Practicum Experience with the Community Acute Stabilization Team: Understanding, Privileging, and Incorporating Different Perspectives into Practice

by

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PRACTICUM REPORT SUBMITTED IN FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF SOCIAL WORK

UNIVERSITY OF NORTHERN BRITISH COLUMBIA

September 2023

Acknowledgements

I would like to respectfully acknowledge that the land on which I reside, play, and where I commenced my practicum placement is the traditional unceded territory of the Lheidli T'enneh First Nation. On this territory, I am an uninvited settler who developed knowledge and skills as a service provider during my practicum in the capacity of a mental health and substance use counsellor.

My biggest acknowledgment goes out to my husband, Dean, my two children, Spencer and Lydia, and my parents, Vic and Suzanne. Without your continuous love, support, encouragement, and sacrifices, the completion of this degree would not have been possible. I am forever grateful to all of you for helping me pursue my academic dream.

I would like to thank my practicum supervisor, Doriana Pantuso M.Ed., RCC, for facilitating an excellent practicum experience that was conducive to my learning and development as a clinical social worker and my academic supervisor, Susan Burke, PhD, RSW, for her guidance, support, and encouragement throughout my master's degree. I would also like to thank my MSW Consultant, Kelly Daigle, MSW, RSW, for her assistance in connecting me with the Community Acute Stabilization Team and her perspective on the importance of self-care, as well as my committee member, Lisa Kyle PhD, RCSW, for her clinical expertise and instruction during the Clinical Social Work Practice course I took along side my practicum.

I am extremely grateful to all the people who allowed me to share in a therapeutic relationship with them during my practicum. Without their willingness to work with me, I would have been unable to improve my clinical skills and further deepen my self awareness. Lastly, I would like to thank all the professionals on the Community Acute Stabilization Team for sharing their knowledge with me and assisting me in my learning journey.

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Chapter One: Introduction

After careful consideration, I decided to pursue an advanced practicum in a clinical social work setting. The time requirement for a practicum in the Master of Social Work program is 450 hours, which I completed on a part-time basis. I completed this practicum in a setting that provides mental health and substance use counselling. My overall goals in choosing the practicum option were to advance my clinical skills, gain confidence in integrating evidence-based modalities in my practice, and develop a personal practice framework by means of reflecting on my practicum experience and receiving feedback from my clinical supervisor during my placement. A more detailed overview of my Learning Contract, consisting of my goals, objectives, learning activities, and measurable outcomes, can be found in Appendix A.

Positionality

As Baskin (2016) states, "the self is always first in the circle" (p. 31). Within Indigenous worldviews, individuals locate themselves within their collective identity geographically, politically, and genealogically (Baskin, 2016). It was important to me to situate myself similarly in my practicum practice. I wanted to be upfront about the privileges my identity affords me; how my lived experiences and interactions with others, my environment, and my spirituality have shaped my reality; how historical, economical, and socio-political circumstances have shaped my personal ways of knowing; and how my values and biases might impact the therapeutic process during my practicum placement.

I am a Métis and French woman born and raised in Prince George. On my father's side, I am Métis and my relations are from Green Lake and Île-á-la-Crosse in Northern Saskatchewan. Both Green Lake and Île-á-la-Crosse are communities comprised of generations of Cree/Dene and Métis Peoples. Île-á-la-Crosse is one of the oldest, most culturally homogenous Métis

communities in Canada. From Green Lake and Île-á-la-Crosse, my father's family moved to Meadow Lake, Saskatchewan. There he attended Meadow Lake Indian Residential Day School. My dad's family moved again to settle permanently in Prince George. Despite being a descendant of many generations of Métis People, I did not find out I was Métis until I was in high school. Since then, I have been on a journey of discovery which entails unlearning established ways of knowing and being, learning what being Métis means to me, and exploring how I can be my authentic self.

On my mother's side, I am French Canadian, and my family is from Montréal, Québec. My maternal family moved from Montréal to Perigord, a small French-speaking farming community in Saskatchewan. They later relocated permanently to Prince George. My mother attended Catholic School in both Perigord and in Prince George. My mom and dad met in Prince George and have been married to each other for 50 years. Both my parents were raised in the Catholic faith and chose to raise me and my two brothers in this faith because they felt having a "good Catholic education" would provide us with more opportunities in life. I attended a private Catholic School in Prince George from kindergarten to Grade 7 and during this impressionable time, my knowledge, belief, and value systems were created to align with that of mainstream Canadian society.

In addition to being a daughter and sister, I am also a wife to an incredibly supportive husband and a mother to two wonderful children. I love being a wife and a mother and my family comes first above everything. I am able-bodied, in decent physical health, heterosexual, and light skinned. The unearned privileges of my personal location set me up to be successful in my professional endeavours. I received my Bachelor of Arts degree in psychology in 2006 from the University of Northern British Columbia and I am currently completing my Master of Social

Work degree. School District #57 employed me as an Aboriginal Education Worker from 2005-2008 and from 2008 to the present the Northern Health Authority has employed me as a Mental Health and Substance Use Clinician. During my employment with Northern Health, I have had the opportunity to work in programs for youth and for adults both in hospital and outside the hospital setting.

My earned and unearned privileges tip the power scales in my favour and specific aspects of my identity are associated with that of oppressors. Being secure in who I am as well as acknowledging the privilege that I hold, has helped me offset or reduce power differentials between me and service users. It has also helped increase my capacity to build relationships during my practicum with the Community Acute Stabilization Team, where I completed my practicum.

Practicum Setting: Community Acute Stabilization Team (CAST)

My practicum took place in Prince George, British Columbia with the Community Acute Stabilization Team (CAST) which is a mental health and substance use program provided by the Northern Health Authority. Knowing the history of Prince George, the mission and values of the Northern Health Authority, and the objectives of CAST has provided me with a greater understanding of the connection between Prince George and the people who reside here. More specifically, I have gained an in-depth understanding of how mental health and substance use needs are met in an individual and collective manner.

Prince George, British Columbia

The city of Prince George is centrally located in the interior of British Columbia on the traditional unceded territory of the Lheidli T'enneh First Nations (City of Prince George, 2021). The development and growth of Prince George is founded on Indigenous history and culture;

colonial influence; resource extraction; geography; and the convergence of rivers, highways, and railways (Varcoe at al., 2016). Prince George offers affordable housing, shopping, sports, arts, recreational activities, a community college, a university, and an international airport, all which appeal to a variety of individuals and families. There are 74,000 persons who reside in Prince George and the population comprises many distinct cultures and includes individuals born and raised there and many who have moved to the city for employment opportunities (City of Prince George, 2021). There are five major employment sectors in Prince George: wholesale and retail trade, manufacturing, accommodation and food services, construction, and healthcare and social assistance. Healthcare is one of the largest employment areas and is provided by the Northern Health Authority (City of Prince George, 2021; Northern Health Authority, 2021).

Northern Health Authority

The Northern Health Authority is one of six regional health authorities in British Columbia that are publicly funded through the Medical Services Plan (MSP). This organization provides healthcare for the city of Prince George (Province of British Columbia, 2021). Approximately 300,000 people receive healthcare from Northern Health (Northern Health Authority, 2021). The values that underpin the healthcare Northern Health provides are empathy, respect, collaboration, and innovation and its mission is to deliver exceptional healthcare services through a culturally sensitive lens (Northern Health Authority, 2021). The Northern Health Authority (2021) offers acute (hospital) care, public health care, and home and community care. Additionally, it offers programs and services to support individuals and their family living with mental health and/or substance use. Mental health and substance use services can include short-term assessment and treatment as well as specialized, long-term programs (Northern Health

Authority, 2021). In Prince George, one specialized outpatient service that Northern Health offers for individuals living with mental health and/or substance use, is CAST.

Community Acute Stabilization Team (CAST)

The Community Acute Stabilization Team (CAST) offers combined mental health and substance use services to adults 19 years of age and older (Northern Health, 2019). The CAST clinicians reflect a variety of master-level backgrounds such as counselling, psychology, and social work and therefore bring individualized frameworks to their practices (Northern Health, 2019). Referrals to CAST can be made by a hospital, family physicians, and/or Primary Care Interprofessional Teams (Northern Health, 2019). The CAST services include individual counselling and group therapy and are offered Monday through Friday from 8:00 am until 4:30 pm (Northern Health, 2019).

Individual Counselling. Individual counselling is provided to individuals experiencing challenges with mood disorders, concurrent substance use-related disorders, bi-polar disorders, grief, adjustment disorders, obsessive compulsive disorder (OCD), post-traumatic stress disorder (PTSD), post-partum depression/anxiety, and/or personality disorders (Northern Health, 2019). The CAST clinicians conduct intake assessments, treatment plans, interventions, and terminations with client input (Northern Health, 2019).

The evidence-based therapeutic modalities integrated into individual counselling by CAST clinicians include a variety of approaches such as Cognitive Behavioural Therapy, Dialectical Behaviour Therapy, Trauma-Focused Cognitive Behavioural Therapy, and Eye Movement Desensitization and Reprocessing. The CAST counselling service provides client-centred, culturally sensitive, and best-practice care (Northern Health, 2019).

Group Therapy. Another service that CAST offers is group therapy. These groups are co-facilitated by CAST clinicians and involve psychoeducation and coping skills. The period during which a given group meets and the length of each session differs for each group, from between 6 to 12 weeks, and each session can last 1.5-2 hours. Below is a list of the groups CAST offers and a brief description of each group's objective (Northern Health, 2019)

Bipolar Disorder Skills Group. The goal of this group is to develop skills to cope with symptoms of bipolar disorder effectively. Topics include symptom management, medication, coping with mood changes, regulating emotion, and interpersonal skills. The requirement to attend this group is a diagnosis of bipolar disorder.

Obsessive-Compulsive Disorder (OCD) Group. The goal of this group is to educate clients about the OCD diagnosis, teach skills to address and overcome OCD and to normalize the experience of living with OCD. Topics include OCD education, strategies to address thoughts and behaviours with the use of cognitive restructuring techniques, and treatment that employs exposure and response prevention strategies. The requirement to attend this group is a diagnosis of OCD.

Panic and Anxiety Skills Group. The goal of this group is to help people learn skills to cope with distressing thoughts, feelings, and physiological responses to anxiety. Additionally, to help individuals develop skills to manage their symptoms of panic and anxiety in ways that minimize the impact on their lives. Topics include coping with stress and worry, applying mindfulness skills, coping in a crisis, regulating emotion, and improving interpersonal effectiveness. To attend this group, individuals must present with moderate to severe anxiety or panic.

Changeways Core Depression/Anxiety Group. The goal of this group is to create positive change in clients' lives by challenging distorted thinking, setting realistic goals, and adjusting their lifestyle. The topics addressed include CBT triangle and goal setting, stress, managing mood changes, and challenging distorted thinking, creating and maintaining healthy support networks, and creating sustainable lifestyle changes. The requirement to attend this group is presentation of mild to moderate depressive symptoms.

Depression Recovery Group. The goal of this group is to help people with moderate to severe depression create positive change in their lives by challenging distorted thinking, setting realistic goals, and adjusting their lifestyle. The topics addressed include behavioural activation, monitoring activity and mood, creating an activation plan, identifying values and strengths, dealing with avoidance, and problem solving. The requirement for participation in this group is presentation of moderate to severe depression with a functional impairment and a score higher than 15 on the Patient Health Questionnaire-9 (PHQ-9).

Self-Esteem and Assertiveness Group. The goal of this group is to increase self-confidence, improve communication skills, and increase self-awareness and self-acceptance. Coping skills are taught by counsellors to effectively work through conflict and set personal boundaries. The requirement for this group is a presentation of low to moderate mood or social anxiety symptoms.

Dialectical Behaviour Therapy (DBT) CORE Group. The goal of this group is to help people develop the skills to cope with symptoms and behavioural patterns such as emotional distress, suicidal ideation, self-harm, and substance abuse. Topics include mindfulness skills, interpersonal effectiveness skills, distress tolerance skills and emotional regulation skills. A diagnosis of borderline personality disorder is required to attend this group.

Dialectical Behaviour Therapy Mindfulness Group. The goal of this group is to reduce emotional reactivity and distress. This group is recommended for individuals struggling with anxiety disorders, attention deficit hyperactivity disorder (ADHD), and OCD.

Dialectical Behaviour Therapy Emotion Regulation. The goal of this group is to understand emotions, reduce emotional vulnerability, and decrease emotional suffering. This group is recommended for individuals who display dysregulated mood symptoms.

Dialectical Behaviour Therapy Interpersonal Effectiveness Group. The goal of this group is to improve interpersonal relationship skills and increase ability to build healthy, balanced relationships. This group is recommended for individuals struggling with low mood, social anxiety, loneliness, and relational conflict.

Dialectical Behaviour Therapy Distress Tolerance Group. The goal of this group is to learn to survive crises without making them worse, reduce personal suffering, and strengthen freedom from having to satisfy the demands of urges, desires, and intense emotions. This group is recommended for clients exhibiting self-injurious behaviour, impulsivity, and destructive urges.

Complicated Grief Group. The goal of this group is to develop skills to cope with symptoms of complicated grief by using a blend of psychoeducation and processing of client emotions and grief. Topics include states of grief, family/relationship roles and expectations, emotional regulation, values, radical acceptance, and rituals. The requirement for this group is a diagnosis of bereavement disorder; a participant's loss must be that of an individual and not the loss of an animal or the experience of a life transition.

Being familiar with the history of Prince George, the purpose and ideals of the Northern Health Authority, and the goals of CAST, have increased my understanding of how CAST meets

the mental health and substance use needs of individuals and families who live in Prince George. This knowledge about my practicum setting helped ground me geographically and enabled me to recognize the unique ways in which CAST, and the Northern Health Authority serve the diverse population of Prince George. This familiarity enabled me to contribute to and participate in my practicum in meaningful ways.

Chapter Two: Theoretical Orientation

Decolonizing Framework

This chapter contains my theoretical orientation which utilizes a decolonizing framework that incorporates the theories of Two-eyed Seeing (Bartlett et al., 2012) and Ethical Space (Ermine, 2007). Both theories provide a framework for decolonization and will be discussed in detail later in this chapter.

Theoretical frameworks can help people make sense of the world around them; they are used to guide social work practice in an ethical and honest manner and are incorporated to prevent purposelessness when providing a service (Howe, 1987). A theoretical framework that aims to promote decolonization invites the respectful sharing of knowledge, experiences, interests, and worldviews between service users and service providers. It also is based on the goals of valuing different perspectives as well as respecting and preserving differences and strengths while negotiating critical challenges (Baskin, 2016; Burrage et al., 2020; Greenwood et al., 2017; McKivett et al., 2019). Decolonization plays a powerful role in reducing racism, power imbalances, marginalization, and the oppression of Indigenous peoples as well as for those with culturally diverse worldviews. A decolonizing framework is a theoretical orientation that aims to transform the social structures, institutions, policies, practices, and processes that create racism, power imbalances, marginalization, and oppression (Mullaly & West, 2018).

My primary intention for selecting a decolonizing framework was to decolonize my personal non-traditional worldview. Being a Métis woman who has been raised without any traditional Métis influences, I held a belief system that closely aligns with that of the dominant society. Decolonizing my personal belief system by learning more about Indigenous worldviews and my Métis culture has guided me to be more authentic about who I really am. My secondary

intention for selecting a decolonizing framework was to explore ways to incorporate both Indigenous and non-Indigenous knowledges into my practice and to explore ways to Indigenize Western modalities when working with Indigenous service users. The service user population at CAST is primarily non-Indigenous; however, exploring ways to practice from a decolonizing lens can be beneficial to all service users, regardless of culture, because this framework promotes collaboration and relationship building, both of which are integral components of providing mental health and substance use care.

The Two-Eyed Seeing and the Ethical Space theories are two approaches that provide a framework for respectful cooperation for presenting and incorporating different and sometimes contrasting worldviews. Both theories underscore the importance of knowing and understanding the impacts of colonialization before the decolonizing framework can be applied to mental health and substance use care and Western modalities. They will be discussed in further detail later in this section.

Setting the Foundation for Decolonization: Understanding the Legacy of Colonialism

To be able to understand the challenges of delivering Western modalities that are culturally sensitive, one needs to begin to grasp what colonialism is and how it has shaped the scope of mental health and substance use care. Colonialism occurs when one society seeks to conquer another society and completely rule over that society (Woroniak & Camfield, 2013). European settlers came to this continent and chose to live permanently on Indigenous lands which they confiscated violently and then forced upon Indigenous peoples a worldview based on Christianity and capitalism (Baskin, 2016; Woroniak & Camfield, 2013). The European worldview of capitalism and Christianity contrasted with the worldview of the Indigenous peoples which was one that held central the interconnectedness of all things on Earth: animate

and inanimate, holism, and spirituality (Baskin, 2016). European settlers removed Indigenous peoples from their lands, abolished their cultural practices that grew out of a relationship with the land, and attempted to destroy Indigenous society and language to establish a way of living that was congruent with their own worldview (Woroniak & Camfield, 2013).

The worldview that motivated and supported colonialization and the founding of Canada created hierarchical, male-dominated, racist structures that exist today in many mental health and substance use services (Baskin, 2016; Pierre, 2021; Woroniak & Camfield, 2013). The legacy of colonialization on mental health and substance use care can be seen in the systems that outwardly pathologize, diagnose, label, problematize, blame, and shame victims. These systems also treat people based on what the dominant society constitutes as "normal" and "abnormal" and disregard differing worldviews (Baskin, 2016; Pierre, 2021; Woroniak & Camfield, 2013). Mental health and substance use care excludes the influences of historical, political, societal, and economic structures. This distain can be the driving force behind the mental health and substance use needs of both Indigenous peoples and those with diverse worldviews who access public services (Reading, 2015; van der Kolk, 2015).

Within mental health and substance use care, there also exists a tendency to condemn individuals for their survival responses, to concentrate on the individual alone, to value self-actualization and independence, and to use judgemental language. The combination of these approaches and values creates a deficits approach to helping (Baskin, 2016; Chandanabhumma & Narasimban, 2020; Dupuis-Rossi, 2021; Sherwood, 2009). There is a tendency to blame personal and collective reactions towards colonial adversity for mental health and substance use issues. They also neglect to thoroughly assess for a trauma history and to frame mental health as neurobiological in nature. In addition, the body, emotions, spirituality, and the

interconnectedness an individual has with family, community, and the land are not taken into consideration (Baskin, 2016; Vukic et al., 2011). Knowledge of what colonialism is and how it has influenced and continues to influence the design and delivery of mental health and substance use care is essential when providing a service that aims to incorporate Indigenous worldviews and Indigenize Western modalities.

The Importance of a Decolonizing Framework

Ideally, reflecting on the effects of colonialism on mental health and substance use care will initiate conversations about decolonization and could facilitate the move towards reconciliation that is desperately needed to redress and reshape the way social workers practice. Wilson and Yellowbird (2005) define decolonization as "the intelligent, calculated, and active resistance to forces of colonialism that perpetuate the subjugation of our minds, bodies, and lands, and it is engaged for the ultimate purpose of overturning the colonial structure and realizing Indigenous liberation" (p. 2). Mental health and substance use service providers are challenged by decolonization to examine and adapt standard Western modalities that do not align with the beliefs of Indigenous peoples or culturally diverse peoples (Chandanabhumma & Narasimhan, 2020). The Two-eyed Seeing Theory (Bartlett et al., 2012) and the Ethical Space Theory (Ermine, 2007) both provide a process for creating a change in thinking from colonization to decolonization, thus offering insight on how a service provider might practice from a decolonizing lens. I will discuss these two theories in more detail below.

