

# REVIVING THE HEART OF THE PRACTITIONER THROUGH RESEARCH IN A MENTAL HEALTH AGENCY

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*In this narrative the author rediscovers something she thought she'd lost – her identity as a practitioner – and finds it again as a researcher doing interviews with mental health practitioners about their clinical work lives with persons with severe mental illness. The nature of the research is the use of in-depth interviews with practitioners using evidence-based practice (EBP) in a real-world setting where EBP had not been used before and understanding key aspects of this change process. Some of the early findings are described in the article. The author's self-transformation is likened to the Buddhist notion of 'beginner's mind': that is, finding something from one's past and seeing it as new again.*

“Very few people really see things unless they've had someone in early life who made them look at things. And name them too. But the looking is primary, the focus.”

- Denise Levertov

“Our truest life is when we are in our dreams awake.”

- Henry David Thoreau

If we are truly alert and have our eyes open to the coincidences of our lives, sometimes we are given opportunities in our research careers to connect with dormant aspects of ourselves that may emerge in the 'doing' of the research and that give us the personal connections that we were yearning for. It may be that those dormant areas of our work lives serve us best in the research arena because they can fuel the research 'intuition' that helps us to see things in a setting, ask questions about what we see, and observe that which may go unnoticed by someone without a personal connection. It doesn't mean that one always has to have a prior connection to the setting and subjects in each research project, but there is something unique that occurs when it all comes together.

My story speaks to the intuitions, the unanticipated rewards, and the personal growth that I have experienced as a result of my involvement in an ongoing research project with practitioners in a community mental health center in western Michigan.

## **Reviving the Heart of a Practitioner Through Research**

Prior to and during the pursuit of my doctorate in social work, I had developed a deep confidence in my skills as a practitioner. I had worked with young adults with severe mental illness, most often schizophrenia, and their family members for over 17 years. My clinical work was nested in an NIMH-funded longitudinal project, and although I was responsible for collecting biweekly data, I was much more active in my role as case manager-clinician. My clinical abilities were honed on the real-world experiences of these young adults and their families as they went through the painful discovery that severe mental illness was now part of their lives. Empathic listening and exploring issues of grief and loss with the individual and his or her family provided me with an early exposure to the practices of mindfulness-based therapy, in which I am very

interested now. As a skilled clinician, I wore many social work hats and became a family ally, therapist, educator, mediator, and guide through the various stages of adjusting to schizophrenia. When I worked as an inpatient clinician on hospital psychiatric units, I often came face to face with the consequences of severe symptoms of psychiatric pain that stretched my clinical capacity as I provided counseling to individuals during those moments when they awakened to find that their suicidal plans had not ended their lives.

My overall treatment philosophy is that recovery is possible, that struggle will be part of recovery, that hope needs to be nurtured, and that empirically-based treatments of psychosocial rehabilitation make all this possible. The great gift of a longitudinal project was that I was able to be closely connected to the life trajectories of these young adults for almost two decades, and so there were many chances to see what belief in oneself coupled with a supportive environment could bring. I attended graduations and funerals for family members, visited at hospitals when relapses occurred, listened to coffee shop music recitals, went to gallery exhibitions for some of the artists in our clinic, and attended our yearly summer picnic, which was a highlight for staff and consumer alike.

My doctoral research on, "The Meaning of Work for Young Adults with Schizophrenia" demonstrated to me that the role of a clinician-researcher could be seamless – both roles were valuable in the pursuit of understanding the research question. In 2001, after the completion of my Ph.D., I took an academic position at the University of Michigan, School of Social Work. For the first two years I was extremely busy adjusting to the nuances of teaching classes of 30 or more students, writing articles, submitting grants, and understanding the politics of the academic setting. From time to time I would sense that something was missing

in my academic life, but I would linger on this notion for only a moment before I plunged into the next task. At some point, I recognized that I had not given myself time to grieve my life as a clinician. Yes, I was utilizing my clinical knowledge and practice experience in the classroom, but I no longer had the active clinical conundrums in my life that my students brought up for discussion. Most of all, I missed the dyadic work of therapy, the excitement of groups, and the growth of my clinical self.

