The Promotion of Psychosocial Well-being Through the use of Individual and Group Therapy in a Mental Health Centre

By

Judy J. Lightfoot

A Practicum presented to the Faculty of Graduate Studies in Partial Fulfillment of the Requirements for the Degree

Master of Social Work

Faculty of Social Work
University of Manitoba
Winnipeg, Manitoba

July 13, 2005

THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

*****

COPYRIGHT PERMISSION PAGE

The Promotion of Psychosocial Well-being Through the use of Individual and Group Therapy in a Mental Health Centre

BY

Judy J. Lightfoot

A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University of Manitoba in partial fulfillment of the requirements of the degree of

MASTER OF SOCIAL WORK

Acknowledgments

I would like to extend my gratitude and appreciation to the following people for their assistance and support during the course of my practicum:

To Tuula Heinonnen, for serving as my practicum advisor and committee chair. I have a deep respect for your knowledge and wisdom. Thank you for being a truly great role model and teacher. I also wish to extend my gratitude to you for your patience and support while working with me.

To Catherine Lambert, my practicum supervisor, for her time and guidance while I was completing my practicum and for the entire staff of the Dartmouth Mental Health Centre for welcoming me and for making me feel like a member of the team.

To Social Work Faculty member Brenda Bacon and to Dartmouth Mental Health Centre's Trilby Sylvain for both serving as members of my practicum committee. Thank you both for your time, your kindness, and for your contributions to my learning.

To my wonderful husband and partner Paul who is my rock and without whom I would have been lost over the past few years. Thank you for helping to keep me on track and for supporting me even when the challenges seemed insurmountable.

To my beautiful child Lainey who gave me a reason to smile every day without even knowing it.

To my mom whose nurturing influence has played a role in my desire to work with and help others.

And finally, to my dad. Dad you are the reason I am the person I am today. You taught me the value of hard work, and inspired me to do something good with my life and to make a difference for others. Because of you, I did not give up when faced with many challenges in the completion of this degree. Dad, I know you are proud of me. I dedicate this report to you and to the memory of a person I consider a great man and father.

Table of Contents

List of Tables

Abstract

This practicum was conducted at the Dartmouth Mental Health Centre in Nova Scotia where I served as a member of the multi-disciplinary treatment team. Clients treated at the Centre consist of adult outpatients who have been referred for mental health treatment. The treatment of depression and anxiety were emphasized in this practicum in both individual and group therapy contexts. For the group, improvement of self-esteem was emphasized. Evidence is outlined that supports the notion that offering therapeutic intervention to mentally-ill clients, including those presenting with depression and anxiety, can both help to improve clients' mental health and overall functioning. Clients treated in both group and individual contexts were primarily diagnosed as having depression and anxiety. The treatment modalities employed included both solution-focused and cognitive-behavioural approaches. Both approaches were employed with individual clients, whereas a cognitive-behavioural approach was employed with the group. This report outlines the interventions that took place and explains how data was collected and analyzed to provide an outcome review. The intervention outcomes were positive overall and indicated that the interventions helped to improve client's mental health. A review of my learning outcomes, recommendations for social work practice, and therapeutic limitations are discussed. In summary, this report presents learning related to institutionally-based social work practice, membership on a treatment team, and the use of solution-focused and cognitive-behavioural treatment modalities with individual and group therapy clients in a community-based mental health centre.

INTRODUCTION

This practicum examines the promotion of psychosocial well-being of mentally ill clients in a community-based mental health centre. Both individual and group treatments were employed, using a combination of solution-focused and cognitive-behavioural methods. As a member of the multi disciplinary treatment team for a period of six months, I examined the use of the above clinical interventions with clientele presenting primarily with clinical depression and anxiety.

Practicum Rationale

Adequate clinical and professional support for the mentally ill is a significant need in all communities. According to an official at the Canadian Mental Health Association, one in five Nova Scotians will be affected by mental illness at some time in their lives (CMHA Director, personal communication, 2001).

This practicum is relevant to the field of social work practice because a wide array of literature offers support for the positive role that clinical social workers can play in the lives of their clients (cf., Bywaters, 1986; Caputi, 1978; Tilbury, 1993; Weick, 1986). There is also much support for the use of group, solution-focused and cognitive-behavioural approaches with mentally-ill clients (cf., Beck & Weishaar, 1989; deShazer, 1991; Dolan, 1991; Durrant, 1993; Gitterman, 1982; Kok & Leskela, 1996; Reid, 1991).

Offering therapeutic intervention to mentally-ill clients can promote their psychosocial well-being, and help them to live and function optimally within their communities. In addition to promoting the well-being of clients, the interventions reviewed in this report provided me a rich and diverse learning experience in a well-established clinical environment.

Learning Goals of the Practicum

There were seven learning goals for this practicum. These goals included: (1) understanding how a community-based mental health practice operates and understanding the role it plays as a service provider in the community; (2) understanding what it means to work as a member of a multi disciplinary treatment team, with involvement all of the typical responsibilities of community-based clinical social workers at the Dartmouth Mental Health Centre; (3) developing a better understanding of the significance, effects and treatment of clinical depression and anxiety; (4) developing a better understanding of the uses and limitations of solution-focused, cognitive-behavioural and group approaches to the treatment of depression, anxiety and mental illness in general; (5) learning how to practice as a clinical social worker who employs solution-focused, cognitive-behavioural, and group therapy approaches with depressed and anxious clients in an effort to help improve their psychosocial well-being; (6) assessing the effectiveness of my therapeutic efforts with clients by using qualitative approaches to investigate the outcomes; (7) understanding how working in a clinical environment like the Dartmouth Mental Health Centre impacts on the practice of clinical social work and how social work perspectives in general are related to working in a clinical facility like the Dartmouth Centre.

LITERATURE REVIEW

Mental Health Care in Nova Scotia Past and Present

A parallel to our modern health care system was virtually unknown in the colonies of British North America in the early 1800's; in fact, hospitals were nearly unknown in Nova Scotia in the first half of the 19th century (MacDonald, 1996). People

who were unfortunate enough to become ill at that time were at the mercy of a very primitive medical system often based more on "superstition or outright quackery than on scientific medicine" (MacDonald, 1996, p.10).

Established in 1785, Halifax's 'Poor Asylum' was the only facility available to house Nova Scotia's mentally and physically ill at the time. The only persons who qualified were those who were seriously impoverished, and no treatment was provided to them (MacDonald, 1996). In 1829, Halifax's first medical clinic was established, and this too was directed toward serving only the poor (MacDonald, 1996). Despite much protest about the expenditure of public funds on health facilities for the poor, by the end of the 19th century, the Nova Scotia Government began to allocate more funds toward the health care of the general public (MacDonald, 1996). By the 1830's, Nova Scotian doctors began to call for the establishment of the first permanent hospital in their province, and as a result, the first general hospital was opened in 1859 (MacDonald, 1996). Meanwhile, dismal conditions at Halifax's Poor Asylum were also leading a call for a new facility to house and treat the mentally ill of Nova Scotia (MacDonald, 1996). Finally, in 1858, 'Mount Hope', Nova Scotia's Hospital for the Mentally Ill was opened (Purdy, 1976). 'Mount Hope' was later renamed The Nova Scotia Hospital. At its conception, the Nova Scotia Hospital was designed to accommodate approximately 300 inpatient residents, though by the early twentieth century the actual number had exceeded five hundred (Purdy, 1976).

By the mid nineteenth-century, little was known about the causes of mental illness, yet at the same time attitudes toward such illnesses were changing and so were the methods of treating them (MacDonald, 1996). At the new Nova Scotia Hospital,

mental illness was now viewed as an illness rather than as an "affliction of divine punishment on the immoral or sinful" (MacDonald, 1996, p.40). As a result of this new perspective, moral treatment of the mentally ill became the focus of practice at the Nova Scotia Hospital (Purdy, 1976).

The 1970's brought about changes in the model of care for the mentally ill as the focus turned from inpatient care to community-based outpatient care (Purdy, 1976). As a result, the demand for services for the mentally ill in communities throughout Nova Scotia increased, and the number of hospitalized patients at the Nova Scotia Hospital began to decrease (MacDonald, 1996). In the early 1990's, the proportion of outpatients served by The Nova Scotia Hospital finally exceeded the number of inpatients, and this trend has become more pronounced in the years since (MacDonald, 1996).

Today one of the main goals of the Nova Scotia Department of Health is to help Nova Scotians to function at optimal levels and to achieve a state of well-being (Nova Scotia Health Council, 2001). In addition, the Working Group on Mental Health (1992) has stated that the Nova Scotia Government is committed to offering a full continuum of care to clients ranging from disease prevention and health promotion to treatment, referral and rehabilitation services. The Nova Scotia Hospital, with its full complement of inpatient and outpatient services, continues to serve mentally ill residents of Nova Scotia as it works toward meeting these goals for its service consumers.

Hospitalization Versus Outpatient Care

In recent years, evidence has demonstrated that many mental illnesses can be treated more effectively and in a less costly manner through the provision of community-based outpatient services (Kiesler & Sibulkin, 1987). In addition, Weithorn (1988), has

demonstrated that community-based outpatient programs routinely offer clients a higher level of positive outcome, without many of the physical and psychological risks that can be associated with inpatient settings. Other researchers have noted that there are no studies that demonstrate the superiority of inpatient services over those of community-based outpatient care (e.g., Butts & Schwartz, 1991; Schwartz, 1989). Thus, with overwhelming support for community-based outpatient services, some researchers have begun to strongly advocate for a decrease in inpatient services (Dougherty, 1988; Saxe, Cross, & Silverman, 1988).

Carling (1995) offers a concise way of thinking about the benefits of community-based outpatient care for the mentally ill. According to Carling (1995), with a community-based support system clients need not "languish for the rest of their lives in hospitals" because with quality community-based supports, clients can "actually have lives" and some may be able to depart the mental health system permanently (p.10).

Today there is a great shortage of adequate mental health services in rural Nova Scotia, and as a result, many individuals are forced to travel great distances to receive appropriate treatment for their mental illnesses (Working Group on Mental Health, 1992). According to the Working Group on Mental Health report of 1992, two-thirds of Nova Scotians with clinical depression do not receive treatment due to the scarce availability of services, particularly in rural communities. Werner and Tyler (1993) argue that if current funding was allocated more toward community-based outpatient services rather than to inpatient care, more individuals requiring treatment would have appropriate access to needed services. Despite its shortcomings, the Nova Scotia Department of Health is aware of the needs of the mentally ill in Nova Scotia, and as

such has begun to focus its attention on helping clients to remain in their communities with their social connections intact, and on increasing the provision of mental health services within communities (Working Group on Mental Health, 1992).

The Institution

The Nova Scotia Hospital is the largest regional psychiatric hospital in the Atlantic Provinces (Nova Scotia Hospital, 1992). Since its founding in 1858, the hospital has developed into a fully-accredited institution providing assessment and treatment to adults experiencing mental health problems. The Nova Scotia Hospital campus, located in Dartmouth, is comprised of eight buildings on 46 acres along Halifax Harbour (Nova Scotia Hospital, 1992). In addition to providing inpatient and outpatient care to the mentally-ill, the hospital is also a teaching facility closely affiliated with Dalhousie University in Halifax.

Institutional Service Overview

The Nova Scotia Hospital provides a wide variety of both inpatient and outpatient services and community outreach that caters to mentally-ill residents of the province. Hospital services are staffed by multi-disciplinary teams of professionals selected from the areas of: psychology, social work, psychiatry, occupational and recreational therapy, nursing, general medicine, dentistry, pharmacy, dietetics, education, chaplaincy and support staff (The Nova Scotia Hospital, 1992).

Community outreach is a relatively new focus for the Nova Scotia Hospital (Purdy, 1976). Community outreach services provided by the hospital include a free telephone health information line, and inter-disciplinary professionals are available for consultation or for conducting presentations within the community.

Inpatient services currently provided by the hospital include: assessment services, short-stay treatment units, an acute adult unit, geriatric psychiatry units, an adolescent unit, long-term care and rehabilitation units, units for the severely mentally handicapped, and a forensic unit (Nova Scotia Hospital, 1992).

Outpatient services at The Nova Scotia Hospital serve new, recently discharged and ready-for-discharge clients of the hospital who are able to live in the community while continuing to receive treatment for their mental illnesses. Outpatient services include: a day hospital, day care services, day and evening programs, and community-based mental health centres where clients can be assessed, receive individual or group treatment, after-care follow-up, and relapse-prevention (Nova Scotia Hospital, 1992).

The hospital operates a total of five mental health centres situated throughout Eastern Nova Scotia; and of these, the Dartmouth Mental Health Centre is the largest.

The Dartmouth Mental Health Centre

The Dartmouth Mental Health Centre (DMHC), located on the campus of the Nova Scotia Hospital, and its three rural satellite clinics, serve an average of 16,000 clients each year (Nova Scotia Hospital, 1992). Staff at the Dartmouth site alone see clients for an average of 28,000 visits per year. Referrals to the Centre are accepted from a number of sources including: family physicians, community agencies, family members and the clients themselves (see Appendix A for a sample community referral form). Referrals also come from Nova Scotia Hospital inpatient services themselves (see Appendix B for a sample internal referral form). Clients must be at least 17 years of age, and must reside in the Dartmouth City catchment area to qualify for service at the Dartmouth Centre.

The mandate of the Dartmouth Mental Health Centre is to provide community-based mental-health services to individuals and families who are affected by serious mental illness (Nova Scotia Hospital, 2001). An additional mandate of the Centre is to work with other agencies, service providers and the community to promote mental health and to address issues related to mental health (Nova Scotia Hospital, 2001).

The interdisciplinary team at the DMHC serves clients in a number of ways depending on the characteristics and needs of individual clients. Services which are offered include: mental health assessments, individual and group therapy, psychosocial rehabilitation, consultation, family and community education, and referral to other mental health services. According to the principles outlined in the centre's Policy and Procedures Manual (1991), all of the services provided by the Dartmouth Mental Health Centre are to be community-based, comprehensive, coordinated, and are to promote a continuity of care.

The treatment team approach at the Dartmouth Centre.

According to Salem (1990), mentally ill clients are a heterogeneous group representing a diverse range of needs and preferences for therapeutic service delivery. The clients treated at the DMHC do indeed represent a very heterogeneous grouping of individuals presenting with unique and diverse treatment needs. Salem (1990) notes that the most effective services that can be provided are those which encourage diversity of service delivery, combined with a variety of resource alternatives. A multi-disciplinary approach to service delivery, such as the one at the DMHC, should therefore offer the diversity of services and resources that Salem advocates for. In her work, Rice (2000) has also offered support for a multi disciplinary approach by demonstrating that a

collaborative form of practice is correlated with more successful client outcomes, better continuity of care, fewer care provision costs, increased job satisfaction, and a better defined sense of professional identity. In addition, in their child and adolescent study, Jemerin and Philips (1988) have found that proper coordination of services can also help to decrease recidivism and rehospitalization of mentally-ill clients. Werner and Tyler (1988) note that this may be true because by moving between agencies and services, clients may lose gains made in one area as new approaches and goals are implemented without proper linkage with those from previous services.

The Dartmouth Mental Health Centre's Policies and Procedures Manual (1991) states that psychiatrists, psychologists, social workers, nurses and occupational therapists should comprise the multi-disciplinary team approach at the Centre. Today all of these disciplines are indeed represented within the Dartmouth Centre, and these professionals jointly provide assessment, treatment and follow-up care for the Centre's clients. In addition, to promote continuity of care and because a client's degree of mental illness may fluctuate and thus require hospitalization, the treatment team at the Dartmouth Mental Health Centre maintains close contact with the hospital's inpatient service staff.

The Short-Term Intervention Team (STIT), otherwise known as the Early Response Team, is a multi disciplinary mini-team within the DMHC. The STIT is responsible for providing services to clients who have been referred upon discharge from the short-stay inpatient unit of the Hospital, or who have been otherwise referred for short-term treatment as a result of being in crisis. The STIT is comprised of a psychiatrist, two social workers, and a nurse. Objectives of the STIT are to provide immediate supportive care, to assess and evaluate the client's status, to attempt to restore

the client's mental health to the previous level of functioning, to work with other health professionals in the community towards maintaining a state of client wellness, and to utilize interventions which are conducive to a limited time frame (Dartmouth Mental Health Centre Policy and Procedures Manual, 1991).

Types of mental illness treated at the Dartmouth Centre.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994) defines mental illness as "a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom" (p. xxi). The Nova Scotia Government's Working Group on Mental Health (1992) defines mental health treatment as "encompassing mental well-being and mental health problems including disorders, in the context of the relationship between the individual, their community and the services and systems designed to support optimal mental health in the context of the individual's family and local community" (p.1). This latter perspective takes individual empowerment and the role of a continuum of community-based services and supports into account. Though the staff at the Dartmouth Centre do use the DSM-IV as a guideline for their practice, they also strive toward promoting the well-being of their clients by employing a community-based approach to service delivery.

A wide variety of mental illnesses are treated at the DMHC, varying from severe chronic forms of illness to minor acute forms. The most common conditions treated at the Centre include: schizophrenia, bipolar disorders, depression, generalized anxiety, grief, abuse issues, phobias, and early psychosis. In addition, according to the Nova

Scotia Hospital Community Teams Referral Form (see Appendix A), referrals are also accepted at the Dartmouth Mental Health Centre for clients who present with issues related to suicidal or homicidal thoughts, sleep or appetite disturbances, substance abuse, anger or aggressive behaviour.

Forms of treatment at the Dartmouth Centre.

Because of the wide variety of professionals who practice at the Dartmouth Centre, therapeutic interventions provided at the Dartmouth Mental Health Centre vary widely. Physical therapies, including the use of medication and electro-convulsive therapy, are employed as needed. Psychologically-based therapies are commonly used at the Centre as well, including: general counseling, supportive therapy, psychotherapy, group therapy, behavioural therapy, couple and family therapy (Dartmouth Mental Health Centre Policy and Procedures Manual, 1991). In addition, one clinician at the Centre is assigned weekly to assume the role of 'Clinician-on-Duty', humorously known as the 'Cod'. It is the responsibility of the 'Cod' to provide services to any of the Centre's clients who may arrive at the Centre in crisis during regular business hours without a prior appointment. In addition to the therapies that are provided at DMHC, complete psychological assessments are conducted by the staff as needed.

Treatment Modalities Implemented in this Practicum

Solution-Focused Therapy

In modern times with extensive caseloads, decreasing funding, and limited time, it is not uncommon for therapists to employ brief therapy approaches in their practice. With a limited number of sessions available "clients cannot afford to be passive or to gradually explore their concerns, feelings, past and present experiences...The process

requires rapid identification of and attention to the primary area of greatest current concern" (Preston, Varzos & Liebert, 1995, p. 9).

DeShazer and colleagues developed solution-focused therapy as a way of helping clients to meet their goals in a minimum number of sessions (deShazer et al., 1986). According to Kok and Leskela (1996), brief therapies like solution-focused therapy are gaining acceptance by therapists as an effective and efficient way of treating mentally ill outpatients. Through their research, however, Kok and Leskela (1996) have also demonstrated that solution-focused therapy can also be a valuable treatment modality within psychiatric inpatient settings. Further, deShazer (1991), Dolan (1991), Durrant (1993) and O'Hanlon and Weiner-Davis (1989) have all shown that solution-focused techniques can be an effective treatment modality in a wide variety of treatment settings with a wide variety of client issues. Greene, Lee, Trask and Rheinscheld (2000) have even gone so far as to claim that a solution-focused approach is the best known treatment of choice for many clients in crisis. In an effort to seek empirical evidence supporting the use of solution-focused therapies, Gingerich (2000) conducted a review of all of the English language empirically-controlled outcome of studies (n=15) that had been conducted up to that time which demonstrated the effectiveness of a solution-focused therapeutic approach. Gingerich (2000) concluded that all of the studies which were examined demonstrated some measure of support for the use of a solution-focused treatment approach, but Gingerich also noted that more studies need to be conducted before it can be definitively concluded that solution-focused approaches are effective.

Based upon the wealth of evidence then, it is not surprising that solution-focused

approaches have gained such popularity in modern clinical practice. Solution-focused therapists assume that their clients want to change, that they have the ability to envision change and that clients are already doing some of the things that can lead to the positive change that they desire in their lives. The primary task of solution-focused therapy is to help clients to imagine how they would like their lives to be different, and what they will need to do to achieve that goal. In other words, solution-focused therapy is undertaken when client and therapist work together to identify therapy goals and to seek solutions to problems based on what the client is already doing that works. With solution-focused therapy, the client is asked to imagine his or her future without the identified problem, then to identify solutions rather than simply focusing on the problem. Once the problem has been identified, the client can begin to generate a "tool kit" for coping with the problem in the future (Preston, Varzos & Liebert, 1995, p.10). Contained within this kit may be: skills for interpersonal coping, more effective problem-solving and conflict-resolution skills, and ways of reducing or managing anxiety, sadness, moodiness, anger or other emotions (Preston, Varzos & Liebert, 1995). Having these tools should help clients to feel a greater sense of control over their lives, which in turn, should help clients to feel more empowered. According to Preston, Varzos, and Liebert (1995), "the goal of brief therapy is not to cure, but to provide support, to facilitate growth, and to increase effective coping" (p.10). In their work, Walter and Peller (1992) also remind us that small change can lead to bigger change, so even the most modest therapeutic gains can serve as the impetus for greater change in a client's life even after formal interventions have concluded.

