

**THE IMPORTANCE OF TRAUMA-INFORMED PRACTICE AND HOW IT LINKS TO  
SOCIAL WORK PRACTICE IN THE FIELD OF MENTAL HEALTH**

by

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## Abstract

This practicum report is intended to provide a summary and reflection for the completion of my Master of Social Work requirement as a clinical social worker at Family Service Thames Valley situated in London, Ontario. Family Service Thames Valley is an agency that provides an array of services for the population of London, Ontario and the surrounding area. The agency's primary focus is the provision of mental health services. Family Service Thames Valley provided an exceptional opportunity to achieve my learning goals, while developing and strengthening my social work skills in the context of working with persons living with the impact of trauma, domestic violence, addictions, depression, oppression, marginalization, and mental disorders. My practicum experience as a clinical social worker at Family Service Thames Valley supports the importance of trauma-informed practices within the field of mental health and helps to understand the link of trauma-informed practices to social work practice.

## TABLE OF CONTENTS

Abstract		ii
Table of contents		iii
Acknowledgement		iv
Chapter One	Introduction	1
	Practicum Site	2
Chapter Two	Theoretical Orientation	4
	History of FSTV	4
	Services at FSTV	5
	Personal Theoretical Orientation and Position	7
Chapter Three	Literature Review	11
	Context for Social Work in Mental Health Services	11
	Models of Intervention in Social Work Practice	15
	Trauma	17
	Trauma-Informed Services	20
	Health care services and trauma survivors	23
	Trauma-Informed Practice ‘links’ to Social Work Practice	28
Chapter Four	Practicum Activities and Learning Experiences	31
	Goal: To learn advanced clinical practice skills in individual practice	33
	Contract Funding Eligibility	41
	Client Caseload	42
	Client Introductory Protocols and Assessment Procedures	44
	Implementing an Integrative approach	46
	Self-Care Practices and Value System Consistent with OCSWSSW	48
	Examining OCSWSSW Code of Ethics	49
Chapter Five	Implications for Practice and Recommendation	51
	Conclusion	56
References		58
Appendix A	Learning Contract	62
Appendix B	Four Principles of Trauma Informed Approach	65
Appendix C	FSTV Assessment Summary	66

## **Acknowledgement**

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Words cannot express my gratitude felt towards my clients who trusted me with their stories. The resilience, growth, and determination, of each and every client reaffirmed my passion for working with people who are seeking services in the field of mental health. My clients at Family Service Thames Valley are continuous evidence that the effects of trauma can improve when an individual receives adequate support throughout their healing process.

A heart felt "thank you" to my late mother, a survivor of childhood trauma, who understood and supported me in my passion of helping others. Knowing that I was being watched over in the process of achieving my masters provided me with strength and comfort. I owe thanks to my four children who never questioned my desire to obtain my Master of Social Work degree as a mature student. Thank you to my friend Jane who knows my story and supported me during difficult times when I felt I was unable to believe in myself. Thank you to my friends in Nunavut, who were aware of my desire to obtain my masters graduate degree and encouraged me on those days I was hesitant to commit. Thank you to the Government of Nunavut FANS Program who supported me in obtaining my Master of Social Work degree.

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## **Chapter One: Introduction**

I previously obtained two undergraduate degrees before choosing to obtain my Master of Social Work (MSW) degree; the first is a Bachelor of Arts (BA) with a minor in psychology and the second, an Honors Bachelor of Social Work (HBSW). This report is my final requirement in finishing my Master of Social Work (MSW) degree at the University of Northern British Columbia.

After living and working as a social worker in Iqaluit, Nunavut, and witnessing the lack of resources for clients seeking mental health services I wondered what the differences in services would be between Nunavut and Ontario. What would a publicly funded mental health agency offer? Would they offer the support and resources that were so sorely missing in Iqaluit? I am fortunate to have completed my practicum at Family Service Thames Valley (FSTV). FSTV provided me with the opportunity to develop my social work skills as a clinician working in the field of mental health. During my practicum experience I was able to work with a combination of mental health issues, some being more complex than others such as: domestic violence, depression, anxiety, childhood sexual abuse, childhood neglect, concurrent disorders, and addictions. My experience at FSTV was rewarding, challenging, and most importantly educational. My learning equipped me with the knowledge required to be competent in the role of a clinical social worker, while remembering it is essential that I remain open to new opportunities and continue engaging in professional development. My previous experience working in a mental health facility did not offer supervision or consultation and through this experience at FSTV, it has highlighted the necessity for both. Nevertheless, it is important for me to recognize the achievements and growth that occurred in my social work practice and in the clients who I assisted during that time. It is my opinion that the role of a clinician should be

accompanied with adequate supervision. My practicum at FSTV provided me with on-going clinical supervision and consultation. Clinical supervision during practicum is a requirement in achieving higher levels of competence in clinical social work practice (Bogo, 2015). My practicum supervision left me feeling confident that I will transfer my learning in assisting others as a MSW graduate working in the field of social work and mental health.

### **Practicum Site**

My practicum placement at Family Service Thames Valley was located at 125 Woodward Avenue in London, Ontario. This location is the primary setting for a variety of support services that cater to the people in London, Ontario and the surrounding area named Elgin and Middlesex.

FSTV is a non-profit agency, which has been in operation for approximately 75 years (Family Service Thames Valley, 2016). The agency is an inclusive welcoming place with skilled counsellors and psychotherapists who provide support in assisting people in dealing with a variety of issues including: stress, mental health issues, home relationship issues, childhood trauma, sexual abuse, displacement, and life transitions. (Family Service Thames Valley, 2016). The staff at Family Service Thames Valley is committed to offering services to all individuals in need (Family Service Thames Valley, 2016).

During the duration of my practicum I was a member of the Clinical Internship Program. The Clinical Internship Program offers postgraduate and graduate level clinicians advanced training in individual, couple, and family therapy (Family Service Thames Valley, 2016). Rhea Lajoie, my practicum supervisor, is also the manager and clinical supervisor of the Clinical Internship Program. My introduction to the agency included an orientation that consisted of a seminar for the current intern students and other student therapists at the agency. My first supervision meeting was on orientation day. My area of interest is in the integration of social work theories and practice when working with individuals, couples, and groups. However, for



the purpose of my practicum experience a psychodynamic approach was the main focus of my training. Psychodynamic theory in social work practice is an effective theory that studies areas such as early childhood attachment and the developmental stages. I have a particular interest in understanding the effects of childhood trauma and helping individuals to better cope and make positive change. Psychodynamic theory has guided me in exploring the lived experiences of FSTV clients'. Through exploration clients have gained insight into their unhelpful thinking and behaviours and learned healthy ways to cope and create change. I have integrated the use of a genogram into my practice, an assessment tool for therapeutic purposes. The genogram helps to explore the clients' history, which provides important information for the therapist to refer to. FSTV offered several clinical opportunities for me to learn various modalities of psychotherapy counselling methods and to hone my practice skills as a social worker in a clinical environment. Although that was my primary goal I had a particular interest in Trauma Informed Practice (TIP) and how it links to social work practice in the field of mental health.

Although I understand there is a need for the medical model in various situations within the health care system, I have learned through research, previous employment, personal experiences, education, and doing my MSW practicum at FSTV of the importance of TIP within these services.

## **Chapter Two: Theoretical Orientation**

Family Service Thames Valley (FSTV) operates from an anti-oppressive approach. In using an anti-oppression approach FSTV acknowledges the impact of oppression in the lives of the clients they serve. Although there are many forms of oppression FSTV recognizes that the following areas oppression exists:

ableism, ageism, sexism, heterosexism, classism, anti-Semitism, homophobia, transphobia, and discrimination based on cultural, ethnic or religious background.

Oppression, evidenced through discrimination, is systemic in our society. It is more than individual acts of violence, segregation, or discrimination motivated behaviour and actions. Oppression is endemic in our institutions and has the effect of exclusion. It is a part of our society and is inextricably linked to the equality rights of women and other marginalized populations. (Family Service Thames Valley, 2016)

In recognizing the impact of oppression, FSTV aims to illuminate discrimination by using an inclusive holistic anti-oppressive approach in the provision of all services. FSTV sees anti-oppression as way of naming oppression that happens based on a person's identity and works towards ending mistreatment, oppression, and violence toward that particular individual and group (Family Service Thames Valley, 2016).

### **History of FSTV**

Family Service Thames Valley, originally known as the Catholic Welfare Bureau (CWB), was founded in 1939 (Family Service Thames Valley, 2016). The founder, Father Monsignor Joseph Cook, lived in London, Ontario, and obtained his Master of Social Work at the Catholic University of America (Family Service Thames Valley, 2016). CWB was a fundamental part of the Federation of Catholic Charities that established social services, an orphanage, a home for the

aged, and two hospitals (Family Service Thames Valley, 2016). The early stages of the organization focused on providing financial assistance to the poor. Eventually, Father Cook along with volunteers helped families and fractured marriages impacted by the war, by providing counselling and intervention services (Family Service Thames Valley, 2016). After the financial benefits of welfare were taken over by the government the organization focused on providing family and marriage counselling and in 1955, changed the name of the organization to the Catholic Family Centre (Family Service Thames Valley, 2016). In recognizing the transition from serving the Catholic poor to serving the larger community the name was changed to the Family Counselling Centre. Then, in 1985, the name changed again to Family Service London to reflect the relationship with the national association of Family Service Canada (Family Service Thames Valley, 2016). Although the name of FSTV has changed a number of times the themes have remained the same in providing services to meet the needs of the community and counselling services to individuals, couples, and families, from skilled counsellors (Family Service Thames Valley, 2016).

### **Services at FSTV**

FSTV recognizes Canada's diverse society. The organization operates using an inclusive holistic, anti-oppressive framework with a strength-based approach. Counselling services are provided to individuals, couples, groups, and families from various cultures, racialized groups, socio-economic backgrounds, sexual orientation, and gender identities. Services are offered in a variety of languages including English, French, Polish, and Spanish. An interpreter can be available if a language is not understood. FSTV fees are on a sliding scale making sure no one is refused services (Family Service Thames Valley, 2016). FSTV social justice roots remain deep and strong serving those who are marginalized, living below the poverty line, refugees, sexual violence survivors, and childhood abuse survivors.

FSTV has an array of services to meet the needs of their clients. Skilled counselors offer each person encouragement and understanding while helping them through life's challenges (Family Service Thames Valley, 2016). A safe therapeutic environment is provided for individual counselling allowing the client to examine painful feelings and develop coping strategies. Partners learn to better understand each other through couple counselling supporting them to resolve conflict, learn healthy communication styles, and achieve intimacy while developing a mutual understanding. The complexities of family life are addressed through family counselling using effective communication to help strengthen family relationships. (Family Service Thames Valley, 2016). Several psycho-educational and therapeutic groups are available at FSTV. *Coming Out Over Coffee*, is an informal support group for persons over nineteen who identify as lesbian, gay, bisexual, trans, two-spirit, queer, or individuals who may be questioning their identity. *Men Moving Towards Healing*, is a group specifically for adult male sexual abuse survivors focused on the impact of abuse and their sense of safety. *Communication Skills Group for Couples* is a group for couples wanting support on healthy communication within the relationship. *Rebuilding After Separation* is a group to support both men and women in moving forward from the impact of separation. *Men Managing Emotions*, is a psycho-educational group helping men learn strategies in dealing with anxiety, hurt, anger, and other emotions. *Managing Anxiety and Depression*, is a group specifically for women who will benefit from support and symptom management. *Women and Anger* is a group offered to help women identify and understand their anger. These women learn conflict resolution and assertiveness skills (Family Service Thames Valley, 2016).

