Therapeutic Interventions with Youth and Their Caregivers

A Practicum Report
Submitted to the Faculty of Graduate Studies and Research
In Partial Fulfillment of the Requirements
For the Degree of

Master of Social Work
University of Regina
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Regina, Saskatchewan
April 2018

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Abstract

This paper chronicles a four-month field practicum at Youth Community Counselling, through Mental Health and Addiction Services under the Saskatchewan Health Authority. This paper provides an overview of narrative therapy and the Neurosequential Model of Therapeutics and how they were applied in clinical practice. There is also a detailed discussion of the variety of groups that were facilitated and attended throughout the field practicum. An outline is provided about the professional development opportunities that strengthened my practice. I also reflected on the ethical issues and challenges I faced during my field practicum. Throughout, ways in which I was able to achieve my learning objectives are examined.
Acknowledgements

Many people have supported, taught, and mentored me throughout my time as a social worker and as a social work student. This pursuit was no different. I would like to thank the Faculty of Social Work at the University of Regina for a rich education. I would also like to thank Dr. Kara Fletcher, my academic supervisor, who I admire greatly, for all her time and support. Thank you also to Dr. Funke Oba who dedicated her time as my committee member. I also want to thank my professional associates, Terri Peterson and Jenn Bauer. Both women have extensive knowledge in different areas and I have been lucky enough to learn from their experience. Thank you for your time, encouragement and guidance. Further, I am grateful to everyone at Youth Community Counselling, who shared their knowledge and time with me. Thank you to Kim and Ron, my mom and dad, for always supporting all that I do.

Finally, I would like to thank all the young people and their families who bravely let me into their lives and trusted me to help them.
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Introduction

I began post-secondary studies in 2007, immediately after obtaining my high school diploma. Since then, there has only been a short time when I was not pursuing post-secondary education. Having been a student for so long, I became accustomed to following direction. So, when it came time to select a field practicum placement, I did not fully anticipate the level of autonomy this process would entail. In addition, I felt as though I was in a unique and favourable position having already had professional experience as a counsellor and a group facilitator. I was able to choose a placement that would help me truly refine my skills as a clinical social worker.

The practicum selection process was refreshing, exciting, and somewhat daunting. I was able to dictate what I wanted to learn and where. I have always been drawn towards the clinical side of social work practice so I knew I wanted a placement in a clinical setting. I aspired to develop new skills and hone pre-established ones. Through reflection and consultation with my academic supervisor, I decided that a field practicum at Youth Community Counselling would be right for me. This is a clinical setting with a singular focus on youth and their caregivers; and, an environment where I would be able achieve the following practicum objectives:

1) Develop a deeper understanding of narrative therapy and apply this modality in a clinical setting with youth.

2) Develop a deeper understanding of the Neurosequential Model of Therapeutics (NMT) and develop the ability to apply this model in a therapeutic setting with youth.

3) Enhance group facilitation skills.

4) Enrich therapeutic skills using expressive arts.

5) Develop further competency in working with caregivers of youth accessing mental health services.
This paper will explore my learning experiences throughout my field practicum, which took place from September 5th to December 7th, 2017. I will provide an overview of Youth Community Counselling as an organization, explore the clinical work I did with individuals and group facilitation, highlight the professional development opportunities I engaged in, and explore ethics. Finally, I will reflect on the successes and challenges I experienced throughout my four-month field practicum. Overall, this paper will explore how I was able to achieve many of my practicum objectives, and how I was able to integrate new opportunities and build capacity in areas that I did not anticipate.

**Agency Overview**

Youth Community Counselling is located at 715 Queen Street in Saskatoon, Saskatchewan. Youth Community Counselling operates under the umbrella of Mental Health and Addiction Services, through the Saskatchewan Health Authority, formerly the Saskatoon Health Region. In 2001, Mental Health Services and Addiction Services combined into one care group, having been two separate entities before this date (Saskatoon Health Region, 2017). Since its inception, Saskatoon Health Region’s mission has been able to improve health through excellence and innovation in service, education and research, building on the strengths of people and partnerships (Saskatoon Health Region, 2017).

The Youth Community Counselling Program offers a wide variety of services to youth between the ages of 12-18, and their caregivers. Youth Community Counselling has a multidisciplinary team which allows for a wraparound approach to caring for the mental health of youth and their caregivers. Intake workers, social workers, psychologists, recreation therapists, addiction counsellors, dietician services, psychiatric nursing, outreach workers, psychiatry and a dedicated support staff all work cohesively to provide services and care to youth.
in the community. In addition to individual and family counselling, Youth Community Counselling offers wide range of groups for youth and caregivers. During my practicum Youth Community Counselling offered the following groups: Helping Teens Cope, a group that aims to provide caregivers with mental health education; Healthy Minds, a drop-in group for teens which is designed to help with coping skills; and Creative Expressions and Mood and Movement, two groups that utilize art and movement as ways to cope and recover from mental illness. Fortunately, I was able to facilitate and observe many groups that Youth Community Counselling offers, which will be discussed later in this paper.

The process at Youth Community Counselling is streamlined to provide better access to services. First, an intake must be completed by an intake worker with the youth, or a parent. Alternatively, referrals can be made by school personnel or outreach workers who work at Youth Community Counselling. Once the intake has been completed the youth is placed on a list corresponding to the service he or she wishes to access. On a weekly basis, staff gather and cases are assigned. For clinical staff, they receive the intake, and follow-up with the client personally. During the first session, the clinician gathers general information and the client signs the required paperwork. This paperwork includes a Privacy Notice, which outlines the limits of confidentiality; and, a Consent for Release of Information which gives the clinician permission to share information with another agency, if necessary. There is also a Consultation Consent which a client can sign giving permission to verbally consult with other service providers. If necessary, the Client Request for Email/Text Message Communication form can also be signed. This form allows clinicians to communicate through electronic means with clients.
Clinical Work

Narrative Therapy

One of my practicum objectives was to focus on specific therapeutic modalities. One of these modalities was narrative therapy. While I had read about narrative therapy in the past, the opportunity had not presented itself to focus primarily on this approach in my current practice. My field practicum was the perfect opportunity to learn more about and focus on a narrative approach.

Literature Review

Narrative therapy is a theoretical approach developed by Michael White and David Epston in the late 1980s (Madigan, 2010). At the time, these two men were influenced greatly by what they perceived as the changing landscape of the field of therapy (White, 2009). They realized that feminism, race and the influence of colonialism were gaining more prominence and that these issues needed to be integrated into theoretical approaches to therapy (White, 2009). Epston and White honored this by moving away from the traditional psychological, psychiatric, and systematic approaches informed by individuality and moved towards a different kind of approach that touched more on relationships, history and culture (Madigan, 2010). Both men were fascinated with literary processes like narrative and metaphor (Madigan, 2010). They honed-in on life’s complexities and believed that how lives are lived is often mediated through the expression of the stories people tell (Madigan, 2010). White and Epston contended that within the context of therapy, there could be more than one interpretation of people’s problems (Madigan, 2010). Further, they advocated that these interpretations were heavily filtered through cultural norms (Madigan, 2010). White and Epston created narrative therapy as an approach that positions people as experts of their own lives (Morgan, 2000). Narrative therapy postulates that the problems people experience are separate from themselves (Morgan, 2000). Further, the narrative approach provides that through
storytelling, people can call upon and refine skills, competencies, beliefs, values, commitments and abilities that will assist them to reduce the influence of problems in their lives (Morgan, 2000).

During my field practicum, I immersed myself in relevant literature and became familiar with the overarching themes and practices within the narrative approach.

