RURAL CLINICAL SOCIAL WORK PRACTICE: SELF-CARE AND COMPASSION FATIGUE PREVENTION

by

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ABSTRACT

The purpose of this report is to summarize my practicum experience at the Central Miramichi Community Health Centre in Doaktown, New Brunswick. The Central Miramichi Community Health Centre is the main healthcare facility in the area servicing the population of Doaktown, Boiestown, and other surrounding rural areas. The rural location of the health centre allowed me to experience rural social work practice as well as work within an interdisciplinary team. This report outlines my expectations and goals within my practicum and how my learning objectives were met through observation, discussion, and practice. In addition to creating an environment to strengthen my social work skills, my practicum allowed me to understand the difficulties and challenges that rural social workers face, such as compassion fatigue. This experience allowed me to further examine and reflect upon issues of self-care and compassion fatigue in social work and its implications for my future practice as a social worker.

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Chapter 1: Introduction

The following report captures my experience of my practicum with Horizon Health Network, which is one of two health authorities in New Brunswick that operates twelve hospitals and over 100 medical clinics and facilities (Horizon Health Network, 2017a). I completed my practicum at the Central Miramichi Community Health Centre while also working in other collaborative agencies and locations. The following chapter will provide an overview of the structure, mandate, and core mission of the Horizon Health Network while providing an introduction of my main agency and its community.

Central Miramichi Community Health Centre

The Central Miramichi Community Health Centre (CMCHC) is a clinic located in Doaktown, New Brunswick, that provides a wide variety of health services including: primary health care, illness and injury prevention, community development services, and chronic disease management (Horizon Health Network, 2017b). The clinic is staffed by one manager, one doctor, one social worker, three nurse practitioners, seven nurses, one respiratory therapist, one dietitian, four clerks, and other allied professionals who provide services from the clinic on a regular basis. The nearest neighbouring health care providers are located a one-hour drive north (Miramichi Regional Hospital) and a one-hour drive south (Dr. Everett Chalmers Regional Hospital in Fredericton).

Client Population and Services Provided

There is a wide variety of services provided at CMCHC thanks to the diverse health care team. The client issues are very widespread in this health centre and the social worker generally works with clients who require support for anxiety, depression, general stress, grief, and addiction issues. The centre has multiple programs and groups which are organized in

consultation with the social worker, such as the methadone program, healthy baby clinics where clients are offered post-partum depression screenings, and a breast cancer survivors group. The social worker also engages with the Alzheimer society and often presents to the Memory Café Group, which is a group for caregivers and Alzheimer patients where she administers the Mini-Mental State Examination (MMSE). In addition, the social worker provides services and delivers presentations at other local schools, and in the community, on subjects such as illicit drugs, assertive communication, conflict resolution, and healthy relationships. Other than social work services, the clinic provides many other programs such as a weekly high-risk foot care clinic (many service users being diabetic patients) and a monthly urology clinic.

Agency Structure and Mandate of Horizon Health Network

The Central Miramichi Community Health Centre is a community health care clinic that works under the Horizon Health Network umbrella. The clinics and hospitals in New Brunswick that work under this network all follow the same guidelines, mandate, policies, and procedures. The importance of learning these guidelines was a crucial aspect of working within the clinic's scope.

The Horizon Health Network operates many hospitals and health centers all over New Brunswick, Canada. Horizon Health Network's mission statement is "helping people be healthy" (Horizon Health Network, 2017b) and they achieve this result by providing a healthcare delivery system that puts patients and clients at the center of care. Being a bilingual province, Horizon Health Network ensures patients and clients can have access to healthcare in the language of their choice, and multiple committees ensure that cross-cultural needs are met, including a Francophone Liaison Committee and a First Nations Liaison Committee (Horizon Health Network, 2017a). Their vision is to provide "Exceptional Care. Every Person. Every Day"

(Horizon Health Network, 2017a) and the Horizon Health Network's values are listed on their website as follows:

> We show empathy, compassion and respect.
>
> We strive for excellence
>
> We are all leaders, yet work as a team.
>
> We act with integrity and are accountable
>
> (Horizon Health Network, 2017a)

The mission, vision, and values, guide how all Horizon Health Network providers work to serve patients and clients in a cohesive and team-oriented manner. They work cohesively to provide patient and client care and work as an interdisciplinary, collaborative team (Horizon Health Network 2017a).

Central New Brunswick Academy (CNBA)

One of my favourite parts of my practicum was my work at a local school. At the beginning of my practicum, my supervisor invited me to join her for a day at the Central New Brunswick Academy (CNBA), a school at which my supervisor had been consistently offering on-site counselling for seven years. After one day of sitting in with her and the students, I immediately knew I wanted to expand my practicum experience to include the school. CNBA was established in 2010 by consolidating two high schools to create one large facility. Consisting of 223 students in grades 6-12, CNBA is located at approximately the halfway point between Boiestown and Doaktown (Central New Brunswick Academy, 2016). Anyone at the school can refer a student to counselling services, and students often seek services on their own as the social worker is at the school every Tuesday morning. Some of the common issues that students bring forward are: depression, anxiety, bullying, and stress. It was instantly apparent that the access to

the same social worker at the school on a regular basis for a long period of time is beneficial and that this is an essential resource to the school. My supervisor had been a consistent resource for the school since its opening, and there were other mental health services available to the students. Due to the rurality of the school, many outside resources did not seem to be consistent and this was the main challenge of integrating new services. The beginning of my practicum lined up with the start of the Integrated Service Delivery (ISD) team and I was able to experience and witness the integration of this new service. The ISD approach is a new collaborative method bringing together multiple departments such as Education, Early Childhood Development, Social Development, Health, Public Safety, school districts, and regional health authorities (New Brunswick Canada, 2018a). Some services they provide include: direct assessment, intervention and support services, case co-ordination, consultation, and training (New Brunswick Canada, 2018b).

Chapter 2: Personal and Professional Location

The purpose of dedicating an entire chapter to define and describe my personal and professional position is to explore my context of practice. It is important to identify and reflect on our own positionality because it raises deep-rooted concerns and biases that may unconsciously affect our practice. During my practicum, I found certain biases and assumptions that I was not fully aware of until my reflection activities. I stayed in a position of not-knowing and did my best to not let my biases and assumptions create any barriers between my clients and myself. However, I realized through my practicum that without continuous reflection it is easy to return to previous ways of thinking and let it affect my practice.

Personal and Cultural Background

I am an able-bodied woman and I recently joined the Canadian Armed Forces (CAF) as a Social Work Officer (SWO). I immigrated to Canada at six years old and returned to South Korea for a year in grade six but have lived in Canada for the majority of my life. I moved within Canada many times, and I will likely continue moving frequently as a result of joining the CAF. Upon reflection, I realized that I struggled with my cultural identity and became very accustomed to moving frequently at a young age. Consequently, I believe I developed the tendency to easily disconnect from others, which is both helpful and hindering in my professional and personal identity.

I am a feminist, structural, and clinical social worker, with a passion for advocating for those with mental health issues. Because of my cultural and professional identity, I have assumptions surrounding every aspect of life which I work on reshaping on a daily basis. Being a former military spouse, I thought that I would naturally be more empathetic towards other spouses who are going through difficulties and feel more connected with them. However, in my

practicum during my Bachelor of Social Work, I found that when military spouses confided in me about their issues I would often have thoughts like “well I’ve been through that too and I was fine”. When I became conscious of these thoughts, I was alarmed by my lack of empathy and reflected on where my thoughts were coming from. The thoughts weren’t extremely prominent but they were enough for me to doubt the hardships that the women were feeling, and I realized this may influence my practice. It is important to stay self-aware and unpack the different biases I might hold unconsciously throughout my entire practicum and future practice.

Due to my mix of backgrounds, I identify my culture as an eclectic collection of all my experiences. Chang (2008) states, “the concept of culture is inherently group-oriented, because culture results from human interactions with each other” (p. 16-17). When looking at this definition of culture, it is evident that I have had a very wide variety of human interactions. I have had close friends that grew up not knowing when their next meal was going to be, and I have shared a dorm with individuals who grew up extremely wealthy. I grew up speaking Korean to my parents while at the same time shedding myself from certain aspects of Korean culture. In my teenage years, I shared a boarding house with fifty other girls, the majority of whom were white, and I adapted in order to fit in. As a young adult, I moved to the other side of the country and adapted to the military lifestyle. These diverse and collective experiences have shaped and shifted my values and ways of thinking so much that it is hard to identify exactly ‘where I come from’. Throughout my social work path, I found that I needed to consciously make the effort to remind myself that a diverse background does not mean disarray, but it means I have multiple experiences to draw from.

Acknowledging my own assumptions is a crucial and difficult part of social work, and assumptions and values are complicated to unpack. I grew up in a smaller town, around friends

with parents who struggled financially, then attended a boarding school surrounded by students with extremely wealthy parents. Reflecting on these two contrasting experiences, I believe that if I had never attended boarding school, I would assume that wealthy individuals are spoiled, unappreciative, and entitled. On the other hand, if I had never gone to my first school in a small town I may have grown up assuming that everyone has the same opportunities and experiences during high school. I must continue to explore and unpack my assumptions and remember that all experiences are different.

Educational Background

I decided to major in sociology in my second year at Queen's University in Kingston, Ontario, before taking a year off to work and volunteer while contemplating my future plans. During my year off from full-time studies I enrolled in the online introductory social work course through Thompson Rivers University (TRU) for an opportunity to gain an introduction to social work. After realizing that social work was the field I wanted to pursue, I transferred to Dalhousie University in Halifax, Nova Scotia and completed the remainder of my undergraduate degree via online distance education while residing in New Brunswick. My sociology education was brief, as the first year was spent taking multiple courses, but the one year of intensive sociology knowledge helped aid my decision to redirect my time towards social work. Reading Anne Bishop's (2002) *Becoming an Ally* in my TRU course had an enormous impact on my decision, as the notions of intersectionality, oppression, and power, resonated deeply.