### **Personal Theoretical Orientation and Position**

My personal and professional background along with my educational experiences influenced my ongoing desire to work with marginalized populations to participate in positive change. Therefore, I use an anti-oppressive strength-based approach in my social work practice. Anti-oppressive practice suggests the need to understand the dynamics of power and oppression. It examines how power divides people, places, and things, in valuing one while oppressing the other. It is not uncommon for mental health clients to have been affected by a type of oppression such as violence, institutional (systemic), exploitation, marginalization, or colonization (cultural imperialism).

In my previous experience I assisted clients in a mental health setting using a social constructionism perspective as my primary model. Although, an anti-oppressive approach is also fitting especially when the clients are living with the impact of colonization. Social constructivism invites new information in understanding everyday situations because there is often more than one answer to any given situation. Social constructivism leaves the door open for individuals to tell their story and acknowledges that each person has something to contribute. It is my belief that anti-oppressive practice and social constructivism compliment one another nicely in practice. Providing a safe place for clients' using mental health services to tell their story while understanding the dynamics of power and oppression is an example of combining both approaches.

I have rich experience working with diverse and marginalized individuals who have lived or are living with multiple forms of oppression. In addition, oppression was not a stranger in my personal life. I am a survivor of childhood abuse, sexual violence and domestic violence. In my quest for freedom I became a single mother who raised four children with parental pride while living below the poverty line. Although at times it was challenging, a wise woman helped me to

develop gratitude as a single mother in recognizing many resources were available for me because I lived in Canada. In spite of having to overcome barriers I managed to keep my faith in believing that all would be well. My personal philosophy is that an individual can be helped more effectively once they are understood. One of my favorite poets is Maya Angelou, a civil rights activist, an advocate, and a woman who survived childhood sexual violence. The quote written by Angelou (2017) relates to my victory in facing my challenges and meeting my expectations is as follows:

*“People will forget what you did, people will forget what you said, but people will never forget how you made them feel” (Angelou 2017).*

This quote symbolizes truth in my lived experience. Fortunately, I was blessed to have the right people in my life that did not judge me in my position within society; instead they took the time to learn who I was.

It has been said that the difference between a good therapist and a bad therapist is one who has done their work. In providing clinical services it is crucial for the clinician not to judge whether a client can or cannot be helped. Greene, Jensen, and Jones (1996) noted a clinician’s responsibility is the need to be aware of their unresolved family of origin issues. Effective treatment requires clinicians to be careful not to allow their own family of origin issues to interfere with the client’s work. This awareness will enable success in treating the client rather than the possibility of reinforcing the client’s problematic behaviours (Green, Jensen, & Jones 1996). I was conscious that being a trauma survivor and a clinician would impact the way in which I practice. I believe my personal experience of working through my trauma with the use of a skilled trauma therapist/doctor who specialized in providing psychotherapy and psychodrama has contributed to the comfort I experience and the level of understanding I have when building a therapeutic relationship with clients. It is my belief that my genuine and caring approach helps to

generate increased awareness of the client's experience. Although I was fortunate to receive long-term psychotherapy, my understanding is that the avenue I took is sometimes not available or not always necessary for all trauma survivors to heal. My trauma experiences were not visually obvious to my clients or others. However, my personal healing is indescribable which contributes to my genuine passion of helping others and my belief that trauma can heal and change is possible.

My passion to help others lead me to previously work in a college setting with persons who had visual or nonvisual disabilities. Most recently, I moved to Nunavut prior to coming to the University of Northern British Columbia to obtain my MSW. In Nunavut I worked as a social worker at a micro and macro level, primarily with the Inuit population. In my experience working at the micro level as a mental health consultant I was made aware that the majority of my clients lived with the effects of intergenerational or historical trauma caused by colonization. The lives of the Inuit people were exploited by acts such as removing children from their homes, relocating families, and dog slaughters leaving the Inuit people with no transportation. The children were forced to go to residential schools where they sometimes lost their cultural identity, had no parental support, were forbidden to speak their language, and many were physically and sexually abused. In my role of working as the Family Violence Specialist at a macro level, evidence supported that the effects of historical trauma contributed to the high statistics of domestic violence in Nunavut. Therefore, the impact of trauma was blatant in the lives of the Inuit people at both the micro and macro level. As a result of my personal and professional experiences as a social worker, at both micro and macro levels, the need for working with a Trauma-Informed Approach (TIA) became more apparent. It was this awareness that inspired my interest in exploring the TIA and its effectiveness as part of my practicum experience. In addition, it furthered my drive to supplement my knowledge.

It is my personal belief that all organizations in the helping industry would benefit from using the TIA, more importantly organizations involved with populations that have experienced collective trauma such as colonialism. However, for the purpose of this report the focus is specifically on the need to use a TIA in a clinical setting. I believe a TIA is the first step of acknowledging the sensitive concerns that may or may not exist within the individual, group, family, or communities that we as social workers serve.

The next step in my process was to do a thorough literature review with an attempt to emphasize the benefits of Trauma-Informed Practice (TIP) and how it links to social work practice within a clinical setting.



### **Chapter Three: Literature Review**

Meeting the needs of people requesting mental health services is an on-going challenge whether the population is large or small. The therapy approaches in treating individuals, couples, and groups, continue to evolve with the intent to provide adequate services. Throughout the years therapy models and approaches have changed. Some have increased in popularity, whereas, others have been questioned for their effectiveness. The purpose of this literature review is to provide information related to my practicum experience as a clinical social worker at Family Service Thames Valley. The review of the literature provides a context of clinical social work, theories and models applied, cases of people who seek assistance in mental health services, and acknowledges trauma in the lives of people seeking these services. Finally, an emphasis is placed on Trauma-Informed Practice and how that links to Social Work Practice in the field of mental health.

#### **Context for Social Work in Mental Health Services**

Although the profession of social work includes casework, group work, and community organization, the term clinical social worker has not always been recognized as a specialty in the field of social work. The profession of social work has experienced many changes throughout the years although its professional values have remained the same. Goldstein (2007) suggests when the term clinical social work entered the profession it was viewed as treating the inner person with an intention to cater to the middle class rather than the poor and oppressed. In spite of on-going controversy, Goldstein (2007) argued the term and definition of clinical social worker achieved respect within the mental health community. Goldstein (2007) notes a continued description within the recognition of the profession:

many professional bodies embraced a broadened use of the term and defined clinical social workers as those who by education and experience were qualified at the

autonomous practice level to provide direct, diagnostic, preventive, and treatment services to individuals, families, and groups where functioning is threatened or affected by social and psychological stress or impairment (p. 16).

Goldstein (2007) points out the later description of clinical social work by the National Association of Social Workers (NASW) as having a central core. This central core is a person-situated perspective, encompassing an array of approaches when working with individuals and environments with the concern of the personal and social context using a biopsychosocial assessment lens (Goldstein, 2007). The NASW is the largest membership organization of professional social workers in the world and they describe the central core of clinical social work as follows:

Psychotherapy was acknowledged as a part but not the whole of the intervention process, which was thought to include differential diagnosis, crisis intervention, brief and extended psychotherapy, case management, and client-centered advocacy. It also encompassed a wide range of client diversity associated with race, culture, socioeconomic status, gender, sexual orientation, age and physical challenges. (Goldstein, 2007, p. 17)

Lukens and Solomon (2013) mention “The National Association of Social Workers Code of Ethics’ states that “social workers promote clients’ self-determination,” and that “social workers seek to enhance clients’ capacity and opportunity to change and to address their own needs” (Luken & Solomom, 2013, p. 62). Empowering the client in the role of a clinical social worker aligns with the promotion of self-determination. In recognizing the need for clients to make their own decisions in the process of change, social workers provide counselling, psychotherapy, psychoeducation, social justice, and advocate where applicable.

Magee, Spaaij, and Jeanes (2015) state that a global priority is for mental health services to provide support to individuals in assisting them to recognize their capabilities so they can lead

meaningful and purposeful lives. They provide a description from the World Health Organization that considers mental health as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” (Magee, Spaaij, & Jeanes, 2015, p. 358). Similar to FSTV, clients with mental health or mental illness concerns are offered services to assist them in learning healthier coping skills to apply in their daily lives. Magee, Spaaij, and Jeanes claim that the definition of mental illness is contentious and provide a description from the biomedical model which “views mental illness as an objectively diagnosable and measurable condition” (Magee, Spaaij, & Jeanes, 2015, p. 358). The DSM-5 (2013) state “a mental disorder is a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotional regulation, or developmental processes underlying mental functioning” (p. 20). Clearly the biomedical model is similar to the medical model which focus is on diagnosis with medical solutions. Magee, Spaaij, and Jeanes (2015) note social organs and its treatment are normally unnoticed with use of the biomedical model. Although diagnosis and medical treatment are often necessary when treating people with mental illness, exploring the client’s overall health needs are equally important. The biopsychosocial model used in social work practice involves working with clients in medical services and extends out into the clients’ environment and community. Considering the needs of both mind and body in the treatment plan of clients seeking mental health services aligns with the principle of social work practice.

A top priority of social work services recognized by the National Association of Social Workers is the access to health and mental health care (Mendenhall & Frauenholtz, 2013). Mental health services have had a history of shortages due to the lack of focus placed on mental health issues. Although stigmatization towards people with mental health issues has decreased,

the lack of services continues to remain a problem (Mendenhall & Frauenholtz, 2013). The degree to which one has the ability to obtain, process, and understand health information, is known as the term health literacy (Mendenhall & Frauenholtz, 2013). Medical staff are educated and equipped to take care of the sick, injured, or dying because their education provides them with knowledge to attain health literacy. Alternatively, low health literacy contributes to worse health outcomes including chronic diseases (Mendenhall & Frauenholtz, 2013). Mendenhall and Frauenholtz (2013) argue that health literacy does not take this into consideration. Therefore, mental health literacy must be included to address all health concerns. Mendenhall and Frauenholtz (2013) acknowledge that social workers with their values and experiences as leaders need to start an undertaking to address the need for mental health literacy. Distinct from the term health literacy, Mendenhall and Frauenholtz (2013) define “mental health literacy to include the ability to recognize disorders and obtain mental health information; knowledge of risk factors, causes, self-treatments, and professional help; and attitudes that promote recognition and appropriate help seeking” (p. 365). Clinical social workers help to bridge the gap of mind and body, which supports clients healing in using a holistic approach. Included in this approach is the implantation of Evidence Based Practice.

Evidence Based Practice is a common model used in social work practice. Three primary areas of evidence-based practice include a skilled clinician, research evidence, and the consideration of the clients’ values, decisions, and preferences in the treatment plan. Stanhope, Tuchman, and Sinclair (2011) note community based mental health is recognized as using Evidence Based Practice more so than any other area of social work practice. The concern of limited mental health services supports the need to use research evidence to target treatment areas. They argue that treatment supported by research is ethically crucial for clinicians to practice (Stanhope, Tuchman & Sinclair, 2011).

### **Models of Intervention in Social Work Practice**

Attachment Theory developed by John Bowlby is a theory that focuses on the importance of parental attachment with the mother as the primary caregiver. In the case that a mother was not present in the child's life the focus is on the early emotional bonds. Bowlby was convinced that the length and type of deprivation between a mother and child contributed to psychopathology (Blakely & Dziadosz, 2015). Attachment theory is a popular method used by clinicians in treating clients using mental health services. Blakely and Dziadosz (2015) note attachment theory is largely used by clinical social workers given social workers are skilled in understanding clients' social histories. Clients' histories can be understood in the context of attachment theory. Furthermore, the clinical social worker can develop an intervention to enable the client to work towards developing a secure attachment style (Blakely & Dziadosz, 2015). Attachment theory complements the person-in-situation paradigm, a key concept used in social work practice (Blakely & Dziadosz, 2015). Social workers are trained to include the clients' environment during an assessment. This training may contribute to attachment theory becoming a popular method for social workers to use when assisting clients who use mental health services. Exploring the clients' interpersonal relationships can help recognize the clients' disruptions in attachments. These disruptions can contribute to patterns of attachment that can leave a client feeling anxious and or emotionally deregulated. The mind and body lived experiences are linked in using attachment theory. Blakely and Dziadosz (2015) argue attachment theory contributes to successful psychotherapeutic interventions that also contribute to maintenance of good health. Therefore one's mental health is linked to one's overall health (Blakely & Dziadosz, 2015). They go on to say, "Psychotherapists and practicing physicians similarly have recognized the co-morbidity of psychological and physical disorders" (Blakely & Dziadosz, p. 283).

