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Vanessa Gorry

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Name of Candidate Nom du candidat	Vanessa Gorry		
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APPROVED/APPROUVÉ

Thesis Examiners/Examineurs de thèse:

(First Reader/Supervisor/Directeur(trice) de thèse) Diana Coholic

(Second Reader/Co-supervisor/Co-directeur(trice) de thèse) Leigh MacEwan

(Committee member/Membre du comité)

Approved for the School of Graduate Studies
 Approuvé pour l'École des études supérieures
 Dr. David Lesbarrères
 M. David Lesbarrères
 Director, School of Graduate Studies

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Abstract

This report explores my experiences and desire to develop my clinical skills while completing an advanced practicum with the Mood and Anxiety Program through Health Sciences North. The Mood and Anxiety Program works with individuals that had been diagnosed with a mental illness and wanted to seek therapeutic assistance to learn how to manage symptoms and challenges of their mental illness. In this instance, mental illness is a health condition that is distinguished by considerable dysfunction in a person's cognition, emotions, or behaviours that could often reveal a disturbance in the psychological, biological, or developmental processes, which could have underlying mental functioning.

Through this practicum, and as shown throughout this report, I was able to create and achieve several goals that I felt would assist me in developing my clinical skills. I planned to refine my skills by working as part of a multidisciplinary team; continuously reflecting on my practice with the use of a journal and clinical supervision; completing assessments and co-facilitating group therapy sessions; and, integrating theory into practice. I was also able to critically reflect upon the theories that I used during my practicum; develop and improve my self-awareness; enhance my therapeutic presence; and develop an understanding of how stigma is present in the mental health field and could it acts as a barrier for people with a mental illness.

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Chapter 1 – Introduction

Mental illness is defined as a “serious disturbance in thoughts, feelings and perceptions that is severe enough to affect day-to-day functioning” (Mood Disorders Society of Canada, 2009, p. 2). Mental illness indirectly affects everyone at some point whether it is through a family member, friend, or colleague and comprises of more than 15% of the diseased in Canada (Canadian Mental Health Association, 2012). According to the Canadian Mental Health Association (2012), one in five adults in Canada, or 4.5 million individuals, will experience a mental illness at some point in their lives. However, they also indicated that that only one-third of those with a mental illness with actually receive treatment through mental health services in Canada. As someone that is new the helping profession, I find that these facts are rather disturbing. My desire to assist people drew me to the mental health sector because I recognized that there was a need for more aid.

To fulfill part of the requirements for the Laurentian University Master’s of Social Work program, I chose to complete and advanced practicum (SWRK 6024E) through the Mood and Anxiety Program (MAP), Health Sciences North (HSN). The intention of the practicum was to build, develop, and refine my clinical skills within a mental health setting. In order to accomplish this objective, I had developed a series of goals that I aimed to complete during the advanced practicum.

These goals, which I will discuss throughout this report, included learning clinical social work skills through working as part of a multidisciplinary team. I also wanted to become skilled at working with clients by completing assessments and group therapy. I was able to utilize the knowledge and expertise of all the clinicians at MAP. Having this ability to work with other

clinicians allowed me to understand different methods and approaches to completing assessments and group therapy. It also encouraged me to be comfortable and gain confidence and develop my practice approach for completing assessments and leading group therapy.

I aimed to utilize and critically reflect upon Cognitive-Behavioural Therapy (CBT) and a strengths-based approach. The objective was to understand how to use these theories within a mental health context. I was able to successfully complete this objective as many of the groups that I co-facilitated used CBT in order to assist clients in recognizing their negative thinking patterns and to understand how these thoughts affected their behaviours (Lau, Dubord, & Parikh, 2004). I learned how important this theory is within a mental health setting because it can treat many people with a variety of mental illness diagnoses.

I was also able to use the elements of strengths-based approach throughout both the assessments and the group therapy. This was useful because I learned how to phrase questions and write case notes that reflected the values of a strengths-based approach. For instance, the intention was not to focus on their problems or deficits, but to discuss how the individual is supported and to recognize the inherent resources and resilience they have. This approach encouraged me to value the capacity, skills, and knowledge of the clients. I was able to utilize this approach in conjunction with the CBT homework to demonstrate the collaborative process between the clinician and the client. The intention was to enable them to work on their goals and to draw out their strengths and assets.

Improving my self-awareness through the utilization of supervision was important because it encouraged me to seek constructive criticism and understand additional approaches to situations that I had encountered. Developing my self-awareness truly assisted in developing my

clinical skills because it offered me an opportunity to ask questions and receive feedback in a trusting and confidential manner.

Similar to self-awareness, I aspired to develop my therapeutic presence. I aimed to complete this task through clinical supervision, journaling, and refining my active listening skills and becoming more familiar and knowledgeable about mental illness and the implications on the clients that use MAP's services. Developing my therapeutic presence through continuously assessing and analyzing my experiences encouraged me to recognize the professional skills that I was lacking and work towards being in the moment with clients and actively listening to the clients. This process allowed me to comprehend and value the client's experiences.

Through the practicum process, I discovered that oftentimes people with a mental illness or suffering mental health challenges face a multitude of barriers stemming from the stigma associated with having a mental illness. I was able to learn how stigma could have a direct effect on their well being by causing challenges directly relating to lack of support, isolation, and avoidance. I was also able to understand how stigma has the potential to be life-limiting for some people with a mental illness.

As stated above, the practicum was completed with MAP. The MAP clinicians provide individual therapy to persons with a diagnosis of obsessive-compulsive disorder and post-traumatic stress disorder; and group therapy to persons with a diagnosis of generalized anxiety, depression, and bipolar disorder. MAP aims to promote quality of life in their clients. With that being said, MAP offers continuous therapy groups to their clients in order to ensure that the clients are able to manage any symptoms, or challenges, they may have. As a Laurentian University Master of Social Work student, I was able to provide support and services to individuals who had been diagnosed with depression, anxiety, borderline personality disorder,

obsessive-compulsive disorder, and individuals with post-traumatic stress disorder. The majority of my advanced practicum experiences allowed me to focus on co-facilitating group therapy. I also had the opportunity to administer assessments, discharge clients, complete data entries, and research client histories of the people wanting to begin group therapy and utilize the services provided by MAP. Although I have social work education and some training as a B.S.W. student within the mental health sector, I have known that I could be of assistance to many people but I felt that I would say something wrong, or do something incorrectly. I certainly did not want to offend a client, so having this additional pressure would often create feelings of anxiety and worry when I would approach a client. As a result, a portion of my advanced practicum was spent on becoming comfortable working with clients and supporting them through their journey and treatment.

The aim of this paper is to show how, through the advanced practicum, I was able to accomplish all, or more, of the objectives that I created and to illustrate how I was able to develop my clinical skills through this process. In this advanced practicum report, I will provide a review of recent and relevant literature as it applies to mental illness, offer a thorough examination of the process of the practicum by examining the practicum setting, supervision, and goals. I will also discuss theories that were relevant and appropriate to the practicum, and researcher reflexivity and reflective practice. I will then go on to discuss the experiences that I encountered during the advanced practicum. Finally, I will conclude the practicum paper by discussing significant findings that were encountered during the practicum and I will offer an examination of the implications for social work practice within a mental health setting.

Chapter 2 – Literature Review

This review will be a general synopsis of current literature that focuses on mental illnesses, more specifically, in relation to mood and anxiety disorders, which were the forms of mental illnesses and challenges that were treated by the Mood and Anxiety Program (MAP) at Health Sciences North (HSN). The World Health Organization (2012) described mental illness as "...comprised of a broad range of problems, with different symptoms. However, they are generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others" (para. 1). The Canadian Mental Health Association (2012) stated that 4.5 million Canadians have been affected by mental illness. According to the Centre for Addiction and Mental Health (2012), "1 in 5 Canadians will experience a mental illness in their lifetime" (para. 1). However, 27% of those surveyed claimed that they were "...fearful of being around people who suffer from serious mental illness" (Centre for Addiction and Mental Health, 2012, para 17). It would seem that although mental illness could affect many Canadians, there appears to be a stigma towards those who could be struggling with the illness (Bathje & Pryor, 2011; Ben-Zeev, Young, & Corrigan; 2010; Starzynski, Gallson, & Ungar, 2012).

Several books and multidisciplinary databases were utilized to gather the information for this review such as Ebscohost, PsychINFO, Google Scholar, Proquest, Social Work Abstracts, and Social Service Abstracts. Additionally, literature was collected from government, social service agencies, and non-profit organizations' websites. The key words that were used to gather the literature that were of significance for this topic included combinations of the terms *alienation, anxiety, depression, challenges, cognitive-behavioural therapy, group theory, groups, mental disorders, mental illness, mindfulness practice, reflexivity, strengths-based practice, stigma, struggle, supervision, and therapeutic presence.*

The first objective of this review will be to define and provide an overview of mental illness. The first section will discuss the definition and the prevalence of mental illness; examine the stigma associated with mental illness, and address relevant anti-stigma campaigns. The second portion of this review will discuss social work practice when working with people with mental illness; it will describe therapeutic presence, reflexivity, and supervision. I will address some of the theories that may guide social work practice when working with people who have a mental illness. These include cognitive-behavioural therapy, mindfulness practice, group theory, and strengths-based perspective.

An Overview of Mental Illness

Mental illness is a broad term and can be characterized in many different ways. The Parliament of Canada (2004) indicated that terms and concepts related to mental health and mental illness could be defined differently according to each country. Within those countries, professionals, agencies, organizations, and associations could have adopted other means of describing and defining key concepts that are relevant to mental health and mental illness (Parliament of Canada, 2004). As a result, one concept could be referred to by many terms, while other terms may hold different meanings for different groups. The American Psychiatric Association (2012) proposed a revised definition for mental disorders in the DSM V, which stated that:

A Mental Disorder is a health condition characterized by significant dysfunction in an individual's cognitions, emotions, or behaviours that reflects a disturbance in the psychological, biological, or developmental processes underlying mental functioning. Some disorders may not be diagnosable until they have caused clinically significant distress or impairment of performance. (para. 2)

Additionally, according to Merriam-Webster (2012), a mental disorder refers to:

A mental or bodily condition marked primarily by sufficient disorganization of personality, mind, and emotions to seriously impair the normal psychological functioning of the individual—called also *mental illness*. (para. 1)

MAP restricted their services to individuals that had a diagnosis and were struggling with symptoms of generalized mood disorders, generalized anxiety disorders, obsessive-compulsive disorder, post-traumatic stress disorder, and personality disorders. For the purpose of this review, mood disorders will be defined as the experience of intense ‘highs’ and ‘lows’ over an extended period of time (Canadian Mental Health Association, 2012b). Mood disorders can include, but are not limited to, depression, bipolar, and postpartum depression. Anxiety disorders are described as persistent and intrusive thoughts (Canadian Mental Health Association, 2012b). Anxiety disorders include generalized anxiety disorders, specific phobias, panic disorder, obsessive-compulsive disorder, and post-traumatic stress disorder (Canadian Mental Health Association, 2012c).

Prevalence

Health Canada (2006) insisted that there are many reasons as to why a person could develop a mental illness. Oftentimes it is a complex interplay of multiple elements that contribute to the creation of mental illness (Health Canada, 2006). Health Canada (2006) suggested that “genetics, biology, personality, socio-economic status, [and] life events” could act as contributing factors to the development of mental illnesses (para. 13). During a webcast that was sponsored by the Ontario Hospital Association and the Mood Disorder Society of Canada, the presenters, Starzynski, Gallson, and Ungar (2012), indicated that 10.4% of Canadians could develop a mental illness at any time. They also stated that 7.9 to 8.6% would have an incidence

of depression, while 12% will develop an anxiety disorder. As previously stated, 1 in 5 Canadians will have a mental illness each year (Centre for Addiction and Mental Health, 2012). According to the presenters of the webcast, seven million Canadians will seek assistance regarding a mental illness this year alone.

Greater Sudbury, Ontario, has roughly 160,274 residents and, according to the Canadian Mental Health Association (2011d), which reported that from April 1, 2010 to March 31, 2011, the Sudbury branch of the Canadian Mental Health Association had 5,009 clients. They also reported that 125 individuals were waiting for services; there were 154 new referrals; 271 individuals were accessing services; and 221 individuals were discharged from services that were offered by the Canadian Mental Health Association. MAP, which is another service located in Greater Sudbury, also provides therapeutic treatment for persons with a mental illness. As of January 3, 2012, there were 450 people registered with the MAP who were waiting to have an assessment. Meanwhile, 273 individuals were waiting to receive counseling with a MAP clinician and it oftentimes took an estimated 160 days until this was accomplished. As of August 2012, the waitlist to receive an assessment and treatment was more than 14 months long (S. Lepage, personal communication, August 24, 2012). It is essential to note that although the Canadian Mental Health Association and MAP provide services for adult mental illness counseling, a characteristic of northern Ontario mental health services is that they are under serviced (Strasser et al., 2013).

Although it is important to understand the number of persons who are struggling with mental illness, it is challenging to obtain an exact number of persons with mental illness. This is because some people may not identify with a mental illness, or having a mental illness, do not want to be diagnosed, do not want to seek assistance, do not know how to access services, or

some people do not want to experience stigmatization due to a mental illness. Stigma is quite powerful and, according to Stuart (2005), stigma against those with a mental illness acts as a significant barrier to overcome in the community (as cited in World Health Organization, 2001).

Stigma

Goffman (1963) discussed that in many ways, society has the ability to determine and categorize individuals and the various attributes that are considered to be 'ordinary' and 'normal' for members of a particular category. As a result, when a person possesses an attribute that sets him or her apart from others, or the majority, he or she could be reduced in the minds of society and could be perceived as 'tainted' (Goffman, 1963). Such an attribute is considered to be a stigma, particularly when it represents a collectively agreed upon quality that is quite discredited or unwanted (Goffman, 1963; Larson & Corrigan, 2010). The term stigma refers to "...any persistent trait of an individual or group which evokes negative or punitive responses" (Al-jiboori, 2010, p. 125). Stigma may also describe a perceived negative attribute that causes a person to devalue another person (Reinecke et al., 2013).