**The position of the therapist.** One theme that emerged from the literature regarding narrative therapy is the position of the therapist. When an individual accesses professional services, the professional is typically characterized as the expert (McNamee & Gergen, 1992). The way that therapy is conceptualized, is that an individual seeks to consult with an expert regarding challenges they are facing in their life and, relies greatly on the therapist to lend their expertise. Narrative therapy moves away from the therapist as the expert, and towards the client being the expert (Morgan, 2002). Michael White described this role as being decentred, yet influential (White, 1997) When using the narrative method, the therapist is not present to give advice, solutions or opinions (Morgan, 2002). In addition, it is not the therapist’s role to be in a position of authority that provides normative judgements or evaluations about the client’s problems (Morgan, 2002). Instead, the narrative approach holds the person’s ideas and resources at the fore and encourages the therapist to provide a consultative stance (Morgan, 2002). In order to do this, Michael White and David Epston implore therapists to refrain from making generalizations and encourage them to strive for a certain level of consciousness (White & Epston, 1990). This is important in order for the therapist to maintain the position of consultant. It also helps therapists be more mindful of declining the invitation to be the expert in peoples lives (White & Epston, 1990; Morgan, 2002). Other ways that therapists may move away from occupying the expert role may be by allowing clients to write down their own notes (Morgan, 2002). Alternatively, the therapist can read their notes aloud and ask for the client’s approval.
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(Morgan, 2002). Therapists can also acknowledge the two-way nature of therapy (White, 1997). One way to do so may be reflecting back to a client how a particular conversation may have impacted their work (Morgan, 2002). When therapists position themselves differently, there is a greater capacity to fully witness and appreciate people’s competencies and abilities (Morgan, 2002).

**Externalization.** When examining literature pertaining to narrative therapy, it becomes clear that externalization is a fundamental aspect of narrative practice. Externalizing is a therapeutic approach that encourages persons to objectify and, on occasion, personify the problems that they experience as oppressive (White & Epston, 1990). By externalizing problems, they become separate and therefore external to the person or relationship that was attributed as problematic (White & Epston, 1990). Problems that may have been considered to be inherent, or fixed and restricting to persons or relationships, are perceived to be less fixed and less restricting (White & Epston, 1990). Externalizing the problem allows the therapist and the client to focus more on relationships with problems and how these might be altered or renegotiated (Morgan, 2002). Further, externalizing enables persons to separate themselves from dominant stories that have been shaping their lives and relationships and perceive these stories in different ways (Madigan, 2010). One popular example of externalization is derived from Michael White’s work with a young boy experiencing encopresis. First, Michael White, the young boy, and his family mapped the influence of the problem in the families’ life. By doing so, the problem’s breadth of influence in the behavioural, emotional, physical, interactional domains are easier to identify (White & Epston, 1990). From there, the group began to externalize the encopresis in a natural way which led to the label of “Sneaky Poo” (White & Epston, 1990). Instead of discussing the boy’s encopresis by saying, “you’re soiling” it came to be referred to as “the Sneaky Poo’s tricks”
(White & Epston, 1990). This enabled the young boy to see encopresis through a different lens. It became an outside invader in his life that he and his family could think differently about and could find ways to manage. Another example of externalization is when a client describes themselves in negative terms. For instance, when a client says, “I am useless” a therapist could respond by saying “am I right in thinking that the problem tries to tell you about the type of person you are?” (Morgan, 2002). Epston and White (1990) have discovered many advantages to the practice of externalization:

1. It decreases unproductive conflict between persons. It can aid in removing blame regarding who is responsible for the problem;
2. Undermines the sense of failure that may have developed for many persons in response to the continuing existence of the problem and how despite their attempts to resolve it;
3. Paves the way for persons to cooperate with each other, to unite against the problem, and to escape its influence in their lives and relationships;
4. Opens up new possibilities for persons to take action to retake their lives and relationships from the problem and its influence;
5. Frees persons to take a lighter…and less stressed approach to “deadly serious” problems;

One point of consideration when discussing the practice of externalizing is that externalization does not mitigate responsibility. It does not separate people from responsibility for the extent to which they participate in the survival of the problem (White & Epston, 1990). It solely allows people to separate themselves from problems and gain new perspective (Denborough,
2014). Once the problem has been named, and once the problems tactics and effects are brought to light, then there is an opportunity for a person and their family to change the relationship with the problem (Denborough, 2014).

**Re-authoring.** Re-authoring or re-storying conversations is another central tenant of narrative therapy. Narrative therapy relies heavily on the stories that individuals tell about their experiences. In the context of narrative therapy, a story consists of events that are linked in sequence, across time, and according to a plot (Morgan, 2000). Many who access therapy have made this choice based on the stories they tell themselves and others about complex circumstances that may have given rise to negative conclusions about themselves (Carey & Russell, 2003). The dominant stories that people tell themselves make a significant difference as to the effects of that event in a person’s life (Carey & Russell, 2003; Morgan, 2000). Everyone faces different circumstances in life that cannot be changed. However, people can change the ways in which these circumstances are understood and interpreted (Carey & Russell, 2003). Re-authoring or re-storying conversations occur between the therapist and client and involve the identification and co-creation of alternative storylines (Carey & Russell, 2003). The premise behind these conversations is that no one story can possibly encapsulate the totality of a person’s experience (Carey & Russell, 2003; Morgan, 2000). People’s lives are multistoried, there are many stories that happen at the same time and different stories can be told about the same events (White, 1997). When a therapist seeks to assist someone in re-authoring or re-storying a dominant storyline, they are taking a position of inquiry and seeking to notice any event that contradicts the dominant story (Carey & Russell, 2003). The narrative approach contends that if one is looking closely and carefully, these contradictions are always apparent – even if they are small (Carey & Russell, 2003). Maggie Carey and Shona Russell use the example of a woman named Mary, who has been
experiencing anxiety (2003). The therapist working with Mary would focus on anything Mary may have done that contradicts what the anxiety usually dictates (Carey & Russell, 2003). Mary’s dominant story is that anxiety has precluded her from participating in life. Through inquiry from the therapist, she mentions that she has been walking her son to preschool. In this case, the therapist, careful not to point out these contradictions, begins to ask more questions about what made this possible (Carey & Russell, 2003). If another similar event where Mary has engaged in life despite her anxiety can be located in Mary’s history, they can be linked together and this can be the beginning of an alternative storyline (Carey & Russell, 2003). The therapist may then ask Mary to name the new story taking shape, and to give it a thicker description (Carey & Russell, 2003; Madigan, 2010). By identifying alternative storylines, the therapist can then begin to consult the client about what these new developments may mean about the person and his or her relationships (Madigan, 2010). Ideally, these conversations encourage a certain reengagement with life and with history and provide options for people to more fully inhabit their lives and relationships (Madigan, 2010).

**Narrative Therapy in Practice**

Fortunately, I was able to integrate a variety of these themes into my practice at Youth Community Counselling. First, I began to reflect on my position as the therapist, particularly as a therapist working specifically with youth. Young people are often characterized as intuitive, spontaneous, imaginative, and innocent (Marsten, Johnson, & Epston, 2011). At the same time, they are often not thought to possess any of the requisite knowledge and skill assumed to be essential in the difficult endeavour of problem solving (Marsten et al., 2011). In my experience, youth are quite eager for guidance or anticipate guidance and direction from adult figures in their lives. Many young people would come to counselling at the behest of adults in their lives, who
had previously identified what aspect of the youth’s behaviour was problematic and instruct the therapist to help. During these moments, it became imperative for me as the therapist to be mindful that the youth were indeed experts on their own lives. It was not up to their caregivers, teachers, or friends to decide what was problematic in their lives, it was up to the youth. They were the expert and I was the consultant.