Another popular therapy commonly used in social work practice is Cognitive Behaviour Therapy (CBT) which is an approach commonly used to help clients change their unhelpful thinking patterns. CBT recognizes the influences external experiences can have on people's lives. Therefore, CBT is a theory that aligns with person-in-environment which is a key concept in social work practice. Negative experiences such as childhood neglect or other forms of abuse can leave a person feeling unworthy. It is not uncommon for clients who access mental health services to discover through therapeutic intervention that they have developed negative core beliefs about themselves. Consequences of negative core beliefs can influence negative behaviours, situations, or decisions such as abusive relationships, addictions, violence, homelessness, poverty, and suicide ideation. Early and Grady (2017) note social workers must honor the person-in-environment perspective and to do that they must understand the cognitive and behaviour theory roots of CBT. This knowledge contextualizes how CBT integrates both behaviour and cognitive histories when working with clients. Early and Grady (2017) argue the term behaviour includes both overt actions and personally private events such as "self-talk, thinking, feelings, dreaming, physiological reactions, cognition, perceptions, and recollections" (p. 40). Clinical social workers with a strong awareness of the roots of CBT can better assist their client in changing unhelpful thinking patterns to helpful thinking and decision-making.

Narrative Therapy is commonly used in social work practice. This therapy enables the client to tell their story while the clinician assists in identifying the client's strengths. Paquin (2006) points out narratives are personal stories that reveal meaning. These stories tell how the client views themselves and others (Paquin, 2006). In making meaning "a narrative approach attempts to open up people's ability to consider different stories through "deconstructive questioning" " (Paquin, p. 131). The combination of narrative therapy and a strength-based approach supports the client in viewing their story from a different perspective and recognizing

their strengths. Paquin (2006) argues a strength-based approach requires more than assessing strengths and reframing. It involves on-going identification of client strengths and utilization of resources to help improve the clients' position (Paquin, 2006). These strengths include "what individuals and families know and have learned through struggles; their talents and virtues; rituals, beliefs, spirituality, and faith; dreams and hopes; and their own communities" (Paquin, p. 128). Other principles included are:

the belief that every individual, family and community has strengths, assets, and resources: that trauma and abuse, illness, and struggle may be devastating, but they also may be opportunities for growth and sources of challenge and opportunity; that the upper limits of any individual's capacity to grow and change are unknown; and that individual, family and community visions and hopes must be seriously considered. (Paquin, p. 128)

### **Trauma**

To help understand trauma the following five types are defined according to the Trauma-Informed Practice Guide: single incident trauma, complex or repetitive trauma, development trauma, intergenerational trauma, and historical trauma (Trauma-Informed Practice Guide, 2013). A natural disaster, accident, sudden loss, witnessing violence, or a single act of abuse, is defined as a single incident trauma one that is unexpected, or an overwhelming event (Trauma-Informed Practice Guide, 2013). Domestic violence, on-going abuse, ongoing betrayal, are described as forms of complex or repetitive trauma. This type of trauma commonly occurs while feeling trapped emotionally or physically (Trauma-Informed Practice Guide, 2013). Developmental Trauma is repetitive or ongoing trauma towards an infant, child, or youth, such as abandonment, neglect, betrayal, physical, sexual and emotional abuse, witnessing violence, or death. This type of trauma interferes with the healthy attachment and development of the child (Trauma-Informed Practice Guide, 2013). Intergenerational trauma is the emotional and psychological effects that

can happen from living with caregivers who are trauma survivors. This form of trauma is passed down through the coping patterns the survivor developed (Trauma-Informed Practice Guide, 2013). The fifth trauma type noted in the Practice Guide is defined as a part of intergenerational trauma:

Historical trauma is a cumulative emotional and psychological wounding over a lifespan and across generations emanating from massive group trauma. A subjugating, dominant population inflicts these collective traumas. Examples of historical trauma include genocide, colonialism (for example, Indian hospitals and residential schools), slavery and war. Intergenerational trauma is an aspect of historical trauma. (Trauma-Informed Practice Guide, 2013, pg. 6)

The effects of trauma can be different from person to person, ranging anywhere from a minor disruption to a debilitating response (Trauma-Informed Practice Guide, 2013). The developmental stage of when the trauma occurs has a profound impact on the response of the survivor. This helps to understand that siblings exposed to similar traumatic experiences can have different reactions. Canadian statistics show that experiencing trauma is not uncommon:

**Among all Canadians:**

- 76% of Canadian adults report some form of trauma exposure in their lifetime, 9.2% meet the criteria for PTSD
- An estimated 50% of all Canadian women and 33% of Canadian men have survived at least one incident of sexual or physical violence

**Among people in BC seeking/needing help with substance use and mental health concerns:**

- 63% of women entering treatment for substance use problems at the Aurora Centre indicated that they had experienced physical violence, and 41% had experienced sexual violence.



- 44.6% of participants in the North American Opiate Medication Initiative (NAOMI) in Vancouver reported a history of physical or sexual abuse, and 62.5% reported emotional abuse.
- Very high rates of trauma and PTSD have been found in people with serious mental illnesses. 58% of women at Riverview Psychiatric Hospital had been sexually abused as children.

**Among BC youth with substance use and related risks:**

- As many as 25% of youth engaging in addictions services reported a history of trauma according to VIHA data.

**Among people experiencing homelessness in BC:**

- 51% of homeless people from three BC communities interviewed reported childhood sexual abuse, 55% reported physical abuse, 60% reported neglect, 58% reported emotional abuse, and 57% met the criteria for current PTSD.

**Among Canadians with mental health and substance use concerns beyond BC:**

- 90% of women in treatment for alcohol problems at five Canadian treatment centres indicated abuse-related trauma as a child or adult; 60% indicated other forms of trauma.
- 90% of females and 62% of male youths in co-occurring disorders treatment at CAMH endorsed concerns with traumatic distress. (Trauma-Informed Practice Guide, 2013, p. 9)

The more that is understood about trauma, the greater the need to take the many adverse effects and far reaching impact into consideration. Dr. Siegel, a clinical professor of psychiatry at the UCLA School of Medicine and co-director of the UCLA Mindful Awareness Research Centre refers to trauma memories as a “mental trap” that causes recurring conflict in our lives and relationships (Siegel, 2010). Shapiro (2001) notes the ““unconscious” is composed of stored memories of earlier experiences that guides us automatically. These stored memories are the cause of the symptoms and negative behaviours and unpleasant thoughts and sensations.”

(Shapiro, 2001, pg. 18)

### **Trauma-Informed Services**

Trauma-informed services include Trauma-Informed Practice (TIP), Trauma-Informed Approach (TIA) and Trauma-Informed Care (TIC). Trauma-informed services create a healing atmosphere of nonviolence, learning, and collaboration, in all aspects of service delivery. Priority is placed on the individual's safety, choice, and control, with an understanding of trauma (Trauma-Informed Practice Guide, 2013). A TIA deals specifically with how clinicians, systems, and organizations, work with individuals that have experienced some form of trauma. Disclosure of trauma is not always required when using a TIA. Instead the focus is on the service providers offering safety, choice, and encouragement, in the decision making process. The primary focus of TIP is in the essence of the approach, not the treatment strategy or method used (Trauma-Informed Practice Guide, 2013).

My approach was to observe all interactions at FSTV from a trauma-informed lens. A trauma-informed lens provides the observer with an understanding of others' unhelpful behaviours by bearing in mind the effect of trauma. This perspective helps the clinician to illuminate judging or labeling clients who are seeking mental health services. Negative responses observed through a trauma-informed lens are viewed as coping-strategies developed to manage traumatic experiences (Trauma-Informed Practice Guide, 2013).

The literature reviewed for my practicum report supports the need of Trauma-Informed Practice (TIP) for individuals seeking health care services. There is a growing body of research on TIP including the necessity to educate practitioners in considering the long-term effects of childhood trauma and how the consequences of that experience can impact individuals in their present-day functioning. It is not uncommon for social workers to be faced with crisis situations whether it is working as a therapist, child protection worker, correctional service provider, with victims of family violence, or victims of sexual assault. Knight (2015) suggests that clinicians

who encounter survivors of childhood trauma should be educated and supported in understanding TIP as an approach in providing services. TIP is not about making assumptions that individuals receiving health care services have a history of trauma. Instead, trauma-informed practitioners are sensitive to ways in which clients' difficulties can be understood in the context of past trauma (Knight, 2015). The approach to trauma-informed practice requires a practitioner to understand how the working alliance can be used to address the long-term effects of the trauma and understand how past experiences influence the present (Knight, 2015). Thus, TIP is empowering and can help the client to manage their present life more effectively (Knight, 2015). The therapeutic relationship is key in working with a trauma survivor. Knight (2015) notes trauma-informed practice recognizes that the working alliance can provide a corrective emotional experience for the client and this relationship can challenge the distorted thinking about self and others.

Butler, Critelli, and Rinfrette (2011) describe trauma-informed clinicians as having an understanding of the impact of violence and victimization experienced by most consumers of mental health, substance abuse, and other health care services. This understanding is to provide and design services to accommodate the requirements and vulnerabilities of trauma survivors, including helping to facilitate their involvement in treatment. Butler et al. (2011) identify the five guiding principles that reflect a TIP approach to care that are: safety, trustworthiness, choice, collaboration, and empowerment. Butler et al. (2011) support Knight (2015) in suggesting effective therapeutic work requires the atmosphere to be safe, respectful, and accepting, for trauma survivors. This is fundamental to build trust and therapeutic engagement. Many trauma survivors have experienced betrayal, which means it is crucial that clients are given the time they require to build trust within the therapeutic relationship. It is difficult to predict how much time the client will need to feel safe. Trauma survivors are not usually in control of the trauma they

experience leaving them feeling trapped or powerless during the event(s). Therefore, it is necessary to include an opportunity for trauma survivors to be involved in decision-making related to their care.

Butler et al. (2011) note informed consent and strict confidentiality are essential, along with appropriate and professional boundaries when emphasizing and encouraging consumer choice and control in the client's treatment. Knight (2015) suggests workers remain open to adjust boundaries to changing circumstances when working with any population and for survivors the worker may need to make exceptions to be more available without losing sight of their professional role and responsibilities. TIP suggests that the client and clinician work together in collaboration. Butler et al. (2011) describe this principle as the sharing of power where the client is treated as the expert of his or her own life. This is an excellent example to highlight the link of the traditional approach in social work practice applied in the field of mental health. The last principle described by Butler et al. (2011) is empowerment which emphasizes the strength and resilience in the client as well as exploring coping strategies and sources of personal strength that have been used in the past. All five principles are intertwined with social work practice, supporting the idea that clinical social workers are a valuable asset to the field of mental health.

In addition to the five principles, Fisher (2014) notes that good trauma treatment requires a delay on the focus of traumatic memories until the survivors feel safe in their daily lives and experience sufficient affect regulation to tolerate the stress of remembering dark episodes from their histories. Fisher (2014) discusses re-traumatization, which is a commonly used term among mental health professionals, and that stabilization first, is a key component of trauma-informed practice. Stabilization is described as cognitive distance from the overwhelming effect of the trauma in which the therapist must believe strongly that the recovery from the traumatic

experience cannot happen without sufficient stability to be able to remember the past without becoming overwhelmed by it (Fisher, 1999).

