2011) indicates that if you question the validity of core beliefs in a client too early in a session, you can lose credibility and endanger the therapeutic alliance. I found myself pushing for the invalidity of some of these core beliefs too soon, and as a result, the client immediately put their guard up in subsequent counselling sessions.

I initially felt as though we did not accomplish very much in the first few sessions. CBT did not appear to be effective or efficient, and I felt like I was failing. After consultation with my professional associate, I determined that developing a therapeutic alliance with the client would be an asset to future sessions, and that it may take much longer with a young individual to build that trust and acceptance in order to facilitate growth. Because the client was someone who was very uncomfortable with their present situation, self and environment, it became difficult to conceptualize quickly what path to take for effective treatment.

After personal reflection, and consultation with my professional associate and academic supervisor, I realized that having someone to sit with the client during their moments of discomfort, and by providing them with undivided attention and affirmations, that could be
enough to form an alliance that would aid in the continued growth of their self-understanding and understanding of the world around them. One of the best predictors of a positive outcome and a turning-around of disappointing results is to solicit feedback from the client after each session (Kottler, 2017). I began to ask the client how they wanted to spend their time, and after each session, I asked them how they felt their time had been spent during our session.

After consulting with the client about what strategies they would like to try and what was working/not working for them during sessions, we began to develop a clear roadmap or path for effective treatment. It felt as though much of the pressure for both of us to perform to a certain standard had been lifted. We discussed their goals for the therapeutic journey, and where they would like to end up. As Beck (2011) recommends, we discussed different pathways to get there, detours we could take, roadblocks we may hit, and what we could do when feeling lost. In the end, the work that I accomplished with this young client did not only integrate CBT, but also integrated mindfulness in practice. As noted previously, CBT techniques were not effective with this client on their own; however, by incorporating mindfulness with CBT techniques, I was able to aid the client in developing the skills to process and positively externalize their presenting situation.

Progressive relaxation and breathing exercises were both utilized during sessions with this client; however, the most notable influence came from the guided meditative walks we took part in together. Research suggests that this form of meditation not only decreases feelings of distress, but also appears to be instrumental in reducing distractive and ruminative thoughts as well as destructive behaviours (Jain et al., 2007). This sort of mindfulness aims to make participants aware of their automatic reactions on a behavioral, emotional, and cognitive level; by encouraging them to observe their emotions and thoughts in a non-judgmental way, and react
in a calm and “wise” manner during stressful situations (Kabat-Zinn, 1994). Although I had initially felt I was missing important aspects of the client’s therapeutic treatment, I learned that this exercise permitted me the opportunity to make adjustments when things were not going well. As Kottler (2017) ascertains, failure can be useful to us in many ways, teaching us to be more creative and experimental, and to try out new strategies when familiar ones are not working. We learn humility and develop a greater reflection of what we do and what impact we have on others when we take the time to reflect.

During our mindful walks, I would ask the client to pay attention to their senses (i.e., sight, hearing, smell, taste, and touch), emotions and thoughts which is a technique informed by the research of Cohen et al. (2012). I noticed during our walks that the client began to let go of their automatic, negative thoughts, and seemed more open to the possibility of hope and seeing situations through a different lens. They began to imagine the possibility of having healthy interactions with friends and became excited when discussing future interactions with people. Segal et al. (2002) notes that the physical sensation of walking seems to “ground” a client in the present moment and relax their thoughts enough to imagine a world different from what they initially perceived it to be not so long ago. One of the most notable statements the client expressed during one of our meditative walks was when they quoted lyrics from their favorite song, “Truce”, by American musical duo, Twenty One Pilots (2012), which includes the words, “the sun will rise, and we will try again”. The client seemed to attribute the lyrics to their newfound resilient nature as an individual, including their perseverance to show up for sessions and move towards healthier changes in their life.

By merging CBT and mindfulness together with this client, I became very aware of my own attunement during sessions. By integrating mindfulness during sessions with clients, I
created a space where they felt more centered and more present. I was given the immense
privilege and opportunity to be present with the client, word-for-word and moment-to-moment.
The use of mindfulness during these sessions not only created a safe and supportive environment
for the client, but also made me a more competent and in-the-moment therapist.

Cognitive Behavioural Therapy (CBT), Mindfulness and Intimate Partner Violence

During this practicum placement, I also had the privilege to work with a mother who was
seeking counselling to address the intimate partner violence they and their child were exposed to.
The client had been exposed to severe domestic violence at the hands of their incarcerated
partner and as result, their oldest child had also been exposed to this same violence. The client
indicated that their partner had been incarcerated for a period of time, but they were still anxious
and fearful of their partner finding out where they lived. They were scared that their partner
would be released from prison and that he would locate them and their children, inflicting more
violence and rage on the family.

My plan was to first meet with the mother, so that I could assess the situation and develop
further treatment goals with them. Paying attention to the clients’ presenting problems, current
functioning (i.e., everyday behaviours), symptoms, and history helped me to develop a
conceptualization and formulate a therapy plan with them (Beck, 2011). We met four times
without their child and throughout these sessions, the client talked extensively about their current
functioning and symptoms, past and current relationship patterns, and how they seemed to
choose partners who were not suitable nor healthy for them or their children. We also discussed
their past childhood and adolescent years, and they disclosed that while growing up, they often
felt rejected from their father and continuously sought out approval/love from them throughout
their life.
The client further discussed how they were often exposed to pornography and other explicit materials at a young age as they stated that their father was addicted to such things. Discussing these events exposed that the client had a core belief about themselves by which their sexuality and physical self were seen as the most important qualities they had to offer in relationships. We began working slowly on modifying her core belief. Once patients change their core beliefs, they are less likely to process data in a maladaptive way (Beck, 2011). As a result, the client was very open to learning more adaptive and realistic thoughts about themselves and believed that there was a lot of truth to these new ways of thinking.

The client had many core beliefs about themselves that were positive, and because of this we were able to activate many of those positive core beliefs to try to override negative ones, such as physical appearance being all they had to offer. By continuously pointing out positive attributes, a new core belief seemed to develop. As they discovered that they were once a child who was deserving of healthy affection from their father, and that as an adult, they also deserve love and affection, the client was able to begin to overcome their negative perception of themselves. The client was able to examine her experiences in a new way and develop workable goals for their future vision.

Using mindfulness with this client was an effective way to help them lessen the overwhelming painful feelings and thoughts they had come to identify with. Mindfulness is a useful therapeutic framework for individuals who have suffered intimate partner violence since research has shown that it lowers levels of shame, avoidance coping, social isolation, depression, anxiety, post-traumatic stress disorder (PTSD), and suicidality (Tesh et al., 2013). This approach provided the client insight into their past and present experiences and gave them the courage to develop new opportunities and make more informed decisions. Once painful emotions and
memories became less overwhelming, they developed compassion towards themselves and their experiences. One of the activities I used with this client was having them talk to their younger self and choosing what they would say to the child who was experiencing rejection from their father. This activity acted as a powerful tool which allowed the client to become compassionate towards their younger self, telling their younger self that none of what happened was their fault, and that they are worthy of a healthy relationship filled with love and mutual respect and affection.

After four sessions with the mother, I was able to bring their child in for a family session. Because the mother had the opportunity to share their story and receive the support they required on an individual basis, they brought their child to the session in order to have their own opportunity to share their story and heal from it as well. By doing this, the mother then felt more confident in implementing changes in their home life and was able to provide their child with the support they needed to get through their challenges. As a side note, I will explore therapeutic strategies utilized with this child in the section devoted to creative interventions found in chapter six.

The Convergence of Solution-focused Therapy (SFT) and Mindfulness in Practice

SFT was introduced to me just prior to my counselling practicum, but it fits well with my personal ideologies as it stems from a social constructivist model which is built on the observation that clients derive personal meaning from the events of their lives as explained through personal narratives (Cantwell & Holmes, 1994). By allowing clients to feel heard and have their individual needs met, they feel like what they have to say has meaning. To practice SFT, counsellors must value a therapeutic alliance that stresses empathy, collaboration, curiosity, and understanding, without taking on an expert opinion. I was able to utilize solution-focused
therapy in sessions during walk-in counselling clinics, but also utilized this approach with repeat clients on a regular basis.

