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CLINICAL SOCIAL WORK AND COMMUNITY PRACTICE WITH CHILDREN AND YOUTH THROUGH CARRIER SEKANI FAMILY SERVICES

by

Jeremy Bissett

B.A. Outdoor Recreation Parks and Tourism, Lakehead University, 2016
B.A. History, Lakehead University, 2016

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Abstract

In this report I weave the practical skills and knowledge I gained from my practicum with Carrier Sekani Family Services (CSFS) with theory related to child and youth mental health. I present human ecology as my grounding conceptual framework in my approach to wellness. I explore theoretical foundations for clinical social work, therapeutic modalities, rurality and cultural diversity through a literature review and build on these to support my practice experience. I include sections on youth mental health, Indigenous issues, ally-ship, trauma informed practice, attachment theory, connectedness, tele-mental health and rural social work practice. Services offered through Carrier Sekani's counselling program that I have practiced include outreach, assessment, treatment planning, safety planning, referral and discharge. I connect practical experiences of working within Carrier culture as a mental health clinician to the literature and explore how I make sense of the shared and created knowledge.

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Chapter 1: Introduction to Practicum

The purpose of this report is to provide a summary of my learning experiences throughout my practicum within Carrier Sekani Family Services (CSFS). This report will present my placement agency, area of focus within social work and my learning objectives. Furthermore, it will introduce my theoretical framework and personal positioning. Included is a literature review that analyses youth mental health, Indigenous mental health, trauma informed practice, ally-ship and rural social work practice. This report will provide a summary of my major learnings during my practicum and will explore implications for my future practice.

Placement Agency

The Indigenous peoples of the Carrier Territories are of mid-central British Columbia and reside in the northern part of the Interior Plateau region (Brown, 2002). The Nechako-Fraser sit to the south while the Finlay, Parsnip, and the Peace Rivers map out the north. To the west of the Carrier Nations there are the watersheds of the Skeena and the Nass (2002). These river systems provide life and once acted as highways that spread through the territory. The people in the Carrier territory identify themselves as a number of smaller nations sharing bonds with each other, but with each nation having its own distinct territory mapped out by lake systems or watersheds (2002). There are approximately 22 First Nations that identify as Carrier over the 76,000 kilometre territory (2017).

The Carrier nations experienced adverse and unfavourable times between the late 1800s and the mid 1900s, when their communities underwent traumatic changes in the wake of colonialism. Traditional systems of governing, culture, connection and community were seriously harmed, but to this day the people have shown resiliency and continue to be relevant in many communities.

Figure 1: Carrier Region of British Columbia. (Brown, 2002, p.26).

Carrier Sekani Family Services originated in the late 1980s out of concern for their Carrier communities' wellness and is an example of the nations' strength in modern times (CSFS, 2017). Losses of culture and the breakdown of families were still obvious long after initial colonial contact.

The Tribal Council took initial measures to provide support for its nation, and by 1990 a not-for-profit agency was formed in attempts to support the health and wellness of its Carrier Sekani people (2020). Modern day CSFS social programs based on traditional knowledge and western medical interventions run to support Indigenous peoples within the interior of British Columbia. CSFS was originally focused to support the needs of the Carrier peoples through programs that specialized in community work, individual counselling, family preservation and day to day support work (2020). CSFS held the mandate to establish a "comprehensive infrastructure for social, health, and legal programs" that are objectively part of working towards "Indian Self-Government" (2020, para. 1).

Both in the mid 1990s and late 2000s, CSFS worked in partnership to gain more control over their Indigenous children in care and are now qualified as a Level 4 delegated child welfare agency (2020). They are now in the process of building a quality child welfare program that allows CSFS to take over full control of all Carrier children (2020). In 2005, CSFS became one of the earliest Indigenous agencies to take on responsibility for research on their peoples and they are able to safely practice qualitative and quantitative research projects (2020). In 2014, CSFS received funding to develop a new health authority and was able to "expand their primary care services to include four physicians and support staff to offer medical services" to the nations' peoples (2020, para. 6). Now in 2020, CSFS celebrates 30 years of providing "holistic health, research, legal, and family services" (2020, para. 7).

Services Provided

CSFS operates out of three major locations. CSFS offices are located in Prince George, Vanderhoof, and Burns Lake. From these head offices, CSFS connects with communities either in city limits or by travel into more remote communities. Each location offers a variety of services, but not all locations are able to offer every service that CSFS provides. Services that CSFS offers include Aboriginal Patient Liaison, Addictions Recovery Program, Aboriginal Supported Child Development, Best Beginnings Outreach Program, Bridging to Employment, Canadian Prenatal Nutrition Program, Community Linkages, Early Years Centre, Family Empowerment Supported Visit Programs, Family Preservation and Maternal Child Health, Family Support, First Nations Health Benefits/Patient Travel, Foster Family Resources; Delegated Child Welfare Services, Health and Wellness Counselling Program, Home Care, Intensive Family Therapeutic Services, Mediation and Family Justice Services, Mobile Diabetes, Nursing, Primary Care, Vanderhoof Indigenous Head Start, Wrap Around Parent Guidance Support, Youth Services, and Child and Youth Mental Health --- the only program that offers support for Indigenous and non-Indigenous people in the Burns Lake Area (CSFS, 2020).

CSFS Principles and Philosophy

It is clear that CSFS has a strong philosophy that supports Indigenous culture as being healing, strong, and responsible. CSFS's mission statement is as follows:

"With the guidance of our elders, Carrier Sekani Family Services is committed to the healing and empowerment of First Nations families by taking direct responsibility for: health, social, and legal services for First Nations people residing in Carrier territory" (CSFS, 2020, para. 3).

The above provides background information, including brief historical, basic geographic and structural information regarding CSFS. This section purposefully provides an opportunity for

understanding organizational systems of which I needed to become familiar with to best support the peoples I would be working with.

Chapter Two: Introduction to Area of Interest

Social work practice covers a broad spectrum of focus areas ranging from family preservation to clinical counselling. My area of interest within the field of social work is youth mental health. Mental health and well-being can be defined differently depending on where you live, what the dominant culture is, and what religion or background you uphold. Vukic, Gregory, Martin-Misener and Etowa state that mental health and illness within the North American context “encompasses personal growth and well-being, everyday problems in living, common disorders such as anxiety and depression, and severe mental disorders such as schizophrenia or manic depressive illness” (2011, p. 67).

Cultural change, oppression, and structural violence have all been directly linked to Canada’s history (Kirmayer et al., 2003) and are all etiological factors that affect mental health. My practicum allowed me to work with a diversity of youth, but they all call community within the Carrier territory home. Much research has been done towards understanding the impacts of abuse, forced removal from family, and segregation, including how these experiences have affected mental health. This research has supported my understanding and supported my practice as a social worker while I worked with Carrier Sekani Family Services.

Connections between mental health problems and disorders and child sexual, physical and emotional abuse are apparent and associated with numerous diagnoses (Jain, 2019). Depression, eating disorders, post-traumatic stress disorders, conduct disorders, attention deficit hyperactive disorders, attachment disorders, suicide, sexual promiscuity, aggression, and substance use and abuse, are only a few mental health concerns that can be directly linked to traumatic childhood experiences. Kimberly (2014), who wrote an article on “Trauma, Resilience and the Role of Cultural Identification and Healing” believes that “experiencing trauma often

results in mental health concerns such as isolation, loss of self-esteem, substance abuse or dependence, post-traumatic stress disorder (PTSD), anxiety and depression" (p. 9). She also posits that "once an individual has connected with others who share the same cultural identification, they are more easily able to speak to, and heal from, their trauma" (p. 9).

It is important to consider how culture plays a role within mental health. We can reflect on the term 'Intersectionality' to highlight individualistic experiences that either support or challenge mental health. Intersectionality speaks to different domains of identity (Robinson, 2005 & Reynolds, 2010) including gender, race or age and how power or oppression can flux depending on the context. Understanding intersectionality is especially important when working with people who have experiences different to yours and provides some foundation for how to progress in a supportive way.

When working with Carrier youth I started to formulate treatment plans that reflected their individual realities. Treatment approaches that are in line with their culture, values, beliefs and experiences stem from the understanding of their place within the structures of society. This has and will continue to help me as a practitioner tap into specific therapeutic modalities, language, therapeutic structures and relationships, and therapeutic goals and objectives.

Learning Objectives

Major objectives I set out to accomplish while working with Carrier and Sekani Family Services were as follows: I hoped to become familiar with Carrier Sekani Family Services as an agency. I hoped to become familiar with the Indigenous cultures residing in the Carrier territories. I hoped to continue to develop my clinical skills as a social worker and foster a personal practice model for working with youth on their mental health. I hoped to become experienced with tele-health practice and navigate similarities and differences as it relates to in

person practice. I hoped to find balance as a practitioner to support my holistic health while working to support others along the way. Furthermore, I hoped to indulge myself in language to try and understand who I am and understand how my ancestors walked through their Indigenous lands. I identified the following sub goals that assisted me in achieving my major objectives during my practicum:

I. Gain familiarity with the traditions and cultures in the Carrier territories.
    a. Educate myself on geography, history and culture of the Carrier people.
    b. Engage with and make relationships with people in Carrier territory.

II. Gain familiarity with Carrier Sekani Family Services
    a. Build relationships with and work collaboratively with co-workers.
    b. Engage within agency structure and participate in team meetings, team building and clinical supervision.
    c. Familiarize myself with agency policy, procedure, ethics and guidelines.

III. Develop Clinical Social Work Skills
    a. Become familiar and comfortable with processes like intakes, assessments, treatment planning and termination.
    b. Explore and become familiar with clinical social work theory and connect theory to practice.
    c. Continue to practice and develop record keeping and case management skills.

IV. Develop awareness and understanding of telehealth practice.
    a. Understand additional risks and safety measures associated with tele-health.
    b. Become familiar with a tele-health platform that can support clinical social work.
    c. Gather clinical tools and resources that support tele-health practice.

V. Continue to Practice Self Care.

a. Continue to stay physically active.
b. Reach out for support and connection with friends and colleagues.
c. Explore Northern British Columbia's rivers, lakes and mountains.

VI. Rediscover my ancestors' indigeneity.

a. Explore my family's traditional languages to try and develop an understanding of how they perceived and connected to the natural world.

I continued to reflect on these goals throughout my time with Carrier Sekani Family Services. These goals have and continue to act as guidelines that frame my practice experience and have been indicators for success as a practicum student.

Chapter 3: Personal Positioning and Theoretical Orientation

"Where lies your land mark, sea mark or soul's star?"

Gerard Manley Hopkins (1886)

This section explores the various narratives that have molded me into the person I am today. Acknowledging where I come from can support an understanding of my biases, assumptions values and beliefs. Anne Bishop's (2002) *On becoming an ally* delves into the critical process of self-reflection and considers the value of challenging one's own perspectives. The value in 'checking' and challenging yourself as a practitioner encourages awareness and openness; I feel that self-reflection can provide opportunity to be adaptive and support healthy change in practice and belief.

*Cynefin***:** A Welsh word that "describes that relationship between the place of your birth and of your upbringing, the environment in which you live and to which you are naturally acclimatised" (Sinclair, 1998). This term from my ancestral Welsh language frames the importance of locating oneself. In the following section, I describe my self-location, which I believe cannot be disconnected from my environment.

I am a young, white, adult male, born in Canada in the 1990s. I feel fortunate to have grown up in a suburban, middle class area with a caring and nurturing family. This allowed me to prosper and grow comfortably without worries around food, security/safety and attachment to primary caregivers. I have continued to be part of the larger socially dominant group within Canada and am supported well by systems that provide me with opportunities for employment, healthcare and social connection.

My understanding of power has been formed as a member of a powerful group within society. I am thankful to be a physically healthy man, but this comes with unintended power over

others, structured within the patriarchal roots of our society (Mullaly, 2010). As a male I have been privileged with supportive norms that aid me, and I acknowledge that I am part of a legacy of "power-over" (Bishop, 2002, p. 42).

My identity is rooted in Ukrainian-Welsh-Manitoban ancestry. Like many others, I have limited understanding of my ancestry, and understand predominantly how my identity has been formed through my family's relationship to Canadian land. This relationship was started anew amongst a wake of dispossession of the land of the First Peoples of Turtle Island. I do not understand richly who my ancestors are, where they come from, and their Indigenous roots. What I do know is that my ancestors too come from their own Indigenous lands of Wales and Ukraine, and in order for me to fully understand my role in decolonizing Canada I should know who I am and where my people come from.

Dyrys: Welsh word for "Tangled, Thorney and Wild" (McFarlane, 2015).

Wales, the "land of song" has a rare and unique language as well as a complicated history (Loyd, 2004, VII.) The Welsh are a Celtic nation and Wales is one of the four countries of the United Kingdom. The dominant religion within Wales is Christianity, although there are many religious or spiritual differences in modern Wales (Wise, 2015). The name Ukraine is theorized to have been born from the Slavic language body and translates to 'Homeland' or 'Borderland' (Vasmer, 1953). Ukraine exhibits both eastern European influence as well as central European due to its geographical location. Early religious and spiritual influences stem from Paganism until the early 20th century when Christianity made its mark. I will not go into much more detail of my exploration for self-identity, but I will briefly speak to my thoughts on how I plan to approach ancestral connection in this report.

