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Cries of the world and joys of the heart: A primer for new counselors in community mental health clinics

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A Primer for New Counselors in Community Mental Health Clinics

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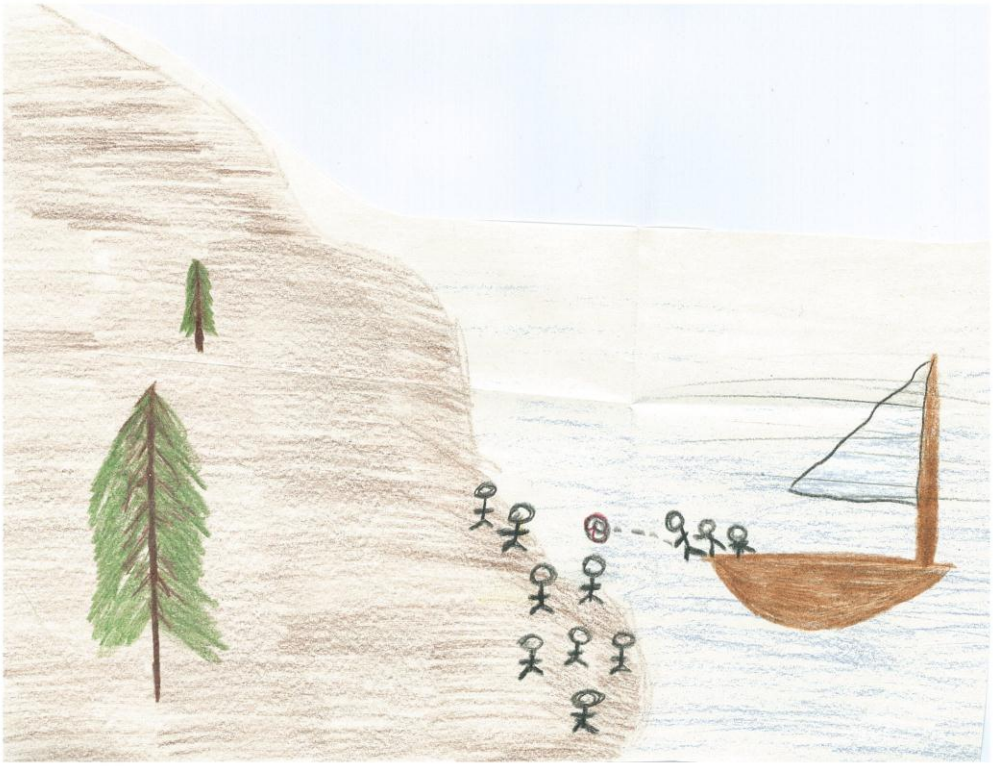
Table of Contents

Abstract

I am neck-deep in the middle of my internship experience, working as a counselor in a community mental health clinic[i] (CMHC). My internship instructor, when asked by a former professor, "What do you wish you had learned that you didn't in this program?", answered, "I wish I had known how hard it was going to be." At first, I scoffed at my instructor's response. I knew how hard this was going to be. Now, however, I find myself uttering these same words to those close to me. I have told friends that I feel like I was trained to be a small-scale community farmer and now work for Monsanto. Had I known what I know now, I am not sure I would have continued in graduate school. That is how neck-deep I feel. I am guessing that in this sentiment I am not unique. Even in the best of internship experiences, we have left the comfort and support of our cohort and are frequently out of touch with our most trusted mentors. Add this to the pressures of work in a clinic beholden to increasingly myopic regulation and designed to require you fit the round peg of your training into the square hole of its practice, and you have a recipe for despair. I would have loved to read the personal journal of someone else in a similar situation before embarking on this journey myself. In this text I provide an intimate portrait of my cries and joys as I work professionally as a counselor for the first time. I do this both for myself, as a much needed coping strategy, and in the hope that something I write better prepares *you*, the reader, perhaps another new counselor beginning their work in a CMHC.



A Pictorial Epigraph

The above drawing was done in session with a client, while she was drawing a picture of her "family doing something together," an intervention I got from Violet Oaklander and my clinical supervisor[ii] (I drew along with her so I would feel less awkward). It is a metaphor that has felt accurate throughout my first experiences working as a counselor, but speaks to my time in public service institutions in general as well. For me, the stick figures on the beach are the children, adolescents and families that I currently work with. The sailboat drifting off to sea is the institution where I work, and the stick figures on board are, of course, us – the hopeful healers. The institutions where we work give us a platform from which to practice but can also take us further from those we intend to serve with policies, paperwork and the need to be profitable. It

seems the best we can do sometimes is to toss a flotation device to help clients survive the incoming tide. Our capacity to hold onto one another in the sailboat impacts how far we can reach out to those on shore. We are all trying our best not to be swept out to sea. The sailboat may not be any safer than the shore.