The construct of stigma has been around for centuries; however, a recurring notion in the literature in this area has been the fear of the unknown, fear that mental illness is contagious, shame for the family, and the idea that mental illness should be hidden from the community (Foerschner, 2010). Stigma is primarily the result of a combination of ignorance and fear that forms a foundation rooted in misrepresentations and prejudices (Babic, 2010). Goffman discussed that in Classical Greece, in 8th-7th Century BC, social stigma was already a part of the pre-Christian culture. For instance, Goffman (1963) indicated that "...[t]he Greeks, who were apparently strong on visual aids, originated the term *stigma* to refer to bodily signs designed to expose something unusual and bad about the moral status of the signifier" (p. 1). These signs

were typically “cut or burnt onto the body”, which illustrated to others that these people were slaves, criminals, traitors, or should be avoided, especially in public (p. 1). These marks further indicated that these people were deviant, flawed, or undesirable (Feldman & Crandall, 2007). Later, in Christian times, the Christian Church added two additional layers of metaphor to this term. “The first referred to the bodily signs of holy grace that took the form of eruptive blossoms on the skin; the second, a medical allusion to this religious allusion, referred to bodily signs of physical disorder” (Goffman, 1963, p. 1). The Church was quite influential at that time and as a result, it had a hand in creating and forming many opinions about people with mental illness (Stuart, 2005).

Another example of stigma was illustrated in Europe during the fifteenth and sixteenth centuries where people with mental illnesses were labeled and known as ‘insane’ or ‘those without reason’ (Dilling, Thomsen, & Hohagen, 2010). At that time, it was common to avoid and socially isolate persons with mental illness out of fear of being associated with the person and further recourse, fear of violence, and fear of the illness being contagious. As a result, many of the people that had mental illnesses were often confined in ‘fools cages’ or ‘mad cells’ that were often kept in horrible and uncomfortable conditions. These early ideas about stigmatization allow us to conceive how deeply seeded it is in notions of deviance and social avoidance, which could influence societal norms. This stigmatizing influence has been transcended and reproduced through continued cultural norms, literature, and media (Feldman & Crandall, 2007; Lauber, 2008). The message that was often reinforced is that people with mental illnesses are dangerous, unpredictable, or aggressive (Cleary, Deacon, Jackson, Andrew, & Chan, 2012; Henson et al., 2009; Feldman & Crandall, 2007).

Today, most of our views, interpretations, and opinions of what someone with a mental illness looks and behaves like, is influenced through strongly held societal beliefs (Goffman, 1963; Holland, 2012). Societal beliefs and cultural norms are predominately founded on the notion of rejection that is based in part on the person's deviant, non-normative, behaviour that could lead to social rejection (Feldman & Crandall, 2007; Lauber, 2008). Mass media, as a reflection of society, has worked to sustain and perpetuate a distorted view of mental illness (Klin & Lemish, 2008, Holland, 2012). For instance, television or movie characters attribute their behaviour such as aggressiveness, dangerousness, or unpredictability to that of having some kind of mental illness. Moreover, television and movies portray killers and often label them as 'psychos' (Canadian Mental Health Association, 2012; Holland, 2012). The Canadian Mental Health Association (2012) stated that these representations and the use of discriminatory language such as the casual use of terms like 'psycho,' 'lunatic,' or 'crazy,' further distort the public's views and merely reinforce inaccuracies about people with mental illness.

Stigma is important to consider because it has a considerable ability to negatively impact people with mental illnesses (Corrigan et al., 2010; Stuart, 2012). Duarte (2011) discovered that people with mental illness experienced a considerable amount of stigma due to the label 'mental illness'. As a result, mental illness could cause a significant amount of challenges and suffering, but the stigmatization of people with such disorders brings about a considerable set of problems and consequences at both a psychological and a structural level (Corrigan et al., 2010; Hinshaw, Cicchetti, & Toth, 2007). The dual burden of experiencing a mental illness and stigma could be a formidable hurdle for an individual. Stigma is quite complex because it is a multi-dimensional construct (Bathie & Pryor, 2011; Wright, Jorm, & Mackinnon, 2011). Stigma encompasses many

facets that could be experienced by anyone with a mental illness (Wright, Jorm, & Mackinnon, 2011). This includes external stigma, self-stigma, and structural stigma.

External stigma. External stigma describes how some people sometimes stigmatize individuals with mental illness (Brohan et al., 2010). People may occasionally create negative stereotypes about people with mental illness. The problem arises when people act on harsh, pessimistic stereotypes in a discriminatory way (Gray, 2002). Bathie and Pryor (2011) argued that stigma could be a significant barrier for individuals wanting to seek assistance and treatment for a mental illness. More so, Gray (2002) stated that even health professionals tend to go so far as to deny their own battles of mental illness. In a survey by the Michigan Psychiatric Society, 50% of 567 psychiatrists stated that they would rather treat themselves in secrecy before they would reveal that they have a mental illness and have it disclosed on their medical chart (Balon, 2007). Ben-Zeev, Young, and Corrigan (2010) discovered that stigma regarding mental illness goes so far as to impact a person's ability to obtain and sustain satisfactory employment and finding appropriate housing. At the same time, they found that employers would sometimes avoid individuals with mental illness by refusing to hire them. Also, landlords may decline renting or leasing to people with mental illness with the intention of 'protecting' other tenants.

The focus of stigma has increasingly shifted towards addressing the social perspective (Alonso et al., 2008; Reeder & Pryor, 2007; Gray, 2002). A key element of external stigma is discrimination (Alonso et al., 2008; Al-jiboori, 2010; Gray, 2002). In this context, discrimination refers to the unfair and negative "...attitudes and actions of the perpetrators and society rather than..." those of the service user (Gray, 2002, p. 72). Therefore, stigma and discrimination tends to "...impede social integration, interfere with the performance of social roles, diminish quality of life, and prevent timely access to treatment, effectively creating a

vicious cycle of social disadvantages” (Stuart, 2005, p. 22). People with mental illness could be internalizing the pessimistic views by society, which leaves them vulnerable to stigma. When someone with a mental illness chooses to seek assistance, or disclose their illness to others, although they may be receiving assistance within the healthcare system, their views and concerns could be dismissed and they may feel that they are ignored or being treated unfairly by healthcare professionals (Starzynski, Gallson, & Ungar, 2012).

Self-stigma. On the other hand, the individual may develop notions of how they believe society views him or her personally as a member of a stigmatized group (Brohan et al., 2010; Barney et al., 2005). These beliefs may not be factual, but they can be debilitating nonetheless (Barney et al., 2005). Within social work, this process is understood as ‘internalized oppression’. Oftentimes, prior to the onset of mental illness, many people are aware of, and sometimes understand, the culturally endorsed stigma that is oftentimes associated with mental illness (Ben-Zeev, Young, & Corrigan, 2010).

People with mental illness will sometimes internalize stigmatizing notions that are widely legitimated by society, which causes them to begin to consider that they are less valued (Bathje & Pryer, 2011; Ben-Zeev, Young, & Corrigan, 2010). At the onset of receiving a diagnosis, a person could begin to believe the associated stigmatizations that he or she may have regarding persons with mental illness, which may lead to an acceptance of these ideas, opinions, and views (Ben-Zeev, Young, & Corrigan, 2010). Individuals who experience self-stigma could possibly internalize the perceptions, ideas, and views of those around them. Internal stigma, or self-stigma, occurs when an individual begins to develop negative attitudes and perceptions about themselves as a result of internalizing the stigmatizing views that are sometimes held by society and the people around them (Barney, 2005). It can also be described as processes wherein an

individual will, either consciously or unconsciously, accept the poor expectations and messages both created by the individual, or by society (Brohan et al., 2010; Lucksted et al., 2011; Livingston, 2012). When living in a society that is so immersed in stigmatizing ideas, persons with mental illness could accept these notions and endure reduced self-esteem and self-efficacy (Brohan et al., 2010; Ben-Zeev, Young, & Corrigan, 2010).

Alonso et al. (2009) discovered that quality of life could be altered due to self-stigma. Alonso (2008b) argued that this is more so found in individuals with “comorbid mood and anxiety disorders” (p. 312). Brohan et al. (2010) further indicated that, oftentimes, these self-thoughts would be in the form of “...shame, blame, hopelessness, guilt, and fear of discrimination...” (p. 2). These thoughts could have implications on the individual’s ability to seek professional assistance and disclose their mental illness to others (Bathje & Pryor, 2011). It was also found that healthcare providers should be aware that people with mental illness are more than likely going to experience bouts of shame and embarrassment with regards to their health condition and perceive discrimination on the basis of their mental illness (Alonso, 2009; Alonso, 2008b).

Structural stigma. The Ontario Human Rights Code (n.d) aims to guarantee “equal rights and opportunities, and freedom from discrimination” (para. 2). It further “...recognizes the dignity and worth of every person in Ontario and applies to the areas of employment, housing, goods, facilities and services, contracts, and membership in unions, trade or professional association”. The Ontario Human Rights Code (n.d), stipulated that persons with mental illness must be able to equally benefit from and have access to services, housing, and employment. However, in the 2009-10 fiscal year, the human rights tribunal received 1,853 applications for hearings into allegations regarding possible discrimination on the basis of disability (Human

Rights Tribunal of Ontario, 2010). As there are not separate categories for mental and physical disability, it could be assumed that some persons with mental illness may have been denied equal benefit and access to services, housing, and employment. Corrigan, Markowitz, and Watson (2004) indicated that structural stigma is the act of intentionally discriminating, or limiting the opportunities of those with mental illness. They also argued that structural stigma further includes the creation of an institution's policies, or the current institution's policies that may not intend to hinder or discriminate people with mental illness, but the consequences of the policies do, in fact, obstruct the choices or options of people with mental illness. Within the private sector, people with mental illness are oftentimes unfairly represented in the news and media. An example of intentional structural stigma from the public sector would be unfair treatment within the workplace (Corrigan, Markowitz, & Watson, 2004). Ahmedani (2011) further stipulated that this sort of stigma creates and reproduces inferiority and that this could lead to disproportionate access to treatment and services or policies that unfairly affect this population.

Starzynski, Gallson, and Ungar (2012) stated that stigma produces serious barriers for those wanting to access sufficient and timely care and services for their mental illness. They further concluded that stigma has a way of influencing mental health professionals. That is, some physicians and mental health professionals also hold the same prejudices and stereotypes as that of the general population against people with mental illness. The Mood Disorder Society of Canada (2011) conducted an online survey in September, 2011. The survey aimed to gather the opinions of the Canadian mental health community with the intention of recording the experiences and concerns regarding the health care system. The survey received 3,125 responses and over 500 individuals provided extensive written comments in the survey. The respondents were made up of person with a mental illness, family members, caregivers, and individuals that

were merely concerned about the state of the Canadian mental health care system. The survey indicated that 35% of respondents with a mental illness waited more than 12 months for a diagnosis by a medical professional. Also, 52% of the respondents reported that they had to visit a hospital emergency room as a result of their mental illness; however, of those respondents, 50% indicated that they were moderately-to-extremely dissatisfied with the care that they had received. The study also found that the negative attitudes towards persons with mental illness from front line workers continued to persist and affect the quality of care. Particularly, 65% of respondents claimed that their local hospital was not able to provide adequate care for persons with mental illness. They indicated that they thought that this was due to the fact that the hospital did not seem to prioritize mental illness.

In summary, The Canadian Mental Health Association (2012) has identified that 1 in 5 Canadians will be affected by a mental illness and that 70% of adults who are living with a mental illness claimed that the onset occurred prior to the age of 18. Further, only 1 in 6 children who are diagnosed with a mental illness will receive treatment. CMHA (2012) has also said that mental illness will affect 1 out of every 4 employees every year and that mental illness will cost the Canadian economy roughly \$51 billion in absenteeism, disability claims, and medical services.

Anti-Stigma Campaigns

There have been many anti-stigma campaigns that have recently been launched by various mental health organizations. For instance, the Mental Health Commission of Canada (2012) launched *Opening Minds* in 2009. When this program was initiated it was "...the largest systematic effort to reduce the stigma of mental illness in Canadian history" (Mental Health Commission, 2012, para. 6). This program worked with organizations and agencies across

Canada to identify and evaluate existing anti-stigma programs, their effectiveness, and potential. Currently, *Opening Minds* is working with 65 partners and 45 active projects nation-wide. These projects target healthcare providers, youth ages 12-18 years, workforce, and media. The goal is to reduce stigma; however, *Opening Minds* serves as a catalyst, which aims to mobilize and focus the actions of others in order to make a real difference in the area of anti-stigma (Mental Health Commission, 2012). Another example of anti-stigma campaigns is the *Bell Let's Talk* initiative from Bell Canada (Bell Canada, 2012). This campaign was designed to be a multi-year charitable program aimed at promoting and supporting mental health nation-wide in 2010. In 2011, Bell Canada launched the *Bell Let's Talk Community Fund*, which focused on improving access to care in local communities (Bell Canada, 2012).

Bell Canada used the assistance of several partners and has planned to create a multi-million dollar initiative that would support a variety of programs that would increase awareness, understanding, and treatment of mental illness, promote access to services, and research across Canada (Bell Canada, 2012). Bell Canada (2012) intended to support programs that are offered by grassroots agencies, hospitals, and best-in-class research and treatment facilities. In 2011, Bell Canada (2012) indicated that they had granted funding for 49 organizations that support mental health in Canada. The objectives of these anti-stigma campaigns was to raise awareness about mental illness and attempt to alter the opinions of people in communities, stigma has existed for centuries and has become entrenched in the minds of some and the ideologies of many.

As stated above, individuals with mental illness could be affected by stigma through external, the self, and structurally. Also, structural stigma could influence the quality of care a person with a mental illness may receive. Despite the active anti-stigma campaigns, stigma is

still present in today's society and has the potential to implicate, harm, and affect an individual that desires to seek assistance for their mental illness.

Social Work Practice: Working with Persons with Mental Illness and Challenges

The second section of this review will discuss social work practice with persons with mental illness as it applies to my advanced practicum with the MAP at HSN. At an early onset of the advanced practicum, it was apparent that it is important to utilize therapeutic presence through constant reflexivity and active supervision. MAP offered individual and group therapy to treat their clients that were struggling with a mental illness. It was apparent that the more relevant and frequently used theories were cognitive-behavioural therapy, mindfulness, group work theory, and strengths-based perspective.