Indeed, it is hard for me to consider what exactly Welsh-Ukrainian identity truly is as I am so far removed from such connections, but I intended to begin learning through this process by developing my vocabulary of Welsh and Ukrainian words or thoughts as they relate to my understanding of place. I hope this strengthens my connection with Welsh-Ukrainian identity and I believe that it can add to the intricate environment of symbiotic elements that make up my self as I am formed by the constructs of culture, place and time (Wise, 2015). Thankfully my grandparents on both sides of the family have been my cultural influences and are a large part of my life. I have been lucky enough to have experienced a sliver of their cultures through old pictures, oral histories, food and art.

Theoretical Orientation: Human Ecological model

Cymer: confluence of two or more rivers or streams (McFarlane, 2015).

Ten years from now, I imagine myself engaged in youth addictions and trauma-related therapy in wilderness and community settings. Specifically, I imagine myself in a role that promotes wellness and connection through unique land-based programs, community-based programs and individual therapy.

My theoretical orientation is grounded in the human ecology model, a broad, interdisciplinary conceptual model that I outline below. I place my anti-oppressive practice approach under the umbrella of human ecology, as I believe that anti-oppression is not solely a human-focused approach but can guide our interactions with nature as well.

Many of the solutions related to holistic health—which I will define as health of our environment and all that live within it—has to do with balance. My education in social work has instilled a sense of First Nations culture and worldviews as they relate to health, wellness and healing. I believe that these theologies sit close to my heart because they speak to human

connection on a worldly scale. Many First Nations ideologies are similar to those of Indigenous peoples from African, Caribbean, European and Asian descent. Cindy Blackstock, an Indigenous scholar and activist, notes that "Aboriginal worldview concepts are commonly interconnected. [There is a belief that] they are part of the natural world and connected across time to those who came before and those yet to come" (2008, p. 3). In order for individuals, family and community to be healthy there must be a balance between physical, emotional and cognitive aspects of health that are all complexly connected to the natural world. Many of my dreams and aspirations include practicing within this realm and worldview. I encountered a complementary perspective in human ecology, an orientation I explore below. Throughout this exploration, I weave personal narratives in the hopes of expressing why human ecology resonates deeply as my theoretical position.

Two vital principles within human ecology include participation and knowledge-to action. Both principles hold a 'grassroots' nature and are pragmatic and realistic. Participation, in many ways, speaks for itself. It is a value that makes space for all affected peoples, animals and ecologies to voice their experience in relation to a problem and/or solution. It defies the conventional 'practitioner as expert' model and centres those with lived experience as vital knowledge holders (Charron, 2012b). Charron believes that "community participation and wider social movements offer creative, surprising and relevant strategies that experts and consultants may never consider" (2012b, p. 31). As a social worker with aspirations to help build community and individual health, I will need to consider how to include and support as much participation as possible. In many ways, knowledge-to-action centres community power, as opposed to distant political or academic power.

Knowledge-to-action has the potential to harness [expert theory] and translate it to a local, pro-active setting (Charron, 2012). Charron reminds us that a “tension” exists between [expert theory] and on-the-ground action. Moving from theory to practice is a challenge that remains but there are many ways in which to allow this principle to be practiced within community.

Cambwll: Whirlpool, pool in the bed of a river (McFarlane, 2015).

Amongst the light, there is a darkness, a part of history that is written in the blood of the discriminated by the hands of the powerful (Balma, 2014). Whole communities have struggled when they have been displaced from their lands, or resources from their lands have been extracted (2014). When people lose connection to the places they call home, they may lose their sense of self (Aruliah, 2014). Tradition, culture, language and practice are all connected to the land we live on, and by losing the land, people may lose parts of themselves (2014).

My previous personal experiences can attest to how displacement and over-extraction of resources create health concerns. Much of what I was taught while studying Canadian history was based on how settler culture held power over and shifted the relationship that First Nations cultures have held with the land. In many ways, the relationships between First Nations and Western cultures paralleled the relationship Western cultures had with the land. Places and people have been, and continue to be, both exploited, taken advantage of and ruptured. Both the land and First Nations peoples feel the effects of these ruptures through their health, as “Over-exploited ecosystems cannot sustain healthy livelihoods and are hazardous to human health” (Charron, 2012a, p. 3).

After reflection, I recognize that I tend to practice many of the pro-active processes presented through my learnings. My past influences have shaped my understanding of the

importance of health, culture, community, environment and relationship with all species. From an early age I was taught the importance of connecting to the land. I would spend time outside in all seasons, camping, canoeing, hiking or simply being. Over time I was able to learn and continue to promote the value of a strong relationship to the land and what this meant for my personal health. I believe this is why throughout different experiences of learning I continue to come back to bridging the gap between human health and the health of the environment through nature-based experiences. These experiences can clarify and solidify our relationships to the land.

As I grew older, I studied History and Outdoor Recreation, Parks and Tourism. Through these programs I further developed an understanding of the importance of stewardship. I was able to add a second component to my relationship with natural environments. Not only do I depend on the environment for my personal health and well-being, but in a consumptive society, it may depend on me for its health and well-being. In learning about advocacy for the health of natural environments and the species that live within them, I was able to learn how to preserve the places that give so much to me. This development moved my land-connection from a personal, hobby-based level, to incorporating ecosystem health into a professional, expertise level. This was a valuable connection because it was no longer singular in perspective. The most important part of this realization was the value of community involvement. Charron (2012a) shares that community helps strengthen all aspects that drive eco-health.

It is clear to me that in order to see positive change happen with eco-health, people need to see the value and hold meaning within that change. Currently, there is a movement within mental health where many experts are advocating for and studying the effects of nature on our mental and physical health. This gateway into establishing a relevant and healthy relationship

with the natural environment has the potential to increase value, passion and a baseline of understanding amongst health professionals. Eco-health is based on the recognition of ecosystems as life-supporting foundations for health and wellbeing, building on long standing knowledge of the links between health, community, environment and economy.

Before beginning my graduate studies, I worked as a team leader at a youth addictions treatment centre. The professional team included nurses, therapists, outdoor guides, and high school teachers. We were all actively involved in promoting a healthy community through a strength-based perspective that incorporated as much connection with nature as possible. Therapists would walk amongst the boreal forest for sessions, teachers would sit in the park for math class and on weekends whole groups of people would go camping to retreat from the residential community. Our role as professionals was consistent in trying to facilitate the connection between the ecosystems and the youth we served.

I have spent time considering methods of sustaining health. I am drawn to Indigenous connection to health and wellbeing, which highlights relationship: “community is closely linked to connection with the land, and from the strength of culture that grows from this connectivity” (Greenwood & De Leeuw, 2009). This is my ‘why’ as an individual who aspires to be part of services that emphasize connection to the land. A social services centre that I worked with in Duncan focused on repairing used, recycled bicycles with youth. *Bike Works* provides local First Nations youth opportunities to learn basic mechanic skills and gain social connections. *Bike Works* also supports the development of local trails, which fosters connection to the land and healthy active living. Not only are they accomplishing participation within the community, they are also promoting sustainability through establishing alternative transportation methods and alternative recreational activities.

As a settler Canadian of Ukrainian-Welsh-Manitoban ancestry, my own early learnings about my ancestors' land-based knowledge and spirituality and my newfound learnings about local land-based knowledge and spirituality informs my resonance with land-based philosophies. Human ecology encompasses these values, and as such provides a strong theoretical foundation for my social work aspirations.

A human-ecology-informed anti-oppressive practice approach

Feggy: of meadow grass: left uncut such that it collapses to lie flat under own weight, and younger grass grows through it.

Influential feminist thinker bell hooks (1984) writes "oppression is the absence of choices" (p. 544). Anti-oppressive theory seeks to challenge structural inequality, and in so doing provoke change within social relations and power dynamics (Hart & Montague, 2015, p. 42). There are several key components layered within anti-oppressive theory: an understanding of who you are and how this influences your practice, understanding power dynamics, and understanding structural impacts, both systemically and on a micro-practice level (Sakamoto & Pitner, 2005; Hart & Montague, 2015; Mulally, 2010).

As an outsider hoping to be involved within communities, it is not my place to hold power over individuals, but to immerse myself with those who live with an "absence of choices" and as such have limited societal power. Therefore, a large component of my practice involves an anti-oppressive theoretical approach, which remains informed by the broader human ecology conceptual model.

As explored above, Indigenous communities experience multilayered oppressions as colonized peoples, and many Indigenous knowledges continue to be subjugated. I hope to incorporate the value of Indigenous knowledge within my practice. I believe that the more First

Nations ideologies and theologies are respectfully practiced, the more the dominant society will employ and honor these knowledges (Baskin, 2016). I am drawn to holistic approaches to health and wellness. Humans are part of a larger system and are not centred in the world, despite powerful ideologies that propose otherwise. Anti-oppressive approaches ground me in an awareness of power and encourage critical self-reflection about my role in maintaining systems of oppression. I aspire to weave this power-awareness within my understanding of human-land interconnectedness.

Chapter 4: Literature Review

In this section, I will explore how colonial histories impact the work I did with Carrier youth in rural and remote British Columbia. I share an overview of intergenerational trauma and its effects on youth mental health. I consider Attachment Theory and its role in human development as well as trauma-informed practice. Finally, I explore ally-ship and my role as a practitioner, as well as our relationship to the land and holistic health. Each of these topics impacted my work with Carrier Sekani Family Services and directly influenced my practice. This literature review will contextualize some major concepts that informed my practicum experience.

Trees
"your trees they are alive
They creak in front of windows
They bite their elbows; wring their hands
Lose their children

Your trees they are alive
They suddenly knock on empty doors
And at the threshold they ask for water
Ask for your soul"

(Myroslav Laiuk, 2015)

Colonial Canada

In 1876, profound restrictions and conditions were placed on First Nations people, limiting independence and movement through the *Indian Act* (Lavallee, 2010). In 1884, further actions were taken that banned cultural and community practice. Ceremonial practices like sweat lodges, potlaches and dances were no longer legal to practice or perform (2010). In 1892, legislation was passed that allowed the full operation of boarding schools for Indigenous children where there were mass amounts of neglect, abuse, and cultural abolition (2010). The following section connects the historical background to contemporary struggles faced by Indigenous youth. I connect issues of mental health to the decontextualization and the blaming of surface level

realities like addiction and poverty to the deeper contexts of colonialism, assimilation and oppression.

An iceberg can be used as metaphor, symbolising loss and can clearly parallel issues and struggles of First Nations children and youth. Addiction, suicide, poverty and mental illness are the most tangible and present matters, being the tip of the iceberg which is most often the only part seen. It is far too easy to impose blame or pity on those living with these realities, but there remains a deeper awareness that can shift our understanding and critique. Colonization and accompanying racism not only oppress individuals and communities but attempt to assimilate Indigenous cultures into ways colonizers deem 'righteous' and 'better'. Historically, dominant cultures with power and influence have defined what is "right and wrong" (Balma, 2014, p. 7). Legislative racism, such as residential schooling and the ongoing government removal of children, continues to form a complex system that perpetuates the dismantling of a whole culture of peoples. Statistics Canada released a document stating that in 2016 "there were 4,300 aboriginal children four years old and younger reported as foster children living in private homes" (2016, p.1) Although Indigenous children accounted for 7.7% of all children within this age bracket, at that time they accounted for more than one half of all foster children (2016). Often tumultuous foster care experiences contribute to mental health concerns in youth. Indeed, the overrepresentation of mental health issues in today's Indigenous children is directly related to and a continuation of the earliest colonial agendas of assimilation, colonization and oppression (Trocme, 2004). Legislated racism, manifested in residential school, child removals, and broader institutionalized racism has reduced the opportunities for cultural connection and has directly contributed to the outcomes that we see today. These underlying issues can be presented as the unseen parts of an iceberg that float underneath the surface.

I see the loss of land, language, traditional healing, knowledge, community connection and power as part of the loss of deeply rooted Indigenous cultures. These losses are traumatic and destabilizing. These cultural losses have profound effects, because in order to heal from such trauma, people need to connect with others from their own cultural background and share a similar belief system (Aruliah, 2014).

If and when we work with Indigenous youth today, we need to be able to consider these etiological factors, framed under intergenerational trauma. Much of the surface level issues presented through behaviour, feelings and cognitions are linked to past traumas in direct and indirect ways. Before engaging with people who have been oppressed throughout generations, I also need to consider my role within these relationships. Part of this process is understanding where I stand, what I offer, and how best to acknowledge what that means for others. Understanding ally-ship can help on individualistic, community and ecological levels.

Ally-ship

The term ‘ally’, while employed for some time in social justice literature, holds multiple meanings, and is still undergoing changes (Bishop, 2002; Reynolds, 2013, & Swiftwolfe, n.d). In her essential work, *Becoming an Ally*, Bishop provides a list of characteristics allies share. She explores “their grasp of the concept of collectivity…their sense of process and change…their understanding that good intentions don’t matter…[and] their knowledge of their own roots” among other illuminating facets (2002, p. 111). An ally, writes Bishop, acknowledges “power-with as an alternative to power-over” and is engaged in a process of their “own liberation” (p. 111). In briefer terms, an ally challenges oppression and utilizes their own privilege to educate others on realities and histories of marginalized people (Bishop, 2002; Fraser, 2004; & Reynolds, 2013). Reynolds supports Bishop’s and Swiftwolfe’s ideas of ally-ship and believes that the role

of an ally is to "respond to the abuses of power…and work for systemic social change" (Reynolds, 2013, p. 56).

As a white settler male, I believe that it is my role to practice to the best of my ability as an ally. Part of this intention is to acknowledge how best I can mitigate the negative influences of my power and at the same time transfer power into a role that fights oppression. This next section considers intergenerational trauma and how as an ally I can consider its effects.

Intergenerational Trauma

Vozdukh: Old church Slavonic word meaning "air".

