Integrating a Narrative Approach in Clinical Practice with Youth Experiencing Disordered Eating and in Family Therapy

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by

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Abstract

This report examines my experience as a Master of Social Work student during my field practicum placement with the Youth Community Counselling Program (YCC), with Mental Health and Addiction Services, Saskatoon, Sk. The purpose of this practicum was to gain graduate level experience and knowledge in providing services to youth and families experiencing disordered eating, and in providing therapy to families accessing services through Mental Health and Addiction Services. I provided individual counselling and family-based treatment, participated in the development of a research project, and worked as part of an interdisciplinary team. This report presents my learning through the integration of theory and social work practice. I explore the literature on evidence-based practice for working with youth and their families, with a focus on counselling approaches incorporating narrative therapy, structural family therapy, attachment theory, family systems theory, and family-based treatment. I also discuss the relationship between my ideological views, values, ethics and self-reflection in supporting young people and their families. The report concludes with discussion of my learning outcomes, intersectional analysis, and ethical considerations.
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Introduction

Much of my work experience over the past six and a half years has been within Mental Health and Addiction Services (MHAS), in the Saskatoon Health Region. During the last three years of my employment in MHAS, I provided individual counselling to youth in the Rapid Outcome Coping Skills (ROCS) service with Youth Community Counselling (YCC). YCC is a program comprised of a multidisciplinary team of thirteen social workers, six outreach workers, two recreation therapists, two psychologists, a prevention educator, a special programs consultant, a psychiatric nurse, a dietician, and a psychiatrist. This program provides a variety of services to youth ages 12-18, and their families including: addictions counselling, individual and family therapy, outreach services, prevention services, nutrition counselling, groups, psychological assessment, and psychiatric services.

In the ROCS position, I used several therapeutic techniques including: motivational interviewing; cognitive behavioural therapy; dialectical behaviour therapy; and solution-focused, strength-based approaches. However, I was clinically limited to these approaches due to the limited training opportunities available to me, and that my role was to provide counselling designed to support stabilization and the development of coping skills. As such, I wanted to deepen my knowledge of therapeutic theory and expand my skills in the use of therapeutic techniques.

I was also particularly interested in the supports available at YCC for youth experiencing disordered eating. This was not an area that I had experience in but one that could offer hands on experience in implementing treatment methods in individual and family therapy. The prevalence of eating disorders in North America is quite low compared to the overall population (Hoek, 2007, Public Health Agency of Canada, 2006). Eating disorders predominately impact women, with men accounting for only approximately 10% of those affected (Public Health Agency of Canada, 2006).
Canada, 2006). However, people with eating disorders often experience comorbidities, and those experiencing eating disorders have the highest mortality rate of any mental health disorder (Sullivan, 2002). Moreover, female adolescents between the ages of 10-19 account for the highest rates of hospitalization related to eating disorders (Public Health Agency, 2006). Given the complexity and potential severity of eating disorders, this placement permitted many learning opportunities.

I completed a 450-hour practicum with the YCC program at MHAS, in the Saskatoon Health Region. As I had been an employee in another MHAS program, I took an educational leave of absence to minimize any conflict of interest. My learning objectives were: to increase knowledge and understanding of treatment approaches for adolescent eating disorders; to participate in the development of a pilot research study on outcomes of clients receiving treatment for eating disorders; and to prepare a presentation for the National Eating Disorder Information Center (NEDIC) Conference 2017. Lastly, I wanted an opportunity to participate as part of an interdisciplinary team that provides client-centered treatment to youth with eating disorders through a Stepped-Care Model in a community setting.

The purpose of this report is to present my practicum placement experience and learning. What follows includes a description and reflection of the activities that facilitated my learning. First, I discuss the practicum placement context. Next, I present my ideology and a literature review of counselling theories. I then detail my learning activities and my experience integrating theory into practice. Finally, I identify challenges, values, ethical considerations and share my learning outcomes.
**My Practicum Placement**

I embarked on my practicum placement, the final chapter of my Master of Social Work degree (MSW) on January 5, 2017 at Youth Community Counselling Program (YCC) under the supervision of experienced clinical social worker. YCC is a program under the department of Mental Health and Addictions Services (MHAS) within the Saskatoon Health Region (SHR). The SHR is public agency which offers a promise to all people accessing its services:

> Every moment is an opportunity to create a positive experience in the way we treat and care for people, in how we work and interact with each other, and in how we deliver quality service. We promise to seize every opportunity (About Us, Saskatoon Health Region [SHR], 2016).

In my experience at YCC, it is evident that the staff is committed to this promise. YCC operates under the philosophy of connecting youth and families to promote well-being and recovery (MHAS, 2016). My observation was that each service umbrella of YCC operationalized this philosophy in practice. For example, during peer supervision staff discussed client care in a manner that was recovery focused and strengths-based. I observed that peer supervision supported collaboration and creativity in supporting client-directed goals. Staff members work collaboratively within the interdisciplinary team, and with schools and other community partners to support the best outcome for youth and families (MHAS, 2016).

One example of how this philosophy is enacted is in the Youth Nourishing Connections (YNC). This service operates under a model which supports client/family determination, engagement, and empowerment across intersectional social identities (race/ethnicity, gender, sexual identity, class, religion, ability). This service supports youth to explore and externalize the pressures connected to food, body, and image, while supporting a multifaceted knowledge of identity. Service and care are client-centered, which translates to the development of personal
empowerment and self-care practices. Principles of collaboration and compassion are emphasized in all the interactions of the team (Yablonski, Peterson, & Kurji, 2016). YNC works to improve access for youth and families by decreasing time away from school and work, and increasing the likelihood of engaging all members of the health care team. YNC improves communication, minimizes conflicting information given to the client and family, and creates a collaborative and holistic experience for the client, their family, and the health care team (Yablonski et al., 2016). The service works to prevent hospitalization and acts as transition for those clients returning to the community upon exiting hospital. Service providers implicitly work from a trauma-informed approach, which is demonstrated through their use of a sociocultural perspective that considers clients’ perspectives on trauma while utilizing a narrative approach.

The philosophy of YNC aligns with my ideological approach to social work.

**Ideology**

Ideology in social work is shaped by theory. The practice of social work is often discussed in the literature within the context of “person-in-environment”; an overarching orienting perspective for working with individuals and families (Canadian Association of Social Workers [CASW], n.d.). This is a common ideological framework for many social workers, in which clinicians aim to understand and assess clients within the context of their environments and to make use of ecological interventions where deemed appropriate (Simmons, 2012). In my experience, environment has always been an important factor to consider in assessment and treatment planning. However, by taking this approach social workers impose their assumptions and ideas about how environmental factors impact the client’s life. By allowing the client to make their own meaning of contextual factors, they can transform their story without being confined to the imposed views of the social worker they are working with. In taking this approach, social workers reject the idea of being considered an expert. Instead, they enter a
feminist means of practice which supports clients in examining how social constructs may be impacting their current circumstance.

Traditional views of therapy place the therapist in the role of an expert while feminist practice dismantles this hierarchy, allowing the client to assume the expert role (Botha, 2016). Social work practice that is progressive in nature must be informed by feminism on micro, mezzo, and macro levels (Ife, 2012). I have long identified as a feminist and recently have learned how to better incorporate feminist ideology into my practice. Feminist ideology critiques traditional systemic therapies suggesting that the therapeutic relationship is riddled with power-imbalances (O’Reilly Byrne & Colgan McCarthy, 1999; Ife 2012). Instead, a feminist perspective emphasizes the importance of supporting the client to deconstruct their social realities and to identify their distinct narrative, and develop a narrative they prefer to live (Freedman & Combs, 1996; O’Reilly Byrne & Colgan McCarthy, 1999). In doing so, there is a shift from “systems-to-stories” in therapeutic conversations (Freedman & Combs, 1996).