Incorporating mindfulness with SFT was fitting as both yield an approach that enhances the therapist's presence and focuses on the present moment. I will discuss two case studies in which SFT was used. The first case study experience occurred through the Thrive Walk-in Counselling Clinic at FSR, and the other occurred in ongoing counselling sessions in my caseload at the Agency. Again, please note that all identifying information has been removed to protect the identity of the individuals I worked with. Verbal and written consent were obtained from each participant in order to discuss aspects of their counselling sessions and highlight the counselling process which was crucial to my development as a clinician.

**Solution-Focused Therapy (SFT), Mindfulness and Anxiety**

I was able to use solution-focused therapy readily and at times exclusively during walk-in counselling sessions. One of the clients I worked with attended the walk-in counselling session on three separate occasions. They had initially heard about the service from their family doctor who had suggested they attend to help manage their symptoms of anxiety which resulted from social isolation. The client was unemployed, lived in their mother’s basement and only left the family home to attend the library once per month. They had very limited social interactions with adults their age, spent nearly eight hours per day on their computer playing video games, and struggled leaving their home as they were worried that something might happen to them if they left (e.g., getting hit by a car, getting attacked, yelled at, lost, etc.).

The client came into these sessions with the desire to feel less anxious as their attempt at feeling less anxiety by staying home all the time, only left them more isolated from the world. Steve de Shazer, one of the creators of SFT, indicates that sometimes the problems for our clients
are the attempted solution (de Shazer, 1985). For this client, their isolating and avoiding social interactions were an attempt to avoid anxious thoughts and feelings, but in the end, it was only making their life more problematic. One of the first questions I asked the client after they iterated their story was “how did you manage to get out of bed today and come to this walk-in session?” This question immediately made the client consider their internal resources and how they managed to anchor their anxiety in order to make it into the session.

Goal formulation was one of the main objectives for the first part of the initial session whereby the client reflected on what would be achieved by the end of therapy in order to say the sessions overall had been useful to them. They were able to advise that they would like to feel less anxious. Asking the client, “what else?” proved to be an effective subsequent question as it made them dig deeper and peel back the layers of their anxiety as they came to realize all that they wanted to achieve. Bednar and Fernandes (2019) state that it is incredibly important to always stay curious, listen intently and compliment our clients who are entering a single session. I was able to do this by taking advice offered by de Shazer et al. (2012) by asking the client what they will be doing instead to better their situation, and what will be the first sign that things are on the right track or improving in their life. Working to understand the client’s expectations and having a measurement in place to determine if the overall therapy journey was successful, allows both the client and counsellor to actively observe development and growth.

Scaling, another exercise offered through the research conducted by de Shazer et al. (2012), was also used during these sessions to have the client rate their anxiety. With a 10 being the highest anxiety they had ever experienced, they rated themselves at an eight during our first interaction. When asking what it would take to get them to a seven, they were able to start looking at small steps to take to be able to move into a direction of feeling less anxious. After
further questions, they were then able to determine that leaving their house and doing something new would be an important way to combat their anxiety. The client’s goal that they had set for themselves was to take the bus to the library twice per week. This goal felt exciting and realistic once they spoke about it, and we discussed how this could be measured if they decided to come back for another session. The client was asked if they would like to return for a follow-up session, and they eagerly stated they would.

The client came back the following week to discuss if, and how, their situation had improved during the week. The client explained they were able to take the bus twice, attend the library, and even ask the librarian for help to locate and take out books. They were then able to get on the bus and walk to their house from the bus stop, on their own. We then used scaling questions a second time to help them rate their progress whereby they noted that they had dropped to a rating of six versus the eight they had rated themselves at during our initial session. When asking the client how they were able to get from an 8 to a 6, they stated that they felt more confident in their abilities to challenge their anxiety after they were able to complete their goal of attending the library.

Incorporating mindfulness practice within these sessions was also an important element in helping the client untangle themselves from their anxiety. During sessions we discussed their experience with anxiety and what their past experiences had told them about themselves. We discussed how easy it was to feed their negative thoughts about their past experiences and how they had a choice to fuel these evaluations, or not to. We also talked about how we can choose to fuel or empower the parts of ourselves that are brave, excited, confident, positive and ready. We then took time to write down different ways that they could empower those parts of themselves. They took these affirmations with them after the session and advised that they would read and
take them with them in their backpack prior to every time they left their house. Having the client express their concerns about anxiety and discuss how it had hindered them by placing more focus on fueling the parts of themselves that were strength-driven, was an important way to fuse together solution-focused therapy and mindfulness in this client’s sessions.

We also practiced breathing strategies the client could utilize when away from the clinic and their anxiety spiked. To calm the body, many professional counsellors recommend using breathing techniques (Kottler & Chen, 2011). By learning to breathe deeply and efficiently, clients can begin to learn how to manage their stress and anxiety (Kottler & Chen, 2011). We practiced breathing in each of our sessions so the client would know how to use this technique when experiencing anxiety and stress symptoms. The client was instructed to breathe through their nose when inhaling and then exhale through either their nose or lips (Erford, 2015). Between deep breaths, the client was subsequently instructed to take one or two normal breaths to avoid dizziness as Erford (2015) suggests. I then asked the client to take note of their breathing prior to the exercise and compare it to progress made during and after.

The client was instructed to practice these breathing strategies, not only when they noticed their worries, anxieties and fears manifest, but also when they were feeling calm and relaxed. By practicing when they felt emotionally regulated, the technique would hopefully become an easy coping skill to use when stress or anxiety showed up. During our sessions we would begin by taking slow, deep breaths and I would instruct the client to imagine their thoughts coming in through the front door of a white room, and leaving out the back door of the room which is another tool to use with this particular breathing exercise as purported by Forsyth & Eifert (2007). This exercise helped the client understand that they cannot choose what comes
into their mind, but they can choose what they pay attention to, how they pay attention to it, and what they can do to better their situation.

When the client came in for their last follow-up session, they were able to answer the question “what is better?” with incredible enthusiasm; their whole demeanor had changed from the initial session. The client had started going to the grocery store to purchase their groceries, was continuing to take the bus to the library weekly and had even applied for a job at a store close to their home. They had also started taking daily walks, and although they continued to experience anxious thoughts, they had become comfortable practicing their breathing strategies and pushing through their apparent discomfort. After I provided them with compliments and congratulations, I then asked how they were going to celebrate all their recent success. The client replied that they would continue to take it one day at a time, moving in the same direction because they now knew their capabilities. Being present with a client, listening to their fears and traumas, reasserting their importance and capabilities, and teaching them positive and constructive exercises, seemed to have a tremendous impact on the individual’s situation. This is just one example of why mindfulness and SFT combined are such a powerful and transformative therapeutic approach in social work and in therapy.

**Solution-Focused Therapy (SFT), Mindfulness and Psychological Distress**

Many clients I saw during my practicum wanted to be able to control their emotions to make their life more “pleasant.” However, when they attempted to control their emotions on their own, the emotions became overpowering and overtaking. I worked with an older adult who struggled with symptoms of psychological distress following a single, traumatic event; the client had found their friend after they had completed suicide. The client sought out counselling support immediately as they were experiencing flashbacks and frequent panic attacks on a
regular basis, similar to symptoms of post-traumatic stress disorder (PTSD). Steve de Shazer (1988) indicates that if the client sets goals to overcome their traumas and perceives those goals as attainable yet difficult, they are more likely to meet those goals than if the goals are perceived as vague or easy to meet. We collaborated on setting a specific goal of reducing the intensity of the panic attacks and to practice mindfulness skills that would actively engaged the client in changing their subsequent troublesome behaviours. Unfortunately, despite all of this planning, the goals set did not seem to help.

Since the client’s feelings associated with the panic attacks were so intense and uncomfortable, they would do everything they could to try and escape the emotions that arose in their body. They would avoid any situations in which the thought of the incident came to mind. This avoidance was causing the client great distress, but their entire life and how they dealt with these thoughts and emotions needed to shift to escape these negative behavioural manifestations. In our sessions, we began to practice observing these emotions, moving through how the client felt before, during and after the event. The client began realizing that when they tried to control their feelings, they often became overpowering, resulting in physical symptoms similar to a panic attack. But when they allowed the feelings to come, giving them time to move through their body – accepting them as they were – the client began to feel less afraid of them, which brought on a new sense of freedom.