Therapeutic Presence

Therapeutic presence is characterized by the ability to analyze and assess development through the utilization of continuous reflexivity and clinical supervision (Ruch, 2002). Geller and Greenberg (2011) further stated that therapeutic presence is the state of having one's whole self in the moment with a client by being able to become completely in the moment on a physical, cognitive, emotional, and spiritual level. Geller, Greenberg, and Watson (2010), maintained that therapeutic presence involved being fully aware and in the moment with one's self, while being completely "...open, receptive, and immersed in what is poignant in the moment, with... a larger sense of spaciousness and expansion of awareness and perception" (p. 599). Campbell and Christopher (2012) also suggested that therapeutic presence should be considered as more of a state of 'being' rather than 'doing'. This grounded and expanded form of awareness is often coupled with the "...intention of being with and for the clients..." (Geller, Greenberg, & Watson, 2010, p. 599). People are often unable to escape the confines of their personal

perspectives. The clinician should practice enhancing his or her therapeutic presence, which is the act of being completely aware of one's own feelings and knowing when it is appropriate to communicate them to the client (Cait, 2011; Campbell & Christopher, 2012)

Tannen and Daniels (2010) maintained that the ability to be in the present moment enables opportunity for an authentic and genuine connection between people. In order to ensure authenticity, the clinician should be able to practice uniformity between values and action, relating to others in ways that enhance their authenticity, and being critical of one's own personal experiences, values, and beliefs (Wang, 2011). Therapeutic presence allows for an open and inner receptive state that would require the clinician to become completely open to the clients' needs on a multidimensional level (Geller, Greenberg, & Watson, 2010). The clinician would become aware of both their own experiences and that of their client through an emotional level and bodily sensations (Geller & Greenberg, 2011). Being fully present and aware "...then allows for a more attuned responsiveness that is based on kinesthetic and emotional sensing of the [client's] affect and experience as well as [the clinician's] own intuition, skill, and the relationship between" (Geller, Greenberg, & Watson, 2010, p. 599). This level of congruence could be considered as learning and knowing when there is a lack of genuineness, or when the therapeutic relationship lacks attunement (Campbell & Christopher, 2012).

Therapeutic presence could refine and develop a clinician's active listening and develop new ways of thinking that are distinct from simply knowing, which could offer a more effective way of responding and treating a client in the moment (Geller, Greenberg, & Watson, 2010; Soloman & Nashat, 2010). Sheppard, Newstead, Di Caccavo, and Ryan (2000) stipulated that practitioners should continuously reflect on their experiences with clients and compare each case and outcomes. The clinician would then be able to engage in reframing and creating meaning for

action (Sheppard et al., 2000). Tannen and Daniels (2010) contended that the relationship between the clinician and the client might be thought of as a significant foundation for a positive therapeutic outcome.

Geller and Greenberg (2011) argued that the therapeutic relationship is an integral factor for constructive outcomes of psychotherapy. Therapeutic presence is the fundamental underlying quality of the therapeutic and interactive process between client and clinician, which helps establish effective therapy and could lead to change (Cait, 2011). Therapeutic presence is not a replacement for technique and theories, but rather it is a foundational therapeutic stance that sustains and encourages active listening and understanding of the client in the moment (Geller & Greenberg, 2011; Soloman & Nashat, 2010).

Cait (2011) stated that “[r]elational theory and intersubjectivity assume an interactive self; that is, a self develops in relation and connection to “other selves”” (p. 248). Arnd-Caddigan and Pozzuto (2008) insisted that it is not external forces that create changes within people, but rather, it is the interactions with others. The self is continually being created, maintained, and re-created with every interaction that a therapist has with the people with whom they work. Therapeutic presence argues that the clinician should be able to engage in reframing and creating meaning for action (Sheppard et al., 2000). The clinician should be able to continually being able to critique their work (Sheppard et al., 2000) This process would encourage the clinician to learn from previous cases and they could then develop their clinical skills. These techniques will be sub-divided into a discussion about reflexivity and clinical supervision, as it relates to therapeutic presence.

Reflexivity

Sheppard et al. (2000) argued that although therapeutic presence could assist in refining

and developing clinical skills, reflexive practice ensures that clinicians are constantly engaging in being highly analytic and critical about their work. Sheppard et al. (2000) stipulated that practitioners should continuously reflect on their experiences with clients and compare each case and outcomes. Reflexivity was initially defined as "...active, persistent, and careful consideration of any belief or supposed form of knowledge in light of the grounds that support it and further conclusion to which it tends" (Dewey, 1933, p. 6). Dewey (1933) further argued that reflexive learning encompasses "...a state of doubt, hesitation, perplexity, mental difficulty, in which thinking originates: (p. 12). Also, it is "...an act of searching, hunting, inquiring, to find material that will resolve the doubt, settle and dispose of the perplexity" (Dewey, 1933, p. 12). Kolb (1983) built on the work of Dewey by insisting that learning is an ongoing practice that is grounded in personal experience. Kolb (1983) further insisted that "[a]ll learning is *relearning*" (p. 28). Lay and McGuire (2010) argued that learning could be conceptualized as a continuous loop that suggests that experience is acted upon through reflective observation, which in turn is the foundation for active experimentation and is followed by abstract hypothesis. Dempsey, Halton, and Murphy (2001) maintained that reflexivity could encourage social workers to develop and refine a stronger understanding of their personal values, and to consider how this could relate to their professional ethics and clinical skills. Reflexivity offers an opportunity to develop an openness to access his or her own bodily experiences in the moment in order to retrieve knowledge, professional skills, and experienced wisdom that is embodied within the clinician (Geller, Greenberg, & Watson, 2010). Reflexive practice adds to developing the ability to make informed choices regarding clinical practice (Dempsey, Halton, & Murphy, 2001).

Lay and McGuire (2010) stipulated that social workers should be able to utilize theories and personal skills in order to question the existing social order and adopt a lens that concedes

inequality that is often based on power differentials in order to comprehend the historical and current influences of multiple oppressions that affect the lives of clients. This social justice context necessitates that the social worker is able to acquire "...not only a reflective, but also reflexive lens in their thinking processes" (Lay & McGuire, 2010, p. 540). Chow, Lam, Leung, Wong, and Chan (2011) further built on to the notion of social justice and reflexivity by insisting that social work practice often incorporates various interactions between social workers and individuals, families, organizations, agencies, and society. The social worker is a key element for many interpersonal processes and is often considered an expert in facilitating change within individuals and families (Chow et al., 2011). Despite practicing maintaining a non-judgmental attitude, social workers are inevitably shaped and influenced by their own experiences, beliefs, and culture (D'Cruz, Gillingham, & Melendez, 2007; Gilbert & Sliep, 2009; Ruch, 2002). These influences have the potential of enhancing, or impairing, the therapeutic relationship and therapeutic outcome (Lay & McGuire, 2010).

Within the context of understanding and becoming aware of one's own actions, reflexivity is also defined as "... the action of the mind by which it is conscious of its own operations" (Chow et al., 2011, p. 142). Kondrat (1999) argued that professional self-awareness is a necessary process for clinicians. Heydt and Sherman (2005) also argued that in order to become an effective instrument of change, the clinician would "...need to examine his or her attitudes, personal habits, and interactional patterns" (p. 28). Having self-awareness through critically reflecting and questioning one's reactions to certain individuals, situations, experiences, and social issues could often act as a fundamental role in social work practice (D'Cruz, Gillingham, & Melendez, 2007; Chow et al., 2011; Gilbert & Sliep, 2009, Lay & McGuire, 2010; Heydt & Sherman, 2005). Wang (2011) further suggested that the clinician

should not act on his or her feelings or try to control them, but rather the clinician should try to understand their origin and learn how to use them constructively.

Gilbert and Sliep (2009) and Wang (2011) maintained that reflexivity also encompasses a critical appraisal of the self. That is, D’Cruz, Gillingham, and Melendez (2007) insisted that reflexivity incorporates reflections on how knowledge and theory are generated in practice. Reflexive practice is comprehensive and holistic because it promotes critical awareness and the creation of knowledge (D’Cruz, Gillinham, & Melendez, 2007; Ruch, 2002). By being reflexive, the clinician would be able to critically reflect, refine, and develop new approaches or techniques to practice from. Fook and Askeland (2007) and Wang (2011) maintained that in order to understand critical reflection, the clinician should be prepared to identify his or her cultural norms, culturally embedded ideas, values and question his or her assumptions. Reflexivity allows for a deepening of clinical work and clinical process by encouraging questioning, testing, and reflecting on the decisions that the practitioner has made (Ruch, 2002, Lay & McGuire, 2010).

Supervision

Fernandez (1998) suggested that social work students spend approximately, up to one-third of their academic career in field placements. These placements often follow an apprenticeship model wherein the student learns by ‘doing’ and the practitioner acts as a role model to the student (Cleak & Smith, 2012). In this instance, “...the field education is characterized by the placement of a student with a professionally qualified practitioner who assumes responsibility for professional practice learning” (Cleak & Smith, 2012, p. 244). The majority of a student’s learning during the field placement is often mediated through a student-supervisor relationship (Cleak & Smith, 2012).

Beddoe (2012) stated that supervision is an important process within social work. Cleak and Smith (2012) discovered that students tend to appreciate the structured time that is allocated for supervision during field placements. The role of a clinical supervisor during the placement, may be intended to facilitate the development of reflection in the beginning of the student's practice, and support the student in building his or her sense of ownership, clinical skills, and understanding of his or her clinical process (Davys & Beddoe, 2009). Adamson (2012) argued that the intention of clinical supervision would be strengthen the clinician's ability to react and respond to uncertainty and complexity. Also, according to Davys and Beddoe (2009), the supervisor's goal is to instruct and guide the student while he or she is completing a field placement.

Cleak and Smith (2012) found that students valued the ability to review skills, theory, values, and professional development with a supervisor. This relationship often characterized the structure and range of a student's learning objectives and experiences (Cleak & Smith, 2012). Davys and Beddoe (2009) argued that the key to learning and developing could be in the "...ability to engage in, and make use of, the workers' experience" (p. 920). Supervision is often viewed as being facilitative and supportive (Beddoe, 2012). Clinical supervision has also offered an opportunity to shape newer clinicians into ones that administer ideal techniques and methods of practice (Beddoe, 2012; McTighe, 2011). McTighe (2011) further argued that many newer clinicians tend to be subject to 'narcissistic vulnerability' because of their lack of self-awareness. This could affect the clinician's ability to attend to the many internal and external aspects of clinical practice, which may seem extremely challenging for a newer clinician (McTighe, 2011). In this case, McTighe (2011) claimed that clinical supervision often affords the student with the opportunity to have a clinician, who may be a positive model for practice, to facilitate the

integration of the student's personality with his or her professional learning. Clinical supervision provides the student with a safe space to grow and develop while he or she explores his or her range of emotional experiences as they enhance and deepen their self-awareness (McTighe, 2011).

Cooper (2006) indicated that supervision is individualized. This could allow opportunity for students to benefit from clear structured facilitation because it may allow the clinician to openly discuss concerns, feelings, or issues that he or she may be experiencing at that time (Davys & Beddoe, 2009). The relationship between the clinicians could focus on reflection without concern of resulting consequences (Busse, 2009). On the other hand, Acker (2010) claimed that supervision is sometimes hindered due to time restraints and work priorities. This could cause inadequate opportunities to discuss work-related problems (Acker, 2010). It is not unlikely that future clinicians, who may feel that they are being professionally unsupported, are more likely to encounter and to have negative attitudes towards their jobs (Acker, 2010; Leung, 2012).

In terms of work place supervision, Chiller and Crisp (2012) maintained that the culmination of stress within the workplace could be linked to higher prevalence of burnout among clinicians, which in turn could result from poor retention and higher turnover among the staff. They further argued that many clinicians prematurely leave their jobs, with the average expected working life being quite shorter than that of similar professionals. Chiller and Crisp (2012) discovered in a recent British study that "...the average working life for a social worker was eight years, compared to 15 for nurses, 25 years for doctors, and 28 years for pharmacists" (p. 233). Although people leave their jobs for various reasons, Chiller and Crisp (2012) recommended that, for those who stay in highly stressful positions, there should be regular and

supportive supervision. Also, along with supervision, there should be encouragement of open communication, opportunities for ongoing training, and professional development. They also suggested that there should be supportive organizational culture and moral, which would allow managers and workers to professionally support each other. In addition to developing good relationships between managers and staff, good peer relationships among the social workers are also posited as maintaining workplace retention (Chiller & Crisp, 2012). Adamson (2012) also stipulated that there are some organizational benefits to having effective clinical supervision within the workforce. Positive supervision could help advance the worker's job satisfaction, organizational commitment, and worker retention (Adamson, 2012). Effective supervision could affect the quality of service that clients could receive, the workers contentment with his or her job, and the level of professional development the worker could achieve (Leung, 2012). Cooper (2006) maintained that supervision is an important process as it allows for open dialogue regarding issues or concerns about clients, skills, techniques, and decisions that were made and should be encouraged while in practice.

Theories Used in Social Work Practice at the MAP

Whitaker (2000) argued, "theories without practice will serve for little" (p. 559). The goal of integrating theory and practice is to help make professional practice, like that of social work, a more informed practice (Thompson, 2000). By becoming more informed, social workers are then able to avoid assumptions, prejudices, and stereotypes that could possibly lead to discrimination and oppression (Thompson, 2000). Informed practice leads to the pursuit of continuous personal and professional development. Theory is an integral aspect of practice, as it offers an opportunity to provide impartiality in complex situations (Thompson, 2000). In this section, I will briefly discuss social work theories that were relevant to my advanced practicum and working with

individuals with mental illness. These include cognitive-behavioural therapy, mindfulness practice, group work theory, and strengths-based perspective.

Cognitive-Behavioural Therapy

Cognitive-Behavioural Therapy (CBT) is based on the rationale that a person's affect and behaviour are, for the most part, determined by the way in which he or she structures their perception of the world (Beck, Rush, Shaw, & Emery, 1979). CBT is predicated on the notion that cognitive thoughts effect the individual's behaviour. At the same time, the desired behaviour could be changed through cognitive changes (Dobson & Dozois, 2001; Taylor & Chang, 2008). Oftentimes these thought processes are undesired or unconstructive and have the potential to negatively affect the individual (Linden, Zubaegel, Baer, Franke, & Sclattmann, 2005; Dozois, 2010). Some examples of dysfunctional or unhealthy thinking include 'catastrophizing' (believing the worst case scenario will occur), 'personalizing' (interpreting external events personally), and 'over-generalizing' (seeing a pattern based upon a single event). CBT is centered on the idea that thoughts, feelings, and behaviour are interrelated (Delaney, 2009; Boyle, Lynch, Lyon, & Williams, 2011; Pilgrim, 2011, Munro, Baker, & Playle, 2005). CBT aims to enable people to understand and manage these processes over time by offering quick and effective therapy (Munro, Baker, & Playle, 2005). It further provides rational treatment to generate the greatest success for large amounts of people (Pilgrim, 2011).