Walter and Peller (1992) note that one of the major advantages of the solution-focused approach is its positive focus. By focusing on the solution rather than on the problem, positive change is facilitated, and this positive focus also contributes to building therapist-client rapport (Walter & Peller, 1992). Salem (1990) believes that therapeutic strategies which encourage client involvement, ownership and control help to empower mentally-ill clients, and thus promote their psychological well-being. In addition, because solution-focused therapy asks clients to imagine their lives without identified problems, an expectation of positive change is created which can also contribute to the development of a positive therapeutic experience for the client. In fact, deShazer (1984) has stated that change is inevitable for clients, and that all clients want to change. By commencing therapy in such a constructive and optimistic way, it is not difficult to imagine how a client can learn to harness his or her life and to gain control over problems through the use of a solution-focused approach.

According to Gingerich (2000), the main components of a solution-focused approach are: a search for pre-session change, the setting of goals, the use of specialized forms of questioning such as miracle and scaling questions, identifying times when the client is not experiencing the 'problem", taking time to think about the progress of a solution construction and to prepare feedback for the client, and providing compliments and homework assignments. There are several specific techniques employed within the scope of solution-focused therapy. The "Miracle Question" is one commonly-used technique in which clients are asked to describe how life would be different if they woke up one morning to discover that they no longer had a particular problem (deShazer, 1988,

p.5). Scaling questions are also often employed in solution-focused therapy. Scaling questions ask clients to rate how things are for them today on a 10-point scale, where, for example, ten represents their ideal status, and 1 represents their worst possible state. Scaling questions help to break down any of the client's vague goal and problem statements into forms that are more constructive and useful for the therapeutic process. In addition, it is not uncommon in solution-focused therapy for the therapist and client to seek to identify exceptions to the problem, which can later be utilized as possible solutions to the clients' problem. Finally, Gingerich (2000) notes that it is common at the end of a solution-focused therapy session to compliment the client and to assign homework to the client.

Carling (1995) believes that the best therapeutic services for the mentally-ill members of our communities are those which are voluntary, empowering and respectful to clients. By using a solution-focused approach, clients are empowered by being invited to take an active role in resolving their own problems, and clients are treated with respect when the therapist assumes that the client has the desire and ability to make positive change a reality. Because a solution-focused approach takes these and other important factors into consideration, the value of the solution-focused approach is apparent, and was therefore employed within this practicum.

Solution focused therapy with anxiety and depression.

In their study which examined the effectiveness of a solution-focused approach in the treatment of depression, Johnson and Miller (1994) found that using a solution-focused therapeutic approach resulted in a significant improvement in the client's

depression. Johnson and Miller (1994) expanded on their findings by also suggesting that using a solution-focused approach with depressed clients can shorten the amount of time needed to treat the client. These results were replicated in another study that examined the effectiveness of solution-focused approaches for treating common outpatient mental health problems including depression and anxiety. In this study it was found that not only did the clients experience a significant improvement in their depression and anxiety, but these outcomes were demonstrated to result more quickly than when other more traditional therapeutic approaches were used (Lambert, Okiishi, Finch, & Johnson, 1998).

The study conducted by LaFountain and Garner (1996) also provides evidence for the efficacy of a solution-focused approach with both depression and anxiety. They found that clients who were in solution-focused groups tended to report higher levels of self-esteem and better feelings and attitudes about themselves. The same subjects also reported being better able to cope with emotions such as anxiety and depression. LaFountain and Garner interpreted this finding as evidence that solution-focused therapy helps clients to focus on taking action toward the solution of their problems, rather than dwelling on the feelings associated with their troubles. This theory is supported by the work of Sharry, Darmody and Madden (2002) who found that even with suicidal clients, solution-focused approaches helped clients to identify their strengths and coping skills and helped them to envision a more positive future.

Cognitive-Behavioural Therapy

In his review of cognitive-behavioral therapeutic approaches, Schwartz (1982)

concluded that there now exists sound empirical evidence to support the use of cognitive-behavioural therapy with mentally-ill clients. Cognitive-behavioural therapy is based on the idea that individuals need to process information in an adaptive way in order to function normally (Beck & Weishaar, 1989). Treatment therefore is centered on the notion that cognitive change can translate into desired emotional and behavioural change.

Mental processing tends to be an automatic process, and with such a process, thinking is not always rational, logical, or necessarily conducive to the promotion of a healthy mental state. According to Beck and Weishaar (1989) people are more likely to engage in unhealthy mental processing when life situations and certain dysfunctional attitudes converge. For example, if a person feels vulnerable to cancer due to his or her family history, and then a sibling becomes ill with cancer, that person may then become anxious in response to any symptom which is known to be associated with cancer, whether or not the disease is actually present. In their work, Beck and Weishaar (1989) also suggest that certain personality characteristics and sets of beliefs can predispose people to psychiatric disorders but that at the same time it is important to remember that cognitions do not cause mental illness, they are instead a part of the illness itself. In other words, when we are depressed or anxious we tend to think in unhealthy and unproductive ways and when we think in negative and unhealthy ways, we tend to become depressed and anxious.

When individuals are experiencing psychological distress, they tend to process their world in more simplistic terms, and this can lead to errors in reasoning called cognitive distortions (Beck & Weishaar, 1989). Cognitive distortions appear to play a

significant role in a number of mental illnesses including: depression, anxiety, hypomania, panic disorder, agoraphobia, phobias, paranoid states, obsessions and compulsions, suicidal behaviour, and anorexia nervosa (Beck & Weishaar, 1989).

According to Dobson and Block (1988) cognitive-behavioural therapies are based on the assumptions that: "cognitive activity affects behavior", "cognitive activity may be monitored and altered", and "desired behaviour change may be affected through cognitive change"(p. 4). The aim of cognitive therapy, therefore, is to modify the dysfunctional assumptions that clients have about themselves and their world in an effort to reduce their psychological distress. Overall, cognitive therapy is directed at correcting faulty information-processing and toward altering the dysfunctional beliefs and assumptions which maintain unhealthy behaviours, emotions and states of mental illness.

Like solution-focused therapy, cognitive therapy requires the collaborative effort of both client and therapist to be effective. In this collaborative relationship, behavioural and verbal techniques are used to identify and systematically challenge the client's dysfunctional beliefs. In cognitive therapy, exercises are used to help clients to practice and integrate healthier and more adaptive ways of mental processing. To initiate positive change in how clients think, their beliefs are logically examined and tested through behavioural experimentation. The desired cognitive change occurs when clients modify their negative assumptions to better fit their new therapeutic experiences. Specific techniques employed in cognitive-behavioural therapy focus on coping skills, on problem-solving and on restructuring cognitions.

According to researchers, the change that occurs through cognitive therapy is

evident in a client's voluntary thoughts, involuntary thoughts, and assumptions (Beck & Weishaar, 1989), and this in turn is evidenced through a change in the client's behaviour (Dobson & Block, 1988).

Several authors have concluded that cognitive-behavioural therapy is an effective form of treatment for many mental illnesses (Beck, Rush, Shaw & Emery, 1979; Beck & Weishaar, 1989; Freeman, Pretzer, Fleming & Simon, 1990; Lindsay, Gamsu, McLaughlin, Hood & Espie, 1987; Scott, Williams & Beck, 1992). In addition, Beck & Weishaar (1989) believe that the reality-testing component of cognitive therapy helps to make it an effective form of treatment for many mental illnesses.

A large proportion of the clients treated at the Dartmouth Mental Health Centre present with many distortions in how they perceive and interpret their worlds. Because there is good evidence to support the efficacy of cognitive-behavioural approaches in altering these distortions, a cognitive-behavioural approach was also employed within this practicum.

Cognitive-behavioural therapy with depression and anxiety.

Cognitive-behavioural therapy is based on the idea that individuals need to process information in an adaptive way in order to function normally (Beck & Weishaar, 1989). In his book, Beck (1976) states that cognitive therapy holds that dysfunctional thoughts are largely responsible for the alterations in mood, behavior and functioning that characterize depression. If this is true, then the dysfunctional thoughts that characterize depression can be the focus of a clinical intervention aimed at resolving a client's depression. Cognitive-behavioural therapy does, in fact, aim to correct faulty

information-processing and the dysfunctional beliefs and assumptions which maintain unhealthy behaviours, emotions and states of mental illness like depression.

In his chapter on the use of cognitive therapy with depressed clients, Perris (1989) summarizes the cognitive distortions that are common amongst depressed clients. He notes that depressed clients tend to view themselves as unworthy, inadequate and defective and that they blame themselves for things that have gone wrong in their past. Perris (1989) adds that depressed clients tend to think of themselves as being socially undesirable and that they don't feel that they fit into their environment. Further, Perris (1989) also notes that depressed clients tend to view their future as unpromising and that they tend to hold ingrained dysfunctional beliefs about themselves. The earlier work of Beck (1976) supports that of Perris by suggesting that people who are depressed tend to pay attention to parts of a situation rather than being aware of the whole, and that depressed persons tend to magnify the negative things in their lives and minimize the good. Beck (1976) notes that depressed clients also tend to draw conclusions without having facts to support them, see things as all good or all bad, and they tend to overgeneralize, personalize and blame themselves for everyday mishaps. It is not difficult to imagine how possessing pervasive and unchecked thoughts like these can lead to feelings of apathy and hopelessness, and ultimately to 'depression". In theory then, a therapeutic intervention like cognitive-behavioural therapy that is directed at helping clients to learn to recognize and replace their negative, unproductive and often irrational thoughts with more healthy and productive ones, should have a positive influence on depression. This theory is supported in the chapter on cognitive therapy with depressed

adults, where Perris (1989) states that cognitive therapy has been demonstrated to be as effective in treating moderate to severe depression as are the most commonly used antidepressant medications.

It is normal for individuals to feel a measure of anxiety or stress in specific situations, and in the proper amounts some stress can even serve to motivate the individual. However, when the level of anxiety or stress becomes too great, does not fit with what would be considered normal under the circumstances, and is impairing the person's ability to cope and function in everyday life, the person may be experiencing an anxiety disorder. When uncontrolled, Freeman and Simon (1989) suggest that anxiety can have a disabling effect on an individual's social, personal or occupational functioning. A prime example of this is the agoraphobic individual who confines himself to his home in an effort to avoid a perceived threat that exists outside the confines of his residence. In doing this, the agoraphobic perpetuates his illness, and seriously inhibits his ability to live a normal and healthy life in the social, occupational and personal domains. Though the expression of anxiety symptoms is manifested differently in different people, some combination of emotional, behavioural, physiological and cognitive symptoms are common (Freeman & Simon, 1989).

Freeman and Simon (1989, pp.348), suggest that there are "real", "neurotic" and "moral" types of anxiety. According to Freeman and Simon (1989, pp. 348) anxiety that is "real" develops in response to real danger, anxiety that is "neurotic" is idiosyncratic, irrational and dysfunctional, and anxiety that is "moral" may result from the violation of personal, religious or societal rules of conduct. According to Freeman and Simon (1989),

anxiety is a reflection on a person's perception of danger or threat. Campbell (1981, pp. 42) states that "fear is a reaction to a real or threatened danger, while anxiety is more typically a reaction to an unreal or imagined danger". In fact, according to the cognitive model of anxiety, our perceptions, thoughts, and beliefs do play a significant role in the development and maintenance of anxiety (Freeman & Simon, 1989), and as such would be appropriate for a therapeutic intervention like cognitive-behavioural therapy that seeks to transform or replace dysfunctional perceptions, thoughts and beliefs.

Cognitive-behavioural therapy has, in fact, been identified as an effective treatment of many mental health disorders including both depression and anxiety (Nathan & Gorman, 2002; Warren, McLellarn & Ponzoha, 1988). Page & Hooke (2003) and Wallis (2002), concluded their studies by noting that patients who were treated with cognitive behavioral therapy showed improvements in their levels of depression and anxiety and they both added that these results were maintained in a 3-month follow up.

Further support for the efficacy and lasting results of cognitive-behavioral therapy for depression and anxiety is evidenced in the work by Warren, McLellarn and Ponzoha (1988). In their work, Warren and colleagues have demonstrated that not only is cognitive-behavioural therapy an effective mode of treatment, but that the gains in these areas appear to be maintained once a 6-month follow up has been conducted.

All combined, there is ample evidence to suggest that cognitive-behavioural interventions can be an effective and appropriate treatment for both depressed and anxious clients. As a result, I opted to employ cognitive-behavioural interventions in my work with clients at the Dartmouth Mental Health Centre.

Group Therapy

The research and literature on group therapy provide much evidence to support its use in a variety of settings, and addressing a wide variety of client troubles. For example, Gitterman (1982) suggests that a group-style therapeutic intervention provides participants an opportunity to experience what he terms a "mutual-aid system" in which common concerns and ideas for resolution are shared between participants (p. 7). Such a system of mutual aid can allow participants an opportunity to learn that their circumstances are not so unusual or unique because there are others who share their experiences, and this in and of itself can be empowering for clients.

In addition to providing mutual support, the group may afford an opportunity for individual members to be challenged to further examine their perceptions or behaviours. Gitterman (1982) also suggests that a group atmosphere encourages the examination of adaptive and maladaptive perceptions and responses, and it allows for new ones to be developed and practiced. As participants get to know one another and to begin to draw support from the group, they are able to begin healing by drawing upon the integrated strength and potential of the group as a whole.

In his book, Reid (1991) offers a comprehensive review of the many advantages of group therapy. According to Reid (1991) the advantages of group therapy are that it creates an opportunity for clients to: instill hope, develop better self-understanding, learn through imitation and interaction, learn that their problems are universal, test their reality, be accepted, be able to self-disclose, experience altruism, and seek guidance. In considering the many apparent advantages of group therapy, it is not surprising that this

approach was also selected as a component of my learning in this practicum.

In planning for a group, it is important to consider how the group will be composed. Gitterman (1982), for example, feels that a group's composition can define how it will develop and progress. Groups which are composed of individuals with common backgrounds or personalities or behaviour tend to be "stable and supportive", and also tend to promote a sense of group identity and cohesion (Gitterman, 1982, p. 14). In addition, persons who view themselves as being completely different from the rest of the group may find the input of group co-members to be inapplicable in the context of their own lives. Yet despite the support for homogeneity, Gitterman (1982) also notes that such groups may lack diversity and vitality, and recommends a more heterogeneous sample of group participants. If group members are all too similar, for example, they may be unsuccessful at challenging one another because they may all be coming to the group with the same perspectives, opinions and experiences to begin with. Some group diversity is necessary for challenging the status quo, for creating the necessary tension for change, and for providing models for alternate attitudes and behaviours (Gitterman, 1982). Based on the evidence then, it seems that the most optimal group composition is one in which clients with common interests and similar backgrounds but varied perspectives, opinions and experiences come together to work toward a common goal, such as improving their self-esteem or becoming more assertive.

Therapy groups can be subdivided into closed or open types. The more traditional, closed group is of limited duration and is not open to the entry of new members once begun. The less common, open type is of an on-going nature and

departing members are often replaced by newcomers. Such an approach offers a degree of flexibility for the admittance of new clients to the group; however, open groups are limited in that the group is not free to develop stable cohesive relationships among members, and the long-term nature of open groups may threaten to erode the motivation and purpose of its members (Gitterman, 1982).

Group leadership is another important factor to consider when planning a group. According to Reid (1991), a group leader should exhibit warmth and respect for the group members, should feel empathy, should be concrete and genuine, should offer self-disclosure as appropriate, and should be an active listener. The responsibilities of the group leader are to guide the group's interaction, to consolidate and re-frame session content, and to support and confront group members when necessary or appropriate (Reid, 1991).

Therapeutic groups are often led by a pair of co-facilitators. However, there can be both positive and negative aspects associated with such an arrangement. According to Gitterman (1982), for example, co-leadership can reflect a facilitator's discomfort or anxiety about working with a particular group. Gitterman (1982) also notes that co-leadership can be an uneconomical way of providing service to clients. Further, problems can arise when different workers unsuccessfully attempt to meld their personal styles and characteristics into a single approach which will promote the goal attainment of the group. Positive co-leadership is therefore based upon mutual accountability, cooperation, and shared work. This can be accomplished when leaders' roles and responsibilities are clearly outlined prior to sessions. In addition, the variety of skills and

expertise available through co-leadership can provide clients a more integrated and diversified experience than may be available from a single leader.

The use of cognitive-behavioural approaches with groups.

Many different therapeutic approaches can be utilized with groups. Cognitive-behavioural approaches are often employed because cognitive behavioural group therapy has been identified as an effective treatment of many mental health disorders including depression and anxiety (Warren, McLellarn & Ponzoha, 1988). Wessler and Hankin-Wessler (1989), suggest that the strengths of individually-focused cognitive therapy, as discussed earlier in this thesis, also apply to the treatment of groups of individuals.

Page and Hooke (2003), conducted a study which examined the effectiveness of cognitive behavioural therapy with groups of inpatients and outpatients of a psychiatric hospital who had been diagnosed as suffering primarily from depression and anxiety. Through their work, Page and Hooke (2003), demonstrated that the levels of anxiety and depression in both groups of patients improved significantly over the course of the program and their 3-month follow up showed that the treatment gains had been maintained post-treatment. In the same study, Page & Hooke (2003) also demonstrated that the therapeutic benefits to the out-patient anxiety levels continued to accrue post-treatment. Perhaps of even greater interest in regards to the present report, they also found that the patients treated with group cognitive-behavioural therapy also showed higher levels of self-esteem than they had pre-treatment (Page & Hooke, 2003).

Further support for the efficacy and lasting results of cognitive-behavioral therapy is evidenced in the work by Warren, McLellarn and Ponzoha (1988) where results

indicate that not only is cognitive-behavioural therapy an effective mode of treatment with depression and anxiety, but the gains in these areas appear to be maintained after a 6-month follow up has been conducted. Taking into consideration the wealth of support for the use of cognitive-behavioural methods with groups, I chose to integrate a cognitive-behaviourally focused group into this practicum.

Relevance to Social Work

Social Work with Mentally Ill Clients

According to Tilbury (1993), social workers in the mental health field aim to "reduce pain, relieve stress, offer practical services, bring in resources, restore social functioning, promote growth and development, speak up for the weak and powerless, protect the vulnerable, and help people take control of their own lives" (p. 33). Yet despite the many important roles that social workers can play in the lives of their mentally-ill clients, some social workers feel that their mission should instead be to advocate for social justice, and that the mental health field should be viewed as being outside the realm of social work (Dean, 1998). At the same time, others feel that rather than removing themselves from the field of health care, social workers should instead expand their roles within the system (Bywaters, 1986; Caputi, 1978; Weick, 1986).

Regardless of differences of opinion about whether or not social workers should play a role in the mental health field, many modern social workers feel that they play an important role in promoting the mental health and general well-being of their clientele. In fact, Erickson and Erickson (1992) provide an overview of the many important roles that social workers can play in the health field, and they note that more social workers

practice within the health field than in any other area. Bracht (1978) feels that social workers are important elements within the health field because they offer a unique service which takes the physical, social, psychological, and environmental needs of clients into consideration when offering treatment or intervention to clients. Few if any other professions take so many factors into consideration when planning or implementing interventions for their clients. It is perhaps this quality which makes social work such a valuable component of services to the mentally and physically ill members of our communities.

PRACTICUM PROCESS AND SUPERVISION

Structure of the Site

The Dartmouth Mental Health Centre (DMHC) was chosen as the practicum setting for a number of reasons. The DMHC is an accredited teaching facility closely affiliated with the Nova Scotia Hospital which itself has an extensive history of providing high quality supervision and learning experiences to students. Staff at the DMHC were very welcoming and seemed confident in their ability to offer me a quality clinical learning experience.

The DMHC operates under a community-based service provision model, and utilizes a multi disciplinary team approach. Services at the DMHC are based upon the notion of respect for the client and the client's ability to seek out and initiate positive change in an effort to arrive at or maintain a state of psychosocial well-being.

Pre-Practicum Preparations

To prepare me for service at the DMHC, I was expected to participate in a full-

week orientation to the Nova Scotia Hospital. This orientation included overviews of various mental illnesses and forms of treatment, as well as information about policies and procedures of the hospital itself.

Prior to beginning the practicum, I visited the DMHC regularly to observe group, assessment and individual therapy sessions at the invitation of the supervisor, in order to become familiar with the responsibilities of social workers at the Centre. These visits also provided me an opportunity to become familiar with the complete staff, policies and procedures at the DMHC prior to formally beginning the practicum.