For my undergraduate practicum, I completed an eight-month, 760-hour practicum at a private counselling agency which began the development of my professional social work practice. During my practicum, I had the opportunity to provide individual counselling to children, adults, couples, and youth for a variety of personal issues. I took two additional

training courses at Dalhousie University which were offered by the continuing education department on counselling skills which further developed my skill set. This experience initiated the development of my professional identity and I was able to develop a foundation to further build my clinical counselling skills.

Theoretical Framework

Currently, I consider myself as working from an anti-oppressive and feminist theoretical framework, utilizing solution-focused methods. However, I believe that my social work framework is constantly changing and evolving as I change and learn as an individual.

Payne (2014) defines anti-oppressive practice as combating the oppressive effects of discrimination by privileged and powerful groups while working toward social equality. I have experienced and witnessed injustice and social inequity throughout my life in Canada and in South Korea, and this aspect of my experience is what causes anti-oppressive practice to resonate on a personal level. Berzoff and Drisko (2015) state that mental health settings have moved away from using developmental theories and how people develop within oppressive social structures and moved towards a neurobiological focus. The process of being aware of, and acknowledging racial and cultural biases, is crucial for anyone to become culturally competent and to practice in an anti-oppressive manner.

Feminist practice has several different perspectives such as radical, socialist, black, and postmodern feminism (Payne, 2014). For my practice, feminist practice means working towards equality between women and men while being conscious of the societal systems and norms that are in place that create oppression for women. For example, as a woman, I have spent the majority of my life not understanding the concept of victim-blaming and have been guilty of victim-blaming in certain situations prior to my social work degree. It is important to be

cognizant of these biases and assumptions and work towards a framework that includes feminist values.

The solution-focused and strengths-based aspect of my framework can be defined as a practice that looks forward while amplifying strengths in clients' lives (Payne, 2014). I wish to bring this theoretical framework into my social work practice and utilize the positive approach of highlighting strengths. However, there are some issues surrounding strengths-based work, as being positive does not always recognize the reality of the client if they are experiencing difficulty (Payne, 2014).

My personal and professional experiences have shaped my perspective and influenced my framework of social work practice. My personal and professional experiences all combine to create who I am today. Who I am may change over time, but it is important to remember to be mindful of my biases and assumptions while practicing social work.

Chapter 3: Literature Review

My clinical practicum provided me with a diverse experience to build my practice on, and the following literature aided in gaining deeper insight of the experiences of my clients and will assist in my future practice as a social worker. This literature review creates a solid foundation of understanding of mental health, Post-Traumatic Stress Disorder (PTSD), and rural social work.

Mental Health

Mental health issues and mental illness have an overwhelming effect on society and human existence (Epp, 1988). Definitions and treatment methods are continuously evolving and it is crucial to keep up with changes and be aware of the history of mental health.

According to Armitage (2005), mental health services include large mental health hospitals, independent medical practitioners, community-based mental health clinics, psychiatric wards within acute-care general hospitals, and independent services provided by larger organizations, such as the Canadian Mental Health Association. In the past and present, institutionalizing individuals with mental illness causes more stigma towards mental illness. This stigma prevents society from speaking about mental health issues and perpetuates a cycle of stigma and silence. Armitage (2005) states in all of Canada's provinces, that major mental hospitals have been closed and mental illness treatment is provided within the community. This change was caused by the demands of parents and support groups for more accessible services, concern for civil rights of those who are institutionalized, cost considerations, and the availability of new forms of drugs and treatment (Armitage, 2005). Furthermore, Levine (2015) states that the transition of mental health care from hospitals to communities began "with the 1961 report of the Joint Commission on Mental Health [… and] the report was the impetus for

President John F. Kennedy's address […] for the Community Mental Health Act passed [in 1963]" (p. S22). According to Levine (2015), in the period immediately after World War II in 1946, the Department of Veterans Affairs made great efforts to train more psychologists, psychiatrists, and social workers, to serve a large number of veterans returning home which created a large influx of mental health professionals. Due to this overarching objective, many of the mental health professionals in psychiatry, psychology, and social work, had a very specific area of expertise in treating mostly veterans who were adult men, and had little experience working with children, women, or the elderly (Levine, 2015). This piece of history is particularly interesting to me, as it brings to light the issues professionals face when they are too focused on one specific area because of the population they serve. Upon reflection, it is even more evident that I must do my best to branch out from my personal interests and try to gain as much diverse social work experience as I possibly can during my practicum.

According to Epp (1988), defining mental health and agreeing on a broad conceptualization of the term is crucial because mental health affects every individual of society. Epp also explains that mental health has been viewed as the absence of mental disorder and past definitions of mental health were focused on "the psychological and behavioural characteristics of individual people rather than on conditions in society as a whole" (1988, p. 332). For the context of my practicum, I will be utilizing Epp's definition of mental health as follows:

> Mental health is the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality. (1988, p. 333)

This definition along with the notion that mental disorder is a single factor of an individual's overall mental health and not the only determining factor of mental wellness will set the foundation for my future work in mental health.

Clinical Social Work

Clinical social work utilizes a diverse knowledge base that includes biopsychosocial development, interpersonal relationships, environmental determinants, clinical methods, prevention, cultural and racial awareness, socially structured oppression, and strengths-based work (Berzoff & Drisko, 2015). Clinical social work draws upon different types of empirical research as well as multiple theories of human research (Berzoff & Drisko, 2015). Furthermore, clinical social work is commonly known as work involving individuals, families, and groups, and the term is designed to unite the diversity found within practice (Munson, 1993). The term clinical social work is constantly evolving. Munson (1993) defined clinical social work as "organized efforts by graduates of accredited schools of social work to assist people to overcome physical, financial, social, or psychological disruptions in functioning through individual, group, or family intervention methods" (p. 10). The key to Munson's definition is that clinical social work assists members of society in multiple facets and in many aspects of life's difficulties.

The National Association of Social Workers (NASW) officially recognized clinical social work as a specialization in 1976 and determined that clinical work requires a master's degree in social work as well as two years of supervised clinical experience (Karpetis, 2014). This official recognition was granted eight years after clinical social work was introduced in the United States of America by social workers who felt client problems were more complex than social and environmental factors (Karpetis, 2014). However, according to Karpetis (2014), the definitions

of the term clinical social work still have many discrepancies and these multiple definitions result in a professional divide.

Due to the flexibility of the social work profession, it can be hard to exactly define what clinical social work means. For example, some authors highly support evidence-based practice and consider it to be essential for developing and maintaining clinical social work practice (McNeece & Thyer, 2004). Conversely, other authors such as Werkmeister Rozas and Grady (2011) believe that evidence-based practice strengthens the social work profession but highlights potential limitations when exclusively utilizing evidence-based practice and promotes a more integrative approach. As social workers, we must remember to define our practice and be transparent about our framework.

Compassion Fatigue and Self-Care

Many authors cite Charles Figley's work from over two decades ago when writing on compassion fatigue. According to Figley, compassion fatigue is the feeling of confusion and helplessness in caregivers and the term can be interchanged with secondary traumatic stress (as cited by Harms & Pierce, 2011, p. 95). Figley also highlights that compassion fatigue reduces the caregiver's capacity to be empathetic (as cited by Adams, Boscarino, Figley, 2006, p. 103). McCann and Pearlman believe that in order for effective social work practice, social workers must utilize compassion and empathy to build rapport (as cited by Radey & Figley, 2007, p. 207). Figley suggests that the feeling of disconnection from others and hopelessness stem from taking on clients' problems causing mental, emotional, and physical exhaustion (as cited by Radey & Figley, 2007, p. 207).

Figley (2002), created a model to predict compassion fatigue as well as identify specific components that can help prevent compassion fatigue. This model includes nine variables

identified that range between the exposure to client and compassion fatigue which forms a casual model of compassion fatigue (Figley, 2002). The variables shown in the model are: exposure to client, empathetic concern, empathetic ability, empathic response, disengagement, satisfaction, residual compassion stress, prolonged exposure, traumatic memories, degree of life disruptions, and compassion fatigue (Figley, 2002, p. 1437). Residual compassion stress is a result of "emotional energy from the empathic response to the client and is the on-going demand for action to relieve the suffering of a client" (Figley, 2002, p. 1437). According to Figley (2002), a sense of achievement or satisfaction and disengagement are two ways to lower compassion stress and prevent compassion fatigue. A common factor of both disengagement and satisfaction is the requirement of a conscious and rational effort (Figley, 2002). A sense of achievement and satisfaction of service delivery requires a conscious effort by the service provider to recognize where their responsibilities end and the client's responsibility starts (Figley, 2002). Similarly, disengagement occurs when the service provider consciously makes an effort to distance themselves from the client (Figley, 2002). Radey and Figley (2007) believe that social workers should not only attempt to avoid compassion fatigue, and instead attempt to seek fulfilment through our work and handle energy from compassion stress to transform into a sense of flourishing.

Self-care is a common term used to identify a way to combat compassion stress and compassion fatigue. According to Harms and Pierce (2011), self-care skills are essential for social workers and it is important to identify and reflect on the differences of personal self-care and professional self-care. Professional self-care is addressing workplace stressors and gaining support while personal self-care is participating in activities outside of work to address stress (Harms & Pierce, 2011). Radey and Figley (2007) state that although there is little empirical

literature on the role of self-care on the overall well-being of social workers, they believe it simply makes sense to take care of ourselves in order to help others.

Interestingly, a study conducted by Killian (2008) showed that there is no evidence demonstrating a correlation between coping strategies and reported levels of compassion stress, fatigue, and burnout. Results of the study showed that many therapists thought self-care was important, but they did not get enough clinical training or professional development in that area (Killian, 2008). The findings of this study also supported previous findings, which showed that individuals are not allotting enough time to self-care while aware of its necessity (Killian, 2008). These findings can help us understand that it is not a mere absence of knowledge or awareness of self-care; it is also the lack of behaviours and action.

Post-Traumatic Stress Disorder (PTSD)

Much of the literature on PTSD focuses on combat-related PTSD. However, there are many other cases of PTSD that are not combat related in both military and civilian settings. With a wide range of causes and treatment, it is important to have a good understanding of PTSD.