We also worked on an exercise designed by de Shazer et al. (2012) whereby the client focused on exceptions to the problematic feelings. Through this exercise, the client realized that there were times in their life when their symptoms were less prevalent. When they reflected on these exceptions, and what they were doing and experiencing during those moments, we were able to focus on replicating those moments when their problematic feelings were not taking over.
The client also practiced body awareness in nearly every session of the six they attended, which helped them practice being present in the here-and-now. These activities reminded the client that they were safe in the present moment and that their thoughts were merely moments that have passed and had no bearing on their present self.

Additionally, we practiced mental exercises to help the client move through the difficult thoughts and feelings that arose when their mind wandered back to the event of their friend’s suicide. One activity they found useful was thinking about their dogs and drawing them out in their mind when negative thoughts surfaced. The client found comfort in the memories of their dogs, and peace in knowing that life is filled with moments of beauty and contentment. Moreover, the client often became triggered when going into their basement as that was where their friend had committed suicide. By bringing a positive image to mind upon entering their basement, it became easier for the client to enter and move around in that space.

Although the client identified as being a very emotionally and mentally strong individual who could move through difficult life events and remain unscathed, it was important for them to recognize that they could be gentle with themselves, and when emotions felt very strong, they could allow themselves to only feel as much as they could take at the time. The client finally realized there was no need to push their own boundaries. To be able to recognize and acknowledge their own limits and what they could manage at that time was an integral part of their healing. By focusing on the present moment, they were able to feel what needed to be felt but were also able to envision a future in which they felt safe, happy and relaxed; all of which were important for their healing process.

After the client had opportunities to share their story, practice the above-noted self-regulation exercises/strategies, and reflect on their thoughts and feelings surrounding the event,
we were able to discuss their future vision and goals. Since we had spent time working through what they had experienced, we were finally able to discuss positive changes they envisioned for the rest of their life. We discussed, for instance, how their partner would notice that they were moving in the right direction, and how that idea made them feel. This gave the client something to envision and look forward to with a positive mindset.

In summary, the recovery from traumatic events is often a long process, and we were able to discuss all the ways in which the client had already started on their journey to recovery. It was important for them to reflect on all that they had done to get to where they were, what they had done to help themselves, who had supported them throughout their journey, and who they could turn to in order to take note and celebrate their personal victories. For this client, the merging of solution-focused therapy and mindfulness was a helpful and practical strategy to practice during individual counselling sessions, and to implement independently. Chapter six will highlight how the therapeutic relationship, reflective practice, transparency and important new skills provided a framework behind the overall counselling experience during this practicum.
Chapter Six: Practical Skills and Theory Integrated

This chapter will highlight important aspects of incorporating theory and practice, and will discuss how both must be fused together to preserve a therapeutic relationship between the client and practitioner. It is an important element of postmodern thinking to acknowledge and recognize the many ways of understanding theories and making meaning of different practices, so that we can be inclusionary (Hawkins et al., 2001). This chapter will focus on how theory is embedded in different elements of counselling practice as a guiding force in best practice techniques. The aspects that I have chosen to highlight are the therapeutic relationship, reflective practice, and transparency. I will also highlight new skills I developed as I worked through my counselling practicum experience.

The Therapeutic Relationship

To maintain a therapeutic relationship, it is essential to build trust and rapport with clients during the initial point of contact with them. It has been proven that by having a positive alliance with a client there is a strong correlation to their positive treatment outcomes (Ardito & Rabellino, 2011). The therapeutic relationship is central to all therapy, and the two-way interaction between client and therapist is the common theme to all therapeutic practice (Ardito & Rabellino, 2011). While different models and approaches make sense and work in different ways, the centrality of the relationship is created by both the client and the therapist together. Bednar and Fernandes (2019) state that the therapist is not the expert on the client’s life; they are the expert on the process. It is not the practitioner’s role to tell the client why they are doing what they are doing, or what they should be doing; it is their job to invite the client to look at their current situation and future aspirations in a constructive manner.
Clients often seek-out therapeutic relationships with counsellors because they are riddled with emotional pain and despair (Germer & Siegel, 2012). The client is often hoping that someone will help them to alleviate some of this pain and maybe even rid them of it (Germer & Siegel, 2012). They come to counselling because they feel no one else has the patience or interest to listen to them and hear their story. With that knowledge in mind, it becomes an incredible privilege and opportunity for counselling practitioners to accompany these individuals as they share their stories. Counsellors have opportunity to hear stories of remarkable pain but are afforded the opportunity to watch the resilience that people have in order to move through such circumstances. Where others may have hurt, violated or rejected the client, the therapist is there to actively support, provide care and accept them no matter what state they are in (Germer & Siegel, 2012). I was able to witness this type of attentive support and care during my practicum experience as my professional associate at Family Service Regina (FSR) engaged in this type of therapeutic interaction with clients, coworkers and students.

Although every counsellor may have their chosen way of providing treatment, it is important to recognize that there is no one-size-fits-all approach to treatment. Bednar and Fernandes (2019) indicate that for every new client, you must invent a new therapy. Yalom (2002) states that when we standardize therapy, it renders the process less effective. According to Yalom (2002), “… the flow of therapy should be spontaneous, forever following unanticipated riverbeds” (p. 34). What is crucial is that the counsellor is attuned to the client and their current state of being, meeting their needs; but how they do this differs from client to client, and from circumstance to circumstance.

When we are attuned to the client, we are connecting with them in the most meaningful and empathetic ways. Together, as a team, we form an alliance that allows us to move through
the therapy process making decisions and setting goals collaboratively. As noted by Ruch (2000), when a practitioner is engaged in relationship-based practice, they need to be able to adapt to the uniqueness of everyone’s circumstance and the diverse knowledge that is required to make sense of such complexities. As noted by Perry and Szalavitz (2006), “Relationships are the agents of change and the most powerful therapy is human love” (p. 258). When I was fully invested in the connection and therapeutic relationship with the client, I was able to do my best work as a student counsellor during my practicum placement.

**Reflective Practice**

As a student counsellor, I was able to acknowledge the complexity and uncertainty that characterizes human behaviour, and that how when we engage in relationship-based practice can lead to a better understanding of the many layers of an individual, including their family. As I acknowledged these complexities in my clients, I was also forced to acknowledge complexities in myself as a practitioner; I too am a complex and uncertain individual at times. As I asked clients to reflect on their own understanding of themselves and their life story, I took the time to reflect on my own – which is another form of mindfulness. By being aware of the client’s emotional responses to my engagement with them as a relationship-based practitioner, I also had to acknowledge my own emotional responses to therapeutic sessions and how those responses impacted not only the client, but also myself.

Discussing my chosen therapeutic approaches, skill set, and intervention methods was practiced following each session by consulting with my professional associate and other counsellors; as well as using reflective journaling. I also constantly worked to further my knowledge of the relevant literature in my area of focus. To be a reflective practitioner as defined by Ruch (2000), I had to acknowledge the multiple sources of knowledge that surround me – the
different theoretical perspectives and research that exists – as well as my intuition and tacit knowledge that I carry from my own experience and circumstances. By engaging with a diverse range of information, I was able to develop a holistic understanding of clients and become a more reflective and competent counsellor.

As a reflective practitioner, I am committed to working in a contemplative and relationship-based way with each of my clients. However, I also acknowledge that this can be an emotionally demanding and draining way of working with clients. Having multiple areas of support are necessary to continue practicing in this way without developing long-term negative effects. Possible long-term negative effects will be discussed in the next chapter of this document. At Family Service Regina, by having the opportunity to engage with a professional support system where I could consult with other practitioners during peer supervision and meet weekly with my professional associate, I learned that these supports proved to be vital sources to maintain my values and viewpoints related to being a reflective practitioner.