The ideological framework that emphasizes supporting client narratives and rejecting developing preferred stories provided a lens through which all my practicum work was shaped. Notably, feminist ideology informed my interactions with the clients and how I supported them in the therapeutic context. Feminist ideology also informed the way how I engaged in supervision with my professional associate, discussions within peer supervision, and in interactions at YNC. Notably, this is reflected in language as language can be powerful in influencing perception (Madigan, 2011). Language is often imposed upon people in a way in which they may experience a problem-saturated identity (Madigan, 2011). For example, saying “She’s anorexic” places the problem in the person and the therapist's job is to “fix” the person (Madigan, 2011). When systems and professionals use language to label “disorders”, it not only
pathologizes people, but can create dependency on systems, and can reinforce messages of dysfunction and blame (Madigan, 2011). The perpetuation of the problem-saturated story through language ignores that people are multi-storied with many abilities, complexities, and skills (Freedman & Combs, 1996). Using therapeutic conversations is a respectful approach to support people in developing their own language which fosters agency in the development of their preferred identity/story (Madigan, 2011). As such, I have made a conscious effort to reflect my personal ideology in the language I use throughout this report.

Throughout this report, I use two terms interchangeably; “eating disorder” and “disordered eating”. I do this because I believe that disordered eating exists on a continuum. This belief has been influenced by practitioners and mentors in the field. Also, adolescents who do not meet criteria for diagnosis may still experience body dissatisfaction and engage in disordered eating behaviours that are problematic. These behaviours may include: recurrent dieting; losing and then regaining weight; feelings of shame and guilt related to eating; excessive exercising; poor body image; fear of gaining weight; or periodic binge eating (Latzer, Spivak-Lavi, & Katz, 2015). It is also well documented that it is important to address disordered eating behaviours at any stage as they place young people at greater risk of developing a diagnosable eating disorder if untreated (Latzer et al., 2015). Eating disorder labels can be pathologizing to young people and impede on their sense of identity. Therefore, I wanted to avoid using such labels with youth unless it was their preferred language.

**Literature Review of Counselling Theories**

One of my learning goals was to conduct a literature review and to integrate evidence-based practice theories related to eating disorder treatment for adolescents. Through my review of the literature, I explored a variety of theoretical approaches for family therapy, and for
adolescent eating disorder treatment. The main theories identified in the literature for family therapy include forms of structural family therapy, attachment theory, family systems theory, and narrative therapy. However, research in evidence-based models for eating disorder treatment in adolescents is somewhat limited. Most of the main approaches to eating disorder treatment with adolescents includes family-based treatment that often refers to the Maudsley Method or New Maudsley Method, and narrative therapy (Eisler, Lock, & le Grange, 2010; Jewel et al., 2016; Kass, Kolko, & Wilfley, 2013; le Grange & Lock, 2005; Lock, Epston, Maisel, & Faria, 2005; Lock & le Grange, 2013; Loth et al., 2015; Rhodes, Gosbee, Madden, & Brown, 2005; National Eating Disorder Association, n.d).

Through my research, I was naturally drawn to a narrative approach to both family therapy and eating disorder treatment. Subsequently, I had the privilege of attending a five-day Foundations Level Narrative Therapy Intensive Training Certificate Program through the Vancouver School for Narrative Therapy. Attending this training further solidified my interest and ignited a desire to shift my method of practice to incorporate this approach. The next section presents my review of the literature. I begin with a discussion of narrative therapy as this has become my preferred approach to practice. I then present an overview of the theories of family therapy, and conclude with the literature on theories of eating disorder treatment with adolescents.

**Literature Review**

**Narrative Therapy Overview**

Narrative therapy was first coined by Michael White and David Epston in the 1980s (Madigan, 2011). This approach was rooted in the work of French philosopher Michel Foucault, aligning with the views of post-structuralism and postmodernism (Freedman &
Combs, 1996; Lock et al., 2005; Madigan, 2011). A narrative world view encompasses the belief that realities are socially constructed. Social construction of reality is established through language and upheld through the stories that are told. As such, there are no fundamental truths (Freedman & Combs, 1996). Since narrative therapy was derived from the work of Foucault and other post-structural and postmodern thinkers, describing a narrative approach to therapy can become quite expansive, as narrative therapy considers the cultural context, social structures, dominant language and discourse. For brevity, this section will provide a limited explanation of narrative therapy.

Narrative therapy is anti-oppressive in nature and aims to move away from pathologizing people (S. Madigan and D. Nylund, personal communication, March 2, 2017). Since its initial conception, narrative therapy has been useful in working with a range of populations and across a variety of presenting issues (Adams-Wescott & Dobbins, 1997; R. Arteaga, personal communication, March 3, 2017; Combs & Freedman, 2016; Freedman & Combs, 1996; Lebow, 2016; Lobovitz & Freedman, 1997; Lock et al., 2005; Lund, Erion, & Dagirmanjin, 2016; Madigan, 2011; Smith & Nylund, 1997). Before discussing narrative therapy, and within the contexts of family therapy and eating disorder treatment, it is important to understand its key components.

The first component of narrative therapy is to separate people from their problems, “the person is not the problem, the problem is the problem” (White & Epston, 1990). This involves externalizing problems which is an essential step in narrative therapy process (Madigan, 2011). Externalization looks at the person’s relationship with the problem (Lock et al., 2005). Through relational externalizing conversations in which the therapist asks questions that are relational, stories and counter-stories emerge (S. Madigan, personal communication, March
As Madigan (personal communication, March 1, 2017) states, “lives aren’t single storiied, but are multi-storiied”. Therefore, it is the job of therapist to have conversations with people to make it possible for them to access other stories of their lives and to thicken those stories. In other stories, there are imbedded skills which people possess. Narrative therapy does not look at the etiology, or cause of problems, rather it looks at what the problem is and what supports the problem. Discourse is not created out of facts, rather once it is accepted by society, it becomes accepted as factual (Madigan, 2011). Therefore, critical thinking is essential as discourse supports and maintains social constructions of privilege and power (Madigan, 2011).

Narrative therapy views the client as the expert on their life, in which the client has insider knowledge regarding the problem (Lock et al., 2005; Madigan 2011; Maisel, Epston & Borden, 2004). By recognizing the privileged knowledge the client holds and externalizing the problem, therapists can work with clients to develop a resistance to the problem (Lock et al., 2005, Maisel et al., 2004). Uncovering this knowledge occurs through a process of mapping the influence of the problem (S. Madigan personal communication, March 1, 2017). Mapping the influence includes two sets of questions: first, questions that encourage people to map the influence of the problem in their lives by asking questions about the practice of the problem (for example, isolation would be a practice of the problem of depression). The second set of questions is around people mapping their own influence in the life of the problem (S. Madigan, personal communication, March 1, 2017).

The second component of narrative therapy examines different types of questions. Typically, this begins with “Landscape of Action” and “Landscape of Identity” questions (S. Madigan, personal communication, March 1, 2017, D. Nylund, personal communication, March 2, 2017). Descriptions of types of questions will be cited to the personal communication of D.
Nylund (March, 2, 2017), unless otherwise stated. Landscape of action questions which involve inquiries into events and actions associated with the problem. These questions imply grammar of agency and can help locate unique outcomes in the client’s historical framework. Landscape of identity questions invite people to reflect differently on their identities and to develop meaning from their unique outcomes. Once unique outcomes have been identified the therapist may ask other questions which are strategically used to help thicken/develop alternative stories. Specifically, further types of questioning include “experience of experience”, “unique possibility”, “circulation questions”, and “consulting your consultants”. It should be noted that the therapist likely will not cover each type of question in one session. Instead, the therapist uses questions at a pace that fits each unique therapeutic context.

Therapeutic questions are not designed to be asked in a linear manner, rather, the therapist uses their judgment to move fluidly between questions. What follows is a brief description of the types of questions mentioned above. Experience of experience questions invite people to see their preferred story from the perspective of others. Unique possibility questions ask the individual to hypothesize about their personal and relational future, which can lead back to landscape of identity. Circulation questions ask the individual to consider who they would like to include in developing their preferred story. Circulation questions are essential in securing and progressing with the development of their preferred story. Consulting your consultant questions invites the individual to move from “client” to “consultant”. This type of question asks the individual their insider knowledge on what advice they would give someone else experiencing a similar problem. By thickening the alternative story, through the process of re-telling and re-authoring in session and in letter writing and inviting audiences of support, clients can move away from the previously dominant story of their lives (D. Nylund, personal
communication, March 2, 2017; Nyland & Thomas 1994; R. Arteaga, personal communication, March 3, 2017; S. Madigan, personal communication, March 1, 2017). With this explanation of narrative therapy as a pretext, I will now discuss theories of family therapy.