I also began to discover through my work at Youth Community Counselling that my practicum objective of using narrative therapy in practice meshed very well with another practicum objective of integrating expressive arts into therapy. I frequently used a narrative activity described in David Denborough’s book, *Retelling the Stories of our Lives: Everyday Narrative Therapy to Draw Inspiration and Transform Experience* (2014). This activity is called the “Journey of Life” and it is intended to be a visual way for individuals to provide thick, rich descriptions of positive events, skills, knowledge and future aspirations (Denborough, 2014). To begin, the individual draws a winding road from one side of the piece of paper to another. In the middle, a circle is drawn. On the left side, the individual writes ‘road already travelled’ and fills that portion with words, drawings, and pictures about where they have come from. This can include favorite places travelled, milestones achieved, obstacles they have overcome or anything that illustrates what an individual has been through (Denborough, 2014). On the right side, ‘the path yet to come’ is written. This side is filled with similar visuals, however, the client describes where they are heading, places they wish to see, gifts they give to others, and obstacles they wish to overcome. Finally, the individual is encouraged to look down at their journey and name it. This viewpoint allows for externalization and a powerful reflection of all that encompasses their life.

While I engaged in this activity several times with various clients one case stands apart from the others. A young girl was seeking counselling for what was described as generalized
anxiety. Anxiety was described as being a prominent force in her life. Her anxiety seemed to revolve around two family members. The first family member was an older brother who had experienced some significant health issues the year before. She was also anxious about a different family member who had struggled with addiction. I decided to use the Journey of Life to provide a creative, fun way to show this young woman that while anxiety seemed to be the main story of her life, she was in fact, multi-storied. She was defined by a multitude of things, not just her anxiety. She was eager to try this activity and soon the page was filled with words and vivid colours. On the left side, she recorded her accomplishments, where she found strength. On the other side, she recorded an obstacle she felt she had overcome. After observing both sides, I asked her to expand on how she had overcome this obstacle. She described that while doing the exercise, she began to realize that the anxiety she felt about her brother’s health was not as prominent. It was no longer her burden to carry, and she now saw that she was the one who needed to be cared for. On the right side, she drew dreams of the future, places she wanted to visit, and one more obstacle she felt she had not yet overcome. When I probed further, it was clear there were unresolved feelings about the family member who was struggling with addiction. I attempted to explore this, but my client was unwilling. The following session she confided in me that this person had assaulted her in the past. I was the first person she had ever told. She had put it down as an obstacle to overcome because she realized that she needed to unburden herself and begin healing. I am uncertain as to whether it was the externalizing nature of this activity, the rapport and trust we had built, some other force, or a combination of all three that gave this young person the courage to speak out. Regardless, I am extremely proud of this young person and her bravery.

As a therapist, I have always been drawn to expressive arts. I wanted to use my field practicum as an opportunity to further explore and incorporate expressive arts into my practice.
Narrative therapy allowed me to explore an expressive art that was not in the form of visual arts but in the form of therapeutic letter writing. There are many different forms of therapeutic letters within the narrative method. One is a letter of invitation, or a letter that a therapist may use to engage someone in therapy who may be reluctant (White & Epston, 1990). Letters of prediction are ones that therapists ask permission to write and they attempt to make predictions for a person, relationship, or family’s future with the therapist hoping it may act as prophecy to be fulfilled (White & Epston, 1990). There are also counter-referral letters and letters of reference. Counter-referral letters are sent to the individual who referred the client, while letters of reference are the therapist vouching for the client (White & Epston, 1990; Bjoroy, Madigan, & Nylund, 2015). There are also letters for special occasions, that can act as a way to mark difficult or celebratory occasions (White & Epston, 1990). Finally, there are redundancy letters. Redundancy letters are often written with the help of a therapist, to inform someone that they are relieving themselves of a job or to inform someone else that they are relieved of their job (perhaps informing someone that they are relieving themselves of a caregiver role) (White & Epston, 1990).

While at Youth Community Counselling, I assisted a young woman to write a redundancy letter to her mother. This young person came to counselling to figure out how to cope with recent feelings of anxiety. After a few sessions working together, it became clear that the anxiety she was experiencing was due to the many roles and expectations placed upon her by her mother. This young person felt as though she was the babysitter, the helper, the protector and these roles were causing her to feel overwhelmed and anxious. Her mother was a single parent, and my client had two younger sisters that she cared for regularly. Further, her mother had been in an abusive relationship in the past. This caused the youth to feel protective and worried. It was not until she came to counselling that she realized how significantly these roles had impacted her mental health.
She decided that she needed to discharge herself from these roles and needed to outline an invitation to her mother to discuss transforming her role in the family (White & Epston, 1990). We spent one session constructing this letter and another session debriefing with her mother. This letter was a transformative experience for my client as it was a way for her to re-author her story and her role in her family. Gaining understanding from her mother led to an improvement in her mental health.

The final narrative activity I used in my work at Youth Community Counselling was “Team Sheets” which are described in Retelling the Stories of Our Lives: Everyday Narrative Therapy to Draw Inspiration and Transform Experience by David Denborough (2014). Essentially, Team Sheets provide a different way to think about life and identity (Denborough, 2014). They encourage individuals to reflect on their lives as a club, association, or a team (Denborough, 2014). This metaphorical act encourages a person to make deliberate decisions about who they would include on their team, and who they would not (Denborough, 2014). This is a distinct type of recollection called “re-membering”. I decided to use this activity with a youth who came to counselling due to low mood and family issues. The dominant storyline of this youth was that she was alone. She felt as though she had little supports and nowhere to turn. While the Journey of Life may have been effective, I felt as though creating a Team Sheet would be more appropriate after hearing about her love for sports. Basketball and hockey were huge sources of happiness and strength, and I felt as though a Team Sheet would resonate more with this youth. This activity was highly successful, it encouraged my client to reflect and consider all the people she did have in her life and the roles that they played. In particular, she identified a teacher that had an enormous impact on her life. Ultimately, this activity helped her begin to realize she was less alone than she initially thought.
Neurosequential Model of Therapeutics

The other modality that I focused on was the Neurosequential Model of Therapeutics (NMT). Fortunately, I was able to observe NMT in practice and I was able to immerse myself in literature relevant to this method.

Literature Review

The Neurosequential Model of Therapeutics (NMT) was developed by psychiatrist Bruce Perry (Perry & Hambrick, 2008). NMT is not a therapeutic technique, but a developmentally sensitive, neurobiological approach to clinical work (Perry & Hambrick, 2008). NMT aims to integrate core principles of neurodevelopment and traumatology into a comprehensive approach for the child, their caregivers and the broader community (Perry & Hambrick, 2008). The approach helps match the timing and nature of particular therapeutic techniques with the developmental stage of the client (Perry & Hambrick, 2008). For instance, when using the NMT method, it may be prudent to use therapeutic methods that may be better suited to a younger individual as the chronological age may not be consistent with the developmental age of the child or youth. Ultimately, the goal is to structure the assessment, articulate primary problems, identify key strengths, and apply interventions in a way that will help caregivers, educators, therapists, and other professionals best meet a child’s needs (Perry & Hambrick, 2008).