CBT is a treatment that is supported by empirical evidence and it is widely recognized to be an effective form of therapeutic treatment for mental illness that includes, but is not limited to, depression, generalized anxiety disorder, panic disorder, social phobia, obsessive-compulsive disorder, post-traumatic stress disorder, and bipolar disorder (Butler, Chapman, Forman, & Beck, 2006; Lopez & Basco, 2010). CBT is utilized as a way to assist clients who wish to learn new

coping strategies so as to manage many of their symptoms of mental illness (Delaney, 2009; Boyle, Lynch, Lyon, & Williams, 2011; Pilgrim, 2011).

Beck, Rush, Shaw and Emery (1979) maintained that this approach consists of specific learning objectives that are designed to teach the individual how to monitor negative, automatic thoughts, and rumination and how to recognize the relationship between cognition, affect, and behaviour. Dozois (2010) further maintained that the idea of 'homework' has been an integral element of cognitive therapy since its inception. An integral objective in cognitive therapy is integrating and transitioning from talking into action (Beck & Tompkins, 2007). Homework offers an opportunity to reinforce and implement key concepts that were sometimes discussed within the session, utilize solutions, try out the ideas, practice important cognitive and behavioural skills, and begin to identify and adjust maladaptive cognitions by discovering and enabling new skills and practicing them between sessions (Beck & Tompkins, 2007; Lambery, Harmon, & Slade, 2007).

The intention of homework, which often includes thought records and evaluating evidence for dysfunctional thoughts, is to assist the individual in recognizing distorted automatic thoughts through the use of evidence and to integrate more reality-oriented and evidence-based interpretations for these biased thoughts. Finally, CBT aims to work with individuals so that they are able to recognize, identify, and alter dysfunctional beliefs that may enable the person to distort their experiences. Tiuraniemi and Korhola (2009) suggested that the ability to reduce negative automatic thoughts, and rumination would be through the utilization of thought records. These thought records encourage people to document negative thoughts, which could help change and alter those negative thought patterns and thereby avoid symptomatic expression of their anxiety and depression. CBT has led to greater improvement in positive symptoms,

successful method of managing symptoms, and fewer hospital admissions for people with generalized anxiety disorders and mood disorders (Grant, Townend, Mulhern, & Short, 2010; Lopez & Basco, 2010).

Rogers (2010) found that the combination of CBT and the consumption of medication, for persons with these types of mental illnesses listed above, could lead to a reduction in incidences of relapse. Lopez and Basco (2010) further discovered that CBT is quite valuable and successful in "...reducing residual symptoms following medication treatment, reducing the risk of relapse, and recurrence of depression and generalized anxiety disorders" (p. 92). Munro, Baker and Playle (2005) stated that CBT could be reflective of a more client-centered approach to therapy in that it allowed for a more recovery-focused view of treatment, and that it could enhance quality of life. In summary, CBT appears to have proven efficacy when used to treat individuals with mental illness because it helps them to challenge negative thinking, rumination, reduce neuroticism, and automatic negative thoughts (Butler et al., 2006; Glinski & Page, 2010).

Mindfulness Practice

Davis and Kurzban (2012) stated that the origins of mindfulness is holistic and can be found in Buddhist traditions, but it also has underlying principles in phenomenology, existentialism, and humanism. Mindfulness is, in essence, an attribute of awareness (Davis & Kurzban, 2012; Mandal, Arya, & Pandey, 2012). Kabat-Zinn (2003) defined mindfulness as being the "awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding experience moment by moment" (p. 145). Kabat-Zinn (2003) also insisted "the primary aim of mindfulness practice is to develop a receptive state of mind that interrupts habitual patterns of perception and reactivity, ultimately fostering clear perceptions and equanimity" (p. 204). The sort of awareness that is encouraged by mindfulness

practice tries to enhance contact with the present moment, which aims to hinder making any attempts of labeling, judging, or avoiding one's thoughts and emotions (Treanor, 2011).

Mindfulness-based practice is an effective form of treatment for people with diverse medical conditions, psychological issues, and mental illness (Beckerman & Corbett, 2010; Davis & Kurzban, 2012; Klainin-Yobas, Cho, & Creedy, 2011; Howells, Ives-Deliperi, Horn, & Stein, 2012; Mandal, Arya, & Pandey, 2012). Davis and Kurzban (2012) insisted that it is not uncommon to use and integrate mindfulness-based practice in treatments for people with mental illness. The use of mindfulness-based cognitive therapy (MBCT) is a successful treatment for people that are experiencing mood disorders and generalized anxiety (Kim et al., 2009; Coelho, Canter, & Ernst, 2007). MBCT "...combines elements of meditation and psycho-education on cognitive processing to teach clients... how to stay in the present-moment... without being distracted by strong emotions or thoughts..." (Beckerman & Corbett, 2010, p. 219). MBCT also teaches clients how to disengage from judgmental processing and move towards developing awareness and being in the present moment. MBCT promotes being able to disengage from depressive thinking and rumination before it becomes depression (Beckman & Corbett, 2010). It could help the client by interrupting thoughts and rumination that is often associated with mood disorders and generalized anxiety (Kim et al., 2009; Coelho, Canter, & Ernst, 2007). Davis and Kurzban (2012) insisted that it is not uncommon to use and integrate mindfulness-based practice in treatments for people with mental illness.

Methods of mindfulness-based practice are incorporated in many of the treatments that are utilized for people with mental illness (Treanor, 2011; Beckerman & Corbett, 2010). Practitioners can teach several mindfulness-based methods to clients, such as, but not limited to, breathing techniques and mindful eating (Treanor, 2011; Beckerman & Corbett, 2010). The

intention of these activities is to develop and refine meta-cognitive awareness (Beckerman & Corbett, 2010). Also, mindfulness teaches us to stay "...in the present moment, noticing, and acknowledging..." physical sensations, sights, sounds, and smells (Beckerman & Corbett, 2010, p. 223). These techniques give many clients the permission to slow down and be in the moment, which could help reduce rumination, reduction in stress, and increases focus (Beckerman & Corbett, 2010). Mindfulness offers persons with mental illness a more objective interpretation of what thoughts are: "...‘thoughts’ rather than ‘truths’ they have about the themselves and the world" (Beckerman & Corbett, 2010, p. 219).

By teaching a variety of forms of mindfulness practice techniques to clients, it may ensure that the client could continue practicing being mindful once the therapy has been completed (Beckerman & Corbett, 2010). Beckerman and Corbett (2010) further stipulated that mindfulness practice, when used in conjunction with CBT, could prevent relapse in mood disorders and generalized anxiety disorders. Mindfulness practice has the potential of assisting many individuals with mental illness because it can be independently practiced (Beckerman & Corbett, 2010).

Group Work Theory

Wodarski and Feit (2012) asserted that as treatments have evolved for client groups, group therapy has grown in popularity. Brandler and Roman (1999) argued that the appeal of group could be due to the notion that people are, by virtue, relational beings. In society, people do not live as individuals that are separated from their environment, but rather, people's lives are enmeshed in the lives of others (Wodarski & Feit, 2012). People yearn for support, approval, feedback, companionship, and the communication of others (Brandler & Roman, 1999; Wodarski & Feit, 2012). By providing therapy in groups it may allow the group members to not

only help each other but also to help themselves by gaining confidence and self-efficacy (Wodarski & Feit, 2012; Yalom & Leszcz, 2005). Wodarski and Feit (2012) found that group therapy has other positive attributes such as "...vicarious learning, role flexibility, universality, altruism, family reenactment, and interpersonal learning" (p. 415). For instance, some people within the group may be able to learn universality because other members of the group are likely to have experienced similar emotions, symptoms, or situations (Wodarski & Feit, 2012).

Burlingame (2010) said that group is an effective modality when compared to that of the individual therapy and when it is used to treat diverse populations. That is, "groups allow a greater level of experiencing rather than advice giving or discussing of future goals" (Wodarski & Feit, 2012, p. 415). Kemp (2010) also stipulated that group therapy is structured in ways that make it nearly impossible for clients to feel that they are alone, to detach from others, and to isolate themselves. Although clients may be ambivalent and resistant at first, it is important to address and normalize people's feelings about the group and past experiences of groups (Rose & Chang, 2010). In many ways, it is through group therapy that truly exposes our communality through collectivity (Kemp, 2010). Also, group therapy challenges individualism, dualism, and authoritarianism (Drumm, 2006).

On the other hand, group therapy presents issues of governance, boundary keeping, and a lack of ensuring confidentiality (Kemp, 2010; Yalom & Leszcz, 2005). Yet, from an economical perspective, a large number of individuals can be effectively treated relatively quickly through group therapy (Drumm, 2006; Tiuraniemi & Korhola, 2009; Wodarski & Feit, 2012). Also, group therapy is significantly less expensive than that of individual therapy (Tiuraniemi & Korhola, 2009; Wodarski & Feit, 2012).

Bouchard and Gros (2010) discovered that group therapy is beneficial for individuals with mental illness, and it could also have an integral role in recovery. Abraham Maslow's Hierarchy of Needs correlates with much of these arguments because it has, and continues to be, used as a means to interpret human behaviour (Benson & Dundis, 2003). Group therapy could assist individuals on their journey to maintain, what Maslow would call, belonging, esteem, and self-actualization (Benson & Dundis, 2003; Gorman, 2010).

Group therapy could reduce oppressive forces, such as that of stigma regarding issues, feelings, and public perceptions of mental illness, that tend to affect marginalized people in group. In this case, it is important to ensure the effectiveness of group is through the awareness and employment of inclusion and respect (Drumm, 2006). Inclusion and respect may be created through the validation of the different experiences and views expressed by the group members. Peer support, or mutual aid, from group therapy could also decrease social isolation and offer a sense of normalcy by recognizing and responding to the needs of the other group members (Bouchard & Gros, 2010; Kemp, 2010; Yalom & Leszcz, 2005; Wodarski & Feit, 2012). Group therapy could present a sense of community and belonging, the ability to relate to others, respect by and for others, communicating with others, acceptance and helping others, while eliminating, or reducing, the individual confrontation of that between the client and clinician (Bouchard & Gros, 2010; Drumm, 2006; Kemp, 2010; Gorman, 2010; Yalom & Leszcz, 2005; Wodarski & Feit, 2012)

Strengths-Based Perspective

The utilization of strengths perspective as an approach to social work practice began in the 1980s at the University of Kansas School of Social Welfare by Charles Rapp and Ronna Chamberlin (Saleebey, 2008). They found that the methods that were being utilized at that time

only connected clients with more formal mental health services that were sometimes lengthy and time consuming, and were not always effective in assisting clients with the goals of independent living, working, positive use of leisure time, and establishing relationships with others. The strengths-based perspective was a way to create change and it promoted the use of a more brief therapy while assisting clients with their goals. It was built upon the belief that all human beings have innate capacities that could drive them to achieve self-actualization (Brun & Rapp, 2001). Also, this approach was predicated on the notion of assisting the individual by identifying and developing his or her strengths in order to achieve 'normalization' (Rapp & Goscha, 2012).

Min (2011) asserted that similar to the values and principles that are central to that of social work, strengths-based perspective aspires to recognize the best aspects of all clients and to work together to prevail despite adversity. Meenaghan, Gibbons, and McNutt (2005) further argued that a strengths perspective focuses on attaining positive change. Strengths perspective views people as being resourceful and having the capacity to learn and grow (Guo & Tsui, 2010; Hill, 2008; Saleebey, 1996). According to Guo and Tsui (2010), people's inner strengths often will assist in making them more resilient during times of adversity. A clinician could then work with their clients to help maintain, cultivate, and enhance their inner strengths. Ultimately, a strengths-based perspective assumes that every person ultimately has resources that can be mobilized and accessed for success in many aspects of life (Lopez & Louis, 2009)

Kobau DiIorio, Chapman, & Delvecchio (2010) indicated that mental health care professionals will often utilize common language and diagnostic criteria to identify and treat individuals with mental illness by using devices such as that of the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*. Although the DSM-IV is explicitly designed to be a diagnostic tool, it does not offer instruction regarding how to assess positive

thoughts, emotions, or behaviours (Kobau DiIorio, Chapman, & Delvecchio, 2010). Min (2011) stated that the social worker has many opportunities to utilize the strengths perspective while working with clients. Min further suggested that practitioners should try to incorporate elements of a strengths-based perspective into assessments. For instance, if the assessment focuses too much on the client's problems, the treatment would then be focused on the client's deficits. Conversely, the strengths perspective would argue that the social worker should recognize and utilize the client's strengths and resources as part of the assessment, which would further illustrate how the client is currently coping and managing with challenges and symptoms of mental illness. Jones, Hardiman, and Carpenter (2008) further argued that strengths-based perspectives offer less treatment disparity and fosters a positive relationship between the client and practitioner.

A strengths-based perspective also reflects the fundamental values regarding human worth and social justice that are stated in the *Code of Ethics and Standards of Practice* (Ontario College of Social Workers and Social Service Workers, 2005). These values naturally promote a client's inner strengths and capabilities (Hill, 2008). A strengths-based perspective is rooted in the belief that all individuals have strengths, despite their problems or disadvantaged circumstances (Guo & Tsui, 2010; Hill, 2008; Staniforth, Fouché, & O'Brien, 2011). By using a strengths perspective, practitioners instill values and encouragement into their practice (Guo & Tsui, 2010).

Conclusion

This chapter has described social work practice in my advanced practicum; I discussed therapeutic presence, reflexivity, and supervision. This chapter also described the theories and

approaches that were used during my advanced practicum such as Cognitive-Behavioural Therapy, mindfulness-based practice, group work theory, and strengths-based perspective.

In the next chapter, I will describe the advanced practicum environment, the agreement with the agency, the training objectives that I had, and the ethical dilemmas that I encountered during the advanced practicum. The intention of the following chapter is to offer a broad overview of the purpose and reasoning as to why I chose this advanced practicum, and why and how I was able to develop my clinical skills through the advanced practicum experience.