Two-Eyed Seeing Theory

The phrase "Two-Eyed Seeing" was coined by Mi'kmaw Elders Murdena and Albert Marshall and is a guiding principle that is used to bring together different worldviews and paradigms (Bartlett et al., 2012). Albert Marshall shares that two-eyed seeing is the act of

learning to see the strengths of Indigenous knowledges and ways of knowing from one eye while learning to see the strengths of Western knowledges and ways of knowing from the other eye. thus using both eyes for the betterment of all; this latter component is the most important part (Bartlett et al., 2012). Two-eyed seeing is about all aspects of life such as social, economic, environmental, and health and it considers the responsibilities we as humans have towards sustaining and protecting Mother Earth (Bartlett et al., 2012). The benefit of two-eyed seeing is that you are always looking for another perspective and better ways of doing things (Bartlett et al., 2012), which is an approach that I believe can be applied to mental health and substance use care.

Applying the two-eyed seeing framework to mental health and substance use care starts with the service provider's ability to be reflexive and transparent about how their own positionality functions as a lens that affects how they relate to and understand others; consequently, having a better understanding of oneself can start the collaboration process to create needed change (Baskin, 2016; Greenwood et al., 2017; McKivett et al., 2019). Another aspect that contributes to the two-eyed seeing framework is the service provider's knowledge about the influence of colonialism on Western modalities and how the ideological underpinnings of these modalities may not be congruent with Indigenous and culturally diverse peoples' ways of knowing and being (Baskin, 2016; Bartlett et al., 2012; Greenwood et al., 2017; McKivett et al., 2019).

Augmented by a new understanding of a disparate worldview, the service provider learns to honour and respect the different worldview and draws on the strengths of their personal worldview and the Indigenous or culturally diverse worldview. This Two-eyed Seeing approach leads, ideally, to mental health and substance use care that is free from knowledge domination

and assimilation (Baskin, 2016; Bartlett et al., 2012; Greenwood et al., 2017; McKivett et al., 2019). The two-eyed seeing framework of "walking in two worlds" (Bartlett et al., 2012), depends on the service provider's on-going ability to be reflexive and transparent, while remaining open to unlearning and relearning different ways of knowing and being. By providing mental health and substance use care that rejects the oppression, marginalization, destabilization, and re-traumatization of Indigenous and other culturally diverse groups, the two-eyed seeing framework can be used to guide a process of decolonization.

Ethical Space Theory

The ethical space framework was conceptualized by William Ermine (2007). It is the space formed when two disparate worldviews are willing to engage each other in dialogue to examine the diversity and positioning of Indigenous Peoples and Western society, brining the unstated and unseen levels of thoughts, feelings, and assumptions into verbal awareness (Ermine, 2007). This process is undertaken to reconcile oppressive and assimilative ways of interacting and to create richer multifaceted knowledge (Daniels & Sterzuk, 2022; Ermine, 2007; Greenwood et al., 2017; Nelson & Wilson, 2018; Nikolakis & Hotte, 2021). This framework is used to describe a philosophical, psychological, and physical space that is created when individuals with differing perspectives converse with the aim of sharing and learning knowledge (Nelson & Wilson, 2018). Ethical space is the neutral zone between cultures and the place in which knowing what harms and/or enhances the well-being of all creatures can be explored in human-to-human dialogue (Ermine, 2007). When service providers intentionally and purposefully share space with service users, different worldviews can be explored mutually and respectfully and the inherent power imbalances between privileged and diverse knowledges can be minimized. In this way, the racism and discrimination Indigenous and culturally diverse

peoples experience can be reduced when they access mental health and substance use care. (Ermine, 2007; Greenwood et al., 2017; Nelson & Wilson, 2018; Nikolakis & Hotte, 2021).

Mental health and substance use providers can establish ethical space for Indigenous worldviews and culturally diverse worldviews that are specific, local, and relevant to the service user and their community. This outcome can be achieved when providers encourage on-going conversations about differing worldviews and knowledges as they pertain to health and healing and by actively listening to understand the benefits of privileging differences to create respectful relationships (Greenwood et al., 2017; Nikolakis & Hotte, 2021). Ethical space offers service providers and service users a framework that enables learning through dialogue, questioning, listening, introspection, and reflection; ultimately, the process aims to deconstruct colonial hierarchies and unequal power dynamics and to allow Indigenous and culturally diverse approaches to be incorporated into the healing process (Greenwood et al., 2017; Nikolakis & Hotte, 2021). The ethical space theory makes space for the service user to share their worldview, knowledges, spirituality, and traditional healing methods; awareness of these elements helps the service provider develop new perspective, clarity, and insight (Baskin, 2016; Bartlett et al., 2012; Greenwood et al., 2017; McKivett et al., 2019). The Two-eyed Seeing framework and the Ethical Space framework complement each other well and, when used together as an overarching theoretical orientation, have helped decolonize my personal worldview and aided me in thinking about Indigenizing my practice at CAST.

Applying a Decolonization Framework to my Clinical Practicum with the Community Acute Stabilization Team

The choice to meet in the venue of ethical space triggers a respectful interaction in which worldviews meet as equals (Ermine, 2007). Applying a two-eyed seeing approach then guides

the process of "weaving back and forth" between disparate worldviews (Bartlett et al., 2012) and encourages the incorporation of the best healing practices from Indigenous and Western knowledge systems. My adoption and application of these frameworks helped me to decolonize my worldview and Indigenize my practicum practice at CAST when working with Indigenous service users. The ethical space framework guided my understanding of how colonialism has supported unseen interests, attitudes, and assumptions that persistently impact communication and behaviours between service users and myself as a service provider. I was able to shift my perspective from the practice of Western universality to a practice that reconciles with the perspectives of Indigenous and culturally diverse peoples. I wanted to be able to create a safe, ethical space in which worldviews can be mutually shared and explored.

I did this by first introducing and locating myself. This step required me to be transparent about who I am and about the experience I hoped to gain during my practicum at CAST (Baskin, 2016). Transparency and honesty are important aspects of relationship building and were a foundation for open and respectful dialogue between the service user and myself. Working with a humanistic attitude showed I am a human first, before being a service provider, which helped create the space where each service user felt safe enough to share their worldview, knowledge, and experience about health and healing without fear of being judged or dismissed. It was my responsibility as a service provider to actively listen so that service users felt heard and understood. The ethical space framework guided my practice to help create a place where service users were invited, and felt safe enough, to share their personal perspectives on health and healing. In this way, I wanted to provide opportunities for everyone's personal perspectives and the Western perspective to work collaboratively to produce new streams of thought.

When an ethical space of engagement was established and continued to be nurtured in the relationship between myself and the service user, then I was able to use the two-eyed seeing framework to incorporate Indigenous and culturally diverse ways of knowing, being, and doing into my practicum practice at CAST. Two-eyed seeing was an approach that I used to not only acknowledge that there was more than one worldview, but also to guide my practice to respectfully bring together the strengths of different worldviews to provide an adapted perspective on Western modalities. I best accomplished this by first understanding my own worldviews which was done by locating myself and using reflexivity (Bartlett et al., 2012). Co-locating myself alongside a service user encouraged reciprocity and the service users and I were able to share in the learning process. This step was one move towards equalizing the power I held as the service provider (Marshal, 2015; McKivett et al., 2019).

After locating myself within the two-eyed seeing approach, using reflexivity helped me better understand how aspects of my location helped or hindered how I related and built relationships with service users (Baskin, 2016; McKivett et al., 2019). My goal was to cultivate my ability to embrace different and divergent perspectives on health and healing and to incorporate these perspectives into my practicum practice at CAST to counter the negative effects of colonialism. The two-eyed seeing approach guided my practice by allowing me to bring together different paradigms and use the strengths of each to honour and reconcile worldviews. By situating my practice within a decolonizing framework that included ethical space theory and two-eyed seeing theory, I was able to decolonize my personal worldview, provide mental health and substance use care that is inclusive of Indigenous and non-Indigenous worldviews, and explore ways to Indigenize Western modalities.

Chapter Three: Literature Review

My practicum interests involved exploring ways to advance my clinical skills, increasing my confidence in integrating evidence-based Western modalities into my practice, developing a personal decolonizing practice framework, and finding ways to Indigenize Western modalities while upholding ethical standards as guided by the British Columbia College of Social Workers. By reviewing the literature relevant to clinical social work practice, I gained a richer understanding of the competencies needed to enhance and compliment my current skill set to proficiently work with the practice complexities that were presented during my practicum. This literature review explores aspects of clinical practice such as relationship building; evidence-based modalities which include Cognitive behavioural therapy, Dialectical behaviour therapy and Trauma theory in therapy; and ethical considerations that were central to establishing a reflective and reflexive practice when working with service users during my practicum with the Community Acute Stabilization Team.

Relationship Building

At the centre of clinical social work practice is the counsellor's identity and how aspects of their identity shape the work that is done in the therapeutic relationship (Baskin, 2016). Identity is a fluid construct and is both a social product and a social process (Baskin, 2016; Drabble et al., 2012; Mullaly & West, 2018). The dominant groups in society impose inescapable, inferior identities on subordinate group members (Baskin, 2016; Mullaly & West, 2018). Other factors that contribute to identity include gender, race, ability, ethnicity, sexual orientation, age, generation, regional origin, nationality, linguistic background, and socioeconomic class (Baskin, 2016; Drabble et al., 2012; Takacs, 2002; Mullaly & West, 2018). These identity factors intersect and overlap with each other, to give people power in some areas

and oppression in others (Baskin, 2016; Mullaly & West, 2018). Understanding where one's own power and oppression originates from can help clinical social work practitioners become more secure in their own identity and thereby create openness to understanding how identity factors intersect and overlap to shape the identities of service users and reveal their privilege and oppression (Baskin, 2016). This openness to understanding is fundamental to exploring biases, challenging power, and building relationships (Baskin, 2016; Drabble et al, 2012; Takacs, 2002; Mullaly & West, 2018).

Intersectionality

Intersectionality can create a deeper understanding of the complexities of identity and how social structures intersect and overlap to potentially reveal privilege and oppression; social structures such as gender, race, ability, ethnicity, sexual orientation, age, generation, regional origin, nationality, linguistic background, socioeconomic class, education, religion, weight, employment, and health have been created and shaped according to the dominant culture's norms and ideals (Baskin, 2016; Ferber & Herrera, 2013; Mattsson, 2014; Mullaly & West, 2018). These categories are used to maintain relations of inequity and to construct an oppressive identity that is deployed to intimidate or oppress individuals who do not identify with all the privileges of the dominant culture (Baskin, 2016; Gorski, 2014; Mullaly & West, 2018). Familiarity with the intersectional nature of social constructs is important to understanding how conscious and unconscious, visible and invisible, and earned and unearned privileges may result in experiencing greater marginalization and oppression and in the shaping of identity (Mullaly and West, 2018).

Not only can awareness of intersectionality increase social work practitioners' awareness of service users' identities and possible experiences of marginalization and oppression, but it can

also be used to inform their understanding of their own identities and the power and privilege they bring to the therapeutic relationship (Baskin, 2016; Ferber & Herrera, 2013; Mattsson, 2013; Mullaly & West, 2018). Many social work practitioners have privileged identity elements such as education, employment, income, housing, age, literacy, and ability (Mullaly & West, 2018). The complexity of intersectional identities and power and privilege can be apparent in how social work practitioners perceive, interact, connect, and converse with individuals and groups in practice (Drabble et al, 2012). Privilege that goes unnoticed by the beholder can hinder empathy and form a barrier to culturally centred practice (Baskin, 2016; Mullaly and West, 2018). When social work practitioners are aware of the intersectionality of their own identities and the power and privilege associated with it, they are better positioned to confront the privilege and oppression they hold to decrease the power imbalance in the therapeutic relationship (Baskin, 2016; Ferber & Herrera, 2013; Mattsson, 2013; Mullaly & West, 2018).

Self-reflexivity

Self-reflexivity is the process of looking inward and becoming aware of how one's own culture, values, and beliefs affect the way an individual understands differences and power imbalances in the clinical practice setting (Baskin, 2016; D'Cruz et al., 2007; Mattsson, 2013; Mullaly & West, 2018; Sakamoto & Pitner, 2005). The reflexive practitioner deconstructs dangerous assumptions that underlie how they perceive practice situations by challenging what they think is real (ontology), by questioning what they know to be true (epistemology), and by identifying the value they place on their own reality (axiology) (D'Cruz et al., 2007; Letherby, 2003; Wilson, 2001). There is a need to unlearn language, jargon, behaviours, and attitudes that support oppression and reinforce privilege (Case, 2012). This complex skill has the potential to change the way a practitioner thinks and acts and thus reduce power imbalances in therapeutic

relationships (Mattsson, 2014). Effective self-reflexivity also increases the client's and the practitioner's capacity to build a productive relationship (Baskin, 2016).

Baskin (2016) suggests that self-reflexivity can be used to build a successful helping relationship with clients when the practitioner exercises self-disclosure to reveal aspects of their social location. She explores how parts of a practitioner's subjective location might impact a client and their unique situation. It is the responsibility of the practitioner to recognize what may hinder connection and what may facilitate connection with a client (Baskin, 2016). Sharing aspects such as age, race, class, sexual orientation, gender, skin colour, religion, spirituality, whether one is a parent or not, the level of experience in the field, or whether the practitioner has ever gone without the fundamentals of survival can be important steps in building relationships with clients; inviting clients to ask questions can also strengthen the therapeutic relationship (Baskin, 2016). Relationship-building using self-reflexivity is a continuous journey of learning about one's emotional, physical, spiritual, and psychological self and then using that knowledge to connect more effectively and transparently with clients (Baskin, 2016).

Understanding how identity is created, how intersectionality overlaps to reveal privilege and oppression, and how self-reflexivity can reduce power imbalances and facilitate relationship-building are important elements in the clinical practice setting. These elements make links between personal challenges and structural causes as well as between perceptions and actions that promote clients' ability to change the way they view themselves (Mullaly & West, 2018). Effective understanding and use of intersectionality and self-reflexivity helps the practitioner to view the world from various perspectives and is broadly beneficial (Baskin, 2016). When practitioners are willing to explore and examine the intersectionality of their privileged and oppressed identities and become acquainted with their emotional reactions, then there is the

potential for systems of power to reconstruct and for relationships to enrich. This dynamic provides an opportunity for service users and practitioners to work collaboratively with different therapeutic interventions (Baskin, 2016; Bishop, 2002; Mullaly & West, 2018).

Cognitive Behavioural Therapy (CBT)

Defining Cognitive Behavioural Therapy

Cognitive behavioural therapy (CBT) is an evidence-based, broad-spectrum, structured, present-oriented, problem-focused, solution-oriented, and time-limited psychotherapy used to initially treat depression (Gonzalez-Prendes, 2021). It was pioneered by Albert Ellis's (1994) rational-emotive behaviour therapy (REBT) and Aaron Beck's (1976) cognitive therapy (CT). In the past 50 years, CBT has evolved and been adapted to treat a wide range of disorders and problems such as anxiety, OCD, PTSD, panic disorders, chronic pain, eating disorders, substance use disorders, and bipolar disorder; these are all experienced by a diverse population in many different settings (Beck, 1993; Butler et al., 2006; Dobson, 2010; Hofmann et al., 2012; Otte, 2011; Salovskis, 2002; Tolin, 2010) Cognitive behavioural therapy has been shown to be the most used modality among clinical social workers (Lord & Iudice, 2012; Pignotti & Thyer, 2012). This theory assumes that individuals participating in the therapy are motivated and ready to participate in action-oriented therapy and that such individuals have the cognitive abilities to engage in the interventions necessary to bring about change (Gonzalez-Prendes, 2021). Despite the growth and adaptations of CBT over the years, the model's philosophical and theoretical underpinnings remain constant; they hold that cognitions (what we think and how we think) are the primary factor in emotional, behavioural, and physiological reactions to life events (Beck, 1976; Ellis, 1994; Hofmann et al., 2012).

Philosophical and Theoretical Underpinnings

Albert Ellis and Aaron Beck both studied under the philosophy of psychoanalysis before questioning the psychoanalytic process and the efficacy of the intervention techniques (Dobson, 2010; Hofmann et al, 2012). According to Ellis (1970), human thinking and emotion are interconnected, and irrational behaviour is both innate and acquired. According to Beck (1976), dysfunctional thinking influences mood and behaviour and is common to all psychological disorders. Combining the tenets of Ellis' behavioural philosophy with Beck's cognitive philosophy formed the conceptual basis of CBT. This model holds that individuals attribute meaning to their past, present, and future experiences in a unique way and it is this individual perceived meaning of, or belief held about, a given situation, not the situation itself, that impacts the individual's emotional, behavioural, and physiological reactions (Beck, 2021; Gonzalez-Prendes, 2021; Greenberger & Padesky, 2016).

Dobson and Dobson (2017) propose that CBT is linked to four fundamental assumptions: access hypothesis, mediation hypothesis, change hypothesis, and realist assumption. The access hypothesis suggests that thoughts both inside and beyond our awareness can be accessed with effort and be assessed. Mediation hypothesis holds that responses to situations are mediated by cognitive appraisals. The change hypothesis postulates that if thoughts can be accessed then they can affect behaviour; those thoughts can then be purposefully targeted and intentionally changed to bring about emotional, behavioural, and physical relief. The realist assumption posits that there is an objective reality in which one can evaluate the validity of their own created subjective reality and thereby reveal a more objectively accurate interpretation. Furthermore, additional research in CBT suggests that not only do cognitive processes change emotional, behavioural, and physical reactions, but all four aspects interact and small changes in any one area can lead to

changes in the others (Beck, 2011; Beck, 2021; Dobson, 2010; Greenberger & Padesky, 2016; Gonzalez-Prendes, 2021; Harms & Pierce, 2007). The philosophy of behavioural therapy and cognitive therapy along with the fundamental assumptions give way to the key practice components that are applied to most CBT treatments.

Key Practice Components

While CBT is an individualized modality, there are common key practice components that are applied in all phases of the therapy process. According to Beck (2021), there are fourteen principles of treatment in CBT used to recognize and assess an individual's culture and family history, the nature of their challenges, their goals, their ability to form a therapeutic bond, their motivation to change, and their prior experience with therapy. The fourteen principles are as follows (Beck, 2021):

1) The therapeutic relationship is built on collaboration and trust. A therapeutic relationship is required for change but is not sufficient to bring about change on its own (Gilbert & Leahy, 2007).
2) The ever-evolving case conceptualization. This principle is based on information provided by the client; it is informed by vital cognitions, behavioural strategies, and factors that maintain the disorder(s) at hand and is utilized to develop treatment plans. Case conceptualizations also incorporate individual strengths, positive qualities, and support systems; they are refined as additional information is shared throughout therapy.
3) The continual monitoring of the client's progress. Outcomes for clients are improved when both client and therapist share verbal and written feedback regarding client progression.