In late spring 2004, I was contacted by my program officer at NIMH to see if I might be interested in following up on some research ideas raised by a mental health center director in Grand Rapids, MI. My program officer told me that this director had been developing some solid ideas about evidence-based practice with severe and persistent mental illness, which had merit and which might lead to a proposal submission; she wanted someone to take a closer look. Although my reply was "yes", I soon found out that Grand Rapids was a four-hour roundtrip drive from Ann Arbor; however, the long drive became my platform for reflection about many of the issues which emerge in this story.

### **The Setting**

My first visit to the mental health agency in Grand Rapids took place in July 2004. I was invited to attend an administrative staff meeting to learn a bit about the current program and the changes that were being proposed for fall. After driving for two hours, I was welcomed by the director and led into a conference room where 15 or so people had gathered. As I settled in and stopped driving in my head, I began to hear the passion of the individuals as they told me the story of the agency. Although I won't dwell on it for this narrative, it is worth mentioning that the persons assembled in this room were the survivors of a three-agency merger that occurred in 2000. Merging any type of

business is rough and these mental health agencies were no exception as they each had their unique emphasis within treatment modalities, their own manner of delivering that treatment, and their own art of individual personalities that needed to be brought together to accomplish tasks. I mention the merger because when I later interviewed practitioners, it was clear that the merger affected each and every person, whether they were present for it or not. There was an agency legacy and folklore that each employee had made personal meaning of.

The members of this administrative team had looked at mental health service delivery in this agency and began to despair at what they felt was inherently inadequate in the case-management model. Rather than having persons manage their own disorder and treatment, it created sustained dependency on the agency to “do for” persons with mental disorders. Of course, this is a basic philosophy and tenet of psychiatric rehabilitation, yet in actual practice, it is far from reality. The team was shifting from a case-management model to a disease-management model that was predicated on a basic rehabilitation premise that you provide persons with resources, medication, and psychosocial interventions to help them find “alternative ways of doing the things they need to do to live on their own” (Blakely & Dziadosz, 2003). They firmly believed that this change would require new beliefs, new skills, and new actions from all the stakeholders involved with each client. There was also new language. The client was the ‘customer’ and the ‘product’ was the ‘desired state of well-being’ for those requesting services. The appeal of these terms was not automatic, and there was some internal struggle for the administrative team in adopting this new language.

### **The Making of an Experimental Team**

The proposed changes involved having one team at the agency become the

experimental team to lead the change. The ‘experiment’ would consist of extensive practitioner training to deliver state-of-the-art, evidence-based treatments in four areas: Dialectical-Behavior Therapy (DBT), Cognitive-Behavior Therapy (CBT), Multi-Family Therapy (MFT), and Co-occurring Disorders Treatment. The experimental team would see their case loads drop from the 40s and above to the 20s during this intensive training and implementation period.

As I absorbed the agency history and proposed changes, it occurred to me that this group sitting here had a story not only to tell but to ‘own’ before they tried to enact the changes. I consider myself a mixed-method researcher, and I have particularly enjoyed using in-depth interviews, ethnographic methods, and focus groups in my prior research. I figured that if they could respond to a good open-ended question, then I was on the right track. The first question I asked was, “How difficult was it for all of you to think about a whole new way of ‘doing business’ at this mental health center?” There was an audible sigh from many, and someone answered that, frankly, it was very difficult for them and that it had taken many meetings for people to accept the notion of change. The director said that it was worse than that. He remembered administrative staff leaving the meetings angrily when these changes were initially posed. It was at this point – maybe 30 minutes into the meeting – that I knew a chord had been struck with the administrators, and I began to formulate how I might help them understand the change process they were undergoing.