Chapter 3 – The Process of the Advanced Practicum Experience

I was able to complete an advanced practicum from June 18, 2012 to August 30, 2012, with the Mood and Anxiety Program (MAP) (a program of Health Sciences North) in Sudbury, Ontario. The intention of this practicum was to develop and refine my knowledge and skills of professional practice in Social Work. I also wanted to improve my competence in social work practice while focusing on individuals with mental illnesses. In this chapter, I will describe the advanced practicum environment, the agreement with the agency, the training objectives, and the ethical dilemmas that were relevant to the advanced practicum.

Description of the Advanced Practicum Environment

In the past, MAP has provided individual therapy to persons with mental illnesses and challenges. The mental illnesses would vary, but the individual would have a medical diagnosis of depression, anxiety, bipolar disorder, borderline personality disorder, obsessive-compulsive disorder, and post-traumatic stress disorder. Prior to January 2012, the waitlist to receive an assessment and treatment was more than fourteen months long. As of January 3, 2012, there were 450 people that were waiting to have an assessment completed with MAP. Meanwhile, 273 of those individuals were waiting to receive counseling with a MAP clinician and oftentimes it took 160 days until this was accomplished (S. Lepage, personal communication, August 24, 2012).

During January 2012, there was a shift in the way treatment was delivered. MAP began to provide group therapy and some individual therapy for individuals with a mental illness. The waitlist, as of August 24, 2012 had decreased to 135, or 67-day waitlist to receive an assessment (S. Lepage, personal communication, August 24, 2012). MAP now offers individual counseling to people that are having difficulty managing symptoms of obsessive-compulsive disorder and

post-traumatic stress disorder; individual and group therapy to people with borderline personality disorder; and group therapy to individuals with generalized anxiety, depression, and bipolar disorder.

The therapy is structured as such: first the client attends four weeks of the welcome group. This group is structured in a way that allows the clients to have an opportunity to understand if group therapy is a good fit for them; recognize the process of group and the support network that is often created; and to choose a goal, or habit, that they would like to work on, or change, throughout the group sessions. After the completion of the welcome group, the client will move onto a more specialized treatment group, either mood/generalized anxiety group or the anxiety group for 10-12 weeks. These groups utilize CBT in order to understand, recognize, and treat the symptoms of depression and/or anxiety. The client has the ability to leave MAP, or they can continue with more treatment. The treatment would break off into a more advanced anxiety group, mood group two, and changing behaviours group. These groups run for 9-16 weeks and focus more on interpersonal and relationship building. If the client wants to continue with MAP, they can partake in the mindfulness-based cognitive therapy group, advanced changing behaviours, and seeking safety, which could run for an additional 9-16 weeks. These groups are quite specialized and tailored to individuals who want to seek more personalized treatment.

Agreement with the Agency

Prior to beginning the advanced practicum, Suzanne Lacelle, the placement coordinator at the School of Social Work, made arrangements with Janice Aitken, the student coordinator from HSN for my Advanced Practicum with MAP. Once I had accepted the placement offer from MAP, I was required to complete mandatory training; sign workplace agreement forms;

review hospital policies and procedures, the Mental Health Act, consent and capacity for clients; and participate in Electronic Learning Packages (see Appendix A for the consent form).

Responsibilities

The team at MAP, consisted of nurses and social workers, but everyone offered specializations and experiences in different areas, methods, theories, and models of practice. This multidisciplinary team offered an opportunity for more comprehensive care and services for clients. Working with the team was a positive experience because they were able to provide assistance, consultation, and resolution for difficult cases. For example, I had an intake assessment with a woman that had a diagnosis of personality disorder. The MAP secretary informed me that the woman appeared scattered and agitated. I discussed how would I approach the client with one of the clinicians and we agreed that she would sit in on the assessment if I needed assistance. During the assessment, I was discussing the confidentiality agreement, which states that the information that is gathered, will be documented and other mental health providers within the hospital system could access the client's therapy file. The client refused to sign the form and was upset that I would have to document our conversation. The other clinician informed the client that we would not be able to continue with our assessment today if she did not want to sign the form. The client became angry and left the office. In this case, it was supportive to have another clinician assist me and resolve the situation. Also, this collaboration was useful during the group therapy sessions. For instance, prior to completing my first mindfulness-based activity that I led, I expressed my trepidations to the other clinicians prior to the group session. They allowed me to practice the activity with them and offered advice. This helped me become confident and successfully lead the mindfulness-based activity.

I was able work with clients early on in my advanced practicum. I shadowed many of the clinicians and led several assessments with clients who wanted to receive treatment from MAP. Prior to conducting an assessment, I was able to access the client's medical history from the Electronic Medical Records (EMR), Medical Information Technology Inc. (Meditech), and BCare notes, which are all medical programs that hold all of the medical documentation from the client's past. The history search allowed me to question the client on some of the events or experiences that they had encountered in the past, which helped me develop a complete representation of their current mental state. Also, it acted as a way to provide me with some insight as to some of the struggles and challenges that the client had dealt with in the past. The intention of the assessment was to discuss the services that the client had accessed in the past, if they were hospitalized for a mental illness, and to uncover if they would be a good fit for the program. These assessments acted as a tool to discuss the client's history, understand why they wanted to pursue treatment now, to identify how have they been managing symptoms, to discuss their supports, to uncover any ambivalence that they may have, and to discuss the details of the program. It has been found by the counselors at MAP that when clients understood the structure of the program, they were more apt to try the welcome group.

Two facilitators led the group therapy sessions; however, I was able to shadow these sessions as well as observe one generalized mood disorder group. I would observe the facilitators and the clients during the group sessions. By doing this, I was able to gain an understanding of how other group facilitators managed and directed group discussions, tasks, and homework. By participating in this manner, I was able to become more confident and this prepared me for opportunities to co-facilitate groups.

I was able to participate in the mood/generalized anxiety group, which was a treatment group that MAP offered. This group used elements of CBT methods such as documenting negative and intrusive thoughts, understanding when this occurs, and learning how to positively react to these thoughts (see Appendix B for the CBT documents). Once I understood the process, expectations, and my role, I was able to co-facilitate two more mood/generalized anxiety groups. Also, I co-facilitated two welcome groups, which are designed to act as an introduction to group and permit people to understand the group environment and process. In many ways, the welcome group was truly the pre-treatment and required the clients to think about goal setting, changing their behaviours, understanding how this would affect their current state mental state, and why change was important. The intention was to prepare the clients for the intense work of the actual treatment groups, become comfortable with sharing their experiences, creating normalcy within the group, and discovering if this style of treatment would meet their individual needs.

My responsibilities included photocopying any necessary materials or documents for the group sessions, retrieving water, obtaining nametag stickers, and staging the room by removing obstacles and placing chairs in a circle. During both the mood/generalized anxiety group and welcome group, I was able to lead mindfulness-based exercises. The mindfulness-based activities included breathing techniques and mindful eating. These activities would encourage the clients to stay in the present moment, reduce stress, reduce rumination, and increase focus (Beckerman & Corbett, 2010). Other tasks that I was responsible for included opening the session by asking the clients how had their week been or if there was anything from the past week that they wanted to discuss. I also led group discussions regarding the client's homework in both the welcome group and the mood/generalized anxiety. The objective was to discuss their change, goals, and their progress. I guided different activities with the clients in the group.

Finally, I was able to end the group sessions by asking the clients things like what will they take away from today's group? Or, what are they excited about doing in the group?

My responsibilities also included maintaining client confidentiality. Confidentiality was important as I had access to clients, client's files, files on BCare, and Meditech. BCare was designed specifically for HSN with the objective of documenting the mental health clients and patients that use services from HSN. Meditech is a computer software program that stores health care information about people who use the health care system. Both of these programs indicate what diagnosis a person had been given, the treatment, and notes from health care professionals. Also, I had access to hospital staff, the program manager and director, my supervisor, community agencies, reading material within the MAP agency, and research literature. Moreover, my responsibilities further extended to data entries such as documenting the assessments and the group sessions into BCare, and updating the client's Ontario Common Assessment of Need (OCAN) and CDs. The OCAN is a tool that captures the individual's needs and highlights service gaps. CDS is an extension of the BCare system; the intention of CDS is to document and update each time a client is viewed for statistical purposes.

Training Goals

As I have limited familiarity, understanding, and experience in social work practice, my overall intent for completing an advanced practicum was to develop and refine the clinical skills that are necessary for social work practice when working with a multidisciplinary team in a community mental health program of northern Ontario hospital.

My learning goals included:

- I wanted to learn and develop advanced social work practice skills.

- That reflect working as part of a multidisciplinary team while working with patients who are seeking assistance, or have been referred for service to, MAP at HSN.
- By completing assessments and co-facilitating group therapy.
- By co-facilitating group therapy sessions with clients that were referred or self-referred to MAP. From this experience, I have gained an understanding the various groups that are available through the MAP and the criteria for each group. By co-facilitating groups, I refined my ability to build on any group work skills that I have now and learned more about the group work skills that are necessary to deliver programs to people seeking services at MAP. Moreover, I am able to integrate theory with practice.
- I aimed to critically reflect upon several theories such as cognitive-behavioural therapy, mindfulness-based practice, group theory, strengths-based perspective and to identify how they are used within a population of people seeking service at community mental health problem.
- I wanted to work on improving my self-awareness through journaling and had clinical supervision with my supervisor. In the past, I have not experienced clinical social work supervision, so I wanted to understand this process better and how I could use supervision to improve my clinical skills.
- The above goal is related to developing therapeutic presence. I wanted to be able to analyze and assess the growth of my therapeutic presence through clinical supervision, journaling, and refining my active listening skills and becoming increasingly more

knowledgeable about mental illness and the implications on the clients that use these services.

- Some research suggested that individuals with mental illness often experienced some form of stigma (Corrigan et al., 2010; Hinshaw, Cicchetti, & Toth, 2007). I aimed to develop a more broad understanding of how and why stigma is present and if it acts as a barrier for the clients with that were receiving treatment by MAP. By having an enhanced understanding of the effects of stigma, I thought that this could assist me in comprehending some of the challenges, experiences, and hindrances that are often encountered by some people with mental illness.

Ethics

Many of the clients that would be referred or self-referred to MAP would be in a vulnerable state and would often have a rather long history of struggling with mental illnesses. Sometimes clients were merely referred to MAP that needed the services that were offered, but sometimes the services were not appropriate for that client. For that reason, it was important to be prepared, by reading the client's history, and by asking detailed questions during the assessment. In this way, we were practicing and maintaining the best interest of the client, which is one of the Code of Ethics from the Ontario College of Social Workers and Social Service Workers (2008).

Confidentiality is an important ethical concern that should be taken seriously, as clients are sharing personal stories, experiences, and feelings. This is also important because clients are vulnerable and perhaps have not shared these emotions or stories with anyone else. As the code of ethics of the Ontario College of Social Workers and Social Service Workers (2008) states,

social workers must protect the confidentiality of the client. However, disclosure of information may be required by law, or if a client consents to disclosure.

Ensuring confidentiality during group sessions was challenging. Oftentimes, during the first group session, we would discuss confidentiality and what that meant to them. During this process, we would create general guidelines and mandate for that group. Sometimes we would request that the group members sign a non-disclosure form, but it had no legal bearing and would oftentimes create more nervousness than necessary. For example, some clients would proceed to ask questions about why they had to sign the form if they agreed to not discuss information from the group. More often than not, we would not present this form to the group. It could break up the group cohesion by making it too formal, people would become concerned about what they would discuss with their family and/or friends; sometimes people would refuse to sign it and see it as a indication of mistrust between the clients and the clinicians.

Conclusion

This chapter has explored and described the advanced practicum environment by discussing the demographic that MAP works with and the services that they offer. I also explored the agreement with the agency and my responsibilities while I was completing the practicum. I went on to discuss the training goals that I had developed and ethical issues that I encountered during the practicum. The following chapter will discuss the intention of creating the goals that I had developed, how I was able to achieve these goals, and I plan to discuss stigma and the implications for persons with mental illnesses.

Chapter 4: Reflection and Critical Analysis of the Practicum Experience

This chapter will explore the intention and goals that were stated in the previous chapter. These goals had been developed prior to completing the advanced practicum with MAP. Prior to beginning my advanced practicum I had limited clinical skills. I often felt unsure of myself, uncomfortable around clients, and afraid that I would make a mistake when working with clients. As I have had limited exposure to clinical settings and clinical supervision, I had hoped to use this practicum experience to refine my clinical skills, to learn how to better integrate theory with practice, to become more self-aware and reflexive, and to explore the stigma regarding mental illness. I was able to complete these goals through the assistance and support of the MAP clinicians and clients. The multidisciplinary team at MAP provided me with an advantage because I was able to utilize the expertise and knowledge of multiple clinicians while working with persons with mental illness. For instance, I was able to audit and co-facilitate various assessments with clients and see how integrating theory into practice was a natural and coherent process. This chapter will discuss my ability to learn about theories in practice and praxis, to increase my self-awareness, use therapeutic presence, use clinical supervision, and develop an understanding of stigma regarding mental illness.

Theories

Several theories were used to guide my therapeutic practice during my practicum at MAP. Thompson (2000) contended that theory is an important element of professional practice. By practicing from an eclectic perspective and being well versed in many theories, the clinician is then able to draw on this knowledge base. Thompson further argued that theory is crucial for capitalizing on the potential effectiveness of the clinician. Theory is considered to be an essential part of informed practice. Turner (2011) also stated "...theory brings order to our practice..." (p.

10). Specifically, Turner stated, "...responsible, ethical practice needs to be built on strong theory, [and] based on relevant evidence" (p. 9). While I was at MAP, I was able to learn how to integrate many theories into practice. The theories that I will focus on that I used most often were Cognitive-Behavioural Therapy, mindfulness-based practice, group therapy, and strengths-based perspective.

Cognitive-Behavioural Therapy

As stated in the literature review, CBT is based on the notion that cognitive thoughts can influence a person's behaviour and emotions (Dobson & Dozois, 2001; Taylor & Chang, 2008). CBT was a preferred form of treatment at MAP and it guided many of the therapeutic sessions because of its ability to encourage clients to become conscious of their negative thinking styles and begin to slowly change them. Beck, Rush, Shaw, and Emery (1979) maintained that CBT was beneficial for clients because it is pragmatic and action-oriented approach. Also, CBT utilizes homework, particularly thought records, as a means to apply the skills that they have learned from the group sessions to multiple situations that could arise in everyday life. The client's ability to use these skills on his or her own is a crucial goal of CBT.