I know a wonderful word: "vozdukh"
They want to take it away from us
Because – they say – it was ours so long ago
That it's already foreign. (Myroslav Laiuk, 2015)

Experts in intergenerational trauma suggest that trauma has a domino effect and can be passed down from generation to generation (Bombay, 2014; Craig, 2007). Bombay notes the links between familial Indian Residential School attendance and a range of health and social outcomes among the descendants of the survivors who attended (2014). Within intergenerational trauma, attachment plays an important role. Disruptive attachment can be outside the control of injured caregivers. Caregivers may be dealing with their own addictions and trauma issues, which is problematic for developing healthy children. A harmful cycle emerges when traumatized parents are not fit to attune healthily to their children. Children are likely to experience various unintentional re-enactments of the traumas passed on from parent to child (Craig, 2007). This promotes an increase in risk associated with either further traumatizing survivors or traumatizing peoples close to them. More often than not, children born into families who suffer from intergenerational traumas will have an increased likelihood of becoming traumatized themselves (Bombay et al., 2014).

Before I explore the specifics of how trauma affects the body, I will consider further how attachment theory plays a role within intergenerational trauma and youth mental health.

Attachment Theory

Mental illness complexities and causes are generally layered and multi-faceted. Recently, there has been much development in practitioners' ability to clearly understand and flag important components that are catalysts for mental health concerns. One such flag is raised when exploring relationships between children and primary caregivers. More specifically, we can look to see how a child may develop with regards to whether basic needs of safety and security in their relationships were met. This etiological perspective of mental health is concerned with attachment within relationships and the development of children's mental health from such attachments. Attachment theory posits that parental care is a critical "mediator of the effects of adversity on infant development" and early relationships set the stage for infants' ability to show resiliency and manage adversity later in life (Philip et al., 2015, p. 333). Attachment experiences are important to healthy development in that early on infants and children are not able to regulate emotion or manage stress responses on their own, but in fact, rely on their primary attachment figures to stay regulated. Phares notes that when regarding infants, "there are four types of attachment to the primary caretaker: secure attachment, avoidant attachment, ambivalent attachment and disorganized attachment" (2014, p. 32-33).

It is important to remember when working with First Nations that constructed Western views regarding attachment may differ from other cultures. A vital understanding is that First Nations children may be raised in an 'open-system' which includes other caretakers such as relatives and friends of the family (Blackstock, 2008; Quinless, 2013).

Understanding Attachment

Children—no matter their background, culture, or gender—have a need for attaching and latching on to caregivers to properly develop into functioning human beings (Christensen, 2001; McKinnon, 2008). Infants and children are unable to regulate emotion, decipher between what is right and wrong as well as comprehend who or what they are (2001). Perhaps most importantly is that they are unable to rely on themselves to be safe. They need to fully trust and attune to caregivers in order to get their primary instincts of safety met (Van Der Kolk, 1994). Attachment is the foundation that makes meaning in our lives. Besides the basic need for safety and survival, it also becomes the proto-type for all our later connections, both with others and with the connection we build with ourselves: "A lack of proper attunement leaves children feeling unimportant, not of much use, baffled about what to do, confused about who they are, unsure of themselves, invisible and lost" (MacKinnon, 2008, p. 158). In order to understand attachment, we need to understand the environments in which children grow up. Specifically, we need to understand how primary caregivers respond to behaviours, which are ways of expressing their need for attachment. Trauma can affect the way primary caregivers respond to behaviours, and in order to properly understand attachment and intergenerational trauma we need to understand the effects of trauma on an individual.

Western world views may only consider one person to be a primary caregiver, while First Nations may have numerous. When numerous attachments are instilling negative beliefs and understandings of the world during important development stages in a child's life, it adds another layer of complexity (Alexander, 2009).

Connectedness

During my practicum experience I continued to reflect on the literature and review certain components that related to my practical experience. Connectedness will add literature to fill the gaps of my practice as it relates to CSFS. One area that supports my learnings about clinical practice and social work that is new to me is 'connectedness'.

My previous learnings about child and youth mental health have been heavily focused on Attachment Theory, but recent reflections with colleagues have expanded my understanding of attachment within a cultural framework. I have come to recognize how my previous framework of attachment often individualized caregiver-child connections, and I could easily overlook the importance of multiple attachments supporting a child's health and wellness. Indeed, "the inappropriate application of attachment theory" in child mental health with Indigenous families can be "problematic" (Carriere et al., 2009, p. 52).

Connectedness emerges as an alternative to Western-centric attachment applications. Connectedness is a feeling of belonging, of being an "important and integral part of the world", in relationship with humans, animals, and the land (p. 52). In clinical work, there can be an emphasis on individual and family deficits, as opposed to attuning to community strengths and connections. As a practitioner, I am recognizing the importance of supporting community connectedness, as opposed to only focusing on attachment insecurities. Attachment theory is foundational to my understanding of child and youth mental health, yet I am recognizing that it must be expanded to include the concept of connectedness since connectedness is foundational to my understanding of Human Ecology. One way I try to do this is through self-reflection and how I relate my practice to theory. Connectedness as a theory has been an important part of my theoretical orientation, adding a deeper layer to my literature on trauma and strength-based

practice. By linking trauma-informed practice, attachment theory and connectedness, I evidence the importance of why I choose to ground myself in human ecology and practice nature based and wilderness-based therapies.

Practical work that I try to immerse myself in includes land-based community activities with children to support their relationships with their peers, adults and ecological relations. This stands in contrast to work that solely addresses deficit attachment experiences, and instead attempts to highlight the pre-existing connections in a human's life.

Trauma Informed Practice

This next section goes into specifics of how trauma effects the body and is important to review when working with individuals who have experienced traumatic events.

Body Response

Agency is the sense of being in charge of your life: knowing where you stand, knowing that you have a say in what happens to you and knowing that you have some ability to shape your circumstances (Van Der Kolk, 2014, p. 97). Naturally, life is adverse, challenging our agency through experiences that push our limits, sometimes shattering the control we have over our minds and our bodies. These adverse experiences are not what cause negative reactions within the body. It is when these adverse experiences remove our control that the body will experience trauma.

Human beings—like all animals—are hardwired to survive through simple instinctual behaviours and action. I was told a story when completing my Wilderness Advanced First Aid course in the fall of 2016. A mother was walking through a forest outside of Whitehorse with her child toddling behind her, when she turned around and saw a cougar. The cougar had its jaws wrapped around her child's head, so she instinctively fought. She was strong enough and vicious

enough to defend her child. She then instinctively picked up her child and ran back to her car where she locked the doors and fastened her and her child's seat belts. What happened after would seem strange but important when understanding trauma. Before driving away from the site, the mother passed out, needing to recharge after expelling all of her energy to save herself and her child. After some time, the mother was able to move on with life, continue to walk in the woods and explore the natural world with her child.

The Body Holds Trauma

The mother in the story at no point lost sense of her agency. She was able through behaviour and action to provide safety and security to herself and her child. During this adverse experience the mother's body reacted in profound ways. She lashed out in readiness, ran in fear and finally, when all was safe, was able to shut down. If she was unable to succeed with her first two instinctual responses, then she may have experienced a third response, the freeze response. Freezing is the final survival strategy hardwired into animal instinct and oftentimes looks like somebody has collapsed in helpless terror (Levine, 1997).Trauma often occurs from this freeze mechanism, even though this reaction serves a purpose. Freezing is a 'last-ditch' survival strategy to potentially escape threats in an unguarded moment. In freezing, the body and mind enter into an "altered state" in which no pain is experienced, preventing suffering (Levine, 1997, p. 19).

It is valuable to consider the mother's fainting episode after the cougar ordeal. Trauma symptoms are not caused by the event itself, but stem from the frozen residue of energy that has not been resolved and discharged. If the mother was unable to fight and run, then that energy would have been trapped in the nervous system where it would wreak havoc on her body and spirit (Levine, 1997). Levine (1997) states that trauma "creates a forceful turbulence inside our

bodies like a tornado", which is the focal point that forms symptoms of traumatic stress (p. 20). This unused energy will stay present in the body, oftentimes festering and forming a variety of symptoms like anxiety, depression and other psychosomatic and behavioural problems (1997).

The adverse experience would have stolen away the mother's agency during the actual event, as well as kept her agency long after the event was over. The excess energy constantly bombards the body with warning signs. Yet, at times it is confusing, random and unknown, and people who have experienced trauma learn to ignore these warning signs and numb what the body is telling them (Van der Kolk, 2014). Suppression of these warning signs does not stop the nervous system from reacting to the energy. The resulting increased stress continues to cause other physical and mental health concerns (2014). Furthermore, ignoring these messages from the body results in "the inability to detect what is dangerous or harmful for you as well as what is safe and nourishing" (2014, p. 99). This trauma can result in people feeling unsafe within their own bodies and minds, and individuals may cope by dissociating, numbing, or distracting themselves.

The Body Can Recover

Human beings stand-alone from many other species of animals because of the development of our brain. This strength is also our weakness. Many popular therapies fall under the realm of 'talk therapies': Cognitive Therapy, Narrative Therapy and Dialectical Behavioural Therapy all focus on the most recently developed part of the human brain, while trauma literature describes the importance of activating deeper structures of our brains (Levine, 1997). In order to emerge from adversity with strength, we may need to focus work with multiple components of the brain. Trauma expert Levine (1997) states that "it is unnecessary [for therapists] to dredge up old memories and relive the emotional pain" through talk therapies (p. 31). Instead, therapy can

focus on identifying the link between physical sensations and emotions (Van Der Kolk, 2014). Re-learning the body and establishing awareness of our sense and feelings will help in the process of healing. People who have experienced adversity cannot recover until they can recognise and befriend the sensations of the body, no matter how hard that may be (2014).

I am drawn to social work practice that is centered on the connection between humans and nature. My experiences have taught me that re-integrating the connection between land and ourselves promotes opportunity for self-growth. Below is a poem written by Myroslav Laiuk, a Ukrainian poet who speaks to the somatic connections between nature and humans.

Segment from: sow-thistle!

"I want to become you
I want to grab foxes and roe deer by their legs
and not to scare them away
to tell the feathered listeners
the dreams seen by my roots
to hide a hoary snake in my bosom
and to warm her children
I want to know
where the herds of subterranean beetles pasture
where the moths with red bellies
and gray wings disappear to
how a locust's heart beats
and how a flute goes through a marten
I want to hand feed bears and crows

I want to become myself"

(Myroslav Laiuk, 2015)

Wilderness Therapy: A somatic approach to healing trauma

I previously worked at an addiction treatment centre leading a team of outdoor guides and youth workers, and constantly collaborated with a wilderness therapist. My job was to keep both my staff team and the group of youth safe in the wilderness, 365 days of the year through blistering heat, frigid cold and any weather in between. My second priority was to engage participants in a therapeutic process to support healing. Much of my work consisted of process groups, one-on-one counselling and community building exercises, but this section will connect the basics of wilderness therapy to somatic-based trauma healing.

Part of the process of taking back control of one's body is the ability to build up internal resources that foster safe access to sensations and emotions (Van Der Kolk, 2014, p. 220). Essentially, this helps expand the window of tolerance, the place where we are able to tolerate sensations and emotions while simultaneously being able to stay in the here and now. Levine describes this as "entering into a strange new land, a land they've often visited without ever bothering to notice the scenery" (1997, p. 9). Similarly, wilderness experiences are strange new lands, although people have lived among and relied on the natural world since the beginning of time. It is relatively recent in human history that we have become far removed from these places our ancestors used to call home.

Mindfulness, movement and meditation are processes that help take back control of the body. They calm the sympathetic nervous system, increasing our ability to handle stress and emotion, and decreasing the likelihood of being thrown into "fight, flight or freeze responses" (Van Der Kolk, 2014, p. 211). Recently, there has been a surge in popularity and research that promotes the validity of practices like yoga, Kungfu, and ju-jitsu that have a strong balance between body movement and meditation. Similar to practices in yoga, Kungfu and other

meditative processes, the wilderness is a medium that connects the felt sensations of body to mind.

When in the wilderness, we are invited to be present with the slower and simpler pace of life. People need to be attuned to the ever-changing states of the natural environment in order to survive and prosper (Pacelli, 2018). Changes in weather and temperature directly influence our bodies sensations, feelings and needs. Rather than disassociating or distracting to survive these sensations and feelings, we need to react to them in order to cope with them. When we slow down, simplify and become present with our surroundings we tend to access the body's wisdom effectively. This mindfulness and awareness can help re-establish a connection between body and mind, changing our ability to cope with traumatic experiences. Van Der Kolk states that "the best way to overcome engrained patterns of submission is to restore a physical capacity to engage and defend" (2014, p. 220). By facilitating a safe and stable wilderness environment, people can experience working through perceived risk in ways they were unable to during previous adverse and traumatic experiences.

Other components of Wilderness Therapy can provide meaningful opportunities for growth in people who have experienced traumatic events. Programming often includes day-to-day tasks like starting fires, tying ropes to set up tarps or tents, preparing and cooking meals and choosing the right gear and clothing to wear to stay safe and comfortable in adverse weather. These responsibilities are often put onto the clients, but by providing them with the skills and resources needed they can work through these adverse experiences. These simple actions are given major significance, which help to develop a sense of accomplishment, survival and self-esteem necessary to promote healing. Providing youth the opportunity to feel, respond and reflect is the key to healing traumatic symptoms. This fosters the creation of a bank of embodied

experiences to reflect upon. Experiencing these moments facilitates a space to connect language and unfold new actions and narratives about experiences, and foster positive emotional memory (Wallis, 2018). It is possible that people who have trauma-defined knowledge about themselves can live differently from their diagnoses. By learning how to canoe, hike with a forty-pound backpack and snowshoe through the deep forest, people are again able to trust their bodies, work through its energy and connect to its sensations.