Prologue

Vocation is where the cries of the world meet the joys of the heart.

- Told to me by a priest in Nicaragua

Me: How do you survive, doing the work you do, in this system?

Him: Saying the system is stupid is like saying rain is wet. Try not to take it personally.

- Dr. Gabor Maté, M.D., in response to my question after a talk he gave in Charlottesville, VA.

If there is a stage at which an individual life becomes truly adult, it must be when one grasps the irony in its unfolding and accepts responsibility for a life lived in the midst of such paradox. One must live in the middle of contradiction because if all contradiction were eliminated at once life would collapse. There are simply no answers to some of the great pressing questions. You continue to live them out, making your life a worthy expression of a leaning into the light.

- Barry Lopez, from his book Arctic Dreams

The first two quotes above have bookended my experience as a counseling graduate student. The first one I included in my personal essay in application to the program. It speaks to why I felt called to counseling, and I am starting to see the cries in my heart meet the joys of the world for the first time, if only in little glimpses. The second I heard as I was looking for an internship, trying my best to stay inspired. Together they capture

a struggle not unique, but especially profound, in setting out down the vocational path of counseling. On one hand, we come to the craft with a passion, certain that this is something we *must* do. On the other hand, this passion is made necessary by the very fact that it is against all odds we will succeed at being helpful. The final quote speaks to why "it is against all odds." Lopez wrote the reflection on his time spent in the Arctic. He compared the landscape metaphorically and literally to the desert, a place where we are required "to live facing despair, but not to consent."[iii] I am quickly learning that work as a counselor can be quite despairing. We are asked to sit down with trauma every day. At some point we have to head home and figure out what to do with everything we have taken in, if we still allow ourselves to take it in at all. We doubt our motives for doing the work. "Is this really just some messed-up acting out of my own wounds and need to heal?" We do not know where to go in our work with clients much of the time, which way is north. But still there is light to be found. Out of nowhere it breaks through.

"I didn't have anyone else, I needed Spider Man. He helped me protect my brother and sister. I had to make their breakfast every morning, and I had to stand in front of them to block the BB's when my mom's boyfriend would shoot us. I'm making my own Spider Man costume now, and when it's ready I'm gonna go out at night to make sure this doesn't happen to anyone else ever again." David looked up at me after he finished telling his story (we were pretending to be doing a radio show and he was asked to tell me any story he wanted as I held up a pretend microphone). This thirteen year-old boy had tears streaming down his face. He had never been so open with someone about why he is obsessed with Spider Man. I feel the weight of his pain as it passes from his hands to mine. It is my turn to tell him his story back to him (according to the directions I am

following from Violet Oaklander), with a slightly different ending. I pause and look down at my hands. I have no idea what to say or how to honor what has just happened.[iv]

My limitations

In high school my creative writing teacher gave us the assignment of making a movie for his class, from screenplay to video editing. We complained that our video recorders were old and that we had no good editing technology. What he said has stuck with me to this day. He looked right at us and said with a dry tone, as was his way, "Use your limitations to transcend your limitations." I relate this story to acknowledge up front that my experience is shaped by all of my idiosyncratic thoughts, feelings, memories and desires. It is in no way intended to be exhaustive. That said, I have spoken to a number of other new counselors who have worked in CMHC's and where appropriate I include their comments as well. In addition, I have worked as a volunteer, intern or employee in half a dozen CMHC's and spoken informally with many others who have done so. While working as a school-based social worker I also frequently collaborated with CMHC's. However, my primary response to the limitation of my singular experience is to dive deep rather than to spread out wide. It is my belief that through this authentic exploration of my own journey I can relate something applicable to others on theirs.

Points of interest on the journey

This exploration falls into four distinct sections. The first reviews background information – my motivations for choosing to work in a CMHC and the details of the hiring process. As I was starting to think through the decision to work where I do, I would have benefited from something like a step-by-step on how to go about the process,

as well as some catalyst for reflection on why I was making this particular choice. This section also lays the general framework for CMHC's and the agency where I work in particular; all of this in the service of a transparency I hope helps with an evaluation of how applicable what I write is to your situation.