Some of the clients in the groups in which I worked stated the homework portion of the therapy allowed them to recognize some of their negative thinking styles (see Appendix B for the CBT thought records that MAP used). Most of the clients appreciated the notion of being able to label those thoughts and develop an understanding as to why these thoughts were occurring. On the other hand, some clients felt that by documenting their negative thoughts and triggers, and discussing them in group therapy, they would be re-traumatized. Some clients said that this task caused them to think about the incident and made them recreate the emotions that they felt during that event. Other clients indicated that they had difficulty recognizing the negative

thoughts in the moment, but would later recognize those thoughts after they occurred and after they were able to reflect on their day. Some clients were documenting their thoughts some time after the occurrence of the situation or event. In the group, we discovered that some of the clients were not completing the homework assignments and we were concerned that they were not reflecting on their negative thought patterns or knew how to recognize them in the moment. Because the homework would overlap and become progressively more advanced each week, it was imperative that the clients continued reflecting and completing the thought records in order to reduce confusion and feeling overwhelmed. This is consistent with Dryden and Branch (2012) who said that homework is a central element to the success of CBT. They also found that clients sometimes do not complete the homework assignments, or merely complete the assignments to please the clinician. They suggest that the clinician should work with the client and help him or her commit themselves to the homework assignments because the assignments have a tendency to coincide with one another.

In one of the generalized mood groups that I co-facilitated, some clients claimed that they were unable to complete the homework because they were initially not able to recognize the thoughts in the moment. Also, as the homework became more elaborate and challenging, some of the clients became discouraged because of the complexities of the expectations. Cully and Teten (2008) claimed that this is common during the homework process and should be used as a way to understand and learn about the clients' level of motivation or level of distress. This could also be used as an opportunity to understand the clients' mental health challenges. These experiences correlated with the information that Tiuraniemi and Korhola (2009) found that people with a diagnosis of depression tend to experience an increase in fatigue, feel powerless, and have a lack of concentration; so completing intricate tasks could be overwhelming for some.

This was experienced by some of our clients because they were not able to complete the thought records on their own, even though we spent a lot of time making sure that the clients understood how to complete the task.

As a new clinician, it was important for me to validate the clients' feelings and be able to work with the group to ensure that they were able to understand how to complete the assignment and how to reinforce and implement skills and key concepts that were discussed in the group. I was able to do so by writing examples of their thought records onto a white board and having the clients participate in filling out each section. During this process we, worked together as a group to ensure that each person knew how to complete the thought records. Although this took up the whole group session to complete, I was satisfied in knowing that the clients had more confidence in completing their thought records.

Mindfulness-Based Practice and Interventions

As discussed in the literature review, Kabat-Zinn (2003) claimed that mindfulness is the act of "awareness that emerges through paying attention on purpose, in the present moment, and non-judgmentally to the unfolding experience moment by moment" (p. 145). Many of the clients had difficulty staying in the moment because of constant rumination, stress, and lack of focus, which is often indicative of most symptoms of generalized mood disorders and generalized anxiety disorders (Beckerman & Corbett, 2010). Some of the clients admitted that practicing being mindful and developing those skills calmed and relaxed them. Many of the clients stated that they particularly looked forward to participating in the deep breathing exercises because it allowed them to develop and maintain focus, attend to physical sensations, notice intrusive negative thoughts, reduce stress, and lessen the tendency to attempt to control cognition and affect through thought suppression. The comments from the clients are aligned with the findings

from Mandal, Arya, and Pandey (2012). Mandal, Arya, and Pendey (2012) stated that being mindful could help people notice and be more aware of their "...automatic thoughts, habits, and unhealthy behaviours..." (p. 150). This statement is similar to some of the comments from some of the clients. Many of the clients stated that they particularly looked forward to participating in the deep breathing exercises because it allowed them to develop and maintain focus, attend to physical sensations, notice intrusive negative thoughts, reduce stress, and lessen the tendency to attempt to control cognition and affect through thought suppression.

Clients sometimes found that some of the mindfulness-based techniques that were discussed, practiced, and demonstrated in the group sessions were creative and flexible enough that they could practice being mindful on their own. This is a similar experience to Beckerman and Corbett (2010) who identified that the clinician should teach a variety of mindfulness-based techniques to clients so as to ensure that they are comfortable and confident to practice these techniques on their own. They further maintained that mindfulness-based approaches are excellent techniques to teach clients because they are flexible and can be practiced independently.

Some clients admitted to using some of the mindfulness-based practice activities in their private lives. The majority of the clients discussed practicing deep-breathing exercises when they were on their own. Many clients did request instructions and other pertinent information on how to perform the mindful eating, body scanning, deep breathing exercises, and observation activities on their own but some clients stated that it was challenging to do these activities independently. Brewer, Davis, and Goldstein (2012) also discovered that practicing mindfulness could be challenging at first because it requires a person to concentrate and ignore intrusive thoughts. These concerns were certainly identified by some clients who claimed that it was

difficult to find a quiet space; their mind would not stop racing; there were too many distractions; they found it to be too demanding; or they found that this was awkward without someone leading the activity.

As part of the group session, a MAP clinician led a mindfulness activity at the beginning of each group session. Examples of these activities included mindful eating, body scanning, deep breathing exercises, and observations. Oftentimes, the facilitators would choose the mindfulness-based activity prior to the beginning of the group session based on his or her comfort in leading the activity. In order to ensure that everyone knows how to perform these activities outside of group, one suggestion is that they could have had the clients request an activity at the beginning of the group session from all of the previous mindfulness-based activities that were completed in the group, or from a list that was created by one of the facilitators. This would allow the clients to feel more involved and we would have had an idea of which activities they liked or found useful. Also, they could have one of the clients lead that activity. In this way, the clients would be able to build confidence and practice, which could help them develop their understanding of the activity when they are outside of group. It is possible that this approach could potentially cause the client to feel uncomfortable so this would not be used as a requirement, but an open invitation for everyone. This would be beneficial for the clients because as Beckerman and Corbett (2010) suggested, when clients learn various mindfulness-based techniques, they could practice these techniques independently.

Group Therapy

The group therapy paradigm was ideal for MAP for several reasons. This format was convenient for the clinicians because they could reduce waitlist times. This is similar to the findings reported by Drumm (2006), Tiuraniemi and Korhola (2009), and Wodarski and Feit

(2012) who all found that a large amount of individuals could be effectively treated relatively quickly through a group therapy format. In doing so, clients are receiving treatment and assistance in a timely manner. Additionally, the group sessions encouraged the clients to discuss their experiences with mental illness and develop a support system that was outside of their family and close friends.

The group dynamic helped many clients because they had peer support, or mutual aid, which further decreased social isolation and offered a sense of normalcy, belonging, and acceptance by recognizing and responding to the needs of the other group members (Bouchard & Gros, 2010). As discussed earlier, Wodarski and Feit (2012) stated that group therapy enables group members to meet with others who have had similar experiences, emotions, and symptoms. This was true for some of the clients with whom I was able to work. During one of the first welcome group sessions that I co-facilitated, we aimed to have everyone connect with each other. We proposed the question, “What brought you here today?” Instantly, the clients were discussing feelings around lack of support from friends and family. These responses correlated with the findings from Robinson, Rodgers, and Butterworth (2008) who claimed that oftentimes mental illnesses are not visible to others, which allows people to assume that the individual is not struggling with the difficulties of the illness. They also claimed that their family did not support their decision in seeking therapeutic treatment. Robinson, Rodgers, and Butterworth (2008) indicated that it is quite common for most of the informal care to be provided by the individual’s family. This could cause the person’s family to feel responsible and uncomfortable with the notion that he or she is seeking assistance without them.

In some ways, the group format was challenging as some clients did not want to openly share their experiences, which is consistent with the work of Rose and Chang (2010) who

suggested that clients may be ambivalent because of their past experiences, fear, and mistrust in discussing personal issues with other people. Also, some people are more introverted than others and it took some time to begin to speak openly. Rose and Chang (2010) contended that this is normal behaviour in a group setting and it does not take away from their treatment and growth. However, Kemp (2010) stipulated that group therapy is structured in a way that would make it nearly impossible for the individual to feel that he or she is alone, to detach from other group members, or to isolate themselves.

Maintaining confidentiality was always a concern within the group. Kemp (2010) and Yalom and Leszcz (2005) argued that group therapy presents challenges surrounding governance, boundary keeping, and a lack of ensuring confidentiality among the group members. For that reason, we would discuss confidentiality at the beginning of the group therapy session and it was addressed when we created the group safety guidelines with the group members at the beginning of the first group session. When asked how the group members would feel about the other group members sharing what had occurred during the group with their family, some clients stated that they did not mind that their stories and experiences were shared. However, they insisted that their names were altered or omitted from the discussions. This was due to the fact that Sudbury is a small community and there was some fear that there could be overlapping relationships.

Some people did not like the notion of acknowledging each other in public in places like shopping centers, restaurants, or parks. This was because they wanted to reduce moments of awkwardness or overt breaches of confidentiality by feeling obligated to explain why or where they knew that particular person from to their friends and/or family. In this instance, it was important to discuss potential boundary issues with the clients so that we could have a reasonable

way of handling potential encounters because group therapy can present issues for those living in rural areas (Kemp, 2010). Kemp, Yolam and Leszcz (2005) argued that managing boundaries in small communities presents some challenges for clients and professional workers such as breaching confidentiality, creating unnecessary stress on the client, or putting them in an awkward situation if they felt that they had to disclose how or why they knew the clinician or other clients. Curtin and Hargrove (2010) indicated that people in rural communities tend to encounter each other more often than those in larger communities. Robinson, et al. (2012) also found that rural areas present some barriers around stigma, limited family and peer support, and there tends to be a lack of privacy. Therefore, the literature supports that in smaller communities, it is not uncommon to have some unanticipated encounter with a client outside of the group or overlapping social relationships. For that reason, it was essential to discuss this topic with the group members to ensure that they understood that this could be a potential possibility of attending the group.

Strengths-Based Perspective

As a social worker who is guided by the strengths perspective, I believe that people have inner resilience and strengths that enable them to endure hardships and promote their own ability to cope despite the presence of adversity. The intention of the strengths-based approach is to not deny the presence of challenges and hardships, but to acknowledge that these problems exist and understand that they could become debilitating and overwhelming (Brun & Rapp, 2001). Challenges and hardships can be disempowering and begin to obscure the client's unique capabilities and strengths. Guo and Tsui (2010) found that to practice from a strengths-based approach, the clinician must be able to identify the sort of positive things the client does, what is useful, and what is effective.

In many ways, a strengths-based approach was valuable with the clients that accessed MAP's services because it encouraged the clinician to focus on the client's strengths and perceive challenges as more of an opportunity to build resilience. Guo and Tsui (2010) stated that the strengths perspective offers an opportunity to identify the client's personal and environmental assets while acknowledging that people are naturally resourceful. For instance, some of the clients that were experiencing depression often lived with the diagnosis for several years prior to seeking therapeutic assistance. Rapp and Goscha (2012) said this approach is predicated on the belief that all individuals are capable of resolving their own problems. Rapp (1998) stated that the strengths-based approach, seeks to define the barriers that are affecting a person's quality of life and aims to find solutions to alter those hindrances. During the assessment at MAP, it was important to acknowledge this and to ask open-ended questions about how they have been able to manage their symptoms, what has worked for them, and what has happened to cause them to want to seek help now. The strengths-based approach suggests that the clinician should assist the client in seeing his or her positive attributes, talents, and achievements (Brun & Rapp, 2001). Acknowledging these struggles and identifying how they were able to overcome some of these difficult times encouraged the clients to recognize their inner resilience.

Therapeutic Presence

Prior to completing the advanced practicum, I wanted to understand more about, and develop, my therapeutic presence. As previously discussed, Ruch (2002) claimed that therapeutic presence is the ability to analyze and assess one's own development through continuous reflexivity and clinical supervision. Parikh, Janson, and Singleton (2012) stated that to reflect is a fundamental tool that is essential to many professions. Gursansky, Quinn, and Le Sueur (2010)

maintained, "...the ability to reflect critically is deemed to allow the formulation of working solutions for ill-structured problems and to deal with existing information that may be incomplete and unreliable" (p. 779). In this instance, reflexivity is defined "...as a means of transforming experiences that are obscure and doubtful to experiences that are more clear and coherent" (Parkh, Janson, & Singleton, 2012, p. 34). They also described reflection as a process in which the unprocessed raw experiences is turned into learning. Personally, I felt that by engaging in reflexivity, it would become a significant aspect of developing my therapeutic presence.

Therapeutic presence is an essential skill within the social work field because it could help refine and develop a clinician's active listening skills, attune skills, and create new ways of thinking in a reflexive manner (Geller, Greenberg, & Watson, 2010). Therapeutic presence could offer a more effective response and approach to working with a client in the moment (Geller, Greenberg, & Watson, 2010). In many ways, prior to developing and working on my own therapeutic presence, I found that it was difficult to be in the moment with the client. I was constantly predicting what the client would say and, because of that, I was not listening to the client, I was not allowing the client to lead the conversation, and I was missing important signals from the client because I was so focused on my own thoughts. As Geller and Greenberg (2011) confirmed, therapeutic presence is a foundational therapeutic stance that sustains and encourages active listening and understanding of the client in the moment. Gursansky, Quinn, and Le Sueur (2010) argued, "...social work comprises [of various] complex and often ambiguous tasks, which can be learned through engaging in action and reflecting on that action..." (p. 779). During the advanced practicum, I was able to accomplish this by journaling and working with the other clinicians at MAP.

During my practicum at MAP, I aimed to develop my self-awareness in order to become more authentic, genuine, and be able to be in the moment with the client (Geller, Greenberg, & Watson, 2010; Wang, 2011). In order to develop and enhance my self-awareness, I would write daily in a reflective journal, which enabled me to document challenging and substantial practice situations. This process encouraged me to continuously reflect, evaluate, and question my therapeutic choices. Richardson and Maltby (1995) confirmed that writing in a reflective diary could be an effective tool for promoting reflection and learning. They also suggested that reflective writing could be used as a tool for clinical learning because the individual could use it as a source of self-assessment and evaluation. For instance, early on during my time with MAP I was asked by a fellow clinician to discharge one of his clients. This was challenging for me because the procedure to discharge a client is time-consuming and I was intimidated by this process. This was also difficult for me to complete because, by that time, I had developed an understanding of how long the process was to receive treatment from MAP and I was concerned that the client would be discouraged from accessing treatment services in the future. In this instance, I had my journal and supervision as a way to uncover why I was having a difficult time discharging this client that I had never met before. Once this was addressed and I was able to become more familiar with the discharging process, I overcame the trepidations that I had before. Documenting situations that I encountered during the practicum further allowed me to critically reflect on the issue, my practice choices, theory, and my clinical progress. This process encouraged me to question, review, and consider additional options of assisting the client. Being able to contemplate how I could improve in the future was an invaluable tool in furthering my learning and developing my clinical practice skills.