Wilderness therapy through somatic experiencing gives participants the experiences and the tools needed to work through their previous traumas. People may be able to better tolerate and process their traumatic experiences if they decide to embark on trauma work. Furthermore, wilderness settings allow people to escape their potentially unsafe environments. Wilderness environments can slow down the buzz and distractions around individuals and allow people to tune into themselves and find their own capacity (Tucker et al., 2016).

Trying to re-create natural experiences that promote instinct and survival for participants can be a safe way to work through and re-process traumatic experiences. The ‘built-in’ benefits of being present in the wilderness also promotes a mindfulness and orientation to one’s body (Ross, 2003). Skills development programs promote self-confidence and mastery, both important in the process of healing. While I explored these particular features, wilderness therapy has much more to offer than the somatic experiences in the process of healing from trauma. Tribal living and natural escape from daily pressures promotes connection and safety, which both hold the utmost importance in healing from trauma (Tucker et al., 2016). Attachment Theory describes the importance of safe and secure caregivers to support the regulation of stress and offer safety. In the same way that a caregiver might co-regulate with a youth, Wilderness Therapy can provide an environment that offers opportunities for youth to foster skills and experience

regulation. In wilderness settings, out of necessity, people connect and learn to rely on each other, stabilizing and creating strong relationships through a perceived sense of survival. Furthermore, the very essence of being present in the natural world has been proven to be grounding, stabilizing blood pressure, and increasing the white blood cell count, promoting a healthy immune system (Hansen, 2017). Many trauma survivors suffer physical ailments as a result of immune suppression, so the health benefits of wilderness modalities must be noted (Van der Kolk, 2014).

I chose to include a section on Wilderness Therapy not only for its somatic connection, but also to highlight the values I hold around strengthening our understanding of eco-health. Wilderness Therapy not only supports a healthy internal relationship, but fosters connectedness through healthy relationships between community, economy and environment. Wilderness and healing are truly an essential influence on my practice as a social worker.

Furthermore, Wilderness Therapy may provide a structured and safe approach to navigating policy and practice during COVID-19. Risks associated with social distancing may be more easily mitigated in settings outside than in classic workspaces and classrooms. In conjunction with wilderness therapy I will need to understand and learn best practice associated with the "new normal"—tele-mental health. The following section will go into further detail on tele-mental health for my social work practice.

Tele-Mental Health

Telehealth covers a broad scope of practice, encompassing professions that practice medicine, education and mental health (Grady et al., 2011; Myers et al., 2017, p. 41). During my practicum I was involved in work under the umbrella label of tele-mental health, which is the practice of mental health specialities at distance (Grady et al., 2011; Hilty et al., 2013; Myers et

al., 2017). Aspects of tele-mental health include interactive video conferencing or phone calls that engage clients in behavioural and mental health conversation, skills development and opportunities for processing client experiences (Myers et al., 2017, p. 41). While practicing with Carrier Sekani Family Services' youth mental health team I focused on practice that includes prevention, early intervention and coping strategies, treatment, maintenance and support. Often times this includes working in conjunction with family, teachers and other supports children and adolescents have in their lives.

Corona Virus 19 (COVID-19), also known as Severe Acute Respiratory Syndrome Corona Virus (SARS CoV) is a new disease that has not previously been identified in humans (Government of Canada, 2020). COVID-19 is an illness that effects humans and is typically associated with flu-like symptoms that one might experience if they had the common cold (2020). COVID-19 has forced our hands as practicing mental health clinicians to become proficient in the use of tele-mental health (TMH) practice. This unique opportunity is a practice that has been utilized for the last 6 decades in some shape or form, but is only now becoming widespread (Hilty, 2013). With mental health practice being shaped by strict policy to implement social and physical distanced rules, many practitioners are forced to consider how to best be productive and supportive. Like in-person practice, TMH practice still includes mental health assessment, treatment, education, monitoring and collaboration (Grady et al., 2011) and strives to deliver the same level and quality of service.

Differences in TMH practice and in person direct practice include environment, required access to technological equipment, confidentiality and ethical considerations (Myers et al., 2017). The American Tele-medicine Association has created practice guidelines for tele-mental health that are specifically formulated for working with children and adolescents. These

guidelines explore such considerations as environment, confidentiality and ethics. Guidelines include practitioner proficiency with tele-mental health platforms, which supports the use of training for practitioners (2017). Proper training is important because it determines whether a practitioner can be comfortable enough to properly assess, evaluate and support children and adolescents over unique platforms (2017). Guidelines include legal and regulatory issues and address "policy and practice standards" (p. 10) which are similar to that of in-person practice. Differences are noticed within the consent process, where practitioners are to include "basic understanding of, and agreement to, the specific use of tele-mental health" (2017, p. 11). Furthermore, the consent process now includes procedures for release of information with "primary care providers, social supports and parents" if need be (p. 11).

There is a growing body of research that suggests tele-mental health practice is both positive and successful (Grady et al., 2011; Hilty et al., 2013; Myers et al., 2017). Myers et al., suggest that tele-mental health "may be especially suited for youth wo are accustomed to the technology" (2017, p. 6). As a practicing child and youth mental health clinician, I am looking forward to working within this format and drawing my own conclusions as I practice with Carrier Sekani Family Services. Adolescents' technological literacy and increased access to technological devices for youth have increased my anticipation for positive experience with the use of tele-mental health. The following section will go into further detail on models of resonance for my social work practice.

Rural Social Work & Strength Based Practice

Rural and remote communities are often perceived through deficit based, deconstructed or structural theories. While relevant, these models bind both the communities and the individuals living in rural and remote areas to the present insufficiencies. This sub-section

explores the practice of using a strength-based modality within rural and remote contexts. I hope to define what a strength-based model involves, and I attempt to place it within a rural and remote context. Furthermore, I will include a critical analysis of why this theory fits within this context and should be a strong model used within most rural and remote.

Strength-based modality (SBM) is an ecological perspective that highlights the significance of and explores peoples' "characteristics, the type of environment they live in, and the multiple contexts that influence their lives" (Jacques et al., 2009 p. 454). I am drawn to SBM for a number of reasons. Rather than focusing on the present problems, SBM looks for strengths within the context and then tries to build on them to move forward (Payne, 2014). A strengths perspective recasts problems or issues in an attempt to build positivity for the future (2014).

I believe that an SBM fits within a northern rural and remote context. Strength perspectives can shift the already clear and present deficit perspectives in the north. It can be creative, challenging and practical to consider the strengths within this context. Strengths-based perspective is an age-old mindset that has allowed for human flourishing in the midst of immense struggle. Rural communities are in many ways more connected to our ancestral ways—not long ago much of the world was rural and operated in small, intimate communities with limited resources. Only recently has the advent of industrialization and urbanization allowed for different resources to promote the safety, health and well-being of larger communities. Rural strengths, then, have been cultivated and honed by humans for millennia! Being urban and "connected" is a relatively new phenomenon.

What are the unique strengths of rural and remote settings?

It is my experience that we often perceive rural areas through a deficit-based lens. Scales et al., (2013) use the analogy of seeing the glass as half empty. When I think of rural communities

through deficit-based approaches, I see dispersed communities with minimal opportunities. I see young people leaving the community, and low-staffed, low-resourced programing. On the flip side, when I look at a rural area with a glass half full perspective, I can start to see the "depths of the human spirit and the richness of the creative potential that exists in rural communities" (2013, p. xvi). I see strong local networks and connections among local associations. I see shorter wait times for essential services and rich opportunities for young professionals to make careers. I see easy access to nature. I see communities coming to together and banding their resources to find creative ways to get things done. I see humble, talented professionals that have experience in a variety of areas. By following the perspectives of strength-based theories, we can see people as citizens with value in rural communities as opposed to seeing them solely as 'clients' (Scales et al., 2013).

Strengths-based work is an approach that aims to build connection before requiring change. It is committed to attunement before breaking ground and building/re-building. Rural social work may have outsiders coming into community, so making connections is essential to meaningful work. From a strengths-based perspective, communities are viewed as the experts on their own needs. This challenges the image of social work outsiders coming in and imposing their notions of 'right' or 'wrong'.

My grandfather would often remind us that "adversity is opportunity in disguise". The adversities we each experience carve our paths and weave the unique tapestries of our lives. Rural communities, like all communities, have unique strengths born from unique adversities. Strength-based modalities emerged as a response to pathologizing approaches, providing a challenge to the ease of diagnosing flaws and seeking quick "fixes". As strength-based

practitioners, we have the privilege of encountering rural and remote settings with an open, creative perspective. We are able to challenge our ‘expert’ status and centre community voices.

Chapter 5: Conceptual Frameworks

Part of my journey towards becoming a professional social worker is developing a practice model that reflects my values, beliefs and perceptions of best practice. I have chosen a selection of therapeutic modalities that I believe best suit my practice, and I will provide an overview of each model within this section. Emotion Focused Family Therapy, Narrative Therapy, Cognitive Behavioural Therapy, Acceptance Commitment Therapy and Play Therapy are nested within my overarching theoretical orientations of Human Ecology and Anti-oppressive practice. Each modality is influenced by these larger theoretical orientations although their individual techniques are quite distinct. These therapeutic frameworks will be explored in more detail later in this report through the experiences I share with clients through Carrier Sekani Family Services. I will provide examples of how I engaged in therapeutic processes with individuals and communities as it relates to these approaches.

Emotion Focused Family Therapy

Emotion Focused Family Therapy as a clinical intervention can lay the foundations for healing and recovery. EFFT is a "Transdiagnostic" intervention of family therapy, where the belief is that people have the skills and strengths necessary to support themselves and/or their family members (Strahan et al., 2017, p. 259). EFFT emerged in part from Emotion Focused Therapy (EFT) and was developed to provide treatment for eating disorders (2017). EFFT is now an evidenced-based intervention that therapists can use to work with clients on a one-to-one and family basis for supporting diagnoses of anxiety, depression and OCD, among other concerns (Foroughe et al., 2019, p. 410). I am drawn to EFFT not only for its accessibility to caregivers and structured skills for clinicians, but for its emphasis on the power of experiencing our emotions. For a long time in my life, I had trouble reading and learning the language of emotion,

and EFFT simplifies and concretizes this 'mystery' into something workable. Exploring emotion can remain safe, as individuals work to better comprehend their emotions and those of others.

Key Practice Components

In practice, EFFT is quite structured, in that within every phase of EFFT there are guidelines for clinicians to follow. EFFT can be broken down into three phases.

Phase one emphasizes emotion basics, essentially giving emotion language while simultaneously trying to understand different felt sensations within the body (Emotion Focused Family Therapy, 2017). Clinicians can explore emotions with clients and give meaning to emotions in that each emotion is attempting to provoke a need that wants to be met. Furthermore, phase one explores actions or tendencies that are most commonly associated with an emotion (2017).

The second phase within EFFT can be broken down into five steps:

1) Clinicians can attend to the emotion and allow themselves to be in a position to take part of that emotion on (2017). It is important to name the emotion that you think is being experienced.
2) It is also reasonable to attempt to name the sensations associated with the emotion alongside naming the emotion.
3) The third step within phase two is validation: this important step speaks to clinicians attempt to understand the experience (2017). Validation can be hard because as humans our natural response is to come to conclusions, but this is counterproductive to the actual process of problem solving.

4) The next step is to meet the need. For example, with anger, there needs to be support to set and defend a boundary that has been crossed (2017). For fear, there is a need to protect from danger.
5) The last step within the process is to 'fix it' or problem solve. This last step may not need to be attempted, since emotion processing can allow people to think clearly and utilize their own cognition to support positive decision making (2017).

The third and final phase within EFFT is relationship repair, where within the therapeutic space clients are able to acquire the tools they need to support family relationships and/or learn how to heal their relationship they have with themselves, or late relationships where there has been no closure (2017).

Narrative Therapy

"If we possess our 'why' of life we can put up with almost any how." – Friedrich Nietzsche

Stories have the ability to express the 'why' of life. I am drawn to Narrative Therapy because it details explanations, connections and contexts about our realities (Morgan, 2000). This model explores how we perceive our personal stories and ultimately how we understand the 'why'. Narrative Therapy is a respectful, non-blaming technique that believes people are the experts of their own lives (2000). I am drawn to Narrative Therapy because it views problems as separate from people and believes that people have the skills and competencies that can assist them to change for the better (2000). This evidences that Narrative Therapy is a strengths-based practice that posits that the client has everything they need to live a holistic, healthy life. Practitioners can find exceptions within stories that are positive and real parts of the client's life. Furthermore, Narrative Therapy, in line with client-centred approaches, allows for the client to lead where conversation and story-telling will go (2000).

Key Practice Components

Narrative Therapy posits that no story is created singular: they are developed and reinforced by outside perceptions (Morgan, 2000). Stories are never produced in isolation from the broader world (2000). There are perhaps many opportunities to explore how a broader historical and cultural context has affected an individual and has created problems in their lives. The story of Canada is in fact, one of oppression, trauma and isolation. Narrative Therapy has the chance to re-tell a story, giving meaning to problems that are unrelated to the person who carries them. McCormick shares that an important part of healing for Indigenous clients is being able to see "intergenerational patterns", telling your story, and having knowledge of residential school history (2006, p. 346).