**Theories of Family Therapy**

In my experience, social workers tend to utilize an eclectic mix of theoretical frameworks in their practice. I have been trained in several evidence-based therapeutic techniques including motivational interviewing, cognitive behavioural therapy, dialectical behaviour therapy, and solution-focused and strengths-based approaches. Through my practice, I have gained working knowledge of attachment theory, family systems theory, and an understanding of family of origin. However, in my professional role, I have not had the opportunity to facilitate family therapy sessions. Therefore, one of my practicum learning objectives was to gain further knowledge of various approaches to family therapy and to develop my skills through practice. In this section, I provide my understanding of structural family therapy, attachment theory, family systems theory, and narrative therapy as primary frameworks that informed and guided my work with families.

**Structural family therapy.** Developed by a psychiatrist Salvador Minuchin in the 1970s, structural family therapy aimed to address problems in family functioning and offered a subjective view of the social systems and family experiences (Levy, 2006). Minuchin believed that the problems did not lie within an individual, but within the family system (Levy, 2006). In recent decades, structural family therapy has been a popular approach to working with families (Reiter, 2016). As such, one of the key elements in structural family therapy is case conceptualization by the therapist (Reiter, 2016). Case conceptualization involves the therapist developing a theory of the problem, and subsequently, a theory of resolution.
Structural family therapists work using 6 Ps: problem, process, pattern, proximity, power and possibilities.

Briefly expanding on these concepts, the problem is typically presented as individualistic, in that the family feels one member of the family is the problem. Structural family therapy shifts the conceptualization from focusing on an identified person as the problem to one in which the problem lies between family members (Reiter, 2016). Process looks at how family members interact with one another. Within the process, family therapists work to help individual family members identify their role within the family and to understand how their role coincides with other’s roles within the family (Reiter, 2016). Family therapists explore patterns of family processes and work to disrupt problematic patterns of interactions from recurring. They observe proximity of relationships to discover further information about family dynamics regarding closeness/distance and boundaries within the subsystems of the family (Reiter, 2016). Therapists utilizing this model examine power within the family (i.e. hierarchies), while offering an optimistic lens to the possibilities that are inherent in the family (Reiter, 2016). Narrative theorists critique the structural framework arguing that it neglects to recognize power imbalances, and limits the attention given to the ever-evolving shifts that occur in family relationships (Freeman & Combs, 1996).

**Attachment theory.** First introduced by a psychoanalyst, John Bowlby, the premise of attachment theory examines relationships and psychological functioning, “drawing on an understanding of the affectionate bonds created in the context of close relationships, initially formed with primary caregivers” (Bucci, Roberts, Danquah, & Berry, 2015, p. 2). Within attachment theory, it has been found that those who experience major mental health problems or chronic psychiatric disorders demonstrate insecure attachments (avoidant or ambivalent) with
their caregivers (Bucci et al., 2015). Since its inception, therapists have been using attachment theory to inform their practice across numerous client demographics (Bucci et al., 2015). More recently, the development of attachment-based family therapy for adolescents with depression has demonstrated promising results in empirical studies (Diamond, 2014; Ewing, Diamond, & Levy, 2015). In addition, early studies show that attachment-based therapy may be a beneficial adjunct to family-based treatment for adolescent anorexia (Wagner, Diamond, Levy, Russon, & Litster, 2016). In this context, attachment narrative therapy provides a framework outlining four stages that occur within therapy to marry the idea of systemic family therapy, attachment theory and narrative therapy (Vetere & Dallos, 2008). Attachment theory as a developmental theory greatly influenced the development of family systems theory.

**Family systems theory.** Developed by psychiatrist Murray Bowen in 1978, family systems theory proposes that individual identity and the concept of “self” emerge from the context of family (Kolbert, Crothers, & Field, 2013). Bowen believed that individuals function as an “emotional unit of the family” (Kolbert et al., 2013, p. 87). This therapeutic technique aims to reduce underlying symptoms (e.g. depression) and assesses the developmental level of the family unit (Kolbert et al., 2013).

Family systems theory looks at how the family system is impacted and intersects with other biological and ecological systems (D. Arbuthnott, personal communication, February 12, 2013). As such, family systems theory allows space for clients to share their narrative through verbal communication and the use of genograms to illustrate how the family system performs, and the relationships that exist between family members (D. Arbuthnott, personal communication, February 12, 2013). Bowen’s view of family therapy was individualistic in nature and was used almost exclusively with adults during his time (Kolbert et al., 2013).
However, Kolbert et al. (2013) suggest that family systems therapy is appropriate for adolescents who “are formal operational thinkers and exhibit an interest in developing self-awareness and insight regarding their families, but whose parents are reluctant or unwilling to engage in counseling” (p. 93). By examining these relationships and systemic interactions, adolescents can externalize their internalized experience. However, there is limited empirical data on family systems theory with adolescents, and research suggests this method of family therapy is not universally appropriate (Kolbert et al., 2013).

While family systems theory is useful for talking about processes and patterns outside of individual family members; family systems can limit considerations for larger social contexts. (Freedman & Combs, 1996). Social contexts such as gender, race, religion, class, and sexual identity, all have a powerful influence on the development of stories and the way people make meaning in their lives (Freedman & Combs, 1996). In addition, family systems theory neglects to identify power relationships within the family and within the therapeutic relationships (Adams-Wescott & Dobbins, 1997). From Bowen’s original conceptualization of family systems, Bateson (1972) shifted the practice to use a method called “circular questioning” (Freeman & Combs, 1996). The aim of this practice is to make meaning underlying the patterns in family relationships. This information is used by the family therapist to create a hypothesis which informs their intervention plan; again, placing the therapist in the expert role (Freeman & Combs, 1996). Traditional approaches to family therapy are widely utilized. During my placement, I heard therapists at YCC describe the use of family systems theory and structural family therapy approaches in their work. It was my observation that therapists using these approaches did not confine their work to one theoretical approach or therapeutic technique. To
demonstrate the benefit of assuming a less individualized approach, the next section will review a narrative approach to family therapy.

**Narrative applied to families.** Since narrative does not ascribe to traditional family system approaches, therapy begins with exploring how the problem arose and understanding the meaning of the problem for each person involved in therapy (Smith & Nyland, 1997). By using narrative therapy with families, the focus shifts to externalizing the problem, which supports the deconstruction of the idea that problems exist within family members (Adams-Wescott & Dobbins, 1996). Epston and White developed the concept of Re-authoring conversations which invited clients to explore events and areas that have been neglected (Madigan, 2011). Therapists engaged in the process of “mapping” which looks at how the problem influenced the person/family in their life and relationships. As family members typically have variations of the problem-story based on their individual perspective, the therapist’s role is to pay attention to each of these stories and support the evolution of “co-authored narratives” (Lobovitz & Freeman, 1997). Therapists use “deconstructive questioning” to assist the client to notice how dominant stories have been constructed and sustained, and to discover that other narratives are possible (Adams-Wescott & Dobbins, 1997; Freeman & Combs, 1996; White, 2011). This process brings forth “stories that do not support or sustain problems” (Freeman & Combs, 1996, p. 16). This approach can be used with eating disorder treatment with adolescents as it removes blame and shame that can occur in an individualized approach. Rather than placing the problem of the eating disorder as something within the young person, the problem is externalized. However, family-based treatment which follows the Maudsley or New Maudsley Method is often regarded in the literature and in practice settings as the standard for treatment. In the next section, I review and provide analysis of each of these approaches to care.
Approaches to Eating Disorder Treatment with Adolescents

Even though eating disorders have the highest mortality rate of all mental health disorders (Hoek, 2007), research regarding youth eating disorder treatment is limited. In fact, no major improvements in treatment efficacy occurred between 1953 and 1999 (Botha, 2015). In addition, anorexia tends to be researched more thoroughly as there appears to be a hierarchy of eating disorders which places anorexia at the top. This is problematic as various forms of disordered eating can have detrimental physical and mental effects (Holmes, 2016). Limited research around eating disorder treatment with adolescents has indicated that families should be involved in treatment; however, the amount of structure needed in family therapy varies (Lock & le Grange, 2013; Botha, 2015). While there is no universal model of treatment, given that eating disorders can cause a multitude of physical symptoms and concerns, the nature in which they are assessed occurs from a medical model which is a biological approach that does not approach health issues from a holistic manner (Anderson, Lavendar, & De Young, 2010).