Sheppard et al. (2000) argued that clinicians should constantly reflect on their experiences with clients. This habit of continuous reflection would require the clinician to develop a willingness to question habits, to reflect on practice, and develop new ways of managing situations. This willingness to question and receive criticism from the other clinicians allowed me to understand how preconceived notions that I may have could have an affect on my own decision-making. By not challenging any preconceived notions that I have developed, I could be working from a position of stigma, discrimination, or bias. For example, I had previous experience working with the Assertive Community Treatment Team (ACTT) within the Canadian Mental Health Association. During that time, I was able to work with individuals with severe mental illness that often included, but not limited to, Schizophrenia, Bipolar Disorder, and Depression. From this work experience, I had formulated preconceived notions of what mental illness was and it truly clouded my perceptions and understanding of all forms of mental illnesses and challenges. As a result, I had to reframe my beliefs and understanding of what is mental illness and begin to understand that there are varying degrees of mental illness. Also, in terms of how these preconceived notions could have had some influence on my early decision-making was apparent when I did not consider the clients' mental illness to be as troublesome as they had articulated. This is problematic because I was clearly stigmatizing people with a mental illness; I could be minimalizing the clients' experiences; and they could feel that their experiences of having a mental illness is being neglected and not viewed as a serious issue.

Clinical Supervision

As a new social worker, I have had limited exposure to clinical supervision. Supervision, for the purpose of the advanced practicum, refers to establishing and creating a learning alliance between the supervisor and the student in which the student learns therapeutic expertise while

developing and refining self-awareness (Coleman, 2003). Coleman continued to state that this form of supervision is "...concerned with teaching the knowledge, skills, and attitudes important to clinical tasks by analyzing the social worker's interaction with the [client]" (p. 1). The supervisor aims to teach and educate the student on what he or she needs know to provide specific agency services and care to certain agency clients (Coleman, 2003). Because of my lack of supervision, this caused me to feel uncomfortable around clients and unsure of my therapeutic decisions. While at MAP, my supervisor and I would meet weekly for an hour. We would discuss any issues or challenges that I was having, and she would advise me on how to approach specific situations with clients, or discuss my clinical growth and skills. For instance, I was able to write several of the initial assessments from the intakes that the MAP clinicians would complete with clients.

Earlier in my practicum, I received constructive criticism from my supervisor regarding the lack of detail in the assessment. She instructed me to question my writing and examine the assessments for gaps or missing information. By noticing these gaps in the assessments and noting what I needed from the client to fulfill the requirements of the assessments, I was more prepared the next time I completed an assessment. Davys and Beddoe (2009) insisted that clinical supervision during a field placement is an opportunity to enhance the student's practice, clinical skills, and process. I found that supervision allowed me to question and reflect on my choices and challenges that I encountered. Parikh, Janson, and Singleton (2012) also found that, "...reflection time with supervisors enhances supervisees' professional decision making and skill development..." (p. 33). They also maintained that reflective practice could offer students the ability to increase self-understanding and engage in professional growth.

For instance, I was able to discuss my difficulty with transitioning topics when completing the assessments with clients. I was able to practice this task with my supervisor, Sue, in a safe environment and she offered some critical advice. Sue explained to me that it should be as easy as a conversation and merely ask questions in a flowing way. She further stipulated that if I am not able to obtain some information from the client, I might be able to find some of it in his or her medical records. This eased my trepidation and nervousness about completing individual assessments and working with clients, and helped me to understand the importance of process and building a relationship with the client as opposed to the task of obtaining every bit of information required. Although Sue was my supervisor, I was also able to utilize the expertise and knowledge of the other clinicians at MAP. This helped me build my clinical skills by co-facilitating several assessments, comprehend different approaches and methods of completing assessments, and learning a variety of ways of writing the assessments. In this manner I was able to develop my own technique when I was completing an assessment with a client and documenting those assessments as case notes.

Utilizing all of the clinician's experiences was also extended to the group therapy sessions. For instance, when I became more confident and comfortable with the group format, I was able to work with the other clinicians and complete more group sessions because I was not limiting myself to shadowing one clinician. In these groups, I had roles in leading many parts of the group like the opening introduction, the mindfulness-based activity, discussions, and the closing activity. Also, the other clinicians offered me constructive criticism and advice, which enhanced my clinical skills. For example, one critique was the idea of never working harder than the clients. This became an issue one time when only four of the ten clients came to the group session. Instead of leading the discussion and keeping it confined within the circle, I chose to

turn the discussion into more of an activity by writing everything onto the white board. The clients were not interested and were quiet. I found that I was working extremely hard on getting the clients to participate and I was doing most of the work. Instead of directing everyone's attention to me, and breaking up the group circle, I should have simplified the activity into a discussion that everyone could work on together.

Stigma

As previously discussed in the Introduction to this report, the literature indicated that both stigma and mental illness could act as a dual challenge for an individual with a mental illness. In some ways, stigma encompasses a wide range of facets that could be experienced by anyone with a mental illness (Wright, Jorm, & Mackinnon, 2011). Knifton (2012) argued that stigma encompasses the combination of inaccurate or distorted notions, negative stances and discriminatory behaviours. Knifton (2012) also described stigma as "...the co-occurrence of labeling of difference, stereotyping, separation or 'us' and 'them', followed by discrimination and status loss" (p. 287). Through my advanced practicum, this was often an issue for many of the clients. I was often working with people who had a diagnosis of depression and those with anxiety. Oftentimes these people have been suffering for many years, sought assistance through different forms, and were eventually referred to MAP by a physician or other health professionals.

Through my personal and professional experiences, I have been able to witness and become aware of several incidences of stigma. Henderson, Evans-Lacko, and Thornicroft (2013) maintained that stigmatizing attitudes could influence an individual's desire to seek help. This was a common thread among the clients' stories. Some of the clients would describe feelings of loneliness and isolation as a result of their mental illness and challenges. They also shared

incidences of rejection and mistreatment from friends and family because they did not understand what it was like to live with a mental illness or mental health problems. Robinson, Rodgers, Butterworth (2008) claimed that this is often a common experience for people with a mental illness because the illness is not visible to others; most mental illnesses are distinguished and identified by emotional and other subjective symptoms; and, sometimes people with a mental illness try to conceal their difficulties from others. When this occurs, people who are unfamiliar with having a mental illness are unable to relate to that particular person. During the MAP groups, some people expressed times of being bullied and ridiculed for having a mental illness. Knifton (2012) found that it is not uncommon for individuals with mental illness to experience harassment in their community. This could be attributed to ‘fear of the other’, dangerousness, and unpredictability that are often associated with people with mental illness (Knifton, 2012). These experiences were often common and tended to be a familiar trend with the people with whom I had spoken. These experiences led me to believe and understand how stigma influenced their everyday lives. These experiences truly represented the notion that stigma is created and reproduced because of a fear of the unknown, fear that mental illness is contagious, shame that may be brought on the family, and the idea that mental illness should be hidden from the community (Foerschner, 2010).

External stigma. Stigma was a commonality for many of the clients at MAP. As stated previously, external stigma arises when people stigmatize others by creating negative stereotypes (Gray, 2002). For instance, during the welcome group, we would show a video that highlighted people’s occurrences with stigma and how this affected them (Madjedi, 2012). This video would ignite a lot of conversation about this topic. Some people indicated encounters of external stigma, claiming that their friends and family did not understand what it was like to have

depression or anxiety. These experiences highlight what the literature argues as the central element of external stigma, which lies within the notion that discrimination could implicate the individual's ability to sustain and maintain social roles, reduce quality of life, create social disadvantages, and prevent the individual from accessing timely treatment and care (Alonso et al., 2008; Al-jiboori, 2010; Gray, 2002; Stuart, 2005). On the other hand, someone indicated that family and friends were encouraging and supportive when they discovered that there had been a diagnosis of depression. I did not find any articles in the literature, which discussed this experience. In fact, the literature portrayed society, and the people in it, as has having pessimistic views of people with mental illness (Stuart, 2005).

Self-stigma. The literature discussed self-stigma, which was described as a form of internalized oppression (Ben-Zeev, Young, & Corrigan, 2010). This may cause the person to develop a reduction in his or her self-esteem (Brohan et al., 2010; Ben-Zeev, Young, & Corrigan, 2010). Moreover, as previously stated, the person could begin to feel "...shame, blame, hopelessness, guilt, and fear of discrimination..." because of their mental illness (Brohan et al., 2010, p. 2). Some clients spoke of the shame about their experiences with mental illness. This was often in response to the rejection that came from friends and/or family. However, some clients used this rejection as a tool to seek assistance in recognizing this rejection as a signal to seek help for mental illness.

Structural stigma. As mentioned previously, structural stigma encompasses the idea that stigma has a way of influencing mental health professions and could go so far as to affect the delivery of health services (Starzynski, Gallson, & Ungar, 2012). The literature has also suggested that some health professionals oftentimes possess the same prejudices and stereotypes as the general populations (Starzynski, Gallson, & Ungar, 2012). This becomes problematic

when individuals with mental illness try to access medical services, but are treated unfairly by health professionals. Ahmedani (2011) found that stigma has a way of influencing medical professionals that often leads to disproportionate access to treatment and services. I only encountered this to be problematic once while I was with MAP. My encounters with health care professionals within the mental health sector were positive. The professionals that I have worked with are passionate and encouraging about the field. Also, they have a deeper understanding and sensitivity of some of the issues and problems with which many persons with mental illness struggle. I am not denying that some professionals in the field of mental illness deliver services in a way that could be considered less than adequate when compared to that of other services. However, I have not witnessed these occurrences.

Anti-stigma campaigns. As has been discussed earlier, there were several anti-stigma campaigns in Sudbury that addressed issues of mental illness. Instead of publicizing these initiatives during the group sessions, we would show a video that a former student had made about stigma against people with mental illness (Madjedi, 2012). The first part of the video depicted several different people, in black and white, and labeled them with their diagnosis. The second part of the video showed those same people, now in colour, but labels were different and portrayed the people with their achievements. This video was encouraging and offered a different perspective and outlook. This was used as a tool to guide and prompt people to discuss their feelings regarding the topic of stigma. It appeared that this topic ignited a lot of conversation, but the clients did not mention the other anti-stigma campaigns that have worked in the past to decrease and eliminate stigma that surrounds mental illness. This made me question whether there are enough anti-stigma campaigns, and whether the media is promoting them sufficiently or

if the people that work with persons with mental illness are endorsing these initiatives effectively.

Conclusion

This chapter has discussed my objectives and intentions for my practicum with MAP. It has discussed how I was able to meet these goals and develop my clinical skills. Also, It explained the significance of stigma and how it impacted the lives of the clients that I worked with. The final chapter will summarize my practicum at MAP, discuss my significant learning experiences, and describe implications for social work practice.

Chapter 5 - Conclusion

In order to fulfill part of the requirements of the Laurentian University M.S.W. program, I chose to complete an advanced practicum (SWRK 6024E) from June, 2012 to August, 2012. This practicum was completed through the Mood and Anxiety Program (MAP) at Health Sciences North (HSN) in Sudbury, Ontario. As has been discussed earlier, the objective of my practicum was to develop advanced social work practice skills. In this final chapter, I will provide a summary of the practicum by discussing the practicum setting, exploring the goals that I created and aspired to fulfill during the advanced practicum, and presenting my significant learning experiences. I will conclude by presenting the implications for social work practice.

Summary of the Practicum

My placement at MAP offered me the opportunity to be part of a team that provided supportive services to individuals with a diagnosis of a mental illness. These services targeted and provided group therapy to people who were experiencing symptoms of depression and/or anxiety. Specialized groups were available for those with an Axis II diagnosis of bipolar disorder and obsessive-compulsive disorder. Also, individual counseling was available for individuals with post-traumatic stress disorder. Before I began my placement at MAP, I developed a learning contract to assist me in developing my advanced social work practice skills. I planned to develop these skills by working as part of a multidisciplinary team; reflecting on my practice with the use of a journal and clinical supervision; completing assessments and co-facilitating group therapy sessions; and, integrating theory into practice. I also aimed to critically reflect upon the theories that I used during my practicum; develop and improve my self-awareness; enhance my therapeutic presence; and develop a broad understanding of how stigma is present in the mental health field and could act as a barrier for people with a mental illness.

My Learning in the Practicum

During the practicum, I was able to co-facilitate and lead numerous assessments with potential clients. Prior to the practicum, I felt nervous and overwhelmed when working with clients. As a new social worker, I understood that I was in a position of power, and I was hesitant to work with clients because I was apprehensive of being incapable of completing the necessary work with them, not knowing how to work with clients in a positive way, or not being able to obtain pertinent information for the assigned task. By collaborating with the MAP clinicians to complete the assessments, it encouraged me to interact and work with clients. By having another clinician with me during this process, it allowed me to gain confidence and trust in my abilities while being able to rely on the expertise of an experienced clinician. By the time the practicum was nearing the end, I was able to lead the assessments with ease and certainty with little, to no, hesitation.

My supervisor taught me the importance of being prepared for the assessments by researching the client's medical history. This process allowed me to gain some self-assurance because I was able to understand some of the issues and challenges that the client may have dealt with in the past. This would assist me during the assessments because I had a basic understanding of what the client's journey within the medical system has been and I would be able to develop some questions based on this knowledge and confirm what was present in the medical history file: medical diagnosis, medications, and reports from physicians. Also, by learning about their medical diagnosis, I would have a better idea as to which group would be a good fit for a client. Although we did encourage the clients to choose a group that they felt would suit their current needs, having read the medical diagnosis would allow me to help in guiding their decision to ensure that they received the best treatment possible.