Practicum Outline and Duration

The duration of the practicum was initially expected to be the equivalent of three months of full-time service, but by the time it was completed I had actually spent approximately double that amount of time at the clinic. Specifically, I was on-site at the Centre from 8:30 am- 4:30 pm weekdays from May 11, 2001 to October 31, 2001. While conducting the practicum, I met with my practicum supervisor, Catherine Lambert MSW, for weekly supervision to discuss my progress and contribution to the DMHC.

Specifically, my practice at the DMHC was as part of the Short-Term Intervention team described earlier. As such, I was responsible for the intake of new clients on a rotating basis, and for conducting initial assessments and referrals of new clients. In this capacity, I initially shadowed and assisted my immediate supervisor in conducting intakes and assessments until I had developed competence in conducting these activities independently. Once conducting assessments independently, I was expected to fully assess no fewer than two new clients each week. It should be noted that assessments at the Centre are of both long and brief types. Brief assessments, which

typically take an hour to complete, are those which are conducted for clients who have been previously treated at the Centre within the past year (see Appendix C for a sample brief-assessment form). Long assessments, which are done more frequently, are for clients who have either never been treated at the Centre, or who have had no contact with the Centre for at least a full year (see Appendix D for a sample long assessment form). Long assessments typically take from between one and a half to two and a half hours to complete.

As a member of the Short-Term Intervention Team, I was responsible for conducting short-term individual therapy with clients in an effort to help them establish a suitable level of functioning or state of well-being. In accordance with existing practices at the DMHC, therapy sessions with individual clients were held for one hour weekly unless the needs of the client warranted more or less frequent sessions. In all, I provided individual treatment to a total of fourteen clients, though an average of four to seven individual clients were treated by me in any given week.

In addition to working with individual clients, I served as co-facilitator for a group of eight clients who met on a weekly basis. Prior to each session, the co-facilitator and I met to discuss and review plans for upcoming sessions, and prepared any materials that would be needed for such sessions. After each individual group therapy session, I was responsible for compiling post-session data which recorded the number of group members who were present for sessions as well as specific information on each client. This information was later entered into the personal files for each of the clients at the Centre. In addition, I was responsible for collecting and compiling session evaluation forms that the clients were asked to complete at the end of session each week.

As part of the practicum learning experience, I participated in weekly, bi-weekly and monthly staff meetings. I participated in weekly team meetings with staff on the Short-Term Intervention Team and assisted in reviewing all of the new referrals and cases which were treated within the previous week. These meetings provided myself and colleagues an opportunity to consider diagnostic questions, to exchange information, and to address case management difficulties that had arisen during the course of treatment. On a bi-weekly basis, I also participated in meetings consisting of the entire multi disciplinary staff at DMHC in which groups of staff were responsible for presenting a case and for discussing specific issues related to the management of that case with their peers. Finally, I participated in monthly meetings of the full clinical staff of the DMHC to discuss clinical programs and aspects related to the quality care of the clients of the Centre.

Target Population

According to existing policies at the DMHC (Dartmouth Mental Health Centre Policy and Procedures Manual, 1991), all of the clients treated by me were over 17 years of age, and all of them resided within the Dartmouth City catchment area. Clients representing both genders and a wide variety of races and religious backgrounds are treated at the DMHC, and were therefore treated by me as well. In addition, I assessed clients with a wide variety of mental health issues, though the majority of those treated by me in both individual and group therapy presented with clinical depression and or anxiety. Because the Nova Scotia Hospital has a separate program dedicated to the treatment of geriatric issues, including dementia, I did not work with this population while at the DMHC.

All of the clients seen by me in individual therapy were treated on a short-term basis only, though most were eventually referred to group therapy or to other members of the interdisciplinary team as deemed necessary and appropriate. In addition to conducting individual therapy, I undertook with a similar population of clients, to perform intake assessments of newly referred clients, and to refer these clients for services when deemed appropriate.

In addition to work done with individual clients, I also conducted a therapy group for male and female clients. All eight of the participants in the group were new or existing clients of the DMHC who were concurrently being treated by individual therapists.

Preparations for Therapy: the Development and Implementation of Treatment

Group Therapy Preparations

When planning a group it is important to select a treatment issue that is relevant to the needs of the clients in question. A large percentage of the clients treated at the Dartmouth Mental Health Centre present with poor self-esteem as well as clinically significant levels of anxiety and depression. In their book, McKay and Fanning (1992, p. 1) help to both identify the significance of self-esteem and suggest the role that poor self-esteem can play in the development and maintenance of mental illness by stating that:

> "Judging and rejecting yourself causes enormous pain. And in the same way that you would favor and protect a physical wound, you find yourself avoiding anything that might aggravate the pain of self-rejection in any way. You take fewer social, academic, or career risks. You make it more difficult for yourself to meet people, interview for a job, or push hard for something where you might not succeed. You limit your ability to open yourself with others, express your sexuality, be the centre of attention,

hear criticism, ask for help, or solve problems."

There are a number of studies that support the views of McKay and Fanning (1992) and that emphasize the role which self-esteem plays in regards to mental health and the overall well-being of an individual. In one such study, Larkin and Thyer (1999) note that children with low self-esteem tend to perceive themselves negatively, exhibit poor impulse-control, often behave irresponsibly and are easily led and manipulated by others. Conclusions like these support the notion that self-esteem is a significant issue in the social and emotional development of children, and it is possible that this relationship endures into adulthood.

In another study that examines methods of measuring self-esteem, Robins et al (2001) have demonstrated that self-esteem has a significant influence on a client's interpersonal and psychological functioning. In addition, a further study which examines the role that self-esteem plays in social development (Leary, 1999) points out that self-esteem is indicative of social status in groups, helps to both motivate and regulate behaviour, and serves an important adaptive function in individuals. When combined, these studies serve to support the notion that self-esteem plays a very important role in how individuals function both internally (in their minds) and externally (in their environments), and as such, poor self-esteem appears to pose a significant threat to the adaptive functioning of that individual.

Poor self-esteem is an issue that affects many individuals, and aside from the limits a poor self-esteem can impose on our lives, self-esteem also appears to play a significant role in both the development and maintenance of mental illnesses including

depression and anxiety. The relationship between self-esteem, depression and anxiety is exemplified in the findings of LaFountain and Garner (1996). In their study, LaFountain and Garner (1996) demonstrated a positive relationship between participants' post-treatment scores on self-esteem and the same participants' ability to cope with both anxiety and depression. Hooke and Page (2002) have also examined the role that self-esteem plays with depression and anxiety and have concluded that self-esteem helps to predict levels of anxiety and depression in clients. Through their work, Hooke and Page (2002) have also found that patients who were treated with cognitive-behavioral therapy demonstrated a reduction in their symptoms and an improvement in their level of self-esteem. This outcome is supported by the work of Wallis (2002) who notes that as depression and anxiety levels in her adult study subjects decreased, their levels of self-esteem increased. Several other studies have also demonstrated the relationship between self-esteem and depression by providing evidence that poor self-esteem can predict subsequent depression (Brown, Andrews, Harris, Adler & Bridge, 1986; Miller, Kreitman, Ingham, & Sashidharan, 1989; Roberts, Kassel, & Gotlib, 1995; Wong & Whitaker, 1994). Taking all of this evidence into consideration then, a group that aims to improve the self-esteem of clients can prove beneficial in a mental health setting like the DMHC where a large percentage of the clients are known to be suffering from anxiety and depression.

Since many of the clients of the DMHC present with poor self-esteem and since it is evident that this plays a role in the development and maintenance of anxiety and depression, the group which was implemented was a closed-style self-esteem group for men and women. Sessions were scheduled to take place weekly for ten weeks on the

campus of the Nova Scotia Hospital. Approximately ten clients were to be sought for participation in the group, and were referred to the group by their present individual therapists at the DMHC. The group was co-facilitated by practicum supervisor Catherine Lambert, and was designed for a heterogeneous population of clients who were all interested in improving their self-esteem.

Generally, the group was intended to allow participants to explore how they can alter their thinking from a more negative to more positive thinking style. Through group activities, it was intended that the participants would acquire and practice skills aimed at helping them to increase their self-esteem. The approaches employed within the group were of a cognitive-behavioural orientation. Larkin & Thyer (1999) evaluated the use of cognitive-behavioural methods where self-esteem was a main focus and they found that cognitive-behavioural group work was an effective means of significantly improving the self-esteem of the participants. Many other researchers including Warren, McLellarn and Ponzoha (1988) and others described previously have demonstrated that cognitive-behavioural approaches are effective at treating self-esteem in a group setting.

Many of the activities to be used within the group were borrowed from the book, Ten Days to Self-Esteem by David Burns (1999). A variety of topics were covered within the ten sessions. These topics included: feeling the way you think, changing the way you think, breaking out of a bad mood, the acceptance paradox, the root causes of poor self-esteem, how to attain self-esteem, perfectionism and procrastination and how they impact on self-esteem. The final session focused on closure and included a celebration and summary of all that had been covered in the previous sessions.

Individual Therapy Preparations

Prior to engaging in individual therapy with clients, I first undertook to learn more about the theory and principles behind the proposed interventions, namely solution-focused and cognitive-behavioural therapies. Once confident that sufficient background had been learned, I joined my supervisor in conducting co-therapy with individual clients. Once competent to begin working independently with individual clients, I began my practice under close supervision, and videotaped some sessions for later review.

Goal setting is based upon accurate information about the client and his or her circumstances. Without sufficient or relevant goals, intervention cannot be appropriately planned or implemented. In addition, these goals serve as a basis for the evaluation of therapeutic intervention with clients. As a result, when conducting individual therapy I was conscious of the importance of setting practical and relevant goals with clients early on, and attempted to remain focused on meeting these goals with clients as the therapy progressed.

Intake and Assessment Preparations

Prior to engaging in intake and assessment, it was important for me to understand what each entails. On a basic level, intake involves identifying a client's problem and life circumstances. Intake is also an opportunity to ensure that the client being referred suits the mandate of the agency in question, and it provides an opportunity for clients to be advised about agency services, procedures, and policies. Intake at the Dartmouth Mental Health Centre is a process in which incomplete or unclear information on referral forms is gathered by telephone from either the referral source or directly from the client. Following intake, the process of conducting client assessments begins.

Assessment is a process by which a worker further examines a client's history and issues to better understand the causes and dynamics of client problems. At this time, the client's social, psychological and physical functioning are addressed. In short, once a client's problem or problems have been identified during intake, more specific information is needed to help shape plans for intervening with the client in question. According to Fischer (1978), the purpose of assessment is to "gather the information necessary to evaluate what is to be changed, what factors are maintaining or currently controlling the problem, what resources are necessary to bring about changes, what problems might arise from bringing about changes, and how change can be evaluated" (p. 249-250). In short, to prepare for conducting both intake and assessments, I needed to possess a solid understanding of the purpose of both, as well as an understanding of the procedures for conducting both intakes and assessments. Once these areas had been mastered, I began to perform these tasks under the direct supervision of the practicum supervisor.

Supervision Arrangements

As an essential component of my learning and practicum experience, it was necessary to ensure that I was adequately supervised. Formal supervision meetings between myself and my supervisor, Catherine Lambert were scheduled on a weekly basis. At these meetings, my supervisor and I reviewed the cases that I had worked on in the previous week, reviewed and discussed videos of my individual therapy sessions, discussed plans for the upcoming week, and the supervisor also reviewed and signed off on the assessment reports that I had completed in the previous week. In addition to these formal meetings, the practicum supervisor provided me with informal supervision on an

almost daily basis.

Other Preparations

According to the DMHC's Policy and Procedures Manual (1991), when non-medical clinicians, like myself, encounter issues regarding suicidal risk of their clients, students are expected to consult with a staff psychiatrist. In the event that such a matter does arise, I was expected to consult with my immediate supervisor or another available social worker prior to approaching the psychiatrist. I took it upon myself to be familiar with all such policies at the Centre in case such an event should arise, fortunately however, I never encountered this issue in my practice at the Centre.

THERAPY INTERVENTIONS

Group Interventions

The Student's Role

The Self-Esteem group was co-facilitated by myself and my practicum supervisor Catherine Lambert. Prior to seeking referrals for the group, my supervisor and I met to plan the content that would be covered in each session and also agreed upon the activities that would be completed in each session. Prior to each group session, my supervisor and I met again to review the plan for the upcoming session and to decide in advance which co-facilitator would cover which portions of the content with the group. My supervisor and I shared equal responsibility for covering the content in each group session. As co-facilitator for the group, I was responsible for: explaining and providing materials to group members, leading discussions, introducing new concepts, encouraging, supporting and assisting participants when appropriate and helping the sessions to run smoothly while helping to maintain a focus on the goals for each session.

Following each weekly session, I maintained a weekly process record on each group member. Aside from keeping track of client attendance in group, records were kept that reflected each group member's: punctuality, interest, participation, understanding, support of others, social interaction, and completion of homework for each session that they attended. Once the group had concluded, these records were placed on each client's file at the DMHC for later review by the clients' individual therapists.

In seeking referrals for the group, I placed notices in the personal mailbox of each member of the treatment team notifying them of the upcoming group and requesting referrals of appropriate clients from their existing caseloads. A total of fifteen clients were initially referred for participation in the group. The referrals were all screened by myself and group co-facilitator, and all 15 clients were deemed appropriate for participation in the group. Once deemed appropriate, all 15 of the clients were sent a letter telling them about the group and inviting them to participate.

Group Members

As previously noted, 15 clients were invited to participate in the group, 10 attended the initial session and two dropped out prior to the second session. All eight of the clients who completed the group were referred as being depressed, many were also diagnosed with a variety of anxiety disorders. The following chart provides an outline of the nature of issues and diagnoses that had been identified for each client at referral to the group:

Table 1: Client Diagnoses and Issues Identified at Referral to Self-Esteem Group

CLIENT	DIAGNOSIS/ISSUES IDENTIFIED AT REFERRAL
A	Anger, Depression (recent job loss and relationship break up)Low self-esteem
B	Bipolar, Low self-esteem, Depressed/Anxious (single parent)
C	Low self-esteem, Dysthymia, Grief (loss of father)
D	Dysthymia, Avoidant/Dependant traits, Lacking confidence & social skills,
E	Domestic abuse history (victim), Lacking assertiveness & poor boundaries,
F	Anger, Chronic Depression (ruminates), Chronic Anxiety (worries)
G	Low self-esteem, Poor health (associated depression), Health-related anxiety (worries about the future, lacks supports)
H	Anger, High anxiety, Chronic depression

Group Process: Focus and Content

A wide variety of topics related to self-esteem were covered in each of the ten Self-Esteem group sessions. Many of the activities and much of the material used in the group were adapted from the book Ten Days to Self-Esteem (Burns, 1999). The focus of each session was intended to build upon the work done in previous sessions. Several types of activities took place in each session. These included: brainstorming, large and small group discussions, partner & individual activities, role playing, completing worksheets and quizzes, and reviewing and discussing handouts. In addition to these in-session activities, each session concluded with the assignment of homework to be completed prior to the next group session. The topics, session goals, main activities and

homework assignments pertaining to each weekly session of the Self-Esteem group are outlined in the following chart:

Table 2: Self-Esteem Group Overview by Session

TOPICS BY SESSION	SESSION GOALS	ACTIVITIES	HOMEWORK
Session 1: "The price of happiness"	How to measure your moods Identify your goals The price of happiness	-getting to know you activity and introductions -group rule setting and purpose discussion -completion of Rosenberg Self-Esteem measure -'identifying your goals' activity -discussion/chart activity: 'you feel the way you think' -review of the top 10 forms of distorted thinking(handout) -'you can change the way you feel' activity -review handout 'reasons not to do homework'	-post sign (provided in group) in home which reads: "Only one person in this world can ever make you feel depressed, worried or angry- and that person is you!" -when you find yourself thinking negatively, turn it into a positive (document examples)

Session 2: "You feel the way you think"	You feel the way you think Most bad feelings come from distorted thinking You can change the way you feel	-opener- 'the mood check in'(name a song that represents how you feel today) -review homework -how to express our feelings (handout & discussion) -(discussion) times when distorted thinkingwas evident, how it made the person feel and what effect that had on his or her self-esteem	-look for your cognitive distortions- how can you modify them into something more positive? -record how you feel when you find yourself thinking in a distorted way, record how you feel when you are not thinking in distorted ways
Session 3: "You can change the way you feel"	The difference between healthy and unhealthy feelings How to break out of a bad mood What to do when you're stuck in a bad mood	-opener, review homework -(discussion) Are all negative feelings unhealthy? -small group exercise on healthy/unhealthy feelings (characteristics of healthy sadness versus depression, healthy fear versus anxiety) -group exercise: 'the emotion cost-benefit analysis' -introduction of daily mood logs (charts used to refute unhealthy negative thoughts)	-begin completing daily mood logs -complete one cost-benefit analysis chart regarding your predominant mood

Session 4: "How to break out of a bad mood"	Learn techniques that can help you to change the way you feel	-opener, review homework -handout 'ways to untwist your thinking' -(small groups) review of techniques that can be used to help you break out of a bad mood	-complete daily mood logs -if you find yourself in a bad mood, try using one of the techniques covered in group to break out of the bad mood & document your example
Session 5: "The acceptance paradox"	Learn more ways of changing negative thoughts	-opener, review homework -identify your self-defeating attitudes (role play) -discussion of double-standards (standards set for others versus oneself) -acceptance paradox (rather than arguing every negative thought, try to accept your weaknesses -talking back to negative thoughts activity	-complete daily mood logs -practice affirmation "I am better when I accept myself as I am" -post & review poster (provided) "Negativity and criticism never build things up, they only tear them down" think about and document what this means to you

Session 6: "Getting down to root causes"	Learn how self-defeating attitudes & beliefs can make you vulnerable Developing a healthier value system	-opener, review homework -(handout/activity) 'common self-defeating beliefs -(discussion) ways of identifying self-defeating beliefs -completion of self-defeating belief scale -ways of modifying self-defeating beliefs	-complete daily mood logs -use at least one technique to modify a self-defeating belief & document your example(s)
Session 7: "Self-esteem; what is it? How do I get it?"	Learn what self-esteem is & it's significance Learn how to develop a resilient self-esteem	-opener, review homework -define self-esteem, analyze self-esteem vs self-confidence, self-esteem vs arrogance -self-esteem cost benefit analysis -(activity) what gives you satisfaction? -(discussion) the consequences of poor self-esteem, conditional vs unconditional self-esteem, gaining self-esteem is a process, -(discussion) worthwhile vs worthless human beings	-complete daily mood logs -look in the mirror and tell yourself that you are a worthwhile person (How does it feel? Do you believe it more when you do it more?) -do something new to treat yourself in a positive, kindly, loving way (like something you would do for a good friend)

Session 8: "The perfectionists script for self-defeat"	Learn the role that perfectionism plays in self-esteem	-opener, review homework -define perfectionism (the costs/benefits of perfectionism) -(handout) are you a perfectionist? What causes it? -(case study) how to handle perfectionism -accepting our flaws without shame	-complete daily mood logs -examine results of the 'are you a perfectionist' handout. Are there any areas you would like to change? How might you get started?
Session 9: "A prescription for procrastinators"	Learn the role that procrastination plays in self-esteem	-opener, review homework -(discuss) the characteristics of procrastination and it's pros and cons -case study (role play) -'How to beat procrastination' (handout) -how to become more productive and creative	-complete daily mood logs -name one thing that you have been procrastinating then list small steps that you can take to gradually achieve your goal

Session 10: "Practice, practice, practice"	Assess your progress so far Plan how you will progress in the future	-opener, review homework -assess progress (review goal statements) -how to overcome relapses -review of learning -administration of Rosenberg -celebration	-keep practicing techniques -review what you have learned and continue to build upon it -be nicer to yourself

Note: Post-Meeting Reaction Forms were also completed by each group member at the end of each weekly session (see Appendix F for sample form)

Individual Interventions

The Student's Role

For many of the individuals whom I treated, I was first responsible for conducting full assessments on them according to the policies and procedures of the DMHC. Any clients who were referred to me for therapy who had not been assessed by me had been assessed by other staff members prior to referral for treatment.

Once referred, I met with each client and worked with them to begin a process of identifying client goals, planning how goals may be achieved, and contracting with clients as necessary. The main contracting issue that needed to be addressed with clients was the fact that my practicum was time limited and as such clients treated by me would only receive short-term therapy and may be referred to other staff at the conclusion of the practicum if longer term client needs were evident.

In providing therapy to individual clients, I employed a combination of cognitive-behavioural and solution-focused approaches to treatment. The actual methods and approaches used varied from client to client depending on the characteristics of the client and the issues of the client in question.