I explained to them that from my vantage point, a very interesting issue to explore would be practitioner beliefs about the evidence-based practices that they were on the threshold of learning. I wondered with them how it might be for those clinicians who had been at the mental health agency for many years. I was very interested in the workplace

culture of this mental health center which might promote or impede the implementation of this change. I proposed an exploratory study that would consist of interviewing the clinicians about their feelings concerning their part of the change process. At that moment I didn't have a full vision of the interview, but I told them I would consult with a senior colleague and get back to them. They were willing to wait for the development of the idea. They were intrigued to have someone follow and document the process because, in retrospect, it was clear that even though they had committed to the change at that point, they were not clear how their vision would be transmitted to the practitioners.

### **Learning About Workplace Culture and Practitioner Beliefs Through the 5Cs Theory**

After meeting with my consultant, the interview began to take shape. Dr. John Tropman (1998) had developed an exploration of the workplace that consisted of understanding five interlinked areas of the company or agency – the *Five Cs Theory of Idea-Leadership and Idea-Management: Characteristics, Competencies, Conditions, Context, and Change*.

#### **The Five Cs Theory (Tropman, 1998)**

1. Characteristics – Individual background, training, temperaments
2. Competencies – Skills – learned pre-job and on-the-job
3. Conditions – Elements favorable to introduction of something new
4. Context – large scale community, macroenvironmental forces
5. Change – What the agency is asking practitioners to do.

I developed an interview guide based on these principles. I interviewed 18 practitioners from September through December 2004 and it worked very well. Most interviews were

about an hour long and yielded rich information. It is worth mentioning that with all the participants it was necessary to establish credibility, not about my research skills but about my former experience as a case-manager. This introduction was purposeful and helped to let them know that I valued what they told me and that I understood the pressures they were facing. It also helped when practitioners were a bit suspicious about how they would be represented and if in fact they could speak truthfully and critically about aspects of the agency with which they disagreed. In the case of the practitioners, I could promise them their anonymity because there were many of them. For the persons that would be identifiable, I let them know that their anonymity might be more difficult to conceal.

In the interview, the first two Cs, Characteristics and Competencies, focus on individuals and their strengths as well as what they bring to the workplace. As a way to get to know people and explore new information, these questions provided an easy entrée. The Conditions section was a time to talk about how it was for them to work at the agency, what kept them there, what supervision they received, and how cohesively they functioned as a team. It was in this section that I focused on the changes that were occurring and how working conditions might change. This was the section where many worries and fears emerged about what would be expected of them. Context represented the view they had of the agency in the larger community. A favorite question here asked, "If change happens here, who notices?" Most people responded by saying, "That's a really good question!" The final question on Change asked them to respond to a global question about what each of them had to do to ensure that the changes would happen. There was also an item that I developed about how much they endorsed the change that was occurring on a scale of 1 to 10.

There were persons I interviewed for whom these guiding questions were not appropriate. In addition to the practitioners on the experimental team, I interviewed all the high-level administrators, an operations supervisor, two consumer advocates, and two practitioners on other teams in the agency. The administrator interviews provided my background material and understanding about the larger agency context, including the merger with which they all had an intimate connection. For the other individuals, I was able to pick and choose among the 5Cs questions and tailor them according to the person's position. The practitioners from the other teams gave me a perspective that I wouldn't have had about the experimental team within the mental health agency.

### **Measuring Practitioner Attitudes and Beliefs About Evidence-Based Practice (EBP)**

There was one standardized measure that was given to all of the practitioners at the end of their interviews to be mailed back to me anonymously. This proved to be a good strategy, and I had 100% participation. The measure I used was developed by Aarons (2004) to understand the attitudes of practitioners in the use of evidence-based practices (EBP) in their professional lives. The 15-item scale consists of four domains regarding the use of manualized treatments. The items in each domain asked if the practitioners would use EBP: 1) if it was required; 2) if it had appeal; 3) if in general they are a person who is open to new things; and 4) if they see these treatments as useful. The items were rated on a 4-point Likert scale about the likeliness to use EBP (1=to a slight extent; 4= to a very great extent). For the experimental group who had already had some training and exposure to EBP, the total score for the group averaged 3.1, indicating a great likelihood to use EBP in their practice. This result was not surprising due to their

recent exposure to EBP, but it prompted the notion that I needed to collect data from the other teams prior to their training in EBP in the future. This measure will be used longitudinally along with the ongoing interviews of the practitioners to see if there are any changes, including some disillusionment with EBP.