In working with First Nations, storytelling does not only contribute to therapeutic elements but also allows for me to be present in a non-authoritarian role. This is an important part of reconciliation and a role that I as a white male can play within this vital process. I can be curious about traditions, customs, values and relations to fill both roles of therapist and advocate. Drawing connections to external elements and holistic approaches can be familiar and important to wellness for Indigenous peoples (McCormick, 2006).

Cognitive Behavioural Therapy

Celebrated Roman Emperor Marcus Aurelius offers this philosophy: "For every action ask… how does it affect me? Could I change my mind about it?" (trans. 2003, p. 101).

Cognitive Behavioural Therapy (CBT) is a structured, time limited, evidence-based therapy that practices within a wide range of emotional and behavioural disorders. Modern CBT is relatively new, but the practice components can be traced back to ancient philosophies used by the likes of Roman Emperor Marcus Aurelius (Roberston, 2010). The focus of CBT emphasizes

an individualistic perspective and seeks to create change on the personal level. I am drawn to CBT as I believe it fits many of the values that I hold. I believe some of my core values highlight community and holistic ecological health, and although CBT can appear more symptom-focused than strengths-based, I am confident that it is a supportive modality for practice. Furthermore, I am drawn to practices of Stoicism and have applied its tenets in my own life. Stoicism has traditionally tried to "accommodate the primary emotion of rational love towards existence" (Roberston, 2010. p. XXIV). This is contrary to the popular belief that Stoicism is founded on anti-emotional "intellectualism" (Roberston, 2010). Within this ancient philosophy there are clear equivalences with CBT, a modality that provides many concepts, strategies and techniques of practical value.

Key Practice Components

The key practice components of cognitive behavioural therapy weave between behavioural therapy—which changes specific human behaviours—and cognitive therapy, which changes potentially inappropriate thinking processes. The focus is on how thinking processes create behavioural patterns. There are two key practice components of CBT- functional analysis and skill development (Leahy, 1996). Functional analysis tries to help clients and counselors explore situations that have the potential to lead to negative coping strategies and to provide insight into a clients' triggers (1996). Skill development supports a client's ability to gain strategies to challenge their behaviours and cognitions on their own outside of the therapeutic relationship.

Acceptance Commitment Therapy

Acceptance Commitment Therapy (ACT), is considered part of third-wave Cognitive Behavioural Therapy (CBT) (Ellett & Kingston, 2020). Ellet and Kingston (2020) speak to third-wave CBT interventions as united in their use of mindfulness and acceptance techniques, which focus on psychological flexibility rather than cognitive disputation. ACT focuses on teaching mindfulness skills to help people accept their adverse experiences and "commit to living in accordance with personal values" (Kelson et al., 2019, p. 2). This is in opposition to the traditional CBT mindset of controlling experiences and analyzing logic or disputing 'maladaptive' ways of thinking (p. 2).

Key Practice Components

ACT works with individuals through six core principles:

1) Contact with the present moment
2) Acceptance
3) Diffusion
4) Self as context
5) Values
6) Committed Action

These six core features of ACT are used within sessions to promote skills for developing psychological flexibility (Harris, 2006). The principles are inter-woven, and mutually support each other.

Contact with the present moment work encourages clients to utilize their senses to ground themselves in the here and now. This is an important first step in ACT, as it lays the groundwork

for psychological flexibility. This work may include formal or informal mindfulness practices. For example, breath-work or mindful walking could be used depending on the client's interests.

Acceptance is the second key step towards psychological flexibility. It allows thoughts, feelings and behaviours to be present, despite discomfort. Acceptance can be confusing for clients, as some may see it as "giving-in" or resigning oneself to experiences that are not healthy. This is not the intention of acceptance, and ACT provides multiple exercises and metaphors to present its rationale and logic for those clients who are hesitant.

We can become "hooked" to thoughts, which can increase our suffering and expend our energy. Diffusion is a technique to support "unhooking" from unhelpful thoughts and feelings. It is an important part of ACT, as it does not attempt to control, remove or fight thoughts, but instead tries to relinquish the grip of these thoughts.

Self as context is an additional technique used to encourage acceptance and diffusion. Clients can learn to notice and reflect on their experiences as an observer, instead of becoming overwhelmed within the experience.

In ACT, values are the things in life that are important to us. They act as a compass to guide our choices, regardless of the thoughts and feelings that are present. Clients will identify their values and aim to live in accordance with these values as a means of building a rich and meaningful life.

Committed action is the final essential piece of ACT work and addresses our behaviours. Once values are identified, we can more clearly take action in the direction of these values. The above principles that foster mindful acceptance are vital in allowing for committed action, as thoughts and feelings can hinder our adherence to our values and subsequent behaviours.

ACT does not promote diminishing or removing unwanted thoughts and feelings. Rather, it works to build space for these experiences so that we can continue to live by our values.

Play Therapy

Child-centred play therapy has not been at the forefront of my development as a practicing clinician but is an important realm of working with young clients. My interest in working with youth at-risk requires an understanding of child development and an understanding of what children need. Play therapy is a well-established and commonly used model for working with children. Play therapy has proven useful with children, as they have yet to develop abstract thought and verbal skills needed to successfully communicate their feelings, thoughts and behaviours (Hall, Kaduson & Schaefer, 2002).

Key Practice Components

For children, toys and play are their medium for expression: “Play is the singular central activity of childhood, occurring at all times and in all places” (Landreth, 2012, p. 7). Play is the only activity of childhood—it happens all the time no matter where or when. Children discover and come to an understanding of “the natural world of space and time, of things, animals, structure’s and people” through their play (2012, p. 8).

In order to connect with children, we need to understand where they are in their developmental stages. Children often communicate through play and therapists must “move into a conceptual lens expressive through play and activity” (2012). Children develop meaning and value at the same time as they explore and experiment through play (2012). Therapists will need to be able to meet children ‘where they are’ and communicate on their level. An important part of connecting with children is the ability to sit with expression and emotion without trying to stop or change them. This allows children to feel safe and comfortable, providing opportunity to

open up and display emotion. Play Therapy, like all therapy, offers a supportive environment where people can express themselves freely, be challenged supportively and understood fully, no matter what stage of development they are in.

As I develop my personal practice model, each of these modalities play a role. The following chapter describes my practicum learning experience, offering further detail about how I implemented components of each modality into treatment planning.

Chapter 6: The Practicum Learning Experience

The focus of this chapter is to reflect upon the practicum goals and objectives that guided my learning experiences. It includes reflections on my experiences with Carrier culture and tradition, Carrier Sekani Family Services and the development of my clinical social work skills in the context of child and youth mental health (CYMH). Despite my previous experience with CYMH work, I experienced tremendous growth at Carrier Sekani Family Services. I had a unique opportunity to work in an agency that supports both First Nations youth and settler youth. My experience with CSFS exposed me to a multitude of challenges that forced me to confront my weaknesses and continuously challenged me to think critically about my practice.

My practicum involved meeting learning goals related to: (1) Gaining familiarity with Carrier tradition and culture, (2) Gaining familiarity with Carrier Sekani Family Services, (3) Developing clinical social work skills, (4) Developing awareness and understanding of telehealth practice & (5) Continuation of practicing self-care. These learning goals were guided by my literature review which explored: (1) the colonial history of Canada and rural social work, (2) Intergenerational trauma, (3) Trauma informed practice, (4) Attachment Theory, (5) Wilderness Therapy, (6) Ally-ship & (7) Tele-Mental Health. I later added literature on connectedness to contribute further richness to my understanding of attachment.

Carrier Tradition and Culture

To work effectively in Carrier Sekani Family Services, it was clear to me that I needed to seek out guidance to better understand Carrier tradition and culture. In the past Carrier Sekani Family Services has had opportunities for new staff to participate in cultural training. Unfortunately, in the summer of 2020 there were no cultural trainings available due to COVID-19. I therefore have taken the opportunity to research Carrier geography and demographics as

part of my report. These learnings can be explored in my earlier work and are found in Chapter 1. Furthermore, I have taken the day to day, small informal, learning opportunities to heart in writing my reflections for this section. I have added a section on oral teachings that may seem somewhat irrelevant to my practice with CSFS, but I do so to add to my holistic understanding of connectedness, grounded in my theoretical orientation of human ecology.

Oral Teachings

I would like to thank Corinne Dawson for allowing me to use her rich and meaningful story telling that shed light into her experiences and learnings of Carrier tradition and culture. Her stories have painted wonderful pictures of beautiful ceremony. Every day I would be welcomed warmly by her and most days I would find myself lost for too long at the front desk listening to her talk about stories of her becoming part of the Carrier community. One story that stands out speaks to tradition, broken relationships and repair.

Corrine's mother-in-law comes from a hereditary Carrier family. Young at the time, Corrine did not realize she was stepping into such tradition and culture; it was only when her future mother-in-law started planning their wedding ceremony that she realized she was marrying into such a prominent family. The wedding ceremony consisted of a large gathering where she would be welcomed into the family but needed to first prove herself through ceremony. The ceremonial array of food consisted of almost every part of every local animal you could think of: boiled fish heads, fried moose tongue, boiled moose intestines, boiled porcupine and beaver's tail. This show of respect and welcoming for a new young bride can be overwhelming if you are unaccustomed to such delicacies. Corrine shared with me that when she saw the presentation of gourmet Carrier food she quickly left the room.

Corrine shared later that she did not realize how she had disrespected her future mother-in-law and had shamed herself in front of her future husband's family and community. Her now husband was not ready to give up hope and fought for her and convinced his mother to make repairs and bring back her future daughter-in-law with pride. The one pathway to repair was a journey onto the land with her mother-in-law and future husband. Corrine's mother-in-law would make repair only if they went out together to bring back a moose from the land for their community to share. So, off the three of them went, to travel together into the heart of Carrier land to bring back a moose. They succeeded in their quest, repair and future.

This story is one of many that I continued to hear along my own journey. I have used this story as an example that sheds light into my learnings of Carrier culture and tradition. This story may not have a direct connection to my practice with Carrier youth, but it provides richness and connectedness that supports a holistic understanding, an understanding that can impact my practice in ways that I may not yet know.

Corrinne's narratives often included experiences on the land, which resonated with my learnings about wilderness-based therapies. Her words support the development of my practice model.

Hearing from Corrinne provided a meaningful educational experience about Carrier cultural practice, and I hope I was able to listen openly as an ally. Bishop reminds us that an ally works for "power-with" (2002, p.111). By listening and integrating Corrinne's narrative into my understandings, I aim to stand 'with' her as she tells tales that are uncommon in dominant cultural space.

Carrier Sekani Family Services

The majority of my learnings on Carrier Sekani Family Services' policy, vision and mission took place during the proposal stages of development. The learnings I experienced as related to agency structure can be found in Chapter One of my practicum report. I was required to read the policy and procedure manual when I first arrived, which promoted a greater awareness and insight into CSFS mandates and missions.

This section will address the sub goals of: (1) building relationships with and working collaboratively with co-workers & (2) engaging within agency structure and participating in team meetings, team building and clinical supervision.

I found that I was able to meet my expectations of the first sub-goal: building relationships and working collaboratively with co-workers, although this did prove challenging due to the current pandemic. Most people worked from home and came into the office scarcely or on a case-by-case basis. I was able to engage with my co-workers during our clinical team meetings and our socially-distanced CYMH team bi-annual gatherings. I was also able to connect through email, socially-distanced conversation or Zoom meetings whenever I needed support. I feel that I was able to build positive and trusting relationships with all of the Burns Lake CSFS CYMH team.

The second sub-goal of engaging with agency structure and participating in team meetings, team-building and clinical supervision was certainly met. The CYMH team met every second week for clinical meetings where we would cover topics such as case formulation, proper procedure for assessment and documentation and team building through experiential activities. There I gained knowledge on how other practitioners approach common barriers we all experience and how we connect to clients in our own way. For example, we connected over how

we approach play therapy in practice and we each shared how we make sense of specific actions young children do during play. I was able to learn about play therapy during these clinical team meetings even though I never specifically worked with young children under the age of nine. During the clinical team meetings, we were also able to connect with each other and provide support through sharing success stories or moments that reflected we were doing 'good' work.

I was also provided the opportunity to have weekly supervision where Trevor and I would go over any concerning experiences I had with clients, and where I could go for direction if I was lost. During these clinical supervision sessions, I was provided the space to reflect on my practice, stay on track with client goals and gain trust in myself as a practicing counsellor.

My experience with CSFS further highlighted the strengths of rural practice. As explored in my literature review, rural and remote social work can be viewed through a strengths-based perspective. CSFS' structure at its rural Burns Lake office effectively shifted the challenges of COVID-19 into a positive, flexible approach, wherein clinicians remained supported to work safely at home or in the office, and clients could continue to receive service via bountiful access to outdoor space.

Development of Clinical Social Work Skills

My time with the Child and Youth Mental Health Program at Carrier Sekani Family Services provided me ample opportunity and experience to gain skills related to clinical social work practice. I developed a case load of four clients who I was routinely able to connect with on a weekly basis. These weekly sessions were the centre of my practice and were the opportunities for exploring intake, assessment, evaluation, treatment planning and termination.

Personal Practice Model

I was trusted enough to develop a case load of four clients with whom I was able to do clinical work and follow through with the following therapeutic relational cycle: intake, assessment, treatment planning and closing practices. I worked with three boys and one girl. The youngest was 10 and the oldest was 18. They were all accessing services from CSFS's child and youth mental health program for differing reasons, but all were seeking support to navigate barriers that related to anxiety, depression, suicide, family dynamics or trauma. The diversity of their individual experiences directed me to practice in a variety of different ways. I drew from differing therapeutic modalities to support my work with my clients and they varied depending on each client's individual strengths and barriers. This next section will explore how I worked with the four clients on my case load, as well as my experience with groupwork. I will explore the practice models I applied and why I decided to practice in these ways. In reviewing my work with clients, I now recognize how I was able to apply concepts such as attachment theory and knowledge about intergenerational trauma and trauma informed practice with each client.