In order to provide this complex service to clients one would expect that a clinician would require supervision in becoming a trauma-informed therapist. Beger and Quiros (2014) focus on supervision as a vehicle for training a trauma-informed approach to practitioners to enhance their knowledge and skills when dealing with clients who have experienced trauma. By following the five principles previously noted by Butler et al. (2011), supervision can be adapted and applied to foster the professional and personal growth of practitioners and enhance their mastery of trauma-informed care (Beger & Quiros, 2014). Knight (2015) states that there is increasing evidence to suggest that exposure to trauma in childhood leads to neurobiological changes in the developing brain. Fisher (2014) makes reference to Van Der Kolk who in the 1970s became interested in exploring trauma while working on the effects of shell-shocked on veterans. Van Der Kolk discovered that survivors lost their ability to put language to their intense emotions, bodily sensations, and movements. These findings were instrumental in bringing greater visibility to non-talk treatments and the insights of neuroscience into the understanding of trauma (Fisher, 2014).

### **Health Care Services and Trauma Survivors**

A review of articles on the topic of TIP with individuals using health care services supports the need for the consideration that clients may be trauma survivors. It is important to note that a trauma-informed practitioner is not a trauma specialist. However, a trauma specialist most likely has trauma-informed training. Wilson, Fauci, and Soo (2015) state that trauma-informed services are not designed to treat symptoms related to sexual or physical abuse; instead they are intended to provide services to the special needs of trauma survivors. It is not mandatory to include trauma-informed practice in health care services in Canada, unlike some places in the

United States. Wilson et al. (2015) note that in the last decade there has been a powerful shift in the attention to trauma in research, policy, and practice highlighting its prevalence and devastating consequences. Wilson et al. (2015) suggest in the last 14 years trauma-informed approaches have spread to public service systems ranging from child welfare, schools, to homeless shelters. TIC is seen as a culture change in the approach to healing and justice; some have described the trauma-informed approach as ethical best practice in bringing new meaning to general practices (Wilson et al. 2015).

For example, domestic violence survivors are survivors of trauma. Therefore, it would make sense to use TIP services in addressing the needs of individuals affected by domestic violence. Wilson, et al. (2015) conducted a qualitative analysis which identified six core principles that reflect a symbolic shift at the heart of TIA. This shift showed a movement from the way in which questions are asked to survivors such as using the words ‘what happened to you’ rather than ‘what is wrong with you’. It also showed the importance of identity, strengths, and context that suggest we must also ask ‘who are you’ (Wilson et al., 2015). Evidence suggests there is a benefit in trauma-informed practice in dealing with trauma survivors of domestic violence, specifically in the approach used when asking questions of domestic violence survivors. TIC is a movement towards person centered care and recovery-oriented care, aimed to move away from the more traditional medical approach that is often seen as disempowering and ineffective for individuals seeking health care services (Wilson et al., 2015). Humphreys and Thiara (2003) note a direct link between women’s experiences of domestic violence and heightened rates of depression, trauma symptoms, and self-harm. Humphreys and Thiara (2013) found a number of practices within the medical model of mental health that were not helpful including: lack of recognition of trauma and delivery of services, focus only on the women’s mental health, blaming the victim and offering medication rather than counselling services.

Alternatively, women found volunteer methods helpful such as naming domestic violence, talking about the abuse, safety planning, response to their special needs, and working with other women to recover from the abuse (Humphreys & Thiara, 2003). Finally, suggestions include assigning further services in the voluntary sector, and addressing insufficient responses within the medical model (Humphreys & Thiara, 2003).

Similarly, women with addictions are a vulnerable population often living with the impact of trauma. Convington (2008) notes an immense majority of women with addictions have suffered violence or other forms of abuse, which contributes to their likelihood of becoming addicted. Developments in health care are identifying that traumatic experiences in women's lives and the role they have with their physical and mental health problems continue to be unrecognized (Convington, 2008). Women who return to substance abuse after treatment to numb the pain of trauma are now recognized as trauma survivors, whereas, these women were previously referred to as treatment failures (Convington, 2008). The need for sensitivity to trauma and offering choices in the treatment plan can promote a healing atmosphere for victims of trauma (Convington, 2008).

Pregnant women who are a vulnerable population require regular visits to health care agencies. Muzik et al. (2013) note pregnant women with childhood trauma are more likely to have health care problems and are more reluctant to seek help during pregnancy due to a lack of trauma-informed services. Muzik et al. (2013) conducted a mixed-method study to understand more about health care preferences of trauma-exposed women in the early postpartum period using qualitative interviews as part of the larger study with a goal to design personalized services. Their study highlighted the importance of the parenting role in seeking healthcare as trauma survivors and found that women see their children as powerful motivators for healing. Muzik et

al. (2013) note children and the motherhood role are motivators for hope and therefore, child friendly services are more likely to appeal to these families.

The medical model does not include trauma-informed practices. Therefore, it is questionable whether the appropriate care for many individuals using health care services is provided. Beecher (2009) conducted a study using a mixed methods approach to fully explore the impact of the medical model on individuals with schizophrenia, the role of social work in mental health, and a critical perspective of the medical model. He expressed concern for nurses having too many clients with schizophrenia on their caseload, which may contribute to seeing these clients as a problem rather than interesting people with an illness. Beecher (2009) notes that clients with schizophrenia and their families hardly work with social workers. Clearly, assumptions are made that individuals with schizophrenia would not benefit from individual or family therapy. Therefore, they are automatically expected to have quick visits with nurses to check medication status or report symptoms. Beecher (2009) argues that there are numerous treatments recommended for schizophrenia including: family interventions, such as family psycho-education, individual interventions, social skills training, and outreach. Finally, Beecher (2009) notes the broad knowledge and skill groundwork of social work and education seems to provide a solid base to work with persons with schizophrenia and their families. Research supports that individuals with schizophrenia can benefit from services other than the medical model. Therefore, it makes sense to provide these services to help them and their families. Although it is recognized that persons with schizophrenia require medical treatment, based on this study, I question how many health care facilities are treating persons with mental illness using medication only rather than exploring other options such as an approach that combines medication and therapeutic counselling. Are these clients trauma survivors, and if so, are they being re-traumatized by the dominant practice of the medical model? The medical model was the



primary model used when previously working in a remote community in mental health services. However, my main role was to provide therapeutic counselling to clients with addictions, concurrent disorders, depression, anxiety, and trauma survivors. The clients with schizophrenia did not receive the option of therapeutic counselling, instead they were provided with walk-in service to pick up their medication from a psychiatric nurse. If there were concerns with the clients' behaviours or mental condition their name would be put on a list for an appointment to see the assigned psychiatrist that entered the community on a monthly basis. Moving away from the medical model, a city in Northern British Columbia provides an array of mental health services from social workers to persons with schizophrenia. Working with these clients in social work practice in Prince George, British Columbia is not uncommon for social workers. What this highlights is an inconsistency in social work practice, whereas, consistency in using a community model would be more effective.

Stickley and Timmons (2007) note student nurses entering higher education focus only on the medical model and hold lay beliefs of mental health and mental illness. They argue that the medical model of mental health and mental illness dominates the health care industry even though there are many other beliefs and approaches. Stickley and Timmons (2007) note student nurses are not adequately taught about theories that challenge the medical model, which contributes to the dominant concepts being used. Rather than using alternative approaches to examine the complexities of abstract ideas about society and culture, the chemistry in the brain gets treated with medication instead (Stickley & Timmons, 2007).

Through research of the many clinical approaches, CBT, Attachment, Narrative, Strength-based, Medical Model and Trauma-Informed, it is clear how beneficial the TIA is. It allows the clinician to acknowledge the trauma and for the client to participate in their healing, independent

of the experienced trauma or demographic. This learning was, and still is, critical in my role as a social worker.

### **Trauma-Informed Practice ‘links’ to Social Work Practice**

Social work practice requires social workers to incorporate the principles of practice in all areas of social work. Many of these practices aligned with the principles and practices of TIP. A clinical social worker is familiar in working with the lived experiences of the clients who use mental health services. Bland (2014) notes the broader social context, which is central to social work, is acknowledged when focusing on the lived experience of mental illness. This approach emphasizes the importance of personal wellbeing on safety, health, work, friendships, family, community, housing, and poverty (Bland, 2014). The effects of mental illness are often more disturbing than the symptoms themselves (Bland, 2014).

Social workers’ practice focuses on the effects of oppression, exploitation, poverty, homelessness, social injustice, colonization, and marginalization in the lives of people they serve. Considering environmental factors prepares the social worker to see the client as vulnerable. Therefore, social workers are aware of the necessity in providing a safe place for the client. TIP requires the service provider to recognize the client’s need for physical and emotional safety plus respects control and choice in the decision making process (Trauma-Informed Practice Guide, 2013). Both practices, TIP and social work practice are mindful in their approach in meeting the client where they are and practice the principle of empowerment. TIP is more concerned about the relationship, and the essence of the approach rather than the treatment of the trauma (Trauma-Informed Practice Guide, 2013). Opportunity for choice, collaboration, and connection is a principle for TIP. This principle provides a safe environment to those receiving care, promoting efficiency, self-determination, dignity, and personal control. The worker is transparent, offers choices in preferences of treatment and equalizes power imbalances (Trauma-Informed Practice

Guide, 2013). Self-determination is a principle of social work practice that recognizes the client's rights and need to be free in making their own choices. This principle requires the worker to inform the clients of the potential consequences of their decision and to provide them with adequate resources (Code of Ethics Standard of Practice Handbook, 2008). TIP principle of Trauma Awareness recognizes an array of adaptations trauma survivors have developed to cope and acknowledges the relationship of trauma to substance abuse, physical, and mental health concerns (Trauma-Informed Practice Guide, 2013). This perspective aligns with anti-oppressive social work practice, which recognizes the impact of oppression. Pollack (2004) notes the anti-oppressive framework seeks to depersonalize clients' problems while incorporating the recognition of coping and resistance to oppression. Pollack (2004) notes that commitment to the anti-oppressive approach is to change social relationships and institutions that continue the exclusion of marginalized groups of people. Anti-oppressive social work practice values the social work perspective of person-in-environment. Operating from an anti-oppressive position permits the social worker to include the clients' environmental experiences when assessing the clients' needs. By noticing the effects of oppression the social worker can help make sense of the clients' experience. Hines (2012) views the anti-oppressive practice model as one that recognizes the dominant feature of oppression and assesses the differences used to divide the individuals or groups from one another. This view recognizes the dominant society as benefiting and the marginalized individuals or groups as the undesirables (Hines, 2012).

Finally, the TIP principle Strength Based and Skill Building identifies the trauma survivors' strengths to assist in developing coping skills, building on resiliency and suggests the practitioners demonstrate skills for recognizing triggers, and learning grounding techniques (Trauma-Informed Practice Guide, 2013). The strength-based perspective is a popular concept used in social work practice. Franklin (2015) points out the humanistic values of social work

practice are incorporated in the strength-based perspective that offers a framework for problem solving focusing on the clients' resources and social environment. This perspective includes a collaborative empowering relationship between social workers and clients (Franklin, 2015). Paquin (2006) argues the strength-based approach requires constant acknowledgement of the clients' strengths and utilization of direct and indirect resources. Paquin (2006) acknowledges trauma and abuse may be devastating but the experiences can be used for opportunities of growth and challenge. Research supports the link in TIP and social work practice that helps to recognize the necessity for clinical social workers in mental health services. For a detailed description of the four principles derived from Principles of Practice of Trauma-Informed Approaches see Appendix B.

## **Chapter Four: Practicum Learning Experiences and Activities**

As a social worker I am passionate about helping individuals learn to help themselves, particularly, marginalized populations coping with the impact of trauma(s). The power of being heard, understood, and validated, is evident in the many success stories of individuals who have received appropriate counselling support while facing life challenges. The goal I set for my practicum was to further develop my social work skills and increase my level of knowledge and clinical skills as a social worker that operates from a trauma-informed approach. This chapter will speak to my goals with objectives, learning activities, and outcomes, which are listed in Appendix A.

