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By

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Embracing a Strength-Based Philosophy and Reflective Practice with Supervision as a Mental Health Therapist at the Alliance Centre of Sturgeon Falls, Ontario

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Abstract

This advanced practicum report will detail my experience training as a Mental Health Therapist at the West Nipissing General Hospital's The Alliance Centre in Sturgeon Falls, Ontario. The 450-hour advanced practicum was completed in the Mental Health Counselling Treatment Program with the direct supervision of Lynn Perreault, program manager and director, and registered psychotherapist.

A strength-based philosophy was the key paradigm of influence in my role as a Mental Health Therapist working at The Alliance Centre. My primary goals were to incorporate a strength-based philosophy within all elements of intervention, assessment, and treatment; and to actively submerse myself into the social work practice of supervision.

Within this practicum report, research surrounding a strength-based philosophy in mental health treatment and interventions will be reviewed including a comprehensive literature review with peer-reviewed literature surrounding the history of madness, motivational interviewing, narrative therapy, brief solution-focused practice and social work supervision will be explored. To conclude, I will summarize how I met my learning goals and discuss how the outcomes of my practicum will influence my work in the future as a mental health therapist.

Throughout my time spent at practicum, I was able to build upon my existing research and incorporate strength-based approaches into my everyday work with people. I also experienced reflective practice through the use of bi-weekly supportive supervision with my direct supervisor at The Alliance Centre and focus on my own strengths and resources as a strengths-based enthusiast. Supervision enriched my practicum experience because it was

reflective of the strengths-based theoretical underpinning that I wanted to model with the people that I had the opportunity of working with.

Abstrait

Ce rapport de stage avancé détaillera mon expérience de formation en tant que thérapeute en santé mentale au Centre Alliance de l'Hôpital général nipissing ouest à Sturgeon Falls, en Ontario. Le stage avancé de 450 heures a été complété dans le cadre du Programme de counseling en santé mentale avec la supervision directe de Lynn Perreault, gestionnaire et directrice du programme, et psychothérapeute autorisée.

Une philosophie fondée sur la force a été le paradigme clé de l'influence dans mon rôle de thérapeute en santé mentale travaillant au Centre Alliance. Mes principaux objectifs étaient d'intégrer une philosophie fondée sur les forces dans tous les éléments de l'intervention, de l'évaluation et du traitement; et de me plonger activement dans la pratique du travail social de la supervision.

Dans ce rapport de stage, la recherche entourant une philosophie fondée sur les forces dans le traitement et les interventions en santé mentale sera examinée, y compris une revue complète de la littérature avec de la littérature évaluée par des pairs entourant l'histoire de la folie, les entrevues motivationnelles, la thérapie narrative, la pratique brève axée sur les solutions et la supervision du travail social. Pour conclure, je résumerai comment j'ai atteint mes objectifs d'apprentissage et discuterai de la façon dont les résultats de mon stage influenceront mon travail à l'avenir en tant que thérapeute en santé mentale.

Tout au long de mon séjour au stage, j'ai pu m'appuyer sur mes recherches existantes et intégrer des approches fondées sur la force dans mon travail quotidien avec les gens. J'ai pu faire l'expérience de la pratique réflexive grâce à l'utilisation d'une supervision de soutien

bihebdomadaire avec mon superviseur direct à l'Alliance Centre et me concentrer sur mes propres forces et ressources en tant que passionné basé sur les forces. La supervision a enrichi mon expérience de stage parce qu'elle reflétait le fondement théorique fondé sur les forces que je voulais modéliser avec les personnes avec lesquelles j'ai eu l'occasion de travailler.

Acknowledgements

I would like to thank my readers, Dr. Diana Coholic, and Mary Jago. I am grateful for your guidance and mentorship throughout this writing process. Your social work expertise and knowledge are admirable and refreshing. This project would not have been completed without your constant support and guidance. I truly admire the work that you both do and remain grateful for this advanced practicum opportunity.

I would also like to acknowledge my supervisor, Lynn Perreault. Thank-you for your constant support and encouragement throughout this process. The relationship that we built throughout this experience has forever changed me. Thank-you for always listening, and for inspiring me to embrace my own strengths in the work that I do with people.

To my family, thank-you for the encouraging words and support throughout this experience. You helped me to see the light at the end of the tunnel, as you all always seem to do. To my mom, thank-you for always shining your bright light in my life. To my dad, thank-you for passing down your brain, as you always tease. To my older sister, thank-you for being my biggest cheerleader since we were kids. And to my little brother, thank-you for choosing me to be your favourite big sister. That means a lot coming from you.

To my loving and supportive spouse that I have shared ten-years of my life with, thank-you for putting up with me throughout this adventure; you are my rock. Together, we beat cancer, a heart-attack, and so many other obstacles. We are resilient, and we have so many strengths within us to endure whatever comes next. I could not have done this without you.

And lastly, I would like to celebrate the life of my dog who passed away last year before this journey began. To my forever soulmate, and best little friend, until we meet again, thank-you for healing me.

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Introduction

The Alliance Centre in Sturgeon Falls delivers various mental health and substance abuse services in the West Nipissing district in Ontario, Canada for adults (16+) seeking services. This advanced practicum project outlines the rationale and learning goals behind the chosen strength-based perspective and reviews relevant strengths-based literature in connection with my learning goals and foundational questions and reflects on my learning experience in mental health treatment and clinical supervision.

I entered the Master of Social Work Program at Laurentian University with the intent on completing a 450-hour practicum in some form of mental health counselling and treatment due to my previous experience with experiential learning. Within my Bachelor of Social Work, I completed a 450-hour practicum with the Near North District School Board working as a social worker with youth. That practicum experience was so valuable to me as a novice social worker, and working with youth experiencing mental health struggles was what sparked my interest in the mental health system.

Soon after graduating from Nipissing University, I became employed as a mental health case manager, working in the Extensive Case Management Program at The Alliance Centre. My previous role entailed working with people living in the community of Sturgeon Falls, Ontario. My role as a case manager consisted of providing on-going assistance to people experiencing severe and persistent mental illness to ensure stability and safety. This often-entailed escorting people to their medical appointments, helping with funding/resources, conducting residential

visits to ensure that the person was functioning and taking their prescribed medications, and being a support to the person to ensure that they maintained proper wellness.

When I enrolled as a MSW student in the Fall of 2023, I was informed that I would have the opportunity to complete my practicum in the Mental Health Treatment Program and was further informed that I could secure the position upon completion of my MSW degree. Thus, my intention throughout this experience was to apply what I value as a social worker and rethink what I had experienced in the previous five-years working as a case manager in what I consider a very flawed Westernized mental health care system. In my previous role, the model of care was very much centered around the person's diagnosis rather than their strengths/resources. Their status was assigned by their deficiencies, which in my opinion robbed them of their inherent powers and potential for growth. With some exceptions, I believe that we live in a society that is infatuated with frailties, weaknesses, faults, and pathologies, hence, why I wanted to re-focus the development of a practice approach. Despite the real-life problems that all people encounter, my point throughout this experience was to listen for glimmers of strengths whenever possible despite a person's presenting symptoms/diagnosis.

Due to the creative freedom provided in this advanced practicum experience, I was able to shift my focus away from a medical lens of treatment and steer my attention to the person rather than their circumstance. The assessment process was beneficial in allowing for collection of strengths due to its consideration of the individual in a holistic sense. Further, I was able to incorporate a strengths-based perspective in my approaches with people by remaining flexible and holistic in my service-delivery. Luckily, The Alliance Centre demonstrated a very person-centered approach within their agency and culture which is why I feel that this practicum was so prosperous.

Chapter 1 – Literature Review

To gain a more complete understanding of my practicum experience, and to provide a better context to the foundation of my overall practicum approach and learning goals, it is imperative to review relevant strength-based literature, and its current mental health treatment methods, tools, and interventions, since the basis of my practicum remained centered around a strength-based perspective and practice approach. I will also explore the history of Westernized mental health diagnosis and link it to mental health treatment. Further, it is important that I review the impacts and experiences of supervision from the supervisee perspective as it was a primary learning goal of mine throughout my practicum to engage in effectual bi-weekly supervision as a new mental health therapist. Thus, within this literature review, varying articles (theoretical, qualitative, and empirical), describing madness and mental health, the strengths-based perspective and social work supervision will be reviewed and analyzed.

To begin, several journal articles focusing on the strengths-based perspective were reviewed as a basis for both learning and relating the methods that I applied with people in the mental health treatment program (e.g., tree of life exercise, motivational interviewing, narrative therapy, brief solution focused therapy). The strengths-based perspective is an approach that The Alliance Centre was very open to including due to their person-centered approach with people. Everyone at the agency was familiar with a strength-based perspective, and many were already applying it within their own work with people, and within assessment and treatment planning.

Entering practicum, I was happy to observe that the current treatment plan, located in the computer database, dedicated one portion of the assessment to the person's strengths.

Admittedly, this was something that I was very excited about, and something that I knew I would be focusing on when meeting with new people and conducting an assessment.

I had spoken candidly with my supervisor prior to beginning this new venture and informed her that my focus was to drift away from assigning social status to deficiencies, differences, and defects, and that I would rather consider this endeavor as a new way of thinking and being (Saleebey, 2004). Reflecting Saleebey's strengths-based practice principles, it is my conviction that we live in a culture where people are often labelled, judged, diagnosed, and dishonored, and I believe that our attention should shift and center around what is missing, what is needed, and importantly, what is possible for the person that we are trying to help (Saleebey, 2004).

In my previous work experience as an extensive case manager, I could not help but consistently notice that people were always so consumed with their diagnosis and how often they spoke negatively about themselves. Throughout these very personal and professional experiences, I remember having such empathy for people, and at times, it was hard to hear the things that they said about themselves. For instance, I had one client that I visited once weekly for several years at her residence when I was working as a case manager. She was a very sweet, resourceful, strong, and personable lady. Reflecting upon my memories of her today, I cannot help but remember all the negative things that she used to share with me about herself, and how defined she seemed to be by her clinical diagnosis. For instance, there was an occasion that she reflected that she felt like no man would ever want to be with her because she was bi-polar, and I remember feeling very confused by her statement and questioning what that had to do with another person wanting to be with her in a relationship. Her statement stayed with me and made me realize that so many people think that they are inadequate because of their mental health

diagnosis and often feel inadequate due to societal constructs. Case management very much reflected the diagnose and treat model as the treatment plan remained focused on diagnosis and reducing symptoms and people in the program were very much aware of this. I found this fascinating, which is why I wanted to explore the history of diagnosis and mental health further in my final practicum report due to the strengths perspectives desire to stray away from the medical model and its constant loud message of diagnosis, treatment, and cure.

Saleebey (2004) reported that we live in a dominant culture that is infatuated with frailties, weaknesses, faults, failures, and pathologies, and suggested that we leaven the intense preoccupation with symptoms and labeling and rather focus our attention to understanding life's problems and the virtues of people who suffer them (Saleebey, 2001). Therefore, I knew going into this experience that it was imperative that I remained mindful of any hints of strengths of everyone that I met with, regardless of where they came from, where they were living, or what their diagnosis was. I wanted to learn from my previous practice experiences and teach people that they were not their diagnosis, or what society perhaps made them believe themselves to be.

The History of Mental Health

Hogan (2016) reported that prior to the 18th century, mental health, alternatively described and labelled as madness by French philosopher Michel Foucault, was coined to describe all abnormal behavior ranging from hallucinations to seizures. Foucault documented that early tracing of the Roman Empire indicated that mad people in civilization were once treated with respect and left undisturbed despite their low social classes and deviant behavior. As time progressed, throughout the renaissance period, Foucault emphasized that the mad shifted in society and became regarded as wise beyond the natural world, divergent, and divine. Despite

their abnormalities and straying from societal norms, the mad were never considered ill nor in need of diagnosis, treatment, or cure.

Hogan (2016) reported that insanity was socially constructed as an illness when it began conflicting with Western culture during The Enlightenment period at the turn of the 18th century. In Western publics, the mad were viewed as no longer able to contribute to society. Thus, became the birth of The Great Confinement, and the asylum for the insane, when the public quickly began rejecting the mad, isolating them from society, behind walls, to be studied and subjected to experiment and procedure. The mad were locked away, and became regarded as diseased, ill, and in need of repair (Hogan, 2016).

Western publics first introduced medical attempts to cure conditions of the mind, including the lobotomy, which gained popularity in the mid-twentieth century, with the concept of restoring normal behavior. The invasive procedure was completed on individuals with symptoms ranging from depression to schizophrenia. Ironically, very few patients were deemed sane after treatment. Most had reduced intellect and were stripped of their unique personalities, strengths, assets, and wit. Despite the negative impacts, the lobotomy paved the foundation to represent the first cure for madness inspiring the era of antipsychotic medication treatments that continue to persist today.

Hogan (2016) also reported that mental illness is not a fixed and objective reality but rather shaped by social and historical factors subject to change over time. Conrad and Barker (2010) shared Hogan's perspective in their work and described how mental illness is socially constructed by diagnosing abnormal behaviors as a form of social control. The authors go on to highlight Michel Foucault's perspective on knowledge and power in the mental health system.

Specifically, they argue that expert knowledge about human normality and abnormality, which is objective or naturally given, is the principal form of power in modern society (p. 69).

The authors related that Foucault's perspective further emphasizes that Westernized medical discourse can influence a person's behaviors and impact their subjective experiences, shape their identities, and legitimate medical interventions by altering a person's subjective identity (Roberts, 2005). Similarly, in a study by Esposito and Perez (2014) it was concluded that most psychiatric treatments merge with neoliberal ideology, where definitions of normal, sane, and illness are determined primarily by market considerations that are determined by large segments of the population as akin to natural law (p. 433).

From a Foucauldian perspective, social control is evident in mental health treatment as individuals continue to modify their mental health and adjust to a chaotic, structured, neoliberal world. For instance, Hogan (2016) highlighted that individuals seeking medications to feel "normal" in mental health treatment reflect a neopositivist system that limits the individual's power and ascribes their identity as someone with a mental health diagnosis that carries prejudice and stigma with them in their everyday narrative. The diagnosis impacts the individual's self-image and how they perceive themselves in society and defines them as abnormal and damaged to fit the prevailing Western market order (e.g., the DSM-IV).

Statistically speaking, half of the Canadian population will have a panic attack at some point in their lifetime (Hogan, 2016). Others may be at the mercy of their own psychiatric experience and find themselves in the grips of despair and unable to find their own strengths after having a negative or traumatic experience (Hogan, 2016). As Foucault highlighted, it is time for open dialogue to begin where we can all admit that we all go a little mad sometimes and

that we have within us the resilience to overcome what happens to us despite our provided labels or diagnosis.

Foucault affirmed that the history of mental health ascribed identity to people by varying parties over time (Hogan, 2016). Once, the helpless victim, next, the madman was seen as having chosen unreason. Then, the madman existed as a danger to society, confined by walls and tucked away for isolation and testing. Finally, the madman, now referred to as mentally ill, is seen as an ill patient, in need of some form of a diagnosis, treatment, and cure. Alternatively, the Ontario College of Social Workers and Social Service Workers (2024) highlighted that social workers should avoid labelling people and emphasized the human capacity for resilience, resistance, courage, strength and ingenuity in hopes of helping people to form and achieve their goals and aspirations.

Grant and Cadell (2009) shared a similar perspective and highlighted that mental health treatment should abandon the medical assumption that understands mental illness as an objective medical fact and rather focus on the strengths of people within assessment and intervention. According to Grant and Cadell (2009), mental health treatment today is judged according to a set of pseudo-scientific norms, protocols, and schematics, and people are deemed as being either normal or abnormal. For instance, Saleebey (2001) emphasized that the DSM-IV provides an insufficient and hard-to-operationalize conceptualization of mental health and insisted that this lack of a clear definition permits an ever-widening net of definitions of disorders so that all manner of common human foibles, annoying traits, and bad habits are captured as mental disorders, according to the DSM-IV handbook (p. 183). For instance, social, medical, political, and scientific processes that have nourished the development of the DSM-IV reflect an evolving social norm that decrees behaviors, altered emotional and mental states, and human conditions as

deficiencies that require diagnosis, medication, and treatment, making it virtually impossible to consider the assets, talents, resilience, and environmental resources of a person (Saleebey, 2001). From my perspective, to ignore these elements disregards the most important resources in helping a person heal and rise above, and adapt to their situations, or simply adjust to the effects of a devastating traumatic experience. As people, we face enough pain and heartache throughout our human experience without having to experience an iatrogenic push toward chronicity and a social nudge toward alienation (Saleebey, 2001, p. 186).

A Humanistic, Strength-Based Mindset

Popularized in the 1980's by a team of social workers at the University of Kansas, Dennis Saleebey, Ann Weick, and Charles Rapp, introduced a perspective that focuses on peoples' strengths rather than their weaknesses, maintaining the belief that strengths can encourage overall health and well-being in all bio-psycho-social-spiritual elements leading to a more holistic picture of the individual (Bozic, 2011; Chen et al., 2011). Throughout practicum, my goal was to consider the strength-based philosophy as more so a mindset, rather than a particular model or intervention (Hirst et al., 2011). Within this mindset, I viewed my clients for their strengths despite their bothersome situations around them. This did not mean that I abandoned the medical model completely, however, I remained focused on implementing a strength-based perspective that considered what people cared about as most valuable to their treatment and recovery. Objectively, my goal was to embrace the client in the working alliance and keep them motivated to change by incorporating their interests, passions, and aspirations, and allowing for a positive therapeutic relationship to form (Starnino et al., 2011).

Saleebey (2000) argued that 'the strengths perspectives can allow workers to understand that, however defeated or sick, individuals have survived, and in some cases even thrived. They

have taken steps, summoned up resources, and developed coping mechanisms. We need to know what they have done, how they have done it, what they have learned from doing it, and what resources were available in their struggle to prevail their troubles. People are always working on their situations, even if just deciding to be resigned to them; as helpers we must tap into that work, elucidate it, find, and build on its possibilities' (p. 461).

Saleeybey (2001) described the long-standing concerns within the DSM-IV and its lack of inclusion for individuals' positive characteristics due to deficit focused intervention models. "To disregard an individual's strengths is to ignore the most important resources in helping a person adapt to stressful or traumatic situations and improve their quality of life" (p. 184). It was further suggested that the DSM-IV include a completely new axis that considers the strengths of the individual and the resources in their environment. This could include any skills, talents, cultural prevalence, traits, interpersonal skills, sense-of-humor, relationships, and personal virtues. Other considerations could include hopes and dreams, occupational goals, and visions for the future, and how the person came to survive and surmount barriers.