Depending on the severity of disordered eating symptoms, youth are typically seen by a team of health professionals, consisting of a paediatrician, psychiatrist, dietician and a clinical social worker or psychologist (le Grange & Lock, 2010; Lock & le Grange, 2013). The literature that exists promotes family-based treatment, mainly the Maudsley Method, and the New Maudsley Method, and/or narrative therapy as best-practice (le Grange & Lock, 2010; Lock & le Grange, 2013; Robinson et al., 2015). While each of these approaches to treatment has some distinct characteristics, they are similarities as well which will be discussed in the Reflections on Theory section of this report. In reviewing eating disorder treatment approaches, I begin with the traditional approach of family-based treatment.
**Family-based treatment.** Research suggests that clinicians should implement family-based treatment, as it is indicated as best-practice for treating eating disorders (Eisler et al., 2010; Jewel et al., 2016; Kass, et al., 2013; le Grange, & Lock, 2005; Lock & le Grange, 2013; Loth et al., 2015; Rhodes, et al., 2005; National Eating Disorder Association, n.d). The Maudsley Method and New Maudsley Method fall under the umbrella of family-based treatment. In my experience these methods are often used interchangably with the term family-based treatment. While each family comes with its unique challenges, family-based treatment models suggest that families focus on decreasing negative aspects of their relationships (Cance, Loukas, & Talley, 2015). Interventions that promote parental involvement can serve to increase their knowledge and parenting skills, which can be particularly effective in reducing disordered eating symptoms (Bauer et al., 2013). In this approach, clinicians encourage family meal times for most adolescents, as family meals serve as a protective factor across different ethnic backgrounds and socioeconomic status (Loth et al., 2015).

If an eating disorder diagnosis has been made, there are clearly outlined protocols for Family-Based Treatment with Anorexia Nervosa (FBT-AN) (Eilser et al., 2010; Lock & le Grange, 2013) and Family-Based Treatment for Adolescents with Bulimia Nervosa (FBT-BN) (le Grange & Lock, 2010). Both FBT-AN, and FBT-BN emphasize that the role a therapist is to serve as a consultant expert to the parents. This type of treatment places heavy emphasis on the role of the parents in the treatment process as parents are the main resource to their adolescent children.

Though family-based treatment for eating disorders has strong efficacy and is the recommended treatment, remission rates with family-based treatment hover at 50% for anorexia and the treatment less successful with other forms of disordered eating (Kass et al., 2013).
Contrary to the standard Maudsley Method’s prescriptive nature, it is important that treatment is tailored to the needs of the individual (Treasure et al., 2017). Some scholars suggest that in situations where young people do not respond well to standard treatment, that narrative practice is used to augment traditional family therapy (Rhodes et al., 2005).

**Narrative approach to eating disorders.** Though there has been limited research on the use of narrative therapy with adolescents experiencing eating disorders, narrative therapy has been effective in the treatment of eating disorders among young women internationally (Madigan, 2011, Maisel, Epston & Borden, 2004, Scott, Hanstock & Patterson-Kane, 2013, Weber, 2007). Narrative therapy has primarily been utilized with women experiencing anorexia-nervosa and bulimia nervosa and it has been effective in treating other forms of disordered eating problems (Scott et al., 2013).

As with narrative family therapy, externalization can be applied to shift blame away from the individual experiencing an eating disorder. Narrative therapists conceptualize eating disorders as a disempowering cultural force whereby, the dominant culture promotes thinness, self-discipline, self-control, and objectifies women’s bodies (Maisel et al., 2004). Subsequently, the therapist seeks the knowledge of insiders to dismantle cultural constructs through the act of resistance (Maisel et al., 2004; Lock, Epston, Maisel, & de Faria, 2005). Insiders are experts on their experience of their relationship with the problem, in this case, disordered eating (Botha, 2015, Lock et al., 2005). The act of de-pathologizing is effective in supporting the client’s ability to practice externalization and in taking an anti-eating disorder stance (Lock et al., 2005; Madigan, 2011, Maisel et al., 2004; Scott et al., 2013; Weber, 2007). Since persons can change the meaning of their experience, developing a new narrative experience can be empowering in nature (Scott et al., 2013; Weber, 2007). The family, therapist,
and young person can come together collaboratively to thicken this new narrative; diminishing familial and therapeutic hierarchies (Botha, 2015).

Research suggests eating disorder labels and weight restoration goals can be experienced as disempowering, stigmatizing and punitive (Botha, 2015, Holmes, 2016). However, some insiders felt that narrative therapy would be best suited for a later stage of recovery when physical health was stable (Holmes, 2016). S. Madigan (personal communication, March 2, 2017) emphasized that ethically, clients who are medically compromised should be seen by medical professionals as a necessary part of treatment. Given the importance of having medical professionals involved in treatment, the next section discusses collaborative care models in a more in-depth manner.

**Community-based collaborative care.** Limited research has been done on collaborative care models in Canada, even though collaborative efforts have proven to be promising (Golan, 2013; Lamb, 2009). The approach at YNC is a community-based model which is vastly different than inpatient and day-programs that exist for youth across Canada (Alberta Health Services, 2017, Baca, 2015, CHEO, n.d., Eating Disorder Support Network of Alberta, n.d., The Looking Glass Foundation, 2016, NEDIC, 2014). Some programs have age restrictions which do not allow for youth under the age of 17 to access services (The Looking Glass Foundation, 2016, NEDIC, 2014). In addition, while major centers across provinces have community-based services, YNC offers a unique approach to client-care through its interdisciplinary and collaborative approach to family-based treatment. Research indicates using a team approach to treatment which includes family members could be effective in reducing clinician burnout (Green, Albanese, Shapiro, & Aaron, 2014). While both inpatient and community-based programs are of value, YNC aims to prevent hospitalization and to act as an
alternative to admission, and a support for those transitioning to community upon exiting the hospital. Community-based eating disorder treatment has been demonstrated as being effective in the matter (Lamb, 2009). Collaborative work that occurs with a team that includes the family and client enhances recovery outcomes (Golan, 2013).

While research indicates that working with a treatment team is beneficial for clients and for service providers, limited research has been conducted on the adolescent experience of eating disorder treatment. As such, the pilot study proposed by an eating disorder research committee (YCC members partnered with a faculty member from the University of Regina, Faculty of Social Work) aims to hear from the young people attending the YNC service. The intent of this study is that it will permit youth to have a voice in the care they receive. The preliminary data obtained can inform a future, larger scaled study of youth attending treatment for disordered eating in Saskatchewan. Since approaches to both family therapy and eating disorder treatment vary, it is important to critically reflect on the forms of therapy currently being used.

Reflections on Theory

It is my perception that theories of family therapy evolve over time. As such, theories tend to draw from each other and demonstrate both differences and similarities between theoretical frameworks. Theoretical eclectism (i.e. attachment-based family therapy and attachment-narrative therapy) may provide many opportunities for serving families whereby adherence to one method, may be limiting. My experience led me to believe that asking narrative questions, which integrate other theoretical ideas, can enhance how clients make meaning. For example, it might be useful to include questions about how a mother-child relationship has developed and is lived (attachment theory) in the form of narrative questions, which allows the client to remain in the expert role, making their own meaning of their experience. However, those who practice
traditional forms of family therapy, which place the therapist in the role of expert, would likely have difficulty integrating the methods of narrative therapy.

Minuchin (1998) reflected that narrative therapists “misplaced the family” in family therapy (p. 403). Though Minuchin and White have been described as being at odds with regards to their preferred therapeutic style (Dickerson, 2014; Levy, 2006), both therapeutic approaches hold strong views on the importance of relationships, and that the family has the capacity to heal (Lappin, Minuchin, n.d.; White, 2011). While structural family therapist and narrative therapists encounter similar clinical presentations, the therapeutic techniques utilized are vastly different (Levy, 2006).