Having a space to reflect on what I did in session and how it was done was an important way for me to consider ways in which I could be doing it “better” next time. This concept of learning and improving from practice, or the continuity of the learning process for clinicians, comes from the work of Ruch (2000). I was able to reflect on moments in sessions during which I hit resistance from clients, or felt the conversation going off track, and openly share these moments with experienced clinicians. Hearing their stories of times in which they experienced similar occurrences, helped lessen my stress when leaving client sessions that did not go as planned. I began to understand that, in order to be a reflective practitioner, you can always be working towards doing things better or differently, and that this is a part of the process of growth and betterment.
Having a constant emphasis on the therapeutic relationship is also recommended in continuing education for licensed professionals (Lambert & Barley, 2001). Research further shows that evaluations of therapeutic factors are vital for experienced clinicians and should be stressed during ongoing training, peer consultation, and supervision (Lambert & Barley, 2001). By practicing reflection early on in my student counselling journey, I was able to quickly identify when my own feelings of inadequacy came up in a session, and notice how they became a distraction and took me away from the moment with the client. As I reflected on these moments and situations, I realized that focusing on my relationship with the client and allowing them the opportunity to be the expert of their own lives, provided me with the confidence to move through these moments of feeling inadequate.

Transparency

Maintaining the therapeutic relationship and being a client-centered therapist involves providing transparency to each client that comes in for sessions. Every client that we work with has the right to make choices based on voluntary and informed consent (CASW, 2005). In order to build a therapeutic alliance and relationship with clients, practitioners must ensure that clients are fully aware of their case plan specifics, confidentiality limitations, goals, expectations during sessions, and expectations from the counsellor (Canadian Counselling and Psychotherapy Association, 2007). During initial sessions with clients, in both walk-in and ongoing counselling, I ensured each client was aware of what to expect during sessions by clearly communicating the limits of my confidentiality. Family Service Regina uses clinical documentation they have developed to ensure all services provided are outlined in print, including the results from their outcome assessment tools such as the OQ45. The OQ45 is a validated questionnaire-style instrument that measures change, progress and outcome of treatments for psychological disorders.
(OQ Analyst, 2006). To ensure clients always felt comfortable, safe and respected, I made sure the intake form was visible to the client, and ensured that it only acted as a guideline, showing my focus was always on the client. Focusing on building this type of alliance was the first step in ensuring there was the possibility of a relationship based on mutual respect, transparency and collaboration.

Prior to engaging in ongoing and walk-in counselling sessions, I always made sure to disclose my student status to all clients. I made sure that each client was aware that I was a new student counsellor and that I was actively practicing my skills during their sessions. I advised each one that any and all feedback would be appreciated and that if they were not happy with my work as a student counsellor, they could request to work with someone else. I noticed that people seemed to appreciate the openness and vulnerability I showed in disclosing my student status. This seemed to put them at ease knowing that there would be another person in the session who was a bit unsure about the process, just as they were.

Coming from an anti-oppressive framework where I am constantly considering my power and privilege, challenging dominant societal ways of thinking and ensuring my actions are equal and collaborative; it was crucial that the client’s well-being and comfort came before my own desire to learn and grow as a clinician. This type of transparency is also supported by the Canadian Association of Social Workers Code of Ethics as social workers have the obligation to be honest in their relationships with all parties, including accurately representing their professional qualifications, credentials, education, competence, and affiliations (CASW, 2005). Once again, this is something that fits with my core values and ideologies as conflicts arise almost every day in this profession; therefore, it is imperative that I am continuously reflecting and consulting with supervisors and professional peers.
New Skills

Throughout my practicum experience, I had the opportunity to engage in different activities and therapeutic practices to facilitate my growth and capabilities. This section of the chapter will discuss how my role as a counsellor has been shaped by learning new skills and knowledge, and by practicing these skills during counselling sessions as part of my practicum.

Slowing Things Down

One skill I focused on during counselling sessions was to create an atmosphere for the client whereby I was fully present, and allowances for personal growth, change and development were made possible. The therapeutic relationship between the counsellor and client is fundamental in the process of healing, and as such, it is crucial the counsellor be fully present with the client at each moment during the counselling session (McCartney, 2004). When we are fully present for our clients, this is where the healing takes place (Welwood, 2000). To be fully present for the client, I knew I had to work on slowing things down during my therapeutic interactions with them. Instead of feeling the need to fill space or have an immediate answer or question, I took time to truly reflect on what the client was saying and respond with validating words or affirming statements. By practicing mindfulness during each session, it allowed me to be fully attuned with clients, so that they felt seen and heard and could fully embrace their own thoughts and feelings in that moment.

The counselling process is more beneficial when both the therapist and client are attuned to the present moment (Germer, 2009). When being aware of the present moment, I was able to slow down my responses to clients and my thought processes, and move at a calmer, more thoughtful pace as encouraged by Germer (2009). Slowing things down seemed like an easy enough task to accomplish during my practicum placement; however, due to my previous fast-
paced experience with crisis management at the Ministry of Social Services, it proved to be more
difficult than originally thought. My mind was innately programmed to maintain a constant
dialogue and move through situations at a fast-paced occurrence to help as many people as I
could in a short period of time.

It can be challenging for counsellors to be consciously in the “here and now” during
therapy sessions when their minds are accustomed to running on “auto-pilot” to keep up with the
fast-paced demands of high-stress positions (McCartney, 2004). I quickly learned it was not only
a benefit to my clients when I was able to take my time and slow things down but was also a
benefit for my own mental/emotional health. Neff (2012) states that, when we care tenderly for
ourselves in response to suffering, we open our hearts to being compassionate with our clients.
This compassion engages our capacity for love, wisdom, courage, and generosity to be shared.

To ensure I was slowing things down during therapy sessions, I knew I had to practice
mindfulness and moving at a slower pace in my personal life. At home, I began practicing
different forms of mindfulness meditation, including jogging, walking, body scanning during
different parts of my day, and reflective journaling during the evenings. By engaging in these
exercises in my own personal life, I began experiencing gratitude and joy in ways I had never
experienced before. I felt more grounded when I attended sessions with clients, and moved at a
slower pace, knowing that the benefits of taking my time and being mindful of the experience of
being fully present were far greater than counselling more clients at a faster pace. This presence
in both my personal and professional life, provided me with a more thoughtful response to both
my family and the clients I had the privilege of sitting with.
**Self-Care and Consideration**

Being a driven and ambitious new counsellor allowed me opportunities to further enhance my knowledge of theoretical approaches, and practice new skills with enthusiasm and excitement. With this ambition, comes the struggle of finding ways to slow myself down and to do things for my own mental health management. To have a purpose that does not require a sense of accomplishment has been a task I am not familiar with. Doing things for my own self-care instead of for my resume, skill sets, or for a sense of accomplishment, was a goal of mine throughout the practicum.

I often wondered over the course of my practicum why it was so difficult to just sit in silence for a few minutes. Balancing family and work schedules leaves very little time to sit quietly with an empty schedule. As a result, I found that embracing opportunities of nothingness seemed rather difficult for me. I often found myself with moments at home where I could be embracing the quiet moments and doing nothing, but instead, filled the time with researching for my project, scrolling through social media apps or checking my email. There was nothing important in those moments that I was expecting or looking for; I had just gotten so caught-up in the fast pace of life and having to juggle the demands of a busy schedule, that I had forgotten how to just sit and be still. This became a major focus of mine throughout this counselling practicum experience as I believe that learning to be still during times of emptiness was a skill that would only benefit me when interacting and cultivating the therapeutic relationship with my clients.

We often teach our clients creative and inventive ways to take care of themselves and to practice self-care; however, I found it difficult to take my own advice. *How could I expect my clients to understand these ideas and interventions that I was teaching, if I had not yet practiced...*
them myself? I made it a goal of mine to practice self-care using meaningful and manageable tactics and made a commitment to be kind to myself if I found myself losing track of this goal. Things I did included taking time for stillness and relaxation on a regular basis, and practicing self-compassion. For these exercises, I did not only want to utilize them when feeling overwhelmed or frustrated, but to begin incorporating them on a routine basis so they would seep into my world just as easily as the busyness and fast paced moments had seeped in. I began telling myself that stillness and time to relax were as crucial and important as the moments of planning, movement and busyness. I involved my husband in my self-care practices as well, having him provide me with gentle reminders to allow the stillness to come and to take the time to relax and unwind during moments of the day which afforded me time to do so.