Along with other debilitating experiences, many trauma survivors have suffered the pain of betrayal. Trauma-informed practices in health care services is a step towards removing one of potentially several barriers clients may face when seeking assistance for mental health issues. A trauma-informed practitioner's goal is to provide clients with emotional and physical safety in addition to supporting them in the freedom of choice and control over their treatment plan (Trauma-Informed Practice Guide, 2013). This is one of the principles of trauma-informed practice that aligns with social work practice. The principle of self-determination is acknowledged by viewing the client as the expert of their own life and including them in their treatment plan informing them of their options. The Ontario College Social Workers and Social Service Workers (OCSWSSW) defines self-determination as follows:

an ethical principle that recognizes the rights and needs of clients to be free to make their own choices and decisions. Inherent in the principle is the requirement for the member to help the client know what the resources and choices are and what the potential consequences of selecting any one of them may be. (2008, pg. 42)

These principles are a good example of how TIP is linked to social work practice. During my practicum I observed the method in which FSTV incorporated TIP. This allowed me to recognize the importance of TIP in the field of mental health and how it benefits the clients' social workers serve.

My practicum learning goals were formulated to further my development as a social worker, working at a micro level, providing trauma-informed mental health services to individuals, couples, and groups. My expectation throughout my practicum was to apply a trauma-informed approach in all areas I was given an opportunity to participate in. My primary position as a practicum student at FSTV was to provide counselling and psychotherapy services in the role of a clinical social worker. Other responsibilities consisted of obtaining on-going clinical supervision with my practicum supervisor, participation at the weekly Clinical Internship Program seminars, and attendance at FSTV agency meetings that includes all staff, students, and interns.

Achieving my goals was supported by my on-going research, education, and professional and personal experiences. However, it was my practicum experience at FSTV that strengthened my skills and advanced my level of knowledge to that of a clinical social worker in the field of mental health. My observations, written notes, and documentation of my experiences, enhanced my learning and offered me tangible information to practice self-reflection. This method of training enabled me to recognize the link of trauma-informed practice to social work practice. My practical experience coupled with supporting research, supports the need for trauma-informed practices in the field of mental health.

While sitting in the waiting room prior to beginning my practicum on orientation day, my feeling of excitement aligned with feelings of anxiousness and uncertainty. What contributed to

this shift was witnessing several people who appeared to be staff entering a room close by. I was curious about the reason for the gathering and questioned whether it related to my orientation to the agency. Rhea Lajoie, who was my practicum supervisor and the Clinical Internship Program supervisor, greeted me with an invitation to follow her into the room. Feeling self-conscious, I spotted an empty seat in the front row and sat down. Immediately, my practicum supervisor introduced the presenter for the weekly Clinical Internship Program seminar, a Master of Social Work graduate who specialized in Animal Assisted Psychotherapy. At the start of the presentation I noticed a Calico Sheep virtually in front of me. The sheep appeared determined to get close enough to lean against my leg. Through the duration of the presentation I patted and caressed the sheep. The presenter, who had a private practice in animal assisted psychotherapy spoke about her research that supports the calming effect animals can have on individuals with anxiety, PTSD, and other mental health issues, such as dementia. Having lived on a hobby farm as a child and comfortable in the company of animals my anxiety subsided. I became incredibly relaxed and comfortably participated in the seminar. This unique experience reassured me that FSTV was the right place for me to accomplish my practicum requirement as a master of social work candidate.

**Goal: To learn advanced clinical practice skills in social work practice**

Learning advanced clinical practice skills was an overall goal throughout the duration of my practical experience. My basic objective was to become proficient in using core-counselling skills such as active listening, expressing empathy, using appropriate self-disclosure, reflecting and paraphrasing, with a Trauma-Informed Approach. I accomplished this goal mainly by aiming to practice these basic foundational skills in all my counselling and psychotherapy experiences.

My practicum experience taught me why and how the provision of counselling and psychotherapy are characterized as two separate services. Counselling seeks to offer first order change whereas psychotherapy addresses second order change. The following explanation from the OCSWSSW defines the difference:

Counselling services are defined as services provided within the context of a professional relationship with the goal of assisting clients in addressing issues in their lives by such activities as helping clients to find solutions and make choices through exploration of options, identification of strengths and needs, locating information and providing resources, and promoting a variety of coping strategies, but do not include psychotherapy services. Psychotherapy services are defined as any form of treatment for psycho-social or emotional difficulties, behavioural maladaptation and/or other problems that are assumed to be of an emotional nature, in which a social worker establishes a professional relationship with a client for the purposes of promoting positive personal growth and development. (Code of Ethics and Standards of Practice Handbook, 2008, pg. 41-42)

My practicum required that I provide counselling services one day a week to individuals and couples who used the Quick Access Mental Health Walk-In Clinic at FSTV. For the purpose of this report from here on the Quick Access Mental Health Walk-In Clinic will be referred to as the Walk-In Clinic. I began this practice by shadowing a master's level therapist to learn the procedure of offering a single session consultation. Solution focused was the primary modality used at the Walk-In Clinic in supporting clients with coping strategies. The main purpose for the Walk-In Clinic at FSTV is to provide timely clinical services to help prevent the clients' from reaching a point of crisis. Inevitably, some clients arrived at the Walk-In Clinic already in crisis. With the supportive staff, including administrative personnel, and the supervisor on Walk-In Duty, each client is welcomed and cared for using non-judgmental, caring, inclusive anti-



oppressive approach. FSTV has not had formal training in using TIP at an organizational level. However, the clinical staff's knowledge in treating trauma is high.

The intake procedure used at the FSTV Walk-In Clinic does not provide the clinician with detailed information of the clients' mental health history prior to the meeting. Therefore, the required skills in crisis counselling are recommended and sometimes necessary. During the first two weeks of practicum I recognized I had a level of uncertainty in trusting my skill level in providing Walk-In Services. What contributed to my concerns was my awareness that the city of London, Ontario, had a population of approximately 380,000 people. Whereas, my previous experience in Nunavut was providing services to a population of approximately 9,000. I practiced positive self-talk to help with my feelings of clinical vulnerability by reminding myself I was not alone and that adequate support was available within the agency if required. Inevitably, I used support from senior staff while counselling individual clients on three separate occasions. Fortunately, my practicum supervisor was supervising the Walk-In Clinic during these times. As previously mentioned, some clients who use the Walk-In Clinic are already in crisis. My opportunity to assist these clients with the support of supervision enabled me to develop an increased sense of comfort and confidence as a clinical social worker. Each client's situation had its own challenges, which enabled me to develop and strengthen skills in crisis intervention. The benefits of using core-counselling skills, including a TIA, were evident in these situations. However, the learning experiences also heightened my awareness of the limitations of my scope of practice as a clinical social worker. My occurrences when I sought supervision during the Walk-In Clinic were all different. One experience was with my very first walk-in client whose partner unexpectedly rushed through the door to the office so she could join in on her partner's session. The intake process at FSTV Walk-In Clinic services includes questioning of type of services such as individual, couple, or family. In this case my documentation showed a request

for individual counselling. I noticed the female partner was highly anxious and felt it was a sensitive intervention that needed to be made in addressing the protocol. With my second experience I had a client with severe mental illness coupled with significant childhood trauma who was experiencing suicidal ideation among other serious concerns. This client feared the police and hospitals. Finally, the third client was exhibiting evidence of depression from the effects of childhood trauma and at the end of session he disclosed he was experiencing homicidal thoughts. My practicum supervisor reassured me that I had made the right decision in asking for support in these circumstances. In fact, she used the scenario of the client experiencing homicidal thoughts to teach 'safety positioning' while counselling at the Clinical Internship Program. These practicum experiences taught me to manage crisis and trauma in a single session and by applying the principles of TIA such as safety, awareness, trustworthiness, choice, collaboration, and connection I was confident in my practice. By following these core principles I listened to two of the clients' trauma stories and assisted in structuring a safety plan. My practicum supervisor also used this opportunity to discuss the limitations in my scope of practice when working in community counselling. This teaching experienced helped me to recognize the importance of acknowledging my limitations and how this awareness can influence my confidence level as a clinical social worker rather than contribute to the possibility of having blurred boundaries. Knight (2015) suggests a therapeutic alliance relies on the worker to use professional boundaries to increase survivors' self-capacities. Otherwise, survivors' sense of urgency could influence the worker to participate in practice that is not consistent in an agency-based setting (Knight, 2105). My counselling experiences at FSTV helped me to develop new skills in managing crises and recognize a strength that I was not aware I had. I also learned to get comfortable in using a solution-focused approach even though I do not feel proficient in the structure. Every Tuesday during my practicum at FSTV I looked forward to assisting clients

who access the Walk-In Clinic knowing that I could offer them a place to be heard, validated, and connected.

My practicum at FSTV offered me my preferred experience in providing psychotherapy to clients in addressing issues in a variety of areas such as domestic violence, childhood trauma, sexual abuse, anxiety, depression, addictions, criminal behaviour, and concurrent disorders. My practicum supervisor and I reviewed client cases and formulated treatment plans beginning in my first supervision session. The session was two hours long and took place on day three of my practicum. My first caseload consisted of thirteen individual clients. One of the expectations of my practicum supervisor was that I explain the reason I chose a particular modality in treating my client. Articulating therapeutic approaches was one of my weaknesses. Hence, the reason I chose 'articulating therapeutic approaches' as a learning outcome of my practicum experience. My supervisor provided constructive criticism, when necessary to help educate me in learning to describe treatment approaches appropriately. An example of this is when I informed my supervisor about a particular theory I previously used when providing couples counselling in Nunavut. After describing the Imago Theory my supervisor noted it was not a theory, but a relationship therapy developed from the integration of ideas and theories of other practitioners. I was not aware, and had not even considered exploring this as a possibility. My supervisor challenged my resistance and encouraged me to research Imago Relationship Therapy, including Sigmund Freud the founder of psychoanalysis and whose contributions I admire, specifically, his emphasis on the importance of the unconscious mind. Although it was humbling to learn that I did not consider this information found in research beforehand, I felt competent in knowing that I can articulate Imago Relationship Therapy to my clients and co-workers in the manner of an educated clinician. During my weekly supervision sessions I was also required to provide an update of my client's goal(s) and therapeutic progress.

While working at mental health services in Nunavut the clients obtaining therapeutic counselling were able to obtain unrestricted counselling sessions. Therefore, offering short-term psychotherapy was a new model for me and required that the client and I work together in developing realistic goals. This experience was a difficult learning curve. It required me to work in the “here and now” and trust that targeting specific goals with a therapeutic focus would assist the client in making change. It was helpful to remind myself of the value of self-determination in social work practice, especially in the therapeutic process of the termination stage in trusting that clients are resilient and will continue to thrive.

FSTV provided a guideline tool for developing an assessment summary. This standard procedure gives the clinician a road map to follow while gathering important information from the client. The initial assessment includes:

The client identifies the presenting problem.

The problem history is documented.

Significant background and relevant information is documented such as, family and psychosocial situations, historical and current factors impacting on the presenting problem.

The clinician provides a case formulation.

The clients’ areas of strength are noted.

The final part of the assessment is to develop the intervention plan. This area requires the clinician and client to work together in developing realistic goals. (Family Service Thames Valley, 2016)

The clinician provides the information for the therapeutic focus and strategy planned to conduct psychotherapy while assisting the client in achieving their goals. After each assessment session my supervisor reviewed my summary in detail.

The majority of supervision was consumed in examining my formulation while providing me with knowledge to develop new skills and techniques. One of my practicum goals was to improve my abilities in written documentation. Although this process was slow for me I learned more about articulating therapeutic modalities and how to shorten my assessment while documenting important details.