I also spent a fair amount of time asking individuals about their personal view on recovery when one has a severe mental illness. I asked this question because I thought that there might be a correlation between belief in the ability to recover and belief in the use of EBP. Almost everyone was as positive about recovery as they were about EBP. Here is one practitioner's quote:

...for me, recovery means getting to that point where, everything that fills up your life from here to the end, is what you want it to be, or mostly – the grand scheme is kind of what you wanted it to be, and you're satisfied with that, and we all struggle with that, whether you're mentally ill or not.

### **The 5Cs: Practitioner Characteristics**

My promise to the agency was to make data distribution an ongoing and participatory process. In February 2005, after all the interviews were transcribed and analyzed for themes around the 5Cs content areas, I presented my emerging findings to the practitioners, supervisors, and some of the administrators from whom I had collected these data.

The demographic characteristics of the group are as follows: 1) there were 4 males out of the 18 total team members; 2) the mean age was 31.6 years; 3) marital status was evenly divided between married and single; and 4) the educational level showed that 7 persons had Master's degrees, 8 had bachelor's degrees, and 3 had taken bachelor-level courses toward an eventual

degree. I was particularly interested in the demographics because there was an initial concern that those practitioners who had been at the agency a very long time and did not have a Master's degree might be less inclined to utilize EBP. This did not prove to be the case when the initial EBP measure was completed, and it will be monitored in future interviews.

### **Practitioner Competencies**

For the competencies category, I asked people what their best skill was. Most were quite fluent and confident about what they felt they did well. Often they told clinical stories to back up their identification with a particular competency. When people were shy about talking about themselves in a self-promoting way, I asked what other people might think they were good at. The most common answers were establishing rapport, developing a therapeutic relationship, listening, handling crises, organization and follow-through, empathy, and mentoring – all good human service and social work values, and all very important reasons why we do the work we do.

### **Agency Conditions**

The next category about workplace conditions was a bit trickier because this was the first time that individuals might have to tell me things they did not like about their work environment. Although the danger is that I would get a watered down version of complaints from some, others used the question as a sounding board since they knew that their anonymous comments might get shared aloud in the feedback session. Some of the more consistent complaints had to do with paperwork demands and worry about the unknown as the EBP practices became standard. They were concerned about the training, taping of interviews, and whether supervisor feedback would be shared publicly or privately.

One practitioner voiced her concern:

I'm very nervous about what all this is going to mean for the next 18 months or however long this goes... and a whole lot hasn't been explained to us as far as what's required. It's more of a fear of the unknown. I think most of us, at least I'm so overwhelmed by all the work that needs to be done before it starts that I don't think about (the EBP training) so much.

### **Agency Context**

Findings from practitioners yielded some interesting ideas about how to strengthen the agency's community profile. Quite often mental health agencies are happy to fly below the community radar and were pleased with relatively limited press – either good or bad. However, if there was a new change about to be launched, it might make the practitioners feel more committed to the change if they believed that someone from the community would notice. Almost all the practitioners felt that there needed to be some type of community education to change the view that other agencies have about services offered at the agency. Here is one practitioner's comment:

I think there's going to have to be some community education. There are a lot of stereotypes and labels and stigma that are pretty strong at times, and I think that will be connected with individual's progressing toward mental stability and wellness. You have to look at collateral resources and maybe hold seminars at the hospitals.

All the practitioners stated that they would want to be part of this education effort. Their ideas in the feedback session had a contagious

effect as they began strategizing about how this could be done and the positive impact it would have on their working relationships with other agencies.

### **Change**

When I developed the change questions, I knew that I hoped to elicit answers about their personal involvement in the change process. I wanted them to rate their own engagement and energy for the change. Part of my thinking had to do with the agency history of trying many new things and sometimes abandoning efforts that didn't show promise. I wanted to understand why this agency was willing to invest in change now.