Family-based treatment and narrative therapy both utilize externalizing practices and support the young person and their family. The biggest difference between narrative therapy and other psychotherapies is that most psychotherapy models are individualist, placing the problem within the person or the family (S. Madigan, personal communication, March 1, 2017). Single stories, or stories that have been told again and again, are often “problem-saturated”. Traditionally, this places the blame for the problem within the individual or family. While there has been more research conducted on the efficacy of family-based treatment than on narrative therapy for eating disorder treatment with adolescents, research emphasizes that the therapeutic alliances has greater impact on client outcomes than use of evidence-based therapeutic models (Duncan, Miller, & Sparks, 2004). Given the lack of evidence of long-term outcomes in family-based therapy, it is important that clinicians and researchers continue to explore alternative therapies to promote long-term eating disorder recovery.
Practicum Activities

During practicum, I fulfilled my learning goals and objectives through several activities (See Appendix A for detailed learning goals and objectives). In this section I discuss the primary and secondary learning activities I participated in. For the purposes of this report, greater attention will be given to primary learning activities in the discussion of integrating theory in practice, and achievement of my learning objectives.

Primary Learning Activities

The primary learning activity of my placement included carrying a caseload of 10 clients and providing family therapy and family-based treatment to youth with eating disorders. I provided family therapy to 5 families with general mental health concerns, family-based and/or narrative therapy to 5 youth experiencing disordered eating. Sessions included both individual therapy with youth and family therapy with youth and their caregivers. Sessions were typically 60 to 90 minutes in duration.

Client demographics, themes and approaches. During therapy sessions, I observed several themes in the presenting issues brought forward by clients. These included parent-teen conflict, communication difficulties, and understanding adolescent development. During family therapy sessions, I utilized several therapeutic approaches including family systems, narrative, and attachment-based interventions. The youth I met with for family therapy varied from age 12 – 15. The families I worked were from diverse socio-economic backgrounds ranging from low-income to upper-middle class. Most of the families were Canadian but had culturally diverse backgrounds including: South East Asian, First Nations and European ancestry. One family I met with had immigrated from Ukraine years ago. The types of families I met with included single-parent families, divorced families, blended families, families in which youth were living with relatives, and nuclear families.
Through my practice providing family-based treatment, I also supported young people and their families battling disordered eating. The approach primarily utilized with these young women was an integration of family-based therapy from the lens of the New Maudsley Method and narrative therapy. The client population I worked with were females ages 12-18. Most of these young women were Caucasian, with varied socio-economic statuses. Given the small number of clients in this area it is difficult to say whether or not most young women accessing YCC services for eating disorders are Caucasian. However, based on discussions with clinicians involved at YNC, this has been the primary demographic of clients accessing that service. There are likely several factors influencing the lack of diversity seen at YNC, including social contextual factors regarding pressures and expectations for Caucasian women. For example, in April 2017 I conducted a Google Image search: “healthy women”; the overwhelming majority images presented were Caucasian, thin, able-bodied women. Many of the women were pictured eating vegetables or fruit (tying into diet-culture). This is not to say that young women of other ethnicities are not impacted by societal expectations of body ideals.

There may be other barriers that prevent young women of diverse ethnicities and men from identifying concerns of disordered eating and accessing services. This could include: how the disordered eating has manifested itself, lack of knowledge regarding eating disorders, lack of knowledge about supports available, and prioritizing other needs (e.g. poverty) above mental health concerns. Research indicates that those who experience intersecting social determinants of health are more likely to experience poor health outcomes (Mikkonen & Raphael, 2010). The social determinants of health include: Aboriginal status, disability, early childhood development, food insecurity, health services, gender, housing, income, race, social exclusion, social safety net, and unemployment/job security (Mikkonen & Raphael, 2010). Based on their social location
within the determinants of health, many youth and families may encounter a variety of factors which deter them from accessing services for disordered eating.

It is difficult for me to say with certainty why young men accessing services for eating disorders are in the minority as there is virtually no research in this area. Lifetime prevalence of anorexia nervosa, bulimia nervosa, and binge eating disorder is higher in females than in males (Hudson, Hiripi, Pope, & Kessler, 2007). I would speculate that young men are impacted in different ways by societal expectations. Body ideals for males are often lean and muscular, as such, disordered eating behaviours (e.g. excessive exercise and dieting) may go unrecognized.

From my previous work experience, there were many times when youth would access services for other presenting concerns, such as anxiety or depression, but upon interviewing the youth, I often discovered that they were experiencing body-image disturbances and engaging in disordered eating behaviours. As such, I hypothesize that the incidence of young people experiencing disordered eating is underreported and undertreated.

**Youth nourishing connections.** In addition to therapy, I attended half days at YNC once every two weeks. YNC follows a model that encourages clients to meet consistently with a pediatrician, clinical social worker, dietician and psychiatrist in one location within the same appointment. Youth and families engaging in this service are provided individual/family therapy at YCC as needed outside of the clinic setting (Yablonski, Peterson, & Kurji, 2016). Using a stepped-care framework, young people and families move through different intensity levels and varied modalities of services including: pediatric medical care, psychiatric services, family therapy, individual therapy, dietician services, and group services (Yablonski et al., 2016).

Traditionally the stepped-care model has three phases: Phase I, focuses on weight restoration. Phase II, focuses on supporting the young person to regain control over their eating,
and Phase III focuses on the young person establishing a healthy identity (Lock & le Grange, 2013). The use of a stepped-care framework at YNC was influenced by the Maudsley Method, while integrating the flexibility of The New Maudsley Method. The youth seen at YNC typically would be in phase I or II of treatment. However, in some instances, young women continued to attend YNC during phase III. This was primarily due to their experience of amenorrhea: an absence of menstruation. In those instances, the paediatrician recommends ongoing attendance at YNC for support with weight restoration until menstruation has resumed and is maintained.

During my time at YNC I observed other clinicians with their clients; and co-facilitated appointments with the interdisciplinary team. Through observation I recognized the therapeutic styles of the clinical social workers and the way in which they engaged in an interdisciplinary setting. While the YNC is founded on a family-based approach to care, the two clinicians I observed used therapeutic conversations that appeared to support client narratives and encourage the young women to feel empowered in taking control of their wellness. Observation informed my practice in this setting and at YCC. It further solidified my belief in the power of narrative and client-directed therapy. I felt encouraged to use these techniques in my practice. As such, narrative therapy quickly became the preferred approach to working with young women experiencing disordered eating.

**Secondary Learning Activities**

To supplement my clinical learning, I observed sessions facilitated by my supervisor and other experienced MSW clinical social workers on the team. I was provided ample opportunity to engage in one-on-one supervision, as well as group supervision with the clinical, and multidisciplinary teams at YCC. When I was not in session or supervision, I spent my time working on preliminary research planning or helping to co-create a presentation to be delivered at a
national eating disorder conference. I immersed myself in the literature and attended a five-day Foundations Level Narrative Therapy Intensive Training Certificate Program.

During my placement, I also conducted a literature review in preparation for the development of a presentation for a national conference. The literature review explored best practice treatment models, and current approaches to community-based eating disorder treatment on national and international levels. This supported my practice and research efforts that the YCC program was pursuing. I contributed to the development of a team-based research project titled, *Hear our voices: Youth perspectives on their experience of disordered eating treatment.* I provided input based on the current literature, helped complete an application to the University of Regina Research Ethics Board, and in formulating the main research question. The goal of the research project is to understand the experiences of youth with eating disorders (past/current) that have accessed services at YCC and in the YNC service. This is consistent with the empowerment-based, collaborative framework that the YNC service utilizes to guide their work.

**Praxis**

Praxis is the integration of theory in practice (Ife, 2012). Prior to my placement, I had an extensive background and clinical skills working with individuals using variety of therapeutic models from a client-directed approach. However, through my immersion in the literature and my ability to practice the theories and interventions I had read about, I observed that my method of practice was transforming.

Shortly after beginning my practicum, I began shifting my practice to integrate the practices outlined in narrative therapy. Initially, I made this shift as I felt a narrative approach aligned best with my personal and professional ethics and values. This included feminist values which emphasize empowerment, and client voice in therapy (Botha, 2016; Lock et al., 2005). I
have always considered my practice to be client-centered and client-directed; however, using a narrative lens enabled me to take this one step further but stepping down from any assumed expert role, and supporting the client in moving away from their problem-saturated story.