Manthey et al. (2020) mirrored similar points and reported that strength-based practice was an initial stance taken to oppose the mental health system with its fixation on diagnosis, deficits, labelling and problems, as witnessed within the DSM-IV. Thus, Manthey et al. (2020) emphasized that strengths-orientated social workers focus on direct interventions that do not identify people according to their diagnoses and avoid negative terms such as psychopath, poor, manic-depressive, an addict, an offender, a child welfare case, or a sociopath, to avoid elevating the deficit to the status of dominant identity of the person.

Strengths have been linked to prediction of positive mental health outcomes (Bozic, 2011; Caiels et al., 2023; Chen et al., 2011; Cohen, 2011; Hirst et al., 2011; Manthey et al., 2020;

Rust et al., 2011; Saleebey, 2000; Saleebey, 2001; Starnino et al., 2011). In a research study by Caiels et al. (2023), the authors reported that many clients tend to focus on what is wrong with them, rather than what is right when speaking with a mental health professional. It was suggested that this is perhaps due to many familiarized, fault-focused medical models within neo-liberalist structures. Caiels et al. (2023) expressed that moving beyond imbedded Western frameworks helps social workers to better embrace a more client-centered approach that contains a mindset that is based on self-determination, motivation, and human capacity. It was further suggested that social workers stray away from medical models and always consider the individual's strengths in all areas of the therapeutic process emphasizing that it helps to regain our orientation to the populations that need it most and assists to generate positive and measurable outcomes in a holistic empowering way (Cohen, 2011, p. 465).

Bozic (2013) argued that when professionals become more interested in the individuals' strengths that the balance of power between professional and client shifts towards a more equal footing simply by introducing different options, including motivational interviewing, and narrative therapy (p. 19). Bozic (2013) went on to emphasize the significance of assessing and identifying strengths early-on in assessment by generating information that can later inform interventions. Similarly, Saleebey (1992) reported that the focus on assessment and its guiding notion in work with clients is a way of learning about their unique qualities and how to effectively collaborate with them throughout the therapeutic process in an empowering way (p. 27).

Throughout practicum, I considered empowerment as both a process and a goal for people. As a process, it was the collaboration between me and the person with a mutual understanding of moving closer to their proposed vision. As a goal, I strived to empower people by providing a

palpable awareness of their achievements and connections to recourses. As Saleebey (2000) promoted, the strengths perspective is about uncovering, naming, embellishing, and celebrating abilities, and talents in the service of desired change (p. 128). Saleebey (2001) further highlighted that practitioners consider all personal and social resources of the individual, including contingent factors that intercede in their lives (p. 130). This includes, how the person views their strengths and assets, how they see their misery and motivation, and their social supports. It also means remaining mindful of the person's biological, social, spiritual, and physical elements including, their relationships, culture, opportunities, and the conditions to which might be positive, joyous, helpful, and/or therapeutic (Saleebey, 2000).

Furthermore, in an article by Saleebey (2000), he emphasized the helping relationship as a powerful tool for healing within a strength-based philosophy. Comparable to the ideology of Carl Rogers, Saleebey (2000) insisted that five key determinants are required in the helping relationship including: genuineness, concern, collaboration, empathy, and respect (p. 131). Throughout my own relationships with people I work with, I wanted to believe that they had within themselves the strengths that could contribute to their healing and recovery, regardless of the matters that they related within treatment. For instance, in a 12-week study by Rust et al. (2011), 131 undergraduates were randomly assigned to two treatment groups. One treatment group included a focus on strengths, and the other treatment group focused on weaknesses. The results of the study indicated that the treatment group that was provided with strengths-based approaches displayed a higher life satisfaction than of those who were provided with a more fault-focused intervention model signaling overall mental health improvement in their everyday lives.

Findings support Schutte and Malouff's (2019) meta-analytic investigation studying the impact of interventions focused on using character strengths. The results suggested that respondents indicated that they felt more positive regarding their overall life satisfaction, as well as improved depressive symptoms and increased well-being. In a similar exploratory qualitative study by Tsoi et al. (2022), researchers observed the impacts of incorporating a strength-based approach to mental health recovery with adults experiencing depression. Participants highlighted that there were three types of strengths that helped to contribute to their recovery including, social supports, spiritual/religious supports, and leisure activities/times of enjoyment. Participants emphasized that simply having access to social networks was important to help buffer stressful times, particularly during the onset period of their mental illness (p. 73). Moreover, religious, and ritual practices including prayer, attendance to church, and teachings were considered vital to participants. Many reported that their faith brought them comfort during difficult times, and when experiencing the loss of a loved one. Finally, doing leisurely activities and listening to music were quoted as two of the most common sources of strength for people. One study participant indicated that music helped him heal and made him feel happy. Most of the participants in the study all agreed that they felt as though strengths were heightened and prompted when engaging in activities that provided them with a sense of purpose and meaning in their lives.

Gray (2011) reported that strength-based practice includes empowering helping models such as motivational interviewing and narrative therapy because they embrace ecological systems and seek to understand the resourses available to clients within the environment in which they live. According to Gray (2011), practitioners should acknowledge the individuals' pain, stimulate discourse and narrative about their personal strengths, act in context, normalize

the problem, and capitalize on the strengths and opportunities. Gray (2011) further emphasized the need for practitioners to provide people with empathy and mutuality, and a relationship that fosters a trusting and supportive partnership that offers a human-centered means of joining the person on equal ground. In the next section, I move the focus to narrative therapy and how it relates to a strengths-based approach.

The Narrative Tradition

Narrative therapy is a strength-based psychotherapeutic approach based on a way of perceiving, hearing, and thinking about client problems (Tadros et al., 2022). It gives meaning to lived experiences by allowing people to have a voice within therapy that is led by empowerment and collaboration (Tadros et al., 2022). As the Ontario College of Social Workers and Social Service Workers (2008) reminds us "A social worker or social service worker shall respect the intrinsic worth of the persons she or he serves in her or his professional relationships with them" (p. 8). Within a narrative philosophy, problems are not seen as defining, but rather as arising from oppressive stories which dominate the individual's life (Bubenzer et al., 1994). Franks (2018) asserted that difficulties in people's lives are a result of cultural, social, and political contexts and that behind any problem lies relations of power. Corresponding to social work ethics and values, a holistic mindset acknowledges that health is a complex system made up of many intricate elements and incorporates an awareness of inequity, an acknowledgement of the social determinants of health, and the power structures that shape society (Ashcroft et al., 2017, p. 462).

Ricks et al. (2012) reported that incorporating narratives into mental health treatment helps to facilitate clients to express their inner thoughts, feelings and experiences and find an alternate resolution by externalizing their oppressive experiences (p. 99). Comparably, Lopes et al. (2014)

embraced the humanistic mindset and argued that the overall purpose of psychotherapy is to help people recount their life stories in richer, more satisfying ways (p. 662).

Thus, my focus within practicum was to hear my clients' stories to better understand their lived-experiences, perspectives, and perceived realities. Language was essential within my client interactions as the research literature asserts that it can be a powerful tool that can help alter clients' stories to express their positive and preferred identities (Tadros et al., 2022, p. 448). Collaboration was also important within treatment to promote a non-hierarchical relationship or trust and mutuality, keeping within the client-centered, strength-based philosophy. Objectively, applying narrative theory within mental health treatment was intended to assist clients in separating from their problematic stories and act as a tool for improving affiliation with their problems (Ricks et al., 2014). Overall, the goal was to help people write a new life story that was more representative of their unique, individual lived experiences.

In a research study by Seo et al. (2015), the authors reported that narrative therapy was useful for treatment of depression in adults, mirroring previous research studies that used narrative therapy with children and adults with eating disorders. Seo et al. (2015) went on to denote that narrative therapy helps to alleviate depression by separating the person from the problem, allowing them to see themselves in a new mindset by the process known as externalization. Similarly, Vromans and Schweitzer (2011) conducted a research study on adults experiencing major depressive disorder and the results indicated that 75% of participants reported significant improvement in depressive symptoms after receiving some form of narrative therapy. Techniques included creative elements such as art, music, journaling, and the tree of life activity. Vromans and Schweitzer (2011) further concluded that narrative therapy was to be utilized, as with any model, with cautions and considerations including the person's physical and

learning abilities, as well as their needs within the counselling process, and what they are interested in accomplishing within a 10-session timeframe.

Motivational Interviewing

Motivational Interviewing was first popularized by Carl Rogers and initially used in substance abuse treatment services during the 1980's and has been described as a client-centered counselling style that elicits behavior change by helping clients to explore and resolve ambivalence (Keeley et al., 2016). Keeley et al. (2021) stated that motivational interviewing is an integrative framework that can enhance the effectiveness of strength-based treatments for depression and behavior change, and highlighted that motivational interviewing is effective in treatment of problems that are common in primary care, including substance use, eating disorders, obesity, mental health, and treatment nonadherence (Keeley et al., 2021, p. 991). Similarly, Arkowitz and Burke (2008) stated that motivational interviewing may be effective in treating people who are clinically depressed and reported that many psychologists described ambivalence as a key element in a depressed person and that motivation is critical for achieving positive client outcomes in psychotherapy work.

In the article "The Impact of Motivational Interviewing by Social Workers on Service Users: A Systematic Review: Research on Social Work Practice" by Boyle et al. (2019), it was argued that there is a spirit behind application of motivational interviewing and defined it as a client-centered force, more so than an intervention/model. Using a systematic review, Boyle et al. (2019) determined the effectiveness of motivational interviewing by social workers on service users' outcomes. They reported that motivational interviewing was helpful across a range of health issues, conditions, and behaviors. It was reported that motivational interviewing had a positive impact on service users due to the shared humanistic values of social work ethics,

flexibility in intervention, and overall service user engagement. Also noted within the study was a need for social workers to explore other relevant interventions holistically and consider what might fit well with the client's needs.

In a qualitative study sought to characterize client experiences of motivational interviewing for generalized anxiety disorder by Marcus et al. (2011), participants were asked to account their experiences after attending four scheduled sessions. Clients identified increases in motivation, self-determination, freedom, and confidence after attending the sessions. Therapists were viewed as empathetic and caring from the perspectives of the participants. It was reported that they felt as though the therapist provided a way of creating a comforting climate that encouraged openness allowing clients to explore themselves more freely and without judgement. Other findings from the study indicated that clients expressed reduced anxiety and behavior changes after receiving treatment and expressed an overall increased internal strength, awareness, and confidence. According to Manthey et al. (2011), both motivational interviewing and strength-based approaches are highly compatible, and both approaches are consistent with social work values and ethical standards of practice. Primarily, Section 4.1 in the Code of Ethics dictates that social workers work with people by showcasing respect, empathy, and compassion without judgement; many of the elements that a strength-based philosophy promotes (Canadian Association of Social Workers, 2024).

Correspondingly, Hou et al. (2016) mirrored similar conclusions in a study to evaluate the outcomes of a strength-based/motivational group intervention for female victims of intimate partner violence (IPV) in Taiwan by applying techniques to increase their goals, solve problems, cope, and believe in their own ability to reach goals. Results found that significant improvements in both elements of depression and hope were improved, and that psychological distress was

reduced at the end of the 12-week program. Boddy et al. (2018) reported that a sense of hope is central to strength-based social work practice to provide people with a buffer to handle life's despair and the ability to cope, resulting in a sense of renewal and better physical/mental health strengths (p. 589). Similarly, Tsui et al. (2014) emphasized that relational, person-centered, strength-based practices are important in mental health treatment, primarily in individual therapy that explicitly seeks to instill hope in others by offering a commitment to narrative, strengths-based and solution focused therapies (p. 592). For instance, the narrative approach (as described above) enables people to engage with hope and focus on their dreams and visions, thus allowing them to begin thinking subjunctively about what might be and how it might come about (Boddy et al. 2000; Saleebey, 2000; Saleebey, 2013).

It is from my experience that I have come to believe that social work is integral from hope. Throughout practicum, my goal was to guide people by integrating their own spirituality, art, and rationality, to move from the present to the future (Boddy et al., 2018, p. 594). With a focus on empowerment, my experience centered around helping people surface their hopes and aspirations and align them with their inner and outer recourses to improve the quality of their lives (Saleebey, 2000). Saleebey (2000) reported that those who adhere to a strength-based philosophy ask themselves, *what are the factors in life and in helping that make things go well?* (p. 130). Saleebey (2000) further emphasized that helpers reflect upon their own strengths and how that can help contribute to the helping process. One way I learned to reflect on my own strengths was using clinical supervision, which I explore next.

Supervision and Reflective Practice

The practicum experience required the examination and interpretation of supervision as a partial guide to maximizing my learning goals at The Alliance Centre and on-going personal

reflection as a new mental health therapist. Thus, this portion of the literature focuses on available research examining the vital role of supervision in social service organizations and the impacts of having an effective supervision experience. Since supervision remained one of my main learning focuses for this experience, I felt that it was important to evaluate the experiences of social workers alike and consider how impactful a positive supervision experience can be for individuals working in the mental health and helping field.

The relevance of supervision is imbedded into the Social Work Code of Ehics and serves as an instrument for supporting and promoting the well-being of social workers, and the individuals that they serve (Canadian Association of Social Workers, 2024; Pack, 2012; Pack, 2015). For instance, The Canadian Association of Social Workers (2024) reported that supervision provides social workers with critical reflection and on-going professional development, both central constituents of ethical social work practice. Furthermore, Value 6 in the Code of Ethics promotes that social workers maintain professional competence and respect the client's right to competent and developed social work services; actively maintain and build their professional skills and knowledge; and contribute to their own ongoing development of the profession (Canadian Association of Social Workers, 2024).

The Ontario College of Social Workers and Social Service Workers (OCSWSSW) underlines the responsibility of the supervisee to utilize supervision to ensure new knowledge and skills are developed to address complex client needs. The College further conveys its expectations that registered social workers take initiative to seek out supervision and consultation when required and to practice within the limits of their competence (Sewell et al., 2021). However, despite the current OCSWSSW recommendations, there are currently no licensing requirements tied to supervision practice in Ontario, nor any organizational standards requiring

that social workers receive supervision in Canada. Ultimately, supervision is dependent on each organization's policies, procedures, and mandate, leaving room for some social workers to slip through the cracks of securing supervision and having the opportunity to reflect and build their professional development in a safe and supportive environment (Sewell et al., 2021).

Fortunately, supervision was something that The Alliance Centre offered prior to my arrival, however, for practicum learning purposes, it was decided prior to my start date that I would meet for supervision bi-weekly to ensure that my goal of focusing on the supervision process was ensured. Typically, supervision is offered every six-weeks to team members; however, Lynn was kind enough to provide 1-hour supervision sessions bi-weekly as a means of a consistent experience throughout my four-month practicum experience. This allowed for 10 total hours of supervision, and any additional debriefing time, depending on the situation/event. In this regard, I felt very supported by my supervisor, and it truly enriched my supervision experience as someone entering a new field of clinical work. I always felt as though I could go speak with my supervisor as needed, and often did whenever I had questions or apprehensions. I felt our shared time brought us closer together in our relationship and accentuated the strength-based philosophy experience. Reflecting upon many different practice situations, my supervisor reminded me of my own strengths and achievements, which was helpful and empowering. Our shared time together and the relationship that formed was the driving force behind having a positive supervision experience.

Indeed, substantial research confirms the theme of the supervisory relationship and its substantial significance within the supervision experience (Barron et al., 2022; Beddoe et al., 2020; Dawson et al., 2012; Hensley, 2003; O'Donoghue, 2012; Pack, 2012; Pack, 2015; Sewell et al., 2021; Snowdon et al., 2019; Stewart & Fielding, 2021; Worthen & McNeill, 1996). In a

qualitative study by Pack (2012), participants were asked to identify what their experiences were like in supervision as new health care workers. A key theme that emerged was the influential nature of the supervisory relationship and its contribution to an effective supervision experience. The study revealed that supervisees gained in many ways from supervision when their supervisor applied an approach that embraced their professional growth, strengths, and support; role modeling of professional and personal qualities; mutuality though an interactive relationship; and shared learning and reflection. Participants further reported that they valued a display of empathy and non-judgement within the therapeutic relationship and a safe environment to discuss difficult practice situations. Participants in the study also voiced that they felt like the relationship was the moral guide throughout their journey and reported that they valued having on-going support from a supportive relationship. One female participant in the study was quoted saying "I admire the relationship in the sense that you have different elements such as trust, and open dialogue, a safe person to talk to, to facilitate your learning, almost like a mentor that helps motivate and encourage you" (Pack, 2012, p. 176).

Comparably, in another qualitative study by Barron et al. (2022), supervisees working with children and families in mental health were asked to reflect on their experiences in supervision. Supervisees expressed that the quality of the relationship progressed over time as rapport was nurtured and voiced that they needed to feel connected to their supervisor to share and be vulnerable in their supervision experiences. The study further identified that supervisees expressed finding significant value in their supervision experiences when a solid relationship was solidified and reported that they appreciated having someone to help guide them along their developmental journey from novice to developed social worker.

These findings mirrored Worthen and McNeill's (1996) phenomenological study that considered positive supervision experiences from the perspective of the early-career social worker. Eight intermediate-level to advanced-level trainees participated in the study. Results indicated that supervisees valued their experiences most in supervision when their supervisor normalized their struggle and helped them to learn from their practice mistakes without judgement or shame. Supervisees further expressed the need for open communication and a supervisor that exhibited traits of respect, support, acceptance, trust, and warmth, and all the supervisees defined the supervisee/supervisor relationship as crucial and pivotal to their supervision experiences (Worthen & McNeill, 2006, p.32).

In a survey by Wilkins et al. (2020), a group of 315 social workers from the United Kingdom rated their supervision experience as helpful in a variety of ways. Most of the respondents reported that they felt that their supervision experience helped with decision-making capabilities and provided emotional support for difficult practice situations and stressful situations. Yet, it was noted within the study that some of the respondents indicated that they felt as though they did not receive supervision often enough, with some people admitting to it not being offered at their current organization. However, despite these challenges, most participants in the study reported that when supervision was accessible, that they valued a genuine connection with their supervisor, and appreciated a focus on their strengths and ability to overcome difficult practice situations.

In Pack's (2015) qualitative study, results documented a need for supervisees to explore their vulnerabilities within supervision debunking the myth of perfection and encouraging flaws to be transformed into strengths rather than weakness. Pack (2015) found that supervisees often reported that they used clinical supervision as a buffer to decompress and work through

traumatic and stressful experiences, and that supervision helped reduce countertransference for some (Pack, 2015). Pack (2015) further narrated that is it important that the supervisor bring their entire self to supervision within the interaction to nullify the myth of perfection by allowing the supervisee to witness their own flaws and vulnerabilities as well as strengths (Pack, 2015, p. 659).