I found it difficult during these times of relaxation and stillness to unwind and soften my mind and body to the exercise. When I did need to be busy and take time to complete activities, I began practicing self-compassion by connecting my physical movements to my mental and emotional well-being. I began paying attention to my physical self and what I needed in order to soothe the stress in my body. My bedtime routine changed, and I incorporated a warm bath and placed my phone on silent, and I also became more mindful of the food I used to nourish my body as well as the amount of time I spent out in the sun. I found I felt my most calm and relaxed when I was running. Research shows there is an inverse relationship between the mind and the body when it comes to physical exercise; the mind races when the body is inactive and the mind calms when the body is moving (Germer, 2009). I usually felt a sense of pride and energy when I accomplished tasks during a busy workday, and I began giving myself credit and praise when I completed tasks that soothed and comforted me.
A Bottom-up Approach

Much of my experience in working with traumatized children and adolescents has shown me that they are often mis-diagnosed or misunderstood. On numerous occasions, I have heard clients referred to as defiant, oppositional, having attention deficit disorder (ADHD), or described as having severe behavioural problems. These labels often lead us to believe that the child is the problem, and leaves little room for empathy or to try to understand the behaviours and the needs behind the behaviour. When working with children who have been exposed to domestic violence, or whose parents had been exposed to a history of trauma, I was quick to provide the family with education surrounding trauma and information about what it can do to change the child’s genetic makeup as well as educating them that many children become hyper-sensitive to stressors within life, due to trauma.

Peter Levine (2010) describes trauma experiences as frozen in time in the memory, which can often lead to a child’s development going “off track” as they get older. Van der Kolk (2015) explains that early trauma, no matter how young the child is, can create an assault on the child’s development over time, leading to unhealthy coping strategies used for survival, and a lack of development of essential daily living skills such as impulse control, problem solving and executive functioning. When working with foster parents, many of them are left wondering why their child acted in such volatile ways even though they provided them with such loving and safe homes. I spent time educating different caregivers on the survival systems of the fight/flight/freeze responses and that traumatized children act on this primitive part of their brain even when no threat is present (Van der Kolk, 2015). Although it is important for caregivers to understand the reasons behind these behaviours, it is also important for them to understand that their newfound relationships with their children, can help to heal their preexisting relationship
trauma. It is all about developing a positive attachment style in the child instead of a negative one.

Allan Schore (2003) indicates that, although developmental trauma happens within key relationships, it can also be repaired within relationships. A strategy I became familiar with during my practicum that can be used to achieve this, was the bottom-up approach. This approach states that if we reduce the stress in the child’s body by helping them to regulate their fight/flight/freeze responses, this has a positive, cascading effect into their emotions (Van der Kolk, 2015). As we relate and connect with the child through a positive, attuned and sensitive relationship, this will begin to have an impact on the child’s thinking, learning and reasoning (Van der Kolk, 2015). Therefore, I started providing parents with concrete tools and activities to practice with their child in relation to the bottom-up approach, including how to spot the flight, fight or freeze responses, and ways or techniques to regulate these same responses.

Working with both the parents and the child in therapy is instrumental to ensuring the child is provided with the best interventions. John Bowlby (1969) stated that if we value our children, we must cherish their parents. I often heard from other counsellors during my practicum that we act as co-therapists with the parents, as they are the ones who need to be empowered to keep taking the risk of offering love, care and consistency to the child to help them manage their world.

**Thrive Walk-In Counselling**

Throughout my practicum placement, I was provided the incredible opportunity to build therapeutic skills and theoretical knowledge during walk-in counselling sessions held at Family Service Regina, the Regina Public Library, and the Mâmawêyatitân Centre. With extensive waitlists at FSR for continuous, on-going counselling services, it seemed fitting that the Agency
adopt a walk-in counselling service to provide clients the opportunity to see a trained professional without having to wait a long period of time. However, while single session therapy like walk-in counselling has proven to be effective in clinical services, the option for continuous counselling is crucial to maintain, as not all individuals will fit with the single session model (Slive et al., 2008). Despite the importance of ongoing counselling, I noticed that those who sought-out continuous counselling, often did not show up for their sessions. Referring these clients instead for walk-in counselling was an opportunity for them to seek-out counselling on their own schedule and as they felt necessary – it also freed up opportunities for others waiting for these types of sessions.

For many clients who struggle with anxiety and depression, it can feel daunting to leave their home some days. Instead of having clients book a week or two in advance for ongoing counselling, they could attend walk-in sessions any day of the week, depending on how they felt. This form of counselling tends to alleviate stress for clients, and results in a sense of autonomy over their own therapeutic journey (Slive et al., 2008). If clients can set their own pace and schedule in the therapeutic journey, they are more likely to succeed.

During my placement, I was able to attend a training session entitled Single Session Therapy & Solution-Focused Brief Therapy. The information I acquired during this two-day training session provided me with an incredible wealth of therapeutic knowledge I was able to apply in my practicum placement, and it will be something I continue to use in my professional career. One of the most important strategies I implemented after the training was the use of a “thinking break” coupled with providing the client a written feedback letter (de Shazer, 1994). Some advantages I noticed in taking a break were that it allowed me the opportunity to step away from the session, take time to process all the information that was shared, and time to consult
with other counsellors at FSR about the session. With this in mind, I began to use the final ten minutes of the walk-in session to type an affirming letter for the client and print it out for them to read at the end of the session or at home.

It is suggested that most clients who are struggling with problems do not expect to hear words of affirmation about what their hopes are, or what they have done already that has been useful (De Jong & Berg, 2002). By taking time away from the client at the end of the session, the purpose was two-fold; not only was I able to reflect on the session personally and with other clinicians, but the client was also provided time to reflect on their own, writing down two or three things that stood out to them during the session as well as two or three next steps they could take to better their situation (Bednar & Fernandes, 2019). Learning how to be able to provide this type of support and encouragement to clients during walk-in counselling sessions was a tremendous gift I will continue to implement throughout my counselling career.

**Creative Interventions**

Many children who have experienced chronically stressful situations suffer serious symptoms which interfere with normal emotional, cognitive or social development for their age (Terr, 1990). Terr (1990) states that “trauma does not ordinarily get better by itself...it burrows down further and further under the child’s defenses and coping strategies” (p. 293). Using developmentally appropriate resources such as creative interventions can be a tool to provide emotional relief from traumatic memories. This next section will describe creative interventions utilized in session with a young client to help them develop the necessary coping strategies to be able to emotionally regulate and feel safe in their environment.

**Tools for Emotional Regulation.** As mentioned earlier in this report as I discussed the case study of a client and her child who had experienced intimate partner violence, I was able to
meet with that child to complete an assessment and determine the appropriate services and treatment plan for them. After two sessions, we began working on an activity that assisted the child with developing their emotional-regulation skills. The client described feeling very angry and would often act out their anger by using physical violence, which left their mother having to physically restrain them for their own safety and for the safety of others. We worked at identifying different triggers that fed the child’s anger and referred to this anger as a physical entity, calling it their “angry monster”, so they could visualize their anger and start taming the monster by using kind words and actions. We then created another monster, the “friendly monster”, which helped the client to understand that just because the angry monster starts out mad, it does not mean that it cannot find ways to feel happy. This exercise also helped the client begin the process of externalizing their anger and moving it away from themselves, so they could effectively deal with the underlying emotions.

White and Epston (1990) surmise that when a person can externalize, their problems become a separate entity and thus, external to the person that was perceived as the problem. Their problems are less fixed and restricting, and there is a strong belief that the problem is the problem, and not that the person is the problem (White & Epston, 1990). By hearing that the child was a wonderful person with amazing qualities who sometimes let their anger get them into trouble, but at the same time, understanding that this did not mean they were trouble, the client felt liberated. They were able to understand that the angry monster did not define who they were and that they could deal with the emotions of the angry monster.