Symptoms of Post-Traumatic Stress Disorder

Symptom relief seems to be a common theme among studies on PTSD. The first priority is seen as resolving symptoms that we can easily see and identify in order for a veteran to heal. According to the DSM-5, the diagnostic criteria of PTSD are summarized as: exposure to a stressor, intrusion symptoms, avoidance of stimuli, negative alterations in cognitions and mood, alternations in arousal and reactivity, duration of the disturbance, clinical significance of disturbance, and the disturbance is not a result of substance use or other medical conditions (American Psychiatric Association, 2013, p. 271-272). The main symptoms of PTSD are intrusive thoughts or images, sleep disturbances, nightmares, dissociative flashbacks, poor

concentration, or severe distress on reminders (Creamer, Wade, Fletcher, & Forbes, 2011). Creamer, Wade, Fletcher and Forbes also note the overlapping of symptoms between PTSD, depression, and generalized anxiety, and acknowledge the issue of possible comorbidity.

Sleep disturbances such as nightmares or insomnia are some of the biggest issues that individuals with PTSD experience. Pruiksma et al. (2016) found that insomnia was the most prevalent and persistent problem among those receiving treatment for PTSD and emphasized the importance of focusing treatment towards better sleep patterns. Insomnia was the most prevalent lingering symptom after receiving treatment; whereas, nightmares and other symptoms were shown to decrease (Pruiksma et al., 2016). According to Van der Kolk (2015), our body is interconnected and fundamental functions such as sleeping, eating, bowel movements, and breathing, are crucial in maintaining mental balance. In addition to experiencing a lack of balance, sleep deprivation can cause impairment to the "medial prefrontal cortex of the brain, which then causes our limbic system to take over and rational thinking [becomes] diminished" (Hoge, 2010, p. 57). In the context of combat-PTSD, sleep deprivation is used as a tool in combination with being in a combat zone (Hoge, 2010). When a person is working in a combat zone and is sleep deprived, it causes physical changes in their body that create stress hormones, adrenaline, and the body becomes hyper-alert, which is ideal in combat (Hoge, 2010). However, when soldiers fail to decompress, their heightened state becomes harmful and unsuitable for non-combat environments (Hoge, 2010). Not only does hyper-alertness create dissonance in their environment, it also causes imbalance in their fundamental functions such as proper sleep cycles and digestion (Hoge, 2010).

According to Van der Kolk (2015), individuals with PTSD have physiological symptoms which become engrained in their body. According to Van der Kolk's examples, some individuals

do not remember the trauma they experienced as a child, but their bodies still react as if they were traumatized recently (2015). Van der Kolk (2015) conducted scans of the brain recalling traumatic incidents and found that other than the expected areas such as the limbic area and amygdala, Broca's area in the left frontal lobe was also affected. The scans showed that there were significant decreases in that area of the brain that were similar to the brains of stroke victims (Van der Kolk, 2015). These scans gave answers to why traumatized people have such a hard time speaking about their experiences, and why after years of living with the memories they still have tremendous difficulty talking about it (Van der Kolk, 2015). In addition to affecting Broca's area, scans from other individuals who have been traumatized revealed a breakdown in the right and left thalamus during flashbacks (Van der Kolk, 2015). This breakdown explains why individuals remember traumatic incidents as "isolated sensory imprints: images, sounds, and physical sensations" (Van der Kolk, 2015, p. 70) rather than being remembered as a full story with a beginning, middle, and end.

The results of the scans are a good example of why post-traumatic stress disorder should be re-named Post-Traumatic Stress Injury (PTSI). According to Keynan and Keynan (2016), changing the term to PTSI from PTSD would make combat veterans eligible for the Purple Heart in the U.S., and help deconstruct the existing stigma that surrounds PTSD. Keynan and Keynan's notion is that changing the term will help begin to eliminate the stigma surrounding PTSD (2016). If the term PTSD was reconstructed to PTSI, it would be perceived as a combat injury and not a disorder, and veterans and current serving members might be more likely to seek help and feel less ashamed to admit they need support. I believe that mental illness should always be treated like a physical illness. The physiological effects of trauma go beyond memories and leave behind a mark that can be felt every day.

There are many different avenues of treatment available to individuals with PTSD such as counselling, psychotherapy, use of prescription medication, use of marijuana, and alternative methods of therapy. Korn (2009) highlighted mindfulness, self-soothing, distancing, containment, grounding, emotion regulation, interpersonal effectiveness, and cognitive self-talk as some of the fundamental coping skills that individuals with PTSD need to develop.

Psychotherapy

In the literature, it was evident that many authors agreed upon the notion that individuals with PTSD do not seek treatment. Fikretoglu, Brunet, Guay, and Pedlar (2007) found that two-thirds of veterans with PTSD sought mental health treatment and that only 50% reported continuing to seek treatment after their first appointment. This study supported previous findings that showed one-third of civilians and military members with PTSD seek any type of mental health treatment and found that military members sought treatment in the military health setting (Fikretoglu, Brunet, Guay, & Pedlar, 2007).

Many forms and methods of psychotherapy utilize evidence-based therapies. Cognitive Behavioural Therapy (CBT), Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) and Eye Movement Desensitization and Reprocessing (EMDR) are the most common forms of psychotherapy used and involve a combination of exposure therapy, analysis of thinking patterns, and body relaxation techniques (Hoge, 2010).

Cognitive behavioural therapy (CBT) can be defined as focusing on the interaction of behavioural, emotional, and cognitive responses, that characterize mental disorders (Williams & Bernstein, 2011). In addition, the basic premise of CBT when working with trauma is that it is generally assumed that telling the story of the trauma in great detail will help people leave it behind (Van der Kolk, 2015). Furthermore, Van der Kolk (2015) describes the preference of

CBT in trauma counselling among academics to be because behavioural treatment can be broken down into steps and manual protocols. Cognitive Behavioral Therapy in the context of the military would consist of focusing on helping veterans become more aware of thoughts and beliefs that trigger feelings of guilt (Beder, 2012). Through self-monitoring and assistance from the therapist, the hope is that veterans are able to realize that the traumatic event was completely out of their control (Beder, 2012). In addition to reducing guilt, cognitive-behavioral therapy may also help increase self-compassion and acceptance (Beder, 2012). Behavioural work is frequently used to treat trauma, and trauma-focused definitions have been created to specify this line of work.

Trauma-focused Cognitive Behavioural Therapy (TF-CBT) can be defined as assisting the person to confront their traumatic memories, as well as external situations that remind them of their trauma that they fear or avoid (Forces et al., as cited by Creamer, Wade, Fletcher, & Forbes, 2011). This form of therapy attempts to address interpretations and beliefs about these situations that may be interfering with recovery, and the strongest evidence within TF-CBT includes prolonged exposure and cognitive processing therapy (Creamer, Wade, Fletcher, & Forbes, 2011). The idea behind prolonged exposure is that if victims of trauma are repeatedly exposed to the stimulus and the bad things they imagine will happen do not occur, they will gradually become less upset every time the stimulus is presented (Van der Kolk, 2015). Regardless, exposure sometimes helps deal with fear and anxiety, but it has not been proven to help with the complex emotions of PTSD (Van der Kolk, 2015).

Lastly, EMDR includes exposure components and works by enhancing the process of trauma memory with new connections that have positive associations with the memory (Beder, 2012). Hoge (2010) believes the exposure component of EMDR is simply effective because the

combat veteran is telling their story and the eye movements might not be necessary. Previously, Albright and Thyer (2009) found that EMDR might have too little empirical evidence to be offered as a method of treatment for military members with PTSD. Since the review was published in 2009, other authors seem to agree that EMDR is an effective and popular method of therapy for PTSD in combat veterans. Van der Kolk (2015) describes PTSD as a memory that has failed the process of integrating into our life events and remains stuck, undigested, raw, and has a life of its own. Therefore, EMDR can be successful as it helps integrate the traumatic material as we would with regular memories (Van der Kolk, 2015). According to Wesson and Gould (2009), EMDR can be more beneficial in combat PTSD when it is used as an early intervention technique while soldiers are still in combat zones. In some cases, EMDR proved to be more successful than Prozac when treating individuals with PTSD who also suffer from depression (Van der Kolk, 2015).

Prescription Medications

Individuals may have preconceived notions and feelings about using medication as treatment from hearing others' experiences and their own past experiences. The stigma that exists around prescription medication ranges from the perception of appearing weak or being seen as an addict and many clients are fearful of adverse side effects (Cigrang et al., 2011).

The use of prescription medications when treating PTSD is generally for sleep assistance to subdue insomnia and nightmares. Traumatized individuals generally prefer benzodiazepines such as Klonopin, Valium, Xanax, and Ativan, which have a calming and soothing effect (Van der Kolk, 2015, p. 227). According to Van der Kolk (2015), prescription medication only dampens the experience of trauma temporarily without "curing" trauma and prescription medication does not teach self-regulation. Other authors agree that medications did not seem to

help with insomnia or nightmares, and cognitive-behavioural approaches may be more effective in providing lasting changes (Pruiksma et al., 2016). Although medications are not a permanent solution and psychotherapies may be a better lasting option, medications can help with immediate issues and provide relief for individuals. Even if that relief is short term, those interventions may be crucial in keeping individuals from giving up on treatment.

Medical marijuana is a common topic in today's society. Many states in the United States of America are legalizing medical marijuana and the number of supporters is growing for the legalization of recreational marijuana. Currently, all of Canada has legalized medicinal marijuana, and the legislation of the legalization of recreational marijuana has received final approval and will come into full effect on October 17, 2018 (Tasker, 2018). Medical marijuana is now commonly used to treat PTSD, and marijuana-related businesses are thriving. Medical marijuana is also sought out by patients suffering from other conditions such as chronic pain, and a study found that 23% of first-time medical marijuana seekers tested positive for PTSD (Bohnert et al., 2014). Similar to prescription medication, medical marijuana is commonly used as a sleeping aid for veterans with PTSD. According to Bonn-Miller, Babson, and Vandrey (2014), this may cause long-term issues because cannabis users may develop a tolerance to the sleep-inducing effects, causing a higher frequency of cannabis use.