In addition to providing therapy, I was responsible for keeping process notes in clients' files which reflected on each individual session that took place. In the process notes, I documented a summary of the session, emphasized any significant observations or important issues that had arisen or been disclosed, made note of the apparent or client reported efficacy of the session toward the client's goal attainment, and finally suggested therapeutic plans for subsequent sessions. As a part of my practice with individual clients, I made an effort to familiarize myself with relevant agencies and programs available in the community and made an effort to refer clients to these services for additional support when and where appropriate.

The Clients

I provided short-term individual therapy to a total of 14 clients during the course of my practicum. The following chart provides a brief outline of the issues that had been identified for each client at referral and from assessment:

Table 3: Presenting Issues of Individual Therapy Clients

CLIENT	PRESENTING ISSUES (FROM REFERRAL/ASSESSMENT)
1	Body dysmorphia (post weight loss)/chronic depression
2	Mild developmental delay/depression/sexual abuse history (with sibling)
3	Sexual abuse history (with uncle)/anxiety (relationship avoidance, fear of men)/depression/anger

4	Incestuous relationship (on-going)/abuse history/mild agoraphobia & social anxiety/depression/low self-esteem
5	Recent relationship break-up (associated guilt and grief)
6	Grief (loss of father)/depression
7	Chronic obesity/sleep disorder (apnea)/depression/poor health
8	Bipolar (long history within mental health system)/taking Lithium long-term
9	Generalized anxiety/mild agoraphobia/depressed mood (regarding isolation/loneliness)
10	Borderline traits/anxiety/some substance abuse (being treated concurrently at specialized clinic)/chronic depression/suicidal threats in past
11	Poor self-esteem/depression/anxiety
12	Family conflict/dependant-avoidant personality traits/depressed mood
13	Claustrophobia/panic attacks (with clear triggers)
14	Chronic parenting stress/self-blame/depression

Note: individual therapy clients were provided an average of six sessions each during the course of the practicum, few however were truly well-suited to short-term therapy and as such were referred to longer-term clinicians at the end of the practicum.

The Process: Therapeutic Focus and Approach

All fourteen of the clients who were provided short-term therapy by me were treated using primarily cognitive-behavioural and solution-focused approaches. The focus, therapeutic goals identified by clients, and approach to intervention for each client are summarized in the following chart:

Table 4: Therapeutic Goals and Approaches with Individual Clients

CLIENT	FOCUS (CLIENT GOALS) AND APPROACH
1	Goal: Better self-esteem, more self-confidence, reduced social avoidance, better mood overall Approach: Use of cognitive-behavioural methods (eg. Identifying/modifying cognitive distortions) to break down perfectionistic standards, graded exposure to social situations (homework), positive feedback & encouragement
2	Goal: Improve self-acceptance, improve self-esteem, shift blame away from self Approach: Use of miracle question to identify/clarify goals, supportive therapy to normalize feelings, cognitive-behavioral approach regarding feelings of guilt/shame/self-blame regarding abuse history/identification and reinforcement of actions client is already taking to feel better about himself
3	Goal: Increased comfort around men- an ability to engage in a healthy relationship with a man, better anger management and less guilt/self-blame Approach: Challenge dysfunctional beliefs related to having caused the abuse via cognitive restructuring, identifying & reinforcing anger management techniques already being used on occasion (insufficient time to specifically address fear of men)
4	Goal: Improve depressed mood and anxiety (reduce panic attacks) and improve self-esteem (Therapist goal: to encourage more open dialogue about the client's relationship with her partner) Approach: Relaxation training, behavioural homework assignments to reduce avoidance of feared situations, focus on improving self-esteem and mood by spending more time doing activities that she enjoyed
5	Goal: Work through grief and guilt associated with terminating relationship, establish new (healthier) relationship

	Approach: challenging guilt via use of cognitive restructuring, normalizing grief feelings, providing support for positive actions client took during and since her relationship to reduce loneliness and grieve, identify more ways the client can deal with her grief and attract a new partner, referral to grief group
6	Goal: Cope better with the death of father (and reduce depressed mood) Approach: Referral to family doctor for assessment for short-term anti-depressant, promoting understanding of the grief process, helping client to recognize what she is doing and thinking differently at times when not depressed and then finding ways to use this knowledge when she begins to feel vulnerable to depression
7	Goal: Develop a healthier and more active lifestyle and better self-esteem Approach: use of miracle question to identify client goals, collaborated on developing a progressive sequence of realistic time-limited goals for improving eating habits and increasing physical activity, referral to staff dietician, reinforcement and encouragement of client's efforts toward goal attainment
8	Goal: Maintain emotional stability through improved ability to cope with stressors (previously identified as a possible trigger of manic episodes) Approach: Relaxation training, identifying triggers and previously successful coping strategies, referral to staff psychiatrist for monitoring of medication
9	Goal: Reduced fear of leaving home and improved control of anxiety and depression Approach: Relaxation techniques (visualization exercises, desensitization regarding fear of being outside the home (homework assignments to gradually increase time and frequency of trips out of home and to promote social interaction), encouragement and support of client efforts

10	Goal: Increase stability of mood, decrease work absenteeism, rebuild damaged social/familial relationships Approach: Boundary setting, encourage focus on goals, monitor level of suicidal ideation (establish safety plans/contracting), focus on present and future (client strongly avoided discussion of her past and began to dissociate when pressed), focus on thoughts/activities that help the client to maintain stable mood and functioning
11	Goal: Improve mood, reduce anxiety and improve self-esteem Approach: Miracle question was used to identify goals in this case because client had difficulty identifying specific goals, cognitive restructuring to challenge self-critical beliefs, promote acceptance of personal flaws, relaxation through imagery techniques
12	Goal: Improve communication skills with spouse and children, improved stress-management (especially regarding parenting issues), depersonalize children's behavior, develop more consistent parenting/disciplining practices Approach: Role-play to rehearse alternative responses to spouse and children, cognitive restructuring to challenge fears of rejection by children (when disciplining), discussing parenting challenges where client's responses/actions have been productive/effective and reinforce these, referral to parenting education program in the community
13	Goal: To be able to take buses to work and ride elevators with minimal anxiety Approach: Relaxation techniques (imagery), cognitive restructuring regarding fears of becoming trapped and regarding embarrassment of public panic attack, homework assignments gradually exposing client to feared situations in combination with relaxation
14	Goal: Identify/access supports, reduce sense of being inadequate as a parent

	Approach: Miracle question, identify parenting and personal strengths and successes, cognitive restructuring re perfectionism/fears of being a burden, referral to family resource centre (re parent-support group and respite)

DATA COLLECTION

Group Data Collection

The Rosenberg Self-Esteem Scale (Rosenberg, 1979) is a scale that measures levels of self esteem, and it is the most widely used scale of its kind (Gray-Little, Williams & Hancock, 1997). The Rosenberg is a quick and easy tool to use (see appendix E for a sample of the Rosenberg measure). The scale consists of ten statements each with four possible responses that range from strongly disagree (1) to strongly agree (4). The first five statements on the Rosenberg are positively worded and the last five statements on the measure are negatively worded. To complete the Rosenberg, the respondent is asked to indicate how characteristic they feel that each of the statements is in regards to themselves. To accomplish this, respondents utilize the strongly agree-strongly disagree scale to either agree or disagree with each statement. Once completed, the Rosenberg is scored by totaling the responses to the first 5 statements, reverse-scoring and then totaling the responses to the final 5 statements, and then adding both of these totals together to determine the overall test score. The resulting scores range between 10-40. The higher the overall score on the Rosenberg, the higher the level of self-esteem that the client possesses.

According to Gray-Little et al (1997), the Rosenberg has undergone more psychometric analysis and empirical validation than has any other measure of self-

esteem. The Rosenberg has been shown to correlate strongly (r = 0.83) with the Coppersmith Self-Esteem Inventory which is indicative of its concurrent validity, has been shown to be internally consistent with a reproducibility coefficient of .92, and has also been demonstrated to be a reliable measure of self-esteem in a study where its test-retest reliability resulted in correlations of 0.85 and 0.88 (Fischer & Corcoran, 1994). Robins, Hendin and Trzesniewski (2001) have demonstrated the strong convergent validity of the Rosenberg when considering dimensions such as gender and ethnicity. Results of the study conducted by Robins et al (2001) help to confirm the construct-validity of the Rosenberg measure. Gray-Little et al, (1997) concluded their article by noting that the Rosenberg is both a reliable and valid measure of self-esteem and as such is deserving of its wide-spread usage and popularity. Taking its support in the literature, ease of use and demonstrated value into consideration, it was decided that I would utilize the Rosenberg Self-Esteem Inventory for assessing the levels of self-esteem evident in the Self-Esteem Group participants.

During the initial session, all group participants were asked to complete a Rosenberg Self-Esteem Inventory (Rosenberg, 1979) to provide an indication of their level of self-esteem at the beginning of the group, and this was completed again at the end of the final group session. Results from both tests were then compared to determine whether clients' self-esteem levels appeared to have remained constant, or whether they appeared to have been altered in some way over the course of treatment. Naturally, it was hoped that clients' overall self-esteem would have improved over the course of treatment, a result that was in fact obtained but will be discussed in more detail later in this paper. The analyses conducted using these forms was quantitative in nature and was

based on average responses to some of the questions, and on identifying categories of meaning or themes evident in regards to other questions on the measure. Data from these tests was also analyzed for both individual clients and for the group as a whole.

In addition, at the end of each weekly group session all participants were asked to complete a 'post-meeting reaction' form (see Appendix F). This form consisted of six questions which provided the facilitators with valuable feedback from the clients about what they learned from each session as well as feedback about what they most liked and disliked about each session. Specifically, clients were asked to rate on a scale of one to five whether the experience was useful in helping them to think and learn about themselves, whether they know themselves any better, and how they rated the session overall. Next, clients were asked to state and comment on whether they had learned something new in that session. The final two sections of the form asked clients to list things that they liked and disliked about that day's session. Analysis of these forms was qualitative in nature and consisted of an analysis of responses that had been sorted into meaningful categories; though unlike before, this data was not analyzed for individual clients because the forms were completed anonymously.

Group Therapy Case Study

In the first Self-Esteem Group session, key concepts related to self-esteem were introduced to the group. These concepts were to be revisited throughout the course of the group. One of these key concepts is the notion that "you feel the way you think" and that you can "change the way you think" and therefore the way you feel. Most of the group members noted that they were already aware of the relationship between feelings and thought, but they also noted that they were not as familiar with how this applied to them

personally. To build upon this concept, a discussion was held in the first session about how "we are responsible for our own feelings". This specific discussion resulted in an interesting shift in how group members reported on their personal feelings, experiences, and perceived causes for their feelings. One group member, for example, commented that her children made her feel depressed and unappreciated. This group member then paused, and adjusted her comment by saying, "I guess it is unfair of me to blame my children because I feel depressed, I suppose I should take responsibility for my own mood". Another group member later commented that her husband made her feel inadequate, but when the other group members pointed out to her that she was blaming someone else for causing her to feel that way, she too corrected herself and commented that her husband really does not do that at all, but rather she feels that she is "not good enough for him" and that "he deserves better." It was encouraging that even this early in the group, group members were already challenging each other to examine how they were thinking and were beginning to consider the impact that their negative forms of thought had on their moods, self-esteem and subsequently on how they responded within their environments.

In session 5, a discussion was held that focused on how people are often good at giving positive advice to others, but that the same people are often not as good at taking their own advice. Several group members reported that this applied to them very well and several members, in turn, provided examples of positive and constructive advice that they had given to others in situations similar to their own. Group members then commented that they imagined their situations would be better if they just paid more attention to these kinds of thoughts and less to those telling them to be insecure, to

withdraw socially and to dwell on the negative aspects of their lives. This discussion appeared to help group members to see that they do already possess skills and knowledge that they can use to address their own troubles. This seemed to be both empowering and 'eye opening' for the group as a whole.

Other key issues that were addressed in subsequent sessions also appeared to result in 'lightbulb' type moments for many of the group members. Most notably the discussions on anger and perfectionism appeared to apply to many of the group members. As part of these discussions, clients were able to assess how and whether these factors were an issue for them, and they began to explore both the causes and implications of their anger and perfectionism on their self-esteem and mood. Then, with the help of the group as whole, members began to identify realistic and achievable goals for addressing and resolving these issues.

A final concept that was discussed toward the end of the group was that of accepting and even celebrating our personal flaws. Clients reported that they had worked so hard to both hide and remove their flaws that they found it a relief to consider that perhaps some of their flaws were the very characteristics that made them unique, human and ultimately lovable. One group member commented that she had worked so hard for so long trying to be thin, that she essentially "forgot" that she is an attractive woman even if she is not the size she would most like to be. This group member noted that she would now make more efforts to emphasize what she does have, to set realistic goals, and to work at learning to love herself the way she is.

I learned a great deal from working with this group. I learned that sometimes it is the simplest concepts that can have the most thought and change provoking impact on a

person. I learned that emphasizing and revising these simple but key "high impact" concepts can gradually help group members to incorporate their learning and experience of the group into a longer-term manifestation of change in their lives. In other words, revisiting, re-examining and building upon the same key concepts from session to session can help clients to fully explore how these issues are relevant in their lives and how they can use this knowledge to make meaningful change in their lives.

I also learned that an improvement in ones self-esteem can lead to an improvement in ones' overall mood. This effect was evident in the group. From session to session, for example, clients began to report that they were beginning to make positive changes in both their thoughts and behaviours, and that when they made these changes they felt more confident, proud of themselves and less anxious and depressed overall. This relationship led me to develop the perspective that a self-esteem focused group or even self-esteem focused individual therapy can be a valuable tool for clients who are seeking treatment of mood disorders. In essence, a self-esteem group could serve as a worthwhile therapeutic 'starting point' for many clients who are depressed and anxious. Overall, I was both pleased to have had an opportunity to co-facilitate the group and was also pleased that the group members appeared to derive positive outcomes from their participation in the group. I liked that the group was positively-focused, that group members were provided with good information and that they were supported and encouraged in exploring how the information was relevant in each of their lives. To me, the group was an efficient and effective means of promoting self-esteem as well as promoting a positive state of mental health for the participants overall.

Individual Data Collection

On a very basic level, I had an opportunity to evaluate my practice by attending to the feedback given by my supervisor in response to viewing individual videotaped sessions. I kept a written record of this feedback, and later qualitatively analyzed it for themes related to my development as a practicing clinician. These themes are presented and discussed in a latter portion of this paper.

Rothman (1994) believes that because only the clients themselves are in "immediate touch with their circumstances and needs", that clients are the best resource for providing "a subjective appraisal of their living reality" (pp. 193). In other words, Rothman feels that the best information that can be derived to describe the clients' reality at the onset or termination of therapy, is that which comes directly from the clients themselves. Since I fully agree with this philosophy, clients were asked to complete brief post-session reaction forms (see Appendix G) at the end of individual sessions. The content of these forms was analyzed collectively and qualitatively to determine overall themes related to client satisfaction with my practice, and to provide information about the success of the interventions provided. It should be pointed out that despite original intentions, I did not sort client feedback into separately defined categories because the feedback from clients tended to be brief, direct and simplistic and as such I felt that sorting the feedback into separate specific categories of meaning was unnecessary.

Individual Therapy Case Study

Lisa (not her actual name) was a mid-thirties aged client who had been assessed by me at referral to the DMHC. From the assessment, it was evident that Lisa was

experiencing significant levels of both depression and anxiety. The anxiety manifested itself as a mild form of agoraphobia and rendered Lisa prone to panic attacks when she did venture outside the home and found herself in social situations. From the assessment, it was also evident that Lisa was lacking self-esteem. In addition to this, Lisa noted that she had sought mental health services many times in the past, but that she had never found it helpful and that she typically stopped attending after only a few sessions.

It was at assessment that Lisa first disclosed to me that her spouse of many years is in fact her biological uncle. Lisa went on to explain that her intimate relationship with her uncle/spouse began when she was very young. Lisa reported recognizing that her relationship is taboo in society and that as such she had made efforts to hide the incestuous nature of her relationship from her acquaintances.

It seemed evident to me that many of Lisa's current troubles were at least related to if not caused by her incestuous and highly controlled relationship and early sexualization by her uncle. Despite the fact that Lisa herself openly acknowledged this fact, throughout her time with me, Lisa remained resistant to addressing the role that her spousal relationship was playing with her mental health.

Knowing that Lisa had a previous history of abandoning therapy after only a few sessions, I had important issues to consider. I recognized that pushing Lisa to address her incestuous relationship may very well result in her terminating her work with me. In addition, from Lisa's disclosures at assessment and in her first few sessions with me, it became clear that Lisa was fearful of her spouse who she reported was controlling and prone to violence. Knowing this, I decided to focus my efforts on helping Lisa to remain

engaged in therapy while simultaneously helping Lisa to build trust in me. In essence, I initially needed to compromise what I thought Lisa could most benefit from in exchange for an approach that would keep Lisa in therapy.

In order to help keep Lisa engaged and to build her trust, I contracted with Lisa to focus on Lisa's depression, anxiety and self-esteem, rather than on the relationship per se. Lisa attended sessions with me fairly regularly thereafter.

Despite Lisa's continued resistance, gradually she did begin spending some of her time with me discussing and exploring the role that her spousal relationship was playing in her mental health, and particularly in the development and maintenance of her depression and anxiety. Lisa acknowledged that she felt guilty and embarrassed about her relationship. She stated that she knew the relationship was unhealthy and at the core of her troubles, and that she felt angry toward her spouse that she had been controlled and both sexually and physically abused by him for most of her life. Ironically at the same time, Lisa reported that she loved her spouse, that he needed her, and that she would never leave him.

The therapeutic goals that Lisa and I had identified early in treatment were for Lisa's depression and anxiety to improve, for Lisa to have fewer panic attacks in social situations, and for Lisa to begin feeling better about herself. It was my hope that as Lisa began to feel better about herself and more aware of her strengths and value as a human being, she would begin to see that she deserved more in life and that it was attainable if she was willing to work toward making positive changes in her life.

In terms of specific therapeutic techniques that were used in my work with Lisa,

several different approaches were employed. I asked Lisa the Miracle Question in an effort to help Lisa identify her therapeutic goals, and this approach was successful in identifying a focus for Lisa's treatment as noted earlier. I employed a number of cognitive restructuring techniques with Lisa. These techniques helped Lisa to better understand how her ways of thinking were impacting on both her mood and behaviour, and how they could be modified into more productive and healthy forms of thought. For example, Lisa was asked to consider how negative self-talk and self-criticism made her feel powerless and worthless and how this in turn made is less likely that she would take chances and make positive changes in her life. Solution-focused approaches were also employed in my work with Lisa. On a few occasions, for example, Lisa noted that she had left her home, had engaged in a social activity with friends, and had enjoyed herself while doing so. I offered Lisa praise for her efforts, emphasized the fact that positive change is possible, and then talked with Lisa about what Lisa can do to ensure that she spends more time with her friends outside her home. Lisa also pointed out that she feels less depressed when she is enjoying herself and engaging in activities that interest her. Again, I sought out opportunities to praise Lisa for times when she did seek out and engage in such activities, encouraged her, helped Lisa to explore ways of engaging in these activities more often, and discussed with Lisa the apparent benefit to her mental health and self-esteem when she is doing things she enjoys. Lisa was given homework at the end of each session that encouraged Lisa to both explore and expand her learning on issues and ideas that had been addressed in session.

I learned a great deal from working with this client. I learned that sometimes

relationship and trust building is more important in the early stages of work with clients than are the specific therapeutic goals themselves. In addition, I learned that when there is trust, progress can begin and resistance, even strong resistance, can be alleviated and even used as a therapeutic tool. For example, as I worked with Lisa, Lisa continued to be resistant but at the same time reported an increasing trust in me and confidence that my efforts were aimed at helping the client to meet her goals. Gradually, I was able to safely point out Lisa's resistance and then at times use it as an impetus for discussion on issues that were relevant to Lisa at various points in her treatment. From Lisa, I also learned that client's troubles can be enormously complicated, and yet small positive changes can serve as a starting point for bigger changes. For example, I noted that as Lisa began to take more chances in social situations, she also began to report feeling less depressed as well as more confident and less prone to anxiety attacks, which in turn made it more likely that she would take more chances in future social situations and so on.

At the conclusion of my time with Lisa, she had begun to make positive progress toward the attainment of her goals. It is my hope that Lisa's progress continued when my practicum ended and Lisa's treatment was continued with a new therapist.

Intake and Assessment Data Collection

To evaluate my proficiency at conducting intakes and assessments, success was to be based upon whether or not I had fully and appropriately completed these in accordance with the policies and procedures of the Centre. In effect, an intake has been successfully completed when the required client information has been obtained, appropriate forms completed, and an appointment for the client's assessment session has

been arranged. Likewise, an assessment has been appropriately completed when I have met with the client, when the appropriate assessment report has been fully and properly completed, and when the information attained in the assessment has led me to develop an appropriate treatment plan for that client. My success at determining a proper treatment plan for clients was evaluated at weekly case conferences in which I was expected to present each case to my colleagues and to justify why the proposed treatment plan was appropriate to the needs of the client in question.