4) Cognitive behavioural therapy is an individualized approach that is culturally adapted to suit each client's uniqueness. Commonly, CBT has reflected the value of the dominant society; however, CBT therapists today are encouraged to practice cultural humility and cultural responsiveness when assessing client and family needs, identifying culturally related strengths and supports, and validating a client's experiences of oppression.
5) Emphasize the positive by inspiring hope and by actively helping clients cultivate positive moods and thinking by highlighting the positive.
6) Therapist and client collaboration and active participation. Therapy is viewed as teamwork and together the therapist and client decide what to work on each session, how often sessions should be held, and what can be reasonably done between sessions.
7) Cognitive behavioural therapy is aspirational, value based and goal oriented. Uncovering what is important in each client's life, how each client wants their life to be, and what each client wants to accomplish with the aid of therapy will inform the overall treatment.
8) Focus is on the present, even as there is recognition that past events such as trauma, abuse, neglect, and loss influence the way an individual thinks about themself, other people, and situations. Asking clients to identify the implicit and explicit messages and lessons they have learned from past experiences will help clients reveal the beliefs, rules, and thoughts that contribute to and shape their current situation.
9) Therapy aims to be educative and make the therapeutic process understandable. A CBT therapist introduces the client to the process of CBT, the structure of sessions, and the cognitive model during the first session; the therapist continues to collaborate with the client during the entire therapy process.

10) Cognitive behaviour therapy is also time sensitive. Treatment is intended to be as short term as possible while still helping clients recover from their symptoms; work towards achieving their aspirations, values, and goals; resolve their challenges; attain pleasure and enjoyment in life; and learn new skills. However, there is recognition that clients need more treatment over a longer period, and CBT can be employed as a long-term modality.
11) The therapy sessions are structured but not rigid; they are organized to maximize effectiveness and the use of time. The initial phase of this structured agenda aims to the re-establishing the therapeutic relationship, discuss progress and setbacks, and review previously assignment homework; the middle phase involves the interventions and actions plans; and the end phase includes a summary of the session, feedback from the client, and formulation of the new homework assignments.
12) Cognitive behavioural therapy uses guided discovery and teaches clients to respond to their dysfunctional cognitions by means of asking questions, evaluating the validity and utility of the client's thoughts, and devising an action plan.
13) Action plans (also known as therapy homework) are an important aspect of CBT. Cognitive behavioural therapy uses written action plans and worksheets that serve as a reminder of what was discussed in the session and as a tool to guide client's practice of skills between sessions.
14) Cognitive behavioural therapy uses a variety of techniques to change thinking, behaviour, and mood by adapting strategies from many different psychotherapeutic approaches within the cognitive framework. The therapeutic interventions serve a specific purpose of teaching clients cognitive and behavioural skills to empower them to cope effectively with their challenges without depending on a therapist.

Purpose

The cognitive framework of cognitive behavioural therapy provides a structure to identify and organize maladaptive thoughts, emotions, behaviours, and physical reactions. The purpose of CBT is to teach clients new skills through the use of cognitive restructuring, behavioural activation, exposure interventions, and action plans that will change maladaptive thoughts, dysfunctional behaviours and, or, physical reactions and thereby reduce or eliminate distressing emotions (Beck, 1993; Beck, 2021; Dobson, 2010; Greenberger & Padesky, 2016; Gonzalez-Prendes, 2021; Hofmann et al., 2012; Otte, 2011; Rakovskik & McManus, 2010; Rees et al., 2005; Salkovskis, 2002; Tolin, 2010). Maladaptive thoughts are the result of core beliefs, intermediate beliefs, and automatic thoughts that influence one's behaviours and emotions.

Greenberger and Padesky (2016) define core beliefs as specific statements about the self, others, or the world that reflect the most fixed, absolute, and fundamental views a person holds. Core beliefs form in early childhood; are influenced by genetic, neurobiological, and environmental stimuli; are constant over time; and are accepted as facts regardless of their validity. According to Beck et al. (2004), core beliefs impact how individuals process information from an environment and determine immediate emotional and, or behavioural responses to events. An individual maintains a core belief over time by favouring cognitive distortions (i.e., incongruencies between the objective reality and the individual's subjective reality) and by engaging in behavioural activities that are consistent with the core beliefs; core beliefs also give way to intermediate beliefs which also begin to form early in life (Gonzalez-Prendes, 2021).

Intermediate beliefs are the cognitions that denote the rules that individuals develop to guide their behaviour through life and can be learned either explicitly or implicitly through the

behaviours and messages expressed by family members, prominent people, or are present in dominant societal influences (Gonzalez-Prendes, 2021). Beck (2021) suggests rules manifest into behavioural coping strategies that can be thought of as either individual strengths or individual deficits, while problematic coping strategies and inflexible behaviours are used to offset supposed deficiencies that are revealed in one's core beliefs. Not only do core beliefs influence intermediate beliefs, but they also influence automatic thoughts.

Automatic thoughts can appear as words, sentences, images, or memories that occur in-the-moment, are judgmental, and are situation-specific. Automatic thoughts happen quickly and non-deliberately (Beck, 2021; Greenberger & Padesky, 2016). In CBT, automatic thoughts consist of two parallel ways of thinking that include the actual thought and, separately, the meaning of the thought (Beck, 2021). The actual thought is usually clear to the individual, while the meaning of the thought is usually more obscure and needs to be uncovered in therapy to establish a connection between thoughts, behaviours, and emotions (Beck, 2021; Greenberger & Padesky, 2016). Certain situations activate self-defeating automatic thoughts that are the cognitive products of the information processing system and lead to problematic behaviours and emotions (Gonzalez-Prendes, 2021). It is the problematic behaviours and emotions that usually bring an individual to counselling and become the focus of CBT interventions (Gonzalez-Prendes, 2021).

One of the main interventions of traditional CBT is cognitive restructuring which is a three-step process designed to change maladaptive cognitions (Beck, 1976). The three steps include (1) uncovering the problematic thought, (2) assessing the problematic thought by looking for evidence for or against the thought or discovering alternative explanations for the problematic thought, and (3) developing a more functional and realistic perspective (Wenzel,

2017). Some strategies that promote the process of cognitive restructuring are the Socratic method, for which the counsellor uses open-ended questions to guide the client through a process of discovering meanings of intermediate thoughts and automatic thoughts, and in this way, the therapist uncovers core beliefs and creates new knowledge. Other strategies include the use of thought records that support identifying situations, moods, automatic thoughts; evidence for or against the automatic thoughts; new balanced thoughts and evaluating a new mood; and the use of the downward arrow technique, which targets automatic thoughts through a variety of questions that eventually uncover core beliefs about the self, others, and the world (Greenberger & Padesky, 2016). Cognitive restructuring is done with the client and counsellor working collaboratively to uncover and modify the client's maladaptive cognitions to help resolve the presenting problem (Gonzalez-Prendes, 2021).

Another intervention used by CBT counsellors is behavioural activation which is an effective technique for clients experiencing depression. Behavioural activation seeks to offset an individual's lack of motivation and loss of pleasure by intentionally and slowly expanding a client's participation in pleasant and healthy behaviours (Orgetta et al., 2017). Turner and Leach (2012) suggest that behavioural activation provides positive reinforcement by engaging the client in a pleasurable and healthy behaviour, which increases one's sense of self-efficacy. Behavioural activation should include activity monitoring to track the activity, level of mastery connected with the activity, and the enjoyment obtained from the activity; in addition, activity scheduling is used to establish when, where, and for how long the activity will occur. The aim of this degree of organization is to increase the probability of the activity happening (Wenzel, 2017).

Exposure interventions are strategies used to address anxiety disorders. The general principle behind exposure therapies is that an individual can change a maladaptive avoidance

response to anxiety by revisiting or re-experiencing the situation that caused the anxiety (Gonzalez-Prendes, 2021). According to Cusack et al. (2016), effective exposure interventions provide an opportunity to fix cognitive and emotional processing of the situation that caused anxiety and to enable new learning and restructuring of the fear structure. Exposure interventions can take place inside and outside of the body, in narrative form, with gradual exposure, and with flooding exposure and they are efficacious in the treatment of anxiety disorders (Gonzalez-Prendes, 2021).

Action plans are a crucial and required component of CBT interventions. Traditionally labelled as “homework”, action plans are used to practice and reinforce new cognitions, skills, and, or behaviours (Beck, 1976; Beck, 2021). The goal of action plans is to extend the gains made in counselling sessions to the client’s life out-side of therapy; they can consist of writing, reading, filling out worksheets, and, or practice between sessions (Beck, 2021; Gonzalez-Prendes, 2021). There are three important aspects of action plans: (1) assignments should be developed collaboratively with the client, (2) assignments should begin with tasks that have a high probability of success before moving onto more complex tasks, and (3) action plans should be reviewed during the following session to allow the client and counsellor to identify successes and to address setbacks (Gonzalez-Prendes, 2021). When clients both actively collaborate in developing action plans and participate in them between sessions, the therapy progresses quicker; the client’s sense of hope, mastery, self-efficacy, and control increase; and their mood and healthy behaviours improve (Beck, 2021). The purpose of CBT is to provide not only a cognitive structure for discovering problematic thoughts, emotions, behaviours, and physical reactions, but to also teach new skills to clients using a variety of interventions to ameliorate these challenges.

Barriers to Cognitive Behavioural Therapy Practice

Cognitive behavioural therapy is often identified as the leading psychotherapeutic intervention for many mental health disorders; however, barriers to practice are also known. A major limitation of CBT is that it tends to focus on what is "wrong" with the individual, which creates a deficits approach in the helping process and attaches both fault and responsibility for change on the individual (Baskin, 2016; Harms & Pierce, 2007). There seems to be a lack of awareness of the pertinent social, cultural, and structural causes of suffering and oppression that are often at the centre of individual experiences (Harms & Pierce, 2007). From a social work perspective, CBT is not a helpful approach for facilitating social change; instead, it tends to lead individuals to blame themselves and others for the cognitive and behavioural challenges confronting them, which, it must be noted, developed as survival techniques in response to societal adversity that was and is beyond their control (Baskin, 2016; Harms & Pierce, 2007).

Another context in which the CBT approach tends to be unproductive is the treatment of individuals who either have cognitive limitations or who have been mandated to engage in treatment. Cognitive behavioural therapy assumes that individuals are motivated to participate in therapy and that they have the cognitive ability to engage in the kin of self-reflection and cognitive debate that is required to identify and change dysfunctional thoughts (Gonzalez-Prendes, 2021). Overlooking a client's cognitive abilities and motivation to participate in treatment may result in pushing an individual in a direction they are not wanting to go; thus, making the therapeutic relationship that is supposed to be based on trust and healthy attachment questionable as well as making the interventions seem coercive in nature (Gonzalez-Prendes, 2021; Harms & Pierce, 2007). Despite these practice barriers, CBT continues to be implemented in many different practice settings as a treatment for mental health.

Implementing Cognitive Behavioural Therapy Skills in my Clinical Social Work Practicum

Payne (2016) suggests that the approaches social workers deploy in practice are often dictated by the demands of the agency that employs them. These agencies tend to rely on evidence-based interventions, which makes CBT the intervention of choice for practice in many settings. Northern Health prides itself on implementing evidence-based practice approaches, of which CBT is one of those approaches (Northern Health, 2019). During my practicum at CAST, one way that I integrated CBT into my practice was by using the theory to better understand human behaviour. Cognitive behavioural therapy provides a foundation for connecting how an individual functions and experiences their outside world with their personal survival skills, motivation, and agency (Harms & Pierce, 2007). By understanding that all behaviour happens for a reason, I could assess presenting behaviours to explore an individual's inner world with gentle, curious open-ended questions.

The use of open-ended questions in CBT is referred to as Socratic questioning. Becoming more familiar with this type of questioning helps clients create new knowledge by uncovering information that might not be in their immediate awareness (Gonzalez-Prendes, 2021). By becoming more familiar with the use of Socratic questions in my practicum at CAST, I was able to help clients discover new strengths, successes, and protective factors. Beck (2021) suggests using a summary sheet of questions to begin with to help guide the process and the conversation until the therapist is comfortable with the questions that lead to a more conversational form of inquiry. My hope was that by learning to ask open-ended questions and by discovering my own style of questioning, I would be able to help clients explore their stories and share them with me.

Case conceptualization was another aspect of CBT that I wanted to become proficient in while implementing it in my practicum at CAST. The use of case conceptualization could

strengthen my ability to understand the links between an individual's presenting challenges and the underlying causes. Case conceptualization provides the framework for treatment, and it could support my efforts to understand an individual's strengths, aspirations, and challenges as well as provide an opportunity to connect the individual's situation with structural influences. In addition, it could help me identify an individual's thinking and behaviour; cultivate therapeutic rapport; learn about the individual's relationship with the outside world in childhood and adulthood; plan and adapt treatment as needed, and select appropriate interventions (Beck, 2021). I think that by becoming more comfortable with and confident in the process of case conceptualization, I was able to provide a more focused, client-centred service to the individuals whom I worked with at CAST.

Two facets of CBT I wanted to implement together in my practicum were the use of behavioural activation interventions and action plans. The effective use of these tools can help clients gain a sense of mastery, pleasure, and connection with an activity and, ideally, have clients engage with a given activity on a regular, predictable basis. According to Beck (2021), scheduling activities is one of the most important initial steps for individuals living with depression; the practice can lift their mood and strengthen their sense of self-efficacy. In my practicum at CAST, I wanted to explore with individuals how they currently spend their time during the day, what activities they found enjoyable in the past, and what activities they might be able to do again. By collaboratively identifying activities that were important to the individual and having the individual identify a specific time when they were willing engage in the activity, there could be a greater probability that the activity be completed (Gonzalez-Prendes, 2021). It is important to keep the activity relatively easy and attainable at first so the individual will be successful in accomplishing the activity and more likely to pursue identified behaviours and

goals. Cognitive behavioural therapy offers advantages that I wanted to implement in my practicum at CAST so that I could develop more clinical practice skills.

Cognitive behavioural therapy offers a wide range of empirically supported interventions to help individuals living with mental health. Understanding the philosophical and theoretical underpinnings, the key practice components and the purpose of CBT enabled me to implement the approach more effectively in my clinical practicum at CAST. A few barriers to CBT practice have been identified above; therefore, I needed to be mindful of these limitations because CBT is not always a suitable approach for all populations or all presenting problems. Having knowledge of and experience with other therapeutic approaches provided me with different strategies and interventions so that I could offer not only an individualized service but also address the larger social, structural, and cultural circumstances of individuals' lives.

Dialectical Behaviour Therapy (DBT)

Defining Dialectical Behaviour Therapy

Dialectical behaviour therapy (DBT) is an evidence-based, wide-range cognitive behavioural treatment developed by Dr. Marsha M. Linehan to treat chronically suicidal individuals diagnosed with borderline personality disorder (BPD) (Linehan, 1993). In recent years, DBT has evolved into a treatment for other behavioural disorders and problems involving emotion dysregulation such as depression and anxiety (Harley & Sprich, 2008; Harned, 2009; Miller, 1999; Ritshel & Cheavens, 2012), substance use comorbid with BPD (Linehan et al., 1999; Linehan at al., 2002), posttraumatic stress disorder due to childhood adversity (Choi-Kain & Wilks, 2021; Bohus & Dyer, 2013), and eating disorders (Safer & Jo, 2010; Safer & Joyce, 2011). The overall goal of DBT is to provide skills to individuals that will elicit acceptance and change emotional, thinking, behavioural, and interpersonal patterns that are influencing everyday

life (Linehan, 2015). The main principles of DBT are based on dialectical philosophy and biosocial theory which highlights how difficulties with regulating emotions and behaviours can impact impulse control, interpersonal relationships, self-image, and distress tolerance (Linehan, 2015).

Philosophical and Theoretical Underpinnings

Linehan (1993) discovered that standard cognitive behavioural therapy (CBT) had some shortcomings when used with recurrently suicidal individuals. According to Linehan (1993), when dialectics is applied to behaviour therapy, the fundamental nature of reality needs to be considered. Linehan (1993) asserts that the fundamental nature of reality and human behaviour shares three key attributes. First, dialectics can make us aware of the individual parts of a system, the interrelatedness of its parts, and of the parts to the whole (Linehan, 1993). Because of the interconnectedness of the individual and the larger context, DBT aims to treat the whole individual, and not merely a specific disease or disorder (Lynch & Chapman, 2006). Second, reality is understood to be fluid. A system and its parts are interdependent and dynamic and change to one element will produce change in the others (Linehan, 2015; Lynch & Chapman, 2006). Reality consists of opposing powers (thesis and antithesis) in which the fusion creates a new set of opposing powers (Linehan, 2015). Third, the individual and the environment both undergo constant transformation. Therapy aims, therefore, to help the individual become comfortable with the change (Linehan, 2015). The focus on change (the thesis) brings about the need for acceptance (the antithesis); as such, DBT strategies and interventions aim to balance and synthesize these opposing elements (Lynch & Chapman, 2015).

As noted earlier, DBT was originally developed for the treatment of individuals who were chronically suicidal and had been diagnosed with BPD. The theoretical underpinning for

DBT is based on the premise that suicidality and BPD are both disorders of emotion dysregulation. The biosocial theory developed by Linehan (1993) conceptualizes emotion dysregulation. The theory proposes that the interaction between biological influences and an invalidating social environment brings about emotion dysregulation (Linehan, 1993).

Emotion dysregulation has been linked to behaviours such as suicide attempts, self-injury, disordered eating, and substance use. These outcomes may be a direct response to an attempt to self regulate dysregulated emotions (Linehan, 1993; Lynch et al., 2006; van der Kolk, 2014). The biosocial theory of emotion dysregulation has led to the assumption that DBT needs to focus on modifying elements of an individual's emotion system (Lynch & Chapman, 2006). In keeping with this theory, reducing emotion dysregulation and increasing behavioural skills are the objectives of DBT (Linehan, 1993).

Key Practice Components

In the context of applying dialectics to behaviour therapy, the strategies and interventions used by the therapist aim to influence acceptance and change (Linehan, 2015). The key practice components of acceptance are mindfulness skills and distress tolerance skills and the key practice components associated with change are emotion regulation skills and interpersonal skills (Linehan, 2015).

For mindfulness skills, the objective is to build a client's capacity to experience and consciously observe oneself in different situations, without judgment, and with curiosity; to live in the present moment; and to perceive reality as it is instead of through the lens of their emotions, assumptions, and beliefs (Linehan, 2015). In teaching distress tolerance skills, the goal is to teach the client to identify patterns of maladaptive problem-solving behaviours such as substance use, eating disorders, self-harming behaviour, suicidality, and other problematic

impulsive behaviours; an additional objective is to teach effective skills of tolerance and acceptance of a degree of emotional distress so the individual can engage in more beneficial problem-solving solutions (Linehan, 2015).

Research suggests that individuals with emotion dysregulation often have chaotic and intense relationships as well (Linehan, 1993; Fisher, 2021; van der Kolk, 2014). Consequently, interpersonal effectiveness skills are taught to help individuals be more assertive in their relationships, to ask for what they need, to learn to say no, to manage conflict respectfully, to develop and maintain healthy relationships, to end destructive relationships, and to find a balance between acceptance and change, which are necessary components of healthy relationships (Linehan, 2015). The final component of behaviour change is teaching emotion regulation skills. Trouble with regulating painful emotions may result in behavioural challenges for some individuals (Fisher, 2021; Linehan, 1993; van der Kolk, 2014). Strengthening an individual's capacity to understand and name emotions, alter undesirable emotions, decrease susceptibility to emotions, and control extreme emotions are the goals of emotion regulation (Linehan, 1993). These key practice components of DBT have been categorized into four modules: (1) mindfulness, (2) distress tolerance, (3) interpersonal effectiveness skills, and (4) emotion regulation, and each component of which is meant to be used in a flexible, client-centred manner (Linehan, 2015). Any module can be dropped out or employed based on the needs of the client and the structure of the treatment (Linehan, 2015).