Prior to attending the Foundations Level Training: 5-day Certificate Narrative Therapy Intensive in Vancouver, narrative therapy added to the practice methods I was already well-versed in. These included cognitive behavioural therapy, dialectical behaviour therapy, family systems theory, attachment theory, motivational interviewing, strengths-based approach, and solution-focused approach. Completing the certification solidified my ethical inclination to adopt this approach to therapy as the primary framework from which I wanted to work. From this training to practice I witnessed firsthand, the power of therapeutic questions and therapeutic documents (primarily, therapeutic letters) (Hugh Fox, Madigan, 2011, D. Nyland, personal communication, March 4, 2017, Epston & White, 1990). Dominant discourse in counselling practice deems therapists to be experts. In my work with individuals and families, I frequently emphasize that they (client/family) are the expert on their lives and have insider knowledge of the problem. Viewing the client as the expert was something I tried to practice in the past with limited success. I suspect success was limited as many of the therapeutic techniques I have been trained in place the therapist as the expert, and suggest that problems exist within individuals. Increasing my knowledge of narrative therapy and practicing these skills helped me to demonstrate the values I had been attempted to practice for several years.

Practice Examples

To illustrate theoretical integration in my practice and specifically the use of a narrative approach within a family-based treatment model, I share three case examples from my
experience. Each of the clients signed a consent form in order for me to share their stories. In each story I have used pseudonyms for client names.

My experience with Jill and her envisioned story coming to life. I began meeting with Jill in the first month of my practicum. Jill was referred for services at YCC by a private therapist, to gain access to a full treatment team for disordered eating. Jill was a teenage girl, highly involved in athletics, and the only child of her divorced parents. Jill and her parents worked alongside the Youth Nourishing Connections team collaboratively. The pediatrician monitored vitals and other indicators of health, and explained that restricting exercise would be required for a period. Jill worked with her parents in developing a plan to reduce her athletic involvement temporarily. The dietician worked with Jill and her parents to ensure she was getting adequate nutrition to support her recovery. Jill and her support system (family & professionals), worked to reject dominant discourse, and thicken her preferred story instead of being focused on the problem-saturated story.

Therapeutic questions and letter writing. Using a narrative approach with Jill and her parents, Jill quickly moved from a place of being medically compromised to taking an anti-anorexia/anti-perfectionist stance. Through the process of externalization, Jill identified the problems she experienced as Ed, and The Perfectionist. Using narrative questions Jill began standing up to The Perfectionist and reclaiming her life from Ed. When I began writing therapeutic letters to Jill, her response to the letters reinforced my decision to include them as a part of therapy. Not only did she say that the letters were helpful for summarizing our session, but she wrote that she felt hopeful about her ability to stand up to her problems. In fact in a small study, Nylund and Thomas (1994) found that the average worth of one therapeutic letter was
equivalent to 3.2 face-to-face interviews, with over half of the participants attributing their gains to the letters alone.

**Preferred reality.** When Jill began living her preferred reality she was able to envision her life without *Ed* and *The Perfectionist*. One moment that resonated with me occurred during a session in which I asked Jill an experience of experience question. Specifically, I asked Jill who would have been most likely to predict she would be able to stand up to *Ed* and *The Perfectionist*? Jill quickly identified her mother and stated the picture she had for her life was slowly coming into focus. Following this session, Jill invited her parents to attend the next appointment to share the vision she had with them. This was an invitation to have her parents join in the development of her preferred story. This collective effort supported the development of Jill’s identity without the problem. Including other supportive people in this way fosters the construction of an anti-anorexia/anti-bulimia lifestyle and the development of the counter-identity (Maisel, Epston, & Borden, 2004).

While Jill’s preferred story developed rapidly, some families presented with some underlying attachment difficulties which prevented my attempts to support the two separate young people in developing their preferred stories. To demonstrate this, I will now share a second example.

**My experience with Lisa – shifting my approach.** When I began working with Lisa, a pre-teen girl, she was restricting her calories, identified as having poor body image and was experiencing suicide ideation. She was taking distance learning at home as she experienced bullying in her former school. Lisa lived with her parents and two older siblings. I requested her physician refer her to the pediatrician at Youth Nourishing Connections as I was concerned about the amount of restriction and pre-occupation with weight Lisa was experiencing. Upon meeting
with the pediatrician, she referred Lisa to a child and adolescent psychiatrist who diagnosed Lisa with anorexia-nervosa and depression. When Lisa’s health deteriorated from increased caloric restriction, the treatment team explained to Lisa and her parents that hospitalization would be required if Lisa was unable to increase her caloric intake to stabilize her vitals. Lisa responded by changing her eating and behaviours to avoid hospitalization; however, she reported she continued to feel depressed and struggled with poor body-image. Towards the end of my practicum, Lisa's family had a breakthrough when they were able to name the problem as something the family was facing. They bonded together and committed to family therapy.

**The New Maudsley Method and narrative therapy integrated.** In my early work with Lisa and her family, I utilized the New Maudsley Method (Treasure et al., 2017) with an emphasis on parental styles and externalizing the disordered eating. I suggested engagement in regular family therapy however, the family encountered several barriers which resulted in inconsistent attendance in family therapy sessions. To further integrate narrative practice, I further focused on externalizing Lisa’s eating disorder and mood difficulties. However, several factors lead me to hypothesize that Lisa’s attachment-relationship with her mother was strained. These factors seemed to impede the effects of the approach I was utilizing. As such I shifted my approach to an attachment informed narrative approach.

**Attachment theory and narrative therapy.** According to Dallos (2004), children with insecure attachment typically have low self-esteem, and experience feelings unworthy of love and affection. These were all things that Lisa had identified feeling. Through exploring her dominant story, Lisa identified that her illness identity helped to get her attachment needs met. As such, I asked questions which explored the attachment narrative and asked the family to consider alternative stories. There were glimmers of the alternative story coming to fruition,
however, toward the end of my placement, the dominant story continued to interject and disrupt therapeutic progress.

**Narrative family therapy.** Near the end of my placement there was shift when I engaged in a therapeutic conversation with Lisa’s parents. They identified that there was a larger problem the family had experienced over the past several years. They agreed that instead of focusing on Lisa’s individual problem, perhaps becoming more connected as a family would support the development of a healthy identity for Lisa. They planned to continue meeting with therapist at YCC for family therapy. This made me hopeful that the family would unify in addressing the problem they were facing together and reject the dominant story of disconnect that had occurred in their family unit.

**My experience with Jane.** Jane was a young woman who described experiencing chronic low-mood, suicide ideation, self-harm, and engaged in food restriction and purging. Prior to meeting with Jane, she was involved with another therapist at YCC for both individual and family therapy. She was also involved with a child & adolescent psychiatrist and was taking prescribed medication.

**Getting caught in the problem-saturated story.** When I began working with Jane, she requested to engage in individual therapy only. Given her age, I respected this request. After a few sessions, Jane agreed I could make a referral to a dietician and she began meeting with her shortly thereafter. Upon reflection, I noticed that the therapeutic focus with Jane was problem-saturated. At the time, I felt this was necessary as Jane indicated feeling highly suicidal. As such, our work focused on safety planning and reducing suicide ideation. During this time, Jane continued to restrict and purge food; she sporadically engaged in self-harm (cutting) and described feeling hopeless. I became discouraged that therapy was not helpful to Jane. However,
upon making a conscious decision to shift my practice to a narrative approach, I noticed a shift in Jane.

_Taking a narrative approach._ Jane began to externalize the problem and through therapeutic questions and letter writing, she began to thicken her preferred story. After introducing a narrative approach, I noticed Jane beginning to take small steps to resist the problem. These steps were demonstrated through her actions of resisting self-harm, increasing food, and decreasing the frequency of purging. While Jane’s progress toward developing her preferred identity was slow, using this approach, she shared experiencing more change than she had in other therapeutic setting. This process is one which supports client agency to reclaim their life from the problem and shift away from the problem as their identity (Madigan, 2011). Each of the case examples offered unique stories which shaped my decisions regarding the therapeutic techniques that would be most appropriate and beneficial in the therapeutic process.

**Analysis of Praxis**

In my role as a student, I learned the benefit of integrating a narrative approach for a variety of presenting problems. As I have previous clinical experience, I noticed several differences in taking a primarily narrative approach. First, I noticed the approach was beneficial in both family therapy and in eating disorder treatment. I appreciated that narrative therapy emphasizes externalization of the problem. It was my experience that youth and their families were generally quick to engage in the process of externalizing. By externalizing, youth appeared to experience less feeling of shame, guilt, and blame, associated with the problem.