THE TREATMENT TEAM

At the time of my practicum at the Dartmouth Mental Health Centre, the entire staff of the clinic consisted of nineteen full and three part-time staff. The following sections provide an outline the roles and responsibilities of the varied members of the treatment team.

Psychiatrists

Due to the often chronic nature of mental illness that is treated at the DMHC, the two full-time and 3 part-time psychiatrists on staff play a pivotal role. The majority of clients treated by the psychiatrists represent some of the most severely and chronically mentally-ill of the entire population of clients treated at the DMHC. One of the main responsibilities of the psychiatrists is to prescribe appropriate medications to clients where necessary and to monitor the use of this medication over time. In addition to prescribing and monitoring the client's use of medication, the psychiatrists are also responsible for assessing clients or for providing diagnostic clarification of clients who are referred to them for that purpose. In addition to the above-noted responsibilities, one

of the psychiatrists serves on the intake team. This person meets with the intake team on a weekly basis and plays a consultative role in assessing and directing new referrals to appropriate members of the treatment team. In addition to these responsibilities, the psychiatrists intermittently serve as the daily clinician on duty for clients in crisis.

Psychologists

The two full-time psychologists on the DMHC treatment team serve as the primary clinicians for the most chronically mentally-ill clients at the clinic. The majority of the clients treated by the psychologists present with anxiety, depression and a variety of personality disorders. The psychologists provide both long and short-term individual therapy to their clients, though the majority of clients treated are most appropriately suited to longer-term therapy as a result of the chronic mental health problems that these clients present with. One of the two psychologists serves on the intake team and as such helps to screen, review and allocate new referrals, and conducts some of the necessary intake assessments with new clients. The psychologists run groups on a variety of topics and utilizing a variety of approaches. The psychologists also assist the in-patient unit of the Nova Scotia Hospital by providing personality and cognitive assessments of in-patients who are being prepared for discharge back into the community, and they play a role in planning for the post-discharge treatment of these clients. The psychologists intermittently serve as the daily clinician on duty for clients in crisis. In addition to these responsibilities, one of the psychologists serves as the staff supervisor at the Dartmouth Mental Health Centre.

Nurses

There are five full-time nurses on the treatment team at the DMHC. These nurses do provide some individual and group psychotherapy. The primary role of the nurses is in monitoring the mental status and psychosocial functioning of the serious and chronic mentally ill clients at the clinic. Having the nurses serving in this role helps to ease the workload of the psychiatrists who are already bound by difficult clientele and heavy caseloads. One of the nurses serves on the intake team at the clinic and also accepts responsibility for conducting some of the intake assessments of new clients. The nurses are highly involved in the community and provide outreach services, including home visits to clients in private and group home settings. The nurses are also responsible for the provision of injected medication to clients, most notably to schizophrenic clients, who attend the clinic regularly for their injections. The nurses intermittently serve as the clinician on duty for clients in crisis.

Occupational Therapists

There are three full-time occupational therapists on staff at the DMHC. Their primary responsibility is to assess a client's life functioning, self-care, daily living, social and occupational skills and to intervene and assist the client in any areas deemed lacking. The occupational therapists work with clients in developing a picture of the client's lifestyles, routines and habits and helping the client to function optimally in their lives and within the community. The occupational therapists routinely partner with other community agencies and service providers, like income assistance, adult protection and adult employment programs, in the provision of services to their clients.

Nutritionist

There is one full-time nutritionist on staff at the DMHC. This staff person works with clients to assess their current eating, food shopping and preparation habits and helps to teach clients about nutrition, about how to recognize, select and prepare healthy food, and about how and why to maintain a healthy diet in general. The majority of clients referred to the nutritionist have a variety of eating disorders and/or are referred because they can benefit from support in these areas as a result of developmental delay or general lack of knowledge about nutrition. The nutritionist tends not to provide long-term services for clients, but rather provides only short-term services for clients who are concurrently seeing other members of the treatment team for longer-term support.

Social Workers

There are three full-time social workers on the treatment team at the Nova Scotia Hospital. Two of the social workers serve on the intake team. On the intake team, the social workers are responsible for screening referrals, for seeking missing or unclear referral information, for assigning referrals to appropriate clinicians and team members, and for referring inappropriate referrals to more appropriate outside services. In addition to this, the social workers are expected add a proportion of the newly referred clients to their own caseloads and are also expected to conduct a majority of the intake assessments of new clients at the clinic. Once the assessments are completed, the social workers must refer the clients to appropriate team members for treatment. The social workers have all been specially trained in the provision of therapy and they utilize a wide variety of treatment approaches with their clientele. Though there are exceptions, most of the

clients treated by the social workers are clinically depressed and or anxious, some are bipolar, few are psychotic. Each of the social workers carries a caseload. Their caseload tends to consist of approximately 30-40 individuals who are seen by the social workers for hour-long sessions as frequently as deemed appropriate by the clinician in consultation with colleagues and the client where appropriate. In addition to providing individual therapy to clients, the social workers facilitate many of the groups that are run through the clinic. Topics that are commonly covered in these groups include: self-esteem, depression, anxiety, and grief. The social workers serve a greater role as client advocate than do other members of the treatment team at the DMHC. In addition, they routinely have more contact and work more collaboratively with other agencies and services outside the clinic, and as such, are often more familiar with the resources that exist for clients in the community than are other members of the treatment team. Like the other clinicians on staff at the clinic, the social workers intermittently serve as the daily clinician on duty for clients in crisis. Serving as the on-duty clinician in crisis occasionally means that social workers are responsible for intervening with psychotic or suicidal clients. Where necessary the social worker dealing with such clients opts to consult with on-staff psychiatrists and/or escort the client to the main hospital for possible admission.

Support Staff

The support staff at the clinic consists of three individuals who all work within the main office of the clinic. These support staff are the first persons that clients encounter as they enter the clinic and as such they play an important role in setting the

mood of the clinic as well as helping to acclimatize the clients as they come into the clinic. The responsibilities of the support staff include: receiving new referrals, answering and redirecting incoming calls, referring clients in crisis to the appropriate clinician on duty, scheduling appointments, maintaining client files, and transcribing recorded clinical sessions or letters for the rest of the team as needed.

EVALUATION OF INTERVENTIONS

Group Therapy Results and Outcomes

As noted earlier, fifteen people were invited to participate in the group. Of those fifteen, ten actually showed up for the first session, and by the second group session, two participants had dropped out. Of the two individuals who left the group, one found herself to be in a significantly better state of mental health than were the other participants, thus she expressed feeling that the group was not the right "fit" for her. The other group member who dropped out reported that she simply lacked the motivation to attend despite the potential benefits of attending. The remaining eight clients remained with the group until the group concluded, and of these eight, seven were female and one was male. All of eight clients had been previously diagnosed, and all had been referred with an existing diagnosis of depression and or anxiety, and one was diagnosed with bi-polar depression. The participants ranged in age from 23-57, with an average age of 34. Seven of the participants described themselves as Caucasian and one described herself as being of African Nova-Scotian descent. The group ran for a total of ten weeks. The weekly attendance at the group was good overall for all participants. All but one the clients missed at least one session, three clients missed two sessions and one client

missed a total of three sessions. None of the clients who missed sessions ever missed two consecutive sessions.

Rosenberg Results

The Rosenberg Self-Esteem Inventory was administered at both the initial (pre-test) and final (post-test) sessions of the self-esteem group. Eight clients completed both the initial and final tests and their results from each of the two times were compared. The Rosenberg results indicated that all of the clients showed improvement in their level of self-esteem from the beginning of the group to the end of the group. Possible scores ranged from 10 to 40 with the larger numbers representing higher levels of self-esteem. The individual client scores on the Rosenberg at the beginning of the group ranged from 18 to 26, and the scores at the end of the group the individual scores ranged from 20 to 31. The results from all 8 of the group members who completed the Rosenberg at both the beginning and end of the group are outlined in the following chart:

Table 5: Rosenberg Scores from Pre to Post-Test

CLIENT	PRE-TEST ROSENBERG SCORES	POST-TEST ROSENBERG SCORES	AMOUNT OF SCORE CHANGE FROM PRE TO POST-TEST PHASE
A	19	23	4
B	18	20	2
C	26	31	5
D	24	27	3
E	25	27	2
F	22	30	8
G	22	23	1
H	21	29	8
Average scores:	22.13 (lowest possible score 10)	26.25 (highest possible score 40)	4.13 (average score improvement overall)

The average score on the Rosenberg at the beginning of the group was 22.13, and the average score at the end of the group was 26.25. The average gain for the participants overall was 4.13. The results all indicate that each group member showed an improvement in their level of self-esteem from the beginning of the group to the end of the group. This was the primary goal of the group and as such this goal was accomplished.

Post Meeting Reaction Form Results

At the end of each weekly session, group members were each asked to complete a post-meeting reaction form (see Appendix F for a sample form). For the first three questions on the form, clients were asked to respond on a 5-point scale that ranged from 1- poor to 5-excellent. The scores provided by the clients at the beginning (first three sessions) and end (final three sessions) of the group were then averaged for later comparison and analysis in an effort to determine whether the nature of client responses overall appeared to change over the course of treatment. The remaining three questions on the form were open-ended which made it necessary for the clients to provide a written response. All of the written responses for each question were later examined and sorted into categories representing common themes or ideas that the clients had provided through their written responses. The following chart illustrates clients' average responses to the first three questions on the post-meeting reaction forms:

Table 6: Post-Meeting Reaction Form Scores Group Beginning Versus End

QUESTION	GROUP BEGINNING (AVERAGE SCORES)	GROUP END (AVERAGE SCORES)
1. Was this experience useful in helping you think and learn about yourself?	3.2	4.13
2. Do you feel you know yourself any better?	2.5	3.63
3. How would you rate your session overall?	3.2	4.43

Score Key:
0-1.5= *Poor*
1.2-2.5= *Fair*
2.5-3.5= *Satisfactory*
3.5-4.5= *Good*
4.5-5.5= *Excellent*

The remaining three questions on the Post-Meeting Reaction Forms cannot be analyzed numerically therefore the chart which follows provides an overview of client responses sorted according to common themes identified in the responses:

Table 7: Post-Meeting Reaction Form Responses by Theme

QUESTION	RESPONSE THEMES BY CATEGORY
4. Do you feel that you learned something new today? (comments) (*clients responded yes to this question without exception)	AN INCREASED SELF-AWARENESS BETTER RECOGNIZING THE IMPACT OF NEGATIVE THINKING
5. Please list at least one thing that you liked about today's session	COGNITIVE CHANGE CAN LEAD TO BEHAVIOURAL CHANGE IDENTIFYING WITH OTHERS AND SOCIAL CONNECTIVENESS AN INCREASED SELF-AWARENESS PROGRAM CONTENT
6. Please list at least one thing that you disliked about today's session	LOGISTICS ACTIVITIES

The results of responses to the post-meeting reaction form questions are described in more detail in the sections to follow.

Post meeting reaction form: question one results.

The first question on the post-meeting reaction forms asked the clients whether

the experience was useful in helping them to think and learn about themselves. At the beginning of the group, the average score on this question was 3.2, or satisfactory, but by the end of the group, the average score on this question was 4.13, or good. This result demonstrates that overall the group participants felt that they found the group sessions to be increasingly more useful at helping them to think and learn about themselves. This result is not surprising since a major focus of the group was in helping participants to learn about themselves and to better understand the role that their thoughts have on their level of self-esteem. It is also not surprising since the learning goals from each session were planned in such a way that they had the potential to be built upon and expanded by the learning goals of each subsequent session.

Post meeting reaction form: question two results.

The second question on the post-session reaction forms asked the clients to report on whether they felt they knew themselves better at the end of each session. Scores on this question ranged from 2.5, or between fair and satisfactory after the first session, and improved to 3.63, or good, by the end of the final session. A main objective for the group was for participants to gradually develop a healthier and more positive view of themselves. To a great extent, this was accomplished by helping group members to better understand, accept and appreciate themselves as they are. As noted earlier, the learning goals for each session were planned to complement and build upon those of previous and subsequent sessions, thus it would not be surprising that participants reported feeling as though they knew themselves better as the group progressed from session to session.

Post meeting reaction form: question three results.

The third question asked group participants to rate their overall satisfaction with each weekly session. The average score on this question was 3.2, or satisfactory at the beginning of the group, but improved to 4.43, or between good-excellent by the end of the final session. This result indicates that the overall satisfaction of group participants improved over time.

Post meeting reaction form: question four results.

Question four asked group participants to report on whether they felt that they had learned something new in each session. Without exception each group participant answered yes to this question for each session they attended. At no time did any group participant report that they had not learned something new from a session. A second component of this question invited group participants to comment on what they felt they had learned from each session. Most of the clients did provide comments, and I later compiled a list of all of the comments that had been made on this question. Once the list was completed, I noticed that all of the feedback provided by clients could be sorted into three main categories which represented common responses that the clients had given. The common themes that arose from this question included comments that reflected on the client's perception of an increased self-awareness; better recognizing the impact of negative thinking; and practicing new and more adaptive ways of thinking and behaving. The content of the three above-noted categories is outlined in the following portions of this paper.

An increased self-awareness

Several clients noted that because of the group, they were learning the difference between self-esteem and self-confidence. One client noted that she now realizes that she needs "self-confidence even more that (she) needs self-esteem". Others expressed a realization that they are perfectionists and that they now have a better understanding of how this can undermine both their self-esteem and confidence in their abilities to accomplish their goals. One group member commented for example, "my expectations for myself are too high, I can never please myself".

Several clients pointed out that they realize that they are responsible for their own feelings, and that they could not expect other people to make them feel better about themselves.

Many participants noted that they now recognize that many of their beliefs have been self-defeating and that as a result it was necessary for them to now pay more attention to how and what they are thinking. One person said that she needs to "listen better to (her) body" and others said that they now recognize a need to listen better to themselves, but also to listen better to others who have perhaps been misjudged or misunderstood by the clients in the past.

Clients noted that they are now more aware of the 'baggage" that they have been carrying around and the role that this plays in their mood and perception of themselves in the world in which they live. One group member noted that she is "carrying baggage" and that she now recognizes that this "triggers (her) emotional outbursts" and contributes to her depression.

Several group members expressed surprise at the realization that anger is an issue common to many of them. Those who were aware of their anger commented on a dawning realization of the source of their anger, and others speculated on what to do with or about the anger in them. One group member noted, "I'm beginning to realize where my anger is coming from, but I don't know what to do with it".

Some clients were empowered by the sense that their levels of self-esteem were not as bad as they had originally thought. One person commented, "its reassuring to see that I am already using some of the methods to change my negative way of thinking" and another said "I'm already doing something right!" One client commented that she has "been a better therapist to others" than she has been to herself and she now recognized that she now needs "put (her) money where (her) mouth is" and start listening to her own advice. Several clients commented that they were going to persevere in their treatment and now had a better idea of specifically what it is that they need to work on, and clients expressed feeling stronger and more secure in this endeavor overall.

Better recognizing the impact of negative thinking

Clients in the group overwhelmingly expressed an increased understanding of the ways in which their negative thinking impacts on the way they feel and the way they view others and their environment in general. One client commented, "my negative thinking has a negative effect on my actions and the reactions of those around me." Others commented on how they now recognized that their self-critical thoughts were making them feel worthless and inadequate and that this, in turn, was making them feel depressed. Another group member commented on how he was being so hard on himself

that he felt anxious when he tried to do anything new because he expected to fail. For this client, a fear of failure had become the trigger for an anxiety reaction that the client could have largely avoided if he had not perceived himself as unable to succeed in the first place. In effect, the clients negative thinking was the element keeping him from his goals, and the resulting anxiety was an unwelcome side-effect.

Practicing new and more adaptive ways of thinking and behaving

Many of the group members commented on having learned and begun to practice new and better ways of thinking and acting in their everyday lives. One person, for example, stated "I am beginning to use new skills to modify my thinking and behavior." By their responses, the group members indicated that they realize that these new skills and behaviours need to be practiced, and that using these new skills becomes easier, more automatic and more natural the more they are practiced. Borrowing some of the terms used in session, one client commented that she needs "to practice positive comments and internal dialogues to override (her) negative inner critique."

Several members specifically noted that they have learned how to more accurately perceive and appropriately respond to situations that they encounter. One group member commented that she "learned how to think and react differently when a situation has occurred" and as a result this client noted that she had begun to strengthen her relationships with her family where there had previously been tension and conflict.

Several group members also commented on identifying with the discussion on "should" thoughts. Most of the group members noted that they were "in the habit of using should thoughts," and they expressed a growing understanding that these kinds of

thoughts are often not productive and can be replaced with more functional forms of thought. Several group members noted that they had begun to "catch" themselves using "should thoughts" and that they now sought to replace these thoughts with other more productive forms of thinking. One client noted, for example, that she felt more empowered and more in control of her life because she was focusing less on what she "should" do and more on what she "wants to do." Another group member commented that in order to feel good about yourself, "you sometimes need to worry less about what you "should" do for others, and instead pay more attention to what you need to do for yourself."

Post meeting reaction form: question five results.

Question five on the post-meeting reaction forms asked group participants to report on what they liked about each session. As explained previously, I once again compiled lists of all of the comments made by the clients on this question then sorted them into four categories representing common themes. The common themes identified in regards to this question included: cognitive change can lead to behavioural change; identifying with others & social connectiveness; increased self-awareness; and issues related to the program content itself.

Cognitive change can lead to behavioural change

Group members overwhelming responded that they liked the notion that changes in their ways of thinking can help them to meet their goals of having a better self-esteem and fewer mental health problems in general. They commented that they liked getting "rid of" their negative thoughts by replacing negative thoughts with more positive ones.

Several group members noted that they liked discussing distorted thinking because it helped them to learn how to recognize and modify the distorted thoughts that they had on a regular basis. Interestingly another client commented that the work she was doing in session had "a calming effect on (her)" and she was finding that by trying to think more positively, she was feeling more relaxed and was finding that her once common panic attacks had become less frequent.

Identifying with others and social connectiveness

Almost without exception, the group members reported liking aspects of the group experience that reflected on how they identified with others or on how they felt connected to the other members of the group. They reported that they "liked feeling not alone," and that other group members were feeling similarly. Several group members noted that they liked having the opportunity to talk and share others in the "safe" environment of the group. One group member noted, "I liked the openness- sharing thoughts and feelings with others without worrying about being criticized." Another person commented, "I like having time to talk openly about my feelings and to hear others who are feeling many of the same things that I am." A third group member commented, "I like being involved as a part of the conversation." A fourth person, who was not as vocal as other members commented, "I like the opportunity to be out with others without feeling pressured to talk when I don't want to."

Aside from providing the clients a safe environment in which to talk and share, clients also commented that they felt that the group members, "care about each other," and are supportive of one another and each person's ability to change in a positive way.

One member commented specifically on the unity of the group by noting that, in her opinion, "it (was) a special group of people who (were) willing to help each other, despite their differences of opinion or experience."

Increased self-awareness

An increased self-awareness was not unexpectedly identified as one of the factors that clients liked about the sessions. Participants noted that they liked that they were becoming aware of the obstacles that they needed to overcome, and that they were learning to recognize how some of their predominant emotions are associated with low self-esteem. One client commented that, "anger is one of (her) major obstacles," for example. Several of the group participants commented that the sessions made more sense to them and they understood and related more as the group progressed. Several also commented that they began to find that the new ideas they learned in session had become a catalyst for even more learning that continued after they left the weekly group session. One client noted for example, "this session opened up new ideas for me to use in my life and I have found that I'm paying more attention to how I think and act." The same person then added that she is, "now finding that (she's) using and building upon new ideas between groups and that friends have begun to tell (her) that they notice a positive change in (her)."

Program content

Several group members made comments about liking aspects of the group that were associated with the activities and exercises that were done, the overall content of the individual sessions, and the setting of the room in which the group was held. Some

group members commented on liking that the facilitators used a white board to write down examples of cognitive distortions because making the examples visual, "made them easier to understand." Without exception, all of the group members noted that they liked the activities that were completed in group and some added that they also liked the homework that they were given to complete between sessions. Several participants noted that they liked being able to work with partners and that everyone participated when activities were done. In terms of session content, group members made several positive comments that speaks to the relevance of the issues that were addressed. One participant noted that in her opinion, "great information was covered and discussed," and another group member added that the sessions, "really got to the heart of the matter."

Post meeting reaction form: question six results.

Question six on the post-meeting reaction forms asked group participants to report on what they disliked about each session. As before, I compiled lists of all of the comments made by the clients on this question then sorted them into two categories representing common themes. For this question, the themes identified included issues related to the logistics of the group as well as to the group activities. It should be noted that many of the group participants reported not disliking any aspect of the sessions on their post-meeting reaction forms, and I also made note of the fact that group members who did identify dislikes, identified fewer dislikes on their forms as the group progressed. A summary of the comments that were made by group members is outlined in the following sections of this paper.