Similarly, Falender et al. (2014) described that a key component to clinical supervision was a relationship grounded in mutuality and strong supervisory alliance enabling openness and connection. Falender et al. (2014) argued that personal characteristics and behaviors such as warmth, honesty, empathy, respect, and transparency are all essential dynamics in effective clinical supervision between both supervisor and supervisee. Cohen (1999) described the implication of strength-based supervision as being an asset to a goal-orientated agency and emphasized its consistency with the social work mission to consider the inherent dignity, and worth, of every unique individual. It was emphasized that strengths-orientated supervisors do more by helping supervisees through difficult practice situations and work with them on evaluating long-term implications by focusing on the skills and strategies for overcoming present and future organizational difficulties (p. 464). Thus, embracing a strength-based supervision model can help us to regain our orientation to the populations that we serve most and help us to generate positive and measurable outcomes mirroring Saleebey's (1996) notion that it can define the uniqueness of the helping profession (Cohen, 1999).

According to Cohen (1999), strength-based supervision creates a more supportive, less threatening environment for strengths-orientated workers by defining the central content of the supervisory meeting as a joint evaluation of the worker's successes as well as their struggles, problems, and frustrations (p. 462). Cohen (1999) further argued that this approach allows for a

deeper, more meaningful connection between both supervisor and supervisee allowing for a more effective supervision experience.

Curry and Epley (2022) conducted a qualitative study using focus groups to explore how practitioners felt about engaging in reflective supervision, and how it impacted their self-care and mental health in positive and meaningful ways. The study indicated that social workers expressed multiple elements of growth, both personally, and professionally from their supervision experiences. For instance, many of the participants reported better self-care, better job satisfaction, and better longevity in the field. The findings of the study further suggested that supervision was able to provide participants with a supportive and reflective experience allowing for them to be emotionally proactive in an ethically complex nature of practice (p. 305). Further highlighted was the consideration of the supervisee's strengths and validation of their achievements.

The above strengths-based research indicates that mental health recovery is a personal journey of gaining meaning in life despite the presence of mental illness. To recover, people need to be confident and believe that they can overcome their conditions by focusing on their abilities rather than their shortcomings, symptoms, and difficulties (Xie, 2011). The practice of mental health has been largely constructed by the medical model where focus remains on controlling symptoms of mental illness (Saleebey, 2001). Shifting the paradigm to a strength's philosophy requires a significant shift for the clinician to disregard what physicians perceive to be important and rather consider what the person thinks is significant. Saleebey (2001) reflected that this is why people are often confused when asked about their strengths when sitting down with a professional and often have trouble identifying what their strengths are, simply because they

were never asked about their achievements, past-resilience, or the hobbies that helped them through a difficult time in their life.

Ibrahim et al. (2014) suggested that the strengths perspective be integrated through both structural and social work practice components whenever possible. The structural components include (1) advocating for manageable caseloads to provide meaningful strength-based service to people, and (2) engaging in on-going reflective supervision to ensure adherence to the principles of the model and ethical social work practice. Practice components consist of incorporating strengths beginning at the initial assessment and authentically within all components of treatment planning/interventions. Structurally, social workers can actively engage in supervision with a supervisor who creates a supportive environment that embraces a strengths perspective by discussing the supervisee's own strengths and achievements rather than only focusing on their professional struggles and stressful practice situations.

Cohen (1998) emphasized that supervision for a strength-based enthusiast should not be crisis-driven and only initiated when the supervisee needs help due to the problem-orientation focus of the process. However, pre-determined and scheduled supervision with the purpose of enhancing professional development and sustaining quality control mirror what strength-based practice reflects. Section 7.1.5 in the Code of Ethics dictates that social workers engage in reflective supervision practice in the context of their professional experiences to expand ideas, knowledge, theory, and skills that improve professional expertise and service provision (Canadian Association of Social Workers, 2024). Thus, the link between the strengths perspective and supervision remains a both a positive and complimentary marriage.

In the next chapter, I will discuss my advanced practicum experience and the agency environment and further detail the daily provision of mental health treatment. I will also discuss

what my practicum goals were prior to completing this practicum and detail how they were achievable throughout my 450-hour practicum endeavor.

Chapter 2: Advanced Practicum Description

In this chapter, I will outline the practicum agency that I had the pleasure of completing my 450-hour experience with and detail the many different programs offered at the agency, including my previous professional role as an extensive case manager. Next, I will discuss the practicum environment and experience including the provision of a typical day in the Mental Health Treatment Program. Finally, I will discuss my learning goals and how they were achieved by detailing some practice examples from my daily work as a strength-based mental health therapist.

The Alliance Centre, Sturgeon Falls

The West Nipissing General Hospital's mission is to provide quality healthcare to a culturally and linguistically diverse population (The West Nipissing General Hospital, 2024). Similarly, the Alliance Centre strives to provide free and quality bilingual mental health and addiction services to any individual that is 16 years of age or older, and that lives in the West Nipissing area. Located in the small community of Sturgeon Falls, Ontario, The Alliance Centre was established in 1985 and sits comfortably in the back of the hospital, tucked away for privacy and confidentiality. There is separate parking at the back of the building, and a private entrance for any individual looking to access services. The Alliance Centre remains committed to serving people with a variety of mental health and substance use needs. Individuals can self-refer by calling for services and by scheduling an intake assessment either in-person or by telephone.

It typically takes two-weeks to receive an intake assessment. The current waitlist for mental health treatment typically takes on year, depending on priority/risk-level. For those

deemed high-risk upon their initial intake assessment, services were prioritized accordingly, and the person was able to receive services typically within 1-week. High risk typically included woman experiencing post-partum depression, and people at risk of suicide and self-harm.

The Alliance Centre recognizes that every person has unique and diverse needs and strives to accommodate everyone accordingly using a human-centered approach, and a flexible service delivery. Adhering to the social work ethical standards and practice act, I embrace similar values within my clinical work to match the mission statement of the agency. As the Ontario College of Social Workers and Social Service Workers (2008) reminds us, "social workers demonstrate adherence to the values and ethical principles of the profession and promote respect for the profession's values and principles in organizations where they work with which they have professional affiliation" (p. 7).

Programs/Services

The Alliance Centre currently offers eight programs free to the public; however, my practicum training was within the Mental Health Counselling and Treatment Program. Referrals typically came from other community care partners such as The West Nipissing Community Health Centre, The West Nipissing General Hospital, local family physicians, and Employment Options Sturgeon Falls. The catchment area of the client population were typically residents of Sturgeon Falls and surrounding areas. The catchment area expanded to residents of Verner, Jacko Point and Warren Ontario. Other services and programs offered at the agency include the following:

1. **Substance Abuse and Addictions Treatment:** Substance abuse services include assessment, community treatment and referral to external services such as withdrawal management services and residential treatment (The West Nipissing General Hospital,

2024).

2. Needle-exchange Program: In collaboration with the North Bay Parry Sound District Health Unit, the Alliance Centre offers an evidenced-based harm reduction initiative through a needle syringe program to anyone in the community. Individuals can drop off or pick up supplies at the Alliance Centre and there is a community drop-off box located on William Street in the downtown core (The West Nipissing General Hospital, 2024).

3. Intensive Case-Management Program: Services include advocacy, symptom monitoring and management, improved access to primary care services, education regarding illness, community re-integration, assistance with money management skills, crisis counselling, supportive counselling, and support in accessing other community services when appropriate (The West Nipissing General Hospital, 2024).

4. Walk-in Clinic Program: The Walk-In Clinic is a service offered to individuals who would like to seek assistance but may not be ready to engage in formal mental health and or substance abuse services. The Walk-In Clinic is available to individuals 16 years of age and older. This service is offered weekly at The Alliance Centre on Wednesday from 11:00-7:00PM, no intake required (The West Nipissing General Hospital, 2024).

5. Psychiatry Program: Visiting psychiatrists provide up to 5-days per month of consultation and follow-up through a shared-care approach with the counsellors and therapists at the Alliance Centre. Referrals are first screened to ensure that all the necessary documentation of demographics, history, medication, past hospitalizations, and treatment are gathered prior to the initial appointment. Referrals are accepted from physicians only. In situations where the person has no family physician, Alliance Centre counsellors or therapists may make a referral to psychiatry (The West Nipissing General Hospital, 2024).

6. **Crisis Intervention Program:** The Crisis Intervention Program offers telephone or face-to-face contact to individuals seeking immediate relief from symptoms of emotional and/or situational distress which affect their ability to cope. Services include assessment and crisis counselling as well as liaison, client advocacy and referral to community agencies when appropriate. The Crisis Intervention Program is open from 4:00PM to 11:00PM, 365 days a year (The West Nipissing General Hospital, 2024).

7. Community Wellness Program: The Community Wellness Program delivers workshops aimed at enhancing mental, emotional, and physical wellness. Topics range from self- esteem, mood, anxiety, grief, relationships, and wellness (The West Nipissing General Hospital, 2024).

Practicum Experience and Environment

The service providers at The Alliance Centre range in knowledge and have a variety of educational backgrounds. The Executive Program Director, and practicum agency supervisor, Lynn Perreault, is a registered psychotherapist with over 25 years of clinical experience and currently registered with the College of Psychotherapists (CRPO) for private practice. She spent the previous 25 years working with adults/seniors, and women experiencing domestic violence. Her program experience ranges from crisis intervention, mental health, psychogeriatrics and clinical management. The various other service provider backgrounds range from registered social workers, registered nurses, and registered psychotherapists. Several of the people at The Alliance Centre have been with the agency for over 20 years, which I find praiseworthy. There is a total of 14-people staffed at The Alliance Centre, including: two receptionists; three extensive case managers; one extensive nursing case manager; two substance abuse counsellors; two mental health counsellors, including myself; one primary intake worker; and one mobile crisis worker (MCP) that works independently with the Ontario Provincial Police. All the current

positions are permanent, full-time and/or part-time positions. Throughout the duration of my practicum, there was also a Bachelor of Social Work practicum student from Nipissing University, in North Bay, that was present and helpful.

The agency environment felt supportive and person-centered throughout my entire experience. Recently, the agency elected to distribute new government funding to purchase updated, more modernized furniture in hopes of creating a more inviting waiting area for people to relax and anticipate their sessions. The new waiting area now offers refreshments, a coffee station, comfortable leather seating, and a cozy aquarium to view and relax. Snacks are free and offered to anyone in need, and a basket of warm hats and scarfs sits by the main entrance door under the coat rack. The working atmosphere was supportive and felt comfortable throughout my practicum. Weekly intake meetings felt as though they brought everyone back together at the end of each week, not only to discuss client referrals, but to laugh, and catch up on some success stories with client cases, or even personal ones. This was where I felt most connected to my colleagues, during the weekly intake moments. I also learned a lot from other clinicians when discussing complex cases and different case scenarios throughout these meetings, and the coffee was pretty good too.

All my colleagues at the agency had a designated office space to meet with people offering confidentiality behind private walls. My private office provided an inviting environment for people to sit and talk and proposed comfort and hospitality as soon as you entered the room. The environment included dimmed lighting, low-vibration frequency sounds, and creative appropriate alternative supports (e.g., fidget spinners for clients, markers, art supplies, coloring books, readings, workbooks). I continuously ensured to ask each person who entered if they wanted a beverage prior to beginning a session. Often, clients attended with their own coffee or

thermos, in true Canadian fashion. Setting up my office space was a big contribution to my experience in practicum. It allowed me to reflect who I am within my work and provide people with my own strengths and assets (e.g., creativity, interior design, human-centered work). I wanted to give clients a piece of who I was and make them feel comfortable.

The people that I worked with were approachable and always there if I had any questions or concerns. With the mixed variety of backgrounds, everyone brought different perspectives to the agency allowing for a positive workflow within the building each day. I worked mainly with the other mental health therapist as we both needed to manage the waitlist and shuffling of the constant new priority one referrals accordingly. Since she had a background in social work, I felt that our mutual partnership was a successful, and positive one, and this helped to enrich the collaborative experience in the Mental Health Treatment Program.

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I continuously felt supported by the people that I worked at The Alliance Centre. Each day, I felt that I learned new practice wisdom and techniques naturally, just within our conversations and group discussions. We all had our own unique strengths to offer, and we were all very much vocal about them as a collective team of people. For instance, many of our weekly intake meetings consisted of group discussions surrounding who was the best fit to work with the

person that we were discussing/referring. On one occasion, we had a new referral for the Mental Health Treatment Program from a female person. Her intake report stated that she really wanted to focus her treatment on cognitive behavioral therapy (CBT). As a brand-new clinical mental health therapist, I voiced my concerns with my ability to provide that service, in compassion to my colleague, who happened to specialize in CBT treatment. Yes, this was her wheelhouse, and certainly not mine. As social workers we know that we must remain authentic, and humble, and I had no problems doing so throughout this experience. I had never lied about my skills, nor did I ever attempt to do something out of my comfort zone. Luckily, as everyone knew what my practicum focus was, it was decided through group discussion that my colleague would work with this person, and that I would work with people looking for alternative supports relevant to my approach with people. From this point on, intakes were an amazing filter to what was helpful to people seeking services, and who would be best suited to help with their presenting situations. There were many other circumstances where the team openly discussed who would be best suited for each clinician. I appreciated this element of practicum because it mirrored my strength-based philosophy and from my perspective, was more beneficial to the people accessing services as well.

Learning Objectives

As a requirement for obtaining my Master of Social Work (MSW) via the three-term practicum route, I had two primary practicum goals prior to entering my new position including, (1) to complete an advanced practicum in a new area of interest with the intent of applying a strength-based philosophy in mental health assessment, intervention, treatment-planning, and (2) to become actively engaged in bi-weekly supervision to better inform my professional practice

and to promote ongoing self-awareness, personal growth, and professional self-care/wellness (Glassburn et al., 2019).

My focus of the practicum experience was to merge a strength-based philosophy with different methods/interventions that inspired change, hope, motivation, and inspiration. Manthey et al. (2011) reported that a strength-based approach and motivational interviewing as a collective have great potential for useful alignment because they both support personal empowerment and embrace the belief that individuals hold within them the ability to solve their own problems and achieve their goals. Thus, after careful consideration and research, I elected to focus my interventions on two different strength-based approaches that complimented a strengths philosophy including narrative therapy and motivational interviewing. These theories paired well with my mindset throughout this experience because it was easy to motivate people when talking about their strengths, or positive things in their life, allowing for true authenticity in my approach.

Supervision was an essential piece of the practicum experience because it is something that I lacked in my previous role as a case manager. Essentially, I had been working in the field for the previous five-years with no support or place to discuss my experiences. Since completing practicum, I have learned that this was something that would have benefited me greatly in my previous role, and something that I did not realize that I was missing until this experience. Reflection was a giant piece of my practicum experience and I learned so much from my supervisor about mental health practice, and myself personally/professionally.

My goals were easy to incorporate into my new role since The Alliance Centre already offered a client-centered, humanistic approach to wellness. This allowed me to have creative freedom within all elements of my individual work with people and provided room for new

pathology by broadening the assessment/intervention process and my creative work with the people accessing services. Luckily, the agency's assessment document already considered the person's strengths, so it was natural for me to focus on that portion of the document with the intent on shifting my mindset throughout this overall experience. Simply knowing that I was able to reflect my own personal/professional values within my new role created a sense of comfort and ease throughout my practicum and allowed me to alter my way of thinking in all elements of the therapeutic experience with people.

Provision of Mental Health Treatment

My practicum consisted of carrying a randomized caseload of people ages 16+ (about 25-30 people). The majority of my caseload was female and differed in age. It is important that I highlight that I refer to the people that I had the privilege of working with as people, and not merely clients, due to my strengths-based philosophy and mindset throughout this experience. The Mental Health Treatment Program mandated that clinicians meet with four people each day, for a 1-hour session. The Alliance Centre Mental Health Program policy dictates that all people admitted to the service receive a maximum of 10-sessions, including an initial assessment, followed by one-on-one counselling and finally, termination/graduation of services.

Typically, I maintained a consistent caseload of people that I worked with that were from the program wait-list, and others were priority-level clients that were referred due to their overall level of risk. Throughout practicum, I found that every few weeks I was receiving a new referral for a person needing mental health services that was deemed a priority one. This was managed effectively by reserving 1-weekly appointment in my calendar for priority level clients, as well as rotating referrals with the other Mental Health Therapist to balance our caseloads.

I managed to remain organized by keeping a secure document of my clients and their demographics/information and by constantly adding new information as new referrals were received. This helped to manage who was a high-priority person, and who was not. For those considered priority-one, I had a pretty good idea going into the initial meeting of their narrative due to attending the weekly intake meetings. During intake, new client referrals were read out loud and then discussed and finally, referred to the appropriate program.

Some of the other people that I had the privilege of working with were referred to the program one-year prior (due to extensive 1-year waitlist time), thus I always ensured that I reviewed their initial intake assessment prior to meeting with them so that I was familiar with their reason for accessing services. I found this part of my practicum difficult considering the number of factors that can change for a person in 1-year. Thus, upon my initial introductory point of contact, I ensured to reflect to people that I would conduct my own assessment upon the initial in-person meeting, which was always well-received by people that waited over 1-year for services.

The introductory point of contact was the initial phone call between me and the person that was referred to the Mental Health Treatment Program. This provided a chance to collect any additional information, prior to the first in-person encounter, and to confirm current interest in mental health services, and personal goals/expectations.

The opening phone call was a good opportunity for me to introduce myself and attempt to make an impact, despite it being less personal, and not in-person. I always attempted to explain the program in-depth to people on the phone and ask them if they had any questions prior to coming into their scheduled appointment to help ease any anxiety, and this seemed to help people, from what they had informed me once meeting in-person. Typically, appointments were

scheduled 1-week post initial contact. I was responsible for managing my own caseload and maintaining proper organization, scheduling appointments, completing treatment plans, termination reports, and all case notes. Using the Google Mail Calendar booking system, typically, I scheduled people for 1-hour sessions, four-times a day; and I always ensured to book 15-30 minutes between each appointment to ensure granted time for documentation, and supervision was scheduled bi-weekly every Thursday at 2:00PM to maintain consistency and proper planning. I scheduled all the people that I worked with in a thematic format to maintain consistency for people, and myself. For instance, many of the people that I worked with came at the same time every single week, which was helpful for so many with work schedules and other obligations. Typically, I would meet with the first person at 9:00AM each morning, and the last at 3:00PM in the afternoon at the end of each day.