The second section contains a series of clinical reflections, which highlight some of my most prevalent challenges and rewards as a new counselor. Of particular interest are the moments where I feel like I have clearly pulled on lessons from my graduate preparations and those where I very much feel like I was in new territory (these seem to be the majority, especially as I work primarily with children, adolescents and families, which was not the focus of my graduate training). It is also my desire that this section serve as a place where I can reflect on mistakes I believe that I have made and discuss those moments we all wait for in counseling, those charged with potential. I do my best to share what I think I have learned in these reflections, and center this on work with children and families. As aforementioned this was not the focus of my training, but it is a common requirement for work in a CMHC.

I finished my graduate training with a strong sense for the basic therapeutic tasks of the counselor. I learned a lot about myself. I'll never forget the first class I took in the program, as a non-degree seeking student, a number of years ago now. After a couple of classes my professor took me aside and said very softly, "You seem pissed." This was only the beginning of my being confronted on a daily basis with how others perceive me. I learned how I come off as "professorial" (in a stern, lecturing way) frequently. But I also learned how I make people feel safe and at ease, while demanding that we be "real" with one another. I learned a lot about how to be a fellow traveler on the journey toward

greater self-discovery and authenticity. I have a whole list of therapeutic interventions memorized for different counseling situations, and can explain the theory justifying each. I walked away with some structure within which to hold my counseling identity. Now that structure has been shaken to the ground by the earthquake that has been working in a CMHC. The third section is the place where I reflect on my cries and joys as I struggle to rebuild. At a summer internship with a hospital's behavioral health program one of the counselors told me that it took her five years before she felt like she had any idea of what it meant for her to be a counselor. I offer these cries and joys with the hope that there is something universal within them. Here I take a closer look at the dilemmas of the clinical assessment and diagnostic process I am required to carry out. Secondly, I discuss finding your role as a counselor in an agency that relies heavily on pharmacological intervention. Navigating supervision for the first time will also receive attention. Finally, I share what it is that keeps me coming back day-in and day-out. Included in this section, I humbly offer a few recommendations, i.e., things I wish I had done before taking the job. Throughout, I also include thoughts and comments shared to me, at the water-cooler you could say, from other new counselors in CMHC's.

The last section of this text lists resources I have relied upon, in lieu of the kind of personal support I was used to receiving as a graduate student.

I look up at David and start speaking slowly. I describe a boy who needed a superhero to survive horrible abuse. I talk about his growing up, the boy getting stronger and the superhero shrinking, as the boy finds people he can trust. It finally ends with the boy leaving the superhero behind, saying, "Thank You." David looks up at me and says, "I think I need to give myself a childhood." Again, I do not know what has

happened, or the true value of what we have done, but I know it is sacred. I scribble notes after the session so that I can bring this up in supervision.

How I got here

I am sitting at a Mexican restaurant in Appalachian Ohio. My first lunch break. I feel wonderful – a real counseling job. My coworkers all seem down-to-earth and my supervisor supportive of the kind of work I want to be doing.

I worry about what this job will do to me. I have it within my grasp to really challenge myself and develop my craft as a counselor but it will require a degree of self-discipline and self-guidance heretofore unknown. This job is filled with the same inanities I was running from, with more opportunity to do real therapy to make up for it, I hope. But I may become over-saturated. I may despair. I may doubt myself to the point of distraction and sloth.

- Excerpts from my journal, the week I started my current position.

Before pursuing work in a CMHC, it is helpful to think through what has brought you to desire this position in the first place. Myself, I come from a family of public service employees. I grew up hearing stories of work in a public school or a state unemployment office. My mother would vote for candidates who had good personalities and who promised support for public education. I did not know exactly what my father did at work but I was proud of the fact that in some capacity he helped people find jobs. He even helped me find one a couple of times. I grew up with a sense of duty to build strong community and loyalty to the ideal of public service. I also grew up in a household with significant abuse and a parent with

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addiction. I grew up with a strong desire to heal the world, in no way disconnected from a strong desire to heal my family, and myself.