While most were optimistic and committed to always trying new things that would benefit the client, some were fearful. One practitioner who had been with the agency for a long time shared her fears:

I need to keep on board with the changes, and it's hard for me, to push all that other old stuff away of what we used to do, and just keep reminding myself why we're doing this, and just keep on board with it, I think. Because I'm comfortable with my old skills and my old stuff, and it's really easy to fall back, sometimes my motivation isn't like [great], because it's hard, it's new.

Some clinicians felt that they might be blamed if the experimental team was not successful. One expressed this sentiment:

It gets frustrating sometimes, because I feel like, sometimes when changes happen, I don't feel like we're listened [to] as well as we could be. We're the hands-on, direct people, and I feel at times we could be more involved. I don't mind change, it's sometimes the approach

that we've taken to do it, and then it fails, and they're like, well, why? And somehow, sometimes, it's been well, you didn't try to make it work, and it's like, we tried to make it work, we tried to bring up these things that we already could see, because we're the ones doing it every day.

### **Evidence of a Heart Revived**

These interviews are the first step in a series of interviews that are proposed to follow practitioners on the experimental team as they begin this new endeavor to implement EBP in a traditional mental health agency. There will be opportunities not only to watch the team develop, but also to watch them train other teams and to see how those new teams take on the delivery of evidence-based practices.

The excitement around this study for me is threefold. First, we desperately need research on practitioner attitudes and beliefs about the use of evidence-based practices. I recently attended an international roundtable at the Society for Social Work and Research Annual Meeting (2005) on the issue of dissemination of empirical research to practitioners that would be useful and applied in their daily work with clients. Many social work researchers have struggled with how to make the translation and use of EBP a reality in the helping professions (Gambrill, 2003; Gibbs, 2003; Howard, McMillen, & Pollio, 2003). The concern is that clinicians lose touch with EBP once they leave school and rely on treatments that have not showed efficacy. This project so far has demonstrated that with the right supports there is sustained enthusiasm for EBP in the agency setting.

Second, as a researcher, I am aware that I have been given a particular opportunity to witness the operationalization of EBP in a community mental health setting. This witnessing is far from common because most mental health agencies are not utilizing the breadth of EBP employed by these clinicians.

Thus, hitting the ground running is an apt description of my involvement in this agency-based research. The agency change process is going to happen whether or not I am a witness to it. The ideas were generated long before I got there and will continue after I leave. I am very aware that down the road personnel might change, the intensity around the training and supervision may wane, clients and families may push to have case-managers treat them in the old style of mental health service delivery, and the entire project may fold. I hope none of these scenarios prevail and that the agency will allow me to continue to follow these practitioners as they take on these new ways of working with clients. The final published story about the project will be about the agency's change process, not mine. But for me, there is no doubt that strengthening my bond between my clinical and research selves has been a vital and necessary integration.

Third, my heart revived. During the interviews I began to feel very close to my clinical roots and training. Why? Well, the practitioners could have been me at an earlier stage in my career – a stage that embodied youth, idealism, and struggle with one of the most difficult populations with which to work. Instead of thinking and feeling that I had grown past this stage with education and experience, I felt that they were inviting me – in their explanations about their practice – to think with them as a new practitioner would think and, in this way, reviving my heart. In Buddhism, there is the notion of establishing a beginner's mind every time you practice meditation (Suzuki, 1973, 2005). You consistently strive to let go of what you have learned along the way which might weigh you down, and return to the pure notions you had when you first began to meditate. Invariably, this leads to a greater understanding of one's heart, when one empties one's head.

In this research project, I began to empty my head and wake up my heart by hearing

the stories practitioners told about their work with persons with severe mental illness. They used the same guiding philosophy and many of the treatment strategies and methods that I used when first beginning to practice. The old felt new again! In asking questions and eliciting thoughtful responses from these practitioners, I discovered a thread of continuity that represented my strong path from practitioner to researcher. I was not outside of the research, as I sometimes feared; I was part of it. This was a wonderful revelation.

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