Most people were consistent in the Mental Health Treatment Program, and rarely missed their appointments. For those that did, I was obliged to terminate their file due to working within the two-missed appointment policy. The policy dictated that if you missed two appointments (exemptions were of course made), that your file would be terminated and closed. I found this difficult in some cases, as people that did not follow through with service often reported that they had simply forgotten or that they were not feeling well that day. Admittedly, I would often forgive their reasoning, and allow them to proceed with services. As the policy dictates, it is up to the clinician to deem whether the person's reasoning exceeds their termination, and working from a strengths-based philosophy, I could not help but be more forgiving in most cases.

My most valued time was the initial point of contact with new people and simply getting to know them over the telephone. I always went into the conversation with a sense of who the person was, after reviewing their information/file, and felt comfortable doing so. I had always

worked with the public and had a natural ability to speak to people and have real conversations. This was a personal strength of mine that I had going into this experience, and a small piece of who I am as a person. At times, I spoke with people on the telephone for over 30-minutes and worked on building a good rapport with them. I wanted them to know that I was there to help them meet their goals and feel validated and understood. I wanted them to know that I was a person, just like them, and hoped that they felt that energy prior to coming in for our first in-person encounter.

The use of language when interacting with people was important throughout practicum and began at our initial point of contact. White (1995) reported that language can blur, alter or distort experience as we tell our stories; and that it can condition how we think, feel, and act and can be used purposefully as a therapeutic tool (p. 128). Thus, the language that I used was deliberately non-sexist, ethnically neutral, and avoided medical terms that unthinkingly pathologize people (e.g., clinical work, diagnosis, referrals). Mirroring Michel White's belief, I elected to remove the word client and replace it with person throughout this experience, and this practicum report, and this was further reflected within my documentation (e.g., client vs. person).

It was during the initial telephone conversation that I would dialogue with people conversationally rather than interview them, keeping their conversations focused as much as possible on their strengths, competencies, assets, and resources (see ROPES Model on page 40). Pulla (2016) emphasized that the kind of rhetoric that social workers use preserves the possibility of promise to people; and that social workers be mindful that people are competent, resilient, resourceful, and of value in all elements of conversation. Saleebey (1996) further highlighted that to embrace true strength-based practice, social workers must only acquire some new

techniques and a different vocabulary in search of resources, options, possibilities, exceptions, and solutions.

Throughout practicum, I was aware that language I used and how I interacted with people was essential within a strength-based philosophy. This included how I interacted with people, how I documented my sessions, and how I engaged in dialogical interactions with people accessing services in the social work field (Greene et al., 2015). It is my belief that language not only reflects a person's reality, but that language can also change/alter it as well. Thus, my approach was to empower people through positive language that helped provide vision and hope.

In the next chapter, I will detail the application and my analysis of a strength-based philosophy in practicum. I will detail the assessment process and provide practice examples when relevant. Moreover, I will outline the different interventions and activities that I used with people in the Mental Health Treatment Program and outline some of the challenges that I experienced when working under this paradigm.

Chapter 3: Application and Analysis of Strength-Based Practice

The following chapter will discuss the application of the strengths-perspective in the Mental Health Treatment Program at The Alliance Centre and detail how I incorporated this perspective within every element of my work with people. Emphasized is the strengths assessment, and treatment planning process, as well as strengths-based practice examples when appropriate. Moreover, I will reflect about the strengths-based approaches that I applied in my everyday work including anti-oppressive practice, motivational interviewing, narrative therapy, and brief solution-focused counselling. The tree of life activity will further be detailed as it was an integral part of my narrative practice approach.

Practicum Approach

A significant focus within my practicum experience was to promote individual strengths, interests, knowledge, and capabilities, and shift away from diagnosis, deficits, and weaknesses. Primarily, I wanted to empower people by uplifting them, and by avoiding labels and keeping a close alliance with their hopes, values, and aspirations (Saleebey, 2006). According to Carl Rogers, the most important elements of an effective strength-based practice approach is to display empathy, congruence, and unconditional positive regard (Saleebey, 2001). Saleebey (2001) further highlighted the placebo effect, and its association with positive expectations and the helper's ability to transform the person's inner power into their reality by providing a sense of hope and possibility of a new or different future. This entails collaborating with people's dreams and aspirations and providing an atmosphere for healing, regeneration, and transformation (Saleeybey, 2006).

The quality of my relationships was essential from a strengths-based standpoint. To adhere to a strength's philosophy, I remained invested in people's experiences, and the matrix of

their lives in all elements of treatment. This included taking into consideration how they felt; how they acted in certain situations; their strengths and assets; and how they viewed their motivations and their current social supports (Saleebey, 2001). This also encompassed being mindful of the person's relationships, culture, and opportunities, and considering what might be supportive, helpful, or therapeutic for them (Saleebey, 2001). For instance, I asked people where they lived, where they worked, and how these elements impacted their overall fulfillment in life.

I wanted to begin where the person is and focus less on their problems and more on what they were doing about them. Cohen (1993) highlighted the vulnerability perspective and how people arrive to mental health services often focused on their problems opposed to their solutions and this was apparent with many of the people that I worked with within our initial encounter. With this research logic, I knew that I would need to look at people differently and view them for their capacities and talents, however dashed and distorted they may have become from their circumstance, oppression, and/or trauma. This entailed having the courage to regard my professional work through a strength-based lens and re-vision of any form of disbelief in people (Saleebey, 1996). Objectively, I wanted to ensure that I was rediscovering wholeness of people and incorporating a strengths orientation even when it felt difficult or impossible.

For instance, I worked with a male person who identified as Indigenous. He had informed me that his grandfather was a residential school survivor, and we had a meaningful conversation about the link between Indigenous culture and resilience. I remember him being thankful for my knowledge and honesty, and we would often have deep conversations surrounding his heritage and how it was reflected today in his everyday narrative. As someone with a previous degree in social work, I was familiar with much of the Indigenous teachings that mirror social work values.

Thus, my goal while working with him was to highlight his cultural and familial resilience and let it empower him moving forward in his adult life.

Saleebey (2001) insisted that we are exquisitely sensitive to changes in context and related the strengths-based mindset to the broken windows theory. The theory conveys that if windows are broken in a neighborhood, with many homes vandalized, and unkept, that criminals will automatically assume that no one will notice criminal activity, or care. However, the theory further relates that when homes are cleaned up, and erased of graffiti and garbage, that they find that things begin to change in a positive way. You can see this theory portrayed within many different projects across Canada, and the world today, that include community organizations that are painting murals over graffiti, growing community gardens, building sculptures, and refurbishing playgrounds, with the context of creating a more strengths-orientated humane world for people to live and thrive (Saleebey, 2001, p. 131).

My practice approach was to focus on what could be altered in people's environments, whilst considering their contextual changes, or own personal, broken windows. I wanted them to know that they had the possibility to recover; that there was a chance of beating the odds; that they had the power to transform or at least fight the disease process; and that they could be confronted with whatever difficult situation they had endured (Manthey et al., 2011; Saleebey, 2001, p. 133). I wanted people to leave with a greater sense of purpose and feel empowered from a collaborative relationship between two human beings, so that people could transform their strengths in pursuit of their visions, dreams, and hopes, and personal discovery (Moore, 2022). Pulla (2014) reported that it is up to the therapist to help the person become transformed by guiding the process and helping to facilitate the discovery of resources, and the relationship with oneself by displaying generosity and authenticity.

I took this practicum opportunity to develop rich connections with people and be supportive, and trusting, which required the use of my own self, enriched by active use of supervision so that I could broaden my focus from eligibility to relationship and connection and deeper insight (Moore, 2022). In my previous role as a community case manager, I did not have the opportunity to experience true relational practice due to the typical unconscious function of more typical deficit focused practice models concerned with problems and diagnosis (Moore, 2022). However, due to my commitment to a strength-based perspective and what that entailed, I was able to invest my true self in the therapeutic relationship and the natural vulnerability that came with this by rethinking the deficit-based system to focus on developing more meaningful relationships through conversations about wellbeing and the insistence for authentic relational connection. Moore (2022) reported that the therapeutic relationship is positive and that this can open the door to a fuller connection and appreciation for people to experience an authentic relationship that offers thoughtful understanding of relational connection, strengths, gifts and personal possibilities to have space to emerge.

Importantly, it was essential that I maintained the professional understanding that suffering is very real for people accessing services in the Mental Health Treatment Program, and that there is no such thing as turning a blind eye, or ignoring of undesirable information related to mental pain, trauma, and oppression (Graybeal, 2001). As Graybeal (2001) reported, the important thing is not to lay blame, but to establish an inclusive perspective that requires placing the medical model within a more holistic understanding of human behavior (p. 234). The strengths perspective does not cease to ignore or minimize diagnosis however asserts that people must be seen as contextual and part of a larger process (Graybeal, 2001).

Strength-Based Assessment

Another one of my goals in practicum was to enrich the traditional psychosocial assessment by applying a strength-based perspective and considering the four elements of the person (biological, psychological, social, and spiritual). It is from my previous social work experience that many assessments give little or no attention to the social/spiritual domains of the person, and of my opinion that the substance of the person's life is played out within those two domains. Objectively, I wanted to transform the assessment process in the way that I asked questions, within my language, and the inclusion of responses that centered around hope and possibility to avoid the usual deficits that have become the primary function of many Westernized models of clinical practice (Rashid, 2009; Saleebey, 2009). Rashid (2012) emphasized that assessing strengths can provide the clinician with a powerful tool to understand a person's repertoires, which can effectively counter troubles (p. 490).

The goal of assessment was to inform people that it was a mandatory tool with no rigid boundaries and to reflect that it would be continuously updated through mutual partnership and collaboration as both a process, and product (Pulla, 2012). There was one portion of the assessment form strictly dedicated to the person's strengths. This portion was where I listed the person's identified assets and resources, and all strengths/attributes were also considered throughout all of the bio-psycho-spiritual-social elements of the assessment document. By using The ROPES Model by Graybeal (2001) I was able to help identify and consider the person's rescourses and strengths. The acronym stands for Resourses, Opportunities, Possibilities, Exceptions, and Solutions. This framework was used as a guide to help provide direction in the assessment process using strength-based language and terms (Graybeal, 2001). By including the ROPES Model within assessment, I was better able to evaluate the strengths of each unique

person in a methodical way that avoided emphasis on problems, pathology, and deficits. This meant taking into consideration the person's talents, assets, recourses, and skills, as well as their desires and hobbies in all elements of the assessment categories (Manthey et al., 2011).

Further attention was focused on considering what was already working for the person and identifying any current/previous coping strategies that the person may have obtained prior to accessing services or that they may have developed on their own. My focus remained rooted in the person's presenting situation rather than their previous pathology; although the past was considered when reflecting on their recourses and assets (Saleebey, 2006). The goal was to shift the frame of reference to define the person's issues and separate them from their presenting difficulties by showcasing a supportive shared mutual partnership and understanding (Saleebey, 2001). It is from my previous helping experience that when people seek out help, that they are typically in vulnerable positions and often feeling powerless and defeated. Objectively, my intent throughout practicum was to minimize the power imbalance through active listening and on-going client discovery, allowing the person to direct their treatment throughout the assessment process.

It was during the initial in-person assessment that I attempted to make people feel most comfortable and supported. I wanted them to come back and feel open to sharing some of the most vulnerable parts of themselves with me, and I wanted them to feel that energy in return and to know that I genuinely wanted to help them. Upon many different occasions, many of the people that I met with had voiced that they felt very secure in my office, and as though they were looked at as a person, rather than a client, which helped ensure that I was providing the humanistic approach that I intended. This was helpful, and motivating as a new therapist, and I appreciated the feedback moving forward with other people.

It was during the assessment process that I learned the most from people and how they viewed themselves and their struggles. Interestingly, it was evident that many of the people accessing services painted themselves in a negative light for various reasons. For instance, one person that I met with labelled himself as crazy more than once throughout our initial encounter. When broached further, he had informed me that his mother used to call him this as a small child and reported that he felt as though that he never got anything right in his life, not even his own marriage. It was in this moment that I realized that his treatment plan, and so many others, would place significant attention to the person's abilities rather than their diagnosis, negative self-perception, and/or label. This included the constant normalization of mental health (e.g., ¼ people experience mental health disorders) and the ideology that all humans will struggle and be affected by different lived experiences throughout their own narratives (Xie, 2013).

Epstein and Sharma (2011) defined the strength-based assessment as the measurement of those emotional and behavioral skills, competencies and characteristics that create a sense of personal accomplishment; contribute to satisfying relationships with family members, peers, and adults; enhance ones' ability to deal with adversity and stress; and promote one's personal, social, and academic development (1998, p. 3). Similarly, Wright and Lopez (2002) argued that the strength-based assessment should give serious attention to the following areas: (1) deficiencies and undermining characteristics of the person; (2) strengths and assets of the person; (3) deficits and destructive factors in the environment; (4) and the person's resources and opportunities in the environment. Rashid (2012) goes on to report that a strength-based assessment includes alternative hypotheses about psychopathology. For instance, when working with people that were experiencing feelings of sadness/despair, I would consider how their

depression may not just be a cluster of symptoms described in the DSM-IV but may also be the lack of positive emotions and meaning in their life.

From my standpoint, I believe that strengths serve us best not when life is easy, but when life is tough (Rashid, 2012). Thus, within assessment, I ensured to ask meaningful questions that would open the door to explore the person's perspective about their own strengths and attributes, even focusing on their skills and personality traits (e.g., social intelligence, kindness, humor) and considering how these traits could counteract their depressive symptoms. For instance, when a person shared that they had anxiety within the initial assessment, I would consider how their reported symptoms of worrying, feeling restless, fidgety, and/or impulsive were linked to their environment and current purpose in life (Rashid, 2012).

Rashid (2012) further reported that the purpose of the strength-based perspective is not to distract people from serious problems or illnesses that need immediate attention, but rather to reiterate that the goal is never to minimize nor mask negative experiences such as abuse, neglect, and suffering, but rather to consider how strengths, talents, and abilities can heal and provide purpose and meaning to a person's life. Personally, within my own life and experiences, I feel that I have acquired strength from many of the negative experiences that I have endured. Although when experiencing those negative elements, I did not understand what life was providing me, as I grew from those experiences and went on with life, I came to realize that those experiences strengthened me and provided new insight and growth that I would have not otherwise have been given.

I worked with one person for 10-sessions that was at first hesitant to engage in service. She was a 40-year-old married woman, who presented with symptoms of anxiety and depression. She lived with her long-term husband and daughter in the community. At the time that she

presented to services, she reported symptoms of sleep disturbances, and identified with constant worry. She reported that she had felt this way for some time and that she was unsure as to why she had felt like this. She expressed that her marriage was healthy, but that she lacked intimacy. She also indicated that she was often alone due to her husband's long-distance career, and indicated that her health was good, and that she did not currently take any psychiatric medications. She also expressed having many friends in the community and family members.

Within the initial assessment, my primary goal was to collect the full holistic picture in an authentic and meaningful way that recorded her strengths, avoiding focus on her self-identified problems and reported anxiety (Rapp & Goscha, 2006). This entailed maintaining the professional belief that she held within her the clues and creativity that could lead her to solutions and recovery, and by asking questions that opened doors for new possibilities and hope (Graybeal, 2001). For instance, when first meeting with her, I politely asked "What does the perfect marriage look like for you?" with the intent on allowing her to reflect on her own views and personal discovery. I wanted her to discover, on her own terms, why she felt as though she lacked intimacy, and why those feelings created feelings of anxiety and personal distress.

After prompting this question, she was able to identify that she did not know what a perfect marriage looked like, nor had she ever witnessed one. In fact, she reflected that a perfect marriage was non-existent, and absurd in her eyes. She laughed and admitted that she was wrong in thinking that her marriage was supposed to be perfect but became tearful when explaining that she missed her husband now that he was working out-of-town. Upon her realization, I felt the need to probe her further, and asked her to list all the good things that she missed about her husband most when he was away, to which she reflected to me all his charms and positive

attributes. She even giggled at one point and said that she missed picking up his socks, and we both laughed about it together. She had a wonderful sense of humor and candor about her.

Throughout the assessment, she was able to identity that a perfect marriage was non-existent, helping to validate her concerns surrounding her feelings of loneliness. She was then able to remain hopeful to repair what she was lacking in her marriage by identifying that her idea of marriage was unrealistic and unattainable, which also made her realize that she had a very loving and supportive husband that provided her with unconditional love and positive regard, despite having to work out of town. It was within my questioning that she was able to recognize that she was only focusing on the flaws in her relationship opposed to all the strengths within it, and that she needed to make greater efforts with her husband when he was home with her and their daughter. It was natural to help her recognize that her marriage was positive, and that the stress of her husband being away was likely contributing to her feelings of uncertainty and anxiety. It was evident that she had many positive strengths surrounding her, including her daughter, and that she just needed some guidance in recognizing them. Throughout the remainder of our sessions spent together, she was finally able to shift her focus on the positive elements of her life through discovering, clarifying, and articulating, and made significant progress throughout her time in the Mental Health Treatment Program (Cowger, 1994).

Throughout each assessment, I maintained strength-based practice values, and I adopted them as sort of a roadmap to the entire working process and alliance. Saleebey (1997) reported that there are five core values that we should maintain when working from a strength-based perspective including (1) despite life's struggles, all persons possess strengths that one can marshal to improve the quality of their lives, (2) we can increase motivation by placing consistent emphasis on person-defined strengths, (3) discovering strengths requires cooperative

exploration between people and helpers, (4) focusing on strengths turns practitioners toward discovering how clients managed to survive vs. judging or blaming, and (5) all environments, even the most bleak, contain resources. Adopting these values was helpful because it allowed me to frame my assessment questions from a place of support, exception, and possibility (Saleebey, 1997). The conversation was intended to provide a collaborative approach in which the person told their story so that I could listen and note the current strengths/coping mechanisms that are embedded within their narrative (Moore, 2012). The conversations typically consisted of questions such as 'what helps you to manage? Or 'what do you find most useful?' Moreover, while actively listening, my goal was to pursue helpful indications of resilience and then reflect those back within treatment and the therapeutic process to help motivate and inspire people (Moore, 2012). Moore (2012) reported that counter-narrating can help people locate their own coping mechanisms and create a platform for further conversations about how people wish to steer the next steps of their life (p. 452).