Group experience

I was given the opportunity by my supervisor to develop and facilitate a group for young men in the community. The group was based on my interest' in challenging gender stereotypes. I ran three two-hour sessions for young men in Burns Lake with the goals of making a space for them to come together to learn about and speak openly about the challenges they face as men. Developing and facilitating group was another great experience that gave me an opportunity to practice clinical skills that I was not able to practice within my individual client sessions. I was aware that part of facilitating a group was to acknowledge group safety, boundary setting and

group dynamics. I was also aware that I needed to put time and energy into developing a structured program so that youth felt engaged and safe.

Engaging in group work enhanced my learning about connectedness, a concept that emphasizes our inter-related links with both human and non-human resources. I wanted to bring men and boys together to strengthen their support network and enhance their sense of connection with one another. My hope was to highlight that they were not walking their path alone.

I struggled during the group process because the young men did not actively engage with the activities. I needed to process my own expectations and emotions of frustration after the group, which I recognize as a valuable piece of clinical work. I appreciate that the boys may not have been ready to engage, but I hope that some connections were formed, even if this was not evident to me at the time. From a human ecological perspective, I see the importance in reminding myself that I am not the only wellness resource in a youth's life—rather, there are many ongoing experiences available to them that can facilitate wellness.

Client # 1

I followed a relatively strict ACT-for-anxiety format with one of my clients who had a goal related to social anxiety. As noted in my literature review, ACT is an evidence-based modality effective for anxiety. I believe it was a meaningful modality for this youth, given their anxiety concerns. The process I used with my first client was based on a six-week ACT for anxiety training I facilitated for youth and teenagers called *Y Minds.* Together we practiced the six key concepts of ACT: we practiced mindfulness, explored acceptance, worked on diffusing from thoughts, framed ourselves in the context of our experiences and navigated values all in an attempt to commit to mindful action for moving forward in life in meaningful ways (Kelson et al., 2019).

I did adapt the sessions to suit my client's needs in a number of ways. For example, my client was not interested in mindfulness as a practice so I navigated the sessions by introducing other approaches for self-attunement and together we agreed on using the word 'awareness' for our practice of checking-in with our thoughts and feelings.

The client's second goal was to process their experience of gender transition. My approach in this area was to validate their reality and explore connectedness. We considered the role of family relationships and the challenges that came with a lack of full support from family. My understanding of attachment was a major influence in my decision to focus on safety and validation in our sessions. Attachment theory emphasizes the importance of child-caregiver relations (McKinnon, 2008). Therefore, when this relationship is compromised, the counsellor can attempt to provide some of the relational needs a child may be seeking. With this youth, I hoped to provide the space to process their transition, while acknowledging that I cannot replace the profound role of their primary caregivers. The goal of this approach was to allow the youth to feel heard, and consequently increase clarity about who they are in this world and the validity of their reality.

I connected the youth to Trans Care BC, so that the youth could continue to receive accurate medical information for their transition. Trans Care BC is a branch of the Provincial Health Services Authority which specializes in providing accessibility of care, surgery, planning and overall community support for trans people in BC (TransCare BC, 2020). It was vital for me to act as an ally for this youth and provide external resources for their journey. A considerable component of my work with this client was background research. I connected with professionals from Trans Care BC to educate myself on language and policy as it relates to youth gender transitions in BC. Through this experience, I recognized that allyship includes educating

ourselves on other's realities so we can best support them, and not requiring the youth to provide the education to the clinician.

I was able to refer the youth to a gender-transition specialized therapist. Our work together highlighted the value of connectedness—I could not be the sole support in their world, and I recognized that there were many resources that could nurture their wellness.

Client # 2

I wove ACT into work with Client #2 but followed a less strict approach to their sessions. I took mindfulness and acceptance aspects from ACT and incorporated them into early sessions, but then moved into Emotion Focused Family Therapy (EFFT). It was clear to me that this child had the necessary skills and tools to manage their anxiety, but I began to recognize that they had a challenging time placing language to emotion and making sense of feelings. I came into my sessions with them with a conscious effort to utilize emotion coaching. I also structured my responses with the EFFT format of '*I (imagine, believe, bet) that you felt (sad, angry, scared) because ____, ____, & ____'* (Emotion Focused Family Therapy, 2017). This EFFT structured response to adverse experiences is part of stage two of EFFT. It is an easy guide to follow to support clients through validation. This client was working through many feelings of sadness, anger and guilt that they experienced in their relationship with their parents. I felt it useful to first validate, then respond to their emotional needs, then move into stage three of EFFT. Stage three, relational repair, was interesting because I was able to include both parents in this stage.

During this stage of therapy my client and I worked together to formulate a letter to his parents telling them how he feels and why. I was also able to involve the parents and worked with them over the phone and face to face in our own sessions. My time with his parents were unique in that they were looking for support through skill development. I drew from EFFT skills

and structured our time together to explore emotion coaching, parenting styles and co-parenting communication.

EFFT employs attachment principles in working with children and caregivers. With this family, I recognized that the onus for change could not be solely on the child. Rather, work needed to be explored with the caregivers to best facilitate sustainable shifts in the youth's life. While working with the child's parents, I learned about intergenerational patterns in their upbringing that were now impacting their parenting. I was able to draw from my literature search on intergenerational patterns to focus my treatment interventions on psycho-education about this intergenerational impact. Drawing from attachment literature, we were able to explore the importance of emotional attunement between children and caregivers (McKinnon, 2008). The child's letter was an opportunity for the child to practice emotional expression, and an opportunity for the parents to practice emotional attunement. Throughout our time together, we continued to build on these skills and concepts.

Client # 3

I combined Trauma Specific Practice, ACT, Somatic Therapy and Wilderness Therapy into a unique practice approach with this client. Client #3 had experienced verbal and physical abuse from their primary caregivers and these adversities presented themselves through adaptive behaviours, thoughts and feelings. Trauma-specific practice required me to: (1) create safety and stabilization, (2) build connection and skill development, and (3) re-process and re-story adverse experiences (Steele et al., 2012). I knew that I may never reach the third stage of our work together so decided to stay within stage one and two.

Peter Levine states that "it is unnecessary to dredge up old memories and relive the emotional pain" (1997, p. 31). Instead of verbalizing, therapy can focus on identifying the link

between physical sensations and emotions (Van Der Kolk, 2014). My efforts to connect physical sensation and emotion during all of my sessions with my client were apparent. I consciously chose to start with body scans, progressive muscle relaxations and other mindfulness practices that tap into our five senses. Each week we would meet, and each week we would practice these tools together.

Early on in my time with this client I realized that he felt more comfortable and present when he was moving in session. Therefore, along with mindfulness practices I focused my attention on somatic movement-based sessions. Together we explored creeks, dirt trails and lakeside boardwalks.

As I reflect upon this particular client, I am cognizant of my worldviews as they relate to human ecology. I consistently fell back onto connection as more than just the ties he had with other humans, including myself and his grandparents. I considered how best I could create a connection between his experiences and the land to foster health and growth in ways that human connection cannot. It was interesting to see the drastic shifts in body language, eye contact, and self-trust when I compare experiences in my office or outside in the natural world. When we were practicing mindfulness by a babbling brook one day, I was able to hear him speak about felt sensation in the body and witnessed the connection between physical sensation and emotion. When I asked him 'easy' surface-level questions during our time together inside he was unable to respond and unable to make eye contact. Together we worked on emotional regulation, body awareness and somatic movement to develop skills, tools and connections.

Client # 4

The last approach I took with a client involved a combination of strength-based practice, Emotion Focused Family Therapy, and Acceptance Commitment Therapy. Early on in our

sessions I realized that they had a hard time noticing and labelling how they were feeling and why they were feeling certain ways. My initial approach to working with them included basic EFFT skills of emotion coaching. I would often ask how certain experiences had made them feel and would challenge them to reflect on these emotions. If they were unable to put how they felt into words I would follow the basic emotion coaching script of '*I (imagine, believe, bet) that you felt (sad, angry, scared) because ____, ____, & ____'* (Emotion Focused Family Therapy, 2017).

I noticed that the more I used language to connect emotion to feeling and experience the more my client was able to tap into this form of expression. Early on there was resistance to connecting with emotion, but over time we were able to explore why they felt numb to their emotional experiences. We were able to acknowledge when and why they stopped tuning into their emotional experiences.

I then spent time working with them on basics of ACT. We did skill building and psychoeducation on the connections between thinking, feeling and behaving. We then practiced mindfulness as a strategy to make space for tuning into how they were feeling in the present moment. I drew these skills from my training in ACT and Trauma, a course that I was taking simultaneously to completing my practicum.

This youth was required to come to session by their social worker and verbalized that they did not see the benefit of counselling. At the start of our work together, I presented multiple tools that I hoped would be supportive for anxiety-inducing situations. The youth did not engage with these tools. After critically self-reflecting, I recognized that some of the concerns the youth had did not present as true barriers to their functioning and overall wellness. I then shifted my perspective and focused instead on strengths-based work. I highlighted their strengths, both

internally and in community, with the goal of building on these skills to help them continue to move forward. This was a good learning experience for me, because it reminded me to continuously evaluate my biases and agendas with clients, and re-focus on client goals. If I want to be a strengths-based social worker, I need to be aware of the values and assumptions I bring to session.

Intakes, Assessment, Treatment Planning and Termination

Another clinical social work development sub-goal was to become familiar with intakes, assessments, treatment planning and termination. Practicing with the CYMH team in Burns Lake gave me a richer understanding of each of these components. CSFS's CYMH program required all clinicians to follow protocol when documenting their encounters with clients. There were specific forms for each part of the process. I found these in-depth forms useful as a new practitioner because they were very structured. I did find that filling out the forms was time consuming and sometimes redundant, which proved to be one of my bigger challenges in working with CSFS.

It is important as social workers to be aware of the power imbalances during intakes, assessments, interventions and terminations. As social workers it is easy to focus on the required forms and paperwork and lose track client goals. Instead of focusing on the client, practitioners have the potential to solely focus on guidelines or rules, which leaves little room for exploring client needs. This interest in structure "emphasises the professionalization of services, protecting the expert status but widening the gap between the practitioner and the client, as well as leading towards rule bound rather than ethical bound practice" (Hart & Montague, 2015, p. 45). As an anti-oppressive practitioner, it is important to consider my power in choosing how I practice. I attended to power in my work through focusing on client strengths and their connectedness with

community, as opposed to highlighting deficits and focusing on my own agenda. This de-centering of the practitioner is foundational for anti-oppressive practice (Hart & Montague, 2015). It is my aspiration to complete the key features of the therapeutic process in a reflective, anti-oppressive manner that honors a person's full humanity, beyond what documentation can describe.

Intakes

I was set up early on in my placement to find comfort doing intakes by sitting-in with other practitioners. Although I had experience with completing intakes in the past, these opportunities were very educational. I had never done intakes where both client and parents were present. I learned that it was important to first meet with everyone together to go over confidentiality, goals and expectations. I would then meet separately with parents and then with their son or daughter. These separate encounters were important for two reasons: (1) I would be able to get a rich detail of family history, developmental milestones and parental viewpoints when I sat in alone with parents. I would also be able to validate parent experiences and provide space for them to feel heard, (2) I was also able to get a different perspective when speaking with their son or daughter. This proved helpful to start to build rapport and an environment where the client would feel safe to share in a way they may not have been able to when parents were present. One major learning I was able to take away is that people have differing expectations when it comes to counselling. Parents came in with their own perspectives and often times their child had different reasons for coming to counselling. I found it hard to navigate my role in relation to my client—the child—and their caregivers. This represents an ongoing learning that I hope to continue in my future practice.

Assessments

Another major part of my learning was how best to use the DSM-V. As a student and an unregistered clinical social worker, I am unable to diagnose clients with disorders from the DSM, but I was able to practice using this tool. The CSFS Assessment Form included a section on tools used; there I was able to write about the 'query diagnoses' from the DSM and the reasons why those 'query' diagnoses were considered. I would sometimes use assessment tools like the GAD-7 (Spitzer et al., 2007) or the PHQ-9 (Kroenke et al., 2002) but only if I considered them to be a useful tool for the client. Other assessment tools I used were the Beck's Depression Inventory (Beck et al., 1961), SNAP- IV Teacher and Parent 18 Scale for assessing ADHD (Bussing et al., 2008) and the Kutcher Generalized Social Anxiety Disorder Scale for Adolescents (Brooks et al., 2004).

Treatment Planning

Treatment planning required another specific form. I found that I became comfortable and confident in the conversations I had with clients about goals, planned actions and how we were able to know if we found success. I found that as a student I was able to place energy and time into treatment planning, as I was only working with four clients. The time available in my day allowed me to deeply explore best options and prepare well with resources. I found that I was able to work with each individual in the way that we planned. I realize this may not always be the case and my caseload as a practitioner later in life will likely be more intense, but as a student this gave me ample opportunity to learn. As I demonstrated in my client descriptions, it is important to purposefully connect theory to practice. I aimed to connect my awareness of attachment, intergenerational trauma, trauma-informed practice, and other models with intentional interventions in each treatment plan.

Termination

I started the terminating process as soon as I began my intake session. Part of the intake included an open conversation of how long our time together would be. I find end dates to be an important part of the therapeutic process because it forces me to be accountable to my clients. End dates require me to continuously check in with my clients about how our goals are coming along and provide space for me to gauge progress from session to session.