To do this, we further identified things the client could do to help their monster transition from being angry to feeling happy/friendly instead. We began working on practicing different breathing strategies and creating their very own coping kit of childhood games to help their
angry monster when it was feeling out-of-control. We used bubble breathing, dice rolling, building a house of cards, sculpting playdough, colouring, feelings Jenga, playing cats and the cradle, and playing with silly putty to help the client self-regulate and move through their anger by way of healthy outlets. It was also imperative that all of these outlets and coping strategies could be implemented at home with the involvement of their mother.

All of these tools and strategies assisted this young client in being able to feel safe and in control of their environment, which in turn, assisted them in regulating their emotions and begin to identify and understand the different thoughts and feelings being experienced. Be that as it may, the most important things required for this client to overcome their overactive stress response, were time and patience. Before there can be any lasting changes in a child's behaviour, they need to feel safe and loved (Perry & Szalavitz, 2006). Supporting and educating the child’s mother in understanding that the behaviours were pain-based, and that providing patient, loving and consistent care were the most important strategies to assist them in improving their behaviours, were transformative concepts in the healing process.

When considering how practical skills and theory are integrated it’s important to reflect on our own thoughts, feelings and values and how this impacts our work with our clients. A counsellor’s theoretical framework is embedded in the counselling sessions as it is experienced by both the clinician and client. Theory acts as a guiding force in delivering our best practice to clients. The following chapter will highlight ethical dilemmas that arise when working with couples and clients labeled as difficult as well as the importance of self-care to avoid burnout.
Chapter Seven: Ethical Considerations

This chapter will highlight the challenges and ethical dilemmas I encountered over the course of my practicum. All of these experiences provided valuable learning opportunities as they challenged me to think critically and ask questions. The challenges I will discuss include working with difficult clients, working with couples, and working to find a balance between personal life and my practicum; in order to avoid burnout.

Difficult Clients

Nearly every therapist has worked with a client who has been termed “difficult.” Many of these clients tend to be drawn to therapy because they are either seeking treatment for their difficulties, or they are forced to seek therapy because their family or society has characterized them as “difficult” (Thompson, 2003). It is suggested that “difficulty” is seen in the eye of the beholder, and that it is dependent on the expectations and tolerance levels of the therapist within the session for how they perceive the client on the difficulty spectrum (Noonan, 1998). Although there is not one specific way to describe a difficult client, one of the struggles I encountered during my practicum was working with clients who seek help but fail to implement strategies or practice the necessary skills outside of their sessions (i.e., clients who are difficult to treat as they will not actively work on themselves or try to change their behaviours).

When working with these individuals, I was often reminded of the research that suggests many people are difficult only because they are deeply ambivalent to change (Noonan, 1998). Humans like to remain static, but these “difficult” individuals do know change could be helpful; it is just scary to them. Apprehension seems to exist in-and-out of session for these clients to practice new skills as there are fears that the change may not. This carries the notion that they will feel disappointed and end up with a lower sense of self-worth (Noonan, 1998). However, the
greater the degree to which a therapist relies on optimistic perseverance and seeing the client through a strength-based and trauma-informed lens, the better a therapist will see themselves as coping with the “difficult” client (Anglin, 2002). Despite how “difficult” the client may be, when a therapist practices empathetic understanding, taking the time to acknowledge and make sense of a client’s pains and situation, it becomes harder for the difficult behaviours of the client to impact the therapist (Anglin, 2002). By understanding that the person’s behaviour is not a personal attack on them, but more so a pain-based response, the therapist is able to take an empathic and compassionate approach to the healing journey with the client.

**Walk-in Counselling with Couples**

During my student counselling experience, I had the opportunity to engage in counselling sessions with multiple couples due to the nature of the walk-in clinic offered at Family Service Regina. However, if a couple attended a session during the Thrive Walk-In Clinic, there was no way of knowing whether they would return for additional sessions. I often noticed that some of the clients from couples’ sessions would come to a second session on their own with the hope of discussing their partner’s behaviours and the relationship more intimately. But since there were no Agency policies surrounding this dilemma, I relied heavily on being present with the client, and allowing the client to determine the course of their therapy session. I also ensured during sessions like these that I was consulting with my professional associate and other professionals within the Agency (SASW, 2020). According to our Code of Ethics, “Social workers have a responsibility to maintain professional proficiency, to continually strive to increase their professional knowledge and skills, and to apply new knowledge in practice commensurate with their level of professional education, skill and competency, seeking consultation and supervision as appropriate” (CASW, 2005, p. 8). Ensuring that I was being fully present with the client, and
consulting with my professional associate prior to these sessions, proved to be an important aspect required in order to provide adequate therapeutic care.

Another dilemma that arose within my practicum was seeing a client for multiple sessions during walk-in counselling, only to have their partner come in on their own for walk-in counselling; demanding to see me as they knew I had been working with their partner. The session request was perplexing for not only myself as the counsellor, but also for the organization as they had not experienced such a situation before. The Standards of Practice for Registered Social Workers in Saskatchewan document outlines that “a social worker shall be aware of the circumstances that may lead to, or be perceived as, a conflict of interest and shall make reasonable effort to avoid such conflict” (SASW, 2020, p. 6). “If a conflict of interest cannot be avoided, the social worker shall disclose the conflict and take appropriate measures to minimize the impact of the conflict on clients, co-workers, and employers” (SASW, 2020, p. 6). By attempting to be client-centered and solution-focused, the options for me in regards to this particular couple were to either have the partner who I had not been previously seen attend a different session with another counsellor through the walk-in counselling clinic, or to have the second-comer return on another day with their partner to see another counsellor for a designated couples’ session. However, the partner was adamant they see me instead, as they wanted the opportunity to share their side of the story in the relationship; they felt that their partner had portrayed themselves incorrectly, and wanted to set the record straight.

Confidentiality was the primary concern during this situation. A cornerstone of professional social work relationships is to maintain confidentiality with respect to all matters associated with professional services to our clients (CASW, 2005). The Canadian Association of Social Workers Code of Ethics states that “social workers demonstrate respect for the trust and
confidence placed in them by clients, communities and other professionals by protecting the
privacy of client information and respecting the client’s right to control when or whether this
information will be shared with third parties” (CASW, 2005, p. 7). In this situation, I was not
provided with informed consent to share any information with the client’s partner. I made sure to
inform the individual that I would not be able to provide them with any information; however, if
necessary, could be a listening ear. The privilege of maintaining a client’s confidentiality must
always be exercised by the counsellor at all times, and I ensured that I made no reference to my
primary client during the session in order to maintain this confidence.

The situation, in general, provided an important learning opportunity for me and the
Agency, as guidelines and parameters are now being implemented at Family Service Regina to
protect clients and practitioners, and ensure a similar situation does not take place again. As
noted by Corey et al. (2007), “as practitioners, we can never know all that we might like to
know, nor can we attain all the skills required to effectively intervene with all client populations
or all types of problems” (p. 360). Discussing counselling sessions with a supervisor and getting
feedback enables practicing counsellors to gain an objective insight into their own performance
and skills. It provides an opportunity to learn and practice new skills as well as find better ways
to help clients. It also aids in developing healthier means of coping, which is essential in
avoiding the phenomena of burnout.

**Burnout**

As a new student therapist, I often felt burdened with fears of self-inadequacy and failure.
Contradictions seem to exist within the social work profession such as getting close but not too
close to clients, being caring yet detached, and providing support without fostering dependency;
all of which seem to foster uncertainty in social work practitioners (Kottler, 2017). As a result,
there is no doubt that burnout becomes a common condition experienced by almost everyone in the profession at some point during his or her career (Kottler, 2017). Burnout as a term was initially applied by Herbert Freudenberger (1989) to describe what happens to a practitioner or counsellor when they become inoperable, meaning they become rigid, resigned, irritable and quick to anger. Among those therapists who work with people who have experienced severe trauma, as many as 25% may struggle with compassion fatigue or burnout (Figley, 2002). One of the risks of choosing to be a practitioner who engages with people in a vulnerable, mindful manner is that it exposes them to the feelings that come with connecting with a client.