Purpose

The central purpose of DBT is to substitute futile, maladaptive, or non-skilled behaviour with intentional responses by targeting cognitive, emotional, and behavioural systems using different strategies in the four modules (Linehan, 2015). To effectively accomplish these aims,

DBT is designed around five functions: (1) improving behavioural capabilities, (2) developing and sustaining incentive to change and participate in treatment, (3) confirming that new skills generalize to the out-of-session world, (4) increasing the effectiveness of the service the therapist delivers, and (5) helping structure the environment in ways that supports the client's advancement towards goals (Dimeff & Linehan, 2001; Linehan, 2015). Dialectical behaviour therapy can promote these functions most effectively by dividing the treatment among modes of delivery that include individual treatment or case management, group skills training, between-session skills phone coaching, and use of a team of consultative therapists (Dimeff & Linehan, 2001; Linehan, 2015). Each mode works with the others to provide a comprehensive treatment that aims to replace troublesome behaviours with skillful responses.

Barriers to Dialectical Behaviour Therapy Practice

Standard DBT practice that includes all four modes of delivery has proven to be effective in treating BPD and reducing suicidal behaviour (Linehan, 1993). Despite its proven efficacy, there are limitations to DBT practice (Burrough & Somerville, 2013; Carmel et al., 2014; Landes, 2017; Popowich & Mushquash, 2019). One criticism of DBT, as with many Western psychotherapies, is its use of a deficits approach that blames the individual for their survival responses and imposes the task of change solely on the individual (Baskin, 2016). The DBT approach pathologizes and problematizes the individual and does not take into consideration environmental sources of oppression and distress (Baskin, 2016). Dialectical behaviour therapy labels behaviours as "abnormal" and strives to teach individuals new skills to solve so-called "abnormal" behaviours. By focusing primarily on the individual, DBT can disempower individuals who have experienced societal or collective adversity and therefore, may not be a helpful approach for enabling change (Baskin, 2016; Burrage et al., 2020).

Another significant difficulty is implementing DBT in a health care setting. This obstacle is often the result of a staffing barrier and is due to high staff turnover, staff who are inadequately trained in DBT, and the generally insufficient number of staff (Burrough & Somerville, 2013; Carmel et al., 2014; Landes, 2017). A second barrier to the delivery of DBT is a lack of administrative support for implementing all four modes of delivery needed to run an efficacious DBT program; additionally, there is a general lack of funding support for training staff in DBT (Burrough & Somerville, 2013; Carmel et al., 2014; Landes et al., 2017). A third obstacle is the time commitment DBT requires, and this reality is coupled with the heavy caseloads in a healthcare setting (Burrough & Somerville, 2013; Carmel et al., 2014; Landes et al., 2017).

Along with implementation barriers, limitations that impact sustainability of DBT programs have also been identified in the literature. Popowich and colleagues (2019) discovered that systemic challenges such as discontinuity of staff, poor system flow due to long wait lists (i.e., clients who could benefit from DBT are often on long wait lists to access the program), and the short length of DBT programs being offered posed a challenge. Consequently, in their research, clients did not have the opportunity to practice and apply skills they had learned in each program and there was a lack of support and funding for between-session phone coaching. Another major barrier by Popowich et al. (2019) were difficulties within the consultative team: personality conflicts, concern of judgment made by other team members, and the alleged absence of safety provided by team members caused DBT teams to dissolve in some cases. Clinician burnout resulting from the demanding nature of the work and the “uphill battle” against the systemic challenges were also identified by Popowich and colleagues (2019) as blockages to sustaining DBT programs. Perhaps because of these challenges to implementing and sustaining a

full DBT program, some therapists have opted to modify and assimilate some DBT skills into their individual practices.

Implementing Dialectical Behaviour Therapy Skills in my Clinical Social Work Practicum

Over the years, due to its proven efficacy in replacing challenging behaviours with more conscious responses, therapists from differing theoretical orientations have begun to modify and assimilate DBT skills training into their individual practices so that they work better with the populations they are serving (DiGiorgio & Glass, 2010; Linehan, 1993). Evidence suggests that teaching DBT skills alone (without the other three modes of delivery) is rapidly emerging as a treatment option for emotion-dysregulation related disorders such as eating disorders, generalized anxiety disorder, substance use disorders, and mood disorders (Bohus & Dyer, 2013; Choi-Kain & Wilks, 2021; Harley & Sprich, 2008; Harned & Chapman, 2009; Linehan et al., 1999; Linehan at al., 2002; Miller, 1999; Ritshel & Cheavens, 2012; Safer & Jo, 2010; Safer & Joyce, 2011). Having the option to modify and, or assimilate key practice components into my practicum at CAST enabled me to provide effective services to meet the diverse needs of service users.

The literature also suggests that emotion dysregulation impedes treatment (Ciarrochi & Deane, 2001; Fisher, 2021; Najavits, 2002; van der Kolk, 2014). Teaching and practicing DBT skills in session might be helpful to focus on first so that clients can establish a sense of agency before moving on to different treatment options and, or tasks (Fisher, 2021; Najavits, 2002; van der Kolk, 2014). The idea of focusing on emotion regulation has been coined as “safety” in the world of trauma work (Choi-Kain & Wilks, 2021; Fisher, 2021; Najavits, 2002; van der Kolk, 2014). The concept of safety envelops gaining control over extreme emotions, reducing

suicidality, letting go of dangerous relationships, stopping self-destructive behaviours, and whatever it is that a client defines as safety for themself (Najavits, 2002).

There were many DBT skills that I wanted to try in sessions to help move clients towards safety. For the mindfulness module, the "wise mind" skill was a technique I wanted to incorporate into my practice to help clients begin to establish safety. This skill is the balancing of emotion with reason (logic) to achieve "wise mind"; a wise mind leads to "wise actions" (Linehan, 2015). In conjunction with the mindfulness skill, the emotion regulation module articulates the idea of emotional self-validation (Linehan, 2015). Emotional self-validation starts with understanding the function of emotions and identifying and labelling emotions (Linehan, 2015). Using a common language for labelling emotions and discussing how emotions motivate one's behaviour are additional ways that I could establish safety. The distress tolerance skill that I wanted to explore in my practicum included quickly changing body chemistry to inactivate emotional arousal by using Temperature, Intense exercise, Paced breathing, and Paired muscle relaxation (Linehan, 2015). The use of interpersonal skills can be dependent on distress tolerance, emotion regulation, and mindfulness abilities (Linehan, 2015). I liked the idea of the client setting individual, interpersonal goals and letting the goals determine which skill would be attempted (Linehan, 2015). By assimilating a few of Linehan's (2015) DBT skills into my practice, I wanted to be able to help service users create a sense of safety inside and beyond our sessions.

The use of DBT as a full therapy program and as a discrete skills training portion are supported by the literature and shown to be efficacious in the treatment of complex mental health. The literature on DBT has provided me with a better understanding of how therapy skills could be incorporated into my practicum at CAST. Barriers to practice have been identified and

DBT may not be an appropriate approach for everyone. Subsequently, expanding my knowledge of another theory provided me with additional competencies I could draw on during my clinical practicum at CAST.

Trauma Theory in Therapy

Defining Trauma Theory in Therapy

Trauma theory in therapy is based on knowledge that the autonomic nervous system is affected by early experiences and shaped by on-going life experiences. Fortified with an understanding of the autonomic hierarchy, neuroception, and co-regulation, an individual can learn to safely listen to their autonomic responses and shape their systems to promote safety and stabilization (Dana, 2020; Fisher, 2021; Porges, 2003; van der Kolk, 2014). Trauma is a complex concept and is shaped by individual experiences that can stem from a single overwhelming event or from long-term experiences of child abuse, neglect, direct or indirect violence, or to collective incidents of historical abuse (Bridgeman et al., 2017; Lee et al., 2021; Poole et al., 2017; Public Health Agency of Canada, 2018; Quiros & Berger, 2015; Varcoe et al., 2016). The effects of trauma produce long lasting results that can be carried for weeks, months, years, or even decades due to their negative effects on the development of the autonomic nervous system (Dana, 2020; Fisher, 2021; Porges, 2003; van der Kolk, 2014). Traumatized brains function differently than non-traumatized brains; therefore, the use of trauma theory in therapy focuses on bringing explicit awareness to implicit experiences by using a neurophysiological framework. This helps individuals develop skills in regulating their autonomic nervous system that contribute to an increase in response control and resiliency (Dana, 2020; Fisher, 2021; van der Kolk, 2014).

Philosophical and Theoretical Underpinnings

The theory on trauma is linked to early investigations of the experiences of veterans returning from war, the impact of childhood abuse, and the study of adverse childhood experiences. The study of trauma expanded to include the impacts of natural and human-made disasters and attacks and of sociopolitical events on individuals and groups (Courtois & Gold, 2009; Fisher, 2021; Knight, 2019; Knight, 2015; Lee et al. 2021; Levenson, 2017; Mersky et al., 2019; Quiros & Berger, 2015; van der Kolk, 2015). The knowledge of trauma theory was made possible through advancements in neuroscience, developmental psychopathy, and interpersonal neurobiological research; it was further developed by Stephen Porges' polyvagal theory (van der Kolk, 2015).

The polyvagal theory describes a physiological and psychological awareness of how and why individuals move through a constant series of fight or flight, disconnection, and engagements (Dana, 2020). According to the polyvagal theory, the autonomic nervous system develops in response to early experiences of safety and connection and acts as a security system to manage risk. The autonomic nervous system creates connection by changing our physiological state, and, for many individuals, the change in physiological state is returned to a regulated state by their resilient autonomic nervous system (Dana, 2020; van der Kolk, 2015). Trauma interrupts the process of building a resilient autonomic nervous system and individuals with a trauma history experience intense autonomic responses that impact their ability to regulate and feel safe in relationships (Dana, 2020; Fisher, 2021; van der Kolk, 2015). Essentially, the autonomic nervous system becomes wired to ensure protection rather than connection because of the trauma an individual has experienced. If left unresolved, the survival response becomes habitual and automatic.

Autonomic responses such as intense physical, perceptual, and emotional reactions are implicit memories of trauma that continuously activate a trauma response that makes the body susceptible to re-traumatization many times a day (van der Kolk, 2015). When these implicit memories are constructed by triggers, a person reexperiences the sense of threat, risk, shame, or the need to escape that they experienced during the initial traumatic event(s) in childhood (Fisher, 2021; Ogden, 2006; van der Kolk, 2015). Not only does trauma leave behind implicit memories that are disruptive to the lives of survivors but it can also lead to a gamut of symptoms that include, but are not limited to, depression, irritability, decreased concentration, numbing, emotional overwhelm, hopelessness, shame, worthlessness, nightmares/flashbacks, mistrust, anxiety/panic attacks, self-destructive behaviour, substance use, eating disorders, and binge eating disorders (Fisher, 2021; van der Kolk, 2015). The polyvagal theory in therapy helps therapists interpret the reasons why individuals act in the ways they do. The theory explains that a traumatized person's actions are automatic, adaptive, non-conscious choices, and are the result of the autonomic nervous system's attempt to protect (Dana, 2020). Trauma theory has key practice components that are informed by the polyvagal theory and are important to consider when implementing the theory in therapy.

Key Practice Components

The three key practice components of trauma theory are an understanding of the (1) autonomic hierarchy, (2) neuroception, and (3) co-regulation, each of which provide a foundation for interventions in therapy sessions. Trauma stories are contained in autonomic routes and in the patterns of response that were necessary and created for survival in the past but that bring about distress in the present (Dana, 2020). Even before birth, the autonomic nervous system takes in and responds to the environment; it continues to do so after birth, responding to

family and other early experiences that prompt habitual response patterns (Dana, 2020; Fisher, 2021; van der Kolk, 2015). When relationships with a responsive caregiver are based on connection and attunement, the autonomic nervous system is wired for resilient regulation, resulting in a sense of safety and connection. When an infant or child's relationships are shaped by a habitually dysregulated caregiver, the relationship is based on misattunement and self-protection and the child's autonomic nervous system creates its own protection patterns (Dana, 2020; Fisher, 2021; van der Kolk, 2015).

The autonomic hierarchy explains the three distinct pathways that work together for protection and survival. The autonomic nervous system is made up of two branches, the parasympathetic and the sympathetic. The parasympathetic component is further divided into the dorsal vagal and ventral vagal (Dana, 2020; Fisher, 2021; van der Kolk, 2015). The ventral vagal is at the top of the autonomic hierarchy, is wired specifically for social engagement, and is considered the circuit where safety and connection are promoted (Dana, 2020; Fisher, 2021; van der Kolk, 2015). The social engagement system of the ventral vagal, can filter the cues of social interaction and respond by welcoming or discouraging physical proximity and social engagement (Porges & Furman, 2011). Traumatic events and adverse experiences can overwhelm the capacity of the ventral vagus to regulate the system; once the capacity of the ventral vagus has been depleted, that capacity is transferred down to the next level in the autonomic hierarchy to the sympathetic system and mobilization may be experienced (Dana, 2020; Fisher, 2021; van der Kolk, 2015).

Mobilization is the fight or flight response; this survival response is fuelled by adrenaline and cortisol that impacts the brain's ability to reason and think logically (Dana, 2020; Fisher, 2021; van der Kolk, 2015). If mobilization does not resolve the distress, the autonomic nervous

system takes another step down to the final level in the hierarchy which is dorsal vagal, or the immobilization or freeze response (Dana, 2020; Fisher, 2021; van der Kolk, 2015). The dorsal vagal experience is a response to what seems like an inescapable situation and includes responses such as numbing, disconnection, and dissociation (Dana, 2020; Fisher, 2021; van der Kolk, 2015). Without a regulating influencer, such as internal resourcing or a connection with another person, the ability to return to the ventral vagus system is stymied and the dorsal vagus system remains shut down.

The second key practice component is the process of neuroception which means the autonomic nervous system monitors the internal organs, looks for signs of safety or danger in the environment, and detects the connection to another regulated nervous system to move individuals carefully up the autonomic hierarchy (Dana, 2020; Fisher, 2021; van der Kolk, 2015). Neuroception happens below the state of consciousness and outside of awareness; when an individual exists in an environment that is safe and supportive, the system reads cues and responds correctly. When an individual exists in an environment that is unpredictable or feels unsafe, the system is honed to protection and reacts accordingly (Dana, 2020; Fisher, 2021; van der Kolk, 2015). Through neuroception, your autonomic nervous system is stuck in an either/or experience; one is either open to connection or one is stuck in a protective response (Dana, 2020). Neuroception is the starting point of thoughts, behaviours, feelings, and worldviews; it is the starting narrative of an individual's story and understanding the process of neuroception can help facilitate changes to the narrative.

Co-regulation is the third key practice component of trauma theory and is based on a shared sense of safety that we create when we connect with others (Porges, 2015). According to Porges & Furman (2011), isolation, or even the perception of aloneness, can lead to difficulty in

regulating one's autonomic states and can impact a person's emotional and physical well-being. In early interactions, babies rely on their caregiver to be able to attune and respond accurately to their changing autonomic needs; this is co-regulation and brings about a shared autonomic experience, a shared emotional experience, and a shared experience of safety (Dana, 2020; Fisher, 2021; van der Kolk, 2015). The ability to self-regulate is developed by ongoing experiences of co-regulation and the need for co-regulation remains throughout one's lifetime (Porges & Furman, 2011). When a child encounters ongoing misattunement in the early years, the autonomic experience of chronic danger shapes the system to generate patterns of protection; thus, trauma produces an adaptive response that keeps the autonomic nervous system from finding safety in connection (Dana, 2020; Fisher, 2021; van der Kolk, 2015). Safety is accomplished within a co-regulated relationship, and this is where healing and change can occur. The three key practice components of trauma theory, (1) autonomic hierarchy, (2) neuroception, and (3) co-regulation, are important elements to understand, particularly their relationship to the autonomic nervous system's ability to not only promote one's survival but also facilitate one's healing.

Purpose

According to Dana (2020), the purpose of trauma theory in therapy is to help individuals move out of habitually activated rigid patterns of protection and reshape the autonomic nervous system so that it is more flexible and resilient. This goal is achieved by using the same neurophysiological process that initially shapes the system. When trauma has shaped the autonomic nervous system, there is a separation between physiological state, psychological story, and behavioural response that locks individuals in a state of seeking protection. By using the trauma theory in a therapy framework, individuals can view cues and triggers in the present

moment rather than only through the lens of past experiences (Dana, 2020). To engage the ventral vagal safety circuit, the autonomic nervous system needs to be repatterned to bring explicit awareness to implicit experiences by "befriending" the autonomic nervous system, attending to autonomic states, reshaping the autonomic nervous system, integrating new autonomic rhythms, and connecting to others (Dana, 2020).

Befriending the autonomic nervous system is the process of tuning in and turning toward autonomic states with curiosity and self-compassion (Dana, 2020). Trauma survivors are often disconnected from their body states; they live in the stories they created from those body states. The ability to sense, name, and identify what is going on inside the body is the first step towards recovery (van der Kolk, 2015). Recognizing and categorizing sympathetic mobilization and dorsal vagal immobilization as adaptive survival responses helps individuals reconsider their responses as survival actions. This shift in perceptual framework can reduce the intensity of nervous system activation (Dana, 2020; van der Kolk, 2015). The art of befriending the autonomic nervous system offers connection, understanding, and compassion for the autonomic hierarchy.

The ability to track autonomic states, to see the movement between states, and to notice large and nuanced shifts reflects a person's learning to attend to autonomic states (Dana, 2020). Having an awareness of where one is on the autonomic hierarchy and where one is going is the first step towards autonomic regulation (Dana, 2020; van der Kolk, 2015). According to van der Kolk (2015), the more skilled an individual is at attending to their autonomic states, the better able they are to quickly return to the ventral vagal state. Learning to attend to autonomic states and experiences sets the foundation to reshape the autonomic nervous system.

The autonomic nervous system can be reshaped to establish new patterns that increase one's ability to stay in the ventral vagal system (Dana, 2020). Trauma compromises the safety component of the ventral vagal state, and an individual can find themself living in a state of intense mobilization and withdrawal, thus navigating the world perpetually dysregulated (Dana, 2020; van der Kolk, 2015). Van der Kolk (2015) does not recommend revisiting the past in therapy unless an individual is able to experience the present moment from a feeling of calm and a sense of safety. By engaging in practices and exercises that rewire neuroception and reshape habitual response patterns, individuals can increase their capacity for regulation and connection which positively influences physical and psychological well-being (Dana, 2020; van der Kolk, 2015). The process of reshaping the autonomic nervous system is slow; taking small steps to climb up the autonomic hierarchy helps create new patterns without adding more stress or activating the autonomic nervous system (Dana, 2020). Once reshaping has started, the process of integrating new autonomic rhythms can take place.