In order to conduct formal NMT assessments, the practitioner must have NMT certification. NMT certification requires an individual to meet specific criteria, which involves ten sessions of NMT case-based training (The Child Trauma Academy, 2006). Once certified, the clinician is able to conduct NMT assessments as they see fit. In short, these assessments include the clinician taking a detailed history about past and current experience and functioning (The Child Trauma Academy, 2006). The clinician asks about adverse experiences, relational...
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health factors as well as strengths and problems in current functioning (The Child Trauma Academy, 2006). This information is synthesized and entered into the online assessment tool. What is generated is a visual representation of the individuals estimated current functioning, called a Functional Brain Map (The Child Trauma Academy, 2006). The Functional Brain Map identifies various areas in the brain that may have functional or developmental problems, which can help guide the selection and sequencing of developmentally appropriate interventions (The Child Trauma Academy, 2006). This assessment gives the clinician a more detailed look at a youth’s development, which in turn, can better inform their care.

While I am not certified in NMT, I was able to identify several core themes that are integral to the NMT method and find ways to apply them to my practice with youth.

Attachment. One of the overarching themes and one of the pillars of NMT is attachment theory. In 1969, John Bowlby developed attachment theory while attempting to understand the distress felt by infants who were separated from their parents (Fraley, 2010; Bowlby, 1969). He had observed infants who were separated from their parent would go to extraordinary lengths to re-establish proximity (Fraley, 2010; Bowlby, 1969). Bowlby believed that these attachment behaviours, such as crying and searching, were adaptive responses to being separated from a primary attachment figure who provides affection, protection, and care (Fraley, 2010; Bowlby, 1969). Bowlby asserted that the attachment behaviours would continue until the child is able to re-establish a level of physical or psychological proximity to the attachment figure (Fraley, 2010; Bowlby, 1969). Often times, the child is unable to re-establish proximity to their caregiver. If this occurs, Bowlby believed that young children experience profound despair and depression (Fraley, 2010; Bowlby, 1969).
Bowlby believed he had theorized the normative dynamics of the attachment behaviours but accepted there are differences in the way that children assess the accessibility of the attachment figure and how they express their attachment behaviours (Fraley, 2010; Bowlby, 1969). In the early 1970’s, Bowlby’s colleague, Mary Ainsworth, developed a technique aimed at exploring the individual differences in attachment (McLeod, 2014). This technique was called the Strange Situation Classification. The Strange Situation involved one hundred parents bringing their 12-18-month-old infants to the laboratory where they were systematically separated and then reunited with one another for approximately three minutes at a time (McLeod, 2014). Mary Ainsworth’s Strange Situation Classification resulted in the development of three main attachment styles:

1) Secure Attachment: Children feel confident that the attachment figure will be available to meet their needs. They use the attachment figures as a safe base to explore the environment and they seek their attachment figure for comfort in times of distress. Secure attachment is developed when infants have a caregiver that is sensitive to their signals and responsive to their needs (Main & Cassidy, 1988).

2) Insecure Avoidant: Children do not orientate to their attachment figure while investigating the environment. They are very independent of the attachment figure physically and emotionally. They do not seek contact with the attachment figure when distressed. Insecure avoidant attachment is developed when children have caregivers who are insensitive and rejecting of their needs (Ainsworth, 1979; Behrens, Hesse, & Main, 2007).

3) Insecure Ambivalent/Resistant: Children develop an ambivalent behavioural style towards their attachment figure. The child will exhibit clingy and dependent
behaviour, but will reject the attachment figure when they attempt to engage in interaction. The child fails to develop feelings of security from the attachment figure but has trouble moving away from the attachment figure to explore surroundings. This attachment style results from an inconsistent response to a child’s needs from the primary caregiver (Ainsworth & Bell, 1970).

Ainsworth’s work demonstrated the individual differences of attachment were correlated with infant-parent interactions in the home during the first year of life (Fraley, 2010). The Neurosequential Model of Therapeutics pays special attention to those interactions and their resulting attachment styles in order to better understand a child or youth’s behaviours and, in turn, provide suitable interventions.

**Trauma & Brain Development.** The Neurosequential Model of Therapeutics is heavily informed by the impact trauma has on the brain development. Brain development is an involved and dynamic process. Brain development occurs from the bottom up, and the first part of the brain to develop is the brain stem (Perry, 2014). The brain stem is responsible for mediating core regulatory functions such as body temperature, heart rate, respiration, and blood pressure (Perry, 2014). Next is the diencephalon cerebellum which regulates arousal, appetite and sleep (Perry, 2014). Together, the brain stem and diencephalon cerebellum make up the reptilian or “survival” brain (Perry, 2014). The limbic system develops next, and it is responsible for emotional responses that guide behaviour (Perry, 2014). The frontal cortex is the final part of the brain to develop. The frontal cortex regulates the most complex and highly human functions like speech, language, abstract thinking, planning and deliberate decision making (Perry, 2009). Trauma, neglect and related experience of maltreatment disrupts this process and significantly impacts the developing brain (Perry, 2009). Depending on the child’s age, the impacts will vary due to the
sequence in which the brain develops. The same traumatic experience will impact an 18-month-old child differently than a 5-year-old (Perry, 2009). Considering the fact that the majority of brain development occurs during the first four years of life, early traumatic experiences have a disproportionate influence on brain organization and later brain functioning (Perry, 2014).

Traumatized children live in a constant state of alarm which results in the higher parts of the brain (cortex) shutting down, making them unable to think (Perry, 2014). Since trauma can cause attachment disorders, children may grow up unable to gain reward from emotional or relation interaction, which many perceive as threatening (Perry, 2014). When trauma is involved, the only part of the brain that is able to function properly is the most primitive, the brain stem and diencephalon (Perry, 2014).

NMT relies heavily on neurobiology to explain trauma because it helps provide an understanding of why children may behave in certain ways.

**Neurosequential Model of Therapeutics in Practice**

The Neurosequential Model of Therapeutics delivers an approach to working with youth that is based in the understanding of attachment and brain development.

A deeper understanding of the impact of trauma on brain development greatly influenced my practice. Before being introduced to NMT, I would use Cognitive Behavioural Therapy (CBT) frequently in my practice. While Cognitive Behavioural Therapy is an evidence-based, effective therapeutic intervention, it may not be the best approach with youth who have experienced trauma. CBT requires a developed, fully functional prefrontal cortex (Perry, 2009). Trauma can shut down the prefrontal cortex and it becomes unable to regulate the lower levels of the brain (Perry, 2014). Using a CBT approach would be ineffective because it relies heavily on the abilities of the prefrontal cortex (Perry, 2014). NMT’s focus on brain development helped me develop a deeper
understanding about where the youth I was working with may be developmentally, and encouraged me to focus on the approach that would be best to use with them.

For instance, one youth that I was working with sought counselling for what she described as anxiety. However, many of the strategies that we were working on did not seem to be effective. Each session this youth was dysregulated, impulsive and could not seem to focus. After gathering more information about her past, it became clear that her upbringing had been quite traumatic. I decided to integrate some of the principles of NMT that are based in trauma and its impact on attachment and brain development. In order to help this youth, I first needed to help her self-regulate. NMT taught me that patterned, repetitive, rhythmic activity is helpful to move from high anxiety states, to calmer more cognitive states (Perry, 2014). This is because the brain stem and the diencephalon have powerful associations with rhythm due to the rhythmic somatosensory activity felt in utero and early childhood (mother’s heartbeat, rocking) (Perry, 2009). Rhythm is regulating, and elicits a sensation of safety. Once someone is regulated, they become more in control of their body and brain functions (Perry, 2009). I decided to integrate patterned, repetitive, rhythmic activities into the work I was doing with the youth who had experienced trauma. Before each session, we performed a pattern of clapping and stomping our feet to a certain rhythm. I noticed immediately how this activity regulated my client and enabled her to participate fully in her counselling sessions.