At the end of the assessment process, the next step was to develop a collaborative treatment plan focused on the person's reported goals/strengths by devising a plan of how the goals would be achieved in the 10-session timeframe. Treatment planning was always completed at the end of the initial-assessment and consisted of focusing on strength-based interventions that nourished all the person's interpersonal, social, and cultural resources. Throughout practicum, I placed immense emphasis on the strengths and resources section of the treatment plan and its role and place in the therapeutic process. It was important that I considered how people defined their situations and how they gave meaning to the dynamic factors related to those experiences. Cowger (1994) reported that emphasizing the deficits of a person can have serious implications/limitations while focusing on strengths has considerable advantages in mental

health treatment. Thus, the treatment plan remained focused on understanding brought on by genuine connection and insight into what mattered to the person (Moore, 2012).

Anti-Oppressive Framework

Within assessment and beyond, the Anti-Oppressive (AO) framework became the baseline of my normative identity throughout practicum. For instance, I found myself constantly deconstructing the medical model as best I could whenever I engaged with people due to my desire to want to reduce Western dominance in mental health treatment which was helpful from an anti-oppressive lens. Objectively, I wanted the people that I was working with to recognize that I did not want to hold the expert title, nor did I want to label them or make assumptions pertaining to any form of report or assigned diagnosis attached to their referral (Larson, 2008). I had no boxes to check-off, nor did I want to focus our time together fixated on their diagnosis assigned prior to our encounter. Thus, incorporating an anti-oppressive mindset within all the elements of assessment/treatment was helpful in enhancing my holistic strengths-based perspective by working to empower people which in turn, provided me with a deeper understanding of their lived-experiences, worldviews, culture, and values.

Being anti-oppressive throughout practicum allowed me to consider the larger injustices and stigmas that people were relating in their narratives, rather than relying on individualistic pathological explanations (Poole, 2019). Embracing an anti-oppressive approach was evident within this practicum experience due to its connection to empowerment and gear towards interventions that aim to provide inclusion and motivation for all people. Anti-oppressive practice links itself to the mission of social work practice because it honors all realms of the human experience and calls upon us to think holistically about the approaches that we provide including empowerment, education, alliance building, intentional use of language, alternative

healing and problem-solving, advocacy, and reflexivity, all central elements to strengths-based practice (Lee et al., 2021, p. 14).

Strength-Based Approaches

Social work has long been identified as an empowering profession. Kam (2021) reported that echoing this specific characteristic of social work should be incorporated into every intervention with the belief of not returning power to those disempowered, but on helping others to discover that the power is within them (both individually and collectively), and that people have the ability to empower themselves (Saleebey, 1996). Kam (2021) described the process of helping people to achieve internal transformation from a state of powerlessness to a state of self-control; and to be transformed from a person who lacks confidence, ability, consciousness, and incentives to combat depression. I believe that empowerment has no endpoint and is a process that entails continuous discovery of unrecognized power as well as possibilities of new power. Particularly, the concept of power is given back in narrative therapy by separating the person from the problem.

Within my practicum, I knew that I wanted to focus on narrative therapy due to its usefulness in treating depression (Ricks et al., 2014). I wanted to provide people with the power to create new meaning in their lives and to overcome the medical model through re-telling stories that contribute to their problems (Seo et al., 2015). White and Epston (1990) reported that people with depression create meaning through dominant stories that tend to prevent infiltration of alternative experiences, hopes, and capabilities, and that people need to break free from the dominant problem-centered stories by separating their identity from the problem (Sio et al., 2015).

Narrative Therapy

Situated in Foucault's philosophical work and constructivist approach to clinical practice, narrative therapy evolved out of New Zealand and Australia during the late 1980s and seeks to prioritize solutions and individual strengths in which clinicians work together with people to prioritize their lived experiences and the meaning that they attach to it (Gates, 2017). Throughout all counselling sessions provided, I incorporated narrative approaches authentically and when relevant, on a case-by-case basis. I believe that people make meaning in their lives based on the stories they live, and the belief that people's lives are derived from social, cultural, and political contexts, and that the origins from which stories manifest are the result of influences from a person's family of origin, peers, and sociocultural directives (Ricks et al., 2014).

My goal was to listen to any forms of negative elements of the person's story and search for unique outcomes/experiences in which they successfully solved their problems or conquered their fears and uncertainties. This was done by focusing on the positive interpretations that could help people develop alternative, more positive life narratives that offered people redefine their diagnoses or disregard them by creating new meanings (Buckman & Buckman, 2016; Seo et al., 2015). My intent was to remain non-blaming, and non-pathologizing. Seo et al. (2015) reported that narrative approaches might facilitate more active learning and lead to new self-representations from the dominant emotions that people with mental illness typically obtain. By applying a narrative approach, I wanted to ensure that I could help people re-tell their story in a way that helped recognize their resilience.

The questions that I asked were creative, curious, and authentic. I wanted to apply my interviewing strength of being able to have authentic conversations with people and use those moments to gather relevant information ensuring that I was clear and concise with my

understanding of their lived experience and timeline. The questions typically aimed to learn about the meanings of the person's world, to examine the socio-politico-cultural assumptions in that world and to find sub-plots that are richer and closer to actual experience and to facilitate co-authoring the person's unique story (Besley, 2010, p. 128). Besley (2010) highlighted that narrative therapists avoid diagnosing problems and prescribing solutions and treatments and rather remain curious and interested in partial participants of the person's story. This entails adopting an optimistic stance that assists people in finding inconsistencies, hidden assumptions, and contradictions in their stories.

My approach was to challenge the way that Western psychology generally emphasizes that experts often appear to know more about people's lives than the people do themselves, and where the professional focus upon personal deficits emphasizes one's failures or weaknesses rather than one's strengths and accomplishments (p. 138). In my previous role as a case manager, I found the mindset to be objectifying based on its biomedical model approach of mental illness. In that role, I was very much considered the expert, and the focus of treatment remained rooted in their diagnosis and symptoms. As a case manager, I noticed that the person's perception of their self-tended to become seen as part of their essential nature and identity. Thus, I wanted to focus on my use of language, and power, and avoid using diagnostic deficits within treatment and my everyday interactions.

As someone learning narrative approaches, I worked with people to examine and edit their stories and promote social adaption allowing people to develop their personal narrative through their interpretations of their life story. This entailed helping people to retell their story from beginning, middle, and end, with the ability to reauthor, or reframe, their life story (Ricks et al., 2014). When someone would describe an event that was traumatic or distressing for them, I

would often ask them to situate the event in a new context in hopes that they could reframe their situation and change the meaning of the event in a positive way. For instance, I had the opportunity to work with a male person that presented to services for symptoms of depression. When I first met with him he reported that he had an unstable childhood and indicated that he grew up with a single father that was a functioning alcoholic. He admitted that him and his father still had a dysfunctional relationship due to his on-going alcohol abuse and reported that he felt that his depression was linked to the environment that he experienced as a child. Within the initial assessment, he acknowledged that he felt resentment towards his now 65-year-old retired father and voiced that he wished that their relationship was better. He expressed that he never forgave his father for his alcoholism but admitted that he still loved him and respected him as a father and provider.

Throughout the following session, I wanted to get to know him better and so I engaged in authentic dialogue to help learn more about his narrative. It was during this conversation that he informed me that he was just three years old when his mother died of a terminal illness leaving behind his father and himself. In that moment, he became emotional and reflected that it made him depressed that he never had the chance to know his mother, which prompted me to genuinely ask him if he felt like his mother's death had an impact on his father, and his alcoholism. "Did your father drink prior to your mothers' death?" I politely asked him. He admitted that he had never considered why his father abused alcohol and stated that his father was never a drinker prior to her passing to his knowledge. "They had the best love story" he smiled. "Love story?" I politely asked. He began to describe all the photo albums, wedding photos, keepsakes/souvenirs, and the home videos in which his mother was still very much alive. He described the love his father had for his mother and informed me that his father still called

her the love of his life today. “He never re-married” he laughed. As he continued reflecting, I witnessed a change in his tone, and he appeared more animated and happier in his speech and body language.

Throughout the therapeutic process, the goal of the conversation was to provide a sense of hope and motivation to shift his perspective and create new meaning in his life about his father. I wanted him to know that he was the author of his life story and I listened for any hints that could help to reframe his narrative in a way that could be healing and empowering for him. I reminded him that he was now father himself and hard-working provider to his family and that he had the power to create the relationship that he wanted with his father and his children’s grandfather, and that there was hope for mending their relationship. “I do wish that my children were closer with my father, but I seem to distance myself whenever he drinks. I suppose it still triggers me today” he reflected.

As the therapeutic process continued, our narrative focus allowed him to remain present in his journey and our therapeutic partnership continued to strengthen. I felt that the narrative format of our working relationship was a great tool to help navigate all our conversations and I always ensured that I was bleeding in my humanistic strengths mindset whenever I possibly could. Typically, this entailed pulling out the strengths and resilience from our conversations and reminding him that he was a caring person who simply wanted the best for his father and his health and wellness. Again, re-framing was very helpful in the narrative approach, and I used it often throughout our conversations.

By our final session, he presented to my office with a glowing smile on his face. Immediately upon sitting down with him, he informed me that he could not help but look at his dad in a different light since our previous session. He reflected that our dialogue made him

separate himself from his father's alcoholism admitting that he developed a new genuine sense of empathy and perspective of his father and his pain surrounding his mother's death. He related to me that he visited his father after our last session and stated that he had what he described as a life changing conversation with him about his alcohol abuse and how it made him feel growing up. He further related that he reflected his feelings to his father and asked him if he drank because of his mothers passing. "So, what was your father's response when you asked him that question?" I asked him. "He started to cry and then told me that it was true. He drank because he missed my mom so much and he still does because he can't handle all the pain of her being gone."

That practicum moment was so powerful for me as a new therapist. In that moment, I witnessed how powerful our conversations were and how that carried over into his personal life and opened the door for that conversation to happen with his father. I was amazed at how powerful this practicum moment was and seeing him as a lighter version of himself was unforgettable, to say the least. Admittedly, I cannot predict what the outcome would have been if I had used another theoretical approach with this person, but I am grateful that I did because it changed his narrative for the better. This was when I fell in love with narrative therapy and realized that this would be something that I would be using moving forward even after practicum was over. The simple act of helping him to reframe his perception about his father created the healing that he was looking for and it inspired me to look at my own narrative in the same light regarding my own relationships with people and my past experiences.

Emphasizing his strengths was important throughout the narrative process from my perspective because I wanted to help him recognize that he was the one who changed his perception about his father in the end and remind him that I was simply a helper in the reflective

process there for support and guidance. Reframing his narrative helped him to look at his father from a different perspective, something that he admitted to never doing prior to our interactions. I praised him for having such a difficult conversation with his father and ensured to emphasize the progress and growth that he accomplished throughout the eight-sessions that we shared together. “Our conversation changed everything” he admitted. Ironically, our conversations changed everything for me as well.

The Life Story Concept

The concept of life stories was introduced to provide better context for his (the client described above) past experiences and feelings about his present life path (Merscham, 2000). It was during this conversation that he had expressed motivation to live a life without resentment not marked by anger, sadness, and trauma, and where he expressed that he wanted to change his perspective and not feel so impacted by his childhood moving forward. Interestingly, when prompted from a strengths outlook, to highlight something positive that his father provided him with, he was able to express that he learned everything that he knew about fixing cars from his father. After reflecting further, he became tearful when reminiscing about the time spent in his childhood garage building engines and cars.

By our third session, I allowed him to understand that discursive conditions and power relations from his past could be re-authored and that he could find his own voice and work on the problem to find his own solution by emphasizing his strengths and resources. Seo (2015) highlighted that people with depression or trauma can dissemble their negative experiences and attempt to re-author their lives on their terms (p. 380). Similarly, I listened to his narrative throughout each session and searched for unique outcomes and experiences in which he successfully solved his own problems and emphasized his resilience as a hard-working,

educated, husband, and father. In this practicum experience, my strengths perspective was helpful because it focused on positive interpretations that were targeted at developing alternative positive life narratives for him, and he reported that he felt empowered to find his own voice throughout all our mutual conversations.

Hope was a central component in my narrative approach because I knew that it would be helpful in providing the motivational power to overcome the harshness of his life. Seo (2015) reported that people with depression might have decreased motivation to live in the present moment and create a better future and that inducing hope can help to alter negative emotions and motivate positive changes for a brighter future. Throughout the working relationship, I knew that it would be essential to focus on finding his positive experiences, events, and emotions. I wanted to maintain a non-blaming stance and be respectful, and let him know that he was the expert in his re-authoring and telling of his past.

Seo (2015) reported that there are many significant elements to narrative counselling, but in my opinion, two seemed to be particularly significant throughout my practicum and included, (1) maintaining a stance of curiosity in my approach, and (2) always asking questions that I genuinely did not know the answers to. Finally, towards the end of treatment, he was able to make progress towards a more strengths-based dominant storyline that emphasized his growth and resilience from his narrative which helped to separate himself from his negative childhood experiences.

Narrative therapy helped him to recognize that what he considered flaws, were inherent gifts given to him because of his experiences and he was able to recognize that he could reflect his passion to make others happy in the current relationships that he had in his life (e.g., wife, children, work, hobbies). In this practicum situation, I learned that helping people reframe their

problems or self-declared flaws can help to shift their entire perspective, or in this case, feelings that they carry with them throughout their timeline.

The Tree of Life Activity

In the spirit of the narrative tradition, I incorporated the tree of life activity as a therapeutic tool to allow for the re-telling of stories about people's lives in hopes that they were able to act into more positive contexts in the future after counselling. Through the construction of their trees, I was able to understand the nature of people's struggles, and strengths, which opened space for discussions about important topics relevant to their presenting situations. The tree of life was chosen as a focus within intervention due to its strength-based narrative and its origins in empowerment with vulnerable groups (Fleming et al., 2023). The intension was to provide an opportunity for people to make sense out of their problems and to evaluate their effects on people's lives by offering deep reflection and awareness and to find new possibilities and assets perhaps otherwise unknown (Fleming et al., 2023).

The tree of life was designed by child psychologist Ncazelo Ncube (2006) while working with children who had lost their parents to HIV/AIDs in Zimbabwe. I often used this approach with younger clients (ages 16-18) who expressed a passion for arts/drawing. Typically, I explained the activity to everyone prior to hosting the activity. I further provided people with markers, crayons, and paper, and informed them to be as expressive as they wished. Many of the people became excited when beginning this venture, and later expressed feeling more connected to their emotions after completing the tree of life drawing. White and Epston (1990) emphasized the importance of witnessing people hearing about their preferred versions of their lives as a way of consolidating and supporting change and helping them connect with past hopes and resources that can continue to sustain them in their everyday lives (Hughes, 2014). The tree of life was

intended to acknowledge the stories of people and allow them to share their tree in a safe and supportive environment.

The tree of life activity was always presented early-on in treatment (typically session 2-3), to learn more about their strengths/resources. Individuals were invited to draw out their lives and trace their cultural and social histories in the roots, which included both words and drawings of their family origins, those who taught them most in life, their religious roots, or a cherished musical lyric (Hughes, 2014). The ground contained elements of their current lives, including where they lived and what their plans for their future were. Their strengths and abilities were drawn onto the main trunk of the tree, with narratives of what others have observed of them, and stories told about how their skills were developed (Hughes, 2014). Finally, their hopes and dreams for the future were put into the branches of the trees, with the names of impactful people from both past and present, and gifts that the person provided them in the leaves and fruits of the tree.

I had the opportunity of working with one person who was 20 years old. She presented for services due to feelings of depression and anxiety. The first time that I met with her for an initial assessment, she reported that she had a love of expressive art/writing but admitted that she had lost her passion since the pandemic. I made a note of this on the strengths portion of the assessment document and wanted to find a way to authentically incorporate it into my relationship with her as the sessions persisted. As the process unfolded, she continued to express that she felt as though she was wandering throughout her life aimlessly with no purpose nor goal. She indicated that she knew she wanted to go back to school but was unsure what to study.

Using the tree of life activity, I was able to help her recognize that she missed expressing herself through her artwork. This was established when she presented her tree to me after

completing it in session. She admitted that she typically had difficulty expressing her identity otherwise, and that this exercise was a positive reminder of that. In real-time, this was the first time that I had seen a glimmer in her eyes. When she presented her tree, it was the first time she spoke freely without hesitation or anxiety. She made eye contact with me and spoke with such knowledge and passion. It was like it was the first time I met her all over again. I felt that the tree of life activity changed her perception afterwards because in her next session she revealed that she wanted to go back to school to study graphic design. She was one of my success stories throughout practicum. She graduated services, enrolled as a new graphic design student, and I truly believe that the tree of life inspired it.

Brief Solution-Focused Counselling (BSFC)

Heading into practicum, I knew that one of the challenges that I would encounter due to working in a provincially government funded mental health agency would be the extensive and at times daunting, mental health waitlist. Mireau and Inch (2009) reported that mental health services are increasingly challenged by waitlists for counselling services, and that a strength-based, brief solution-focused counseling (BSFC) model is effective in increasing the number of people served while maintaining high-quality and professional services.

It is no question that waitlists are extensive everywhere, and that demands for services continue to grow with limited recourses (Mireau & Inch, 2009). Thus, a concern that I had throughout practicum was how I would service people effectively and efficiently using my strengths mentality in a 10-session, brief solution-focused format. My goal was to engage people and keep them focused and motivated on their goals and priorities right from the initial encounter. With a focus on the therapeutic partnership, I worked cooperatively with people to

create solutions built on their strengths rather than their problems/diagnosis throughout the entire helping process.

By doing so, people were able to deal with a wide variety of concerns and were able to set goals for positive change right from the assessment and treatment planning session. I always ensured to inform people that the sessions provided were limited, and that my practice approach as a mental health therapist was to emphasize the strengths and abilities of each unique person that I had the privilege of working with. I wanted to achieve a healthy balance between empathy and strategy, two components central to solution-focused, strength-based work (Saleebey, 2001). Much like narrative therapy, the first step when applying a (BSFC) was to validate the person's presentation of the problem and help them to separate the meaning of it into an attempted solution while directing their energy away from the problem and towards new choices. Davidson (2014) reported that if BSFC sessions promoted a problem-saturated stance that depressive symptoms would persevere and make problems seem even more chronic for people experiencing diagnosis and symptoms. Further highlighted is the need to focus on solutions and to become more attentive to change that is not illness driven or problem-saturated (White & Epston, 1990).

For instance, I worked with a young woman throughout 10-sessions who was referred to services by her family physician for diagnosed/treated clinical depression. When first meeting with her, I asked her when she had received that diagnosis and how it was deemed clinical, as detailed on the referral report. In that conversation, she had shared that she had visited her family physician 1-year ago after losing her father to a heart attack and expressing fleeting thoughts of suicide. She expressed that she was prescribed an anti-depressant after voicing feelings of sadness, grief, guilt, and anger. She informed me that she did not know how to deal with her

feelings since losing her father and expressed that she would like to live a life without taking medications.