The integration of new autonomic rhythms is the process of bringing the implicit experiences into explicit awareness and utilizing new patterns to create a new story (Dana, 2020). The integration process encompasses an unfamiliar in-between space in which individuals are no longer confined to old patterns but have not yet adopted new, predictable patterns. This in-between state is an essential part of wiring new neural networks (Dana, 2020; van der Kolk, 2015). Resilient pathways enable an individual to move up and down the autonomic hierarchy in response to daily challenges and not get stuck in either mobilization or immobilization; the process of integration trains and enables individuals to navigate life from a ventral vagal state (Dana, 2020; van der Kolk, 2015). When one can regulate their autonomic nervous system, creating safe connections is possible.

The autonomic pathways build the foundation of an individual's experience of themself, how relationships are created, and how the world is navigated based on connection (Dana, 2020; van der Kolk, 2015). Being able to befriend your autonomic nervous system, attend to autonomic states, shape your autonomic nervous system, and integrate new autonomic rhythms provides an individual a new lens to view relationships and illuminates which relationships elicit dysregulation and which relationships co-regulate the autonomic nervous system (Dana, 2020; van der Kolk, 2015). An increased capacity to evaluate current relationships, reshape old relationships, and seek out new relationships creates safety and connection that facilitates the healing of trauma (Dana, 2020; van der Kolk, 2015). The purpose of trauma theory in therapy is to bring the possibilities of health, growth, and resilience to individuals by empowering them to listen to their implicit stories, recognize signs of safety, and establish new ways of living their lives (Dana, 2020; van der Kolk, 2015).

Barriers to Trauma Theory in Practice

Trauma theory in therapy has many strengths to offer specific to teaching coping skills and reducing distress (Bryant-Davis, 2019). Additionally, it provides a scientific foundation that describes how trauma impacts the nervous system (Porges, 2003; van der Kolk, 2015). Like many other Western psychotherapeutic models, trauma therapy carries with it many barriers to practice such as a deficits approach, cognitive abilities, motivation to engage and change, and insufficient attention to cultural differences and intersectionality (Baskin, 2016; Bryant-Davis, 2019; Gone, 2009). Trauma theory in therapy focuses on how the individual's nervous system has been wired incorrectly due to the experience of trauma; it is the responsibility of the individual to unlearn old lessons and learn new ways to reshape their nervous system to facilitate their own healing (Bryant-Davis, 2019; Gone, 2009). This limitation of this approach is that it

singles out what is “wrong” with the individual and puts the responsibility for transformation solely on the individual when, instead, it could examine ways that society could change to reduce trauma and traumatic experiences for individuals and groups of people (Baskin, 2016; Bryant-Davis, 2019; Gone, 2009; van der Kolk, 2015).

Another two limitations of trauma theory in therapy are the assumptions that all individuals have the cognitive capacity and the drive to take part in trauma therapy. In reviewing many of the interventions that Dana (2020) proposes, there seems to be a high level of self-reflection, perception, and intentionality required to be able to reshape one’s autonomic nervous system. According to Fisher (2021), “slower is faster” is the best approach for the process of trauma therapy and neglecting to assess an individual’s cognitive abilities and, or their readiness to engage in therapy may result in going too fast in the therapy process. Consequently, the individual may be retraumatized and the therapeutic relationship compromised. Despite these barriers to the effective use of trauma therapy interventions and the model’s need to attend to more cultural, intersectional, spiritual, and collective aspects of an individual’s life, trauma therapy is still widely implemented in many practice settings.

Implementing Trauma Theory Skills in my Clinical Social Work Practicum

Bringing trauma theory into therapy provided me with a model with which to present the autonomic nervous system to individuals and help them become effective operators of their own nervous systems (Dana, 2020). I believe that offering individuals information through psychoeducation about trauma and all its manifestations and consequences can be an empowering process that removes or reduces the guilt and shame that is often associated with trauma symptoms and reactions. Psychoeducation about trauma does not have to be academic in nature; it can be relational in that we can use the individual’s own stories and link them to

experiences of the nervous system (Dana, 2020; Fisher, 2021). Psychoeducation about trauma can also be individualized and include attunement to an individual's autonomic state and interests (Fisher, 2021). Both Dana (2020) and Fisher (2021) have each developed flip charts to promote information and understanding of the science of trauma. The use of the flip charts could be used to draw connections between trauma symptoms and the reactions an individual is experiencing in the present and a larger context that validates and normalizes what they feel.

If the individuals that I provided a service to seemed interested in trauma theory, or if the trauma theory resonated with them and their experiences, then I could suggest various interventions and have the individual choose the intervention they wanted to try first. Dana (2020) presents different intervention exercises that focus on befriending, attending, shaping, integrating, and connecting that aim to help individuals engage in and begin their journey toward finding safety and connection. One intervention exercise based on befriending the autonomic nervous system that I wanted to incorporate in my practice is that of ventral vagal anchors (Dana, 2020). This exercise invites an individual to identify past or present experiences that bring about a sense of feeling safe, anchoring to a ventral vagal state by reconnecting or by reactivating the memory of the "anchor". Ventral vagal anchors ground individuals in the present and help them become aware of what moving along the autonomic hierarchy feels like. Another befriending exercise I thought could help bring awareness to different autonomic states was having an individual draw, create, and colour their own "ladder" to represent the autonomic hierarchy and then have them discuss how they connect and compare their autonomic experiences (Dana, 2020). The process of designing and personalizing the hierarchy expands the individual's connection to the hierarchy (Dana, 2020).

There are a couple of intervention exercises in the attending category that I wanted to implement in my practicum practice as well. Dana (2020) suggests using short stories to intentionally add narrative to an autonomic experience by using five prompts: (1) my autonomic state is…, (2) my system is responding to…, (3) my body wants to…, (4) my brain makes up the story that…, and (5) when I review my short story, I notice….These elements can create an integrated story and enable a client to reflect on the ways an activated autonomic state begins to create personal narratives.

Another exercise I wanted to incorporate into my practicum practice was attending through nature which can be done in an outdoor space or with images; this process can be useful as a regulating activity (Dana, 2020). Inviting individuals to explore their surroundings and natural environment as well as to track their autonomic responses, would help them identify the places, objects, or images that bring on a ventral vagal state (Dana, 2020). Attention to the regulating influences of the natural environment as individuals move through their daily lives could provide them with opportunities to intentionally connect with their surroundings and thus build their ventral vagal capacity (Dana, 2020).

Finding glimmers is one of Dana's (2020) interventions that is based on shaping the autonomic nervous system. The intervention involves individuals actively searching for micro-moments of regulation throughout their day. According to Dana (2020), glimmers routinely appear in everyday life yet go unnoticed. This intervention requires individuals to look for a certain number of glimmers each day by noticing a spark of ventral vagal energy, to name the moment, to track the moment, and to create a list of such moments. As glimmer encounters accrue, individuals commonly try to find more; consequently, the reshaping of the autonomic nervous system begins to take place.

Music is another intervention that affects one's physiology and feelings and can be used to shape the autonomic nervous system. Not only can music activate a ventral vagal state, but it can also enable individuals to safely connect to their sympathetic and dorsal vagal states (Dana, 2020). Inviting individuals to explore music as well as how different pieces of music could take them to different places on the autonomic hierarchy, was an intervention that I wanted to implement in my practicum practice. Having individuals share their music in sessions could highlight how music can shape the autonomic nervous system and create safety and connection with others (Dana, 2020).

Integrating new autonomic rhythms was another function of trauma theory that could be implemented in my practicum practice. One intervention that helps to integrate new rhythms is inviting individuals to create "If-Then" statements that identify when, where, and how to respond to a situation (Dana, 2020). If-Then statements bring recognition to situations by producing a connection between cues and responses which can make it easier to prepare for experiences and to act (Dana, 2020). For If-Then statements to be effective, it is important to have individuals check their autonomic response after each statement to assess whether the statement brings about (1) a neuroception of safety and (2) no activation of movement to the sympathetic or dorsal vagal response (Dana, 2020).

Another intervention for integrating new rhythms that I hoped to incorporate was the concept of re-storying, which encourages the development of a new story by choosing words and qualities that are directly related to the ventral vagal state (Dana, 2020). The re-storying process can also anchor an individual in the ventral vagal state and help them define who they are and how they navigate their world beyond the old stories that were wired for protection (Dana, 2020).

Connecting to others is the last concept of trauma theory in therapy. The two interventions I wanted to implement during my practicum focus on connecting individuals to something greater than the self (Dana, 2020). The first intervention aims to use gratitude and compassion as a platform to build a ventral vagal state of safety (Porges, 2003). I wanted to invite individuals to practice gratitude daily by looking for experiences that they might otherwise miss and to keep a list of these experiences. When experiences of gratitude are brought to conscious awareness, the pathways to ventral vagal regulation are strengthened, and thus the capacity to connect with and feel a connection to others increases (Dana, 2020).

The second intervention aimed to increase one's ability to connect with others with compassion and self-compassion. I believe that by implementing Dana's (2020) compassion exercise in my practicum could benefit the healing process. Dana (2020) suggests inviting individuals to create both a compassion statement and self-compassion statement to use when they notice someone or themself in a dysregulated state. The utility of the compassion and self-compassion statements is found in saying it internally or out loud; this cue reminds the autonomic nervous system to find its way back to regulation so one can be a co-regulator (Dana, 2020). When incorporating Dana's (2020) trauma interventions in my practicum, I wanted to invite individuals to explore their implicit memories, build new patterns, move out of adaptive survival responses, and create safety and connection from a regulated autonomic state.

Trauma theory in therapy presents a scientific understanding of trauma and provides a foundation for interventions that assist individuals with reshaping their autonomic nervous systems. Equipped with knowledge about the philosophical and theoretical underpinnings of trauma, the key practice components, and the purpose of trauma theory in therapy enabled me to competently implement pertinent interventions in my clinical practicum at CAST. I needed to be

cognizant of the barriers to practice that have been identified above because trauma theory in therapy may not be a relevant approach for all situations or populations. Understanding multiple modalities enhanced my confidence and skills in integrating the interventions in my practice, which helped strengthen the ethical integrity of my practice.

Cultural Limitations Associated with Western Modalities

Western modalities such as Cognitive behavioural therapy and Dialectical behaviour therapy approaches have been said to be disempowering when used with cultural groups that have worldviews that differ from the dominant Western worldview (Baskin, 2016; Gonzalez-Prendes, 2021). Western mainstream society focuses on individualization, self-actualization, and independence when treating mental health, but these are not elements of, or values shared by all individuals (Baskin, 2016). By neglecting to consider different worldviews in the approach, a CBT or a DBT approach can cause individuals to feel further marginalized and oppressed. The norms, beliefs, and ways of defining individual challenges are usually those based on the therapist's perspective of "normal", which can be problematic for clients who do not conform to the therapist's worldview (Baskin, 2016; Gonzalez-Prendes, 20021; Harms & Pierce, 2007).

A cultural limitation to the effective use of trauma theory in therapy is the insufficient attention paid to how cultural differences and intersectionality influence trauma conceptualization and treatment (Bryant-Davis, 2019; Gone, 2009). Trauma therapy evolved from the life experiences and intellectual training of the dominant culture and can be alienating, assimilative, and harmful to those who are culturally different and those who experience multiple forms of oppression (Baskin, 2015; Bryant-Davis, 2019; Gone, 2009). Societal traumas, which include historical trauma, intergenerational trauma, oppression, and racial trauma, are on-going realities that continue over time and across location and are not the same as traumatic events that

have only occurred in the past (Kira et al., 2014). The literature suggests that trauma therapy very rarely includes the treatment of societal trauma in its models and interventions (Bryant-Davis, 2019; Comas-Diaz et al., 2019; Gone, 2009); therefore, trauma therapy may not be an appropriate modality for use with the complexities of all cultures or intersections of identity.

Despite the cultural limitations of Cognitive behavioural therapy, Dialectical behavioural therapy, and Trauma theory in therapy, it was important for me to be trained and comfortable with these Western modalities. Many Indigenous people live in a Westernized society, and some are highly acculturated, and it would be inappropriate for me to assume that all Indigenous peoples want only Traditional methods of healing. I set out to become confident in integrating these Western modalities into my practice and to use a decolonizing framework as a guide to explore ways to Indigenize these Western modalities where possible during my practicum at CAST.

Ethical Considerations

This section will describe ethical considerations and discuss how these considerations were applied to my practicum at CAST. The British Columbia College of Social Workers (BCCSW) (2009) Code of Ethics and Standards of Practice purposefully inform social work practice in a way that aims to guide and evaluate the professional actions of the social worker and to resolve challenges of practice while maintaining the best interest of the client. Social workers are in a position of power and must create and uphold well-defined boundaries in their professional relationships to ensure the safety of clients (BCCSW, 2009). Establishing and maintaining clear boundaries in the social work profession has been demonstrated to be the most challenging and problematic ethical issue (Brocious et al., 2013; Gillespie & Redivo, 2012; Green, 2003; Piche et al., 2015; Reamer, 2003; Schmidt, 2000). Boundary issues occur when

conflicts of interest are encountered by social workers in the form of dual or multiple relationships (BCCSW, 2009; Reamer, 2003). Within rural, remote, and northern practice settings, dual or multiple relationships may occur more frequently, due to the community size; consequently, many social workers will often encounter clients and client family systems in multiple community roles and activities outside their professional role (Brocious et al., 2013; Gillespie & Redivo, 2012; Green, 2003; Piche et al., 2015; Reamer, 2003; Schmidt, 2000). Although Prince George is not as rural, remote, or far north as other communities in British Columbia, possible ethical challenges such as conflicts of interest and dual and multiple relationships still need to be considered to provide ethically safe care.

Conflict of Interests

The BCCSW (2009) defines conflict of interest as a set of circumstances in which a social worker has a personal, monetary, or other professional responsibility or benefit that may influence how the social worker carries out their professional discretion and impartial judgment within a reasonable apprehension. Conflicts of interest happen when social workers find themselves in a situation where one endeavour leads to a disregard or a clash with another endeavour (Reamer, 2003). An example is a social worker who invests in a client's business: the social worker's financial interests may clash with their ability to provide non-judgmental care if the business partnership becomes strained because of a disagreement about the business (Reamer, 2003). Alternatively, if a social worker provides a counselling service to a colleague, the social worker's personal interests may clash with their professional obligations. Some conflicts of interest issues are exploitive in nature and when they occur, may present shocking forms of ethical misconduct that should be avoided; however, many boundary concerns are more subtle, such as developing friendships with clients, accepting small gifts from clients,

participating in social activities with clients, serving on community boards with clients, and crossing paths at community functions (Brocious et al., 2013; Gillespie & Redivo, 2012; Green, 2003; Piche et al., 2015; Reamer, 2003; Schmidt, 2000).

These more subtle conflicts of interest are not always avoidable and will depend on the community setting. Taking proper precautions, however, can enable the social worker to navigate conflicts ethically (Brocious et al., 2013; Gillespie & Redivo, 2012; Green, 2003; Piche et al., 2015; Reamer, 2003). The literature on rural, remote, and northern social work practice suggests that providing services in such communities is often accompanied by the potential blurring of professional boundaries that can result in conflicts of interest (Brocious et al., 2013; Gillespie & Redivo, 2012; Green, 2003; Piche et al., 2015; Reamer, 2003; Schmidt, 2000). Being an active member of a community can engender additional conflicts of interests that result from dual and, or multiple relationships (Green, 2003). Such conflicts can be viewed as a unique aspect of providing social work services in a smaller community setting such as Prince George.

Dual and Multiple Relationships

A dual relationship is said to occur when a social worker enters into a second role with a client, such as social worker and friend, colleague, employer, teacher, business associate, or family member or where the social worker receives a service from the client regardless of whether the personal or business relationship occurs prior to, during, or after professional relationship ends (BCCSW, 2009; Brocious et al., 2013; Gillespie & Redivo, 2012; Green, 2003; Kagle & Giebelhausen, 1994; Piche et al., 2015; Pugh, 2007; Reamer, 2003). In rural, remote, or northern settings, dual and multiple relationships can also occur due to greater social visibility of both the social worker and the client (Brocious et al., 2013; Gillespie & Redivo, 2012; Green, 2003; Kagle & Giebelhausen, 1994; Piche et al., 2015; Pugh, 2007; Reamer, 2003). There is an

increased possibility of contact outside the professional setting as people go about their ordinary lives shopping, taking kids to school or activities, participating in social events, and using local facilities. Additionally, there is a greater likelihood that people will already know each other before entering a professional relationship (Brocious et al., 2013; Green, 2003; Pugh, 2007).

Dual and, or multiple relationships that are highlighted by the greater social visibility of people in smaller communities can lead to a lack of anonymity for the social worker and their family as well as the client; heightened visibility can create confidentiality issues (Brocious et al., 2013; Gillespie & Redivo, 2012; Green, 2003; Kagle & Giebelhausen, 1994; Piche et al., 2015; Pugh, 2007; Reamer, 2003; Schmidt, 2000). The probability of a social worker being approached in a community by clients while he or she is out with family is greater than in larger community settings, which makes it more difficult for the social worker to maintain privacy in their own life (Green, 2003). When a client approaches a social worker or a social worker approaches a client outside the professional setting, it increases the likelihood that the client's confidentiality will be violated (Green, 2003; Piche et al., 2015; Pugh, 2007). Dual and multiple relationships are said to be often unavoidable in smaller communities (Brocious et al., 2013; Gillespie & Redivo, 2012; Green, 2003; Kagle & Giebelhausen, 1994; Piche et al., 2015; Pugh, 2007; Reamer, 2003; Schmidt, 2000). The awareness of the greater likelihood that such conflicts could arise prepared me to manage these relationships if they were presented during my practicum at CAST. Examples of how to manage potential ethical considerations are discussed below.

Likely Ethical Considerations during my Practicum with CAST

As mentioned above, Prince George is not as rural, remote, or far north as other communities in British Columbia. Having been born and raised in Prince George, however, the

community can, from my perspective, sometimes seem relatively small. My family and I have always been active members of the community and have participated in many activities that utilize the local facilities here; hence, I have met a lot of people in Prince George in my 42 years. Additionally, being a parent of two active kids, I have also met the parents and family members of my children's friends. There was a strong probability that I might have had a friendship or been acquainted with someone who may have accessed services or been referred to services at CAST during my practicum. Furthermore, I have a large extended family on my paternal and maternal sides; they also call Prince George home, and I could have had a family member referred for services or currently accessing services at CAST.

Another ethical issue that might have come up was me crossing paths in the community with clients to whom I provided a service to at CAST. That may have included my family members and clients going about their everyday lives while grocery shopping, attending the same social events, participating in the same activities, and, or cheering our children on together at sporting events. Not only can there be a lack of anonymity for clients in Prince George, but there can also be a lack of anonymity for clients in Northern Health. Having worked in many different areas in Northern Health and currently holding a permanent position there, I have provided services to many individuals during my 15 years as an employee. Similarly, I have referred many individuals to CAST for services. There was a possibility that any one of these individuals could be referred to or accessing services at CAST while I was doing my practicum. I needed to be mindful of the personal information I hold about an individual that I obtained in a different role while with Northern Health or at a different time in the individual's life. Legitimizing the reality of dual and multiple relationships helped me to be open to different ways of managing these complex ethical issues during my practicum at CAST.