NMT also encouraged me to be more mindful as a social worker. For many traumatized youth, touch may be associated with pain or abuse. A touch on the shoulder to some may be perceived as a friendly gesture, but to youth who have a traumatic background, this could be perceived as threatening. As a social worker and therapist, it is imperative to always be attuned to how clients are responding to any attempts at nurturing and then respond accordingly (Perry,
THERAPEUTIC INTERVENTIONS WITH YOUTH AND THEIR CAREGIVERS

2001). I am now more conscientious about how small, innocent actions may be distressing for youth. It is important to strive to achieve a balance between being nurturing but also being sensitive to client needs. I believe that this comes with being attuned to clients, which NMT emphasizes.

NMT also provided me with an opportunity to integrate more psychoeducation in my practice with youth, and their caregivers. Developing a deeper understanding of attachment, brain development, and trauma gave me the confidence to deliver this information to youth and caregivers. Many times, I explained how the brain develops, and what functions each part of the brain are responsible for. To do this, I integrated Daniel Siegel’s (2009) hand-model of the brain. This involves creating a representation of the human brain by putting your thumb in the middle of your palm and curling your fingers over (Siegel, 2009). The wrist represents the spinal cord. When you lift up your fingers and raise your thumb, you’ll see the inner brainstem represented in your palm (Siegel, 2009). When placing the thumb back down, the approximate location of the limbic area is represented (Siegel, 2009). When the fingers are curled back over the top, the cortex is in place (Siegel, 2009). Further understanding of NMT principles encouraged me to learn more about brain development, and in turn, I was able to find ways to use this information to provide creative, understandable ways to educate youth and caregivers.

Finally, certain NMT principles and approaches provided very simple interventions that are not exclusive to a therapy session. Every youth can engage in a variety of patterned, repetitive, rhythmic activities including walking, running, yoga, dancing, singing, massage, breathing, and drumming, which are only a few of the activities that can help activate the brain and regulate behaviours. It feels good as a clinician to be able to give interventions that can be used easily, and inexpensively, at home. I was able to suggest and integrate these activities into my practice and will continue to do so going forward.
While I am not certified in the Neurosequential Model of Therapeutics, I have made efforts to understand some of the fundamental underpinnings of this model and use them in my clinical work.

**Groups**

Another one of my learning objectives was to enhance my group facilitation skills. I was able to observe, facilitate, and even participate in various groups that Youth Community Counselling offered during the fall of 2017. This not only helped me become more proficient in group facilitation, but I was also able to see the impact and importance that groups have in our community.

**Parent-Therapist Program**

One group I participated in was the Parent-Therapist Program. This program was developed through a partnership between the Ministry of Social Services and the Saskatchewan Health Authority. Individuals interested in becoming parent-therapists are first screened by a senior social worker who currently oversees the program. The screening involves a questionnaire, criminal record check, and home visit. If a potential parent-therapist is approved, they must then meet separate criteria established by the Ministry of Social Services.

While I was at Youth Community Counselling nine parent-therapist homes were operational. On a bi-weekly basis, parent-therapists would meet with my Professional Associate and myself as well as case workers from the Ministry of Social Services. Parent-therapists receive training, attend workshops and are required to attend all meetings. Parent-therapists are foster parents, and their homes are intended to be therapeutic environments where youth in care can feel safe and comfortable. The parent-therapists are expected to have a basic set of skills to provide therapeutic interventions when necessary.
A typical parent-therapist meeting begins with psychoeducation. While I was participating, the psychoeducation was a DVD entitled Understanding Traumatized and Maltreated Children: The Core Concepts by the Child Trauma Academy. After, the parent-therapists had the opportunity to discuss any challenges as well as report any successes they experienced over the prior two weeks. This served as an opportunity for the parent-therapists to receive some clinical guidance and support from myself and my Professional Associate.

Fortunately, I had the opportunity to facilitate this program on my own. This was a different experience as the majority of my experience with group facilitation is with children and youth. I had to balance the needs of the parent-therapists as well as the representatives from the Ministry of Social Services. This required patience and assertiveness in order to ensure that everyone felt heard and understood. Overall, this experience helped me develop more confidence in my skills as a group facilitator.

This program had an interesting dynamic because of the diversity of the parent-therapists. They all had different professional backgrounds and while some continued to work, others were solely employed as parent-therapists. They also had different parenting styles. Most had adult children and had to re-learn how to parent based on the different needs of the youth in their homes. Fortunately, they were all more than willing to adapt and enhance their knowledge.

One challenging aspect of the parent-therapist program centred around communication. Youth Community Counselling’s stake in the parent-therapist program centred around placement and clinical consultation, while the caseworkers from the Ministry of Social Services had an entirely different set of responsibilities. In addition, roles were defined based on what section of the Child and Family Services Act the youth fell under. At times, there were misunderstandings
about who fulfilled each role and this was obviously frustrating for the parent-therapists. While I was there, there was a concerted effort made to clarify roles and streamline service.

I was very fortunate to be a part of this program. It was inspiring to watch the parent-therapists be so open about their mistakes, their successes, and their fears. It was also encouraging to watch two separate organizations form a partnership that was fuelled by helping vulnerable youth in the community find caring homes. While there may be challenges, they pale in comparison to the positive outcomes this program provides.

**EGADZ Consultation**

Youth Community Counselling has also developed a partnership with EGADZ. EGADZ is a community organization that provides a variety of services and programs to youth in the community (EGADZ, n.d.). EGADZ operates several staffed, mentored, and structured independent residential homes in the city where youth are able to live (EGADZ, n.d.). On a bi-weekly basis, my Professional Associate and myself, along with a community health nurse would meet with EGADZ youth workers and deliver clinical consultation. The youth workers would present a case they were struggling with and would seek support and guidance. During one consultation, one youth worker described her concern about a youth. She described this youth as having grandiose delusions, sleep issues, and general erratic behaviour. The community health nurse inquired about her medication, and offered possible explanations about how the particular medication she was taking could impact her current behaviour. There were discussions about attachment and how the youth’s traumatic upbringing may be a contributing to her behaving erratically. Ultimately, through discussion and consultation with one another, the consensus was that this youth may be experiencing the early stages of psychosis and consulting with a doctor or psychiatrist would be necessary.
The youth worker knew this youth and recognized that her behaviour had changed. She articulated these changes during consultation and based on various professional judgements, this youth was able to get the right treatment. I believe that this response was made possible through collaborative consultation. Again, I feel fortunate to have been a part of another partnership between two agencies in the community. This initiative exemplifies what can be accomplished when professionals with different backgrounds, from different organizations, work together.

**Early Psychosis Intervention Program Education Group (EPIP)**

Helping to facilitate EPIP was an opportunity that presented itself late in my practicum. The clinician who facilitated the group asked whether I would be interested and I jumped at the chance. EPIP is a program that is offered through Mental Health and Addiction Services for individuals that range in age from 16-35 and who are experiencing the early symptoms of a psychotic illness (Mental Health & Addiction Services, n.d.). The goals of EPIP are early identification, reducing delays in treatment, treating primary symptoms and optimizing individual’s quality of life (Mental Health & Addiction Services, n.d.). EPIP provides psychiatry, community mental health nursing, recreation therapy, social work, psychology, occupational therapy, and addictions counselling. This particular group was the education portion of EPIP, which provides education about psychosis to family members who have a loved one involved with EPIP.