I am also highly motivated by my Christian faith. I was raised Christian and my faith has been a constant, if not always comforting or easy, presence in my life. Recently, this presence has become larger, you could say. Working in a CMHC, with clients impoverished, not afforded the easy capacity to hide their hurting, and marginalized, I find my place as a counselor most appropriate. I am careful not to pity or glorify suffering, but I wanted to become a counselor to be present with those who suffer because I believe it can redeem (both the witnessing and the suffering), and to bring dignity where dignity is not afforded as the right it should be (like in public health and human service institutions). However, this motivation is something I bring up at my job with much valid caution and anxiety. For one thing, my faith still carries a great stigma, amongst both my colleagues and clients, because of the understandable association of Christianity with judgment and threats, two tendencies not seen as favorable for counselors to possess. I mention this because it will be important to consider what parts of your motivation for this work feel like they must be kept hidden. We must have someone we share absolutely everything about our counseling journey with - our motivations, fears, and deepest longings[v]. It is in considering this question that finding the right person to do so with becomes an easier process.

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In working in public service institutions I have heard the phrase, "wounded healers," many times. Working in a CMHC, it is apparent quite rapidly that many of us are embedded in our own struggle through grief and healing as we endeavor to be with

others in their own. The tracker and writer, Jon Young, once said in a talk to nature-based mentors, that our wounds and gifts are inextricably wound together; when one comes to the surface so does the other. I chose work in a CMHC in part because of a conversation between my wounds and gifts as they began to rise. I clearly cannot speak for others, but I invite you to pay attention to the content of your own internal conversation as you pursue this work. I know that when I am not doing so I am most capable of hurting those I intend to help. While this step is continually necessary, it is an essential first one.

There were other practical considerations that led me to apply for work in a CMHC. I wanted to work with clients with a variety of presenting concerns, and with some degree of autonomy right away. I knew that in this setting this would be a possibility given their seemingly never-ending stream of referrals and overworked staff. That is, in a CMHC, many clients walk through the door with motivation outside their own. For example, many of my current clients have been recommended or directly mandated to attend counseling by the courts or a public children services agency. In addition, while there are many options for counseling for those who either have decent insurance or can pay out of pocket, in a given county there is usually only one provider for those who have no insurance or who have Medicaid[vi].

I was also led to work in a CMHC because I needed an internship that paid (and let us be honest here, this was a BIG part of my motivation) and CMHC's will often offer a full-time, permanent, paid position to interns and cover supervision as well. The catch here is, of course, that many of these positions are not counseling per se. While I was looking for an internship I applied for over two-dozen and interviewed for at least half a

dozen. In Virginia, none of these would have been counseling positions. I generally applied for anything that required a master's degree or less, and did not mention in my application or cover letter[vii] that I was seeking an internship. The positions in Virginia would essentially have been case management positions – coordinating the services and support needed for someone to live successfully in a community rather than residential setting. Though placement in a residential setting is often not a real possibility, case management is often recommended in a client's service plan in a CMHC because Medicaid covers case management (or community psychiatric support services, the terminology varies depending on the state). In some of the community services boards where I applied, the possibility to do counseling would have been included in the deal as well. It was always really a matter of trying as hard as possible to get an interview and then feeling out the situation in person. I found community services boards to be incredibly diverse depending on department and personnel. For one position, where I was actually offered the job, I was to work as a case manager in a long-term residential setting for dually diagnosed male clients with SPMI (Medicaid language for: Severe and Persistent Mental Illness – someone with a long-standing diagnosis and history of treatment, along with residential stays in most, if not all, cases). I remember deciding before the interview that I was going to truly be myself and not edit what I said to come off as professionally as possible (a difficult thing to do with a job on the line). As it was a position involving substance abuse treatment, I spoke about my own history of substance abuse, the addiction in my family, and when asked about self-care I even mentioned my faith. I could tell the interview was going well because we started talking about all kinds of topics unrelated to the position. I left knowing that I had gotten the job.

Ultimately, it was a matter of location, because I would have taken this job to work with these two therapists, when "on paper" there was not much appealing. My clinical supervisor was present at the interview and I was able to get a sense from him that he took supervision seriously and with deliberation (two things that are rare to find in a CMHC).

Looking outside of Virginia can be beneficial, however, because it may be the case that more positions are open to students. For example, in Ohio, where I work, there is a provisional licensure available to students, called the Counselor Trainee (CT) status. In this way, CMHC's can bill for counseling provided by students, thereby allowing them to be employed as counselors. This has allowed me a unique opportunity, in that I work in small outpatient clinic as an equal with fully licensed LPC's. As I will discuss below, however, I am not always so sure that I am ready for this. I remember how pursued I felt for this position. At first, I thought, it must be a reflection of my resume, counseling skills (though of course there was no testing of these), or interview prowess. I am discovering now that it was because I work in a rural and severely economically depressed setting; it is hard to get counselors to work in Appalachia. Those of us here are either pretty new at the game, or unfortunately, not too inspiring as mentors. This is the most difficult professional position I have ever had and pays less as well. I made more money working construction.