Managing Dual and Multiple Relationships during my Practicum with CAST

The BCCSW (2009) recommends avoiding dual and multiple relationships. In smaller communities, however, these relationships are not always avoidable and can be managed effectively to provide ethical care (Brocious et al., 2013; Pugh, 2007; Reamer, 2003). The literature on managing dual and multiple relationships suggests a pragmatic approach based on social workers' deep understanding of the ethical implications of dual and multiple relationships, and, armed with this awareness, making moral decisions while keeping the best interest of the client in mind (Brocious et al., 2013; Gray & Gibbons, 2007; Pugh, 2007; Reamer, 2003). While acknowledging this reality, there does not seem to be a "one size fits all" approach to managing unavoidable dual and multiple relationships in rural, remote, northern, or smaller practice settings. The use of supervision, critical thinking, reflexivity, transparency, and knowledge about organizational policies and ethical standards will inform the decision-making process used by social workers to protect clients and colleagues when faced with dual and multiple relationships (Brocious et al., 2013; Reamer, 2003).

During my practicum at CAST, I anticipated the potential for dual and multiple relationships to exist. To manage these ethical issues in a safe way, I reviewed the confidentiality, conflict of interest, and dual relationship policies that Northern Health has in place. I developed a plan to manage ethical considerations prior to starting my practicum. However, I knew that before implementing my plan, I would first seek consultation from my supervisor and colleagues if such issues arose. Below are some of the ways in which I planned to manage dual and multiple relationships if I was presented with them during my practicum.

If avoidance of dual and multiple relationships were not possible, some ways in which I would have navigated this would be by asking if another practitioner would work with the

individual or family member instead of myself, I would protect the individual's right to privacy by not having access to any of the individual's personal information in the electronic file, or if their name came up in a team based meeting, I would excuse myself from that portion of the meeting. If I crossed paths with the individual in the CAST office, I would be transparent about my role with CAST and that I adhered strictly to the confidentiality policy set forth by both Northern Health and the BCCSW Code of Ethics and Standards of Practice.

In circumstances where I might have come across a client in the community, and if we happened to make eye contact, I would have simply smiled politely, as I would if I were to make eye contact with a stranger. Another way I planned to manage boundaries with clients I might have seen in the community would be to explain during our first appointment that Prince George can seem small at times and that there maybe a chance we might see each other outside of our scheduled meetings. I would clarify that if we did see each other, I, to protect their privacy and confidentiality, would not bring attention to the fact we know each other and would act as though we had not met before. If clients would have chosen to approach me, I would have tactfully explained in our first appointment that our scheduled sessions are the best place to share sensitive information and to discuss progress. Being prepared to skillfully manage dual and multiple relationships enhanced my ethical integrity while I took part in the practicum at CAST.

Chapter Four: Learning Experiences and Reflections from the Practicum Placement

As mentioned in my introduction, I completed a 450-hour practicum placement at CAST as a requirement of the Master of Social Work degree. Before starting this practicum, I had set specific Learning Goals that pertained to my development as a clinical social worker (see Appendix A). My learning experiences are best organized into three sections, (1) head learning; (2) heart learning; and (3) a combination of head and heart learning. This chapter summarizes my experiences and shares my learning reflections as they pertain to my Learning Goals.

Head Learning

This section will discuss the Head Learning I participated in during my practicum experience. When using the term Head Learning, I am referring to certified training courses that I completed, independent learning of therapeutic modalities that I was interested in, as well as any resources that I used to help build theoretical and practical knowledge during my practicum experience. The aim of this section is to provide a brief synopsis of the Head Learning content and to discuss important reflections.

Cognitive Behavioural Therapy

My knowledge of CBT dates to 2014 when I first took a two-day, basic CBT training course offered by my employer, Northern Health. Since that initial two-day course, I have independently continued to learn more about CBT through synchronous virtual platforms, resource manuals, and literature articles. During my practicum at CAST, I was presented with an opportunity to observe an in-person, 12-week CBT group, Changeways Core, for depression and anxiety. This group is deeply rooted in CBT theory. It provides participants with concrete coping skills and strategies for managing symptoms of depression and anxiety and teaches participants how to apply these ideas to their own life.

Not only was the information provided in this group a good refresher on CBT but it also offered me different ways to present and use the concepts in sessions. I really find my learning is enhanced when I can observe, in real time, with real people, the talking, teaching, explaining, and applying of the theory to people's real-life situations. Being able to observe how the facilitators wove the CBT theory into the group sessions in an interactive, conversational way and presented appropriate interventions based on participants' real-life situations really provided me with a different perspective on how to use CBT in sessions. This different perspective is one where I strive to be more flexible and less rigid in how I incorporate the CBT modality.

Dialectical Behaviour Therapy

I took part in a virtual synchronous DBT course with live instruction and interaction. The course was delivered by the University of Northern British Columbia Continuing Studies and instructed by Sheri Van Dijk, MSW, RSW. Through 14 hours of lecture and experiential activities, I learned about the four modules of DBT (Mindfulness, Distress Tolerance, Emotion Regulation, and Interpersonal Effectiveness) and how to teach these skills to service users.

This course provided me with basic knowledge on DBT theory and on how to introduce and apply DBT specific skills into my sessions to help service users move towards change. As part of the course, printable worksheets and information sheets were also available which I found very helpful to provide to service users when teaching the skills. The CAST counsellors participated in an intensive DBT training course taught by Marsha Linehan and my practicum supervisor was able to supplement my virtual DBT learning with her training. She was also able to guide my application of the skills in my one-on-one client sessions.

Taking part in this live virtual DBT course that provided psychoeducation, case scenarios, discussions, and practical application of skills was integral in increasing my overall

understanding of DBT. Having Sheri explain the skills in different ways and how they can be used in different situations as well as having us practice the skills with partners benefited my "hands on" learning style. My prior knowledge of DBT came from self directed reading of literature articles and manuals and I found I was struggling with how to transfer the knowledge to real life sessions with service users. Practicing the skills with partners during the DBT course and being observed by Sheri bridged the gap between theory and applying the skills in session for me. Also, having my practicum supervisor show me how she teaches the skills and integrates them into her practice was extremely helpful to my overall learning and inclusion of DBT in some of my one-on-one sessions during my practicum at CAST.

Trauma Competency for the 21st Century: The Empowerment & Resilience Structure

To enhance my understanding of trauma and to learn interventions and protocols to implement in my practicum when working with survivors of trauma, I enrolled in this Trauma Competency for the 21st Century course. This course was taught by Dr. J. Eric Gentry and delivered asynchronously and virtually through the Trauma Institute International. The Trauma Institute International provides training opportunities for professionals aiming to further develop skills and knowledge in many different areas. This course provided principles and techniques for safely working with service users living with traumatic stress. Dr. Gentry offers a historical overview of trauma, current conceptualizations of trauma, an approach that is relational to each service user's learned experiences, and practical skills that can be implemented in practice.

What I appreciated most about this course was the initial focus on the clinician mastering skills of introception and acute relaxation before teaching the skills to service users. Dr. Gentry proposes that being able to monitor and self-regulate one's own autonomic nervous system are primary counselling skills that are needed to remain intentional instead of reactional when sitting

with a service user. I have come to realize the importance of being able to monitor and regulate my own autonomic nervous system while in sessions as it ameliorates my anxiety symptoms. When my body feels more comfortable, I can be more present. Overall, this course increased my knowledge and practical skills about trauma and trauma interventions and, more importantly, it provided me with the opportunity to develop my introception and relaxation skills.

Survivor Therapy

While participating in my practicum, a service user that I was working with shared that her intimate partner was psychologically abusive. In my pursuit to support this client, I took the initiative to learn an approach that was specific to women experiencing domestic violence. I chose Dr. Lenore Walker's Survivor Theory because it integrates principles from feminist theory and trauma theory. It directly addresses the woman's physiological trauma response and integrates the impact of traditional socialization of women and men. An essential tenet of survivor therapy is for the therapist to be sure not to blame the woman for the abuse. The goals of this approach are to help women become safe (environmentally, psychologically, and viscerally) and to establish a sense of personal power, despite whether they choose to stay in the relationship.

The survivor therapy approach complimented my prior experiences of supporting women who have survived domestic abuse during the time I was volunteering with Royal Canadian Mounted Police (RCMP) Victim Services. The added component of trauma theory and techniques in survivor therapy helps women reclaim control and choice in their lives. I think being able to regulate one's autonomic response in the face of real danger is empowering, especially for women that choose to stay in the abusive relationship. Being able to regulate one's autonomic response makes accessing the executive functioning of the neocortex possible during

a dangerous event and this can help a survivor make faster and smarter decisions about their immediate need for safety. This is an approach that I would like to explore further and have more supervision around in the future.

Narrative Therapy

Narrative therapy is not a modality that I previously used. My practicum supervisor provided me with lots of resources on different modalities to peruse during my time at CAST and narrative therapy piqued my interest. I have since purchased resources on narrative therapy to build my theoretical and practical knowledge of the modality. What I appreciate most about narrative therapy is that the focus is on the problem being the problem and not pathologizing or problematizing the person. I have noticed that service users are often labeled by or blamed for their problems, diagnosis, or alleged deficits. The belief is that it is the responsibility of the service user to change their basic nature to fix their problematic self. Narrative therapy's process separates the person from the problem and uses both a solution-focused and strength-based approach that empowers the service user to re-author their life stories.

During my practicum, I was enrolled in the Clinical Social Work Practice course that is offered as an elective in the MSW program. In this class I had the opportunity to practice some narrative therapy skills in a mock 40-minute session with a fake client. This mock session was video recorded and observed by the instructor. In reflecting on my experience using some of the narrative therapy skills, I found it difficult to come up with exploratory and reflective questions to develop both the story and a deeper understanding of the problem. This made me feel inadequate. This inadequacy came out as a cynical response made by me when the fake client was questioning the abstract concepts of the approach, and this was brought to my attention by my instructor. I recognize now that my feeling of inadequacy was overriding my ability to

consider the fake client's experience with the abstract concept of narrative therapy and answer their question in an empathetic way. I still find myself struggling at times with applying narrative therapy to my practice. However, I am working on being able to recognize when feelings of inadequacy are creeping in and learning to engage in self-compassion when learning and practicing new intervention skills.

Respectful Relationships: Culturally Safe Indigenous Health Care

The Respectful Relationships' curriculum was co-developed by the National Collaborating Centre for Indigenous Health (NCCIH) and Northern Health. Registration for this course was offered through UNBC Continuing Studies. This course was delivered asynchronously via a virtual world wide web platform. The two fundamental principles of this course are, first, we learn throughout our lives, and second, we can deliver culturally safer healthcare even though we live and work in colonial systems and institutions. The four modules explore Cultural Safety, provide context about the role of past and present events for Indigenous Peoples, enhance critical self-reflection of self in colonial systems, and extend an understanding of how to apply Cultural Safety to practice, respectively.

This course not only supplemented my prior knowledge base on the historical events and structures that have severely shaped Indigenous and non-Indigenous relationships, but it also challenged me to reflect on my own experiences as a Métis and French woman. I recognize that walking in both worlds, Métis and French, affords me an advantage professionally. Having experienced individual and collective racism in my life, I understand the importance of creating change in my personal practice and within the colonialized healthcare system.

My action plan for creating change based on my personal reflections from the Respectful Relationships' course starts with listening to the voices and experiences of the people who live

with racism everyday and to truly try to understand their experiences outside of my own. I will also continue to educate myself on racism, discrimination, and privilege by reading articles, books, and watching documentaries and films. Continued education will not only enhance my understanding of how false assumptions and beliefs underpin racism and discrimination, but it will also hold me accountable to explore, understand, and confront my own privilege. Another action I can take for creating change is confronting everyday racism and discrimination. This action will be a challenge for me as engaging in confrontation is outside of my comfort level. I am determined to challenge myself to bring awareness to family, friends, or colleagues when I notice racist and discriminatory jokes, stereotypes, or insensitive comments.

Psychotherapy.net Videos: Great Therapists Never Stop Learning

Psychotherapy.net is a World Wide Web based counselling resource that offers training videos featuring master therapists conducting psychotherapy as well as interviews and articles with leading therapists discussing their work. It was created by Victor Yalom in 1995 with the premise of providing new and experienced therapists with a way to learn from other therapists and to stay current on new research in the field. Psychotherapy.net offers more than 350 training videos that are organized by approach, therapeutic issue, expert, or population. The training videos provide a direct observation learning experience that demonstrates what the therapists say, how they say it, the intonation in their voice, the body language of the therapist and client, their facial expressions, and therapeutic relationship or lack thereof.

During my practicum at CAST, I came to realize that clinical social work is often performed in isolation. Although my practicum supervisor and colleagues were physically in the same building as me and I knew I could have sought them out when I needed too, the opportunity to watch others perform counselling sessions or have my sessions watched did not

seem to be a common or on-going part of the clinical social work process. I have thought to myself on numerous occasions, “how am I supposed to know how to do counselling if I have never watched someone do it?” The training videos that Psychotherapy.net offer provided me with exactly what I needed. The essence of therapy was portrayed, and I was able to apply what I visually learned to my one-on-one sessions at CAST. The experience of watching other counsellors conduct therapy sessions has become an integral part of my head learning reflections, which I will expand on more below in my head learning reflections.

Head Learning Reflections

When I reflect on the head learning I engaged in during my practicum, there are three specific aspects that really stood out for me. Two of which can be related back to my theoretical orientation of practicing from a decolonized lens. Throughout my head learning experience, I kept my decolonized lens in the forefront of my mind and thought about how I might Indigenize the Western modalities I focused on. I did not have an opportunity to work with any Indigenous service users during my practicum at CAST; therefore, Indigenizing Western modalities was not something I was able to try. However, I was able to find aspects from some of the Western modalities that did complement my decolonized lens. These aspects include a non-pathologizing framework and the importance of including interactive and relational context to the therapeutic process, both of which I reflect on below. I also reflect on how directly observing therapists through videos and in-person filled a much-needed gap between learning and training for me.

Non-pathologizing Approaches

My understanding of pathologizing, in the therapeutic perspective, is to believe psychological distress is abnormal. These abnormal responses to situations imply the service user is the problem. However, non-pathologizing is to believe the situation as abnormal and not the

service user's response. Understanding one's reaction as a normal response to an abnormal situation can be cathartic. The person is no longer the problem, the problem is the problem.

Three approaches that did not involve pathologizing the service user stood out for me during my head learning. These were Dr. Gentry's Trauma Theory, Dr. Walker's Survivor Theory, and narrative therapy. Each of these approaches separated the problem from the person by externalizing the problem. In narrative therapy, the problem is given a name and talked about as its own entity. In both trauma theory and survivor theory, the problem is a dysregulated autonomic nervous system. I think frameworks that externalize the problem are a much-needed alternative to the focus on pathology, personal deficits, and dysfunction. This alternative view of the problem lines up well with my decolonized lens.

My hope in using a non-pathologizing framework with Indigenous service users in the future is to be able to frame a discussion that validates the historical issues that have had a significant intergenerational impact on Indigenous peoples. I think that putting the historical harms into perspective instead of focusing on the reactions to these harms encourages Indigenous people to recognize their present situation are due to colonization. I think this could lead to a shift in one's perspective of feeling stuck and experiencing shame in that they are the problem to seeing the problem as the problem and acting. Applying a non-pathologizing framework to my practice could be one way in which I honour my decolonizing lens, keeping in mind that as I grow as a clinical social worker, different ways to honour my decolonizing lens may be presented to me.

Interactive and Relational Context

Another aspect of my head learning experience that stood out for me was the importance of providing interactive and relational context with psychoeducation and before introducing an actionable coping skill. The reason this stood out for me is that I had noticed when checking a

service user's understanding of a concept I had explained or whether a skill I taught was helpful, the service user's body language and lack of eye contact suggested that I was not producing the understanding I was hoping for. I know for my own learning style that I really need to understand the "why" behind concepts and skills. I like to know how they work and what I may notice because of using them. When concepts and skills are presented in a way that are interactive and relational, I tend to practice them more because it makes sense to me on a personal level.

In the course, Trauma Competency for the 21st Century, Dr. Gentry validated what I had noticed when presenting psychoeducation and/or teaching a coping skill to a service user. His segue into teaching about the autonomic nervous system started with an interactive and relational activity that elicited personal opinions about stress. Once he gathered this information, he continued to ask personal views about safety and used personal examples to differentiate between real danger and perceived danger. With the personal beliefs he had gathered about stress and safety, he was able to start dismantling old belief structures by introducing how the autonomic nervous system operates.

The way Dr. Gentry mapped out the function of the autonomic nervous system by starting with terms that most individuals are aware of and can identify with on a personal level, such as "stress" and "safety", was a lightbulb moment for me. Using relatable terms not only enhanced my own understanding of how the autonomic nervous system functions, but it also made me want to try to bring more interactive and relational context to my sessions. My hope is that if I can elicit a personal "why" for service users when introducing psychoeducation and coping skills, that it might create a deeper understanding of themselves and increase their tendency to practice an actionable coping skill.

In reflecting on the importance of being more interactive and using relational context, I can also see how these strategies might be able to reduce power imbalances between the service user and myself. My current way of "telling" the service user about how the autonomic nervous system functions and introducing coping skills without the "why", really speaks towards me being the "expert" and the service user being the "listener". I think a more interactive approach encourages more collaboration between the service user and me; it invites the service user to be an active participant in the counselling process. Exploring more relatable context privileges the service user's own experiences and knowledge. Both collaboration and privileging personal experiences and knowledge are directly related to my goal of exploring how to practice from a decolonized lens. I think being collaborative and exploring relatable context creates an atmosphere that may allow for the incorporation of both Indigenous and non-Indigenous worldviews into my practice.

Direct Observation and In-person Learning

As mentioned above, watching Psychotherapy.net videos and participating in in-person learning groups became an integral part of my learning experience. I have always known that I learn best by watching and felt that my learning style was not well supported in a lecture type environment. I struggled with visualizing how to apply what I was learning in lectures and books to the real-life counselling I was expected to do in my practicum. The direct observation of watching master therapists portray both the art and skill of counselling filled this gap for me.

Another aspect of watching the videos and participating in the in-person groups that I found beneficial was the narrated sessions. In the videos, the sessions would be paused, and the therapist provided explanations on intentionality of questions asked, they would talk about therapist and client body language, the use of humour, self-disclosure, and/or reflect on thoughts

and feelings that were coming up for them while in the session. In the in-person groups, especially the DBT course with Sheri Van Dijk, she would also explain intentionality of questions and give examples of how she uses humour and self-disclosure in her session. This was invaluable to me as a new clinical social worker. It provided me with a deeper understanding of the essence of therapy; it was the alternative to lectures and book learning that I needed to help me grow professionally.

Watching Psychotheapy.net videos was and will continue to be a way that I learn about approaches and keep current on new research pertaining to the counselling world. It gave me the courage to venture into domestic violence counselling and the confidence to apply what I watched to sessions with a service user at CAST during my practicum. Knowing that there is a platform that supports my learning style and benefits my overall development of a clinical social worker is reassuring.