I was able to connect with other clinicians in the last few weeks to help transition two of my clients. For one of my clients I was able to hold a joint session in order to provide a slower and more comfortable transition. This clinical decision was made to promote the safety and stability of this client. They were working through adverse experiences of trust and safety with their primary caregivers and I felt that a joint session to build connection and to let the client know that the person who was going to be working with them next was safe was an important step in the therapeutic process.

I was able to refer another client to Trans Care BC. They were able to connect with a specialist and continue to access support after my departure.

Developing awareness and understanding of telehealth practice in a COVID-19 context

A subsection of my practicum proposal was written to develop my understanding and awareness of telehealth practice. Going into my practicum with CSFS, I found myself expecting to do the majority of my work from home and online. These expectations were consistent with health authority guidelines, work expectations and my work experiences of completing my classes online and facilitating my ACT for anxiety groups online.

My experience with CSFS was unique. Firstly, finding a place to stay in Burns Lake was very challenging. The town was seeing an influx of people to work on the pipeline, and youth

that would have left for school were staying with their parents because of COVID-19, reducing the suite rental availability. Ultimately, I was unable to find a home. I was eventually able to find housing in a single bedroom cabin 40 minutes from town on a family's property. I had no internet service and was required to go into the office to work. Furthermore, the clients that I worked with were more comfortable visiting in person. I would set up the majority of my sessions outside, and if we were not outside, we would be socially distanced in a counselling office. I am unable to say that I met my goals for telehealth practice. I did, however, learn to adapt and stay safe through other measures. I relied on connecting with youth outside through walking, biking and socially distanced connection. This is important learning for practicing during Covid-19, but did not apply to the goals that I had for Tele-health practice.

I reflect upon this unique experience and connect it to some of the earlier literature I describe on rural social work practice. While some might see this rural experience as a barrier to my growth as a practitioner, I choose to approach rural practice from a strengths-based perspective. The aspects of rural community living that proved challenging for me, such as housing, internet and commuting opened up doors that I otherwise would not have experienced. I was able to adapt my practice in a safe way that followed all COVID-19 protocols and managed to work with youth through the safe means that rurality provided. I was lucky enough to be able to access large amounts of green space close to my office and could easily walk with youth to areas that promoted connection to the land. COVID-19 became a good excuse to get outside, walk around and explore the creeks with youth who may not have otherwise been drawn to these approaches. I was able to facilitate movement and connection to the land in ways that may not have been accessible in a different location.

Chapter 7: Implications for Practice

My practicum placement at Carrier Sekani Family Services gave me significant insight into the future work that I hope to do as a child and youth mental health counsellor. It also re-instilled my desire and passion to pursue additional practices that I did not focus on during my time as a student. The key social work implications I offer are connectedness, the importance of historical awareness for anti-oppressive practice, and linking theory to practice through purposeful planning.

Connectedness

Connectedness emphasizes a philosophy of holistic community engagement in tandem with traditional individual clinical work.

My time with CSFS proved to be very experiential and educational, and I was able to meet the majority of my learning objectives. My practicum has led me to the realization that I hope to continue to practice community work alongside clinical social work. Although I was working in a community agency, my practice felt somewhat disconnected from other supports, such as Indigenous bands, schools, healthcare, and even families. Through this learning, I came to acknowledge that I want to focus more time and energy towards collaboration among these supports in my role as a clinical social worker. Clinical counselling is only one part of the equation in pursuit of health and wellness, and I feel I am in a position to link community connections into my practice with youth.

During my time in Burns Lake I was able to seek connections to community practice in other ways, including volunteering with Spirit of the North. Spirit of the North is an initiative that “aims to support First Nations youth in pursuing healthy lifestyles by engaging them with outdoor recreation sport and activities” (Spirit North, 2020). I was able to support their youth

mountain biking program. Each Thursday we would come together to learn, grow and empower one another through mountain biking. One goal of the program was to support youth to thrive in an effort to facilitate the strength and vibrancy of their community. The term ‘connectedness’ has supported my awareness of the importance of facilitating the relationships we have with our culture, our land and our community. My experience with this program provides one example of the important connections woven within the larger web of connectedness. Engaging with the land-based, community-based programming inspired my own aspirations to contribute to such programs in my future practice.

As I reflect on my experience with CSFS, I consider the balance between connecting youth with their relations, while also placing some accountability on the client to take action in their lives. This is a balance that I am still processing. I realize the importance of building youth connections with family, land, and peers, while recognizing the role of therapy and individual responsibility for change.

As a profession, social work must continuously reflect on the power dynamics at play in the all-too-easy ‘savior’ complex. A ‘savior’ complex focuses on the worker’s capacity to ‘fix’ or shift a situation, and in so doing, overlooks the various strengthening features that already exist in community. I believe connectedness reminds social workers that we do not need to carry the burden alone. Rather, we can support balance for our clients by honoring the other connections in their life. Ideally, in spending time to connect clients with their community, we reduce the weight on the individual worker, and the client. This may decrease social worker burnout.

Interdisciplinary practice

A key feature of connectedness and human ecological perspectives is interdisciplinary practice: it is vital to collaborate across the disciplines in order to effectively innovate and create change (Charron, 2011). Interdisciplinary practice can be defined as a "complex process in which a variety of different experts collaborate together" to formulate a wholistic understanding of a situation (Nancarrow et al., 2013, p. 1). At CSFS, I had the opportunity to attend several webinars led by Compass BC. These webinars brought together psychiatrists, diverse school staff, and clinicians. I valued the opportunity to connect with these other professions.

In clinical practice, the focus of the interdisciplinary team is the youth we are serving. Varying parties involved might include family members, community leaders, such as First Nations leadership, school supports, medical professionals, child welfare workers, the counsellor, and certainly the youth. An important piece of this work is maintaining open communication so all parties can share their voice. It is important to facilitate this dialogue to best support youth. Instead of coming to a care team meeting with my own agenda, I want to step into a facilitation role and support a team approach. Ultimately, I see great value in interdisciplinary practice because I recognize its capacity to hold a complex situation in a fluid, organic way (2011). The youth's situation is never static or individualized, but instead ebbs and flows through the different perspectives, hopes and goals of their supports. When multiple parties come together to support a youth, we can have more success in achieving their goals.

On a very pragmatic level, it can be challenging to bring together each of these parties given the diversity of schedules and needs we may have. I am grateful for the technologies we now have that can facilitate this. For instance, instead of emailing back and forth among care team members, I could send out an online survey with potential times and make a plan based on

the data. I am committed to supporting various parties coming together, and I believe as social workers, we can play a role in facilitating these relationships.

The importance of historical context for AOP

In my literature review, I explored the history of colonial Canada. As an outsider, it was vital for me to learn this history as I entered practice in an Indigenous organization. Understanding history offers context for the 'here' and 'now' realities of Indigenous youth and families. The external presentations of clients are profoundly informed by history, including legacies of inter-generational trauma. For clinical social workers, understanding history will allow us to make more informed assessments, and ultimately more deeply make sense of people's lived realities. Practically, we can support clients to consider historical influences on their situation so as to reduce self-blame. Exploring these complex topics requires both clinical skills and attunement.

As a profession, social work is committed to social justice. Acknowledging history is an essential component in deepening our social justice allyship. As an aspiring ally, I aim to educate myself on the history and context of the peoples I work with, so as to best meet them with humility and openness. Understanding history allows us to respond to the call of allyship. For example, without historical knowledge of intergenerational trauma as a result of colonization, it can be all too easy to individualize struggles, and remain clouded by our own social locations. As a white settler male working at an Indigenous organization, historical awareness allowed me to practice allyship as a colleague with Indigenous practitioners. Additionally, historical awareness allowed me to locate client experiences within a larger system as opposed to individualizing their challenges. This contextualizing can be an important tool for social work practice and can support social workers in a variety of roles.

Linking theory to practice: purposeful treatment approaches

An additional important social work implication I gathered through my practicum focuses on the importance of intentionality in our work. It can be easy to draw techniques from therapeutic modalities and use these tools blindly, without intentional consideration of their purposes. It is important as social workers to have a deep understanding of the therapeutic modalities and theories that we use, and to know why we are employing a certain intervention. Additionally, it is important to have awareness of our theoretical underpinnings so as to address potential biases in our approaches.

In the next section, I provide an example of connecting trauma-informed practice to nature-based interventions. This is one example of several provided throughout my report. In chapter six, "The Practicum Learning Experience", I address the connections between attachment theory, allyship, intergenerational trauma, and strengths-based modalities, within intentional client interventions.

Applying trauma-informed nature-based interventions

I have always known personally that it is vital for me to ground myself in nature. I am now able to draw the connections between my passion for nature and clinical mental health outcomes, drawing from literature on wilderness therapy, somatic therapy and trauma-informed therapy.

A large component of my practice at CSFS combined mindfulness approaches with nature-based experiences. I aimed to be a facilitator for the youth's connection to the land. Components of my literature review illuminate the research supporting land-based engagement for mental health.

I had the opportunity to visit creeks and walk in forests with youth—but what implications does this truly have for clinical social work practice? It is not sufficient to simply go on a pleasant walk in the sun with a client—I must connect this to treatment planning and client goals. I can now with more confidence plan nature-based interventions with an awareness of the specific purposes of these interventions. For instance, when working with an individual with complex trauma, I can purposefully support safety and grounding through experiencing the sensations of dipping one's hand in cold creek water. This practice also allows a youth to put language to their sensations, which encourages deeper mind-body connection. This mind-body component can be added into the treatment plan as a means of addressing dissociative experiences and emotional numbness. I can effectively argue for the benefits of such practices as mental health interventions.

My theoretical orientation of human ecology is undeniable in this approach. I want to encourage youth's connection and relationship with land, because I believe that the land offers care, and we can experience this support, and also reciprocate care towards the land.

I appreciate that this is my perspective on human-land interconnection. It is important for all social work practitioners to be self-reflective and name our biases. In naming my bias towards a human ecological approach, I can be cautious of my underlying assumptions and goals in practice, some of which may not be shared by the client. For example, I want everyone to share a sustainable relationship with the land and value the land as I do. I am passionate about this approach but must recognize that there are many perspectives on wellness, and it is never my position to change a client's perspective.

Chapter 8: Conclusion

This report summarizes my practicum with Carrier Sekani Family Services' child and youth mental health program in Burns Lake, British Columbia. I ground myself in a human ecological theoretical orientation. Human ecology encapsulates the entirety of my practice, and I have come to sink more deeply into its key principles, which include participation, knowledge-to-action, and the connectedness among humans and ecology. Within this broad perspective, I uphold an anti-oppressive practice approach, which honors the interplay of power dynamics on both structural and relational levels.

As a white settler male and social worker of Welsh and Ukrainian ancestry, I will continue to self-reflect to practice from an anti-oppressive approach, with attention to the historical context of colonial Canada. My literature review provides important foundational information for my ongoing learning as a practitioner. I will continue to reflect on theories of strengths, attachment, allyship, trauma-informed practice, and connectedness, to move forward in my practice.

As part of a CYMH team I was able to see the rich adaptions in practice that promoted a sense of connectedness to each other and to the land despite the adversity of this pandemic. Our rural practice did not become hindered from the barriers of the pandemic, but shape shifted and made sense of practice with geography and land in mind. As I continue to practice during the pandemic, I will carry these learnings forward. Instead of focusing on the hindrances of COVID-19, I am inspired to adapt creatively and continue to integrate land-based activities with clients. As Stoic philosophy reminds me, *Amor fati,* or "I love fate" (Daily Stoic, 2019, para. 1). As a social worker, I am committed to actively responding to our changing world with integrity and utmost professionalism.

My learnings with CSFS have shaped my aspirations for future practice. Although I greatly valued the one-on-one clinical experience I received, I came to realize that I want my future practice to be more deeply interwoven with community. I continue to dream about being involved with nature and movement-based community initiatives in tandem with therapeutic work. Following my time with CSFS, I can now more clearly recognize the importance of community connections for holistic health and hope to be a part of building these resources.

I have learned a great deal from my experiences with CSFS and hope that I was able to give back in a meaningful, reciprocal way. I have learned that I am not able to do this work alone and I look forward to making space for unique forms of connectedness between health and community in my future social work practice. In order to move forward I will continue to fall back on an anti-oppressive, community-centred practice that dips into the interconnections of human ecology.

References

Alexander, P. C. (2009). Childhood trauma, attachment, and abuse by multiple partners. *Psychological trauma: Theory, research, practice, and policy*, *1(1), 78*.

Apolinário-Hagen J, Drüge M, Fritsche L. (2020). Cognitive Behavioral Therapy, Mindfulness-Based Cognitive Therapy and Acceptance Commitment Therapy for Anxiety Disorders: Integrating Traditional with Digital Treatment Approaches. *Adv Exp Med Biol*., 1191: 291-329. doi: 10.1007/978-981-32-9705-0_17. PMID: 32002935.

Aruliah,N. (2014). The Impact of Difference. *Visions, 9(4), 5-8.* Retrieved from http://www.heretohelp.bc.ca/sites/default/files/visions-culture-vol9.pdf

Balma, S. (2014). Editor's message. *Visions, 9(4), p.4-5.* Retrieved from http://www.heretohelp.bc.ca/sites/default/files/visions-culture-vol9.pdf

Baskin, C. (2016). *Strong helpers' teachings: The value of Indigenous knowledges in the helping professions*. Canadian Scholars' Press.

Beck, J.S. (2011). *Cognitive behaviour therapy: Basics and beyond*. Guildford press.

Beck, A.T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961) An inventory for measuring depression. *Archives of General Psychiatry, 4*, 561-571.