Coping-oriented use of marijuana is discouraged by some authors because the sudden discontinuation of medical marijuana can be problematic (Bonn-Miller, Babson, Vujanovic, & Feldner, 2010). Bohnert et al. (2014) found that the positive PTSD group had higher percentages of previous prescription opioid use of 55% and prescription sedative use of 41% compared to the non-PTSD group in first-time medical cannabis users. Therefore, many individuals who turn to medical marijuana have likely already tried prescription medications. According to Jobe-Shields,

Flanagan, Killeen, and Back (2015) having children residing in the home is associated with higher use of marijuana and higher symptom severity in veterans with PTSD. This shows that there are more factors to explore and analyze before concluding that all individuals who use marijuana become dependent users or high-frequency users.

Alternative Methods

Hoge (2010) provides a list of Complementary and Alternative Medicines (CAM) which include drugs such as MDMA as well as non-medication treatments such as neurofeedback, dance therapy, massage, Reiki, herbal supplements, yoga, and pet therapy. It is interesting and encouraging to see prescription medications that are commonly seen as problem-causing to be repurposed for positive treatment use and listed in the same category as other forms of therapy with positive reputations.

Bensimon, Amir, and Wolf (2008), conducted a study presenting a music therapy group with six soldiers diagnosed as suffering from combat or terror-related PTSD. Data were collected from digital cameras which filmed the sessions, open-ended in-depth interviews, and a self-report of the therapist. Results showed that some reduction in PTSD symptoms was observed after drumming, and participants felt an increased sense of openness, togetherness, belonging, sharing, closeness, connectedness, and intimacy (Bensimon, Amir, & Wolf, 2008). Consequently, the music therapy group achieved a non-intimidating access to traumatic memories, facilitating an outlet for rage, and regaining a sense of self-control (Bensimon, Amir, & Wolf, 2008).

The reason behind the success of music therapy with individuals with PTSD is based on the nature of how traumatic memories are presented as flashbacks and nightmares rather than one continuous story (Bensimon, Amir, & Wolf, 2008). Traumatic memories are stored in a primitive

and visual way, presenting in the form of fragments whenever they are stimulated by a similar sensory input (Bensimon, Amir, & Wolf, 2008). Due to the nature of how traumatic memories are stored and presented, it is difficult for individuals diagnosed with PTSD to translate their emotions or memories into words, and creative acts such as drumming can assist in creating a detour to access them in a non-invasive and non-intimidating manner (Bensimon, Amir, & Wolf, 2008).

Similar to music therapy, art therapy has similar reasons behind its success. Avoidance is a key feature of PTSD, and art therapy assists in overcoming this by creating a non-threatening environment to tune into the trauma memory (Lande, Tarpley, Francis, & Boucher, 2010). By tapping into a person's nonverbal work through the use of various symbols that are used in artistry, it provides an opportunity for participants to express their personal thoughts and feelings through a pictorial depiction (Lande, Tarpley, Francis, & Boucher, 2010).

Many animals can play a significant role in animal-assisted therapy. Stern et al., (2013) conducted a study looking at the beneficial effect of living with an animal. They found that respondents indicated that they experienced improvements in several areas including feeling calmer, less lonely, and less depressed since adopting an animal into their home (Stern et al., 2013). The results of this study suggest that living with any animal, regardless of their training certification, may help relieve some forms of psychological distress that are associated with PTSD (Stern et al., 2013).

Substance Use Disorder and Alcohol in the Context of PTSD

In the context of combat PTSD, alcohol misuse is likely the most common form of Substance Use Disorder (SUD) that combat veterans exhibit. Research indicates that 50% of men with PTSD reported alcohol misuse or dependence, and 63% of Operation Iraqi Freedom (OIF)

and Operation Enduring Freedom (OEF) veterans with alcohol use disorder meet the criteria for PTSD (Angkaw et al., 2015). Alcohol misuse can be a consequence of attempting to self-medicate through excessive substance use to cope with symptoms of PTSD (Jobe-Shields, Flanagan, Killeen, & Back, 2015). Other substances are also commonly used by combat veterans with PTSD such as marijuana and cocaine. Marijuana is used to deal with insomnia and to numb anxiety while cocaine may appeal to those who want to relieve depression, hypomania, and hyperactivity (Beder, 2012). As previously mentioned, the history of substance use disorders with marijuana and illegal drugs created obstacles for research and experimentation with using these drugs for PTSD treatment. The stigmatizing notion that addiction and misuse are inevitable when using illegal drugs is what deters those who may benefit from them. It is crucial that research done on the long-term effects of substances such as marijuana and MDMA stay unprejudiced and be conducted without any predetermined negative beliefs. Like any other research, studies and researchers must stay unprejudiced in order to truly determine the benefits and disadvantages of repurposing illicit substances.

Rural Social Work

In preparation for my practicum, the rural component of my experience was overlooked by my focus on mental health and interest in PTSD. Once beginning my practicum, I quickly realized the significance of rural social work practice ideologies and theories within my ongoing practice. The knowledge on rural, remote, and northern social work practice that I gained through the University of Northern British Columbia proved to be extremely beneficial as a foundation of understanding while I was immersed in rural practice.

Definition

Defining the term rural is important for one main reason: context. Without clarifying the definition of rurality, notions may be misinterpreted. The term rural is not consistent throughout the practice of social work because there is an unclear definition of what defines communities as rural and non-rural (Cooper, Streeter, & Scales, 2013). This is similar with the concept of 'north' in social work practice (Schmidt, 2000). With many definitions of rural existing in environmental and economic contexts, social work is much more complex and requires a multidimensional framework (Cooper, Streeter, & Scales, 2013). According to Cooper, Streeter, and Scales (2013) moving away from a rural-urban dichotomy and asking the residents if they think of themselves as a rural community will help us develop a framework that is more behaviorally based. This notion is incredibly useful because it is shifting the focus from the physical environment while redirecting the decision power to the residents and utilizing a more client-based approach. Cooper, Streeter, and Scales (2013) introduce a multisystem model that combines the person-in-environment and systems-based perspective and they believe that the interactions between different systems are important for reflecting the complexity of rural people.

Similarly, Zapf (2009) describes an alternative term for person-in-environment as the expression is fundamentally an ecological term used to represent the relationships between the person and the social environment. Zapf (2009) suggests that we use the term 'people as place' which is a phrase that conveys unity and holism (p. 39). Zapf (2009) argues that the physical environment is often forgotten in social work, and social workers tend to focus on social environment as the integral portion of an individual's life. The grammatical structure and vocabulary used in 'person-in-environment' shows that the 'person' and 'environment' are two

different units and highlights Western society's views that the physical environment is an object that is separate from people (Zapf, 2009). Separating ourselves from the environment we are in and suggesting that we are affected by our environment causes us to neglect the notion that we affect our environment as well.

The use of place "combines location and physical environment with character, meaning, and emotional significance for people; it is a multidisciplinary concept [… and] social components cannot be easily extracted" (Zapf, 2009, p. 39). The term 'geopsyche' is when a place that individuals have occupied for a long period of time assumes human traits (Zapf, 2009). This term is fascinating because it makes the relationship between people and place so much more intimate and creates a sense of respect. In rural areas, individuals may find a deeper connection to their place in comparison to urban areas. This can be explained by a rural identity rooted within a sense of belonging and attachment to place created by a shared history and lifestyle (Zapf, 2009). Contextualizing the concept of rural using a critical lens will allow us to gain a deeper understanding of our client's experiences and remain open-minded rather than defining their rurality as an outsider of the community.

Culture Shock

Zapf (1993) describes culture shock as an experience where an individual is unable to connect or interact in a new environment in a meaningful way. Culture shock is common among social workers in rural and remote areas, and "misunderstandings and conflict are inevitable because of the differences in meanings, rules, and values between the two cultures" (Zapf, 1993, p. 696). This notion of culture shock from someone going from urban to rural and vice versa is crucial to recognize for the context of rural social work.

New social work graduates are likely the most prone to culture shock, as they move to different areas in search of work with little experience. Gillespie and Redivo (2012) found four themes that attract clinicians to their rural practice setting: “mainly professional opportunity, mainly community characteristics, a combination of professional opportunity and community characteristics, and a desire to move to Canada or British Columbia” (p. 36). Those who go mainly for professional opportunity and who wish to live in British Columbia may not always know exactly what the area they will be working in will be like unless they have previous rural experience. This creates the perfect setting for culture shock. They may struggle with “issues of professional values and personal integration with the community [… which] is not a unique challenge for social workers, as other groups of professionals and workers also experience difficulties related to living and working in the north” (Schmidt, 2000, p. 342). Although culture shock occurs in workers who move to rural and remote areas, professionals dealing with confidentiality can run into additional issues such as dual relationships.

Dual Relationships

According to Pugh (2007), dual relationships are used to describe the relationships social workers form outside the work setting with service users. Distinguishing between a dual relationship that is ethical and unethical can be challenging, as it is the nature of the relationship that is in question and not the existence of a dual relationship itself (Pugh, 2007). According to Gillespie and Redivo (2012), some of the major difficulties for rural social workers include balancing personal and professional boundaries. This was especially the case for those who were recruited from within the community where they acquired work; whereas, social workers recruited from outside the community identified challenges surrounding isolation (Gillespie & Redivo, 2012). Due to the nature of the close proximity to all community members in rural and

remote settings, it is safe to say that dual relationships can be inevitable and simply avoiding them might not be the answer.

Once social workers have built the skills to decipher between acceptable and unacceptable dual relationships, they are faced with the challenge of how to address each situation. Pugh (2007) states that there is little guidance on how to manage social invitations in social work literature. Similarly, Gillespie and Redivo (2012) suggest that in social work academic programs there is little preparation or practical experience on how to manage dual relationships. Literature in northern and remote social work has suggested the need for including northern practices in mainstream social work education (Brown & Green, 2009). The inclusion of this topic in all social work academic programs will have a long-term benefit for future social workers.