Logistics

By far, the greatest number of dislikes identified by the group participants were associated with the concept of time. Some group members commented that there was not enough time to demonstrate exercises and for group members to have individual time with the facilitators in session. A few members noted that they would have liked having more time to discuss the specific issues that were relevant to them personally. One participant, for example noted that she recognizes that she has an anger problem and wanted to, "spend more time talking about that." Another member added that there is, "simply not enough time to discuss my own issues." A few clients commented on how they felt time was occasionally "wasted" in session. One group member noted that, in her opinion, the facilitators spent too much time introducing the topic for each session which then, "cut info the discussion time," for that session. A few other group members expressed their frustrated with wasted time by commenting that, "getting off topic", "long stories" and "interruptions" by group members, "wasted valuable time that could have been used doing something else." Other than issues related to the use or lack of available time, some group members mentioned that they sometimes felt as though they had been "sitting too long," and they noted that they didn't find the chairs to be especially comfortable.

Activities

A few of the group members made comments associated with their dislike of some of the activities that were conducted in-group. One person noted that she does "not like to hear someone telling (her) what her negative thoughts are," and the same group

member also noted following a later session that she did not like feeling that she had to participate in group discussions even

though she was told that she didn't have to talk if she didn't want to.

A few other group members noted that they were sometimes confused about the directions for some of the group and individual activities that were completed, but that also added that they knew they could ask for help when they needed to.

From analyzing the post-meeting reaction forms, I have made note of the fact that the feedback was positive overall and that the comments made by participants were largely reflective of changes that I anticipated and hoped for. The clients overall appeared to be satisfied with the group and with their participation in it.

Group Participant Evaluation Form Results

At the end of the final group session, group participants each completed a participant evaluation form (see appendix G). Scores for each question on the form ranged from 1 or strongly disagree, to 5 or strongly agree, never 1 to everyday 5, or very unhelpful 1 to very helpful 5 depending on the section of the evaluation form in question. Eight clients completed evaluation forms and their results were averaged to obtain an overall picture of their appraisal of the group.

Group participant evaluation form: question 1-17 results.

The responses of group members on the Participant Evaluations Forms are summarized in the following chart and are described in more detail in the sections to follow:

Table 8: Group Participant Evaluation Form Responses by Question

QUESTION	AVERAGE GROUP RESPONSES PER QUESTION (INCLUDES NOTATION OF HIGHEST AND LOWEST SCORES)				
	AGREE STRONGLY (5)	AGREE (4)	NEUTRAL (3)	DISAGREE (2)	DISAGREE STRONGLY (1)
1. The overall objectives of this program were met	highest score	4.0 average group score	lowest score		
2. My personal goals for this experience were achieved		highest score	3.38 average group score	lowest score	
3. The sessions were clear, understandable and well-organized	highest score	4.25 average group score/low-est score			
4. The teaching methods were helpful to me	highest score	4.13 average group score	lowest score		
5. The room was comfortable and pleasant	highest score	4.25 average group score	lowest score		

6. The group was a valuable learning experience	highest score	4.38 average group score/low-est score			
7. This experience will be helpful in my personal life	highest score	4.25 average group score	lowest score		
8. How often did you do the self-help exercises between sessions?		highest score	3.13 average group score	lowest score	
9. How helpful were the self-help assignments between sessions?		highest score	3.63 average group score	lowest score	
10. How helpful were the discussions during sessions?	highest score	4.25 average group score/low-est score			
11. How helpful were the group exercises?	highest score	4.14 average group score	lowest score		
12. How helpful/ supportive were the facilitators?	highest score	4.43 ave/lowest			

13. How helpful and supportive were the other group members?	highest score	4.0 average group score	lowest score		
14. How helpful was the group in understanding your moods?	highest score		3.75 average group score/lowest score		
15. How helpful was the group in learning to change your moods?	highest score		3.75 average group score/lowest score		
16. How helpful was the group in developing better self-esteem?	highest score		3.88 average group score/lowest score		
17. How helpful was the group overall?	highest score	4.25 average group score/low-est score			

The first question on the form asked participants to rate whether they felt that the overall program objectives had been met, and the client responses indicated that they agreed that they had (score 4.0). The second question asked participants whether they felt that their personal goals for the experience had been achieved. The average

participant response on this question was the second lowest on the evaluation form with a score of 3.38, or roughly in the neutral range. On the third question, participants were asked whether they felt that sessions had been clear, understandable and well-organized. Participants responded that they agreed with an average score of 4.25. Question four asked participants whether they felt that the teaching methods were helpful to them. Participants responded that they agreed with a score of 4.13. Question five asked participants whether they felt that the room itself was comfortable and pleasant. Participants responded that they agreed that it was with an average score of 4.25. On question six, participants were asked whether they felt that the group was a valuable learning experience. Participant responses on this question were the second highest on the evaluation with a score of 4.38, which indicated that participants overall felt that the group had been a valuable learning experience for them. Question seven asked participants to report on whether they felt that the group experience will be helpful in their personal lives. Participants responded by agreeing with a score of 4.25. Question eight asked participants how often they did self-help exercises between sessions. The average participant response on this question was the lowest on the evaluation form with a score of 3.13 or roughly in the 'sometimes' range. On question nine, participants were asked how helpful they felt the self-help assignments were between sessions. They responded that they felt they were helpful with an average score of 3.63. Question ten asked participants how helpful they perceived the group discussions to be. Participants responded that they found them helpful with an average score of 4.25. Question eleven asked how helpful the group exercises were, and participants responded that they were

also helpful with an average score of 4.14. Question twelve asked participants how helpful and supportive they perceived the group leaders as being. Participant responses to this question resulted in the highest score on the evaluation, 4.43, which indicated that the participants perceived the group leaders as being helpful and supportive. On question thirteen, participants were asked how helpful and supportive they perceived the other group members as being. The average response to this question was that they agreed with a score of 4.0. Question fourteen asked participants how helpful the group was in helping them to understand their moods. Participants responded to this question with a score of 3.75 indicating that the group was helpful overall in this area. Question fifteen asked how helpful the group was for participants in learning to change their moods. Participants responded that it was helpful with an average score of 3.75. Question sixteen asked how helpful the group was in helping participants to develop better self-esteem. Responses from participants indicated that it was again helpful with an average score of 3.88. The final question that was rated on the evaluation form asked participants to identify how helpful they perceived the group as being overall. Participants responded with a score of 4.25 indicating that they found the group as being helpful to them overall.

It should be noted that none of the average scores that were calculated were in the strongly agree, very helpful range. This result is not surprising to me as the clients were specifically asked by the facilitators in advance to provide the facilitators with "constructive criticism" that I could then incorporate as part of my learning in this practicum. The group co-facilitator and I had earlier agreed that overly positive and

facilitator-pleasing responses from group members on these questionnaires would contribute little to my learning.

The remaining five questions on the group evaluation form consisted of open-ended questions that required a written response from participants. Responses from clients on each of these questions are discussed in the sections to follow.

Group participant evaluation form: question 18 results.

Question eighteen on the group evaluation form asked participants to explain any of the previous seventeen questions that they had rated low. One person indicated that she had not achieved her goal of having good self-esteem. However, this person also commented that because of the group she now recognizes that she is a perfectionist and expects too much of herself too soon and is then disappointed in herself when she does not reach her goals. Another participant commented that they had rated the setting low because they found the chairs uncomfortable. A third participant commented that she had found some of the group members to be distracting and occasionally off topic.

Group participant evaluation form: question 19 results

Question nineteen asked what participants liked least about the group. Some participants responded that they would have liked more discussion on some topics and more time in general. Some participants noted that they were uncomfortable role playing, found the seats uncomfortable and would have preferred to remove the tables in the room. One participant noted that she found she often lacked the energy to attend but at the same time disliked missing sessions.

Group participant evaluation form: question 20 results.

Question twenty on the participant evaluation forms asked group members what they liked most about the group. Participants responded that they found the group to be very helpful and that it helped them to change their way of thinking by replacing their negative thoughts with more positive ones. Participants responded that they felt comfortable and accepted in the group, that they felt that participants were sincere, and enjoyed participating and discussing issues with the other group members.

Group participant evaluation form: question 21 results.

Question twenty-one asked participants what they had learned that will be most helpful to them. Group members reported that they now know themselves better and are now feeling more self-content and can better relate to others. They commented that they liked the feedback they were given in the group, and learned from and enjoyed the group activities and exercises. Group members noted that they will now try to think before they react, especially in new situations, and will try to be more in control of their emotions in general. Participants concluded that they will now look at themselves as being more worthwhile in general.

Group participant evaluation form: question 22 results.

The final portion of the evaluation form, question 22, invited group participants to note any general comments that they wished to add. Without exception, the comments made by participants on this question were positive in nature. Participants noted that they had enjoyed the group, had made new friends and found the content to be helpful and useful. They noted that they found the facilitators to be informative and kind, that

they would happily recommend the group to others, found the group to be good overall, and several concluded by simply saying "thank-you".

Self-Esteem Group: Summary of Results and Outcomes

As intended, the self-esteem group that I co-facilitated ran for a total of ten weeks, included an appropriate number of clients who all came to the group with similar troubles, similar goals, and all with an identified need for a better self-esteem. The topics that the we intended to focus on in the group were focused on as planned. In addition, the post-meeting reaction forms, self-esteem measures and participant evaluation forms that were intended to be completed were completed and the results obtained were largely positive as well as informative.

The group participants' self-esteem scores improved over the course of the group and all of the group participants provided a great deal of positive and very little negative feedback about their experiences with the group. Wessler and Hankin-Wessler (1989) suggest that a cognitive group process can provide clients an opportunity to learn about their belief systems and behaviours and feedback from the group facilitators and other group members can help to facilitate this learning. In a variety of ways the group members all reported that they had met their goals of attaining a better self-esteem from participation in the group and from feedback they obtained from the facilitators and other group members, and they also provided evidence that they had learned new tools that they will be able to use into the future. In fact, as part of their study, Larkin & Thyer (1999) have demonstrated that self-esteem level gains resulting from participation in cognitive-behavioural group therapy do tend to be maintained post-treatment as

demonstrated in their five-month follow up with self-esteem group participants. This is an encouraging result, though it should perhaps not be surprising as authors such as Page & Hooke (2003), have pointed out that cognitive-behavioural approaches emphasize the generalization of skills outside the therapeutic setting.

Researchers Hooke & Page (2002) noted that self-esteem helps to predict levels of anxiety and depression in clients. If this relationship is true, because the group participants in the present study all reported an improvement in their levels of self-esteem from the beginning of the group to the end of the group, one could also assume that the same clients may therefore also report improvements in their levels of anxiety and depression post-group. With the self-esteem group, it would have been interesting to have conducted assessments of the actual depression and anxiety levels of group participants before versus after the group. Unfortunately the co-facilitator and I did not collect specific data on this and could only rely on the information from the participants initial group referral forms and from the clients' self-reports as provided in-session. I expect that the depression and anxiety of the group participants would have shown improvement over the course of the group, but this could not be determined. At least, even if improvements in self-esteem are not clinically significant at the end of a self-esteem focused group, the gains may still have the potential to allow clients to begin individual treatment at a more advanced starting point, (Hooke & Page, 2002), or in other words, may effectively "jump start" the client's individual treatment in the areas of depression and anxiety. Considering the apparent value of a focus on the treatment of

low self-esteem, it may be worthwhile to consider this as a productive and worthwhile pretreatment intervention for depressed and anxious clients in the future.

Individual Therapy Results and Outcomes

As noted previously, during the course of this practicum I provided brief individual therapy to a total of 14 clients as part of the Short-Term Intervention Team (STIT) at the Dartmouth Mental Health Centre. Of the 14 clients treated by me, only three were male and the average age of the clients was 41. Though my full practicum lasted for approximately six months, I began conducting individual therapy with clients approximately three months into her time at the centre. Once I was conducting individual therapy sessions, I treated an average of 4-7 clients for an hour each per week. The number of individual sessions which were conducted per week depended on how many clients I was carrying on my caseload at any given time, how many clients actually showed up for their scheduled sessions, and was also partly dependant on the needs of the individual clients. Most of the clients who were treated by me had initially been referred to me for assessment. When deemed appropriate by myself and my supervisor post-assessment, I invited the clients to engage with me in the provision of short-term therapy. None of the clients who were offered treatment by me declined, and all were told at the onset of therapy that their work with me would be time-limited and that as such, they may need to be referred to another clinician as the practicum drew to a close. Though some of the clients expressed frustration with the prospect of needing to be transferred to another clinician once they had already established a relationship with me, all of the clients opted to continue working with me. All of the 14 clients who were provided

individual therapy by me had been diagnosed as suffering primarily from varying amounts and forms of depression and or anxiety at their initial assessments. As noted earlier, I employed both solution-focused and cognitive-behavioural approaches in my work with individual clients in an effort to help the clients to establish or reestablish a suitable level of functioning and overall state of well-being. Despite the relatively limited time that I had to work with individual clients, I gathered data that was later analyzed to derive an impression of my efficacy as a clinician for these clients. These results are discussed in the following sections of this paper.

Supervisory Feedback Outcomes

As part of my learning experience, it was agreed that my practicum supervisor and I would meet on a weekly basis for a discussion and review of my learning in the previous week, to address any problems or issues, and to also discuss plans for the upcoming week. As part of these formal supervision meetings, my supervisor and I reviewed tapes that I had recorded of myself conducting individual therapy sessions with clients who had consented to being videotaped. While reviewing the videos, the practicum supervisor provided me with feedback that I recorded for later analysis. The feedback from the practicum supervisor to me was eventually combined and was sorted into three categories that reflected what I had already mastered, refined throughout the course of my practicum, and areas that I need to continue to improve on. The main points for each of these three areas are reviewed in the following sections of this paper.

Mastered skills.

The main feedback from the practicum supervisor in this area was that I was good

at relationship and rapport building with clients in individual therapy, and that I was also adept at building an apparent sense of trust with the client. I was told that I am skilled at helping clients to feel comfortable in session and comfortable about attending the mental health clinic in general. The supervisor noted that I keep good process notes on clients and am organized and adept at developing an appropriate treatment plan with clients.

Refined skills.

Several of my skills in treating individual clients developed and improved over the course of the practicum. This improvement was evidenced by the nature of the supervisor's feedback over time. At the beginning of my work with individual therapy clients, I tended at times to provide too much information to the client rather than allowing the information to be elicited from the clients themselves. I was conscious of this issue and over time found that I was talking less in session and the clients subsequently were talking more. Another comment that was made by the supervisor early in my practice was that I tended to ask too many closed questions that did not permit the clients to provide meaningful responses to me. In order to correct this shortcoming, I gradually learned to take more time before asking questions in order to choose the right kind of question, with the right wording for the right purpose. Once I had become more skilled in this area, I noticed that the sessions tended to remain better focused on identifying solutions to the troubles that had brought the clients to the clinic in the first place.

Initially the first time that I met with a new client for individual therapy, I was in the habit of advising clients that if they threatened to commit suicide or made any other

serious disclosures to me, I would be obligated to report the issue to my supervisor and that the issue may then be reported to the police or other outside agencies as needed. In regards to this practice, the supervisor suggested that though these types of routine warnings are necessary, over emphasizing them or spending too much time on such issues could be detrimental to the establishment of trust between the client and student at the onset of therapy. As such, I continued to advise clients of such policies without over emphasizing them, and continued to monitor issues of concern and reminded clients of the obligation to report as and when it seemed appropriate to do so.

A final observation that was made by the supervisor of my practice with individual clients was that I occasionally responded in a physical or verbal way to comments or disclosures made by clients where it would have been more desirable for me to have remained neutral. This was particularly interesting feedback for me as I was unaware of how some of my own body language, for example, might have been perceived by clients following a disclosure. Over time I learned to be more aware of my own body language and was also more careful about not making comments that reflected my personal judgement once disclosures or comments in general had been made by clients.

Areas for improvement.

There were a few areas that my supervisor and I agreed still needed some refinement by the end of the practicum. The supervisor suggested that I need to be cautious of attaching labels to issues that are discussed in session. In doing this, I acknowledge that I was defining the clients' troubles rather than helping the clients to

identify their own goals. In addition, the supervisor also pointed out that I need to be more cautious of "missing" or not sufficiently attending to important disclosures made in session. I now appreciate that these disclosures often reflect the primary concern of the client at that time, and though they may not be closely related to the main therapeutic goals of the client, they are often worthy of attention. At the very least, I have learned that if there is insufficient time to address these issues as they come about, I can at minimum tell the client that they can see that the issue is important to them and that it can be a focus or component of the next therapeutic session.

Post-Session Reaction Form Results

At the end of therapy sessions with individual clients, the clients completed post-session reaction forms (see appendix H). In total, 64 forms were completed. It should be noted that the forms were not completed in a small number sessions due to occasional oversight on my part due to insufficient time, and due to the fact that on a few occasions clients failed to turn in their forms before leaving the session. My initial intention was to complete the forms with the clients and then to use the feedback on the forms to analyze each client's progress over time. However, after having proceeded in this way in the first two sessions, it quickly become apparent that the clients were hesitant about providing written non-anonymous feedback directly to me. I speculated that this hesitance was at least partly due to the fact that clients were motivated to please me as well as to respond in a way in which they would not be judged negatively despite my request for honest and critical feedback. To address this issue, I opted to have clients complete the forms anonymously and without my assistance. The feedback from the completed and

submitted forms of all 14 individual therapy clients was then analyzed collectively. Though this approach did appear to help address the clients' hesitance in completing the forms, it meant that I would be unable to later compare and assess how clients progressed through therapy over time. As noted, responses were compared collectively to derive an overall picture of client responses to the questions on the post-session reaction forms. These results are outlined in the following chart:

Table 9: Post-Session reaction Form Responses by Question

QUESTION	RESPONSE OPTIONS (N=64)				
	VERY MUCH	SOMEWHAT	NEUTRAL	NOT VERY MUCH	NOT AT ALL
1. Was this experience useful in helping you to think and learn about yourself?	N=23 36% of total responses	N=32 50% of total responses	N=9 14% of total responses	N=0 0% of total responses	N=0 0% of total responses
2. Do you feel that you have learned any new skills or ways of thinking that might help you to overcome your problem?	N=33 52% of total responses	N=29 45% of total responses	N=2 3% of total responses	N=0 0% of total responses	N=0 0% of total responses

3. How optimistic are you that you have the ability to make a positive change in your life?	N=9 14% of total responses	N=21 33% of total responses	N=21 33% of total responses	N=9 14% of total responses	N=4 6% of total responses

The first question on the form asked clients whether they perceived the session as being useful in helping them to think and learn about themselves. Possible responses to this question ranged from 'very much' to 'not at all'. None of the clients indicated that they had learned nothing, nor did any clients respond that they had learned 'not very much". However the responses on this question did vary within the 'neutral' to 'very much' range. Specifically, 36% of clients responded in the 'very much' category, 50% within the 'somewhat' category, and 14% of responses were within the 'neutral' category on this question. One client indicated that she was in the neutral range on this question because she already perceived herself as being a very self-aware individual.

The second question on the post-session reaction form asked clients whether they felt that they had learned any new skills or ways of thinking that might help them to overcome their problems. Again, none of the clients provided a negative response to this question, few responded in the neutral range and the majority of responses ranged in the 'somewhat' to 'very much' range. Specifically, 52% of clients responded in the 'very much' category, 45% within the 'somewhat' category, and 3% of responses were within the 'neutral' category on this question. Several clients specifically noted that they better recognized much of their thinking as being distorted and were learning how to both

recognize their distortions ands modify or replace them with more productive or healthy ways of thinking.

Question three asked clients how optimistic they are that they have the ability to make positive change in their lives. Client responses to this question could best be described as hesitant. Some clients responded that they felt more optimistic, others reported feeling "somewhat" more optimistic and still others reported not feeling very optimistic at all. Specifically, 14% of clients responded in the 'very much' category, 33% within the 'somewhat' category, 33% within the 'neutral' category, 14% within the 'not very much" category, and 6% within the 'not at all' category on this question. One client in particular noted that he was not feeling very optimistic and he theorized that this was a result of being a very self-critical person. It should be noted that the clients in question had only worked with me on a short-term basis. Many of these clients were, in fact, better suited to a longer-term therapeutic approach as they were presenting at the clinic with often very extensive, long-term and pervasive mental health issues. Perhaps given sufficient time and attention, these clients would have expressed a greater level of optimism about their ability to make positive changes in their lives. A client noted that she wondered how she is ever going to change the way she feels about things. Again, it is possible that with sufficient time and effort, her perspective would change over time.

Question four asked clients to list what they liked about each session. Clients responded that they felt that I was caring toward them and they noted that they found me to be a likeable person to work with. They noted that I am a good listener and that they liked having someone to listen to them and felt comforted knowing that they were being

supported. Clients noted that they found the relationship with me to be helpful in nature. They noted that they liked that new ideas were discussed, though often they were not new ideas at all but rather positive things that the clients were already doing, just not consistently or regularly enough. Clients noted that they were pleased that there is a place like the Dartmouth Mental Health Centre were people can go for help.