During the initial assessment I was taught the importance of asking clients questions about prescribed medication, and the clients' relationship with doctors and psychiatrists. In doing so, I used this opportunity to talk about the importance of community support and relationships. It is my belief that this intervention helped the clients see that they are not alone and that we can work together as a circle of support within the community in the best interest of their health. I appreciated my supervisor's keen knowledge of medication and was made aware of my lack of understanding in that area. Learning about different medications and their purpose is an interest I developed since doing my practicum. My practicum supervisor informed me that the combination of medication and psychotherapy is most effective in helping clients with the effects of trauma or mental illness. However, it is important to note that not all clients with trauma or mental illness need medication. Some individuals recover living healthy lives using a holistic approach.

I discovered during my practicum that using a genogram is my favorite assessment tool as a clinical social worker. The genogram is a visual tool that gives the clinician an opportunity to collect information about the clients' history including their family of origin. This information provides the clinician with an understanding of the clients' relationships and culture. Pope and Lee (2015) note the genogram helps to understand relationship dynamics and behaviour patterns which helps to encourage the clients' understanding of self. It is my belief that noticing the dynamics in close relationships helps the client to release the shame attached to poor behaviours

or unhelpful decisions they may have made. Pope and Lee (2015) note the genogram explores the clients' family of origin while acknowledging the client as the expert of their life. This process allows the client to view their experience from an external perspective, which aligns with the narrative approach in telling their story. It helps the client to see that they are not the problem and that the problem lies within the family system, or is socially constructed. I identify myself as a clinical social worker that practices an integrative approach when assisting clients. An integrative approach leaves doors open to integrate concepts and techniques from multiple therapeutic methods. For example, I like to explore areas of attachment, give space for my clients to tell their story, and sometimes work with cognitive behaviour therapy in helping the client change their unhelpful thinking by identifying negative core beliefs.

Two very important concepts in clinical social work, counter-transference, and transference were routinely discussed in my practicum supervision along with the topic of boundaries. I was familiar with transference from my experience working with the Inuit population as a white middle class social worker. It was not surprising for a client to project their feeling of distrust towards me driven from their past or present experiences of colonization. Gehart (2014) defines transference as “when a client projects onto the therapist attributes that stem from unresolved issues primarily caregivers; therapists use these interactions to promote insight” (p. 244). I used these opportunities of transference to validate my clients for their lack of trust. It made sense to me that this could happen so I was prepared in my role as a social worker. However, examining my own countertransference was not a conscious practice until I started my practicum at FSTV. My supervisor described countertransference as being ‘something that happens’. Her approach helped me to let go of embarrassment as she provided appropriate self-disclosure openly for the purpose of exploring my unconscious attempt to counter-transference. Gehart (2014) goes on to describe countertransference is “when therapists

project onto clients, losing their therapeutic neutrality and having strong emotional reactions to the client” (p. 244). When providing psychotherapy to a couple I recognized myself thinking that my clients were acting in a way in which my parents did. In noticing my thoughts I silently told myself not to think that way. However, in my supervision when speaking about compassion for my clients it was noted that my level of compassion was not equally dispersed. It was then that I identified with a personal experience of counter-transference. Although, acknowledging these faults in my role is humbling, I understand the experience as crucial to learn from and the necessity for a clinical social worker to regularly practice self-observation. My supervisor used this example to convey the importance of on-going supervision when providing clinical services. Identifying and talking about my own counter-transference with my supervisor allowed me to experience a difference in the following sessions in my ability to view both my clients as equal in their struggles within their relationship. Acknowledging my counter-transference seemed to allow for a ‘closer connection’ to the client I discovered I had least compassion for. The shift appeared to make a difference in the therapeutic progress of myself with the client.

### **Contract Funding Eligibility at FSTV**

I was required to learn about the contracts that provide the funding for clients’ sessions at FSTV, which range from 8 to 12 sessions per client. Upon completion of their therapy the client must wait 6 months before they can complete an additional intake process to receive another set of sessions. Once they have completed the process the waiting period is approximately 8 to 10 weeks. In the meantime, all clients are welcomed to use the weekly walk-in service for an unlimited amount of time. The total of sessions per client is based on the funding contract the client is eligible for. For example, male and female childhood sexual abuse survivors, and female domestic violence survivors are funded up to 12 one-hour sessions. Unemployed clients approved by Ontario Works, a social assistance program under the Ministry of Community and

Social Services, are funded for a total of 12 one-hour sessions. Clients referred by the Children's Aid Society are funded for 12 sessions. First Nations, and Inuit are funded by Health Canada for 10 sessions in a 6-month duration with a condition that the therapist must have a minimum of an MSW and be approved by Health Canada. All other categories are placed on a sliding scale fee from zero to one hundred and fifteen dollars, and allotted up to 8 one-hour sessions. My practicum role as a clinical social worker at FSTV allowed me to advocate for my clients in requesting an extension of sessions provided I was able to justify adequate reasoning to my practicum supervisor.

I advocated for extensions for clients who had experienced trauma, infidelity, domestic violence, clinical depression, sexual abuse, and in particular, a client with multiple traumas and a concurrent disorder. Each time I made a request for an extension I felt heard and validated in my clinical decision made on behalf of my client. My supervisor operated from a TIA framework and is well educated in trauma and recovery. Therefore, she has a clear understanding of the complexities in the therapeutic process and was open to providing an extension in meeting the clients' needs. Experiences like this filled me with gratitude for my practicum experience at FSTV, knowing I was with like-minded people with a genuine desire to assist in making positive change.

### **Client Caseload**

My client caseload consisted of individuals seeking help in several areas such as childhood trauma, sexual abuse, spiritual abuse, anxiety, depression, PTSD, work stress, co-occurring disorders, and domestic violence. I discovered there were a significant number of female clients with unresolved feelings of betrayal primarily from previous romantic relationships. I felt comfortable working with clients who were living with or have lived with domestic violence, betrayal, sexual abuse, or addictions. However, my learning goals included



further development in honing my skills, and increasing my knowledge, which I had sufficient opportunity to do so.

On one occasion I was encouraged by my practicum supervisor to stretch beyond my comfort zone and provide psychotherapy to a client convicted of several child sexual abuse offences. In examining my reservations I thought about the extreme consequences of childhood trauma and made a conscious decision to put any stigmatization aside. After I made this decision I then reflected on my current thinking to help make sense of my resistance. Through self-reflection I approached the case hopeful that psychotherapy could help my client make positive change. In using the service delivery of Trauma-Informed Care (TIC) I was equipped with a non-biased approach in providing a safe place for my client to begin his therapeutic process. With the use of talk therapy and exploring family of origin relationship dynamics, my client grasped for the first time that he endured a substantial amount of childhood abuse and neglect. Working through his denial brought to the surface memories of his childhood experiences. I worked closely with my practicum supervisor throughout the therapeutic process and requested an extension of services to reinforce his positive change and to provide a proper closure to our sessions. It was evident that the client had severe attachment wounding throughout his childhood into his adult life. At the stage of termination it appeared that the client reached his goal in developing self-compassion with the hope that he will have gained compassion for others. Levenson (2014) states clinicians can help sex offender clients by applying TIC to look at their maladaptive and abusive behaviours through the lens of early trauma. This approach can help the client understand their negative interactive patterns, learn new skills, and improve their overall wellbeing (Levenson, 2014). The experience of working with this client helped me to develop a deeper understanding of the extreme effects of childhood trauma and to be opened to the challenge of assisting clients who other clinicians may be unwilling to provide services to.

As a practicum student an opportunity to debrief was available upon request. All clinicians, including my practicum supervisor were approachable and readily available to provide space to debrief or give valuable feedback when asked. A senior staff approached me to take a client being referred to FSTV for emergency service, which is an unusual request for the agency. The person was in crisis reliving his history of childhood sexual abuse and was triggered by recent charges against his perpetrator. The client talked fast while describing his sexual abuse experiences in detail. It was evident to me he needed to disclose his abuse. However, I attempted to slow him down while being cautious not to have him think I did not want to hear his story. The last part of the two-hour session we discussed symptoms of post-traumatic stress disorder, triggers, and created a safety plan. Afterwards, I knew I needed a debriefing. I recognized I was visualizing the horrific treatment the client endured while picturing him as a young child. Afterwards I sat with two clinicians who listened to my need to talk about my experience. They validated my feelings of distress and informed me that I had an unusual experience with the request in meeting the needs of the client. I met with my practicum supervisor and shared I was bothered by my client's horrific story of abuse. My supervisor provided me with an opportunity to do psychodrama in releasing the 'stuff' that seemingly stuck to me. This experience was helpful in debriefing, as I have done many pieces of work in psychodrama during the process of my own recovery and believe that psychodrama is an effective method of therapy.

### **Client Introductory Protocols and Assessment Procedures**

My practicum supervisor assisted me in applying the following practices with all clients contracting, assessing, creating a therapeutic map, making a hypothesis, and developing treatment goals. The principles of practice are offered to clients for review before starting their first session. However, my role was to start the first session by highlighting the limitations of confidentiality in explaining how and why information will be released about the client without

their consent. Issues around confidentiality were not new to me having learned about the ‘Duty to Report’ while obtaining my Bachelor of Social Work degree. The duty to report is a responsibility to report child abuse or neglect under the Child and Family Services Act, whereas, FSTV mentions a total of 5 limitations of confidentiality including child abuse or neglect. Each client then signs a consent form with the clinician agreeing to the conditions outlined in the Principles of Practice. This mandatory procedure of practice increased my confidence by offering transparency to my client in terms of them knowing what to expect. Since having practiced this protocol during the introductory session with each client I have gained confidence that this will be an on-going practice in my future endeavors as a clinical social worker. Integrating this as a clinician is especially important to me having had to previously report a client for child abuse while working as an undergraduate social worker. In this position I did not have a standardized first session procedure to follow. Unfortunately, on one occasion I neglected to mention the duty to report to a client before she disclosed child physical abuse. This error on my part was quite disappointing in my role as her mental health counsellor. I supported my client through the reporting procedure that ended with minimal consequences. However, I strongly believe she felt a breach of trust because she did not return for her on-going services. A structured assessment invites fairness to both the client and the clinician. A pre-service questionnaire at the start of treatment, and a post-service questionnaire at termination, is given to every client. The purpose of the questionnaires is to give the clinician an idea how the client is doing and to measure if the services were helpful. Experiences were often different when providing psychotherapy to clients. However, practicing these procedures was helpful in reiterating the need for professionalism as a practicum student in the role of a clinical social worker.

### **Implementing an Integrative approach**

Implementation of modalities in the treatment plan was encouraged as being flexible practice. As a practicum student it helped with my confidence to learn that the therapeutic modality chosen to work with a client can be interchangeable and allow for integration of other ideas or modalities. My practicum supervisor believed in using an integrative approach providing I could articulate what treatment I was doing and explain a valid reason for its purpose. Integrating ideas from other modalities is an acceptable therapeutic practice and I learned it is important to have a guiding theory. My supervisor has taught me that the theory chosen guides the therapist in what they attend too.

Bowen's Multigenerational Therapy focuses on providing information that examines the areas such as unresolved emotional attachments, emotional cutoff, triangles, and examining the multigenerational system to determine patterns. A focus on these topics adds valuable knowledge that contributes to my style in providing therapy. Childhood attachments have an impact on an individuals' life whether it is positive or negative. Often the negative attachments become the focus in therapy in helping clients work through the pain of neglect, betrayal, and sometimes sexual, physical, and emotional abuse. However, the positive relationships can be used in helping the client see more than the despair of what the client is experiencing. I also value how a genogram can provide a visual for the client. Perhaps I am bias as I am a visual learner and when I am shown something visually, it enables a deeper understanding. The genogram offers a gentle approach to looking at the whole picture including environmental factors that may contribute to the client's presenting problems. There is much more about Bowen's Theory for me to learn that will benefit me in my career as a clinical social worker.

Bowlby's Attachment Theory includes valuable information in examining attachment disruptions and how they help to understand patterns of attachment that can leave a client feeling

anxious and or emotionally deregulated. Attachments and relationships are a key focus in understanding the clients' attachment style. The therapeutic relationship can help heal an attachment wound.