According to Gillespie and Redivo (2012), isolation can be a result of attempting to manage or avoid dual relationships for clinicians who were recruited from outside of the community. These clinicians reported that building a social support system and making friends to create a social peer group was their most frequent initial challenge when working in a rural community (Gillespie & Redivo, 2012). These social workers may also feel subconscious pressure to stay disconnected from the community in attempts to protect service users' privacy. The consequence of isolation can also have an impact on social workers' retention in rural social work practice. Schmidt (2000) and Cheers, Darracott, and Lonne (2005) all reference isolation in the high turnover rate of social workers in rural and northern communities. Schmidt (2000) addressed culture shock, lack of integration into the community, and urban educated social workers as some main concerns regarding retention. Cheers, Darracott, and Lonne (2005) corroborated this through their longitudinal Australian study, focusing more on the positive

effect of community bonds rather than the negative effects of disconnection. Additionally, they shed light on issues surrounding employer-related factors and the effect on early departure of rural social workers (Cheers, Darracott & Lonne, 2005).

The purpose of this literature review was to create a solid foundation for my practicum experience through understanding mental health, PTSD and rural social work in greater detail. The literature review was an important aspect of preparing for my practicum because I was able to explore specific areas of my interest, and it helped in my learning process by creating room for questions and points to reflect on during my practicum. Through this literature review, I found that in clinical social work, it is important to decrease stigma and increase awareness for self-care and compassion fatigue. The section on PTSD allowed me to become more familiar with the symptoms and different methods of treatment. Lastly, the section on rural social work was an extension of my knowledge from the Issues in Northern/Remote Social Work course I took at the University of Northern British Columbia. The opportunity to connect the literature to practical experience was extremely beneficial and interesting.

Chapter 4: Practicum Experience and Learnings

The overall objective of my practicum was to further develop my clinical social work skills in different settings. My main focus was individual counselling for mental health issues while also learning more about the different realms of social work practice within a clinical setting. This focus creates specific goals within my overarching learning objective of clinical social work, and I have identified the main goals along with the activities I believe have helped achieve these goals below.

Learning Objectives

I. Learn how each agency works differently under the same umbrella of Horizon Health Network and become familiar with the different policies and protocols the agency structures require
    a. Review agency policies and Horizon Health Network policies and procedures.
    b. Ensure my work is being completed to the correct standards both practically and administratively.
    c. Work cohesively with supervisors and coworkers in different professions.

II. Learn to work in an interdisciplinary team and work collaboratively with nurses, doctors, and other health care professionals at each clinic.
    a. Communicate clearly and respectfully and be straight forward with questions.
    b. Keep in mind that different health care professions have different scopes so differences may need to be addressed and acknowledged.

III. Continuously work on developing my professional social work identity and learn to identify clients' issues in a clinical setting.
    a. Continue developing my clinical social work lens and working toward defining it.

b. Practice working from a structural, feminist, solution-focused, and anti-oppressive lens.
c. Consistently practice reflecting upon experiences and new knowledge and routinely document these reflections.

IV. Continue to develop clinical social work skills.
a. Observe individual counselling sessions and carry a small caseload once I feel comfortable and my supervisors have agreed upon autonomy.
b. Become familiar with theories and practice methods that are practiced by supervisors and become comfortable applying them to my own practice.
c. Learn how to adapt my practice to be more client-centered.
d. Develop administrative skills that come with clinical social work such as case management skills and keeping up with paperwork required by the agency.
e. Continue growing clinical skills such as intake, assessment, treatment planning, and successful termination.
f. Learn to make referrals to the necessary supports when needed
g. Co-facilitate group sessions managed by my supervisors to build group-facilitations skills.

V. Develop a better understanding of therapeutic modalities to treat PTSD
a. Become familiar with PTSD symptoms, treatment options, and screening tools.
b. Continue to research and explore different methods of treatment of PTSD.
c. Explore trauma-informed therapy methods and develop, practice common methods such as CBT, and become more comfortable with trauma-related work.

VI. Maintain Self-Care strategies that have helped my social work practice and education thus far to support my emotional and mental wellbeing

   a. Continue self-care methods such as exercising, cooking, journaling, spending time with family, and regular stress-relieving massages.
   b. Remember to talk about self-care with supervisors during regular supervision meetings and add any other strategies that may prevent burnout

How Practicum Objectives Were Achieved

Practicum objectives were achieved through observation, carrying my own case load while consulting with my supervisor, and engaging in interdisciplinary care with Nurse Practitioners. Through frequent discussion with my agency supervisor I was able to practice my skills and become more confident in my role as a social worker. My MSW supervisor, Audrey Cochrane, was always available to me for questions and concerns and was a helpful resource throughout my practicum. Prior to beginning my social work education, I thought that social workers and counsellors were the experts and clients were to listen to their advice on relationships, life, and mental wellness. I have been to many counsellors who took this stance and gave me their own personal opinion on my life and I did not find it helpful. Now, after years of social work education and some practical experience, I know that my preferred technique is to help and guide my clients to learn to help themselves and figure out their own solutions. Having someone listen and act as a sounding board about obstacles in life is sometimes all a client is looking for.

Observation

At the beginning of my practicum, I sat in with my supervisor and observed her sessions. I observed her with new clients to learn how assessments are done and also sat in with clients she

had seen for years. I took notes and shared them with my supervisor and learned how the charting system worked at the agency. I began to chart on all the sessions I sat in on and my supervisor signed them after review. This process helped me learn what the expectations were when writing notes for charting in the Horizon Health Network records and I became comfortable with taking notes and charting on my own cases quickly. Through this observation and practice, I also quickly learned to work within the client-centered and collaborative method of Horizon Health Network's mandate.

In addition to observing one-on-one sessions, I attended meetings and events with my supervisor to observe what my supervisor did outside of clinical counselling. I attended a social work day event for all the social workers who work in the area, staff meetings, a methadone program meeting, an ISD meeting, inter-professional consultations, and a compassion fatigue workshop run by my supervisor.

The social work day event for all Horizon Health social workers in the area was filled with different workshops and created an environment for all the social workers to discuss different methods and bring forward case examples they wanted input on. It was a great opportunity to network and meet the social workers working in rural and urban areas of Fredericton. There were a couple of presenters from other government organizations to share their available resources that might help our clients, such as an employment counsellor who helps individuals find jobs and ways of funding further education. The event was informative, and the opportunity to discuss different case scenarios was beneficial for all attendees.

The monthly methadone program meeting is held to discuss the progress and recent events of the members of the program. The meeting consists of all the professionals involved in the program, which is nearly the entire clinic staff. At this meeting the physician, nurse

practitioners, nurses, clerks, and social worker, discuss how a methadone patient is doing in the program by consulting about the patient's attendance at appointments, mental health state, how many 'carries' they have, their drug test results, and other relevant information. Due to the nature of the small community, many methadone patients are often seen outside of the clinic at social events, and the team is also able to have insight on their social interactions as well as how they seemed when at their appointments. Sitting in on a meeting gave me an opportunity to learn that the team at CMCHC really look at the whole picture when working with methadone patients and take a client-centered approach when making decisions. It was incredible to see the amount of time and care it takes to go over each patient's progress and it was very evident how passionate and caring the team were towards the patients.

The ISD meeting I attended was held at the Central New Brunswick Academy, and the meeting consisted of the principal of CNBA, an ISD representative, guidance counsellors, teachers, nurse practitioner, and social worker (my supervisor). The meeting was the first attended by both ISD and my supervisor, who have had some overlap in students and had some miscommunication issues with other members of the ISD team. This meeting was a great help in opening up communication lines and beginning to work collaboratively rather than as separate units between ISD and the existing social work resource. It was also a space to bring up any issues or causes of concern that the principal or other members of the faculty had about students.

The compassion fatigue workshop was an event held by my supervisor where she discussed and spread awareness about compassion fatigue to health care providers at a clinic in Fredericton. The workshop included self-assessment quizzes to determine levels of stress and self-care and the presentation provided information on how to detect symptoms of compassion fatigue. My supervisor used her personal examples of compassion fatigue she experienced

throughout her career and opened the space up for more conversation on the subject. I attended the workshop nearing the end of my practicum and realized that I was experiencing many of the symptoms my supervisor was explaining during the presentation. This allowed me to take a better look at my self-care and look back to my learning goals.

Discussion

My supervisor was available to discuss my clients with me frequently, and throughout my practicum I used her expertise to debrief on all my clients and ask questions on a regular basis. Some of my clients were individuals who saw her before and switched over to me to get a fresh start so I ensured that I kept my supervisor updated. The most beneficial part of this ongoing and frequent conversation was the feeling of being supported and having someone to speak to about my ideas and thoughts. My supervisor also asked me questions that got me thinking about certain scenarios and what I could have done differently. She also gave me similar examples of her previous experiences and educated me on what she did in those situations. My supervisor was there to support me in more difficult situations, such as calling child protection and speaking with the child's parent about the report. Debriefing after those phone calls was crucial and she even called me later on at home to ensure I was doing okay and doing some self-care. Our conversations were often about specific clients, but they also included many discussions on the experiences of a rural social worker and the different situations and unique methods that come with them. For example, during a particularly heavy snow storm, my supervisor was being driven to work by her father in his truck, and during the drive he received a phone call from an individual in the community asking him to plow her out of her home. She explained to him that she needed to be plowed out so she could take her counselling appointment with his daughter and would appreciate the help. This situation would be very unlikely to occur in an urban setting and

shows the interconnectedness of the community. An example of rural contact that affects her practice is when there is a conflict of interest. During my practicum, I was able assist Lynsey in avoiding conflict of interest by taking clients that were related to her. My supervisor and I discussed that when she does not have a student or another social worker in the clinic working with her, she has no choice to refer individuals to Fredericton, Saint John, or Moncton. Through this process, I learned that it can be a difficult task to refer out family members, close friends, and other individuals that cannot be seen by the sole social worker and it can create certain barriers for the clients and social worker. Through many years of experience, my supervisor has finessed the process to make it as smooth as possible for the clients. This skill of effective communication to clients in this context and dealing with the logistics of rural contact was a great lesson for my future practice.

Throughout my practicum, some of my sessions with clients were observed by my supervisor. We informed my clients that she would be observing me and not them to ensure their comfort, and she observed my sessions with minimal interjections. These observation sessions were an important aspect of building my confidence in my clinical social work skills. Being able to answer questions on my techniques and explain my thought processes gave me a sense of self-assurance and external validation.