I realize that taking a narrative approach removes assumptions from the equation by inviting the client to share their story, name the problem they experienced, and identify the preferred story/identity they hoped to have. I felt positive about the conversations I had with
people as this type of practice exemplified the values I have as a social worker. Specifically, I felt that I was working from an empowerment-based approach that aims to reduce oppression and enhances client voice. This is something I have been striving to do since beginning my career in social work seven years ago.

As a therapist, I noticed my questions became more thoughtful as all questions are asked in a purposeful manner. This will also change the way I conduct my initial “assessment”. I no longer plan to read through pages of previous clinician notes, or reports from a psychiatrist. This is because the notes are the stories that others have told about the individual. Through this process, I also changed the way I wrote my progress notes. Instead of providing a detailed description of session content and my clinical content, I wrote a brief note and attached the letter I sent to the client as a summary of content. This became my practice as therapeutic letters include direct quotes and language used by the client which further exemplifies their voice.

While I achieved my learning goals and objectives during my practicum placement, there were a few challenges I experienced which are discussed in the next section.

**Challenges Identified During My Practicum**

Overall, my practicum offered an incredibly enriching experience as I gained experience working with a population I feel passionate about serving. However, there were some limitations. First, referrals for disordered eating treatment and family therapy are unpredictable in nature. As such, my first few weeks in placement offered less clinical practice. Subsequently I spent much of this time reviewing literature and observing other clinicians. My time at Youth Nourishing Connections enforced the value in collaborative care where youth and their parents are positioned as part of the team. Nevertheless, my ability to participate and observe this service was impeded on a few occasions due to the pediatrician’s limited availability. As with any service there were some barriers (mainly distance/travel conditions and financial strain) that
impeded families from being able to attend appointments on a consistent basis. Though this was somewhat challenging, it required me to be creative in the way I provided service using telephone calls, email, and Telehealth to bridge the gap between appointments. Finally, while the Foundations Level Training: 5-day Certificate Narrative Therapy Intensive was invaluable to my learning; I did not attend until March 1st, which was toward the end of my placement. Given the opportunity, I believe it would have been beneficial to take this training at the beginning stage of my placement.

**Achievement of Learning Objectives**

During my practicum placement, each of my learning goals and objectives were fulfilled (See Appendix A). I completed a literature review on best practice treatment models, and current approaches to community-based eating disorder treatment in Canada. This supported my practice and development of a pilot study research proposal. My placement permitted me to carry a caseload in which I could provide family therapy and family-based treatment. Through direct clinical practice I integrated theory and expanded my clinical skills. Praxis was further supported through the observation and co-facilitation of collaborative appointments at the Youth Nourishing Connections service. Through regular meetings with my professional associate for clinical consultation and supervision I regularly assessed my progress in achieving my learning goals and objectives.

**Intersectional Analysis**

Intersectionality recognizes that individual narratives are multi-layered and that people experience multiple identities (Crenshaw, 1989). This is further impacted by the social constructions people experience in everyday life. These constructions include but are not limited to: gender, class, race/ethnicity, ability/disability, and religion. Within different social contexts,
social constructs can manifest discrimination and perpetuate stereotypes associated with a person’s social location.

**Multi-Level Analysis**

Within the umbrella of intersectionality, the issues of power, social justice, and equity are present. These issues occur on macro, mezzo and micro levels. As such, it is important for social workers to be critical of governments and systems through an intersectional lens. Reflecting on my practicum placement, multi-level analysis is necessary within a mental health care context. The social determinants of health have a tremendous impact on health outcomes (Mikkonen & Raphael, 2010). However, there is virtually no research on the connection between social determinants of health and eating disorders. Moreover, the Canadian Mental Health Association (CMHA) does not include any questions about eating disorders in adolescents in their research. This is problematic as research can impact the ways in which policies are shaped, and in how funding is allocated. The ways in which policies, and systems are designed can impact how a person experiences health and illness. For example, having policies and systems which promote health across intersections including food security, job security, adequate housing, and living wages lead to better health outcomes (Mikkonen & Raphael, 2010).

**Macro and mezzo analysis.** The services available to people experiencing mental health concerns are directly impacted by macro and mezzo level policies. In particular, policies of universal health care, and funding by the federal and provincial governments require critical analysis. While Saskatoon is fortunate to have a number of services available for people of all ages, other regions across Canada, and Saskatchewan, do not have equal access. In recent years there has been an increase in suicide depicted in the media. This has demonstrated the dire need for further mental health services in northern regions across Canada (Courbrough, 2017, Geens,
2017, Stefanovich, 2017). Yet, it has been my experience that short-term fixes are used (e.g. bringing in mental health workers from other regions) rather than long-term solutions. The approach fails the people of these communities, neglects to address issues of colonization, poverty, and addictions, and sends a message that they are not entitled to the same care as other Canadians (Courbrough, 2017, Geens, 2017, Stefanovich, 2017). Provincial governments dictate how health care budgets are disseminated. As such, it has been my experience that some communities and programs are granted funds over others. Given the recent media attention, mental health services are not at risk of losing funding at this juncture. However, it is my impression that governments continue to prioritize physical health concerns over mental health concerns.

The way in which different mental health diagnoses are discussed are influenced by the social construction of how we view each mental health diagnosis and the treatment of such. For example, there is greater awareness and subsequently, less stigma associated with depression and anxiety, with the help of campaigns like Bell Let’s Talk. I suspect most Canadians could identify symptoms of either of these mental health concerns. However, despite the fact that eating disorders have the highest mortality rate of any mental health disorder, there is little awareness about how to identify disordered eating, and minimal funding for eating disorder programs. Furthermore, I recently learned that in Canada physicians do not have a billing code for treating eating disorders. As such, it is likely that the data on rates of eating disorders, co-occurring disorders, and health related concerns are underreported.

Through my research and experience, I learned that there are limited resources for people experiencing eating disorders across Canada. For example, YNC was an initiative developed by caring healthcare providers without any additional funds. Despite the lethality and long term
health consequences associated with eating disorders, eating disorder prevention and treatment are not prioritized by federal or provincial governments. I wonder if this is influenced by multi-layered identities of those who experience eating disorders: primarily women, with mental health diagnoses.

**Micro level analysis.** It is equally important for social workers to be aware of their location in professional and personal contexts; and to recognize how intersectionality impacts the people they work with (International Federation of Social Workers [IFSW], 2012). My location is that I am often viewed as expert in my role. This automatically creates a power-imbalance in the therapeutic relationship. It is important for me to recognize that I have power by virtue of my role and to utilize an approach that aims to dismantle this power imbalance. In addition to my role, I am a Caucasian, cis-gender woman, midde-class, able-bodied, heterosexual, and am married. I am privleged by virtue of falling within some of these social contracts. This is important to recognize in my professional and personal roles. However, I also recognize that as a cis-gender woman, I am impacted by the societal expectation of women’s bodies and am not immune to persistent messages promoting diet-culture. Many of the young women I worked with during my practicum came from a social location to mine. While they too may not have been impacted by intersectional oppressions, the young women experienced oppression that constricted their ability to take up space, influenced them to attempt to conform to social norms and impacted their mental and physical health. Having an awareness around the social justice issues interconnected to body-based oppression and disordered eating has been essential in the conversations I have had with young women around rejecting cultural discourse and claiming their right to take up space.
Adults and adolescents that experience eating disorders encounter the highest comorbidity rates of psychiatric disorders (Rojo-Moreno et al., 2015). Additionally, research indicates that people with eating disorders have the highest rates of suicide attempts and completed suicide (Arceus, Mitchell, Wales, & Nielsen, 2011). Once more, it is problematic that those accessing mental health services face stigma associated with mental illness. In addition to stigma, the clients I have worked with have been impacted by various form of descrimination including classism, racism, sexism, homophobia, and ageism. From a narrative perspective it would be important for therapists to ask their clients to share their experience of intersectionality in a trauma-informed manner, rather than to make assumptions about their experience.