Heart Learning

The Heart Learning this section is referring to is the development of me moving out of my head, the content, and into my heart, the process. Throughout the eight months of my practicum, I had the opportunity to work directly with service users in one-on-one sessions and was an observer in two different group therapy series. I also had the privilege of having my sessions directly observed by my practicum supervisor and I was provided with constructive feedback on these sessions. My practicum supervisor and I met weekly to discuss my reflections on knowledge learned, skills used, judgments, professional development, personal insights, and to set weekly goals. Another integral component of my learning experience was meeting with my MSW consultant throughout my practicum. Through my experience with direct observation and clinical supervision I was challenged to attend to my own reactions in sessions, thus learning to

pay attention to what my heart was saying. This section focuses on my experiences sitting with service users in one-on-one sessions and observing group therapy sessions and provides my Learning Reflections that directly relate to my goal of developing clinical social work skills.

One-on-one Sessions

I was entrusted to provide counselling to five service users during my practicum at CAST. This entailed being responsible for intakes, assessments, treatment planning, interventions, and termination of services. My caseload consisted of four females and one male all living with a variety of challenges related to their mental health. I provided an in-person service to all but one service user. The one service user was provided a service via the virtual flatform Zoom to navigate their barrier of not having transportation to attend in-person. The service user's strengths, availability of resources and supports, barriers, and individual life experiences directed me to use an array of therapeutic modalities to best support their individual goals. For each of the five service users I worked with, I was also responsible for keeping concise records that utilized critical information that I recorded in their personal Electronic Medical Record that became part of their permanent health file.

Providing a one-on-one service is a process that I am extremely familiar with. I am very comfortable sitting with people in a supportive role. Before starting my practicum, I thought that learning about different modalities and interventions would help me grow into a competent counsellor. To be honest, it felt very overwhelming trying to absorb all the skills I wanted to know and, additionally, using them in sessions felt forced and uncomfortable. I put a lot of pressure on myself to use these new skills flawlessly and, at the same time, I was fighting with my fear of making mistakes. I started feeling anxious before sitting with service users. I was so focused on using the skills that I was barely present in some of my sessions. I was thinking about

the next question to ask and/or about the skill I should teach before the service user was even done talking. I was not really hearing or understanding what the service user was sharing with me.

I came to realize that I was losing sight of the importance of establishing rapport, safety, and trust with the service user. I was forgetting to bring "Natalie", my authentic self, to the sessions. I could feel the lack of connection with the service users. It felt like a one-sided relationship, one where I held the power, because instead of actively listening, understanding, and holding space, I was too caught up in my head thinking about what I would say next. I was over focused on me and my own agenda of needing to be the expert on integrating the interventions into the session, further oppressing the human sitting across from me.

With the help of my practicum supervisor, I was challenged to move out of my head by attending to my own reactions in sessions. I struggled immensely with the self-reflection process because it forced me to shed light on my own insecurities and vulnerabilities. However, the process also helped me understand how my reactions shape my therapeutic relationships. I recognize that when I am aware of my own thoughts and feelings towards a service user or towards the content they are sharing, the better I can work *with* them. Being able to shift old ways of interacting when they are no longer working is an important piece of establishing rapport, safety, and trust. Below in my Learning Reflections section, I will further discuss the concepts that became a major focal point of my Heart Learning based on my experience with one-on-one sessions.

Group Therapy Sessions

An unexpected but pleasant addition to my experience at CAST, was being an observer of two separate group series. I sat in on a 12-week *Depression and Anxiety Group*, as mentioned

above, and a 12-week *Panic and Anxiety Group*. Each group series met in-person for two hours per week for 12 weeks. The groups focused on psychoeducation and building coping skills. My role as an observer was to familiarize myself with the group process, to learn how different counsellors present psychoeducation, and to learn how to teach coping skills to manage symptoms of depression and anxiety.

In reflection of my experience, I am now more aware of how different counsellors have their own unique style of creating group safety, teaching group material and skills, paraphrasing, self-disclosing, questioning, challenging, addressing group concerns, and re-directing participants back to the goals of the group. I was under my own impression that there was a "right way" to facilitate groups. Now I understand that there are many "different ways" as each counsellor is different and brings their own experiences, knowledge, and perspectives to the group process. I specifically noticed that when facilitators spoke about their personal experiences with depression and/or anxiety, that this seemed to create an element of relatability for participants, and they were more likely to share their own experiences and openly contribute to the group discussions. I think sharing our humanness establishes deeper connection, belonging, and safety. All of which, I have learned, are important to the group process.

Sitting in on both groups was also a way for me to become aware of what I was experiencing in the group. At the start of each group, for the first few sessions, I merely filled a seat as I sat very quietly and observed without contributing. I felt anxious, uncomfortable, and intimidated. These feelings were stemming from a fear of being judged negatively by the co-facilitators and the participants. As mentioned above, I thought there was a "right way" to facilitate and contribute to the groups, and this thought influenced a worry that I would contribute the "wrong way". Choosing to not verbally contribute during the groups protected me

from doing it the “wrong way” and receiving negative feedback. However, it also prevented me from gaining valuable group facilitation skills. I needed to face my fears of doing it the “wrong way” and use the feedback as an opportunity for growth.

My practicum supervisor and the co-facilitator of one of the group series, along with myself, made a goal for me to run a check-in at the beginning of a group session. I was challenged by the co-facilitators and myself to speak up more often in each group. This started out as small validation statements towards other participant’s experiences and moved up to me sharing personal experiences to provide examples that supplemented some of the psychoeducational information that was presented and to eventually running a group check-in. The feedback I received, which included be yourself, smile and laugh like you normally would, don’t over think it, and speak from the heart, was very constructive and supportive. I will carry this feedback with me as a reminder of how important it is to choose to be your authentic self. I am not completely convinced that group facilitation or group co-facilitation is something that I want to pursue in the future. However, I am more aware of the personal work I need to do around changing my narrative from one where I fear negative judgment to one where I see uncomfortable and intimidating experiences as opportunities for personal development.

Direct Observation/Feedback

As part of my learning opportunities, I was able to have several of my sessions directly observed by my supervisor and I was able to directly observe my supervisor in one of her sessions. Direct observation allowed my supervisor to watch how I integrated different therapeutic techniques and skills, how I nurtured or did not nurture the therapeutic relationship, how I did or did not bring my authentic self to the session, and how I was able or not able to stay present during the session. After each observed session, my supervisor and I would meet to

discuss our reflections on the session. It was through this process of observation and feedback that helped me become more aware of my blind spots; where I struggled, got stuck, or seemed uncomfortable. The feedback was also helpful to point out what I did well, when I appeared comfortable, or when I fully "brought" Natalie to the session.

Clinical Supervision and MSW Consultant Encounters

My practicum supervisor and I met once every week for at least an hour throughout my entire practicum. We both built this time into our schedules at the start of my practicum to be sure we had the time to discuss my caseload, any challenges I had with applying knowledge and skills to my sessions, to set weekly goals, and to focus on reflective practice. Every week I filled out a Clinical Supervision Experience Form that explored highlights and reflections on my knowledge, skills, judgments, professional development, personal insights, and looked at strategies and next steps for the following week. Filling out these forms kept me accountable and responsible for my own learning throughout my practicum. These forms were reviewed by my practicum supervisor and were discussed more in-depth as needed.

Clinical supervision was not something I had ever participated in prior to starting my practicum. I was unsure how to use my time effectively and appropriately with my supervisor and this led us to develop a contract based on both our expectations and goals for the work we wanted to do together. A major common goal for both of us involved reflective practice. My supervisor committed to guiding me through the art of being self-reflective during my sessions and did so in a deft and gentle manner and I committed to learning how to be self-reflective in my sessions. Which turned out to be challenging and humbling. At first, I struggled with identifying specific emotional reactions and I was not willing to voice my thoughts. Having goal-focused supervision meetings with a skilled clinical supervisor provided me with the space to

explore and fumble through the process of self-reflection. Self-reflective practice is a work-in-progress for me. I recognize that it is a skill that needs to be nurtured with continual patience, practice, and good supervision.

During my practicum at CAST, I was also fortunate to have access to my MSW consultant. We met on an as-needed basis and her office door was always open for me to pop in with any questions or comments I had. Many of our conversations revolved around self-care and she provided me with valuable insight and resources on the importance of taking care of myself during my practicum. The changes I made to my self-care plan reflect her insights. It also made me think more critically about self-care overall, which I will discuss further in my Recommendations/Implications section.

Another component of the work my MSW consultant and I did together was navigating ethical considerations. At the beginning of my practicum, I encountered a conflict of interest. I brought this forward to my MSW consultant and together with the CAST team, we mapped out the best course of action to manage this ethical consideration. Below in my Head and Heart Learning section, I will speak more in-depth about this ethical consideration and the course of action that was taken to protect the service user and myself. My MSW consultant was an integral part of my learning journey as she provided a social work lens that helped me navigate situations that pertained to self-care and ethical considerations.

Heart Learning Reflections

As mentioned above, the process of moving out of my head and into my heart was a challenging and humbling experience. I have come to realize that the ability to establish rapport, safety, and trust do not come from the interventions and techniques I have read about, but from the manner with which I use them. Through direct observation of my sessions and clinical

supervision from my practicum supervisor, I was guided through the practice of self-reflection. The ability to self-reflect or to witness myself made it possible for me to become more aware of my intentionality in sessions, any countertransference taking place, and how to contextualize client safety. I was continuously challenged to be curious about my own triggers and reactions in sessions so that I could be fully present when sitting with service users. Intentionality, countertransference, and client safety came up numerous times during my clinical supervision sessions and/or from the feedback I was given after being directly observed and became the main take-aways of my Heart Learning experience.

Intentionality

Over the duration of my practicum, I had many conversations with my practicum supervisor about intentionality, including what it is and how to use it. My understanding of intentionality was knowing the difference between a question that benefits the service user instead of feeding my own ego or between a self-disclosure that serves the service user instead of myself. Being curious of my own agenda or purpose can help the process stay focused on the service user's best interests and keeps integrity in the therapeutic relationship.

In one of many conversations with my practicum supervisor, I was questioning the effectiveness of my clinical skills. In this conversation we were discussing ways in which I might explore the effectiveness of the work I was doing. I brought up asking the service users directly about how they felt the process was going. I recall thinking that this would be a great way to check in and get feedback on the service user's overall experience. My practicum supervisor agreed that periodically checking in throughout the counselling journey can be a beneficial way to explore the service user's experience of the therapeutic relationship, if we were on track of meeting set goals, and if the service user thought the interventions were a good fit. My practicum

supervisor then went on to challenge the purpose of my question to the service users given the context of me not thinking my clinical counselling skills were good enough. My answer made me laugh with embarrassment. My sole purpose of checking in with the service users, at that moment, was to be reassured that my clinical skills were effective: my ego needed stroking. This conversation about where my questions are coming from and who they serve has solidified my understanding of intentionality. Even appropriate questions can have a hidden agenda.

Another aspect of intentionality that my supervisor and I discussed at lengths was the use of self-disclosures in sessions. Self-disclosures, from my point of view, are the personal information about us that we share with a service user. My practicum supervisor practices from a psychodynamic lens and shared that during her sessions she remains neutral and does not self-disclose often. However, after observing four other CAST counsellors in a group setting, I have found that the use of self-disclosures varies greatly depending on the counsellor. In my own experience with self-disclosures, I believe that sharing appropriate personal information and/or stories reduces the power imbalance between myself and the service user. Connection, rapport, and safety can be established when humanness is exhibited. Although my supervisor and I view the use of self-disclosures differently, we do agree on being intentional with the use of them. To use self-disclosures in an ethical and effective manner, I do think it is important to consider the who, what, when, why, and how before using a self-disclosure. Again, the purpose or agenda behind the self-disclosure is important to reflect on to keep the focus on the service user's best interest.

One area where I did consistently use self-disclosures is during intakes. I purposefully tried to balance the power by telling the service user a bit about myself. I considered this my "introduction" and shared my name (again), that I was a practicum student, what my role as a

student was, that I also worked for Northern Health in a different capacity, my previous and current experience working in a supportive one-on-one role, what motivated me to work in this area, and provided an opportunity for service users to ask any questions they had about me or the work we would embark on together. I found that when I chatted briefly about myself before jumping into the intake questions, the service users seemed more at ease, their body's relaxed more in their chair, and their affects brightened. Based on my own experience of purposefully using self-disclosures, I honestly believe that modelling openness, and sharing of appropriate feelings, thoughts, and/or stories invites service users to do the same; thus, cultivating safety, connection, and rapport.

Countertransference

In one of the very first emails between my practicum supervisor and myself, a month before even starting my practicum, my supervisor had asked me to start thinking about what kind of clients may I struggle with and why? What clients may I dislike? And what clients may I be more drawn to? She went on to explain that being curious about the answer to these types of questions would be helpful as I begin my work into deeper therapy with clients. She signed off on the email stating, "Countertransference is such as powerful concept". Being the thorough person I am, I looked up countertransference right away to remind myself of what it meant. I was not unfamiliar with the meaning of the concept but I was unfamiliar with how often it happens and how powerful the concept really is.

My understanding of countertransference was that it was the reactions we have towards the service users we work with (mostly related to the counsellor's unresolved personal problems) and that it was a toxic trait of counselling that needed to be avoided. However, my supervisor presented countertransference in a very different way. To her, countertransference was

something to be aware of, something to be curious about, and something that could be used as a therapeutic tool. I have learned that even feelings about myself, when they arise in response to working with a specific service user, is also countertransference. I have come to realize that countertransference is very complex, it impacts the way I interact with service users, and can be used to get to know myself on a deeper level.

I have always known that I struggle when I work with service users living with depression and I had never explored why this was. I brought this up with my supervisor in response to her question about what type of clients may I struggle with and why. One of the service users I worked with was seeking services at CAST for challenges related to their diagnosis of Recurrent Depressive Disorder and I was again struggling with how to support them with reaching their goals. My supervisor encouraged me to be curious about my thoughts and feelings as they were coming up and to be nonjudgmental towards them. I was able to identify that I felt stuck, ineffective, and inadequate when their mood and situation never seemed to improve despite the interventions I was using. I found myself hoping they would not show up, feeling relieved when they did not show up, or feeling anxious when they did show up. My clinical work with this service user changed from us working together to me taking a more directive approach. I was wanting to “fix” their mood and situation by setting behavioural activation goals for them. I knew at the time and still know now that this is not client-centred, nor is it the way I wanted to practice clinical social work. I was reminded by my supervisor that this is countertransference and to explore how this new awareness could be used to benefit the therapeutic process with this service user.

By being acutely aware and curious of my want and need to see improvements for service users, I can work on refocusing my attention on meeting the service user where they are at.

Which increases the integrity of the therapeutic relationship and facilitates the use of countertransference as a therapeutic tool. I have come to realize that countertransference can tell me a lot about myself, if I am willing to listen, and it is nearly impossible to ignore or avoid. I value my supervisor's insight on allowing countertransference to be part of therapeutic process and to use it to increase self-awareness. Countertransference is such a powerful concept.

Contextualizing Client Safety

Before beginning my practicum, I knew that understanding different ways to nurture a service user's sense of safety was an important aspect of the work I wanted to do. Having read lots of literature on contextualizing client safety in sessions, I recognized that there were numerous facets of safety that needed to be considered along with the service user's unique understanding of safety as well. Through conversations with my supervisor, I was able to identify personal areas that I wanted to focus on to provide an atmosphere that was accepting, nonjudgmental, and open to the nuances of each service user's process. These areas consisted of learning to be more present, more self-aware of my thoughts, senses, intuitions, and physiological states, more able to set healthy boundaries, and to be more transparent about my own therapeutic intentions while working with service users in a one-on-one setting. I have come to realize that contextualizing client safety takes patience and practice.

During my practicum at CAST, I recall a specific interaction with a service user where I compromised their safety. In the middle of the session their presentation completely changed from relaxed, bright, and open to leaning forward, and posturing in their chair. Their volume became louder, their eye contact was intense, and their communication was aggressive and defensive. I debriefed this session with my supervisor, and she encouraged me to be curious about what was coming up for me prior to the service user's presentation change. I recalled

feeling skeptical about the content the service user was sharing and frustrated by my inability to pause the conversation to explore some of the content. I stated to my supervisor that I was disappointed that I did not think to explore in the moment what had brought on the sudden presentation change. I thought it probably had to do with the question I asked or how I asked the question. I felt that my skepticism and frustration undoubtedly spilled out into the session. My supervisor assured me that it is never too late to go back and explore something with a service user, even if it is in the next session.

That session really helped me understand the importance of practicing self-awareness and presence while in a session. My own thoughts and feelings created an atmosphere that was judgmental, closed, and dismissive, thus jeopardizing the service user's sense of safety in that moment. What I also learned from that experience is that by going back to explore that interaction with the service user in the next session, I was able to start re-building connection, rapport, and safety again. Holding myself accountable and being transparent about my part in the interaction seemed to strengthen the integrity of our therapeutic relationship.

Head and Heart Learning

This section combines both the head learning and the heart learning I engaged in during my practicum. I have come to realize that these two concepts do not stand in isolation of each other. Head and heart learning are both needed to achieve my goals of advancing my clinical skills, to gain confidence in integrating evidence-based modalities in my practice, and to develop a personal practice framework. My experience and reflections over the eight months of my practicum at CAST has taught me the importance of continued work on decolonizing my personal and professional lens, of establishing an integrative approach, and of navigating ethical

considerations as they relate to my efforts of understanding, privileging, and incorporating different perspectives into my practice.

Head and Heart Learning Reflections

Self-awareness

When thinking about using both heart learning and head learning together as part of developing myself as a clinical social worker, I have come to realize that being self-aware is at the centre. My supervisor and I worked together through out my practicum to develop my self-awareness as it related to which approaches to apply in sessions, my case load, and the therapeutic process; however, I knew that much deeper work needed to be done. At the start of my practicum, I sought out a Métis counsellor in Prince George as a way for me to increase my self-awareness of being Métis and to explore ways to decolonize my personal and professional lens. These two goals were part of my Learning Contract and I never imagined how essential this journey of self discovery would be for me personally and professionally.

As mentioned in my Positionality section, I found out I was Métis in high school, and I have always wondered what being Métis meant to me. I thought that when I found out the answer, I would become a "different" person. I cannot define what I mean by "different"; just "different". I still feel like my old self, except prouder, since learning that I have been Métis all along. I was born Métis, it is in my blood, it is who I am, and it has always been a way of life for my family. Some people call it *blood memory.* Blood memory is believed to be responsible for the transmission of firmly held cultural values and knowledge. I have come to realize that traditional teachings can be learned and experienced in different ways.

For as long as I can remember, my dad has been a hunter and fisherman. He spent his childhood and young adulthood fishing and hunting with his dad, uncles, and brothers, and he

has spent countless hours hunting and fishing with my brothers. The skills and techniques needed to process moose meat and fish have been passed down through generations. I grew up eating moose stew, salmon, and Bannock. I had no idea these were traditional Métis foods until I started learning more about Métis culture in university.

The value of family has always been implicitly taught. I have a large, extended, close-knit family. When we get together, everyone attends, and this happens often. Family is included in all aspects of our life. We share sorrow and celebrate triumphs together. My aunts and uncles have raised me just as much as my own parents have and my cousins are more like siblings. Even my parent's friends have become family and I refer to them as aunties and uncles. Their children are my cousins. I have a deep understanding that blood and chosen relationships are all important and unique. I am very much connected to my family, and we do depend upon each other for support. I am also keenly aware that each of us in the family contributes in different ways to the relationship, some positive and some negative, and this impacts all of us. I have learned that this is interconnectedness; a concept directly associated with a Métis worldview.