In this practicum experience, it was evident that her emotions were very much a reaction to what she was experiencing as a young, 19-year-old woman who had just lost her father. In that conversation, I felt compelled to validate her and simply let her know that she was having a human reaction to a very sad experience. I reflected how strong and resilient she was often throughout that session and reminded her that she had the ability to flourish and grow from her circumstances beyond taking medication.

After agreeing to services, it was decided that we would work together to complete the strengths portion of her assessment so that we could focus our time on a BSFC format that was motivating, goal-orientated, and holistically healing. Within the assessment process, she expressed that she had a passion for creative arts and theatre, and detailed how she was hopeful about returning to school when she was in a better mindset to pursue the arts. After completing the strengths portion of the assessment form, it was clear that we would focus our time on building upon her confirmed strengths in hopes of creating positive changes in her life, beyond using medication. It was during the strengths assessment that I was able to establish what would be healing for her grief, which in this case, was her passion for creative arts and theatre.

Throughout all our time spent together, I continued to work with her to create motivation and to help identify where her current resources were and how they could be accessed and used effectively to aid in her healing, a good principle of BSFC (Davidson, 2014).

Helping her to re-imagine a new vision entailed mapping out a preferred story, and so, I asked her what her ideal career and future looked like to which she informed me that she wanted to open her own theatre in the community or perhaps become an actress in films or television

shows. She also related that she wanted to go back to school and make her father proud of her and honor him in her work. In this questioning, she was able to define her preferred vision and feel motivated about her future as a young, intelligent woman. Ultimately, by working together throughout the BSFC session framework, we were able to find solutions by utilizing her resources and strengths within her own world and environment, including her passion and desire to be an actress and honor her father.

Moreover, I wanted to ensure that I was highlighting what she was already doing well in her life, such as maintaining a full-time job successfully, taking care of herself financially, and how resilient and capable she was. I applauded her for her strength, and how she ever-so-graciously wanted to honor her father's life with her passion for the arts. Admittedly, her strength inspired me. She was a young resourceful woman that was impacted by an experience that no 19-year-old person should have to endure, but there she was, still standing.

Motivational Interviewing

I incorporated Motivational Interviewing often throughout my strengths-based practicum approach due to its positive alignment with social work values and a strength's mentality. MI was incorporated since it is flexible and adaptable to other types of person-centered approaches (Boyle et al. 2019). I appreciated the mirrored values that MI offered as I found elements of this theory to align well with the traditional strength-based social work values of empathy, respect, and empowerment (Canadian Association of Social Workers, 2024). Jones (2020) characterized MI as an empathic relationship between therapist and person and an avoidance of confrontation and persuasion (p. 98). Thus, in spirit of MI, I ensured to emphasize autonomy and make people feel validated and listened to whenever possible, while eliciting content rather than imposing my own views and opinions. I wanted to demonstrate a non-judgmental stance, and make people feel

comfortable talking to me, and trusting of the collaborative partnership. In essence MI was not necessarily an approach used throughout practicum but rather an underlying spirit and communication style incorporated throughout all the techniques/approaches that I incorporated as a holistic therapist.

Greene et al. (2020) reported that language has its own independent healing quality and that it either reflects a person's reality or alters it. Keeping with the strength's perspective, it made sense that I would examine and reflect upon my language throughout practicum while carefully engaging with people in dialogical interactions and conversations that would facilitate the social construction of the person's sense of self as competent, resourceful and capable of personal agency (p. 270). I wanted people to know that they were the expert, and most knowledgeable to their story by offering positive therapeutic dialogue that avoided the language of help, often beginning each session with statements such as "What are you wanting for yourself today?" or "What concerns would you like to address?" Questions such as these offered respect to the person as an equal participant in a collaborative process that was capable of being self-directing and self-determining (Saleebey, 2001).

Often, I strived to encourage positive reframing within my approach by helping people to shift their worldview and redefine their reality to include more alternatives and perceive their deficits as being recourses rather than flaws. Encouraging positive reframing allowed for people to widen their perspectives because I encouraged plausible, alternative positive interpretation for something that they defined as negative and unchangeable. For instance, I would try to help people reframe negative statements that they made about themselves such as "I have such a temper, I just can't control my anger" by asking them to consider alternatives such as "could it be that you are a very passionate person with very high standards?" (Greene et al., 2020).

Throughout practicum, each time that I incorporated positive reframing within my work, I always ensured to offer it in a way that was compatible with the person's beliefs and values as a means of maintaining cultural competence and ethical social work standards of practice (Ontario College of Social Workers and Social Service Workers, 2024).

In the next chapter, I will discuss the application of the supervision process throughout practicum and reflect on the overall process and experience of supervision and how I progressed as a strengths-based therapist working in a mental health discipline. I will then detail how I was first introduced to wellness/self-care throughout the supervision experience and reflect on my new passion for journaling and maintaining professional holistic wellness as a means of embracing my theoretical perspectives and imprinting the approach into everything that I strive to be and promote in my work with people. Furthermore, in this next chapter, I will provide different supervision experiences that reflect a deeper understanding of how fulfilling the supervision experience was throughout my practicum experience, while also describing how self-reflective the overall experience was as a new clinical supervisee.

Chapter 4: Application and Analysis of Supervision in Mental Health Practice

To offer a basis for analysis of reflective social work practice and use of supervision during my practicum at The Alliance Centre, a description of the supervision experience will be detailed throughout this chapter. My rationale for wanting to focus a large portion of my practicum on supervision remained rooted in The Ontario College of Social Workers and Social Service Workers (OCSWSSW) non-binding expectations that registered social workers take initiative and seek out supervision or consultation and practice within the limits of their competence (Sewell et al., 2021). As a new mental health therapist working in a clinical setting, I wanted to embrace core social work values and standards of practice and enhance my professional reflective self-awareness in hopes of becoming more aware of present realities in the mental health system, as well as being able to recognize my own perceptions, feelings, strengths, and nuances of my own behaviors in supervision, and practice.

Prior to going into this experience, I knew that I would have many practice experiences to reflect on as a novice therapist; and I felt that I needed to focus detail on my need for reflexive awareness, an integral component to working with people (Kondrat, 2011). Another element that I knew that I would often consider throughout the supervision experience was how my own life experiences/worldviews would contribute to my own clinical perception and judgements as well as, in part, to my behaviours and reactions to specific practice situations. With so many new elements of practice, I wanted to ensure that I was utilizing supervision proactively so that I could become increasingly aware of the ways in which the practice situations that I experienced were being filtered through my own lens so that I could become a better therapist and develop a deeper level of clinical insight with the intent on becoming a better mental health professional in the future (Kondrat, 2011).

In essence, I wanted ethical and supportive supervision in the context of a confidential, strengths-focused supervision that would be considerate of my own strengths, feelings, professional wellness, and of my practicum experiences (Beddoe & Davys, 2016). Due to my current peer-reviewed research findings of the main tenants of supportive supervision, both my supervisor and I agreed that we would avoid focusing on administrative and/or the organizational needs of the agency throughout the practicum process and rather shift our attention to a more supportive supervision model that would embrace my accomplishments and challenges throughout this venture and mirror what I was doing in my work with people.

When first meeting with my supervisor, we established that my supervision sessions would be utilized as a means of providing on-going reflective practice while also ensuring my professional wellbeing was maintained throughout this new endeavor. For the purpose of this practicum report, well-being is linked to my own bio-psycho-social-spiritual model of mental health from a holistic, strength-based orientation. Well-being from my perspective, consists of living in a positive state rather than neutral one, connected to living well and feeling good both personally and professionally, similar to the strength's philosophy of wellness (Saleebey, 2001).

I knew that in order to meet my practicum goals of actively submersing myself into a supportive supervision process that I would need to be supported throughout this venture by someone who could recognize my strengths and successes in the work that I did with people, and I knew from my practicum research that I was seeking a supervisor that would help to deepen my practice wisdom through authentic conversations and shared theoretical underpinning, and I wanted to deepen my growth and maintain wellness throughout this experience, which I feel was achieved.

Entering the first initial supervision session, I had a hopeful stance about what to expect due to all of the pre-planning and rapport building with my supervisor prior to officially meeting for an official session. After careful research and examining the effects of supervision from the supervisee perspective, I had some basic understanding of how I would feel entering a new area of practice at The Alliance Centre, and what the benefits of supervision would be for my own professional reflective practice and overall wellness as a human being. I was excited about the supervision experience and felt compatible with my supervisor and confident in the relationship that we could build.

During my first supervision session, my supervisor and I went over my practicum learning goals and conversed about what I was hoping to get out of the supervision practicum experience. In that conversation, I had expressed that I wanted to focus on building the supervisory relationship so that I could feel comfortable in sharing throughout the process and reflected that I wanted to actively engage in supervision as a means of practicing my own wellness as a professional, and MSW student, and further reflected that I resonated most with a supportive supervision approach due to its mutual person-centered mentality.

I related that I simply wanted to grow professionally and become a well-balanced person for the people that I would be helping at The Alliance Centre and shared my excitement about securing a permanent position upon my graduation from the MSW program. Mutually, it was established that we would focus on my current professional strengths and capabilities and celebrate my successes whenever possible as a means of embracing a strengths mentality. Beddoe and Davys (2016) reported that theoretical differences can create dissonance in the supervision relationship and experience if not mutually compatible. Luckily, as a strengths-based enthusiast focused on removing people from their labels and diagnosis, it was rewarding to have

the opportunity to engage in supervision with someone who mirrored a similar theoretical orientation; and that was clearly displayed within our strength's dialogue, and person-centered practice approaches that we embraced in our work, as well as the mission statement of the organization, which promotes a person-centered philosophy to mental health treatment in the community of West Nipissing, Ontario.

Mack (2012) reported that supervisors should be applying a strengths-based philosophy within supervision highlighting that it can be the impetus to supervisees feeling hopeful and open to strategies that may reduce symptoms of stress and burnout. Similar to the approach that I was providing to the people that I was working with, I was also receiving this in supervision, which was helpful in increasing my own motivation throughout the practicum experience. Interestingly, it was fascinating to be working with people in my office and applying the same approach in all of my interactions while in turn also receiving the same humanistic treatment from my supervisor in the supervision process. Truthfully, throughout my practicum, I learned that the approach that she provided was consistent which why I was able to be so open and authentic, and why we related so much in our conversations and shared humour. Her sincere warmth, and empathy, was the true cornerstone of our therapeutic relationship that we built throughout the four-month timeline and our matched values and ethics enriched the supervision experience and allowed me to grow tremendously as a helping professional.

Throughout practicum, I always felt that there was an equal partnership between both me, and my supervisor, likely due to our open and authentic conversations surrounding our own cultural identities and how they had the potential to interpose into supervisory authority, leading to potential conflict in the supervisory relationship (Pack, 2012). My supervisor and I had many meaningful conversations about our shared genders, similar educational

achievements/backgrounds and closeness in age in an open-dialogue format. Beddoe and Davys (2016) reported that we all have internalized and embodied social structures in which our everyday practices are ingrained and unconsciously perpetuated without much critical reflection and that our ways of interpreting the social world are influenced by our own social milieus (p. 41).

With a genuine approach and interest, we often discussed the importance of the limitations that come embedded in our individual worldviews and how important it is to be culturally aware of our language both in supervision and practice. Our open dialogue was always helpful because it allowed us to explore our own privilege, as two self-identified white, able-bodied, heterosexual women, which prompted further discussion about our similarities and our differences. It was evident that my supervisor was very culturally aware and able to recognize her own social location, and how we all arrived at our heritage, and ecology of how and where we live and work (Beddoe & Davys, 2016).

A great deal of the research that I reviewed for this project highlighted the significance of the consideration of the dynamics of the supervisory relationship and the importance of matching on certain variables. Examples of variables include sexual orientation, religious/spiritual preferences, ethnicity, age, culture, and gender, all variables which shape our worldviews and the meaning that we attach to it (Cheon, et al., 2008). Cheon et al. (2008) highlighted that contextual variables can set the stage for creating conflict in the supervision relationship if not considered and openly discussed. Issues for suitability in terms of goals, theoretical framework, learning styles, personality, and gender were also emphasized in the study (p. 56).

Throughout our initial conversation surrounding our background and history I discovered that my supervisor and I had similar intersecting dimensions and lived experiences that

merged-well together and felt authentic. Pack (2012) emphasized the significance of similarity in cultural background and insisted that having similar connections can foster a better therapeutic relationship between supervisor and supervisee enriching the overall supervision experience. Thus, with the blend of our similar cultural backgrounds and mutual childhood upbringings, we agreed that we would maintain the mutual perspective that everybody has their own unique lived experiences of whichever culture they identify with, and that we would carry this value with us throughout each supervision session by working through any differences we had, should they arise. Luckily, throughout the supervision experience there were no conflicts or disagreements between us, and I think that was largely due to our similar practice approaches and in the way that we connected as human-beings with similar lived-experiences.

One clear identifier that we openly discussed throughout our cultural dialogue was our privilege of living in a country that has a history of colonial conquest, settlement, and establishment of liberal Western society that subjugated and marginalized Indigenous Peoples, or Nipissing First Nations Peoples. It was interesting to converse about the many aspects of white privilege and how our identities were congruent with the dominant global narratives of success and entitlement that give us taken-for-granted privileges over many people in the world. Acknowledging our power helped us to reflect about the many advantages that we have experienced in our normalized lives versus many of the people that we service in the West Nipissing community.

Having the experience of being so open with our cultural competence and our own identity in supervision was essential due to my desire to want to challenge normalized medical and psychiatric diagnoses and their oppressive potential. I wanted to remain open and non-defensive about my culture as a white, cis-gendered woman, and not hold any biases

towards my supervisor for her beliefs and/or our cultural differences. Plainly, I wanted to honor our cultural complexities and unique lived-experiences and maintain my person-centered philosophy of continuing to search for a more thorough-going and humane inquiry in all the interactions that I had with people.

Social Constructionist Theory

Advocates promoting cultural awareness in supervision encourage supervisees to consider constructivist thinking by questioning the existence of objective and knowable realities and the conceptualization of the ideas shared, conversations had, and thoughts and behaviors reflected within the supervision experience (Guiffrida, 2015). From a constructivist perspective, the world is shaped by the meanings that we impose, and meaning is derived from social, historical, and cultural contexts, which are mediated through language and interactions over time (Beddoe & Davys, 2016). Thus, from a constructivist perspective, supervision is not a definitive model, nor should it be considered a quest for absolute truth, but rather, a co-creative process of new meaning through conversations (Guiffrida, 2015; Hair & O'Donoghue, 2009).

I felt that embracing a social constructivist framework helped to adjust my lens throughout supervision because I immersed myself into the experience with the assumption that the knowledge that we would share would be shaped by our own traditions, language, and cultural experiences. For instance, throughout all the conversations that I had with my supervisor, I maintained the awareness that her knowledge was subjective and from her own perspective and lived experience. This included the assumption that my supervisor had her own version of reality that was constructed through her own social processes and interactions with people. Maintaining this perspective throughout the supervision process was helpful because it shifted my perspective and helped to enrich my strengths mindset by allowing me to understand that my supervisor

would have her own meaning of what is important in mental health treatment. When conversing about this perspective in supervision, my supervisor agreed that we all come to practice with our own lens and knowledge, and she was welcoming with my own values and perspectives throughout the entire process. Often, when reflecting her experiences about different practice situations she would make authentic remarks about not being an expert and I valued her humility and ability to showcase her humanness.

Becoming Inspired Through Supervision

My supervisor was always effective in demonstrating a strength-based perspective throughout supervision by constantly striving to identify, amplify, and capitalize on my own strengths and resources so that I could improve my practice with people. By offering constant support and compassion rather than compliance, she always inspired me to focus on what my practicum/professional goals were and was there to remind me about what was significant in the work that I was doing with people. For instance, it was decided fairly early-on in supervision that I had a very flexible, strengths-based perspective in my service delivery which was very helpful to certain people accessing services in the Mental Health Treatment Program. My supervisor and I had reflected about my strengths during one of our earlier supervisions because I had expressed that I appreciated the other approaches that the unique mix of people that I worked with offered people. From this conversation, we opened the window to discuss the idea of triaging people to the most appropriate person that would best support their needs and later discussed it during one of our weekly intake meetings. After our team discussion, we had come to a mutual decision that this would be a great consideration during intake meetings to ensure that people were being provided with the best possible service that they needed. I felt proud of this change at The

Alliance Centre because I felt that our supervision conversation inspired it, and encouraged it, mirroring the strengths-based work that I wanted to reflect throughout this practicum experience.

The change was positive throughout the remainder of my practicum because intake meetings became more person-focused and about what their presenting needs were, which led us to have more open discussions about whose strengths would be best suited to help the person referred to services. I appreciated this about our team meetings because it was refreshing to witness everyone recognize their own assets as helpers and human-beings. For instance, I became inspired by one of the supporting therapists that I had the pleasure of working with had special training and certification in Cognitive Behavioral Therapy (CBT) something that I was open about not being familiar with. Throughout practicum, she taught me the relevance of CBT in brief structured treatment programs through our countless interactions and team conversations and I got to witness the approach that she showcased to the people that she helped which was inspirational and rewarding to experience. Since completing practicum, I have become interested in the concept of CBT with its link between changing thoughts, actions, and emotions, and I do aspire to learn more about it due to its relevance in mental health treatment beyond this experience (Balaskas, 2024).

Beyond this experience, I felt like I had a voice that could reflect changes at the agency, and I appreciated the team's reciprocity and authenticity throughout every single team meeting in the way that we were all willing to teach and learn from one another. The impact of the supervision experience beyond the office walls was magical and when I most felt connected to strengths-based practice in the sense of its power to those impacted by it. It was life changing to be experiencing the mindset that I was researching, advocating for, and showcasing in my everyday work. This was when I felt that the strengths mindset was most formidable, moments

when I got to experience just how contagious it was to embrace the amazing things that people offered not only in the service that I was providing people, but in the everyday interactions that I was having with my colleagues and friends.

The Supervisory Alliance

As the process continued to unfold, I developed a sense of trust in the provision of supervision due to our progressive relationship. I always felt that I could explore my practice experiences and emotions due to the on-going support that I was constantly receiving and feeling from my supervisor. She created a safe environment that allowed for the development of a positive supervisory alliance, often regarded as the most important construct in an effective supervision experience (Pack, 2012).