**Values and Ethical Considerations**

Given the contextual factors which can impact a person’s mental health, it is essential that trauma-informed social work be practiced. People accessing mental health services in my experience, often do not cite trauma as a primary presenting concern. As such, it is ethically imperative to practice trauma-informed social work. Trauma-informed social work aligns with the CASW Code of Ethics, as trauma-informed practice aims to recognize vulnerabilities, avoid re-traumatization, and provide support that is respectful (CASW, 2005). As a mental health professional and social worker, I was aware going into my placement that people experiencing mental health concerns often have experienced some form of trauma (Substance Abuse & Mental Health Services Administration [SAMHSA], 2014). Trauma-informed practice is an approach in which service providers have an awareness of the impact trauma can have on people (SAMHSA, 2014). It is a sociocultural perspective which views trauma through both ecological and cultural lenses, and recognizes that context plays a large role in how people experience trauma. From a narrative perspective, it is important to have conversations which support clients to identify what
effect trauma has had on them, rather than to make assumptions about their experience. Trauma-informed practice is a strength-based model which looks at risk and protective factors (SAMHSA, 2014). The basic principles of trauma-informed practice are: safety, choice, collaboration, and empowerment (Levenson, 2017). My experience at YCC was that all service delivery models were designed to support these principles and that staff were informed about the impact of trauma. For example, though peer-supervision was not specifically identified as trauma-informed, in each case discussed, ecological and cultural contexts of individual clients were discussed regularly. Moreover, trauma-informed practice can be integrated into existing models of therapy/services and can strengthen therapeutic alliances (Levenson, 2017). As the therapeutic alliance is greatly impacted by clients’ outcomes, social workers must strike a balance to maintain the alliance while addressing any ethical dilemmas that occur (Duncan, Miller, & Sparks, 2004).

During my practicum, I faced situations which fell into an ethical grey area. Since I had worked within Mental Health and Addiction Services most of my career, I felt apt to deal with ethical dilemmas regarding confidentiality, and was comfortable seeking consultation when needed. One of the greatest challenges of my values and ethics I experienced occurred in my work with young women experiencing eating disorders. I felt particularly conflicted when the pediatrician would recommend involuntary hospitalization due to medical instability. While I knew the young person’s safety was at risk, part of me feared the repercussions of forcing the young person to be in hospital to support weight restoration. I worried about infringing upon the young person’s autonomy and revoking their self-determination to make choices on voluntary informed consent (Canadian Association of Social Workers, 2005, Value 1). I worried that by
hospitalizing the young person they would feel disempowered, and that it would damage our therapeutic rapport.

Though I was fortunate that none of the young people I worked with were hospitalized during my practicum, there were a few clients that were at risk of being hospitalized during that time. In these incidents, it was most helpful for me to work through my feeling ethically conflicted in supervision and consultation with senior staff members. In addition, having the Canadian Association of Social Workers Code Ethics (2005) to provide guidance was most helpful in easing my discomfort and helping me to make ethical decisions.

It is evident that the CASW Code of Ethics (2005) strongly influenced the way in which I provided service to clients accessing services at YCC. More specifically, each of the values within the CASW Code of Ethics can be applied to direct practice. Value 2: Pursuit of Social Justice strongly fits with a narrative and anti-oppressive approach to practice by analyzing social constructs and systemic constraints (CASW, 2005). It is important that the construction of clinical interviews is conducted in a manner that is not oppressive and does not make assumptions about client need (Ife, 2012). As such it is important the social worker not assume a stance of power to act on behalf of clients (Ife, 2012). This value is demonstrated through the collaborative, narrative approach to care at Youth Nourishing Connections. Value 3: Service to Humanity which recommends social workers work to promote individual growth, and working towards achieving goals was an unofficial guiding principle of YCC team (CASW, 2005). Value 4: Integrity in Professional Practice emphasizes the importance of establishing clear boundaries and developing honest, reliable relationships with clients (CASW, 2005). Awareness of how boundaries are constructed and an analysis of how boundaries inform practice is essential (Ife, 2012). Value 5: Confidentiality in Professional Practice is the most strongly emphasized value at
Mental Health and Addiction Services, and perhaps within the entire Saskatoon Health Region (CASW, 2005). Employees are committed to ensuring the privacy and confidentiality of all clients “consistent with the Criminal Code of Canada, The Child and Family Service Act, The Mental Health Protection Act, The Health Information Protection Act and the guidance from professional associations” (SHR, 2014, Privacy Notice). Finally Value 6: Competence in Professional Practice emphasizes the importance of the providing the highest quality service possible (CASW, 2005). It also highlights the importance of professional development and the development of new knowledge (CASW, 2005). This value was demonstrated in the achievement of my learning objectives. Moreover, the research efforts being pursued, and the plans for members of the YNC treatment team to present their model of care at the NEDIC conference demonstrates that ongoing efforts of service providers to provide the best care possible.

**Conclusion**

In summary, this report provides a full overview of my practicum experience at YCC. An explanation of my practicum placement, a description of the client demographic I served, as well as my learning goals and objectives, were provided. My ideological framework was discussed, as was theory which informed my practice. My primary objective of gaining experience and knowledge providing treatment to adolescents experiencing eating disorders was fulfilled through direct practice, observation, and working within a collaborative team at Youth Nourishing Connections. The secondary learning activities described included: working on research projects, developing a national conference presentation, and participating in clinical consultation. Clinical supervision further supported the achievement of my goals.
As a clinical social worker with training and experience in a variety of therapeutic techniques, my knowledge base and clinical skills deepened during my 450-hour placement. My practicum reflected praxis, but also allowed me to engage in critical analysis of the systems and social structures that impact the way in which client care is provided. Through my discovery of narrative therapy and intensive training, I became equipped to engage in therapeutic conversation which aligned with my feminist ideology. I learned how to ingrate a narrative approach to care in both family therapy, and in family-based eating disorder treatment.

Any challenges I faced during my practicum were shared in this document, as were ethical considerations and potential value conflicts. Throughout my experience, my practice was informed by evidence-based models of care, research, supervision with my professional associate and consultation with other staff. I felt my sessions supported client goals and autonomy, and promoted empowerment to further thicken their counter stories. I believe the knowledge and experience gained during my practicum will continue to inform my future social work practice. My practicum experience further solidified my interest in working with families and young people experiencing eating disorders. As such, I hope to pursue a career which supports my continuation of this important work.
References


Appendix A

**Practicum Proposal**

**Student Information:** Kayly Yablonski, 402 Kirkpatrick Court, Saskatoon, Sk, S7L 6Z2, 306-381-7836

**Placement Information:** Youth Community Counselling, Mental Health and Addiction Services, Saskatoon Health Region. 715 Queen Street, Saskatoon, Sk., S7K 4X4

**Academic Supervisor:** Dr. Darlene Chalmers

**Academic Committee Member:** Dr. Gabriela Novotna

**Professional Associate:** Joanne Brothwell, MSW, RSW (Sk), 715 Queen Street, Saskatoon, Sk., S7K 4X4, 306-655-7815

**Period of Practicum:** 450 hours practicum will be completed full-time, from January 5, 2017 – March 16, 2017.

The intent of this practicum is to enhance my clinical direct practice with youth experiencing eating disorders and their families, within an interdisciplinary environment. This will include deepening my theoretical knowledge in this area and integrating this understanding into my practice.

i. **Learning goals:**

1) To gain hands on experience in implementing treatment methods by providing individual and family therapy to youth clients experiencing disordered eating;

2) To provide family therapy to clients accessing Mental Health and Addiction Services
3) To expand my knowledge of best practice for clients with eating disorders, and participate in local research efforts regarding outcomes of clients receiving treatment for eating disorders.

4) To participate in an interdisciplinary team that provides client-centered treatment to youth with eating disorders through a Stepped-Care Model in a community setting.

ii. **Learning objectives:**

1) To observe and co-facilitate sessions in ‘Nourishing Connections’ interdisciplinary clinic appointments as a foundation to my learning.

2) To conduct a literature review on best practice treatment models, and current approaches to community-based eating disorder treatment in Canada. This will support my practice and proposed research efforts.

3) To contribute to a team-based research project(s) by providing input based on the current literature in the development and implementation of a research study.

4) To carry a caseload that fits my learning goals (individuals with disordered eating and/or family therapy cases)

To apply critical self-reflective knowledge in evaluating the theories, evidence-informed practice, and overall learning experience throughout my practicum.

iii. **Learning outcomes:**

1) Meet regularly with my professional associate for clinical consultation and supervision related to case review and service delivery.

2) Discuss my emerging understanding of the literature with my professional associate and the interdisciplinary team.

3) Complete a MSW Field practicum report and presentation.