Despite the fact that I was asked to help facilitate, this group was an educational experience for me. During my time as a social worker, I have had few experiences with individuals experiencing psychosis. EPIP provides a broad and comprehensive understanding of psychosis. The symptoms of psychosis were described, and information about how to respond to these symptoms was provided. The program outlined potential causes, and contributing factors to
psychosis. The cause of psychosis was a common curiosity amongst the group, and many expressed worry that it was their fault. What they learned reassured them that nothing that they did caused their loved one to experience psychosis. The program also provided family members with different things they could do to minimize symptoms and direction for what their role was in treatment. Much of what I learned in EPIP was new information for me. After being involved in this program, I feel much more confident in my ability to assess whether or not an individual may be demonstrating symptoms of psychosis. This was something I would not have had confidence in before EPIP. EPIP was a good reminder that ethical and skilled social work practice requires life-long learning.

Further, this group exemplified Youth Community Counselling’s commitment to supporting people who have had their lives impacted by mental illness. While I may not have been able to provide education on psychosis, I was able to provide support to the family members who were part of the program. Many of them were confused, worried, and afraid for their loved one. The education that they received through EPIP helped them understand what their loved one was experiencing, and it equipped them with tools to help support their loved one’s recovery.

**Helping Teens Cope**

On two occasions, I facilitated Helping Teens Cope, a drop-in group that covers the same material each week. This group provides tools for parents to support youth who are experiencing anxiety and depression. Helping Teens Cope delivers an overview of mental health, anxiety and depression. It also covers how anxiety and depression may manifest in youth and ways that caregivers can help youth with their mental health.
Facilitating this group was rewarding as it gave me a chance to work exclusively with caregivers. It also challenged me to strike a balance between providing a supportive environment where people could openly share with the obligation to provide the necessary education that will help them understand anxiety and depression. The education materials outlined things parents should avoid saying if their child is experiencing anxiety or depression. For example, one of the problematic statements that parents may make to their child suffering from mental illness was about how they have a good life and there is no reason to be depressed or anxious. In the group, one parent began to express guilt about saying these things to her child. It was my job to provide support, invite others to support her, and then help this parent transition back to the education materials.

While this was challenging, I was privileged to be able to facilitate this group and hone my group facilitation skills, while educating and supporting caregivers.

**Healthy Minds**

I was also asked to facilitate the group Healthy Minds on two occasions. Healthy Minds is a drop-in education session for youth that provides positive coping and self-care strategies for anxiety and depression. I was encouraged to make this group my own which gave me the chance to integrate tools I use frequently in my practice. I provided youth that attended the group with information about deep-breathing and progressive muscle relaxation and took time to practice these strategies with them. I also used this opportunity to integrate expressive arts and narrative methods into the group. The youth in attendance were all struggling with anxiety. I asked them to use art supplies to draw a manifestation of their anxiety. I wanted to encourage them to externalize their anxiety in a creative way. I then followed up by asking the group what they would say to their, now personified, anxiety. Many shared words of anger, sadness, frustration,
and hope. Overall, this proved to be a cathartic experience for the youth as they were able to articulate how having anxiety and depression impacted them and what they wanted to change. Finally, by externalizing, they hopefully felt like they were not the problem. This group was an intersection of many of my learning objectives. For instance, I enhanced group facilitation skills, and integrated narrative therapy and expressive arts into practice.

**Mood and Movement**

I was able to co-facilitate Mood and Movement on one occasion. Mood and Movement is a group based on research indicating that exercise is associated with improvements in mental health including mood and self-esteem (Raglin, 2012). Youth that are experiencing low mood and or anxiety meet once a week and participate in one or two physical activities. Before and after each group, they fill out scales rating their anxiety and depression. The week I participated, we played ultimate frisbee and dodge ball. It was amazing to watch youth who described themselves as depressed or anxious laugh and support each other while being physically active.

The group provides opportunities for youth to exercise and have fun, and in turn, improve their mental health. In addition, they are able to socialize with peers, make friends, and learn sportsmanship. Group facilitators participate in the activities, which provides the unique opportunity for clinicians to model appropriate behaviours to youth. When integrating an activity into therapy, I am often drawn to expressive arts and this was a welcome chance to integrate and experience a different approach.

Overall, one of my learning objectives was to enhance group facilitations skills. Having such a wide variety of groups to participate in certainly helped me to accomplish this objective. I was able to facilitate groups with a variety of people including fellow professionals, caregivers, and youth. Upon reflection, group participation also helped me fulfill other learning objectives as
well. I was able to integrate narrative methods into group work with youth, and I was able to develop further competency working with caregivers of youth by facilitating groups that were solely for them and I was able to integrate expressive arts.

**Professional Development**

Youth Community Counselling is an environment where I was able to grow as a clinician. I was able to advance my clinical skills, use more expressive arts in practice, and observe and facilitate many different groups. These are all activities that I set out to do, and I am fortunate my learning objectives became a reality. However, upon reflection, it dawned on me that the breadth of professional development opportunities I engaged in while at Youth Community Counselling enriched my field practicum significantly. As social worker, it is my responsibility to uphold Value Six of the *Code of Ethics* which pertains to competence in professional practice. Value Six explains how social workers should strive to maintain and increase their professional knowledge and skills, and to apply new knowledge in practice commensurate with their level of professional education, skill and competency, seeking consultation and supervision as appropriate (Canadian Association of Social Workers, 2005). Essentially, social workers should always be striving to maintain and increase their professional skill (Canadian Association of Social Workers, 2005). I was able to engage in many professional development activities while at Youth Community Counselling that enabled me to fulfill this duty.

First, I was trained in the Partners for Change Outcome Management System (PCOMS). This is a tool that the Saskatchewan Health Authority introduced in 2014 (Mental Health & Addiction Services, 2014). This system was introduced due to a growing call for evidence-based practice in mental health and substance abuse services (Mental Health & Addiction Services,
Mental Health and Addiction Services is publically funded, and PCOMS is a tool to help deliver outcomes to the public (Mental Health and Addiction Services, 2014).

To use the system, a clinician administers two, four-item scales to clients before and after the service is provided (Partners for Change Management System, n.d.). The first is the Outcome Rating Scale (ORS) which is designed to assess early progress (Miller et al., 2003). The other is the Session Rating Scale (SRS) which endeavors to measure the quality of the alliance or match between the client and clinician (Duncan et al., 2003). Many clinicians can also enter the data on the web application of PCOMS, which is called Better Outcomes Now (BON). BON gives the clinician and client a more comprehensive picture of their progress (Duncan, 2016). As a student, I did not have access to BON.

Overall, the rationale behind PCOMS is that clinicians often do not know how effective they are and this system allows for tangible insights into client’s progress. PCOMS also gives the client a voice and opportunity to give their clinician feedback. Further, PCOMS ensures that clinicians are being mindful of their practice and are working in a way that best serves clients. For these reasons, I found PCOMS to be a valuable tool.

I was also able to attend the Fetal Alcohol Spectrum Disorder Network of Saskatchewan’s three-hour training session for front-line workers. This training is designed to aid professionals in a variety of fields gain knowledge that will allow them to make sense of behaviours and tailor supports to an individual’s needs (Fetal Alcohol Spectrum Disorder Network of Saskatchewan, n.d.). I was able to attend this training with the parent-therapists from the parent-therapist program. I felt this training was important for me as an estimated 135 infants are born with Fetal Alcohol Spectrum Disorder (FASD) in Saskatchewan every year (Public Health Agency of Canada, 2012). FASD is accompanied by a myriad of symptoms that can not
only impact the person affected, but their caregivers as well. Often, these individuals and their caregivers will seek professionals to help cope. In order to deliver the best service possible, I feel that it is imperative that social workers understand FASD and its complexities. This training furthered my expertise around FASD.