The final question on the post-session reaction forms asked clients to note what they disliked about the sessions. Many of the clients were reluctant to respond to this question, but with my encouragement a few noted that they found it intimidating to attend at the Nova Scotia Hospital site for therapy due to the social stigma that is still often associated with attending a mental health institution. Other clients reported that they disliked the fact that they would soon need to be referred to another therapist as the practicum was drawing to an end.

Summary of Individual Therapy Results and Outcomes

In terms of the provision of individual therapy to clients, I did put my plans into practice as I had intended. I worked with the number of clients that I intended to, did employ both solution-focused and cognitive-behavioural approaches in my work with these clients, and I did develop and refine my therapeutic skills overall over the course of the practicum.

The feedback that was provided by the clients themselves suggests that they perceived their time with me to be both positive and helpful for them. Additionally, the feedback provided by the practicum supervisor suggests that I progressed as a therapist over the course of my practicum in an effort to provide a quality service to my clients.

In terms of my use of solution-focused therapy with individual clients, I did find that solution focused therapy is a time-effective, practical and optimistic method of working with clients. I also found that solution-focused work is client empowering, and this is relevant because authors such as Hooke & Page (2002) have noted that being empowered helps clients to have a more internal locus of control which then has a positive influence on the client's levels of anxiety and depression.

Gingerich (2000) notes that it is common at the end of a solution-focused therapy session to compliment the client and to assign homework to the client. By ending a session in this way, clients are given the encouraging message that they have made progress, are capable of making positive change in their lives and can in turn be even more motivated at finding and implementing solutions to the challenges in their lives. In my work with individual clients, I did make an effort to end sessions in this way and did observe that the clients tended to leave sessions being more positive overall than they were when sessions were not concluded in this manner.

I believe that one of the keys to promoting positive change in a client is for the client and social worker to develop a positive working relationship. Such a relationship is built upon mutual trust and respect and its very nature is both supportive and empowering for clients. Sundman (1997) supports this notion by stating that the solution-focused client-therapist relationship begins with a broader and more positive view of the client's problems which in turn leads to a more personal and goal focused working relationship. I fully agree that the quality of the relationship between therapist and client is an important component of a quality therapeutic experience, and also feel

that this remains true whether a solution-focused or cognitive-behavioural approach is being employed.

In his chapter on the use of cognitive therapy with depressed clients, Perris (1989) points out that the goal of cognitive therapy is not only to remove the problematic symptoms, but also to promote the insight of the individual being treated. The importance of this 'promotion of insight' is highlighted in the work by Beck and Weishaar (1989), where it is noted that clients need to process information in an adaptive way in order to function normally. I agree with this view and consequently made an effort to promote the insight of the individual clients that were treated during this practicum. Like Dobson and Block (1988), I believe that desired behavioural change can result from desired cognitive change. I, in fact, observed in this practicum that as individual clients began to replace or modify their dysfunctional or distorted thoughts, they began to report feeling less psychological distress in general. This outcome is supported by the work of Beck (1976) who has identified this relationship in the past in his work with depressed clients. I feel that cognitive change is a tool that can be used effectively in the treatment of anxiety and depression, and is optimistic that its benefits can help to prevent the future onset and development of mental illness including, but not limited to, depression and anxiety.

Intake and Assessment Results and Outcomes

Intake Results and Outcomes

My success as a member of the intake team was based on my ability to contact referees in regards to missing or unclear referral information as well as actively serving

on the intake committee itself. As part of the intake team, I was expected to contribute, to comprehend what was being discussed, to help plan for conducting assessments and to make appropriate referrals to other programs and services where appropriate. I feel that I was successful in all of these areas.

I actively participated on the committee by attending every weekly meeting of the intake team during the course of the practicum. At intake meetings, I accepted responsibility for presenting new referrals to the team. This involved providing the team members with a verbal summary of each referral where the main issues bringing the client to therapy were emphasized. I then engaged with the group in a discussion of whether referrals were appropriate for the clinic, and if deemed appropriate, how to most appropriately allocate the new clients to members of he treatment team. A determination of the client's apparent type and level of need combined with an evaluation of the existing workload for the treatment team member in question helped to determine which clients would be assigned to which members of the treatment team. When it was decided that new referrals were not appropriate for the clinic, these clients were referred to other agencies or service providers in the community. I made an effort in advance of the practicum to become familiar with the services and agencies that exist in the community, and as such was able to contribute in this area as well.

One challenge that I occasionally faced in participating on the intake team was with possessing an adequate understanding of some of the mental illnesses that new clients were presenting with. In an effort to address this shortcoming, I began to review the new referrals prior to each weekly intake team meeting to determine whether any of

the new clients were being referred for the treatment of mental-illnesses that were unfamiliar to me. When such particular mental illnesses were identified, I took time to educate myself in advance of the meetings so that I could both contribute and comprehend the discussion that subsequently ensued when the intake team reconvened.

Once all of the new referrals for each week had been reviewed, discussed and allocated to appropriate members of the treatment team, I accepted responsibility for conducting intake assessments on a proportion of the newly referred clients.

Assessment Results and Outcomes

My success in conducting intake assessments of new clients was based on whether I was able to conduct the interviews appropriately and in a timely fashion, to complete the assessment reports with all the required information and in the appropriate format, and to make tentative diagnoses of the presenting mental-illnesses.

I began sitting in on intake assessments conducted by my supervisor very early into the practicum. In time, and once approval had been given to do so, I began regularly conducting assessments with 2-3 clients per week. In all, I assessed a total of 17 clients on my own and another seven in conjunction with the practicum supervisor. I was responsible for writing all 24 of the assessment reports for which she was involved. Because all of the clients assessed by me were new to the clinic and had not been recently released from the inpatient unit of the Nova Scotia Hospital, the assessments conducted by me were all of the long-assessment format described earlier (see appendix D). It initially took me 2.5 hours on average to complete each assessment, though I became more efficient at conducting the assessments over the course of the practicum

and by the end of the practicum, assessments were being completed in less time.

Once assessments had been conducted, I was responsible for combining the results into a report format. The guidelines for the reports were very specific, but with experience I was able to complete the reports appropriately, efficiently and with the necessary content. As part of the assessment report I was expected to identify tentative diagnoses for each client. I was hesitant to provide diagnoses, but since they were required elements of the report, I noted possible diagnoses then consulted with my supervisor prior to identifying any specific diagnoses on the assessment reports. Once the reports were completed, I provided them to my practicum supervisor who reviewed and signed off on them before they were placed in the client's files.

Other Outcomes

In addition to the responsibilities and actions that have already been reviewed, during the practicum I was also responsible for attending and participating in weekly case conferences and bi-weekly staff meetings at the clinic. I attended lunchtime presentations on a wide variety of mental health issues on a weekly basis, and when time permitted, I assisted in the main office of the clinic writing and transcribing reports for other therapists, writing letters for staff and answering phone calls from clients.

Preparation for Termination of Student's Practicum

My practicum at the Dartmouth Mental Health Centre lasted for approximately a 6 month period in which I attended on roughly a full-time basis. All of the clients that I worked with were told from the commencement of their treatment that my tenure at the clinic would be limited and that this may necessitate the clients being eventually

transferred to other clinicians. Any clients who may have expressed discomfort with this arrangement would not have been treated by me, however, by agreeing to see me, most of the clients were able to bypass an otherwise lengthy wait list and clients therefore expressed a desire to work with me. As the end of the practicum drew nearer, the self-esteem group which I was facilitating concluded on schedule and I began making arrangements for the majority of my individual clients to continue in longer-term therapy with other members of the treatment team.

I reviewed each client file and discussed with the clients what their priorities and wishes were in terms of continued treatment at the clinic. I then considered the status and needs of each client combined with the wishes of each client to begin developing a plan to transfer them to appropriate clinicians or services. Each individual file was then reviewed with my clinical supervisor and modifications to the referral plan were made as agreed upon by myself and my clinical supervisor. Once a final referral plan had been made, I proceeded to complete the appropriate referral forms and sent case review letters to the original file referees (who were routinely the clients' family doctors). I then briefed other treatment team members about the clients who were being transferred to them and the main issues that each client was presenting with. In the final session with each client, the client was advised on who would be taking over their treatment, provided information on the new clinicians background, noted when the clients should expect to hear from their new clinicians and the client and I discussed and reviewed the clients' progress and plans for the future.

Practicum Limitations and Recommendations

In terms of identifying specific limitations in regards to my practice at the Dartmouth Mental Health Centre, a few issues come to mind. In planning for this practicum, I had intended to provide short-term therapy to appropriately-suited clients. The fact is, however, that only a small percentage of the clients who are treated at the Dartmouth Mental Health Centre are truly appropriate for short-term intervention because of the nature of their often serious and chronic mental illness.

As part of a completed assessment report, I was expected to identify and specify client diagnoses. I was reluctant to do this partly as a result of not feeling sufficiently experienced or qualified to provide some of the very precise and complex diagnoses that were appropriate, but also because I felt that identifying diagnoses was synonymous with a problem rather than solution-focused approach to treatment. Further limitations evident in this practicum will be addressed below.

Individual Therapy: Solution-Focused Limitations

In his work, Sundman (1997) points out that the key solution-focused concept of "goal" is a complicated concept that requires ongoing negotiation. Sundman adds that because the goal concept is complicated, it is sometimes difficult to know exactly when there has been an agreement or even what the agreement was about. I found this issue to be a complication in my work with individual therapy clients in this practicum. I found at times that the goals that had been identified previous sessions were no longer as relevant for the clients in the subsequent sessions, and as such, the focus of treatment needed to be altered accordingly.

Sundman (1997), notes that a drawback of a solution-focused approach is the therapist's tendency to make errors in their approach devoid of sufficient solution-focused training. He points out, for example, that inadequately trained and experienced therapists employing a solution-focused approach may pay more attention to what clients "say" as opposed to interpreting what it is that clients actually "mean". Sundman (1997) points out that it is important for therapists not to take their clients' views at face value without first reflecting on them. In his report, Gingerich (2000) also notes how important it is for clinicians using a solution-focused approach to be properly trained, to use clear and specific procedures, and he suggested that the consistent use of treatment manuals could help to alleviate some of the variance that exists between therapists. These were also issues for me in this practicum. I had studied solution-focused therapy prior to my time at the centre, however I found that actually using the skills I had studied necessitated some measure of trial and error to perfect, and even now I feel that she would still benefit from more experience and specific training in the use of solution-focused therapy.

In practice, a solution-focused approach is not intended to include a focus on determining diagnoses, history taking or problem exploration. The limitation of this, in a setting like the Dartmouth Mental Health Centre, is that clinicians are often expected to include many of these details as part of the client's clinical record. At the Dartmouth Mental Health Centre, for example, an intake assessment report must be completed on every client and the intent of the report is to thoroughly explore the client's history and background in an effort to define their "problems" and to determine a client diagnosis.

Essentially, there are problems inherent in any form of therapy where the approach of the clinician is not going to fit with the expectations of the employer, or in this case, the expectation that a diagnosis will be given and that any therapeutic intervention will all be aimed at resolving the identified problems rather than at seeking solutions that can help clients to meet their goals.

Individual Therapy: CBT Limitations

In her book, Judith Beck (1995) discusses a number of factors that can be detrimental to the treatment of a client when cognitive-behavioral approaches are utilized. Beck (1995) notes that a strong therapeutic relationship is important, that the client and clinician should both have a clear idea of what the client's therapeutic goal is, and the client should be committed to working toward that goal. She notes that the client must believe that his or her thinking influences his or her mood or behavior and that dysfunctional thinking undermines her emotions and behavior. In addition, Beck (1995) notes that the client must be socialized to productively participate in cognitive-therapy. If the client is not willing to contribute to the discussion, refuses to work collaboratively and provide feedback to the therapist for example, the desired change may not be forthcoming. Finally, Beck (1995) points out that the client's biology may also work against progress when cognitive approaches are used if, for example, the client is highly medicated and unable to think clearly or has a specific brain injury. Remedies to these issues do exist however, and employing them can help to alleviate factors that have the potential to limit the effectiveness of a cognitive-behavioral intervention. Doing a thorough assessment of the client and their needs, and then reviewing the results with the

client to check that the client has been properly conceptualized can help to clarify for both the client and therapist what the goals of therapy should be. These goals should then be revisited throughout the course of therapy to ensure that the treatments have remained on focus and relevant to the changing needs of the client over time. Referring the client for a physical or neuropsychological assessment can help to identify things like brain injury or cognitive impairment as a result of medication and these matters can then be addressed or adjusted for when planning a cognitively-based treatment for that client. A prime example where a referral for a physical assessment by a general practitioner may be appropriate is when a client who presents as depressed is screened for thyroid problems. If the thyroid is not functioning properly, it may be very difficult for the client to overcome their depression without the thyroid hormone levels first being properly regulated. To assess whether cognitive-behavioral treatments are being helpful to clients, therapists can simply ask the client to provide feedback about their experiences and about the approach being taken in therapy and they can ask the client to express any doubts they have about the treatment or to ask for clarification when they don't understand. In addition, it is important for the therapist to monitor their own thinking to try to ensure that their own inherent biases are not impacting negatively on the client's progress, and it is also important for the therapist to remain flexible taking into account that the client is a complex individual who is ever-changing and will benefit the most from treatment that adjusts with them.

Group Therapy Limitations: Rosenberg

One limitation of the Rosenberg Self-Esteem Inventory as identified in the study

by Robins et al (2001) is the susceptibility of measures like the Rosenberg to socially-desirable responding. I would not be surprised, for example, if some of the group therapy participants had enhanced their responses on the Rosenberg to appear to have made more progress then they actually had. Taking this point into consideration however, one must also consider the demonstrated validity of the measure and assume that socially-desirable responding was taken into consideration when the measure was being validated.

Group Therapy Limitations: Homework

Page & Hooke (2003) point out that one difficulty with cognitive-behavioural approaches is homework noncompliance. It seems that the more compliant the client is, the more benefit they are likely to gain from the overall course of cognitive-behavioural treatment (Kazantzis, Deane & Ronan, 2000; Page & Hooke, 2003). A part of their feedback on the group, participants noted that they were often not inclined to complete the homework that was assigned for between meetings. Though group members appeared to develop better self-esteem over the course of the group, it is possible that the results would have been even better if they had complied in completing their homework assignments.

PRACTICUM LEARNING AND EVALUATION

Post Intervention Assessment

As noted earlier, prior to commencing this practicum, I had identified seven learning goals to be achieved. The first goal was for me to understand how a community-based mental health practice operates and to understand the role it plays as a service provider in the community. I believe that this goal was achieved as I now possess

a full understanding of how the DMHC operates, and I also understand and appreciate the role the that clinic plays within the community. The clinic exists because it is needed and because there are no other programs and services in the community that can so completely, appropriately and efficiently meet the needs of the many mentally-ill members of the community.

The second goal was for me to understand what it means to work as a member of a multi disciplinary treatment team, with involvement all of the typical responsibilities of community-based clinical social workers at the DMHC. I believe that this goal was achieved. I familiarized myself with the entire staff of the clinic and made an effort to learn what their individual responsibilities are and what roles they play as members of the treatment team. It is evident to me that all members of the team play an important role in the overall provision of service to their clients, and it is also evident that all of the work done by individual staff supports that which is done by other staff members. In effect, each staff member is a spoke on the wheel that is the treatment team, and missing a spoke, the wheel will not be strong and the clinic will not function and serve its clients optimally.

In terms of understanding the specific roles and responsibilities of social workers on the treatment team, I have achieved success in this area as well. Not only did I learn what the social workers do, I actively participated in doing all of the same work that the social workers do at the clinic.

The third goal was for me to develop a better understanding of the significance, effects and treatment of clinical depression and anxiety. Through extensive reading

about clinical depression and anxiety, through observing videos on the topics, through extensive discussions with staff at the clinic, and through my practice at the clinic in general, I did develop a much better understanding of the significance, effects and treatment of both depression and anxiety.

The fourth goal was for me to develop a better understanding of the uses and limitations of solution-focused, cognitive-behavioural and group treatment approaches to the treatment of depression, anxiety and mental illness in general. Again, through extensive reading about these treatment modalities, through observing videos where these approaches were employed and critiqued, through extensive discussions with staff at the clinic, and through my practice at the clinic in general, I did develop a better understanding of the uses and limitations of these approaches to treatment.

The fifth goal was for me to learn how to practice as a clinical social worker who employs solution-focused, cognitive-behavioural, and group therapy approaches with depressed and anxious clients in an effort to help improve their psychosocial well-being. This goal was achieved as I employed these approaches while actively engaged in the treatment of both individual and group therapy clients and the outcomes of those endeavors are described in detail within this practicum report.

The sixth goal of the practicum, was for me to assess the effectiveness of my therapeutic efforts with clients by using qualitative approaches to investigate the outcomes. This goal was also achieved and the results are again reviewed in detail within this paper.

The seventh and final goal of the practicum was for me to understand how

working in a clinical environment like the DMHC impacts on the practice of clinical social work and how social work perspectives in general are related to working in a clinical facility like the Dartmouth Centre. I believe that this goal was achieved.

As noted by Tilbury (1993), social workers in the mental health field aim to "reduce pain, relieve stress, offer practical services, bring in resources, restore social functioning, promote growth and development, speak up for the weak and powerless, protect the vulnerable, and help people take control of their own lives" (p. 33). All of these roles and responsibilities have proven to be evident in the practice of social workers at the DMHC, and were elements of my practice that I valued and placed great emphasis on. More than other staff at the clinic, for example, the social workers assume responsibility for being aware of the programs and services that exist in the community, and they routinely use this knowledge to help connect their clients with and advocate for appropriate community-based supports for clients. Like other social workers, the social workers at the clinic want to assist clients to function in their everyday lives and not just within their therapy session. In addition, social workers at the clinic, like other social workers, have a desire to help clients to help themselves and this is routinely the focus of therapy despite differences in the specific approaches that are employed to achieve this goal.

As noted earlier, many modern social workers feel that they play an important role in promoting the mental health and general well-being of their clientele, and I believe that the role played by social workers is unique and as such should be valued within the field of work with mentally-ill clients. Bracht (1978) suggests that social

workers are important elements within the health field because they offer a unique service that takes the physical, social, psychological, and environmental needs of clients into consideration when offering treatment or intervention to clients. Few if any other professions take so many factors into consideration when planning or implementing interventions for their clients. It is perhaps this quality which makes social work such a valuable component of services to the mentally ill clients at the DMHC, and to the mentally-ill members of our communities as a whole.

Educational Benefits and Concluding Remarks

Having an opportunity to learn and practice at the Dartmouth-Mental Health Centre was a tremendous and highly valued opportunity for me. I learned much more about myself as a clinician and social worker, learned about the needs of clients, ways of working with clients and about the value of being a member of a community-based treatment team.

It is evident that social workers can and often do play an important role in promoting the well-being of mentally ill members in our communities. This can be accomplished through engagement in a number of specific activities and services within the community. It is the opportunity to explore the varied roles and responsibilities of social workers in a community-based mental health setting that has been the focus of this paper. I enjoyed completing my practicum and learned a great deal about what it means to be a member of a treatment team in a community-based mental health centre.

As stated by Wessler and Hankin-Wessler (1989, p.580), the procedures we use in therapy vary, but our goals are the same "to aid clients in their attempts to live more

effectively in their own social environments." This was my goal in my practice with clients at the Dartmouth Mental Health Centre, and I believe that this practicum report provides evidence that this goal was achieved.

References

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington DC: Author.

Beck, A. T. (1976). Cognitive therapy and the emotional disorders. New York: International Universities Press.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). Cognitive therapy of depression. New York: Guilford Press.

Beck, A. T., & Weishaar, M. (1989). Cognitive therapy. In A. Freeman, K. Simon, L. Beutler & H. Arkowitz (Eds.), Comprehensive handbook of cognitive therapy (pp. 21-36). New York: Plenum Press.

Beck, J. S. (1995). Cognitive therapy: Basics and beyond. New York: The Guilford Press.

Bracht, N. (1978). Social work in health care. New York: The Haworth Press.

Brown, G. W., Andrews, B., Harris, T. O., Adler, Z., & Bridge, L. (1986). Social support, self-esteem and depression. Psychological Medicine, 16, 813-831.

Burns, D. (1999). Ten days to self-esteem. New York: Quill William Morrow.

Butts, J., & Schwartz, I. (1991). Access to insurance and length of psychiatric stay among adolescents and young adults discharged from general hospitals. Journal of Health and Social Policy, 3, 91-116.

Bywaters, P. (1986). Social work and the medical profession: Arguments against unconditional collaboration. British Journal of Social Work, 16, 661-677.

Campbell, R. J. (1981). Psychiatric dictionary. New York: Oxford University Press.