The supervisory alliance helped to enhance my strengths-based characteristics and helped to enrich my well-being and professional self-awareness by offering a dynamic relationship that inspired me to share my professional and personal strengths/expertise and unique lived-experiences. My supervisor was constant in providing trust, openness, understanding, and effective communication and always ensured to provide an open platform for sharing, self-disclosure and mutual dialogue. Truthfully, without my trust and security throughout the supervision process, I do not feel that it would have been as beneficial, nor would I have disclosed as much as I did during each session, as reflected among the literature (Pack, 2012).

Throughout each supervision, I ensured that I also got to know my supervisor and her previous narrative and work experience. I wanted to take the time to learn new things about her because I genuinely had interest and looked up to her as someone who had been in the field much longer than me (20+ years). I always employed my practice wisdom when interacting with my supervisor and incorporated all the elements that I displayed with people in each supervisory

session. For instance, I always ensured to maintain a non-judgmental stance, asked open-ended questions, displayed empathy throughout our shared conversations, and constantly offered reflective responses that would aid in the supervisory relationship.

It was evident that my supervisor mirrored a similar approach because she was always effective in role modeling a motivating style that was engaging throughout our moments spent together. I was always comfortable in sharing my experiences with her and I knew that when I was feeling vulnerable, that I would be supported and validated in my feelings and emotions. Pack (2012) reported that to continue to develop competencies that social workers need to be engaged in an ongoing process of learning where they can reflect their experiences and be transparent about their mistakes and their celebrations. Throughout this experience, I valued my supervisor's ability to display such a level of comfort and attentiveness. I felt like she was always available to help me process my emotions and help with any uncertainties that I had to ensure that I was still nourishing my professional growth and development which always seemed to rekindle my hopefulness throughout practicum. For instance, whenever I reflected about any uncertainties that I had in my theoretical approach, we would mutually explore my emotional responses and concerns and she would ask me why I was second guessing myself.

In a sense, I considered the supervision process a constant state of moral reasoning because it felt like I was constantly reflecting on my emotions and actions with the help of my supervisor and journal. This is where I felt most human. The simple act of sharing my own doubts and flaws as a new clinician and admitting that I felt slightly pressured about wanting to help all the people that I was working with. Thankfully, my supervisor was helpful in preserving my self-confidence in the face of my uncertainties and had a special gift at reframing my thoughts in a strengths-based way. She helped me to recognize that my approach was unique and

an asset to the agency, and she was always encouraging of the work that I was doing with people. For instance, during one of the supervision sessions, we discussed the tree of life activity and the potential of offering it at The Alliance Centre. This idea excited me because I witnessed the progress that it made for the people that I completed it with. My supervisor informed me that we could consider creating one and insisted that I host it. This was a perfect example of how she was gifted at transforming my thoughts into new perspectives that were inspiring and motivating. Beyond this conversation, anytime I felt any sense of doubt in my approach, I would shift my perspective and reflect on the conversations that I had with my supervisor about what an asset I was to the Mental Health Treatment Program. Throughout these reflections, I had realized just how much I had grown both personally and professionally, and have since taken this learning with me beyond practicum.

The premise of the entire supervision experience was built upon the foundation of a strength-based, supportive relationship that encouraged my professional growth and helped to continuously empower me. From my perspective, my supervisor provided a formative evaluation in the way that she provided feedback, often providing positive feedback throughout each supervisory session on an on-going basis. Mainly, my supervisor was helpful in monitoring my practicum goals and ensuring that I was meeting them effectively and timely. This entailed highlighting my strengths when I needed to be redirected and helping to identify the continuous growth and learning that I was experiencing when faced with any practicum challenge.

On the occasions in which I felt in distress or as though I was struggling, my supervisor was helpful in normalizing my struggles as part of my on-going development and was able to create a space that reduced my anxiety by displaying an empathetic, non-judgmental stance that was validating and encouraging. It was evident that she wanted me to know that I was able to

overcome any uncertainties which set the stage for non-defensive analysis by the dyad, and the confidence in our relationship was continuously strengthened (Beddoe & Davy's, 2019). Having the opportunity to continuously reflect in supervision enhanced my understanding of therapeutic complexity, and expanded my ability to understand that any difficulty or struggle that I may have encountered could be overcome and learned from by incorporating my own strengths, talents, resources, gifts, assets, and professional knowledge, just as I reflect in my work.

Self-Care and Professional Wellness

Another practicum goal that I wanted to explore further throughout the supervision process was the consideration of my own bio-psycho-social-spiritual well-being, which is philosophically and conceptually consistent with a strength-based perspective of supervision. Glassburn et al. (2019) defined professional wellness as the utilization of skills and strategies by social workers to maintain their own personal, familial, emotional, and spiritual needs while attending to the needs and demands of others (p. 693). The Canadian Index of Wellbeing (2011) reported that wellness is focused on good living standards, robust health, a sustainable environment, vital communities, balanced time, and access to leisure and cultural activities. Either way, I feel that everyone has their own definition of what wellness looks like, and that those are the elements that we need to build upon to strengthen our own wellness as helping professionals at risk of burnout, transference, vicarious trauma, and all of the other elements that link to social work practice and the importance of maintaining wellness (Glassburn et al., 2019).

The wellness portion of my practicum was achieved by immersing myself entirely into the supervision experience with a supportive and motivating supervisor. Remaining reflective and self-aware allowed me to make meaning out of my practicum experiences/emotions and placed emphasis on my achievements and successes throughout practicum. Glassburn et al.

(2019) highlighted that in order to help others, we need to reflect and effectively manage work related stress by engaging in reflective supervision to increase our development and have a supportive space to debrief and normalize the practice situations that we continuously experience.

My supervisor was effective in promoting wellness by being a positive and healthy role model throughout the entire supervision process. Throughout each supervisory meeting, she ensured to ask me about my own professional/personal wellness and encouraged me to incorporate self-care activities into my weekly routines. She would often reflect some of the activities that she would engage in to remain healthy as program manager, and human-being, and inspired me to reflect about my own stress reduction, relaxation, and activities in which I was engaging in to reduce my own stress from my everyday life.

Admittedly, our initial conversation surrounding wellness and self-care prompted me to reflect and admit that I had put my wellness at the back burner since the global Covid-19 pandemic, which inspired me to reflect further about the dialogue that I was promoting with the people that I was working with. In brief, my supervisor reminded me that in order to promote wellness that I needed to make it part of my routine so that I could become the message that I was relating to others. “Practice what you preach” she reminded me.

I believe that to be effective as humans that we need to heal, and help each other heal, and that we need to intentionally create healing contexts that support our personal and professional wellness including our supervisory practices and what we promote (Scheyett, 2011). Throughout my practicum, The Alliance Centre funded an eight-week yoga/meditation workshop at one of the local health centres as a means of promoting wellness to people in the community. I ended up registering for the workshop and engaging in the process throughout the eight-week

time frame as a means of promoting the messages that I was telling others. My supervisor was right. How could I promote strengths-based wellness if I was not focusing on my own wellness as a human-being? It seemed that I was continuously inspired by the in-depth conversations that we had surrounding self-care and wellness and I appreciated her for holding me accountable to my promises. In fact, moving forward, I have developed a new appreciation for self-care and remain dedicated to implementing wellness in my daily routine as a means of balancing the personal, professional, emotional, mental, physical, and spiritual components of myself so that I can do good work with people.

Supervision can change a person simply by experiencing it. What I mean by that is that since practicum finished, I now find myself incorporating wellness into my everyday work and life. For instance, within one supervision session we discussed the importance of being mindful each day and taking time to rest and reflect. My supervisor suggested in that conversation that I take two 15-minute breaks and strive to leave for lunch whenever possible. We laughed about our unpaid lunch and chuckled that we had the ability to leave the premise should we choose. I appreciated her candour and followed her advice as a means of achieving self-care which has been very helpful and enlightening moving forward in both my professional life, and my personal life. For instance, sometimes I choose to walk home from work as a means of debriefing my day and thoughts. Prior to completing practicum, I had never walked home, nor even considered it. This is a primary example of how the supervision process has changed me and made me a healthier professional.

Reflective Journaling

The research reflects that journaling is an effective tool often used to assist in developing the reflective supervision process and to create meaning from our practice experiences

(Gursansky et al., 2010). One of my goals throughout practicum was to engage in journaling since a big portion of my focus was to actively reflect and promote self-awareness and professional growth while being well and caring for others. Journaling has been linked to narrative therapy. Thus, I wanted to share in the work that I was doing with the people at The Alliance Centre and incorporate it as a routine object and practice both within and beyond my supervision sessions as a means of enhancing my ability to reflect and move forward with greater insight, awareness, and mastery (Glassburn et al., 2019).

I brought my journal to each supervisory session which was helpful in prompting the different thoughts and ideas that I wanted to reflect when meeting with my supervisor. The journal was helpful because I enjoy reflective writing as a creative outlet, and I found it to be something that I looked forward to engaging with during each supervision session. My supervisor was very receptive to my journal and the ideas that were reflected throughout supervision and expressed that she very much appreciated my candour and self-awareness. I wanted to embrace a narrative philosophy and record my practicum experiences and as a means of reflecting upon the theoretical perspective that I was embracing and experiencing in the work that I was doing with people.

Journaling allowed for my supervisor to build upon my written reflections because I would often read some of my passages during supervisions to go over topics that I may have otherwise forgotten or overlooked. Consistently, my supervisor was able to help me process my written reflections and was always able to highlight the successes and growth from my expressed practicum experiences in a supportive way that focused on my strengths. Having the ability to journal my thoughts and experiences and reflect on them with a more experienced clinician made

me feel understood and like I was in good hands which provided a sense of confidence and security throughout the process.

For instance, there was one supervision session that I read my journal to my supervisor highlighting a practice experience that I felt slightly triggered about. I had reflected that there was one person that I was working with for four-sessions that did not end up following through with services. In that situation, I personalized the experience and reflected that I felt that it was potentially because they did not like my theoretical approach, or perhaps feel confident in our therapeutic relationship. In that supervision moment, I was able to recognize that my own insecurities came out and bled into my professional work because I questioned if it was simply a matter of them not liking or valuing my work as a new helping professional. This was a hard emotion to process because it was a new experience for me. In a sense, I considered it a failure in my work and questioned if I had enough to offer the people that I was helping. Prior to their termination of services, I had felt that we had built a solid rapport, and the person had informed that they were invested and committed to the therapeutic process which is why I felt so confused by their departure.

When reflecting these emotions to my supervisor, she was able to help redirect me and allowed me to realize that I could not personalize the outcomes of the people that I would be working with, and further asked me to recognize that I was a genuine, caring person that simply wanted to have a successful practicum that was effective in helping the people that I was working with at The Alliance Centre. She informed me that I was passionate about the work that I did with people, and this was a nice reminder.

In that supervision experience, my supervisor reminded me of my strengths and highlighted all the other successful people that had graduated from services and emphasized my

desire to want people to leave service with their best potential possible. This was rewarding because she emphasized my humility and complimented my journal reflection and my ability to remain authentically human. Sharing this portion of myself created a sense of safety in that experience and made me feel supported and validated. Her kindness was contagious, and it was nice to feel so supported and reminded about my passion for the work that I was doing with people. This was a good lesson because it made me realize that so long as my intensions were pure that I was doing good work regardless of the outcomes with people in the mental health treatment program.

Journaling felt effective in enhancing the supervision process because it helped heighten my reflections and provided a voice to my experiences. With constant motivation and support, I felt compelled to journal each day about at least one thing that I learned or felt proud about. I wanted to mirror my theoretical framework and reflect it into journaling because I needed to become what I was conveying to others. Recording my strengths and resilience throughout this process was helpful because it helped me to recognize that I could use my own talents and turn my own negative self-perceptions into alternate positive thoughts (e.g., failure into passion and caring).

Being challenged throughout practicum at times allowed me to reflect about my thoughts and reactions and allowed me to recognize my own resilience and growth throughout the experience. In a sense, it was validating to talk with my supervisor about my experiences because she would share similar emotions about practice experiences that she encountered throughout her career which helped normalize my feelings and reflected statements. For instance, there was one occasion that I had reflected that I felt pressure to have all the answers for a young person that I was working with that had very high and complex needs. I expressed this to my

supervisor, and we reflected about transference and countertransference which was helpful in changing my perspective. I remember using the words “I feel stuck” and by talking about it, my supervisor helped me to recognize that I was taking on the feelings of the person that I was helping, which gave me a whole different perspective on the helping relationship leaving that supervision session.

It was often that my supervisor provided new perspective on my perceived challenges which provided me with new focus and motivation in my work with people. It was evident that my supervisor was effective in playing a significant role in mediating any conflicts or uncertainties because she helped me to recognize that learning from my mistakes was essential to my personal/professional growth and that it encouraged enhanced self-awareness in terms of becoming aware of my present reality. Journaling was also helpful in embracing my objective to maintain wellness throughout this process because I was constantly encouraged to disclose my self-care tools/practices throughout our conversations and reflect on what I was doing to practice wellness. By embracing a strengths philosophy, my supervisor was consistent in helping to remain present in each supervision session and made me feel very supported with the way that she was so attentive to my practicum goals and self-care plan.

Mack (2015) related that using a strengths perspective in the supervisory process can increase supervisees’ sense of hope and effectiveness when working with people by addressing topics of work-related stress, burnout, and self-care practices. Openly discussing my self-care practices and utilizing my supervision sessions to unpack my feelings about my own wellness felt validating and motivating and as though my supervisor was invested in my obligation to take care of myself, just as I was others. Each session, my supervisor was always alert and focused and able to pick up on both verbal and non-verbal cues. Each time, the environment felt

distraction-free, and I felt that my supervisor was invested throughout the entire process in the way that she provided her undivided devotion (e.g., silenced telephone, do-not-disturb sign on office door).

Journaling helped to provoke discussions each and every time I arrived to supervision and made me feel prepared and optimistic about completing my practicum goals. By writing about my practicum experiences, I was able to focus on the positive aspects of my own life and envision my future as a strengths-based therapist working in mental health even after practicum was completed. By constantly being reminded of my professional strengths and successes, I felt that I navigated my practicum confidently and effectively because I was always encouraged to celebrate my successes which in turn motivated me throughout this entire process thus creating successful outcomes with the people that I was working with.

Supportive Supervision

With a constant focus on my strengths and successes, having the ability to experience strengths-based supportive supervision provided a non-hierarchical relationship that was motivating, encouraging, and a practice that I very much looked forward to. Having the ability to experience a supervisor that constantly highlighted my talents and potential had a positive effect on my professional wellbeing and was enriching to the supervisory experience and alliance and in turn, with the work that I got to do with people. My supervisor mirrored everything that I was striving to be as a mental health therapist and ensured that I knew that there was no right way of doing anything. She recognized my potential and helped me to build upon my strengths and skills which helped to facilitate my personal/professional growth and encouraged on-going reflection. I felt so valued throughout the entire supervision process and as though my opinions and emotions were respected and appreciated. My supervisor ensured that my skills and abilities

were amplified and remained consistent with my strength's perspective regards to empowerment, self-determination and authenticity. Even as an MSW student, I felt recognized for what I contributed to the agency by all of its members and as though people genuinely appreciated my revisional outlook on mental health treatment.

My supervisor knew my strengths fairly early-on and had the ability to help me progress towards my practicum goals in a collaborative and effective way. I felt that my supervisor maintained a respectful stance throughout every conversation that we had and that our shared partnership was achieved due to her constant authentic interest in emphasizing my skills, abilities, attributes, creativity, determination, and practicum goals.

The supervision experience proved that having a supervisor that mirrors your theoretical framework, culture, values, social location, and background, is an integral part of a positive supervision experience and what connects us together (Pack, 2012) Plainly, I could not have had such a positive experience without the bond and relationship that we forged and created together. My supervisor has helped me recognize strengths that I forgot to even consider and continuously reminds me of the amazing work that I do with people. By having the opportunity to apply a strengths-perspective while also receiving the same approach in supervision, my practicum goals have been achieved.

My previous research affirms the significance of how impactful strengths-based theory truly is in social work practice and I am beyond grateful that I had the privilege of experiencing it with the people that I worked with. Supervision opened my eyes to how impactful and effective it can be to focus on the strengths of people, including myself. Having the opportunity to experience the same approach was inspiring and made me feel secure in the message that I was advocating to others.

The final chapter will conclude my practicum project in a reflective way that highlights both the challenges and celebrations of my practicum experience, theoretical underpinning, and supervision experience. Moreover, I will reflect about my journey moving forward and discuss what I will do with the experiential knowledge that I have acquired when continuing to work with people in the mental health system at The Alliance Centre.

Chapter 5: Conclusion and Implications for Social Work Practice

To fulfill the requirements of the Laurentian University MSW program, I chose to complete a 450-hour advanced practicum in a new area of interest and practice at The Alliance Centre in Sturgeon Falls, Ontario, in the Mental Health Treatment Program as a means of gaining experiential knowledge. As previously stated, the objective of my practicum was to embrace a strength-based perspective in mental health treatment whilst also emerging myself completely in the supervision process to improve my clinical skills, embrace reflective practice, and to achieve professional wellness as a new clinician. Therefore, in this final chapter, I will discuss the successes of my practicum approach, as well as the challenges that I experienced along the way. Moreover, I will look ahead at the future and reflect about the practicum experience and how it has affirmed my passion for embracing the strengths of people.

My primary goal in wanting to focus on a strength's perspective emerged from my professional desire to want to stray away from the more typical fault-focused medical model that in my opinion, strives to diagnosis, prescribe, and label people. As someone with a social work background and education, I felt that it was significant to showcase a person-centered orientation throughout this practicum experience that viewed the person holistically, and capable of achieving many levels of goals, while focusing on strengths, resources, environment and opportunity.

The Ontario College of Social Workers and Social Service Workers (2024) guideline for practice highlighted that we must ensure the inherent dignity and worth of each unique individual and focus on the person within their environment in terms of strengths, resources, and possibility. The guideline further insists that social workers apply a strength-based perspective and view individuals, families, and communities as resourceful, resilient, and of significant value.

In relevance to social work guidelines of ethical standards of practice, this practicum project was heavily influenced by social work values, which is why my theoretical perspective was intended to empower people and allow them to recognize that they were all unique, talented, capable, resourceful, and strong despite their narrative, label, or prescribed diagnosis/treatment. By remaining grounded in a strength-based perspective, throughout this experience, I was able to help people become more spirited and less defined by their diagnosis/labels which was the overall purpose of my chosen theoretical underpinning.