My supervisor treated me as a professional peer and as a friend in her supervisory method. This was my preferred method of supervision prior to beginning my practicum. Treating the supervisee as a professional peer allows for a more professionally orientated approach which focuses on enhancing professional growth with respect to skills and knowledge (Tsui, 2005). Additionally, treating the supervisee as a friend as well as a colleague creates a space for more discussion about personal concerns and feelings and the supervision will be more supportive in

nature (Tsui, 2005). Both types of supervisory relationships have room to facilitate a more autonomous practice for the supervisee and my supervisor maintained the necessary boundaries in our supervisory relationship while creating a safe space for both of us to consult each other. The nature of my practicum location caused the professional peer relationship to occur organically, as we were the only two social workers working together in the community. This resulted in mutual reliability to consult and debrief throughout my time there.

Interdisciplinary Consultation

The opportunity to be part of an interdisciplinary team allowed me to gain insight about the importance and benefits of joining forces with other healthcare providers and educators. The ability to consult with another health professional who already had background knowledge on a client was both useful and efficient. I consulted with nurse practitioners who gave me information and insight on medications and different medical intervention strategies that were outside of my field of knowledge. Instead of waiting for a response to an email or a phone call, the ability to walk down the hall and get the professional opinion of a nurse practitioner made consulting extremely accessible. Having multiple health care professionals work towards a treatment plan and get on the same page for one individual is so powerful and valuable. Working collaboratively proved to be beneficial when one of my clients' parents continuously questioned her medication while trying to lower the client's dosage. Knowing that it wasn't my field of expertise, I discussed the situation with the nurse practitioner working with the client and came up with a way to explain the treatment plan to the parent.

Working at a school also meant that communication and collaboration with teachers and administrative staff was a crucial aspect of my practice. Many students seeking support for mental health issues also faced obstacles in their school and personal life. Working at the school

and becoming familiar with the principal and other staff members created a positive and more comfortable atmosphere in consultation and collaboration. Consulting with teachers and the principal over specific issues brought forward by students allowed for collaborative plans to be created not only with mental health treatment in mind, but with academic goals as well. This eased the stress for many of my students and having the school support and be a part of the plan was successful. Learning to work in an inter-professional team was a great way to learn about the roles of other professionals and gain insight on how the differing roles can collaborate to create a client-centered approach.

Case Examples

During my practicum, I carried a manageable caseload at CNBA, CMCHC, and the Boiestown Health Center. Having my own caseload and being responsible for schedules, charting, entering stats, and treatment plans was eye-opening. Below I have included case examples of two individuals I worked with throughout the duration of my practicum. For confidentiality purposes their names have been changed to Jane and John. I have several clients who came to see me for support and were able to gain what they needed and I 'closed' their file. The two examples I will give are not those clients. These two are the clients I had the most difficulty with and who I believed I learned the most from. Both clients had been previously working with my supervisor and my supervisor thought it would be beneficial for them to have a fresh start with a new face. I chose to share and document these clients because they were my first clients who had been with me for the full duration of my practicum and I learned immensely from working with them both.

Jane

Jane is a sixteen-year old student I met during my first month of practicum. She was struggling with anxiety and depression and had a hard time feeling happy. She lost interest in things that used to make her happy and felt that nothing could get her in a good mood. During our first few sessions, we spent time talking about her life and some of the obstacles she was facing in order to slowly build rapport and trust.

The main issue Jane experienced during the beginning of our sessions was that her mother got angry at her a lot because she was missing school. Jane explained that her mother did not seem to understand what she was going through at all and the lack of understanding hurt her deeply and frustrated Jane on a daily basis. We worked on different ways to convey to her mother about her feelings and thoughts, and Jane and I did some role play to act out some ways of communication that might work better. Jane even tried showing her mother different YouTube videos of other women explaining depression and anxiety. Jane's efforts did not have an impact on her relationship with her mother, so Jane brought her mother in for a meeting with me in attempts to get her to understand her better. At this meeting, I educated Jane's mother on the realities of depression and anxiety, and spoke with her about the challenges Jane faces on a daily basis. Jane's mother replied with challenges of her own and being unsure of the balance between being supportive and being strict on school attendance. The meeting was effective and communication lines between Jane and her mother were opened. Jane's mother was more involved in treatment plans and began to understand her daughter better.

Throughout my practicum, Jane went through ups and downs. I tried giving her homework such as: journaling, going to the gym to boost endorphin levels, doing yoga through an app or online videos, went over sleep hygiene, muscle relaxation, and taking more baths to

calm anxiety. Jane always reported back that she forgot her homework and the only thing that stuck was taking frequent baths to calm her mood. Jane seemed to be doing better initially after working on validating her feelings and working on communication with her mother. She was social again and finding joy in hanging out with her friends. However, her parents stopped her many times from being social if she had missed any school and the arguments led her to stop wanting to go out with friends and I had to have a conversation with her mother again. After months of generally low mood and anxiety over school, the nurse practitioner at the school and I collaborated and suggested that it might be beneficial if Jane saw a psychiatrist at mental health.

Jane had issues with attending school and being at school heightened her anxiety and lowered her mood immensely. Jane was missing multiple days a week and finding it unbearable to sit in class most days and it was starting to affect her grades. After discussing her class schedule with Jane, I set up a meeting with the school's principal, Jane, and her mother to try to come up with a plan. During the meeting Jane was unable to express her feelings, but privately was able to discuss options. I suggested that Jane move to half days at school, and slowly incorporate full days when she was ready. All parties agreed to these terms initially, but Jane told me that her mother and grandmother only supported half days for less than a week before suggesting she go back for full days. This constant back and forth was an issue for a while before she got on a steady schedule.

Jane is still on half days at school and still finds those days to be difficult to maintain. The plan initially worked very well and we saw some progress, but currently she is still having a very hard time attending school and still experiences very low mood. She will be followed by the ISD team who have a direct relationship with mental health in Fredericton and she will continue to be followed by a psychiatrist for her medication.

Jane was the first client that I had where I sought the help from nurse practitioners and educators and the experience was empowering and helpful. Jane's situation is one that I have felt distraught over many times in the past and present. I felt that I failed because she is not happy and healthy as she once was and I felt that there was more that I could do for her. Upon discussion with my supervisor and personal reflection, I know that I did not fail, and that I did do everything in my power at the time to help her. I went to the school on days that I was not scheduled to try to see her if she was not at school on my regular day, I called her at home and called her into CMCHC for last-minute appointments. I learned through this that in this profession, it is easy to think that our job is to 'fix' every aspect of an individual's life and have control over the outcome when that is not the case.

John

John is a 23-year-old man who experienced trauma and sought support with my supervisor for a year prior to meeting me. John's employer required him to drive in extremely snowy conditions on a very dangerous road which was traumatizing and he felt that his life was in constant danger. Since then he has been diagnosed with PTSD and was experiencing low mood and some suicidal ideation when he first met with me. John suffers from many other medical conditions that require to him to take medications which consequently have a negative effect on his mood. He has a case worker with social development and a psychiatrist that follows up with him for this medication to treat his insomnia and depression. The first thing John and I did was start from the beginning of his story and engage in narrative work. John was the first client that I met with and he was very willing to work with a new social worker. John had known my supervisor since high school and my supervisor and I both agreed that a new face would be beneficial for him.

John instilled trust in me very quickly and found the sessions to be helpful with his mood. We spent many of the first sessions talking about his experiences and his perception of life as well as his thoughts of others' perception of him. We began incorporating behavioural work in order to reduce his feelings of guilt and increase self-compassion. John felt guilty towards the event that led to his PTSD diagnosis, which eventually led to the loss of his job. This guilt towards the notion of failure left him with debilitating self-doubt and low self-esteem. We worked a lot on self-esteem as well as empowerment as John began to see himself in a more positive way. In addition to low self-esteem, John struggled with anger, communication with his wife and family, financial issues, and career goals. I wanted to find a step-by-step program for him, but quickly found that rather than a structured program with lots of homework (which he did not enjoy), John gained more from narrative therapy and behavioural work.

As autumn was ending and it started to get colder, John's past symptoms of flashbacks and nightmares returned as he began to fear driving in snow again. His suicidal thoughts became much more severe and the verbal contract of staying safe was no longer sufficient to ensure his safety. We decided to bring his wife into a session to get her on board with a more vigilant safety plan, and she agreed to lock up all his tools, knives, and guns that he enjoyed using recreationally. Upon meeting his wife, we decided it would be beneficial for her to come in for her own sessions as well to discuss some obstacles she was facing with her husband's situation. I began to see her separately as well for her own issues as well as having sessions with both John and his wife to discuss how they are doing as a couple. John started cancelling more appointments when there was snow on the ground, and I encouraged him to start driving short distances in little snow with his wife present rather than avoid driving in snow all together.

Once John and I built trust and comfort, we started to work on some specific aspects of his life. First, we worked on more effective communication and anger management with him and his wife as well as his parents. We implemented some calming techniques for his anger which ended up making him even more angry, so we used a strengths-based and solution-focused method of finding ways he can face a problem rather than becoming angry. This seemed to work much better and also boosted his self-esteem. John began to become more accepting of his past and focus on the future, while actively reducing his self-deprecating thoughts of guilt.

He quickly reported back that his relationships with his parents and wife were getting much better and he was having a better time containing his emotions and expressing them in a more productive way through communication rather than yelling. The issue of finances remained, as he and his wife were living on social assistance. Throughout my time at CMCHC, John was reluctant to try new career paths even after many sessions of searching together for job possibilities, different career options, and training.

John and his wife became visibly happier, and most of their issues came from financial difficulty rather than their relationship and John reported better mood and sleep. Nearing the end of our sessions, he informed me that he felt ready to go back to work and start driving trucks again after a good offer was given to him in Alberta. He told me he thought the offer through carefully and had thought of a clear plan on how he was going to make it work for him. On our last session, John informed me that he had a different job offer which was better for him and had bought his plane ticket to leave at the end of the month. He said he felt excited about this job and very little nervousness, and felt he was ready to take on a new challenge. He said he feels confident that he will overcome similar situations in the future as he overcame this one, and he feels comfortable seeking support when needed.