However, I am paid to do my internship, which is rare. In addition to this, if I work at this agency for two years after receiving my licensure I will be eligible for up to $60,000 in student loan forgiveness through the National Health Services Corps. Many counselors at my agency have taken advantage of this benefit. I encourage you to look at

the NHSC website to find qualifying agencies in your region. Qualification is based on socioeconomic factors of the region served and the availability of services. Virginia has few qualifying agencies, but nationwide there are many.

Where I work

As stated above, I work in a non-profit agency in Southeast (Appalachian) Ohio, which provides services in various counties. The county where I work is very rural, white and poor. It was big coal and brick-manufacturing country in times past (the two largest mining unions started here, and the largest coal mine in the country was here) but has been pretty economically depressed since. Some of the areas where the clients I work with live are old company towns with an eerie air of loss, claustrophobic and careworn. Appalachia is in part defined by a legacy of exploitation and hard-won survival. Many of my coworkers are from the area and they talk of suspicion of outsiders running high, though I have not sensed this in any dramatic fashion. However, I am frequently reminded that what faces the families I work with first and foremost is poverty. I often find myself reflecting on Maslow's hierarchy. Is someone living in poverty unable to transform in a deep way, or less desirous of living a more meaningful, unfettered life? Is it my own hubris that misses the practical reality of the families we work with in favor of abstract conceptualization? These questions are surely outside the scope of this paper but worth consideration.

Drugs are also a part of the landscape in a major way here, especially opiates, both prescription and heroin (of the black tar variety). More people die of opiate overdose than in car crashes in this part of the country; there is a mountain of grief around addiction and its many tolls on family and community.

It is more difficult for me to write about community strengths, and this is likely because I have not thought about it much, which is telling. Looking for strengths is one of the things I like most about the identity of counselors, and one of the most difficult things to protect in this professional climate where treatment is predicated on deficit. That said, many of the clients I work with are part of families that have lived in this region for generations and there is a strong sense of belonging to this particular place. Most of my clients hunt, as well, and have an intimate connection with the surrounding natural environment, and lots of experience interacting with it for the provision of basic needs. Self-reliance is an admirable cultural norm in an area where social services have either been scarce or grossly condescending.

Another unique aspect to working as a counselor in this region is the way being in a sparsely populated, rural county affects the counselor/client relationship. Staff members who are from the area know almost all of the families we work with from other settings (e.g. they went to high school together), and some clients have received counseling from the agency as far back as they can remember. There is a community feel, and the concept of dual relationship is made complicated, in both heartening and damaging ways. On the one hand, the risk of an overly professional culture hampering authentic human connection is not as profound. On the other hand, it lends itself to a tendency to believe you really know the families you work with, and subsequently, what is best for them.

Before choosing to work in a given agency it is worthwhile to examine the assumptions you have about your ability to connect with the populations it serves.

There are advantages to my being new to the area, but I have come across risks as well. As implied above, over ninety-percent of the population of the county where I

work is white, as am I. This leads me to more easily fall into the trap of believing I can either identify with my client's struggles or at least know a little about them. Truth is, the culture here is distinct in ways I am just learning to identify, and it has caused me to look closer at my own cultural upbringing. In particular, the struggles of poverty here are continuously new to me, and I have to own my privilege in ways I have not had to before. I have worked with impoverished communities of color, politically and in a human services capacity for years. In doing so, I was able to be the "cool white guy." Whether seen this way by others or not, I could feel that I was disregarding the most stained aspects of the racial legacy I inherited. Now, working with poor white folks, there is none of that cultural caché, I am faced with a whole new set of challenges in finding a human connection with those incredibly different from myself in a number of ways. There is much more to explore here, no doubt, but suffice it to say that before choosing to work in a given agency it is worthwhile to examine the assumptions you have about your ability to connect with the populations it serves. Having these assumptions out in the open may help keep them from guiding your work too heavily. Specifically, having another person to check-in with about these issues will greatly serve you and your clients.