Practicum Challenges

A constant challenge throughout practicum was moving beyond pathology-based medical models while working in a clinical setting due to the mandate of our service and the policies and procedures that I was obligated to adhere to. Despite my intention to avoid clinical diagnosis and Western views on mental health, there was absolutely no way of escaping it. I remember reading some of the paperwork that people would have in their file prior to meeting with them and at times I found myself reading multiple diagnoses/discharge reports and additional relevant documentation. Of course, it was relevant to the person's history and treatment plan, however, it almost felt stigmatizing before having an authentic conversation with them. Thus, keeping with my strength's mindset, I always elected to give people their own voice when meeting with them and I avoided using labelling/pathologizing language throughout every interaction.

Despite my efforts to avoid stigmatizing labels, on many occasions, I noticed that people had been inculcated into their own stereotypes and that they would often come to treatment with a lack of confidence or sense of hope about their diagnosis. For instance, I worked with one person that presented to services due to the loss of her teenage daughter and declared symptoms of depression and grief. When I first met with her, she reported that she felt like she had no

further reason to continue living, nor did she want to, and that her family physician informed her that she likely had clinical depression. She was prescribed a medication to help reduce her symptoms, but reflected within assessment that she would rather not be medicated, if possible, hence her desire to access services at The Alliance Centre.

Working with her was challenging at times because I assumed that she would struggle to find her surrounding strengths due to her presenting situation. Thus, session after session, I would ask open-ended questions and try to help her to recognize her resilience while emphasizing how indestructible she was for trying to heal herself since her loss, while also helping her recognize and regain her power. After building rapport with her and developing a positive therapeutic alliance, by session five, she started to open up about her second-born child to which she stated that she was very close with. Finally, she was able to recognize that her son was her biggest source of strength and motivation in life, leading her to disclose how much she cherished their relationship and wanted to protect it. In that moment, she reflected that her son needed a strong mother that could pick up the pieces, and care for him after losing his sister, and she detailed all of the growth that she would need to do to be that strong person for him. During that session, I noticed her eyes light up when she began speaking about her son and their loving relationship. She indicated that her son was her reason and purpose in life, and that he wanted to become an Oncologist since losing his sister to cancer so that he could help others live cancer-free.

In that moment, she became tearful when describing her love and admiration for her son and disclosed that she could not leave this world despite her thoughts of suicide because she wanted to live to see her son graduate school and become a physician. During that session, I was able to discover her biggest strength and pillar in life, which was the love and purpose that she

felt for her son. She was a proud mother, and her son was her greatest source of strength, and she needed to be reminded of this. She needed to be reminded about how she survived an experience that nobody should have to endure, and she was reminded about how she was still standing, despite her misfortunes.

"Is there any part of your grief that you feel was useful to you?" I politely asked her with empathy and authenticity. She was quick to verbalize that she had a new appreciation for her relationship with her son, describing her grief as useful in the way that it made her value their relationship even more since losing her daughter. In this practicum experience, I learned that at times, when it seems like there is no hope for redemption or words to express to someone for their loss, that people oftentimes, still have something to live for, despite their assumed or prescribed verdicts.

By the end of treatment, when graduating from services, she disclosed that she felt more hopeful about her future moving forward and indicated that she would spend the rest of her life dedicated to cherishing and nurturing the relationship and bond that she had with her son. This gave her something to look forward to and feel hopeful about. She once again, had purpose and a reason to be alive. He was her greatest strength, and the biggest element in her environment.

Abiding by the clinical structures and embracing a strengths perspective fell short at times due to my professional obligation to incorporate diagnostic terms and diagnosis in individual treatment plans (ITP). Although I was provided with the opportunity to dedicate one portion of the ITP to the person's strengths, I also had to incorporate narratives about decompensation, and symptomatic struggles and manifestations. Axes 1 and Axes 2 diagnosis of the DSM-IV were at times reflected and featured in ITP simply due to program policies and procedures. Admittedly, at times, it felt like the strengths portion of the assessment was overshadowed by medical terms

and diagnosis, and evaluation therefore, in my accountings of the person's narrative and in the language that I reflected within documentation, and ITPs I incorporated my strengths outlook and approach as much as I possibly could.

Other times, I felt it was hard to give up the idea of problems as the essence of the work that I was doing in a clinical mental health system. I felt somewhat responsible for others to find a place to take hold, and it was difficult to try to drift away from some of the problems that they disclosed within assessment. At the onset of the initial referral to services, the focus was always the problem, so it was a challenge for me to shift focus to what was possible opposed to what was missing or debilitating for some people (Saleebey, 2004).

Living in a Canadian Western culture that is infamous for pointing out people's insecurities, faults, frailties and weaknesses, I sometimes found myself reflecting about how I had always subconsciously been surrounded by a popular culture where people were often humiliated, disregarded, and/or diagnosed (Saleebey, 2001). I reflected about how I still felt so hopeful and optimistic despite the many flaws of the medical system and how I attributed that to my personal values as a mental health therapist. For instance, one of my journals was written in the context of how I felt socialized and conditioned to derive at a diagnosis from symptoms simply by means of normalized societal structures, norms, and my previous Western college/university education (Xie, 2012). After reflecting and sharing my viewpoints in supervision with my supervisor, we both reflected about how mental health is still heavily influenced by the medical model with a focus on diagnosis/cure which does not translate well to the mental health system.

Practicum Highlights

In the spirit of the strengths-based perspective, I wanted to balance my practicum challenges with some practicum highlights to shift attention to all the positive elements that I encountered throughout all my experiential learning. The strengths-based perspective allowed me to look at people in a different light despite their circumstances and helped me to work with people effectively at The Alliance Centre using various strength-based techniques (e.g., narrative therapy, brief solution-focused therapy, tree of life activity, motivational interviewing).

It took a great deal of courage and diligence to approach this practicum with a different theoretical lens in comparison to what I had previously experienced as a community-based case manager. My re-vision of mental health treatment and counselling demanded that I suspend any assumption with the people that I encountered regardless of their narrative and that I embraced the wholeness of the person rather than their presenting diagnosis or pathology. Each day, I had the opportunity of working with people in a possibility/solution-focused format that embraced their personal qualities despite their lived trauma, sickness, abuse, and/or oppression. This approach helped me to recognize that elements such as having a good sense of humor, or simply just loyalty, could become the source of energy for successful growth for many people (Saleebey, 2001).

Applying a strengths-based perspective did not seek to disregard the lived reality of the people that I was working with at The Alliance Centre, but rather, sought to help refrain, and to develop a new attitude and language about the essence of possibility and opportunity and the nature of the person beneath the diagnostic label so that they became the ticket to expanded choices and routes to change (Saleebey, 2001). Saleebey (2001) highlighted that critics of the strengths-based perspective have argued that people have the potential of being beyond

redemption due to their inability to accept or understand their circumstance, however, throughout practicum, I ensured to find useful glimmers of applicable skills and motivations that people had within them to help meet their needs and resolve their conflicts as a means of avoiding the assumption that someone is incurable, broken, or untreatable.

Embracing a strengths-based perspective in practicum has allowed me to better communicate with people at work and changed my overall outlook regarding the work that I continue to do with people. Throughout this experience, I knew that many of the people that I would be meeting would be presenting to service with unconscious labels or ascribed diagnosis, so I wanted to provide them with the power to heal themselves and separate themselves from their situations/conditions and empower them. From my perspective, people are more motivated to change when their strengths are highlighted, emphasized, and validated; something that I observed quite frequently throughout my practicum and within supervision. Committing to a strengths-based perspective changed my outlook as a mental health therapist and inspired the acquired value that almost anything can be considered a strength under certain conditions (Saleebey, 2006). Strengths-based work has helped me to constantly examine people for their positive traits and has encouraged me to listen to people's narratives in an entirely different way that embraces all that they offer (Saleebey, 2006).

Looking Ahead at The Future

Moving forward in clinical mental health practice, I think that at times, it will always be somewhat challenging to incorporate a strength-based perspective due to the ever-so-many Western driven taxonomies of pathological states where weaknesses, limitations, problems, and failures remain the filters through which many helping professionals view the people that they serve. However, after all of the experimental knowledge and research that I have attained

throughout practicum, and after experiencing countless successes with people, I remain committed to not focusing on a person's deficiencies/diagnosis but rather on embracing their resilience and strengths regardless of their narrative or context. This is not to say that I will disregard their suffering or pain, however, I remain committed to helping people realize that they have walked through the fire and that they have the ability to conquer any path and go on to live a happy, and fulfilling life (Saleebey, 2001).

Looking ahead, I want to continue to embrace a strengths perspective in my practice and move beyond empirical and rational levels by recognizing the full potential of everyone that I have the opportunity to continue to work with at The Alliance Centre. Since I was offered a permanent position as a Mental Health Therapist post MSW graduation, my intention moving forward is to continue providing people with purpose and motivation to navigate the psychological, social, cultural, and physical elements of their everyday lives, and to highlight the resources that pull together during difficult times.

As a novice mental health therapist working in a department of The West Nipissing General Hospital, I remain obliged to work within the perimeters and contexts of the mental health system and to adhere to Westernized legislations, hospital policies, and procedures. Despite the medical models ever-so-present appearance within many of the daily tasks that I will continue to do in my everyday work (e.g., individual treatment plans, intake assessments, referrals, psychiatric reports), I remain committed to going beyond the assessment and/or diagnosis and people's presenting problems and will continue to foster therapeutic relationships built upon elements of hope, empowerment, aspirations, and vision (Pulla, 2012).

The purpose of the work that I wish to pursue in mental health treatment remains rooted in person-centred practice that strives to provide liberation and holistic wellness built upon the

strengths of all people. I wholeheartedly believe that all people have the ability to change and grow and thrive, and that with the proper supports, that they have the potential of overcoming their adversities and ascribed identities.

Since I will be remaining in the mental health therapist position moving beyond practicum, my practice approach remains dedicated to embracing the good in all people in hopes of providing an atmosphere for healing, transformation, regeneration, and resiliency both with the people that I serve, and the people that I have the pleasure of working with (Saleebey, 2006). Thankfully, the people that I worked with and whom I will continue to work with at The Alliance Centre have taught me just as much as I taught them in our authentic conversations, intake meetings, supervision sessions, and so on. Indeed, all of my relationships throughout practicum were purposeful, reciprocal, friendly, trusting, and empowering, and inspired by strengths work, and for that, I am eternally grateful.

Shifting The Paradigm

This practicum experience was much more than simply shifting my theoretical framework. Becoming a strengths-based mental health therapist demanded for a deeper inner transformation that was far more complex than just learning some new tools/methods and changing my vocabulary. This practicum approach entailed changing my entire conditioned Western outlook and unravelling what the history of mental health and madness previously emphasized in regard to diagnosis/treatment. This practicum allowed me to drift away from what I had previously known and learned, which was an emphasis on deficit, disease, and dysfunction (Pulla, 2012).

I had to remain committed and dedicated to finding the assets among each unique person and maintain the belief that I could look beyond people's wounds and hypothetical destinations.

How can we expect to find people's strengths among the damage if we only see damage? I asked myself this question each and every single day that I worked with complex people (Pulla, 2012).

In my continued work at The Alliance Centre and beyond, I remain devoted to challenging the basic foundations of Western practice knowledge of disease/diagnosis and expertise (Pulla, 2012), and to see beyond the pains of people, I remain actively engaged in supportive supervision as a means of fighting against myself, my biases, my training, and even my own culture and privilege. This allows me to maintain holistic wellness by experiencing supportive and reflective supervision which in turn helps me to be a healthy professional for the people that I continue to serve by providing a reflective space that somehow continues to change me.

As I learned throughout this experience, I had to become what I was preaching to others, and I feel that I have encapsulated a strengths philosophy as I continue to persist in my mission of who I am, and what I want to be moving beyond this project and experience. Engaging in effective supervision has allowed me to continuously reflect about the work that I do with people and become more aware of my own strengths and resilience as a human-being and working professional. Pulla (2012) highlighted that any helper must develop a deeper self-awareness to effectively promote a strengths-based perspective and can do so by engaging in the personal process of reflection and transformation; recognizing that supervision will be a continuous process of becoming more aware of themselves and their attitudes, strengths, biases, and position in the helping relationship.

Reflective Supervision

The continued method of supportive supervision has allowed for a process of self-discovery of my own strengths, resources, and capabilities; resilience; hopes and capacity for transformation as a new mental health therapist. My supervisor helped me to realize the

growth that I displayed throughout this entire process and was always supportive in motivating me each and every step of the way. Moving forward in my career, I will continue to engage in supervision as a means of taking myself away from my comfort zone, subconscious habits, and hidden meanings. The supervision process continues to nourish my professional goals of being a strengths-based therapist and has affirmed the notion that without the expert hat in the supervision relationship, that we are only human, who care and believe in the human being sitting across the room.

Supervision continues to support my personal self-care plan and professional wellness by holding me accountable and encouraging me to encapsulate the work that I strive to promote. My supervisor and I have developed a strong bond and therapeutic relationship from this practicum experience, and I am grateful that I was provided with a compatible match for a supervisor. As mentioned, our relationship was the pillar to how successful the supervision experience was, and moving forward, I will continue to journal and hold myself accountable to my own wellness simply because I had this experience.

Conclusion

Throughout this experience, it was evident that my self-awareness was enriched and that my practicum goals and needs were met both in supervision, and in the work that I got to do with people at The Alliance Centre. This practicum experience far exceeded my expectations and provided me with the experimental learning that I was hopeful for. I think that I was able to achieve my practicum goals due to the flexibility that The Alliance Centre offered in terms of their shared person-centered philosophy, as well as the on-going support from my supervisor who shared the same theoretical underpinning in her own work with people. By being able to embrace a strengths-based perspective throughout my 450-hour practicum while working in

mental health treatment, and in supervision, I was able to look beyond disease and diagnosis and focus on factors that supported human mental health and well-being in a strengths-based way that was enriching to not only myself personally/professionally, but as well as to the people that I worked with in the program.

This experience has forever changed my outlook on mental health treatment because I got to witness the positive effects that the strengths-based perspective offered people. Too often, we define people as dysfunctional, abnormal, or ascribe them labels/diagnosis and then act surprised when they start exhibiting aggressive reactions to their self-fulfilling prophecies. My mindset is forever changed, and this experience improved my own mental health and well-being simply by submersing myself completely into this theoretical framework that has now become my professional mindset. Strengths-based work is not simply a theoretical approach in mental health treatment, it's a way of thinking, and being, and from this experience, I am stronger.

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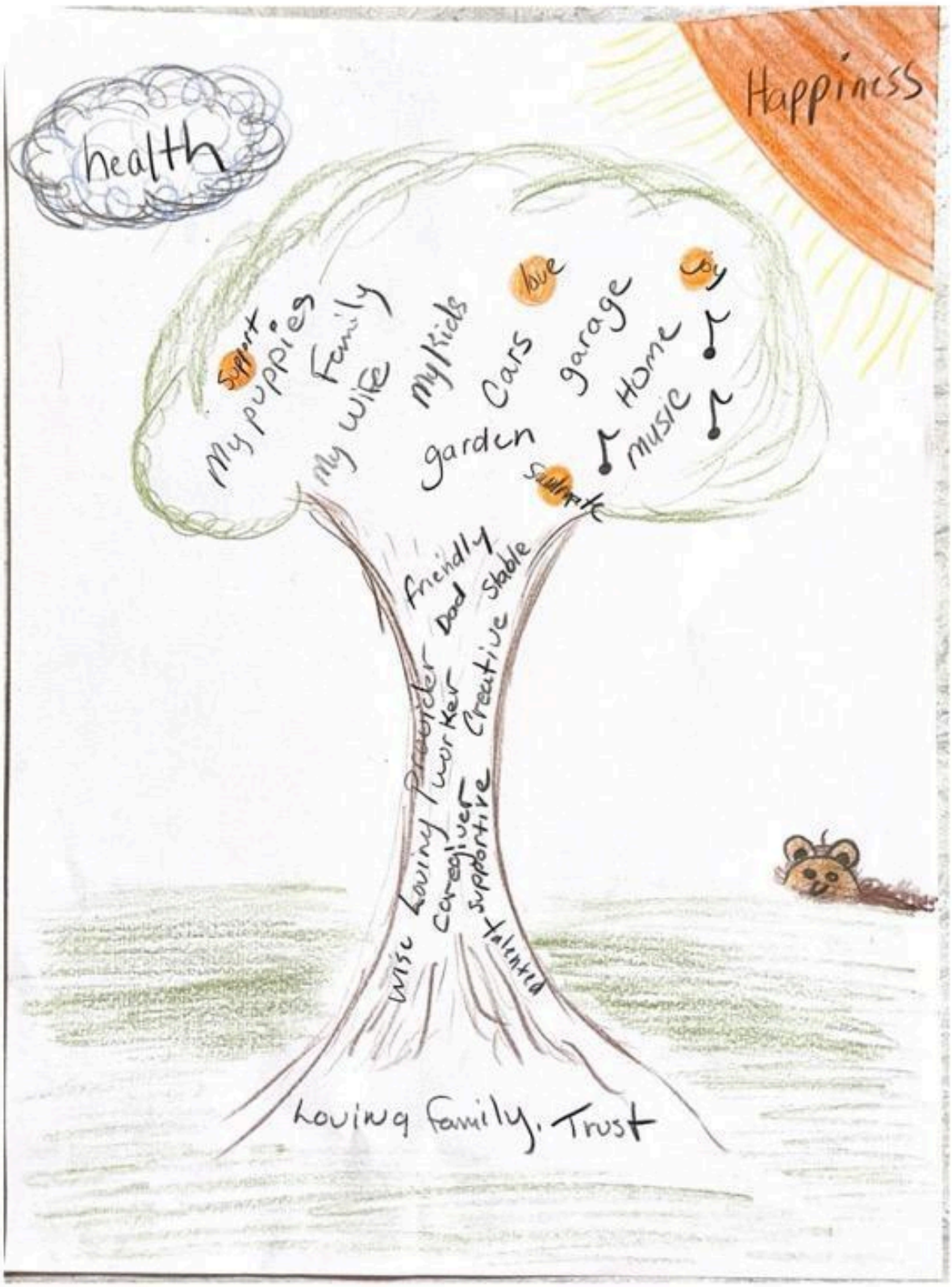
Appendices

Appendix A: The Tree of Life Activity, "George the Tree."

Appendix B: The Tree of Life Activity, “Life and Death.”

Appendix C: The Tree of Life Activity, “Groundhog Day.”


health
Happiness
My puppies
Family
my wife
My Kids
Cars
garage
Home
music
Garden
Friendly
Dad
Stable
Creative
Loving
Caregiver
supportive
Talented
Loving family. Trust