I also attended Social Work Education Day which took place on October 26, 2017. The topic was social work with transgender people. I found this learning opportunity to be very informative and essential as the suicide rate and suicidal tendencies among transgender persons are much higher than the general population (Virupaksha, Muralidhar, & Ramakrishna, 2016). The presenters discussed many important aspects of working with transgender people. In particular, the presenters discussed terminology as well as some background information about the classification of transgender people in the Diagnostic Statistical Manual. The presenters also outlined how further education, advocacy, and respect are other ways clinicians may meet the needs of transgender people (Coates & Richards, 2017). I aspire to continue to work with children and youth, and this presentation helped me to develop competency around these issues.

In addition, the Canadian Association of Social Workers and Canadian Association for Social Work Education released a joint statement on the affirmation of gender diverse children and youth. This statement explains how Value One Respect for Inherent Dignity and Worth of Persons and Value Two, Pursuit of Social Justice of the CASW’s Code of Ethics ensures that gender diverse young people are to be affirmed as the gender they understand themselves to be (Canadian Association of Social Workers, 2005). This fortified my resolve to further educate myself about gender-identity and made me proud to be a social worker. It was a tremendous learning experience and the insights gained will be reflected in my practice.
While at Youth Community Counselling I became familiar with the tool they use to assess suicide risk. According to a 2009 study by Statistics Canada, suicide was the second leading cause of death of people between the ages of 15-34 (Navaneelan, 2009). This means that clinicians need strong suicide assessment skills, as well as effective tools to properly assess risk. Youth Community Counselling exclusively uses the Columbia-Suicide Severity Rating Scale (C-SSRS) (The Columbia Lighthouse Project, 2016). The C-SSRS identifies suicide risk through a series of simple, plain language questions (The Columbia Lighthouse Project, 2016). The answers to these questions make it clearer whether someone is at risk for suicide, clarifies the severity and immediacy of the risk, and gauges the level of support an individual may need (The Columbia Lighthouse Project, 2016). Unlike other tools I have used, the C-SSRS screens for a wide range of risk factors without becoming unmanageable or overwhelming for the clinician or client (The Columbia Lighthouse Project, 2016). Once the assessment is completed, if a risk for suicide exists, the identified youth are placed on Youth Community Counselling’s suicide protocol. This means that the clinician diligently follows up and continuously assesses suicide risk. Once there is no foreseeable risk, the client is then removed from the suicide protocol.

While it is unfortunate that so many youth experience suicidal ideation, I am enthusiastic about having the ability to use a new tool that may mediate risk and ensure that the client receives proper care.

Finally, I was able to engage in some informal professional development by observing and meeting with other clinicians outside of the field of social work who provide services at Youth Community Counselling. I was able to spend an entire day out in the community with an outreach worker. I valued this experience as I was able witness the impact of meeting youth in an environment where they may feel more comfortable. This experience also allowed me to gain
further understanding of the importance of outreach services. Outreach fills in the gaps that in-office counselling cannot provide. Outreach workers pick youth up and take them to appointments, check in on them at school, and spend quality time with them in their own community. This is a less intimidating and more relaxed approach to mental health care that many youth benefit from. On the day I spent with outreach, we visited three different schools, and met with six youth. To be able to witness the relationships the outreach worker had formed and their dedication to the work was truly inspiring.

I also had the opportunity to observe one of the psychologist’s clinical work. Youth Community Counselling has two psychologists on staff who take internal referrals only. Each psychologist works within their own competency. One specializes in forensic psychology, while the other specializes in learning disabilities. Between the two of them, they administer cognitive, intelligence, personality and learning assessments. Fortunately, I had the chance to watch one of the psychologists administer the Wechsler Intelligence Scale for Children (Wechsler, 2014). This test provides a comprehensive picture of a child’s intellectual ability (Wechsler, 2014). Throughout my career as a social worker, I have always worked closely with psychologists. I have relied on their ability to conduct assessments to help better serve the clients I work for. This was my first opportunity to actually witness an assessment being conducted. This experience was incredibly valuable to me as I now have a more complete understanding of the work that my psychologist colleagues do.

Youth Community Counselling is also fortunate to have a psychiatric nurse on staff. She provides counselling and is also very knowledgeable about psychiatric medication. As a clinical social worker, I have worked with many clients who are using psychiatric medication to treat a diagnosed mental illness. At times, it can be difficult to navigate and understand how medication
impacts a client. The ability to consult with a psychiatric nurse about medication was extremely valuable. I learned so much from her that I will be able to carry forward in my practice.

I also discussed the intake process with an intake worker. This was important as intake is the first point of contact for someone seeking professional mental health services and has the capacity to set the tone for the client. Fortunately, Youth Community Counselling has very skilled intake workers who are able to provide support while gathering the necessary information that helps the client to access supports. It was important for me to understand what this process is like so I could have a greater picture of the entire experience a client goes through after making the decision to access services.

**Ethics**

During my time as a social worker, I have experienced many ethical dilemmas. I believe that this is common for many social workers who are tasked with helping real people navigate multi-faceted situations. I feel fortunate to have had experiences in organizations with high ethical standards and this continued to be true while at Youth Community Counselling.

While at Youth Community Counselling, I was trained in the Partners for Change Management System (PCOMS). While some practitioners had been using this system frequently, others had just begun. I found this system to be congruent with social work ethics and values and therefore found it effective and welcome in my practice. PCOMS uses the Outcome Rating Scale (ORS) which gives the clinician tangible data about their effectiveness (Miller et al., 2003). Based on the data, clinicians are continuously mindful of their practice and how best to help the client. Further, the Session Rating Scale (SRS), measures the quality of the alliance and match between therapist and client, with the goal of providing feedback to clinician that would help improve the therapeutic alliance (Duncan et al., 2003). Both of these tools align with Value Six,
Competence in Professional Practice as they ensure that the clinician is getting constant feedback from the client. Value Six contends that it is the right of the client to obtain the highest quality service possible (Canadian Association of Social Workers, 2005) When clinicians use tools like PCOMS which encourage them to always strive for improvements, clients are benefitting.

In addition, clients may feel empowered by being asked to give constant input into their mental health care. It is the right of clients to be advocate for themselves and PCOMS helps them do this. I believe that this upholds Value One, Inherent Dignity and Worth of Persons, particularly because this value upholds each person’s right to self-determination. PCOMS provides clients with this self-determination.

Narrative therapy is also extremely congruent with social work practice and ethics. Narrative therapy encouraged me to reflect on my role as a therapist. By doing this, I was feel as though I upheld my duty to remain professionally accountable and competent as per Value Six: Competence in Professional Practice of the Canadian Association of Social Workers Code of Ethics (Canadian Association of Social Workers, 2005).

Further, narrative therapy positions people as experts on their own lives. This concept aligns with Value One: Respect for the Inherent Dignity and Worth of Persons, a principle social work was founded on (Canadian Association of Social Workers, 2005). It may feel disempowering to an individual to seek help from a professional only to have that professional take an expert or authoritative role. For example, narrative practice encourages therapists to allow clients to take their own notes, or for therapists to read aloud anything they may write down in session. This practice fulfills Value One of the Code of Ethics as it may help clients feel dignified and empowered which a fundamental goal of social work practice. Further, it speaks to Value Four:
Integrity in Professional Practice, considering this value promotes social workers being open and transparent in their professional practice (Canadian Association of Social Workers, 2005).

The concept of externalization fits well with social work’s commitment to anti-oppressive practice. Anti-oppressive social work theory contends that often there are institutional and structural forces that oppress people (National Association of Social Workers, 2002). These forces can often be the reason for many people’s problems. Externalization may help an individual understand these forces and how they have played a role in their lives, and how these forces may be contributing significantly to the problem. Narrative therapy and anti-oppressive practice are congruent as they both depathologize the individual. If people do not feel like they are problematic, it may be easier to move towards change.