Working with John reinforced the notion that there are many different ways of working with a client. I may want to follow a strict plan with specific goals for each session with homework and learning goals, but sometimes that is not what works for the client. Plans and treatment plans are meant to be followed while also maintaining flexibility for the clients' needs. Flexibility is crucial to maintain client-focused and it is important to not remember to avoid feeling I am not making progress because we got off track.

Reflection

Many of my reflections can be detected throughout this report, and I found it helpful to revisit my reflections while writing. Doaktown is located a little over an hour drive from my home, and I used this driving time to reflect. At first I did not enjoy the long drive, but once I used it as my own space to prepare myself for the day or to decompress after a particularly difficult day, the drive became quicker and easier. In order to use my time efficiently, I recorded my thoughts and emotions during my drive by filming myself talk about my day. The recordings were meant to act as a journal, and the reason I chose to film myself rather than only record my voice was because I wanted to capture my raw and unedited emotions while telling stories and reflecting on my day. Watching the recordings months later, I was able to identify some themes and interesting thoughts I had during my experience.

Recordings

In September, the majority of my recordings showed that I was excited, and in awe of the work that my supervisor did at CMCHC. I was also emotional and shocked by the level of poverty in a community only an hour away from my home. Upon reflection, I realized that the fact that I was shocked was a significant indication of my naivety and privilege. I felt angry and

frustrated, mostly at myself, and partially at life and society for being unfair. The initial months of my practicum was a crucial start to reflect on my privilege on a regular basis.

In October, I could see that I started to understand the frustrations when working with outside resources that are further away. Quickly it became increasingly evident that many clients who need additional support or resources from Fredericton are often forgotten about. Funding was cut for a mental health social worker to come to Doaktown from Fredericton Addiction and Mental Health Services every two weeks, which had a great impact for clients who were unable to find transportation to Fredericton regularly. At this time, I also began to feel more confident with my clinical skills and expressed in my recordings that I was getting more comfortable with assessments and clinical notes. I spoke about my conversations with my supervisor, and how I appreciated the honest discussions surrounding the life of a social worker outside the clinic and the importance of self-care, self-awareness, and reflection. I learned that being aware and cognizant of my own triggers within my practice was important and working with clients who experience similar events or hardships as myself can be very difficult. Self-reflection was crucial to ensure that I was practicing within my own boundaries and the recording helped a lot during this time to talk aloud some of my own thoughts and concerns.

In November, I began to doubt myself because the different treatment plans I was making for my clients did not seem to be ‘working’. I was having trouble getting my clients to stay focused on the goals and activities I had planned out and was getting stressed out. This is when I realized that it isn’t always about meticulous planning and stressing over not staying on track is making the counselling experience about my own agenda rather than going with a client-centered approach like I had intended.

In December, I experienced driving in snow to CMCHC for the first time and experienced the inconvenience and difficulty of finding transportation to and from Fredericton. Many of my recordings in December was reflecting on how to prepare my clients for the holiday season as well as my absence during my vacation. Watching the recordings, it is very obvious that I was nervous and worried about not seeing my clients on a regular basis and I was taking those feelings home.

In January, my recordings were used as a tool to debrief to myself and think aloud about the issues and struggles I was experiencing. I was doing more role-playing with my students at CNBA to speak about their mental health more openly and speak with teachers in attempts to break the stigma on mental health issues. I spoke about how everyone who works at CMCH works extremely hard, and self-care is lacking. I expressed my ideas around needing self-care to be incorporated into policies and be something that is supported more by the organization rather than the responsibility be completely on the professional. My practicum recordings and personal journal showed that I was getting frustrated more easily and I was distancing myself from social events and friends because it felt like work to listen to their troubles. Now, I realize I was showing signs of compassion fatigue during this time.

Self-Care and Compassion Fatigue

I didn't realize I was experiencing compassion fatigue or burnout until I attended my supervisor's compassion fatigue workshop and I started writing the reflection portion of my report. The workshop went through the definition and symptoms of compassion fatigue, and although I knew most of the information already, I found myself deeply resonating with the content of the presentation. I was in denial, but once I began writing it became clear that I was experiencing compassion fatigue. I realized that my self-care portion of my learning goals were

not being met very well and I had failed to be consistent with self-care throughout my practicum. I had an injury that prevented me from going to the gym to exercise regularly, which is normally my main method of self-care, and I did not replace the activity with anything else.

The other self-care activities I listed in my learning goals prior to starting my practicum were cooking, spending time with family, journaling, and regular massages. Another lesson I learned through this realization of my lack of self-care was that I was doing these activities I had identified as self-care, but I was doing them mindlessly. I wasn't getting regular massages and only booked them when I had time or money, I was cooking only on Sundays when I meal-prepped, and journaling was for the purposes of my practicum and not for myself. I was spending time with family but had started to distance myself from social groups and friends and slowly, my self-care strategies became chores. It is evident now that I was neglecting my self-care, and the symptoms of compassion fatigue started applying to me long before I realized. Contrary to my prior beliefs, I have learned that I am susceptible to compassion fatigue, and that no amount of research can prepare us fully. I could not have predicted that I would care and empathize with my clients to this extent. However, through this experience I learned that about myself and that compassion fatigue can sneak up on any social worker if we are not vigilant about our own self-care.

I noticed this pattern nearing the end of my practicum and started becoming more vigilant about my self-care and revisiting the different strategies that might work for me. I tried new hobbies and asked individuals around me what their self-care strategies were regardless of their profession. Through discussing with my partner, parents, and friends, I realized that I was missing a key aspect of self-care: rest. I was distracted trying to find active ways I can refill my "cup of care" as my supervisor calls it, and I had forgotten the simplest way to rejuvenate the

mind and body. Through self-reflection I realized that my own negative cognitions restrict the amount of rest I give myself. I realized that when I am resting my thoughts are filled with to do lists, anxious thoughts from previous social and professional exchanges, and criticizing thoughts, telling myself that I need to be productive and stop being lazy. I continually tried to add more things to my personal and professional life that I thought would make me a good social worker that I forgot to take things away to lighten the load.

Rural Social Work Practice

Compassion fatigue and self-care are unique in rural areas for a couple reasons. I found that through my observation of the Central Miramichi Community Health Center that the general consensus of the staff is that self-care is important. However, due to the nature of being in a rural community, I noticed it might be harder for health care providers to take sick, personal, or mental health days. For example, there is only one social worker at CMCHC, so if that one social worker is away from work due to sickness, personal, or mental health reasons, there is no social worker at the clinic. This kind of responsibility combined with the high need of social work services creates a very difficult internal environment for a social worker to take days off comfortably. Feelings of guilt and concern surpass feelings of needing self-care and without encouragement from others or very vigilant self-awareness, it becomes easy to overlook their own care. Having a sole social worker also results in a long waiting list where the social worker is booking client appointments months in advance. Therefore, if the social worker was to take a needed day off, the clients' schedules for that day might have to be rescheduled to a much later date which invites more feelings of responsibility and guilt. Succumbing to these feelings may be beneficial to individual clients and the social worker in that moment. However, giving into

feelings of guilt may lead to burnout and compassion fatigue and a longer stress-leave might be required which ultimately leads to inefficiency.

Being the only social worker in a building also makes it increasingly difficult to engage in frequent discussions and debrief with peers. Debriefing is a common method of professional self-care as well as supervision and discussion (Killian, 2008; Radey & Figley, 2007). Thankfully, technology can be utilized so that social workers in rural areas are able to contact other social workers in surrounding areas. This is what my supervisor and other rural social workers in the network utilize when needing a second opinion. However, it was evident that having someone regularly accessible and face-to-face to debrief and discuss clients was extremely helpful for both myself and my supervisor.

The literature highlights issues surrounding dual-relationships and the difficulty of its management. However, through my practicum I have learned that if these relationships are managed well, dual-relationships can be beneficial to creating a comfortable environment and building effective rapport and trust. Through my practicum experience, I had the opportunity to see dual-relationships first hand.

My supervisor is born and raised in the community that she works in and she knows almost everyone and everyone knows her. I was interested to see how she manages her inevitable dual-relationships and I found that most times, her dual-relationships were advantageous. She was already familiar with individuals, or was able to make connections with them more quickly, and it was evident that community members trusted her almost immediately. Not only was trust built more quickly. I noticed that the stigma of going in to see a counsellor was very minimal compared to previous experiences.

During my first month at CNBA, I was often with my supervisor in the cafeteria during break times with the students. While I hesitated to approach my students to talk to them about appointment times, my supervisor was very nonchalant and talked to many students. I realized that unlike my previous experience, where I was told not to approach clients in public in case they did not want others to know they were seeing a counsellor, the students' attitudes were very different. As previously mentioned my supervisor is well known in the community and has been consistently going to the school weekly since it opened in 2010. Due to my supervisor's familiarity around the school and existing relationships with many of the students, the students did not seem to care that their peers knew they were going to see a counsellor. This was similar in the adult population. Every time I entered the waiting room at CMCHC, it was full of people chatting and I have heard clients tell others that they are coming in to see Lynsey multiple times.

Although there are some definite benefits to having a social worker who is very familiar with the community, I also saw the situations that the literature warned us about. For example, my supervisor was at a public social event and a client approached her to update her on recent changes in the client's life. Times like these are difficult to avoid and depending on the client it might be harder to divert the conversation. Another unique difficulty is when family members or people who are too close to my supervisor needed support. During my practicum I was able to see these individuals, but when my supervisor is alone she has no choice but to refer them to social workers or private counsellors who are generally far away. Through this observation, I was able to see real-life examples of how inevitable dual-relationships can be managed with finesse.