The work I have been doing with my counsellor has uncovered many more examples of traditional values and knowledges that have been part of my upbringing. It has never been explicitly stated that we hunt because we are Métis, that family is important because we are Métis, that we laugh a lot because we are Métis, or that the deep connection I feel to nature when I am at our cabin in the woods with no running water, electricity, or gas is because I am Métis. All these things and more are just part of what we did, what we know, and who we are. I cannot not be Métis and I cannot not bring my Métis self into my work as a clinical social worker.

I feel strongly that my goal of wanting to practice from a decolonizing framework was influenced by my own need to explore my identity as a Métis woman. My (unrealistic)

expectation was that once I felt different, more Métis, I would be able to come up with a concrete recipe to follow to decolonize my self and my practice. I do not think a concrete recipe exists. After continued exploration with my counsellor around decolonizing my personal and professional lens, and discussing other theoretical orientations, my perspective is that self-awareness of your own values, beliefs, and cultures centres all theoretical frameworks. I am never truly neutral or objective; feelings, thoughts, and experiences all influence my therapeutic relationships and the therapeutic process.

I do not think it is possible to acknowledge that there is more than one way to view and experience the world without being curious about where my own biases, judgements, and beliefs are stemming from. I think that being able to witness myself in clinical social work sessions and in my everyday life, creates a safe space that is receiving of any experience and/or worldview that differs from my own. The ability to create this safe space in my mind and in sessions with service users, through the process of self-awareness, is a way for me to decolonize my personal and professional lens.

Integrative Approach

When reflecting on my experience of using head and heart learning together to develop myself as a clinical social worker, using an integrative therapy approach emerged intuitively. I started my practicum journey with the belief that evidence-based modalities such as CBT, DBT, and Trauma Therapy were going to provide me with all the tools and skills to effectively work with the many different experiences service users wanted to work on. I still believe that each of these modalities are effective and do help service users reach their therapeutic goals. However, I noticed that during sessions with service users, I was naturally drawing on different interventions and adapting my approach to best suit their specific needs.

One of the service users at CAST that I worked with wanted to learn how to manage their symptoms of anxiety. In exploring how they experienced anxiety, we discovered a strong visceral response, avoidance behaviours, negative thoughts about self, and an early childhood memory that was linked to their anxious feeling. During our journey of working together, I introduced ways to achieve a relaxed muscle body. These interventions were borrowed from Trauma therapy and chosen specifically to help manage the visceral response. We mapped out that the negative thoughts about self were stemming from a core belief that was learned in early childhood. These negative thoughts about self also contributed to avoidance behaviour. Using strategies derived from CBT, I introduced different cognitive restructuring techniques to help challenge the negative thoughts about self. Since the service user was able to connect their core belief to a childhood experience where this belief was first encoded, I invited them to write a letter to their younger self explaining that these beliefs were untrue. This technique I borrowed from compassion-focused therapy.

This is one example of how the integration of approaches unfolded for me. My original plan with this service user was to practice from an entirely CBT framework. I knew that CBT could effectively treat anxiety. While sitting with this service user I quickly realized that the CBT framework felt too rigid given the complexity of their anxiety symptoms. I found that being able to incorporate different approaches led to a more individualized and inclusive therapeutic experience. Rather than focusing on a problem from a single perspective or in isolation, service users can explore their challenges, and I can introduce interventions that consider all aspects of their situation and experiences. Using an integrative approach suits my framework of understanding, privileging, and incorporating different perspectives into my practice.

Ethical considerations

Throughout the duration of my MSW journey, the importance of following the guidelines of the British Columbia College of Social workers' Code of Ethics and Standards of Practice has been deeply embedded in the program. I have been taught about conflicts of interest and dual/multiple relationships and how to manage these situations in an ethically safe way. As part of this practicum experience, I was asked to be vigilant of any potential ethical considerations. Thankfully, all the head learning about ethical considerations in my MSW classes helped me identify a conflict of interest. With the help of my MSW consultant and the CAST team, we were able to process this situation and agree on an outcome that was in the best interest of the service user.

This ethical consideration came up in response to a therapy group that I was going to be observing. Before the start of the group, I was provided with a participant list. There was a participant on the list that was a friend and past colleague of mine. I brought this conflict of interest up to my MSW consultant, and with some other members of the CAST team, we discussed different options on what the best course of action for the service user might be.

We considered having one of the group facilitators talk with the service user about me being a student in the group and establishing if they would be comfortable with this. We decided against this option. We all thought that even if they said they were comfortable with it, they might not be, and this might impact how they learned, participated, or interacted in the group. We also contemplated moving the service user to the next group that was going to be offered four months later. However, we decided that this was not in the best interest of this service user either because they had been on the wait list for this group for a very long time.

The option that was collectively decided upon was to pull me from observing the group and to move me to the next group that started four months later. We also decided that before the next group, I would preview the wait list again to make sure there were no other conflicts of interest. The process of navigating this conflict of interest was far more complex than I imagined it would be. The CAST team looked at the ethical consideration from many different angles. They not only considered what would be in the service users' best interest, but they also considered the importance of my learning experience. I initially thought pulling me from the group was the only way to avoid the conflict of interest. The thoughtfulness of trying to find a way for both of us to be in the same group was profound to me. That day I learned how essential supportive colleagues are when navigating ethical considerations; clinical perspectives can be very diverse, and each brought different ideas to the conversation.

Chapter Five: Implications for Personal Professional Practice

My journey at CAST as a practicum student has been humbling, challenging, and exciting. I have gained a new perspective on the qualities I require to continue practicing clinical social work in an empathetic, compassionate, and safe way. These qualities have not only changed the way I function as a student and social worker, but also as a human. In this chapter I will discuss how vulnerability and humility were implicitly taught through my learning experiences and describe how they will pertain to my continued development as a clinical social worker with Northern Health. I will also discuss how being challenged with feeling overwhelmed and exhausted contributed to a shift in my self-care practice.

Vulnerability

During my practicum, I discovered that vulnerability can positively shape the development of my personal professional practice. I was raised to believe that being vulnerable is being weak. I counter feeling vulnerable with perfectionism. My perfectionism makes it difficult for me to ask for help, admit to my mistakes, and to receive feedback. I started this practicum with the belief that I should know exactly how to be a clinical social worker and that if I did not perform perfectly, I would be judged as incompetent. All aspects of this practicum experience made me feel vulnerable. I knew I would have to talk about the times I felt stuck working with a service user, or about times my biases, beliefs, and values clashed with a service user, or about times when strong emotions came up in response to a service user or the content they brought up, and that I would be given feedback when my sessions were directly observed. All of this hung heavy over my head. Thankfully my practicum supervisor caught on right away to my feeling of vulnerability and my tendency of perfectionism.

My supervisor provided a supervision space that felt free from judgment and encouraged curiosity, which enabled me to start the process of embracing my vulnerabilities. This process is still in its infancy, and I recognize that I have much more work to do. I learned that when I embraced some of my vulnerabilities throughout my practicum, that the opportunity for growth presented itself. Having my sessions be directly observed by my supervisor, with the knowledge that feedback would be provided, made me feel incredibly vulnerable. However, by using lots of self-compassion and by reminding myself that I had never felt negatively judged by my supervisor, I had the courage to lean into the uncertainty of being directly observed. This experience taught me that displaying my imperfections does not mean I am an incompetent clinical social worker; it means I am willing to be authentic, willing to learn, and willing to improve.

The process of leaning into vulnerability continues to teach me about authenticity, compassion, and courage. All of which, I believe are essential in the therapeutic relationship and process. I recognize how being challenged to embrace my vulnerabilities has increased my comfort with asking for help, admitting to mistakes, and seeking out feedback. A big act of embracing my vulnerabilities, to facilitate growth in my role as a clinical social worker with Northern Health, will be to engage in on-going clinical supervision. Although I know I have made lengthy strides in both my belief about being vulnerable and my ability to be vulnerable, I know that my future personal professional practice requires continued development in this area with the guidance of a clinical supervisor.

Humility

Another quality that I discovered during my practicum that can change my personal professional practice, is humility. My understanding of humility is a willingness to learn and

consider other points of view joined with an understanding of my strengths, limitations, and where I can make improvements. Humility also allows me to admit when I am wrong. I think that humility has a strong association to self-awareness and building self-awareness can ensure that I am bringing humility into my relationship with service users. Engagement in my own counselling has been a beneficial way for me to build self-awareness of my strengths, limitations, and areas of improvement.

I have come to realize that many of the limitations that contribute to my life's challenges, such as boundaries, also enter my therapeutic relationships. I struggle with setting boundaries in my personal relationships. This looks like trying to be everything to everyone all the time. In my therapeutic relationships this looks like allowing a service user to continue sharing their story well after the time limit on the session has ended. The outcome of both is the same, it leaves me little time for myself, frustrated at my inability to say no, and playing catch up with all the other things I need to get done. Adhering to the time-boundary in my sessions lets the service user know that we have a specific amount of time and that it is important to honour that time. Boundaries, even time-boundaries, set clear expectations in relationships. This is one of many examples where doing my own work in counselling has helped me understand about myself. I know that continuing to connect with myself on a deeper level is an important aspect of relationships.

I am firm believer that we need to be connected to ourselves before we can develop deep connections with others. If I want to develop meaningful connections with service users in my future personal professional practice then I need to continue to develop an accurate understanding of my strengths, limitations, and where I can make improvements through on-going personal counselling. This knowledge, along with a willingness to learn and consider

different points of view will assure that I continue practicing humility in my therapeutic relationships.

Self-care

Before starting my practicum, I was encouraged to think about how I was going to take care of myself during my practicum. I added a self-care goal as part of my Learning Contract and for the most part, I followed the plan. I spent time with my husband and children, I spent time outdoors hiking and biking in the fall and spring and skiing in the winter, I cooked, read the odd book, and attended counselling sessions. However, I still felt overwhelmed and exhausted from working my regular job, participating in my practicum, taking my last MSW course, being a mom, wife, daughter, sister, aunty, and friend, and battling with perfectionism. I also experienced the death of my cousin in the middle of my practicum. I started to question if self-care works and wondered if there was another way to think about and do self-care because what I was doing did not prevent, nor did it help me manage, any of the physical and emotional symptoms I was experiencing.

In my quest to learn what other people do for their own self-care and to get validation that I was not alone in feeling overwhelmed and exhausted, I sought out my MSW consultant. Their insights into self-care changed my view on self-care and changed how I practiced self-care during the second half of my practicum. They introduced me to Emily Nagoski and Amelia Nagoski's (2020) idea of completing the biological stress cycle. The premise is that when our stress response is activated by a stressor, our bodies release stress chemicals that prepare our bodies to either fight or flight the stressor. Once we either fight or flight the stressor, our bodies complete the biological stress cycle, and the stress chemicals are released from our bodies which signals we are safe. Since most of the stressors in our lives are perceived threats, meaning that

our lives are not in imminent danger, we do not have to fight or flight the stressor. When we do not fight or flight the stressor, the stress chemicals stay in our bodies and the stress response stays activated. For many people, the stress response is chronically activated and there is a build up of stress chemicals in the body. Getting stuck in the stress response can negatively impact our health.

The Nagoski's (2020) propose that everyday we need to give our bodies the resources to complete the biological stress cycle. The best way to complete the biological stress cycle is to do anything that moves your body enough to increase your breathing for twenty to sixty minutes a day. Since learning about completing the biological stress cycle, I have been intentionally trying to incorporate some type of movement into my day. I have noticed a decreases in my anxiety, restless legs at night, and busy head at night. Even though many of my stressors remain, I feel more relaxed in my muscles and better able to manage them. The idea of dealing with the stress response has made a significant difference to my self-care approach.

My experience with feeling overwhelmed and exhausted during my practicum also made me wonder if social workers were being asked the wrong question about self-care. At the beginning of my practicum I was asked, "how are you going to take care of yourself during your practicum?" I find this question places the sole responsibility of self-care on the individual and I do not think the expectation should be that the individual must look after themselves. I think we should be presenting self-care in a more collective way. We could ask, "how can we take care of each other?" I do not think humans are created to get through hard experiences alone, I think we are created to work together, and I think that establishing connection in workplaces is one way we can work together to take care of each other.

The way I view connection, is the sense one gets in a relationship when they feel they are understood and appreciated. I think we need to be brainstorming ways we can create and maintain connection within the social work profession and in workplaces. Team bonding is one example that comes to mind. I have worked in health care for 15 years and I have only experienced one Team Lead that made team bonding a priority. Although we would laugh and joke about the games they wanted us play, or how silly it was to go for a team picnic, the whole team would still show up and participate. This is the only team I have been on where I felt truly connected to my colleagues. The team bonding created connection between employees, and it also created a work environment that felt safe and supportive. Essentially, through connection, we were taking care of each other.

My practicum experience made me realize that I needed to change my self-care plan because what I was doing, was not working. The new perspectives I have gained on self-care helped me make the necessary changes to my plan. Moving forward in my personal professional practice of clinical social work with Northern Health, I will continue to complete my biological stress response cycle daily. I will also present the idea of self-care being a collective approach to my future teams and see if my colleagues are willing to brainstorm ideas of how we can take care of each other to establish and maintain wellness.

Conclusion

My practicum experience at CAST began with the desire to achieve five learning goals. (1) To develop clinical social work skills; (2) To contextualize client safety in a clinical social work setting; (3) To explore and appreciate my identity as a Métis woman and its influence on my practice; (4) To explore how to practice from a decolonized framework; and (5) To take care of myself physically, emotionally, and spiritually while participating in my practicum. Although I believe that I have exhibited increased competency in the areas I sought to improve by participating in specific learning activities during my practicum, other preliminary clinical social work skills, such as self-reflection and self-awareness, stand out as the most influential and significant changes to my practice.

By allowing myself to feel vulnerable with my practicum supervisor and my personal counsellor, I was able to start learning the art of self-reflection and to be more self-aware. Both of which I deem imperative to increase my effectiveness as a clinical social worker. I am better able to build connection, relationships, and safety with service users when I am aware of and curious about my own struggles. Self-reflection and self-awareness also allow me to understand, privilege, and incorporate different perspectives into my personal practice; thus, creating a framework that parallels my purpose of practicing from a decolonized lens. Moving on from this practicum, and into my future of clinical social work practice, I am confident that this practicum has provided me with a solid foundation for continued professional and personal growth.

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Appendix A

MSW Practicum II: Learning Contract

Student: Natalie Grigg

Practicum Supervisor: Doriana Pantuso

MSW Consultant: Kelly Daigle

Academic Supervisor: Susan Burke

Agency: Northern Health Authority: Community Acute Stabilization Team

Length of Placement: September 8, 2022 to April 28, 2023

Hours and Days of Work: 8:30am – 4:30pm/ Thursdays and Fridays

Learning Goal #1- To develop clinical social work skills.

Objectives	Learning Activities	Measurable Outcomes
1)To become proficient in intakes, assessments, treatment planning, intervention, and termination. 2)To become comfortable and confident in integrating evidence-based modalities, such as CBT, DBT, and Trauma Theory, into my practice when working with individuals. 3)To appropriately use psychoeducation in individual sessions. 4)To develop a charting practice that is concise and utilizes critical information	-Increasing my knowledge of evidence-based theories independently or through any learning opportunities that may arise during my practicum. -Shadow my practicum supervisor and other colleagues as they perform intakes, assessments, treatment plans, interventions, and terminations. -Shadow and observe how my colleagues integrate psychotherapies into their practice. -I will become more familiar with the BCASW code of ethics requirements on record keeping as well as read	-I will develop a personal caseload where I will be responsible for intakes, assessments, treatment planning, and termination. -I will appropriately apply evidence-based theories into my sessions with guidance from my supervisor and colleagues. -My confidence in my clinical skills and approach will increase. -My ability to actively seek out and participate in consultation with my supervisor and colleagues will increase.

appropriately as guided by the BCASW code of ethics.	charting that my supervisor and colleagues have completed, and have my charting read by my supervisor and colleagues and I will be open to any feedback they provide me. -I will also complete a weekly reflective journal about my learning experience and any insights as they develop. -I will meet with my practicum supervisor weekly to ask questions, debrief, and allow for feedback.	-My charting practice will reflect the master's level of record keeping.

Learning Goal #2- To contextualize client safety in a clinical social work setting.

Objectives	**Learning Activities**	**Measurable Outcomes**
1)To understand different ways to nurture a client's sense of safety.	-To learn more about "safety" as an umbrella term both independently and through any learning opportunities that may come up during my practicum. -To observe how my supervisor and colleagues apply the philosophy of safety to the work they do with clients. -To be able to identify and understand what safety means to individual clients.	-I will be able to demonstrate how I apply the philosophy of safety to the work I do with clients. -I will be able to recognize when safety has been established or needs to be fostered more in individual practice.

Learning Goal #3- To explore and appreciate my identity as a Metis woman and its influence on my practice.

Objectives	**Learning Activities**	**Measurable Outcomes**
1)To connect with and meaningfully explore my identity and culture.	-To continue my own healing journey through connection with relatives, independent research of familial histories,	-I will be able to recognize when my beliefs, values, and biases have entered my

2)To understand how my experiences, biases, values, and beliefs may show up unintentionally in the clinical setting.	and attending my own counselling sessions. -To keep a journal to guide my own reflexive process and to keep my biases, values, and beliefs in check for me to provide non-judgmental care.	practice and debrief with my practicum supervisor.

Learning Goal #4- To explore how to practice from a Decolonizing framework.

Objectives	**Learning Activities**	**Measurable Outcomes**
1)To acknowledge that Prince George is located on the traditional unceded land of the Lheidli T'enneh First Nations. 2)To understand Indigenous worldviews and knowledges that are local to the Lheidli T'enneh First Nation Peoples. 3)To understand the role colonialization played and continues to play today in the lives of Indigenous, Metis, and Inuit Peoples. 4)To understand intergenerational trauma and the present-day impacts. 5)To learn how to support and validate clients that continue to experience intergenerational trauma.	-To explore ways to Indigenize Western modalities by applying the Two-Eyed Seeing and the Ethical Space frameworks into my practice approaches. -To explore ways of knowing and worldviews with individual clients and to learn to respectfully share knowledges, experiences, and interests with clients. -To observe how my supervisor and colleagues work towards Indigenizing their practice approaches. -To connect with Elders for guidance on how decolonize my personal worldview -To explore how to incorporate Indigenous and non-Indigenous worldviews into my practice	-I will be able to demonstrate my ability to incorporate local Indigenous knowledge and worldviews into my practice and debrief with my supervisor if any challenges about racism and power imbalances arise. -I will be able to demonstrate my ability to Indigenize Western modalities where possible during my practicum

Learning Goal #5- To take care of myself physically, emotionally, and spiritually while participating in my practicum.

Objectives	Learning Activities	Measurable Outcomes
1)To engage in activities that positively increase my well-being.	-I will continue sessions with my own counsellor, spend time with my husband and children, spend time outdoors, move my body daily, cooking, reading pleasure books, going for walks by myself, mountain biking, skiing, and meditating. -I will create a vision board with pictures of all these activities and put it on my wall where I will see it everyday and be reminded of the balance, I need in my life to create wellness.	-I will be able to articulate how I took care of my own wellness.

Signatures

Student: _____ Date: _____

Practicum Supervisor: _____ Date: _____

Academic Supervisor: _____ Date: _____