Brene Brown (2012) states that empathy is not only a choice, but a vulnerable choice because, to connect with someone, the practitioner must connect with something within themselves that has known that feeling. By understanding the concept that the client’s pain is real, but it is not mine to take on, I have found I have been able to be present with the client without feeling exactly as they feel or, in other words, not feeling those emotional repercussions from connecting with them on an empathic level. One of the most important lessons my professional associate spoke about was that every client can heal themselves and that we as practitioners can give our best skills to clients, without giving away ourselves (Dombo et al., 2013). Every individual, whether professionally trained or not, has the capability to move away from pain caused by trauma, but it is the therapist as a catalyst who can facilitate that healing based on how engaged and empathic they are to the client.

Just like many of our clients, such as the client I had who initially refused to deal with their emotions experienced due to their friend’s suicide, denial can also act as a major impediment in the successful treatment of social worker or therapist burnout (Kottler, 2017). I have found that, as a professional, it can be difficult to ask for help and even more difficult to
accept treatment. One of the most important lessons I have taken away from this counselling practicum experience is that it is not only okay to ask for help, but it is necessary; and asking for help should be seen as strength. We have a duty and responsibility to promote not only the well-being of our clients, but also our own.

An important aspect outlined in the Saskatchewan Association of Social Workers Standards of Practice for Registered Social Workers in Saskatchewan document is that social workers will “maintain a reasonable level of self-awareness necessary to appropriately manage personal needs, feelings, values, and limitations in the context of a professional relationship” (SASW, 2020, p. 16). It is also imperative that social workers maintain their health and well-being as an important part of competent practice (SASW, 2020, p. 16). These standards were encouraged throughout my entire practicum, as flexibility was held when I needed extra time in the morning to get my children to daycare, or when I needed a longer lunch break to process a difficult client. By providing me these allowances, FSR embodies the understanding of the importance of care for self, care for others, and care for colleagues. We have entered this profession to make a difference in the world and the place to start is within ourselves.

All of the ethical challenges I encountered throughout my practicum have led to growth and knowledge that I would not have otherwise experienced. I have learned that although there is no cure for burnout as some degree of ongoing stress is part of what is meant to be a social work therapist, there are effective strategies to counteract the effects of burnout such as self-care (Kottler, 2017). The social work profession is bound with moral obligations that require a practitioner to continually self-examine and explore the relationship between ethics and practice (Reamer, 1999). Throughout my practicum, I was fortunate to experience ethical dilemmas surrounded by supportive professionals who helped to guide and aid me on my journey. My last
ethical dilemma that I will share, relates to working with children without the proper or necessary involvement of their caregivers.

**Family Therapy in Conjunction with Child Therapy**

Law, et al. (2003) defines family-centered service as “a philosophy and method of service delivery for children and parents which emphasizes a partnership between parents and service providers, focuses on the family's role in decision-making about their child, and recognizes parents as experts on their child's status and needs” (p. 357). When we practice from a family-centered lens, we place families in the central role of making decisions about their lives, and what supports they require (Dunst et al., 1991). The counsellor acts as an ‘instrument’ of the family, intervening in flexible, individualized and responsive ways that support and strengthen the family functioning (Trivette et al., 1995). Family-centered service is arguably the opposite of the approach I had to take on while working for the Ministry of Social Services when I had to intrusively insert myself, exerting power and position, into the life of a child and their family.

While completing my practicum at Family Service Regina I had the opportunity to work with children along with their families in the counselling process. According to Novick and Novick (2005), parents should be involved in the treatment process with therapists, as treatment for the child is proven to become more efficient in doing so. Parent engagement is one of the five key elements for best practice for mental health professionals according to Romanelli et al. (2009). Family involvement is not only important in terms of child outcomes but is imperative when the goal is to reintegrate children in care back into their families or communities (Underwood et al., 2004). When working with children as the primary clients, I made it a priority to have my initial session with the parents or caregivers of the child.
Dougherty (2009) supports the notion that if counsellors are working with children, they will need to consult with the adults living with the children. Although we cannot control engagement levels of all parents, we can try to ensure we are involving the parent in the child’s treatment. This is not an easy task as many of the parents that bring their child in for counselling present with anxiety concerning their own parental failings in relation to their child’s symptoms (Kottman, 2011). As discussed in the case study of the mother and her child who experienced trauma from domestic partner violence, the caregiver of a child must also be reassured in their abilities to deal with, and help with, the problems of their child.

One of the families that sought out my counselling and treatment for their child was flooded with their own personal issues which only exacerbated the child’s issues. When I was presented with parents such as this, I intervened by listening and responding to their needs for 2-3 sessions first. This helped to form an alliance with the caregivers and gave them an understanding as to how their personal history and story may be impacting their reactions to their child’s behaviours. When we respond to the parent’s needs, this benefits their child’s sessions as they are more inclined to practice the necessary skills and interventions within the home (Kottman, 2011). When listened to, they also feel as though they have had a chance to share their story and feel heard, which opens them up to allowing their child to feel fully and completely attended to during the family session with them.

Throughout my practicum, I experienced situations where I had to provide care and guidance for parents even though my primary client was the child. Teaching parents about attachment was crucial in helping the family understand their important role in their child’s therapeutic journey. I would often spend time explaining to parents that their child’s attachment system is always on, and that to be a secure base for a child, the child must feel that their
caregiver knows, accepts and is committed to them (Dozier & Bernard, 2019). When parents take an active role in learning about their child and trying new techniques in their home, it tells their child that the entire family is committed to making the home a safer place.

Working with the family on activities that they can do together to foster attachment, and how they can continue to meet emotional needs even when behaviours are challenging, was a focus of my family work while in this practicum placement. I referenced the work of Siegel and Bryson (2012) with every family that I encountered, as this body of work provided simple ways for parents to help their children thrive. This reference also gave concrete examples of how parents can connect with their children more deeply and respond to difficult situations more effectively (Siegel & Bryson, 2012). Continuing to involve parents and caregivers in counselling sessions will be a practice I will stick with for the rest of my counselling career. Parental involvement is key and fundamental to successful child counselling outcomes.

Every challenge that I experienced during my practicum experience held an incredible learning experience that has deeply influenced my counselling skills. These opportunities provided me with insight into my own growth and development and how I wish to continue my journey as a counsellor. My final chapter will conclude my experience as a student counsellor, and how I envision my future as I continue down my path of growth and learning.
Chapter Eight: Conclusion

Chapter eight will conclude my overall experience as a practicum student at Family Service Regina (FSR). This chapter will include my final comments, provide discussion about how this practicum has influenced my future aspirations as a social work practitioner and clinician, and will include my vision for the future of my social work practice.

My Future as a Social Worker

While completing my practicum, I was afforded the opportunity to not only practice new skills, but develop the confidence to make mistakes, challenge myself and move through the discomfort of the unknown. Counselling was a term that elicited fear in me prior to my practicum. I often felt inadequate when practicing my skills and was left wondering if I was truly making a difference. However, this practicum experience grounded me in a way that I never thought possible; I have been able to recognize that every therapist operates in a slightly different way, even if they subscribe to the same approach. I have learned that it is beyond our means to help everyone, and that I do not always have to make brilliant judgments or have my clients appreciate all my teachings or works.

Psychiatrist Frank Pittman once stated in an interview with Jeffery Kottler (2017), “You want an example of failure? Do you want one that happened today? I’ve got so many I don’t know where to begin” (p. 110). Failures and successes are a continual and plentiful part of successful social work counselling, and just because we are well-seasoned practitioners does not mean we will not fail. I was humbled by the opportunity to continually reflect on my therapeutic journey, adapt to new challenges, and take comfort in knowing that making mistakes and experiencing failures is a part of being a therapist. Having the space to critically process and reflect on these experiences felt uncomfortable at times, but it is what led to a growth that will
forever impact my role as a social work counsellor. By effectively owning, acknowledging and talking about my mistakes with trusted mentors, I was able to learn new ways of doing, and accept that throughout my career I will do good therapy, but mistakes are still bound to happen. What is important is noticing the difference and making attempts to do better the next time – just as a reflective practitioner should.

