Self-Evaluation of Counseling

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During the spring 2021 semester, I completed my practicum at the Horizon Behavioral Health Women's Recovery Residence in downtown Lynchburg, Virginia. The Recovery Residence is a residential women's substance use treatment facility that can serve up to ten women for a treatment stay of 30 to 90 days. Women are referred to this program through private and state psychiatric facilities, inpatient medical detoxification facilities, and area jails. The overall goals of the Recovery Residence are to provide safe and stable housing for women as they recover from their substance use disorder. The Recovery Residence offers structured programming, including nine hours of intensive outpatient substance use group therapy, individual substance use and trauma therapy, medication management, case management, peer recovery support, and linkage to community recovery supports, such as Alcoholics Anonymous and Narcotics Anonymous. While the women are living at the residence they work toward long-term safe and stable housing and employment (unless they are on disability or otherwise unable to work).

One of the challenges that I faced during this experience was increasing my learning around acute detoxification symptoms. In particular, I had little knowledge about detoxification symptoms of methamphetamines. My previous clinical experience has been in an outpatient setting where my clients had already gone through the detoxification process. Thus, my awareness of signs and symptoms of drug withdrawal for women in the Recovery Residence was limited. To address this barrier, I reviewed several educational videos from Psychotherapynetworker.com. I learned from the clients I worked with at the residence, along with the treatment staff. We met weekly for triadic supervision, and I used this opportunity to learn from seasoned staff in this treatment setting. The knowledge was valuable as it helped to

provide an understanding of some of the challenges presented by clients when they first arrive at the residence. For example, many of the women had difficulty focusing or concentrating during group counseling. They would often get up during group, pace, and fidget with their hands and legs. I learned that this may be attributed to detoxification from methamphetamines. This knowledge assisted me in facilitating group counseling sessions. This challenge has led to a success I experienced in expanding my knowledge of substance use by ensuring that my expectations were in line with clients in early remission from substances. Two additional challenges or weaknesses were a lack of training in the trauma model used in group (i.e., Seeking Safety) and being called away from my practicum site to manage an emergency in one of the programs I supervise. To address these challenges, I sought training in the Seeking Safety model, and I found time in my schedule to make up practicum hours when I was pulled away.

Some of my strength areas included my openness to learn from all team members, including my site supervisor, faculty supervisor, peers, clients, peer recovery specialists, and case managers. Since returning to graduate school after 25 years in the field, I have learned that longevity in the field does not equate to expertise in all aspects of counseling. The importance of a treatment team approach in working with complex and challenging clinical issues is another lesson I have learned. During weekly staffing, my site supervisor facilitated a biopsychosocial case conceptualization process as we reviewed each case. During this staffing, all perspectives from team members were welcome and included in our conceptualization and treatment planning. Two additional strengths are that I am trained and certified in an evidence-based substance use model, and I have a good knowledge of community recovery supports to assist the women in developing pro-recovery behaviors.

Areas of continued growth for me are integration between substance use and trauma treatment. Almost all of the women in the residence have experienced trauma, including physical, sexual, and/or emotional abuse. Furthermore, many of the women have experienced complex trauma and domestic violence. Thus, a competent and ethical counselor must be skilled in provision of both mental health and substance use evidence-based treatment modalities. I plan to continue to pursue training on evidence-based trauma approaches in order to integrate trauma-informed care into my clinical work. I am enrolled in a training on this topic on May 3, 2021. Two additional growth areas are continued education about withdrawal signs and strategies to assist clients in managing withdrawal. My action plan consists of reviewing two educational sessions on Psychotherapynetworker.com by June 30, 2021.

My theoretical orientation is rooted in behavioral and cognitive-behavioral therapies. In particular, with substance use treatment I use the empirically supported treatment model, Community Reinforcement Approach (CRA). CRA has a broad research base for adults with substance use disorders and has been found to work with a variety of populations (e.g., different ages, cultures, genders). The goal of CRA is for the client to replace his or her substance use with healthy and positive behaviors, improve positive relationships, and generalize problem solving and communication skills (Hunt & Azrin, 1973). In providing counseling to the women at the Recovery Residence, my focus was to offer an open and non-judgmental space and assist the women in working on their identified reinforcers or motivators for sobriety.

I experienced countertransference during an individual session with one of the women in the recovery residence. We had a session to develop a relapse prevention plan, and she discussed how her anxiety had affected her negatively in the past and contributed to her substance use. While I am not in recovery from a substance use disorder, I have experienced anxiety in my

personal and professional life that has impacted me in a negative manner. I began to connect to my own internal challenges over the years as my client discussed how her anxiety impacted her functioning. I chose not to self-disclose to the client because I did not feel that self-disclosure in this instance would be conducive to working on her relapse plan. After the session, I had some self-reflection to process the countertransference. I did not feel the need to take additional action beyond self-reflection.

A goal that I developed in my practicum, with input from my practicum supervisor, was to assist their treatment team in reviewing their assessment tool and offering feedback. This was a goal that I did not fully meet during my internship due to time constraints. However, I have developed positive relationships with my practicum supervisor and his treatment team so this may be an area that I can work on in the future. Overall, I had an excellent experience with my practicum. My practicum supervisor was knowledgeable, available, and fostered a true treatment team environment where all team members felt valued and heard. I truly enjoyed faculty supervision as this was an opportunity to learn from others in different practicum sites in an atmosphere that was positive and supportive. One aspect of faculty supervision that I thought was very helpful was the focus on how our practicum experiences might apply when we are working with our own master’s levels students. This allowed me to reflect on how I might respond to different scenarios as they arise with master’s level students. Finally, collaboration and teamwork would best sum up my experience with the course and counseling. I always felt that I could reach out to ask a question or for support at every point during the semester.

Reference

Hunt, G. and Azrin, N. (1973). A community-reinforcement approach to alcoholism. *Behaviour Research and Therapy*, 11(1), pp.91-104. DOI: 10.1016/0005-7967(73)90072-7