As previously mentioned, I have experienced assisting clients using the genogram for assessment, cognitive behaviour therapy to help clients understand the association with thinking, feeling and behaviours, and have provided therapy using a narrative approach. I recognize my chosen approach coupled with the TIP is becoming my style in assisting clients. I also recognize I am still in the process of figuring out what my primary approach is however; TIP is the umbrella of all approaches for me. The goal of trauma-informed practice is not about replacing the approach the clinician applies, it is about educating and being knowledgeable about trauma-informed approaches (Trauma-Informed Practice Guide, 2013).

With my previous experience working frontline in Nunavut I provided a safe place for my clients to tell their story while practicing the foundation skills of active listening, expressing empathy, and reflecting and paraphrasing. My practice was mainly from a social constructivist perspective in providing narrative therapy using a strength-based approach. Paquin (2006) describes narrative therapy as looking at the client's story and their alternatives to create a way to use the client's strengths. This helps the client to recognize their resilience and begin to understand that they are not the problem. Paquin (2006) states the story telling can help the clients separate themselves from the problem by externalizing the problem. This perspective enables the client to acknowledge that they are not the problem and see it is the story that is a problem (Paquin, 2006). The majority of my clients were Inuit people who live with the impact of intergenerational trauma. Therefore, my intention was to avoid using any language that pathologized my client. However, attending to the therapeutic relationship with a specific modality in mind, developing goals, and having a time line, was a whole new experience for me.

This challenging practice as a practicum student met more than my expectation plus enabled me to accomplish a learning goal, which was to provide me with knowledge to articulate a range of therapeutic modalities. Gaining this understanding enhanced my level of competence and reaffirmed my passion of working with others.

### **Learning Goal: Self-Care Practices and Value System consistent with OCSWSSW**

#### **Self-Care Practices**

Self-care is an important practice to me, one that I adopted into my lifestyle in the early 1990s. To consider myself healthy is to be mentally, emotionally, physically, and spiritually fit. In being a trauma survivor I learned of the importance of connection. Therefore, I have a small circle of trusted friends that I can talk to about anything personal. My mental health requires that I respect my limits and know what I can participate in and what I choose not to, realizing that there are always consequences to the decisions I make.

Physically I am an active person who enjoys yoga practice, exercising, and walking. During my practicum I signed up for hot yoga in London, Ontario, which enabled me to continue my yoga practice consistently. My yoga practice reminds me of the importance of staying in the 'here and now'. It enables me to work on the meaning of letting yesterday's and tomorrow's worries go. My yoga practice offers focused self-care to my body as I stretch my muscles and become mindful of my bones, and parts of my body that tend to be forgotten about while assisting others in making change. I believe that my self-care not only benefits me, it benefits the people with whom I spend my time such as family, relatives, friends, co-workers, and clients. My self-care practice enables me to feel secure and grounded. I habitually remind my clients of the importance of self-care and believe as a clinician we are sometimes viewed as a role model. Eating healthy is important to me. Therefore, I am mindful of what I eat. I self-identify as an

emotional eater, meaning I will eat for other reasons than being hungry. I consciously work towards fueling my body rather than seemingly comforting my soul.

Finally, my spirituality is very important to me. I do not practice formal religion. However, I do have faith in a higher power that I choose to call God. It is my belief that spirituality and religion are personal and should be respected. Therefore, I respect people's meaning of faith, and understand that different practices represent spiritual or religious beliefs. I am reminded fairly often how I was cared for in times of despair knowing that I have not had to walk alone. My personal experience is evidence that trauma can heal, providing the survivor has adequate support and is determined or can participate in working towards making change happen.

### **Examining OCSWSSW Code of Ethics and Standards of Practice**

The social work code of ethics and standards of practice are important to me. Hence the reason I listed examining them throughout my practicum as a goal. I have remained a member in good standing with the OCSWSSW for the last 5 years. During my practicum I joined the Canadian Association of Social Workers (CASW). The OCSWSSW provides updated information to its members. I have made it my practice to read the college's resources. More importantly, I reviewed the area of continued competence. The values and ethics at FSTV align with the OCSWSSW. This alliance enabled me to see that the clients of FSTV are the primary concern within the agency. It has been a privilege to do my practicum at a place that views their clients from a person centered perspective in meeting client needs. Developing a greater understanding of the OCSWSSW code of ethics and standards of practice has improved my practice in examining my personal value and belief system. In being consciously aware of my values and beliefs I am more equipped to respect the beliefs of others. Awareness of the code of ethics and standards of practice along with my other learning experiences at Family Service

Thames Valley has enabled me to feel equipped to conduct myself accordingly as a MSW graduate.



## **Chapter Five: Implications and Recommendations for Social Work Practice**

My experience at Family Service Thames Valley fulfilled my need in learning the expected skillset of a clinical social worker at a graduate level. I am privileged to have had the opportunity to complete my practicum requirement at an agency that is committed to delivering mental health services using an inclusive holistic, anti-oppressive approach. It was an enlightening experience to be a part of Family Service Thames Valley in achieving my final requirement for the MSW degree. My hope is that Family Service Thames Valley continues to be supported with the necessary funding to remain able to provide their much-needed services to the people in London, Ontario, and surrounding area. My practicum experience rekindled my passion for assisting people as a social worker in making change, specifically people who are marginalized, oppressed, trauma survivors, have substance abuse issues, and who suffer from the effects of mental illness.

Family Service Thames Valley clinicians participate in on-going professional development training to enhance their skills or to learn new research in supporting their therapeutic specialties. I am extremely grateful to have had the opportunity to obtain knowledge from skilled clinicians at a graduate level. I have been inspired as a witness to their commitment as professionals working in the field of mental health. Observing and learning from the clinicians, including my practicum supervisor influenced my decision to obtain my basic training in Eye Movement Desensitization and Reprocessing (EMDR) during my practicum commitment at Family Service Thames Valley. EMDRIA (2016) states “Eye Movement Desensitization and Reprocessing (EMDR) therapy is an integrative psychotherapy approach that has been extensively researched and proven effective for the treatment of trauma (EMDRIA, 2016). EMDR is a set of standardized protocols that incorporates elements from many different treatment approaches” (EMDRIA, 2016). It made sense to me to take advantage of the

opportunity for EMDR training so I could add an additional trauma treatment therapy to my clinical skillset. However, I did not use EMDR with my clients during my practicum at Family Service Thames Valley.

My practicum experience has increased my confidence and ease in clinical approaches, relationships; dealing with triggers (both my own and those of my clients) in addition to better understanding the long lasting impact trauma can have on an individual. Implementing a TIA to my practice enabled me to notice what is helpful when assisting mental health clients and what needs to change. My practicum experience guided me in my role as a clinical social worker and has contributed to my knowledge and skill development leaving me competent to move forward at a graduate level in social work practice.

### **Implications for Social Work Practice**

My practicum learning at Family Service Thames Valley has enabled me to clearly see the benefits of clinical social workers in mental health services. Social workers are educated to assist their clients in a treatment plan that includes the clients' level of functioning in their environment. In other words, social workers are trained to think of the clients' well being both in and out of the clinicians' office. Starnino (2009) notes the 1900s was the first involvement for social workers to assist mental health clients in the form of aftercare with severe mental illness. At that time, there was minimal recognition of mental illness varying from extreme to mild severity, which contributed to institutionalization as being the norm for these people (Starnino, 2009). It was social workers coupled with instrumental physicians who raised awareness of the need for people to obtain assistance when returning to their communities after leaving mental institutions (Starnino, 2009). Eventually, minimal aftercare services were developed between 1906 and 1918 to meet the needs of persons with mental illness; social workers were hired to work in this area (Starnino, 2009). Mary Jarrett, a psychiatric social worker recommended at the

1918 National Conference of Social Work that caseworkers could identify and treat mental and emotional difficulties to help prevent acute psychiatric episodes in the community (Starnino, 2009). Transitioning from institutions to communities was a slow process. Advances in medication coupled with the view that long-term stay in hospitals was ineffective provoked a wide-scale deinstitutionalization in the 1960s (Starnino, 2009). Fleming (1982) argues that the movement of deinstitutionalization in the 1960s was influenced by an increased social and judicial emphasis on civil rights for minority groups including the mentally ill. Others also examine the motivation behind deinstitutionalization that explores additional possibilities. The point being made is that social workers engaging in mental health services have a long history that supports social work practice as being beneficial in meeting the needs of the clients they serve.

### **Recommendations for Social Work Practice**

I noticed the benefits of my training in social work practice while assisting clients during my practicum at Family Service Thames Valley. My skills evolved from assisting clients in mental health services in my previous social work experience with no formal structure in gathering information to acquiring knowledge and skills to conduct a thorough assessment summary. Although I did not have formal training in the area of developing an assessment summary when delivering mental health services to Inuit peoples, I credit my achievement to using a TIA coupled with narrative therapy. I believe my level of comfort without formal assessment training was a result of my social work education, my knowledge of TIA, and my personal experiences in healing from trauma. When learning the clinical procedure to conduct a client assessment summary in my practicum, I had a sense of ease in spite of not having done it before. Using the assessment summary at Family Service Thames Valley in gathering client information made complete sense to me in my social work practice. I found the assessment

summary extremely useful in planning the therapeutic process. In developing the assessment summary I included the genogram an assessment tool to aid in gathering important aspects of the clients' relational history. The assessment procedure informed me of where the client was at and also provided me with the clients' meaningful history. Most importantly, I learned how to include a therapeutic focus and to develop realistic goals with my client. Although I started my practicum questioning the result of short-term psychotherapy, I grew to trust the process in believing the services are impactful. The assessment is integrative, meaning it encourages a collection of information in all areas of the clients' life. It is my belief the assessment summary works in the best interest of the client and clinician equally. Although social workers are trained and educated from the person-in environment perspective when assisting clients, I recommend the school of social work include courses in their curriculum that teach an assessment protocol similar to that of Family Service Thames Valley. The Family Service Thames Valley Assessment Summary is in Appendix C.

At my practicum I learned of the importance in exploring the clients' prescribed medication. Unfortunately, my knowledge of medications used to treat depression, anxiety, and other mental disorders is minimal. My practicum supervisor was adamant in conveying the importance of knowing the clients' medications and their purpose, and how this information is necessary when developing a therapeutic treatment plan. Although I admired my supervisor's expertise in medications and their purpose, I recognized I was at a disadvantage with my lack of knowledge in this area. I learned to include asking clients about medications and documented the name(s) of the medications during the assessment session then took the information to supervision to discuss. It was interesting and meaningful to learn from my practicum supervisor my clients' purpose of medication and the training enabled me to feel confident to discuss it with my client. However, I have made it a future goal to continue learning of mental health

medication and its purpose. My practicum experience and research supports that many clients using mental health services are coping with mental illness or trauma. Therefore, it makes sense for social workers to have an understanding of the pros and cons of medication and their purpose for clients with mental illness. I recommend the school of social work include courses in their curriculum that teach the basics of mental health medications.

My practicum experience, education and research shows a significant number of clients using health care services have experienced a form of trauma in their lives. Evidence in the literature cited in Chapter 2 supports the need for a trauma-informed approach for individuals seeking health care services such as domestic violence survivors, pregnant women, and individuals with mental illness. As noted throughout this report, the trauma-informed approach has aided me in my clinical practice to bring about transformation for my clients, whether it be in a single session counselling or a number of psychotherapy sessions. In Chapter 2 similarities of trauma-informed practice and social work practice were discussed helping to see the link of the two practices. However, there appears to be very little, if any, research that supports the 'link' of social work practice to trauma-informed practice. My recommendation is for future research to examine the link between social work and trauma-informed practices.