One thing I observed while at Youth Community Counselling was a struggle with long wait times. The amount of time that youth spent waiting to access services fluctuated, but at one-point youth were waiting as long as six weeks to see a counsellor. From a social work lens, this conflicts with Value Six, Competence in Professional Practice, which upholds the right of clients to be offered the highest quality service possible. I had to ask myself, if youth were facing significant wait times, was Youth Community Counselling offering the highest quality service? This is an important question considering that individuals may deteriorate while waiting for care (Wait Time Alliance, 2014). To be clear, Youth Community Counselling is not to blame for wait times. Wait times often carry political, financial and systematic roots. Youth Community Counselling tries to navigate long wait times by implementing certain policies. When a clinician was assigned to a case, a counselling appointment needed to be offered to a youth within two weeks. Youth Community Counselling also provides a wide variety of groups to the public.
Youth and caregivers were encouraged to participate in these groups while waiting for services or to access groups as a possible alternative to individual counselling.

When considering long wait times, I was surprised at the system that Youth Community Counselling used to assign cases. At staff meetings, clinicians inform the group how many cases they will be taking. Sometimes clinicians did not take a case, and sometimes they took many. Initially, I could not reconcile long wait times with clinicians opting to not take cases. However, after observing this system over four months, I gained a new perspective. I realized that this system ensures that clinicians do not become overwhelmed with high case loads. This system shields clinicians from burnout. This is important as social workers are a group of professionals with above average risk for burnout (Söderfelt, Söderfelt, & Warg, 1995). Burnout occurs when a committed professional disengages from his or her work in response to stress or strain experienced on the job (Söderfelt et al., 1995). Burnout can lead to a variety of issues including depression and anxiety (Söderfelt et al., 1995). Receiving services from a social worker experiencing burnout may only be more harmful to client’s long term. If their clinician is burnt out, the client is not receiving the highest quality service possible. The case assignment system Youth Community Counselling has put in place allows professionals to use their judgement about their capacity which I believe benefits individuals accessing services. Clearly, this is a complicated ethical grey area, but one I feel it is important to continue to reflect on.

Overall, my field practicum was an excellent way to continue to facilitate further reflection about ethical practice.

**Challenges**

Any worthwhile pursuit brings with it challenges. Accordingly, I will outline the challenges I faced while completing my field practicum.
The first step in securing a placement at Youth Community Counselling was interview to with my potential supervisor. While doing this I was informed that I would have two supervisors. I was excited about this as I have always gained a lot from supervision and knew this would only be enhanced by being able to consult two different people with different expertise. Two supervisors also meant, however, managing two sets of expectations. Alternatively, I found that there were times where both supervisors may have been under the impression I was being supervised by the other. This forced me to be more vocal about what I needed from each of them. At times, I struggled with this but it forced me to work on advocating for myself and articulating what I needed to learn, instead of waiting to be told what to do.

“You cannot treat an empty chair” (Clark, 2010). One of the most significant challenges I faced during my practicum was high no-show rates. I know I am not the only clinician to face this challenge, as missed appointments are a common phenomenon. Unfortunately, missed appointments affect productivity as clinicians are often waiting for clients who never arrive (Lasser, Mintzer, Lambert, Cabral & Bor, 2005). While missed appointments are challenging for all clinicians, I found it more difficult as a student operating under time constraints. For example, one young woman I was working with attended one session in September and then did not attend her next appointment. After my efforts to follow up with her were unsuccessful, I closed her file. In late November, she called to re-engage. I was able to have one session with her before transferring to another clinician. Unfortunately, I was not able to see many clients through an entire episode of service from beginning to end. However, I realized that the reality is that life circumstances often get in the way and it is important for a clinician to be compassionate, flexible and understanding. This is especially important when working with individuals experiencing mental health issues. Further, the high no show rates compelled me to reflect on
my practice and what, if any, changes clinicians can make that reduces these rates. Studies show that reducing wait times, and implementing reminder calls are some ways to reduce no-show rates (Roth, Kula, Glanos & Kula, 2004). More simply, research also suggests that when an environment is clean, orderly, and well decorated, individuals are more likely to return (Tsai et al., 2007). Clients not attending appointments can function as an opportunity to reflect and make positive changes to the way service is delivered to clients.

Time constraints are another inherent challenge of a field practicum. I had four months, or 450 hours to achieve all of my learning objectives. This time frame was particularly difficult when it came to clinical work. When I began my practicum, my goal was to see my clients through an episode of service; meaning a beginning, middle, and end. I believed this would be possible and I would have enough time. However, many clients were only able to attend sessions bi-weekly, or monthly which meant that I was unable to see them as regularly as I initially anticipated. Further, I used clinical judgement and did not find it necessary to see many clients weekly. For some, this may have been too overwhelming. This exemplifies what it is like to be a student in the field. I, perhaps naively, assumed my practicum would unfold exactly as planned. Once I was in the field, I quickly realize that I needed to be adaptable. When things did not go how I expected, I had to draw on what I have learned and what skills I already possessed to navigate any challenging situations I experienced.

Individuals seek support from counsellors with the hope that their problems may be solved or minimized. I believe that most counsellors have had moments where they feel as though they are making no impact. Clients may continue to come to counselling but they are showing no improvement. Throughout my time as a clinical social worker, I have struggled with internalizing clients’ lack of progress. I am confident in my skills and I constantly reflect on my
practice and despite this there are times I feel like I am not doing enough, or I am missing something. Fortunately, I was able to share this with my Professional Associate. During supervision, I discussed a case where I felt as though no progress was being made. This case involved a young woman who came to counselling to work on anxiety and self-esteem. Each session, she regaled me with stories about feeling anxious, school, her friends, her interests, and much more. I attempted many times, and many different methods to refocus sessions and all were unsuccessful. I was hoping my Professional Associate would have some suggestions about what I could do to help this young person. What she said during supervision has resonated with me ever since. She explained that “there are many paths to wellness.” While counselling may be right for many, it is not the only way to heal. When you work in a clinical setting, it may be easy to lose sight of this. With this on my mind, I thought about young girl I was working with. While she enjoyed coming to counselling, it was not productive for her and I needed to shift focus and think about what would be a better path to wellness for her. I seemed to be a social outlet for her. She loved to tell me stories and jokes, and she was always showing me her art work. I decided that the group Creative Expressions may be a good fit as it involves art and there would be young people her age she could socialize with. I was transparent with her about why I was suggesting transitioning from individual therapy to group therapy and fortunately she was enthusiastic about the idea.

**Conclusion**

The four months I spent at Youth Community Counselling was a transformative experience for me professionally and personally. I witnessed the inner workings of Youth Community Counselling, an agency that is fundamental to the mental health care of youth in the community. I enhanced my clinical skills by exploring two modalities: narrative therapy and the
Neurosequential Model of Therapeutics. I also was able to participate in a variety of groups and enhance my group facilitation skills. I was given the opportunity to partake in a variety of professional development opportunities that strengthened my practice. I also had the opportunity to reflect on the ethical issues and challenges I faced during my field practicum. Throughout, I was able to integrate expressive arts into various aspects of my practicum. I also worked with youth as well as their caregivers which was one of my learning objectives. Youth Community Counselling provided me with an environment where I was able to explore and achieve my learning objectives. I have grown as a clinician and this will be reflected in my practice going forward.
References


THERAPEUTIC INTERVENTIONS WITH YOUTH AND THEIR CAREGIVERS