Bishop, A. (2002). *Becoming an Ally: Breaking the Cycle of Oppression*. Fernwood Publishing.

Blackstock, C. (2008). Rooting mental health in an Aboriginal worldview. *Inspired By Many Hands One Dreams. Ontario. Canada: The Providencial Center of Excellence for Child and Youth Mental Heath*, 23-28.

Blackstock, C. (2008). Reconciliation means not saying sorry twice. *From truth to reconciliation: Transforming the legacy of residential schools*, 164-178.

Bombay, A., Matheson, K., & Anisman, H. (2014). The intergenerational effects of Indian Residential Schools: Implications for the concept of historical trauma. *Transcultural psychiatry*, *51*(3), 320-338.

Brooks, S. J., & Kutcher, S. (2004). The Kutcher Generalized Social Anxiety Disorder Scale for Adolescents: Assessment of its Evaluative Properties Over the Course of a 16-Week Pediatric Psychopharmacotherapy Trial. *Journal of Child and Adolescent Psychopharmacology, 14*(2), 273–286. https://doi.org/10.1089/1044546041649002

Brown, D. (2002). Carrier Sekani self-government in context: Land and resources. *Western Geography*, *12*(2002), 21-67.

Bussing, R., Fernandez, M., Harwood, M., Hou, W., Garvan, C. W., Eyberg, S. M., & Swanson, J. M. (2008). Parent and teacher SNAP-IV ratings of attention deficit hyperactivity

disorder symptoms: Psychometric properties and normative ratings from a school district sample. *Assessment, 15*(3), 317–328. https://doi.org/10.1177/1073191107313888

Carrier Sekani Family Services. (2020, September 27). *History.* CSFS. https://www.csfs.org/about-us/history

Carrier Sekani Family Services. (2020, September 27). *Mandate, Objectives and Mission.* CSFS. https://www.csfs.org/about-us/mandate-objectives-and-mission

Carrier Sekani Family Services. (2020, September 27). *CSFS Member Nations.* CSFS. https://www.csfs.org/culture/overview-culture

Carriere, J., & Richardson, C. (2009). From longing to belonging: Attachment theory, connectedness, and indigenous children in Canada. *Passion for action in child and family services: Voices from the prairies*, 49-67.

Carrion, V. G., & Wong, S. S. (2012). Can traumatic stress alter the brain? Understanding the implications of early trauma on brain development and learning. *Journal of adolescent health*, *51*(2), S23-S28.

Charron, D. F. (2012 A). Ecohealth research in practice. *Ecohealth Research in Practice*, 255-271. Springer.

Charron, D. F. (2012 B). Ecohealth: origins and approach. In *Ecohealth research in practice*, 1-30.

Craig, C. D., & Sprang, G. (2007). Trauma exposure and child abuse potential: Investigating the cycle of violence. *American Journal of Orthopsychiatry*, *77*(2), 296-305.

Christensen, M., & Manson, S. (2001). Adult attachment as a framework for understanding mental health and American Indian families: A study of three family cases. *American Behavioral Scientist*, *44*(9), 1447-1465.

Daily Stoic. (2019). *Amor fati: the formula for human greatness.* Retrieved from https://dailystoic.com/amor-fati-love-of-fate/.

Ellett, L., & Kingston, J. (2020). Third-Wave CBT Interventions for Psychosis. In *A Clinical Introduction to Psychosis*, 379-393

Emotion-focused family therapy (2017, September 14). *Emotion Basics - Emotion-Focused Family Therapy* Retrieved January 15, 2020, from https://www.emotionfocusedfamilytherapy.org/emotion-basics/

Foroughe, M., Stillar, A., Goldstein, L., Dolhanty, J., Goodcase, E. T., & Lafrance, A. (2019). Brief Emotion Focused Family Therapy: An Intervention for Parents of Children and Adolescents with Mental Health Issues. *Journal of marital and family therapy*, *45*(3), 410-430.

Government of Canada. (2020). Coronavirus disease (covid-19): *Symptoms and Treatment.* Retrieved from the Government of Canada website: http://canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/symptoms.html

Hart, A., & Montague, J. (2015). "The Constant State of Becoming": Power, Identity, and Discomfort on the Anti-Oppressive Learning Journey. *Journal of Psychological Issues in Organizational Culture*, *5*(4), 39-52.

hooks, b. (1984). Black Women: Shaping Feminist Theory in Marable M. & Mullings, L.(Ed.), *Let Nobody Turn Us Around: Voices of Resistance, Reform, and Renewal; An African American Anthology* (544-550). Bowman & Littlefield Publishers.

Robinson, A. L., Dolhanty, J., & Greenberg, L. (2015). Emotion-focused family therapy for eating disorders in children and adolescents. *Clinical psychology & psychotherapy*, *22*(1), 75-82.

Saint-Jacques, M. C., Turcotte, D., & Pouliot, E. (2009). Adopting a strengths perspective in social work practice with families in difficulty: From theory to practice. *Families in Society*, *90*(4), 454-461.

Saleebey, D. (1996). The strengths perspective in social work practice: Extensions and cautions. *Social work*, *41*(3), 296-305.

Spirit North. (2020). *Spirit North*. Retrieved from: spiritnorthxc.ca

Steele, W., & Malchiodi, C. A. (2012). *Trauma-informed practices with children and adolescents*. Taylor & Francis.

Strahan, E. J., Stillar, A., Files, N., Nash, P., Scarborough, J., Connors, L., … & Orr, E. Lafrance, A. (2017). Increasing parental self-efficacy with Emotion-Focused Family Therapy for eating disorders: a process model. *Person-Centered & Experiential Psychotherapies*, *16*(3), 256-269.

Grady, B., Myers, K. M., Nelson, E. L., Belz, N., Bennett, L., Carnahan, L., ... & Rowe, N. (2011). Evidence-based practice for telemental health. *Telemedicine and e-Health*, *17*(2), 131-148.

Greenwood, M. & de Leeuw, S. (2009). Teachings from the land: Indigenous people, our health, our land, and our children. *Canadian Journal of Native Education, 30*, 48-53.

Hall, T. M., Kaduson, H. G., & Schaefer, C. E. (2002). Fifteen effective play therapy techniques. *Professional psychology: Research and practice*, *33*(6), 515.

Hansen, M. M., Jones, R., & Tocchini, K. (2017). Shinrin-yoku (forest bathing) and nature therapy: A state-of-the-art review. *International journal of environmental research and public health*, *14*(8), 851.

Harris, R. (2006). Embracing your demons: An overview of acceptance and commitment therapy. *Psychotherapy in Australia*, *12*(4), 2-8.

Hilty, D. M., Ferrer, D. C., Parish, M. B., Johnston, B., Callahan, E. J., & Yellowlees, P. M. (2013). The effectiveness of telemental health: a 2013 review. *Telemedicine and e-Health*, *19*(6), 444-454.

Hofmann, S. G. (2011). *An introduction to modern CBT: Psychological solutions to mental health problems*. John Wiley & Sons.

Jain, Rahul. (2019). Module 2*: Attachment and its relationship to mental illness*. UNBC.

Kaplan, R. M., & Saccuzzo, D. P. (2017). *Psychological testing: Principles, applications, and issues*. Nelson Education.

Kelson, J., Rollin, A., Ridout, B., & Campbell, A. (2019). Internet-delivered acceptance and commitment therapy for anxiety treatment: systematic review. *Journal of medical Internet research*, 21(1), e12530.

Kirmayer, L., Simpson, C., & Cargo, M. (2003). Healing traditions: Culture, community and mental health promotion with Canadian Aboriginal peoples. *Australasian Psychiatry*, *11*(sup1), S15-S23.

Kroenke, K. & Spitzer, R.L. (2002). The PHQ-9: A new depression and diagnostic severity measure. *Psychiatric Annals, 32*, 509-521.

Laiuk, M. (2015). *Myroslav Laiuk*. Received from https://www.versopolis-poetry.com/poet/208/myroslav-laiuk

Landreth, G. L. (2012). *Play therapy: The art of the relationship*. Routledge.

Lavallee, L. F., & Poole, J. M. (2010). Beyond recovery: Colonization, health and healing for Indigenous people in Canada. *International Journal of Mental Health and Addiction*, *8*(2), 271-281.

Leahy, R. L. (1996). *Cognitive therapy: Basic principles and applications*. Jason Aronson, Incorporated.

Le Vay, D., & Cuschieri, E. (Eds.). (2016). *Challenges in the Theory and Practice of Play Therapy*. Routledge.

Levine, P. A., & Frederick, A. (1997). *Waking the tiger: Healing trauma: The innate capacity to transform overwhelming experiences*. North Atlantic Books.

Lloyd, J. E. (2004). *A History of Wales: From the Norman Invasion to the Edwardian Conquest*. Barnes & Noble Publishing.

McCormick, R. (2009). Aboriginal approaches to counselling. In L. Kirmayer and G. Valaskakis (Eds.), *Healing traditions: Mental health of Aboriginal peoples in Canada*, 337-354. UBC Press

Macfarlane, R. (2015). *Landmarks*. Penguin UK.

McKinnon, J. A. (2008). *An unchanged mind*. Lantern Books.

McLeod, S. (2007). Maslow's hierarchy of needs. *Simply Psychology*, *1*.

Minahan, J. (2000). *One Europe, many nations: a historical dictionary of European national groups*. Greenwood Publishing Group.

Morgan, A. (2000). What is narrative therapy? An easy-to-read introduction. *Dulwich Center Publication*.

Mullaly, R. (2002). *Oppression: An Overview. Challenging Oppression: A Critical Approach to Social Work*. Oxford University Press

Myers, K., Nelson, E. L., Rabinowitz, T., Hilty, D., Baker, D., Barnwell, S. S., ... & Comer, J. S. (2017). American telemedicine association practice guidelines for telemental health with children and adolescents. *Telemedicine and e-Health*, *23*(10), 779-804.

Pacelli, J. (2018). *Somatic Experiencing Trauma and Wilderness Therapy*. Received from: https://evoketherapy.com/family-involvement/blog/jenna-pacelli/somatic-experiencing-trauma-and-wilderness-therapy/

Payne, M. (2014). *Modern social work theory*. Oxford University Press.

Phares, V. (2014). *Understanding Abnormal Child Psychology* (3rd ed.). John Wiley & Sons.

Quinless, J. M. (2013). First Nations teenaged female lone parent families in Canada: Recognizing family diversity and the importance of networks of care. *The International Indigenous Policy Journal*, *4*(1), 12.

Reynolds, V. (2013). " Leaning In" as Imperfect Allies in Community Work. *Narrative and Conflict: Explorations in theory and practice*, *1*(1), 53-75.

Robinson, T. L. (2005). *The convergence of race, ethnicity, and gender*. Merrill.

Ross, S. (2003). The therapeutic effects of an adventure challenge program on the personal empowerment of women survivors of sexual trauma. *The Journal of Experiential Education*, *25*(3), 350.

Saint-Jacques, M. C., Turcotte, D., & Pouliot, E. (2009). Adopting a strengths perspective in social work practice with families in difficulty: From theory to practice. *Families in Society*, *90*(4), 454-461.

Sakamoto, I., & Pitner, R. O. (2005). Use of critical consciousness in anti-oppressive social work practice: Disentangling power dynamics at personal and structural levels. *The British Journal of Social Work*, *35*(4), 435-452.

Scales, T. L., Streeter, C. L., & Cooper, H. S. (Eds.). (2013). *Rural social work: Building and sustaining community capacity*. John Wiley & Sons.

Spitzer, R., Kroenke, K., Williams, J. et al., (2006) A brief measure for assessing generalized anxiety disorder: the GAD-7. *Arch Intern Med,*; 166:1092-1097

Statistics Canada. (2016). *Diverse family characteristic of aboriginal children aged 0-4* [Data file]. Retrieved from https://www12.statcan.gc.ca/census-recensement/2016/as-sa/98-200-x/2016020/98-200-x2016020-eng.pdf

Sinclair, N. (1998). *The Land and The Sea*.

Trocmé, N., Knoke, D., & Blackstock, C. (2004). Pathways to the overrepresentation of Aboriginal children in Canada's child welfare system. *Social Service Review*, *78*(4), 577-600.

Tucker, A., Norton, C. L., DeMille, S. M., & Hobson, J. (2016). The impact of wilderness therapy: Utilizing an integrated care approach. *Journal of Experiential Education*, *39*(1), 15-30.

Van der Kolk, B. (2014). *The body keeps the score: Mind, brain and body in the transformation of trauma*. Penguin.

Van der Kolk, B. (1994). The body keeps the score: Memory and the evolving psychobiology of posttraumatic stress. *Harvard review of psychiatry*, *1*(5), 253-265.

Vasmer, M. (1953). *Russisches etymologisches Wörterbuch* (Vol. 1, pp. 627-627). Heidelberg: Winter.

Vukic, A., Gregory, D., Martin-Misener, R., & Etowa, J. (2011). Aboriginal and Western conceptions of mental health and illness. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health*, *9*(1), 65-86

Wallis, R. News and Views: Featured Article-Bringing Outward Bound into Trauma Healing. *The Outward Bound Canada Journal of Education*, 24.

Wise, A. (2015). *Identity Politics or "Minority Nationalism?" The Scottish Referendum Through Welsh and Ulster Scots Eyes* [Doctoral dissertation].

Work, K. (2014). Trauma, Resiliance and the Role of Cultural Identification and Healing. *Visions*, 9(4). Retrieved from http://www.heretohelp.bc.ca/sites/default/files/visions-culture-vol9.pdf