Social work practice in its teaching encompasses trauma informed practice. As a student I recognize we as social workers do trauma-informed practice when working with vulnerable populations. Social work practice is threaded with trauma-informed aspects, which defines the link to both practices. Social work education ingrains trauma-informed practice in its teaching. However, it is not identified as that. Instead, it is a social worker's natural approach when assisting the clients we serve. I believe it would help to make the link of both practices more explicit in recognizing that trauma-informed practice is actually inherent in social work practice. If social workers were made aware of the terminology and of the similarities of the practices they

could articulate what they know and teach other health care providers about the importance of the trauma-informed practice when providing health care services. Knowing of the terminology of trauma-informed practice has the potential to improve social work practice for social workers in the field. Evidence based research supports the benefits of using trauma-informed services for clients who use health care services. Therefore, my recommendation is that schools of social work include courses in their curriculum on the association of social work practice and trauma-informed practice. I also recommend that training in trauma-informed practice is mandatory for social workers who provide health care services.

### **Conclusion**

My practicum experience at Family Service Thames Valley has met my expectations in providing me with a rich experience enabling me to expand my social work scope of practice as a clinical social worker in the field of mental health. My experiences have strengthened my skillset as a clinical social worker and broadened my knowledge. I have learned to integrate appropriate concepts and methods when assisting individuals and couples while using a trauma-informed approach.

My practicum experience reinforced the importance of health care services including trauma-informed practices. Although TIP has been discussed in organizations during the last few years I question whether the approach is truly being applied specifically in health care settings where the need is evident. Knight (2015) suggests trauma-informed practitioners are well served by their core training as social workers. Given the facts about trauma survivors as seen in Chapter 2, I support the inclusion of trauma-informed social work practice as being a valuable asset to health care services especially when helping vulnerable populations. My hope is that this final report of my practicum experience will help all service providers in health care settings recognize the benefits of using TIP and view the approach as a necessity rather than a responsibility in a

social worker's role. I am confident my practicum experience and accomplished goals at FSTV has provided me with the required knowledge and development in moving forward as a trauma-informed social work practitioner.

Finally, examining my personal and professional values and reviewing the social work code of ethics has supported me in being a proud member of the Ontario College of Social Workers and Social Service Workers (OCSWSSW). It has increased levels of flexibility, comfort, and confidence about my own values and beliefs and has enabled me to apply the Social Work Code of Ethics in all areas of my social work practice. I am filled with gratitude to have had the experience of doing my Master of Social Work practicum at Family Service Thames Valley. Much of the credit for my gratitude goes to the clients who trusted me in guiding them through their therapeutic process, and for that I am forever thankful.

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*Appendix A*

**Learning Goal** - To learn advanced clinical practice skills in individual practice.

Objectives	Learning Activities	Outcome
<p>Become proficient in core counselling skills such as: active listening, expressing empathy, appropriate self-disclosure, reflecting and paraphrasing using a trauma-informed approach.</p> <p>Document using a technique in shortening assessment but including important information</p>	<p>*Observe counselling sessions with master level therapists with clients in a co-therapy session.</p> <p>*Debrief with supervisor and colleagues.</p> <p>*Receive evaluative feedback from colleagues (where applicable) and supervisor (Ongoing).</p> <p>*Self-reflection through journaling and identify transferences and counter-transferences. (Ongoing)</p> <p>*Ask relevant questions in supervision in documentation style</p>	<p>*Independently provide counselling services to individual clients and couples</p> <p>*Develop increasing sense of comfort and confidence while using advanced counseling skills. (Ongoing)</p> <p>*Help clients to develop their capacities for managing distress.</p> <p>*Improve in written documentation of that of a graduate level</p>
<p>Implement an Integrative Approach to my counselling method by using the Humanistic, Existential and Narrative Therapies learned through reading, supervision and direct observation.</p> <p>Provide an empathic environment and promote awareness. Help to increase client's self-awareness.</p> <p>Facilitate psychodrama and role-playing with clients.</p>	<p>*Receive feedback regarding my skills and practice.</p> <p>*Strategizing with my supervisor about ways I can improve my interview skills and assessment techniques.</p> <p>*Self-reflect in my journal on these theories, considering anticipated strengths and possible challenges when applied to practice (Ongoing). Discuss outcome with supervisor.</p>	<p>*Increase ability to describe the therapy techniques.</p> <p>*Efficiently practice learned techniques with individual clients with presenting issues around presenting problem and traumatic experiences.</p> <p>*Use practice experience to inform scientific inquiry.</p> <p>*Improve clinical counselling skills to follow a client's story and ask/discuss sensitive topics when appropriate.</p>
<p>Become familiar with Trauma-Informed Stabilization Treatment and its purpose.</p>	<p>Read relevant information, converse with master level certified psychotherapist and attend volunteer information sessions on trauma.</p>	<p>Gain competence as a trauma-informed practitioner and use the language to articulate the need of TIP in clinical settings.</p>

Continue with self-care to maintain mental and emotional health in and outside of my practice.	Engage in self-care activities regularly in order to maintain balance such as debriefing, eating healthy, walking, connecting with others and continue my yoga practice.	Remain healthy mentally, physically, spiritually and socially.
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**Learning Goal -** To examine how the agency is implementing Trauma-Informed Practice (TIP) within Family Service Thames Valley (FSTV) functioning.

Objectives	Learning Activities	Outcome
To understand how trauma-informed practice is interpreted in the operations of FSTV when servicing clients. More so, in the clinical setting when providing psychotherapy or counselling services.	To review and get familiar with the terms in the Trauma-Informed Practice Guide (2013).	Describe the differences between Trauma-Informed Practice, Trauma-Informed Approach and Trauma-Informed-Care and how TIP links to social work practice.
Acquire knowledge regarding the overall structure of Family Service Thames Valley i.e. policies and procedures and relationship with other agency's.	Participate in agency orientation, read agency materials, converse with colleagues, and directly observe.	Independently describe the Organization of Family Service Thames Valley and how the agency provides a safe and supportive environment using a anti-oppressive approach.
Understand trauma and its dimensions	Read and review definitions of trauma and its dimensions.	Understand and explain the types of trauma that can overwhelm an individual's capacity to cope.

**Learning Goal** - To understand my personal and professional value systems in work with clients and to practice consistent with Ontario College Social Workers Social Service Workers (OCSWSSW) Code of Ethics.

Apply learned knowledge of OCSWSSW Code of Ethics and the manual to identify ethical dilemmas that may arise in practice	<ul style="list-style-type: none"> <li>*Re-read the OCSWSSW Code of Ethics.</li> <li>*Identify one situation where client invites counselor on unethical behaviour and how the situation was handled.</li> </ul>	Proficiently discuss the application to practice of the OCSWSSW Code of Ethics where required. (Ongoing)
Demonstrate awareness of and respect for cultural differences in practice with clients.	<ul style="list-style-type: none"> <li>*Express sensitivity and openness to working with both staff and clients of various cultures.</li> <li>*Discuss with supervisor regarding counseling of cultural difference, and apply learning to client interactions.</li> </ul>	Increased levels of comfort and competency to work with clients from various cultural groups, ethnicity, sexual orientation and religions. (Ongoing)
<p>Develop greater understanding of personal beliefs and value system while respecting the values of social work profession and the clients.</p> <p>Develop self-care and coping strategies to maintain mental and emotional health in my practice.</p>	<ul style="list-style-type: none"> <li>*Identify one personal value that will be conflicting with the agency's policy.</li> <li>*Discuss the identified policy/ethical issue with my supervisor.</li> <li>*Attend integration seminars and receive feedback from fellow master students.</li> </ul>	Increased levels of flexibility, comfort and confidence about my own values and beliefs. (Ongoing)

## *Appendix B*

### **Four Principles of Trauma Informed Approach**

**TRAUMA AWARENESS** - A trauma-informed approach begins with building awareness among staff and clients of the commonness of trauma experiences; how the impact of trauma can be central to one's development; the wide range of adaptations people make to cope and survive after trauma; and the relationship of trauma with substance use, physical health, and mental health concerns. This knowledge is the foundation of an organizational culture of trauma-informed care.

**EMPHASIS ON SAFETY AND TRUSTWORTHINESS** - Physical, emotional, and cultural safety for clients is key to trauma-informed practice because trauma survivors often feel unsafe, are likely to have experienced abuse of power in important relationships, and may currently be in unsafe relationships or living situations. Safety and trustworthiness are established through such practices as welcoming intake procedures; adapting the physical space to be less threatening; providing clear information about the programming; ensuring informed consent; creating crisis plans; demonstrating predictable expectations; and scheduling appointments consistently. The safety and needs of practitioners must also be considered within a trauma-informed service approach. Safety measures and changes in treatment culture are key aspects of implementation of a trauma-informed approach. Trauma-informed services demonstrate awareness of vicarious trauma and staff burnout. Whether or not providers have experienced trauma themselves, they may be triggered by client responses and behaviours. Key elements of trauma-informed services include staff education, clinical supervision, and policies and activities that support staff self-care.

**OPPORTUNITY FOR CHOICE, COLLABORATION, AND CONNECTION** - Trauma-informed services create safe environments that foster a sense of efficacy, self-determination, dignity, and personal control for those receiving care. Practitioners try to communicate openly, equalize power imbalances in relationships, allow the expression of feelings without fear of judgment, provide choices as to treatment preferences, and work collaboratively with clients. In addition, having the opportunity to establish safe connections with treatment providers, families, peers, and the wider community is reparative for those with early/ongoing experiences of trauma. This experience of choice, collaboration, and connection is often extended to inviting individual involvement in evaluating the treatment services, and forming service user advisory councils that provide advice on service design as well as service users' rights and grievances.

**STRENGTHS BASED AND SKILL BUILDING** - Clients in trauma-informed services are assisted to identify their strengths and to (further) develop resiliency and coping skills. Practitioners emphasize teaching and modeling skills for recognizing triggers, calming, centering, and staying present. Sandra Bloom, in her Sanctuary Model of trauma-informed organizational change, described this as having an organizational culture characterized by 'emotional intelligence' and 'social learning'. Again, a parallel attention must be paid to practitioner competencies and learning these skills and values. (Trauma-Informed Practice Guide, 2013, p. 13)

*Appendix C*

FAMILY SERVICE THAMES VALLEY

**ASSESSMENT SUMMARY**

Client Name(s):

File #:

Session Date:

Counsellor:

Type of counselling Service (please check): ☒ Individual ☐ Couple ☐ Family ☐ Group

\*this summary was written based on information that emerged in the context of a single meeting.  
It should be considered selective and partial.

I. Presenting Problems as Described by Client(s):

II. Problem History:

III. Significant Background/Relevant Information: (*family and psycho-social situations, historical and current factors impacting on the presenting problem*)

IV. Assessment Screening and Related Action when Applicable:  
(*any 'yes' response will be detailed in Significant Background/Relevant Information*)

Suicide/self harm\*\*                      yes ☐    no ☒

Violence/harm to other/property\*\*    yes ☐    no ☒

Woman abuse                                yes ☐    no ☒

Child abuse\*                                yes ☐    no ☒

Sexual abuse                                 yes ☐    no ☒

Significant mental health and/or physical health concerns                      yes ☐    no ☒

Problematic drug and/or alcohol use and other addictive behaviour                      yes ☐    no ☒

\* *If yes, Child Abuse Documentation form will be completed.*

\*\* *If yes, Suicide/Homicide Documentation form will be completed.*



V. Case Formulation:

Clinical conceptualization of client presenting problem and family system data gathered

VI. Client's areas of strength

VII. Intervention Plan

1. Therapeutic Focus

Short-term Goal

Strategy

2. Therapeutic Focus

Short-term Goal

Strategy

3. Therapeutic Focus

Long-term Goal

Strategy

☒ The above service/treatment plan was developed in collaboration with and agreed upon by the client

☒ The available service options, resources, time frame of service were discussed with client

**Counsellor's Signature**  
(with credentials)

**Clinical Supervisor's Signature**  
(with credentials)

**Date Written:**