Another concern that I had was that I did not know what questions to ask that would be appropriate for the assessments. This would often make me nervous. The clinicians taught me that preparing questions prior to the assessment could help in easing some of that nervousness. Also, they encouraged me to develop a series of questions that I could use as a guide for the assessments. This process allowed me to be prepared, organized with the questions, and it assured me that I would obtain enough information that I would have a thorough case note after the assessment.

From this experience I learned how to lead assessments, how to ask a variety of questions, and how to trust my own instincts. For instance, during one assessment with a young client, I could sense that the individual was nervous and timid. This person was not open and forthcoming about some aspects of their mental health illness or challenges. Sometimes this could be problematic, but as the assessment progressed, the individual began to trust me and the other clinician. Our aim for the assessment was to create a relaxed atmosphere that was comfortable for the client. In order to ensure that the client was comfortable and confident with us, we would begin by stating some of our professional background. For instance, I would state that I was a social work student with an interest in the mental health sector. The intention was for us to help the client know that we had an interest in their needs. Also, the trust developed more as the assessment progressed. This was achieved by actively listening to the client, being empathetic to his or her emotions, and by showing the client that they were in a professional atmosphere and that our intention was to assist him or her with their mental illness or challenges. When the client began to trust us, I was able to reiterate some of the questions that this person did not discuss in detail, and I was able to create a more thorough and detailed case note after the assessment was completed.

In order to refine my clinical skills, it was important to learn how to lead assessments, and working with clients and writing case notes were important for me to understand how to conduct. I also was able to develop my clinical skills through the use of supervision, using a strengths-based approach and CBT, group work, and understanding how stigma could hinder a client with a mental illness.

Supervision

Having supervision was important to me because I wanted to be able to receive constructive feedback while having someone guide me through times of uncertainty. For instance, after each assessment I wanted to have the responsibility of writing the case note. As I did not have any experience writing case notes before, it was important that I had Sue review the document before I would write the document into the BCare program. Sue would read the case note and provide comments that would encourage me to be as thorough as possible and ensure that the document represented the client's true and accurate situation at the time of the assessment.

Supervision was particularly useful because I was able to discuss issues or concerns that I had during the practicum. For instance, one client was quite emotional during an assessment that I led and completed with another clinician. I wanted to be empathetic and allow the client to take her time. I paused frequently to allow her to gain her composure and reassured her that her feelings were normal given her situation. When the assessment was completed I asked the client if she felt well enough to leave the office. I reassured the client that we were able to help her with her mental illness and challenges. My concern was that I did not know if I did enough to ensure that the client was able to leave. I was also worried that the assessment had re-traumatized the client. The clinician confirmed that the assessment was obviously difficult for the client. She

also said that I handled the situation effectively. In talking about this experience in supervision, I learned that I need to trust my instincts, but it is also appropriate to seek assistance when I am unsure of my abilities. At the same time, as a social work student, I appreciated the opportunity to seek assistance when I am unsure of my clinical skills and choices.

Theory

As a student social worker, I learned many theories through my education, but I did not have a lot of experience applying theory in practice. In the practicum, I was able to use elements of a strengths-based approach both during the assessments as well as in the group therapy sessions. For instance, during the assessments I would focus on the client's resilience. I would be positive and thank them for coming to the assessment and address how difficult it must have been for them. I also tried to recognize their resources. I would encourage the client to discuss resources through family, friends, associations, groups, school, or occupations. This would help them comprehend that they were not alone and that they had support through these resources.

In the group sessions, we tried to focus on goal setting and achieving success. These goals were things that the clients wanted to achieve and strive towards that would promote quality of life for them. Some of these goals were completed through using CBT homework. Through this process, I was able to understand how CBT offers and encourages people to be the experts in their own lives by recognizing when their goal has been achieved. Also, I learned how CBT focuses on how thoughts are able to influence people's behaviour, which in turn affects emotions and thinking styles.

As mentioned before, theory is an integral aspect of practice because it helps make professional practice, like that of social work, a more informed practice (Thompson, 2000). I appreciated using both of these theories discussed above because it helped guide my clinical

practice. I was able to learn that theory enables decisions to be justified by examining evidence and not by uniformed judgments. I also learned that humans are complex and social work is quite broad, so it is important to understand theory and recognize that although a theory might seem to be suitable at that time, it may not necessarily mean that it is the correct approach or theory to use. I learned the significance of being open-minded and did strive to maintain the best interest of the client.

Group Work

I was also able to co-facilitate several welcome, or introductory groups, and mood groups. Through co-facilitating these groups, I gained self-assurance in my abilities to lead and direct treatment in a group setting. For example, I led group discussions concerning homework assignments. I would often discuss with the group what they had accomplished each week for their CBT homework and offered constructive feedback by using elements from a strengths-based perspective. For example, some clients would discuss the feeling of not doing enough to achieve their goals. In this instance, I would encourage them to focus on the goals that they had achieved and reminded them that this process could be difficult at times. I would also discuss any issues, concerns, or problems with the clients in order to assist with any challenges that they were encountering either with filling out the homework sheets or completing the tasks. By co-facilitating the groups, I developed an appreciation for the group process. I valued the clients ability to work together to help each other through their challenges, their ability to create normalcy within the group, and their openness to discussing their challenges.

Stigma

Prior to completing this practicum, I had some experience in the mental health sector. With that in mind, I knew that stigma could present as an issue for some people with mental

illness; I knew this because of mass media, readings that I had completed, and basic personal understanding. However, it was not until this practicum that I gained an appreciation for how significant stigma could become in a person's life. For instance, some of the clients indicated feeling ashamed and embarrassed. They described their experiences with mental illness as being lonely and isolating. They were able to depict specific incidences of stigma, which illustrated how stigma could be a significant barrier to achieving quality of life for someone with a mental illness or challenges. From this experience, I learned that in the group setting, it was important to address and acknowledge that stigma exists. From my experience, this conversation tended to allow the clients to have an opportunity to discuss their fears, challenges, and it created a bond within the group.

Developing New Goals During the Practicum

While I was completing the practicum with MAP, I was able to focus and appreciate the skills and knowledge that I was acquiring. As a result, new goals emerged through this process. For example, I learned the importance of confidentiality within a smaller community and the benefits of using mindfulness-based practices.

Confidentiality

A new goal that emerged while I was completing the practicum was understanding the significance of confidentiality within a smaller community and particularly within the mental health sector. Although I knew the significance of maintaining confidentiality from my previous studies and work experience, I was able to appreciate this ethical dilemma from the client's perspective. While working with the clients in a group format, I understood how significant confidentiality was because everyone was sharing quite personal stories and experiences. People were sometimes cautious and hesitant when it came to sharing at first because of past encounters

with social rejection, isolation, and lack of support. Some people were fearful that their experiences would be shared with other people that were not a part of the group. According to Kemp (2010), this apprehension is often common within a small community and confidentiality is sometimes challenging for those living in rural areas. In addition, Robinson et al. (2012) also discovered that rural areas could present limited privacy.

The Ontario College of Social Workers and Social Service Workers (2008) maintained that the clinician "...shall protect the confidentiality of all professionally acquired information. He or she shall disclose such information only when required by law to do so, or when clients have consented to such disclosure" (p. vi). Although I am legally obligated to maintain and protect the confidentiality of the clients that I worked with, it was difficult to ensure that the clients would respect the experiences of the other group members. I learned that it was critical to have a discussion with the group about confidentiality in order to ensure that the group members felt secure and confident that their stories and experiences would not be shared outside of the group.

Mindfulness-Based Approaches

Prior to the practicum, I had little knowledge about mindfulness-based practice. As I began to co-facilitate the groups, I was exposed to this approach because it was used regularly in the group sessions with clients. As a result, another goal that emerged through the practicum was developing an understanding of mindfulness-based practices and learning how to apply techniques from this approach. Through the practicum, I was able to learn that mindfulness-based practice promotes the notion of being in the moment. Also, Kabat-Zinn (2003) identified that mindfulness is the act of "awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding experience moment by moment" (p.

145). Through the group process, I began to understand the usefulness of this approach because many of the clients had problems with rumination and negative thinking styles (Beckerman & Corbett, 2010). Mindfulness-based practice was able to assist these clients by giving them permission to ignore negative thoughts and stay in the present moment (Beckerman & Corbett, 2010).

I began to understand how this approach was beneficial for the clients because they would state that it helped them reduce their symptoms of mental illness and that they enjoyed the activity. As I developed more understanding, I began to lead mindfulness-based practice techniques within the group sessions. Some of the activities that I led were mindful eating, deep breathing, and observations. Through this experience, I learned the importance of being open-minded and accepting of all therapeutic approaches. Although I was apprehensive to try this approach, I saw how beneficial it was for the clients. This helped me to understand that I should be open and aware of new approaches, methods, and techniques that could help clients.

Implications for Social Work Practice

From this advanced practicum experience, I have determined that social workers who want to enter the mental health sector should have some prior knowledge and desire to strive to continuously become familiar with mental illness and mental health challenges. The Ontario College of Social Workers and Social Service Workers Code of Ethics (2008) supports this notion by stating, “a social worker or social service worker shall have and maintain competence in the provision of a social work or social service worker to the client” (p. vi). As this sector is continuously changing through medication, therapeutic treatment, and mass media it is imperative that mental health social workers are aware of fluctuating conditions and readily adapt to maintain the optimum interest of the client (Mental Health Commission of Canada,

2012; Ontario College of Social Workers and Social Service Workers, 2008). For instance, mindfulness-based practice is a relatively new approach to the field of social work and it has been gaining in popularity. Social workers should be aware of new ways of treating clients as we are supposed to maintain the best interest of the client and ensure optimum treatment for them.

With the experience of my practicum, I have also determined that quality supervision is significant for all social workers. Beddoe (2012) claimed that supervision is an integral aspect within the field of social work. Davys and Beddoe (2009) stated that the intention of supervision is to instruct and guide clinicians during times of uncertainty and complexity. At the same time, Chiller and Crisp (2012) indicated that some jobs could be highly demanding and stressful, which may be connected to burnout among clinicians. They went on to state that clinicians who feel overwhelmed may prematurely leave their jobs. Effective supervision might be able to assist clinicians before they feel overwhelmed by being supportive, encouraging positive relationships with other staff members, and promoting open communication and learning (Chiller & Crisp, 2012).

Also, mental health social workers should be aware and have some sensitivity around barriers that could impinge on a potential client. A social worker should be aware that, historically, there is often stigma that surrounds mental illness (Babic, 2010). Some people with mental illness tend to feel isolated, lonely, and believe that they may have a lack of support (Rose & Chang, 2010). Due to these barriers that could hinder a person's success and quality of life, mental health social workers should strive to work with the client in a way that supports and accepts the inner resilience of the client. Social workers should also be involved in anti-stigma campaigns and help to change attitudes towards mental illness whenever and wherever possible.

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Appendix A: Consent Form



Community Mental Health Program INFORMATION YOU SHOULD KNOW

Information regarding our filing systems:

As a clinic of H.R.S.R.H. mental health programs, our new filing system is on-line as part of the hospital's electronic data system. This means that other mental health providers within the hospital system can access your therapy file. The ability for these programs to access information will facilitate prompter service should you require it. These programs include H.R.S.R.H. Emergency Department, the Crisis Intervention Program, the Inpatient Psychiatric Units at both sites, the Central Intake and Referral Co-Ordination Program, the Early Intervention Program, the Eating Disorders Program, the Senior's Mental Health Outreach Program, the Mood & Anxiety Program, both ACT Programs, the Intensive Case Management Program and the Rural Counselling and Treatment Teams.

Your file should only be accessed if the professional health care worker needs the information to provide care.

Information regarding Personal Health Information Protection Act, 2004 (PHIPA): Privacy of personal information is a concern for many of our clients. It is important that you know we will keep matters confidential as far as possible, but there are some limits. Our program operates on a team basis and we must be able to discuss matters with other clinical staff. Our clerical support team also has access to files. All staff are required to keep client information confidential.

The Community Mental Health Program staff must abide by the Personal Health Information Act, 2004. This act allows us to consult with your doctor, counsellors and other H.R.S.R.H. partners that make up your circle of care. Unless you clearly tell us not to, the provincial privacy law allows us to use and disclose your personal health information for reasons listed in the Personal Health Information Protection Act, 2004 (PHIPA). Information about this act is available upon request.

If you have requested that your personal information is not to be shared, there are situations/communications that supersedes this request. They are:

- We have reason to believe that you are a danger to yourself
- We have reason to believe that you are a danger to others
- We have reason to believe that a child under the age of 16 years is being abused or neglected or is at risk of being abused
- Disclosing a sexually abusive act by a Registered Health Professional
- The _____ Program – is in receipt of a court-ordered request of information with a subpoena.

Signature: _____

Date: _____

Witness: _____

Appendix B: Cognitive Behavioural Therapy Homework Assignments

MY GOAL FOR MOOD / ANXIETY GROUP

After 12 weeks of attending this group, I will know it has been worthwhile for me if I am able to -----.

Some examples of clients in other groups:

- get out and walk around my block 3 times per week
- start picking up the phone and answering it instead of letting it go on to messages
- organize my personal papers and begin paying bills again
- take a shower and clean teeth daily
- accept invitations from family members to go over to their house
- get dressed every day again and go out of my residence
- start playing with my children for 30 minutes 3x per week
- get outside in the fresh air every other day
- start reading again each night before bed

your goal needs to be reasonable and measurable... something that matters to you and would be a good sign to you that things are different. Often, goals related to ways you are currently procrastinating or avoiding are helpful to start getting you "unstuck?"

Vanessa Gorry 13-8-20 10:04 PM

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Action Schedule

Note: Grade activities M for Mastery and P for Pleasure

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
9-10							
10-11							
11-12							
12-1							
1-2							
2-3							
3-4							
4-5							
5-6							
6-7							
7-8							
8-12							

Anchoring in the Present

At least once per day, Practice anchoring yourself to the present by noticing at least one thing going on around you. This can be a sound you hear, something you see, or something you can physically feel (like your chair, a computer keyboard, a dish sponge). You can use you breath to help anchor yourself to the Present moment. The goal of this exercise is not to think about the meaning of what you notice, nor is it to try to understand your reaction to it. The purpose of this exercise is simply to practice paying attention to what is going on around you *right now*. Also record any thoughts, feeling (physical sensations), or behaviours that you may have noticed.

	What did you notice	How effective were you at anchoring your self in the present 0 - 10 (not at all) (extremely)
Sunday		
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		