**Final Comments and Recommendations**

As stated previously, mindfulness was a practice I was able to weave into every session with every client. It felt like the thread that held everything together for me during this practicum placement; and through this experience, I have developed the desire and skillset to continue with incorporating mindfulness strategies in my practice and my own personal life to ensure I am practicing the skills I teach to my clients. Balancing family life and career aspirations is a heavy load for any practitioner, and mindfulness provides acknowledgement and coping with this reality. As a result, this practicum has made me accountable to myself and my own self-care strategies. Having a personal mindfulness practice that I am incorporating on my own time has helped me to stay grounded and connected to the present moment, and has increased my ability to quiet my mind, both within my counselling practice and within my private life.

Having the opportunity to practice and implement mindfulness to reduce my own anxiety and stress has provided me with a new habit which I will continue to foster. It is my hope that all counsellors will take the opportunity to learn to be mindful within their practice and in their personal lives, so that they can be more present with their clients – just as I have learned to do. By opening up to awareness, we can create a space for more empathy, understanding and compassion for the individuals we serve as practitioners.
Utilizing family-centered approaches in a counselling setting is a useful way to help parents or caregivers manage stress, feel more confident, and be better equipped to interact with their children and provide the entire family with education surrounding the familial issue. When a child has behavioural difficulties, and that is the reason for seeking out support and counselling, helping the parents by providing specific training and education to deal with their child’s social-emotional skills can strengthen the family system. Although, family-centered practice can be challenging and requires creativity at times, it is important that counsellors prioritize working with the whole family in practice.

Family Service Regina as a social service agency in the community acts as a beacon of hope to the most vulnerable, oppressed and displaced members of society. It is an Agency that has adopted a trauma-informed and anti-oppressive approach to practice, and is one that serves to provide individuals with hope and opportunities to make changes within their lives. It is the goal of the Agency and the counsellors that work in the Agency to continue to challenge systemic oppression so that those who are the most vulnerable and need the most support can work to rebuild their lives. It is impossible to not be touched by what we see, hear and experience with our clients. Having the privilege to get as close as possible to another human being bearing their soul, creates a sense of joy when we witness their positive emotional and attitudinal transformations.

Taking pride and the same amount of excitement when we also notice our own internal change and transformation, is also important work that we need to notice to feed our own souls and prevent burnout. There is light and emotional freedom for clients beyond their horizons of pain and trauma; it just takes asking for help, seeking the appropriate means for treatment, having the right support and mindset in place, and putting in the work required to change for the
better.
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Appendix A

Client Consent Form – Field Practicum Report

You have agreed to receive counselling support from ________________________, in their role as a practicum student completing a Master of Social Work degree through the Faculty of Social Work, University of Regina. The student’s University Academic Supervisor is: ___________________ (PHONE NUMBER __________).

As part of the practicum, the student is required to submit a final Field Practicum Report outlining and discussing knowledge and skills gained from the practicum experience. The student’s final report will discuss and analyze aspects of their counselling/therapy learning experience. This integrative Field Practicum Report will focus on social work and counselling practice and theory and will discuss skill development within the context of counselling sessions under supervision.

You are being asked permission to have elements of your counselling experience with this student counsellor included in the student’s final report. Elements included in the report may highlight issues that arise in the course of your sessions, and the student’s theoretical analysis of the issues and the particular theoretical or methodological approach they applied in the sessions. All identifying information will be changed and pseudonyms used to ensure that you cannot be identified.

Confidentiality:

• To ensure confidentiality, clients will not be identified by name and no identifying information will be used in any portion of the final report or drafts leading up to the completion of the final report. As stated, the final report will serve to highlight aspects of the client sessions and the counselling theories and methods used that were instrumental to the student’s learning process.

Right to Review and Withdraw:

• Upon request, you will be provided with the final draft version of those aspects of the student’s Field Practicum Report that may pertain to your sessions with the student.
• You have the right to agree/not agree to the inclusion of aforementioned elements of your counselling sessions in the student’s final Field Practicum Report. The availability and quality of services provided to you will not be impacted by this decision.

• You have the right to agree and subsequently withdraw your consent for information related to your situation from the report at a later date. Please contact the student by _______________. After this date, the information cannot be removed, as the final report will already be submitted for review and approval. The student can be contacted by phone through their Academic Supervisor at: PHONE NUMBER ____________.

• Student reports are maintained by the University of Regina library, and therefore become part of the public record. Field Practicum Reports will be available online for public viewing.
INFORMED CONSENT AND SIGNATURES

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

I, __________________________________________________________ give permission to __________________________________________________________ (Student’s name)

to incorporate elements of my counselling sessions with him/her, as a student counsellor during this practicum placement, into his/her Final Practicum Report. I understand that this final report is submitted to the Faculty of Social Work as required for completion of a Master of Social Work degree. I understand that a copy of this form will be placed on my confidential file within (Name of Agency), ____________________________ or if no such file exists, with the student’s Academic Supervisor in his/her confidential and locked filing cabinet at the University of Regina. I understand that the final report becomes part of the Institution Library and the public record. I understand that if I elect to NOT review the final Practicum Report, that this consent will continue to apply.

________________________________________ (Client’s signature)  ______________________________ (Date)

________________________________________ (Practicum Student’s signature)  __________________________ (Witness)
Appendix B

Client Consent Form (Minor) – Field Practicum Report

You have agreed to that your child _________________ (Name) would receive counselling support from ___________________________ (Name of MSW Student), in their role as a practicum student completing a Master of Social Work degree through the Faculty of Social Work, University of Regina at ___________________________ (Name of Agency). The student’s University Academic Supervisor is: ___________________________ (PHONE NUMBER ____________).  

As part of practicum, the student is required to write a final Field Practicum Report outlining and discussing knowledge and skills gained from the practicum experience. The student’s final report will discuss and analyze aspects of their learning experience. This integrative Field Practicum Report will focus on social work and counselling practice and theory and will discuss skill development within the context of counselling sessions under supervision.

You are being asked to give permission to have elements of your child’s counselling experience with this student counsellor included in the student’s final report. Elements included in the report may highlight issues that arise in the course of the sessions, and the student’s theoretical analysis of the issues and the particular theoretical or methodological approach they applied in the sessions. All identifying information will be changed and pseudonyms used to ensure that your child cannot be identified.

Confidentiality:

- To ensure confidentiality, your child will not be identified by name and no identifying information will be used in any portion of the final report or drafts leading up to the completion of the final report. As stated, the final report will serve to highlight aspects of the sessions pertaining to your child and will describe the counselling theories and methods used that were instrumental to the student’s learning process.

Right to Review and Withdraw:

- Upon request, you will be provided with the final draft of the student’s Field Practicum Report.
- You have the right to agree/not agree to the inclusion of aforementioned elements of your child’s counselling sessions in the student’s final Field Practicum Report. The availability and quality of services provided to your child will not be impacted by this decision.
- You have the right to agree and subsequently withdraw your consent for information related to your child’s situation from the report at a later date. Please contact the student by _______________. After this date, the information cannot be removed, as the final report will already be submitted for review and approval. The student can be contacted by phone through their Academic Supervisor at: PHONE NUMBER _____________.
- Student reports are maintained by the University of Regina library, and therefore become part of the public record. Field Practicum Reports will be available online for public viewing.
INFORMED CONSENT AND SIGNATURES:

I have read and understand the information provided; I have had an opportunity to ask questions and my/our questions have been fully answered. A copy of this Consent Form has been given to me for my records. I hereby give consent to, ______________________ (Name of MSW student) to incorporate elements of my child’s counselling sessions in their final report. I understand that this final report is required for the completion of a Master of Social Work degree. I understand that a copy of this form will be placed on my child’s confidential file within (Name of Agency), ______________________. I understand that once the final report becomes part of the Institution Library and the public record I cannot withdraw consent. I understand that if I elect NOT review the final Practicum Report, that this consent will continue to apply.

_________________________________________  ______________
(Parent’s signature)                         (Date)

_________________________________________  ______________
(Child’s signature - for children over the age of 12 years) (Date)

_________________________________________  ______________
(MSW Practicum Student’s signature)          (Witness)

FSW Graduate Studies Committee Approved February, 2017
Appendix C

List of webinars