Chapter Five: Implications and Recommendations for Social Work Practice

Being from a university that was outside of the area, I initially had difficulty securing a practicum in New Brunswick. I went through the same difficulty during my Bachelor of Social Work practicum, and in both instances I had to face rejection repeatedly before securing a practicum. Although it was frustrating at the time, I am glad it led me to the practicum opportunity at the Central Miramichi Community Health Centre with Lynsey as my on-site supervisor. My practicum at CMCHC was to fulfil the requirements for my Masters of Social Work, at the University of Northern British Columbia, and the experience allowed me to strengthen my skills as a clinical social worker on a graduate level.

Completing my degree requirements in a rural area within an interdisciplinary team was a great opportunity to connect the literature I studied to real-life, practical situations. I am grateful for the team at CMCHC who were incredibly welcoming and treated me with respect and kindness when I had questions or concerns. They helped me adjust and worked around me when space was limited, and I instantly felt a part of the team. Additionally, the members of the Doaktown community were welcoming and open to working with a new student. Seven months is not a long period of time, but in the short time I completed my practicum at CMCHC and the Central New Brunswick Academy, I felt like I was a part of the community. When speaking with other health care professionals who work at CMCHC and other rural areas, this is the crucial key to making professionals want to stay in the community. My last day was also the last day of a nurse practitioner from Fredericton whose temporary contract was over. During our car ride back to Fredericton we both agreed that we would go back and work in that clinic if the opportunity presented itself because of the team and the community. I learned valuable lessons not only on

my practical clinical social work skills, but in my personal identity and what it means to be a social worker.

Implications for Practice

The opportunity to complete a practicum placement at CMCHC has instilled a level of confidence in my clinical skills, while staying humble and aware of my constant development of skills and knowledge. Throughout my practicum I faced obstacles where there was a discrepancy between my ideal treatment plans and what worked with my clients and I faced similar issues with my own social work identity. I was too focused on the development of my tangible skills and got caught up in my practice rather than staying present and reflective. My experience has given me the tools I need to stay balanced in my personal and professional identity as well as the ability to remain a client-focused and anti-oppressive social worker.

An integral aspect of my learning was understanding the reality of intersectionality in my clients' issues as well as working from a structural perspective. Social issues are all connected and interwoven in a way that allows oppressive social structures to stay existent (Bishop, 2002). It is impossible to eradicate one form of oppression without affecting the other. As long as competition, power, and hierarchy are the underlying priorities of society, the interwoven system of the power structure will be maintained (Bishop, 2002). It is important to analyse our own privilege and our stance as oppressor and oppressed while unpacking the underlying assumptions and beliefs that surround our framework of practice. Bishop (2002) highlights the reality of how oppressed groups fight and struggle with other oppressed groups to gain dominance and compete, which causes the dominant and privileged group to continue reaping the benefits.

Pease (2010) stresses the importance of how this intersection of oppression affects all our lives. According to Collins, "oppression operates on three levels: the personal, the cultural, and

the structural" and many people who are oppressed also have experienced some form of privilege in their lives (as cited by Pease, 2010, p. 21). Many individuals find it easy to identify their experience of being oppressed but find it more difficult to think about how their thoughts and actions can oppress others (Pease, 2010). For social workers, a major part of structural social work is identifying when oppression is taking place. As Payne (2014) says: "you have to live structural practice – it is not a technique. Structural social work is inclusive because it is concerned with all forms of oppression, one is not more important than the other" (p. 335). It is crucial to acknowledge the different layers of oppression that we are located in and bring our privilege into awareness. It is a difficult task to confront your own privilege and internalized dominance, but this is a responsibility that we all have in order to become better advocates and allies.

When listening to my client's issues, many of them highlighted how they were oppressed throughout their lives, and there were many intersectional issues that arose. For example, one client who had issues at work because of their socioeconomic position felt oppressed due to their gender. It was easy for clients to list their daily challenges and barriers but difficult for them to understand their own privilege and their own position as an oppressor of others. Focusing on this lack of understanding and attempting to educate my clients may not always be beneficial, but it is important for me to understand the intricate intersectionality of their issues. This will allow me to have a better understanding of the client's positionality and approach their situation from a not-knowing perspective.

In my future practice, I will continuously self-reflect and ensure I have a variety of self-care tactics to prevent compassion fatigue and burnout. I learned through my practicum experience that self-care activities must be done mindfully and can change over time. With this

in mind, I will make sure to include time to self-reflect on my mental, physical, and spiritual wellness throughout my practice. Due to my tendency to focus on my physical health more than my mental and spiritual health, I will set reminders for myself and begin to accumulate more activities that surround mental and spiritual self-care. Seeking regular counselling, spending time in nature, maintaining a social support system, and reading literature unrelated to work are all self-care tactics that I have added to my list. I learned that in order to be an effective social worker, self-care needs to be higher on my list of priorities, and I hope this realization will allow for longevity in this field.

Recommendations: Self-Care Policy on an Organizational Level

Throughout my practicum, I had many ideas and thoughts about the lack of self-care in the healthcare professions. I contacted a massage therapist school in the area to set up a day to get massage students to the clinic to provide stress-relieving treatments to the staff. However, due to the distance between the clinic and the school the coordinator was skeptical and eventually the event did not happen. This idea sparked a series of questions that addressed the need for self-care to be engrained into the policies of healthcare organizations. Burnout and compassion fatigue prevention should be a core pillar in the well-being of health care professionals. However, only some professionals are taught the importance of self-care throughout their training. I believe the overarching organization should be implementing strategies to incorporate self-care into their regular activities, rather than putting the responsibility of compassion fatigue prevention solely on the worker.

Through conversations with other professionals and seeing the trends of topics on social media, it seems that self-care is lacking in many areas of our society. Self-care can be perceived as selfish, which is typically not an ideal characteristic in our culture. This notion causes many

individuals to not prioritize self-care, and consequently experience burnout in many different professional and personal situations. This notion combined with the caring nature of social work and other healthcare professions is what results in compassion fatigue and burnout at higher rates.

Common forms of individual self-care highlighted in the literature include: leisure time, physical activity, socialization, self-reflection, and spirituality (Harms & Pierce, 2011; Killian, 2008; Radey & Figley, 2007). Additionally, Hesse points out that organizational self-care is a way that agencies can utilize methods to facilitate self-care such as "limiting or diversifying caseloads, and providing appropriate supervision, adequate benefits, and staff development opportunities" (as cited by Radey & Figley, 2007, p. 201). Providing a warm and welcoming atmosphere is another way to facilitate a space where discussing self-care and compassion fatigue as a norm is also very important (Figley, 2002; Radey & Figley, 2007). Individual self-care is often talked about in the social work profession, but organizational self-care is not a common topic when discussing efforts to prevent and combat compassion fatigue.

From a structural perspective, it is important to address self-care at an organizational level. Structural models of social work "aim to promote justice through changing oppressive and discriminatory structures within the present social order" (Schmidt, 2000, p. 343). Structural social work takes the issue from the individual and focuses on the whole picture, deconstructing societal structure to reveal the rooted issues. Placing the responsibility of self-care solely on the social worker and other health care professionals can be unintentionally oppressive if the environment is not systematically designed to support it. A shift toward the shared responsibility of healthcare staff may create an environment where healthcare professionals become much more vigilant in carrying out their own self-care habits rather than only agreeing with the theory.

In my experience at CMCHC, self-care and prevention of compassion fatigue and burnout are a common topic and concern of the management as well as the staff. Despite a positive view of self-care and awareness of compassion fatigue, it can still be easy to forget about conducting self-care routines. Without the support of coworkers and their verbal encouragement to take time for self-care, health care professionals fall into the habit of thinking of the well-being of the patients, clients, and the clinic before their own. By sharing the responsibility with the organization, the weight can be slightly lifted from the professional.

As highlighted in the literature review, studies show that the lack of awareness of self-care is not a factor of levels compassion fatigue. I think if an organization created policies and procedures surrounding obligatory self-care habits, healthcare professionals would be more likely to prioritize their own well-being better and decrease levels of compassion fatigue. It is important to note that while I believe the importance of policies on the organizational level, there needs to be a coinciding level of autonomy for the professional staff to decide what works for them. In future social work research, an in-depth look at different approaches to include self-care in the organizational level would be a beneficial addition to research on self-care and compassion fatigue.

Conclusion

My masters of social work practicum created an opportunity for me to learn what it means to be a social worker in and out of the office. I learned to build rapport and use my clinical skills while remaining empathetic towards my clients. This experience gave me more than I expected and I also learned to be empathetic towards myself. By completing this requirement for my MSW, this opportunity gave me insight towards my future as a clinical social worker and expanded my knowledge on the healthcare system.

My practicum reinforced my anti-oppressive and feminist theoretical framework and allowed me to embrace being an eclectic social work practitioner. I effectively utilized solution-focused methods while incorporating a strengths-based approach throughout my practicum. Prior to this practicum, I had a preconceived ideal list of what were considered 'skills'. I thought that being genuine, building rapport, active listening, being transparent and open, and showing empathy were all things that all social workers naturally did. During a discussion with Audrey, my MSW supervisor, she informed me that all those traits that I considered to be natural were actually social work skills that we need to learn and build on. I realized that I had taken the skills that came naturally to me for granted and was stressing out about learning what I considered to be skills such as teaching sleep hygiene, Cognitive Behavioural Therapy, narrative therapy, and other tools used in social work practice. It was interesting and eye-opening to realize those innate skills are important and need to be practiced and developed constantly as well.

The opportunity of working in a new and smaller community was such an enriching experience both professionally and personally. I am confident that my time at CMCHC has provided me with the knowledge and experience to accomplish my learning goals as well as leave me with questions and thoughts for my own future practice. Experiencing the symptoms of compassion fatigue first-hand has taught me the importance of self-care, and I will take what I've learned throughout my practice and utilize my knowledge to prevent burnout and compassion fatigue prevention. The experience also allowed me to strengthen my personal and professional values and beliefs while reconstructing my professional framework and identity. I am extremely grateful to the Doaktown and Boiestown community for being so welcoming, especially to the Central Miramichi Community Health Centre family for their generosity and kindness. I thank my supervisors, who were incredible throughout my learning process and remained patient,

compassionate, and supportive every step of the way. Lastly, I am incredibly thankful to my clients, who allowed me to be a part of their healing process, and I am grateful for the knowledge I will take forward in my future social work practice.

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