Caputi, M. (1978). Social work in health care: Past and future. Health and Social Work, 3, 9-29.

Carling, P. J. (1995). Return to community: Building support systems for people with psychiatric disabilities. New York: Guilford Press.

Dartmouth Mental Health Centre. (1991). The Dartmouth Mental Health Centre policy and procedures manual. Dartmouth. NS: author.

Dean, H. E. (1998). The primacy of the ethical aim in clinical social work: Its relationship to social justice and mental health. Smith College Studies in Social Work, 69, 9-24.

deShazer, S. (1984). The death of resistance. Family Process, 23, 11-21.

deShazer, S. (1988). Clues: Investigating solutions in brief therapy. New York: W. W. Norton.

deShazer, S. (1991). Putting difference to work. New York: W. W. Norton.

deShazer, S., Berg, I. K., Lipchik, E., Nunnally, E., Molnar, A., Gingerich, W., & Weiner-Davis, M. (1986). Brief therapy: Focused solution development. Family Process, 25, 207-222.

Dobson, K. S., & Block, L. (1988). Historical and philosophical bases of the cognitive-behavioural therapies. In K. Dobson (Ed.), Handbook of cognitive-behavioural therapies (pp. 3-38). New York: Guilford Press.

Dolan, Y. M. (1991). Resolving sexual abuse: Solution-focused therapy and Ericksonian hypnosis for adult survivors. New York: W. W. Norton.

Dougherty, D. (1988). Children's mental health problems and services: Current federal efforts and policy implications. American Psychologist, 43, 808-812.

Durrant, M. (1993). Residential treatment: A cooperative, competency-based approach to therapy and program design. New York: W. W. Norton.

Erickson, R., & Erickson, G. (1992). An overview of social work practice in health care settings. In M. J. Holosko & P. A. Taylor (Eds.), Social work practice in health care settings (pp.3-19). Toronto: Canadian Scholars' Press.

Fischer, J. (1978). Effective casework practice: An eclectic approach. New York: McGraw Hill.

Fischer, J., & Corcoran, K. (1994). Measures for clinical practice, Vol. 1(2nd edn.). New York: Free Press.

Freeman, A., Pretzer, J., Fleming, B.. & Simon, K. M. (1990). Clinical applications of cognitive therapy. New York: Plenum Press.

Freeman, A., & Simon, K. M (1989). Cognitive therapy of anxiety. In A. Freeman, K. Simon, L. Beutler & H. Arkowitz (Eds.), Comprehensive handbook of cognitive therapy (pp. 347-365). New York: Plenum Press.

Gingerich, W. J. (2000). Solution-focused brief therapy: A review of the outcome research. Family Process, 39(4), 477-498.

Gitlin, M. J. (1990). The psychotherapists guide to psychopharmacology. New York: Free Press.

Gitterman, A. (1982). The use of groups in health settings. In A. Lurie, G. Rosenberg & S. Pinsky (Eds.), Social work with groups in health settings (pp. 6-24). New York: Prodist.

Gray-Little, B., Williams, V. S. L., & Hancock, T. D. (1997). An item response theory analysis of the Rosenberg Self-Esteem Scale. Personality and Social Psychology Bulletin, 23, 443-451.

Greene, G. J., Lee, M., Trask, R., & Rheinscheld, J. (2000). How to work with clients' strengths in crisis intervention: A solution-focused approach. In A. A. Roberts (Ed.), Crisis intervention handbook: Assessment, treatment and research (2nd ed., pp. 31-35). New York: Oxford University Press.

Hooke, G. R.., & Page, A. C. (2002). Predicting outcomes of group cognitive behaviour therapy for patients with affective and neurotic disorders. Behavior Modification, 26(5), 648-658.

Jemerin, M. D., & Philips, I. (1988). Changes in inpatient child psychiatry: Consequences and recommendations. Journal of the American Academy of Child and Adolescent Psychiatry, 27, 397-403.

Johnson, L. D, & Miller, S. D. (1994). Modification of depression risk factors: A solution focused approach. Psychotherapy: Theory, Research, Practice and Training, 31(2), 244-253.

Jones, J. M. (1993). A comparison of the safety and efficacy of Alprazolam versus other agents in the treatment of anxiety, panic and depression: A review of the literature. Journal of Clinical Psychiatry, 54, 25-48.

Kazantzis, N., Deane, F. P., & Ronan, K. R. (2000). Homework assignments in cognitive-behavioural therapy: A meta-analysis. Clinical Psychology: Scientific Practices, 7, 189-202.

Kiesler, C. & Sibulkin, A. (1987). Mental hospitalization: Myths and facts about a national crisis. Beverly Hills CA: Sage.

Kok, C. J., & Leskela, J. (1996). Solution-focused therapy in a psychiatric setting. Journal of Marital and Family Therapy, 22, 397-406.

LaFountain, R. M., & Garner, N. E. (1996). Solution-focused counseling groups: A key for school counselors. School Counselor, 43(4), 256-267.

Lambert, M. J., Okiishi, J. C., Finch, A. E., & Johnson, L. D. (1998). Outcome assessment: From conceptualization to implementation. Professional Psychology: Research and Practice, 29, 63-70.

Larkin, R. & Thyer, B. A. (1999). Evaluating cognitive-behavioral group counseling to improve elementary school students' self-esteem, self-control, and classroom behavior. Behavioral Interventions, 14, 147-161.

Leary, M. R. (1999). Making sense of self-esteem. Current Directions in Psychological Science, 8, 32-35.

Lindsay, W. R., Gamsu, C. V., McLaughlin, E., Hood, E. M., & Espie, C. A. (1987). A controlled trial of treatment for generalized anxiety. British Journal of Clinical Psychology, 26, 3-15.

MacDonald, A. H. (1996). Mount Hope then and now: A history of the Nova Scotia Hospital. Dartmouth, NS: The Nova Scotia Hospital.

McKay, M., & Fanning, P. (1992). Self-esteem: A proven program of cognitive techniques for assessing, improving, and maintaining your self-esteem (2nd ed). Oakland: New Harbinger Publications Inc.

Miller, P., Kreitman, N., Ingham, J., & Sashidharan, S. (1989). Self-esteem, life stress and psychiatric disorder. Journal of Affective Disorders, 17, 767-770.

Nathan, P. E., & Gorman, J. M. (2002). A guide to treatments that work (2nd ed). New York: Oxford University Press.

Nova Scotia Health Council. (2001). Nova Scotia's health goals. Halifax, NS: Government of Nova Scotia.

Nova Scotia Hospital. (1992). A guide to the Nova Scotia Hospital [Brochure]. Dartmouth, NS: Author.

Nova Scotia Hospital. (2001). The Nova Scotia Hospital and capital district mental health program. Dartmouth, NS: Author.

O'Hanlon, W. H., & Weiner-Davis, M. (1989). In search of solutions: A new direction in psychotherapy. New York: W. W. Norton.

Page, A. C., & Hooke, G. R. (2003). Outcomes for depressed and anxious inpatients discharged before or after group cognitive behaviour therapy: A naturalistic comparison. The Journal of Nervous and Mental Disease, 191(10), 653-659.

Perris, C. (1989). Cognitive therapy with the adult depressed patient. In A. Freeman, K. Simon, L. Beutler & H. Arkowitz (Eds.), Comprehensive handbook of cognitive therapy (pp. 299-319). New York: Plenum Press.

Peterson, L. (1989). Navane vs. Haldol: Treatment of acute organic mental syndromes in the general hospital. General Hospital Psychiatry, 11, 412-417.

Preston, J., Varzos, N., & Liebert, D. (1995). Every session counts: Making the most of your brief therapy. San Luis, CA: Impact Publishers.

Purdy, E. C. (1976). History of the Nova Scotia Hospital. Dartmouth, NS: The Nova Scotia Hospital.

Reid, K. E. (1991). Social work practice with groups: A clinical perspective. Pacific Grove, CA: Brooks Cole.

Rice, A., H. (2000). Interdisciplinary collaboration in health care: Education, practice, and research. National Academies of Practice Forum: Issues in Interdisciplinary Care, 2, 59-73.

Roberts, J., Kassel, J. D., & Gotlib, I. H. (1995). Level and stability of self-esteem as predictors of depressive symptoms. Personality and Individual Differences, 19, 217-224.

Robins. R., W., Hendin, H. M., & Trzesniewski, K.H. (2001). Measuring global self esteem: Construct validation of a single-item measure and the Rosenberg Self-Esteem Scale. Personality and Social Psychology Bulletin, 27(2), 151-161.

Rosenberg, M. (1979). Conceiving of the self. New York: Basic Books.

Rothman, J. (1994). Practice with highly vulnerable clients: Case management and community-based service. Englewood Cliffs, NJ: Prentice Hall.

Salem, D. A. (1990). Community-based services and resources: The significance of choice and diversity. American Journal of Community Psychology, 18, 909-915.

Saxe, L., Cross, T., & Silverman, N. (1988). Children's mental health: The gap between what we know and what we do. American Psychologist, 43, 800-807.

Schwartz, I. (1989). Hospitalization of adolescents for psychiatric and substance abuse treatment. Journal of Adolescent Health Care, 10, 1-6.

Schwartz, R. M. (1982). Cognitive-behavior modification: A conceptual review. Clinical Psychology Review, 2, 267-283.

Scott, J., Williams, J. M. G., & Beck, A. T. (1992). Cognitive therapy in clinical practice: An illustrative casebook. New York: Routledge.

Sharry, J., Darmody, M., & Madden, B. (2002). A solution-focused approach to working with clients who are suicidal. British Journal of Guidance & Counseling, 30(4), 383-399.

Sundman, P. (1997). Solution-focused ideas in social work. Journal of Family Therapy, 19, 159-172.

Tilbury, D. (1993). Working with mental illness: A community-based approach. London: Macmillan.

Wallis, D. A. (2002). Depression, anxiety and self-esteem: A clinical field study. Behavior-Change, 19(2), 112-120.

Walter, J. L., & Peller, J. E. (1992). Becoming solution-focused in brief therapy. New York: Brunner Mazel.

Warren, R., McLellarn, R. W., & Ponzoha, C. (1988). Rational-emotive therapy vs general cognitive-behavior therapy in the treatment of low self-esteem and related emotional disturbances. Cognitive Therapy and Research, 12(1), 21-37.

Weick, A. (1986). The philosophical context of a health model of social work. Social Casework, 67, 551-559.

Weithorn, L. (1988). Mental hospitalization of troublesome youth: An analysis of skyrocketing admission rates. Stanford Law Review, 40, 773-838.

Werner, J. L. & Tyler, J. M. (1993). Community-based interventions: A return to community mental health centers' origins. Journal of Counseling and Development, 71, 689-692.

Wessler, R. L., Hankin-Wessler, S. (1989). Cognitive group therapy. In A. Freeman, K. Simon, L. Beutler & H. Arkowitz (Eds.), Comprehensive handbook of cognitive therapy (pp. 559-581). New York: Plenum Press.

Wong, J., Whitaker, J. (1994). The stability and prediction of depressive mood states in college students. Journal of Clinical Psychology, 50, 715-722.

Working Group on Mental Health. (1992). Draft consultation paper: A vision for the future of Nova Scotia mental health care. Halifax NS: Nova Scotia Government.

Appendix A: Sample Community Referral Form

 RE:_____(Name of Client)

MENTAL HEALTH HISTORY (including outpatient therapy, hospitalizations and diagnoses):_____

MEDICAL HISTORY AND ALLERGIES: _____

MEDICATION HISTORY (include start date of present medications, and comment on adherence to and effectiveness of prior treatment plans)_____

PRELIMINARY DIAGNOSTIC IMPRESSION: _____

OTHER COMMUNITY AGENCIES / SERVICES INVOLVED (Worker's Name and Phone #.):_____

WHAT IS BEING REQUESTED? (Pick One) ☐ One-time Consultation; ☐Ongoing Therapy; ☐ Other (Explain):

Specify Goals:_____

Would you be willing to follow the client ***for these mental health issues*** after the assessment, with consultative support as needed from our clinical staff? ☐ Yes ☐ No

Form completed by:_____Signature:_____

INTAKE WORKER ONLY

Date intake completed:_____ Priority level for follow-up: ①☐ ②☐ ③☐

Disposition of Referral: ☐ Closed Assigned to:_____Referral source informed?_____

Comments: _____

Intake Worker:_____Signature:_____Date:_____

Appendix B: Sample Internal Referral Form

Mental Health Services
INTERNAL REFERRAL FORM
This form is to be used to make referrals within Mental Health Services -
Bed/Sack ☐ Dartmouth ☐ Hfx.Co. ☐

CLIENT NAME: _____ NSH UNIT # _____

PHONE NUMBER: _____

DATE OF REFERRAL: _____ REFERRED TO DISCIPLINE [ ]

Psychiatry [1] Psychology [2] Nursing [3] Social Work [4] O.T. [5] Dietitian [6] Recreation [7] Other [8] _____

NATURE OF REQUEST (Additional Information)

☐ Consultation
☐ Assessment
☐ Individual Therapy
☐ Group Therapy (specify group)
_____
_____
_____

☐ Primary Clinician to Continue Involvement
☐ Primary Responsibility Transferred to Receiving Clinician (includes group leader)
☐ Recent Other Group Involvement (names)
_____
_____
_____

Client Availability: ☐ anytime ☐ morning ☐ afternoon ☐ evening

RELEVANT CLIENT INFORMATION (include preferred location to be seen and clients supports outside system)

_____
_____
_____
_____
_____

DETAILS OF REQUEST (include areas requiring assessment/intervention or specific issues you would like addressed). This section must be completed.

_____
_____
_____
_____

HAS THIS REFERRAL BEEN DISCUSSED WITH THE CLIENT? [ ] YES [ ] NO

REFERRED BY: _____

ASSIGNED TO: _____ DATE ASSIGNED: _____

Appendix C: Sample Brief Assessment Form

Form #46
Jan. 17, 2000
/ws

THE NOVA SCOTIA HOSPITAL

BRIEF ASSESSMENT

CLIENT NAME: _____

CIRCUMSTANCES OF REFERRAL:
HISTORY OF PRESENTING ILLNESS/PROBLEMS:
RELEVANT PSYCHIATRIC/MEDICAL/SOCIAL BACKGROUND (include allergies):

THE NOVA SCOTIA HOSPITAL
BRIEF ASSESSMENT

CURRENT TREATMENT/MEDICATIONS:

MENTAL STATUS EXAM:

PROVISIONAL DIAGNOSIS/TREATMENT PLAN:

Attachments: MMSE ☐ Psychiatric Note ☐ Additional Page ☐ Tests ☐

Signature: _____ Date: _____ Time: _____

Appendix D: Sample Long Assessment Form

Form #47
January 17, 2000
/ws

THE NOVA SCOTIA HOSPITAL
ASSESSMENT

CLIENT NAME: _____

CIRCUMSTANCES OF REFERRAL

HISTORY OF PRESENTING ILLNESS/PROBLEMS

History of Present Illness Cont'd...

PAST PSYCHIATRIC HISTORY:

MEDICAL HISTORY (past and current health status):

Allergies/Sensitivities:

Substance Use/Abuse/Dependency:

THE NOVA SCOTIA HOSPITAL
ASSESSMENT

Current Medication (including non-prescription drugs):		
Medication	**Dosage**	**Remarks**

PHARMACY USED: **METHOD OF PAYMENT:**

FAMILY HISTORY:

Genogram:

PERSONAL/DEVELOPMENTAL/SOCIAL HISTORY:
Birth/Early Development:
Abuse (emotional/physical/sexual):
Education/Employment:
Social/Sexual/Marital Relationships:
Forensic/Illegal Acts:

THE NOVA SCOTIA HOSPITAL
ASSESSMENT

PERSONALITY/STRENGTHS:

LIFESTYLE (support networks/financial status/daily activities/routines/cultural/spiritual values and beliefs):

MENTAL STATUS EXAM:
Appearance -
Behaviour/Psychomotor Activity/Involuntary Movements -
Speech -
Thought Form -
Thought Content -
Perceptual Disturbances -
Mood -
Affect -
Suicidal/Homicidal Ideation -
Cognitive Status (orientation and memory)
Understanding of Illness and Treatment -
Judgement -

THE NOVA SCOTIA HOSPITAL
ASSESSMENT

SUMMARY/PROVISIONAL DIAGNOSIS (Indicate Axis I-V):

TREATMENT PLAN:

Key Issues	Interventions/Recommendations

Attachments: MMSE ☐ Additional Page ☐ Tests: _____

Rights and Responsibilities/Consent and Confidentiality have been discussed: Yes ☐ No ☐

Assessed by: _____ **Date:** _____ **Time:** _____

PSYCHIATRIC NOTE:

Signature: _____ **Date:** _____ **Time:** _____

Appendix E: Sample Rosenberg Self-Esteem Inventory

ROSENBURG SELF-ESTEEM INVENTORY (RSEI)

Instructions:

Please indicate how characteristic each of the following statements is of you by using the scale below to show whether you agree or disagree with each statement.

1 - strongly disagree
2 - disagree
3 - agree
4 - strongly agree

_____ 1. On the whole, I am satisfied with myself.

_____ 2. I feel that I have a number of good qualities.

_____ 3. I am able to do things as well as most other people.

_____ 4. I feel that I am a person of worth, at least on an equal plane with others.

_____ 5. I take a positive attitude toward myself.

Total items

1 to 5 _____

_____ 6. At times I think I am no good at all.

_____ 7. I feel I do not have much to be proud of.

_____ 8. I certainly feel useless at times.

_____ 9. I wish I could have more respect for myself.

_____ 10. All in all, I am inclined to feel that I am a failure.

Total items

6 to 10_____

Total Items 1 to 5 _____

total items 6 to 10 + _____

Total Score = _____

Appendix F: Sample Post-Meeting Reaction Form

POST MEETING REACTION

1. Was this experience useful in helping you think and learn about yourself? (Circle the one that most closely represents your opinion.)

1 poor	2 fair	3 satistactory	4 good	5 excellent

2. Do you feel you know yourself any better?

1 poor	2 fair	3 satisfactory	4 good	5 excellent

3. How would you rate your session, overall?

1 poor	2 fair	3 satisfactory	4 good	5 excellent

4. Do you feel you learned something new today? Yes ☑ No ☐

Comments:

5. Please list at least one thing you liked about today's session.

6. Please list at least one thing you disliked about today's session.

Appendix G: Sample Group Participant Evaluation Form

PARTICIPANT EVALUATION FORM FOR SELF-ESTEEM GROUP

Date:_____ Please Check: ☐ Morning ☐ Afternoon

	Circle the number to the right that best describes how you feel	Agree Strongly	Agree	Neutral	Disagree	Disagree Strongly
1	The overall objectives of the program were met.	5	4	3	2	1
2	My personal goals for this experience were achieved.	5	4	3	2	1
3	The sessions were clear, understandable, and well organized.	5	4	3	2	1
4	The teaching methods were helpful to me.	5	4	3	2	1
5	The room was comfortable and pleasant.	5	4	3	2	1
6	The Group was a valuable learning experience.	5	4	3	2	1
7	This experience will be helpful in my personal life.	5	4	3	2	1
		Every Day	Frequently	Sometime	Almost Never	Never
8	How often did you do the self-help exercises between sessions?	5	4	3	2	1
		Very Helpful	Helpful	Neutral	Somewhat Unhelpful	Very Unhelpful
9	How helpful were the self-help assignments between sessions?	5	4	3	2	1
10	How helpful were the discussions during sessions?	5	4	3	2	1
11	How helpful were the group exercises?	5	4	3	2	1
12	How helpful and supportive were the group leaders?	5	4	3	2	1
13	How helpful and supportive were the other group members?	5	4	3	2	1
14	How helpful was the group in understanding your moods?	5	4	3	2	1
15	How helpful was the group in learning to change your moods?	5	4	3	2	1
16	How helpful was the group in developing better self-esteem?	5	4	3	2	1
17	How helpful was the group overall?	5	4	3	2	1

PLEASE COMPLETE OTHER SIDE!

PARTICIPANT EVALUATION FORM FOR SELF-ESTEEM GROUP (Page 2)

18 Please explain any low rating:

19 What did you like the least about the group?

20 What did you like the most about the group?

21 What did you learn that will be the most helpful to you?

22 General Comments:

Thank-You!

Appendix H: Sample Post Session Reaction Form

Client gender (please circle): male female
Presenting problem: _____
Date: _____

POST SESSION REACTION

1. Was this experience useful in helping you to think and learn about yourself? (circle the one that most closely matches your opinion)

   very much somewhat neutral not very much not at all

2. Do you feel that you have learned any new skills or ways of thinking that might help you to overcome your problem?

   very much somewhat neutral not very much not at all

3. How optimistic are you that you have the ability to make a positive change in your life?

   more less neutral

4. Please list at least one thing that you liked about today's session.

   _____
   _____
   _____

5. Please list at least one thing that you disliked about today's session.

   _____
   _____
   _____