The nitty-gritty

In Ohio, there are regional boards as in Virginia, to funnel federal and state funds for public provision of mental health services. However, here these boards do not provide any services themselves, but rather distribute the monies to a number of different non-profits in a given region for service provision. The agency where I work was started with an emphasis (still maintained) on substance abuse treatment. My outpatient clinic is a division of the agency providing mostly mental health services (vs. substance abuse,

though these divisions are quite arbitrary in terms of what is going on with clients) to children and families. There are four counselors and approximately 10 case managers at the clinic, along with administrative staff and our clinical director (not my supervisor, but the "boss") who is in about twice a week as she supervises two other sites in the region. There is also a psychiatrist who is in once a week. There are few other social services agencies in the area. There is one other major mental health provider in the region but they do not do as much work with children. The clinic also has a driver who can pick clients and families up from school and home, which is extremely helpful as there is no public transportation here and many do not have cars or disposable income for gasoline. It is also the norm to meet with clients at schools and at home, or to otherwise venture out into the community in addition to, or as a part of, therapy. Even though case managers do the bulk of this, it is nice knowing there is support for taking a client on a hike or doing other nontraditional activities as a part of therapy, as long we can justify it as therapeutic and for billing purposes.

As a counselor I am expected by my agency to maintain fifty percent productivity (measured monthly), or I could lose my job. From my experience, this kind of requirement is typical. This means that of my forty-hour workweek, twenty hours should be comprised of billable time (meaning direct client contact). I am able to bill in 8-minute increments, so both a fifty minute counseling session and an eleven-minute phone call are billable. It is not easy for us to bill for family or group counseling sessions at this time, primarily because the agency does not wish to hassle with the logistics of making it economically viable

It will be quite useful to ask who is responsible for making the counseling schedules at the agency where you intend to work.

(billing is still a multi-headed hydra I am learning to wrestle – I am realizing how important this learning is, as billing dynamics can both open and shut doors to the kind of counseling I wish to provide). For each billable unit it is required that I write a note for the client's record. My boss requests that I schedule for roughly eighty percent productivity to account for cancellations, trainings, holidays and other unforeseen events that may make it impossible for me see clients. My caseload is expected to eventually be around forty clients, some of whom I will see weekly and others biweekly. In some agencies, administrative staff does all of your scheduling for you, and in others (as it is where I work), each counselor is required to schedule with all clients on their own. The benefit with this is that I can make my own schedule. The downside is that this can be very time-consuming, and figuring out a counseling schedule requires a handle on advanced mathematics that my graduate program did not cover. It will be quite useful to ask who is responsible for making counseling schedules at the agency where you intend to work.

Each week I have a scheduled assessment time as well, for new clients. During this time I am required to have clients or guardians sign a mountain of paperwork and gather about twenty pages of biopsychosocial information that I then use to complete a multi-axial diagnosis according to the DSM IV. An Individualized Service Plan (ISP) with counseling and case management goals needs to be written within a month and updated every six months. Assessment updates need to be completed any time an agency service is added, removed, or diagnosis is changed. All and all, this makes for a situation in which counselors are *always* behind on paperwork and having to juggle being present with clients and fulfilling agency expectations around documentation. This leaves little

time for reflecting, preparing for clients, consulting, and reading up on presenting issues or new techniques. At my agency, counselors routinely work unpaid overtime to get everything done, though I am dead-set against doing this myself. Add this to counseling full-time for the first time, listening to stories of severe trauma, neglect, chronic abuse and generally being confronted with human beings bearing to you what they keep from most, all on a daily basis – and you have a mountain to climb for sure. With each step toward the summit, however, the views can be breathtaking.

Clinical Reflections

Below are a series of reflections stemming from my first year of experience. They are a mixture of stream-of-conscious process mid-session and subsequent analysis. I write them as examples of significant issues I have faced during this time and my initial responses. There is, perhaps, an unfortunate sense that things are unfinished in each of these cases. This is because they are. I hope this is not too limiting, as I am learning that things feeling finished is not common when clients are facing chronic stress and violence.

I. "Being a counselor is learning to be comfortable with not knowing what the hell to do."[viii]

My clinical director calls me into her office one day. She is only in the office a couple of times a week, so this is rare. She wants to talk with me about how comfortable I feel taking a "really difficult case." The client, an eleven year-old boy named Nick, is to be released from six-months of residential treatment this Friday. He was placed in residential care because of multiple incidents of physical aggression with school staff and at home. I am told he has been given a bipolar diagnosis and I later find out that he also has a rare neurological condition of which relatively little is known. In part because I

believe I know something about children and what they need, and that this differs little regardless of whether or not they are "difficult", and in part because I feel no other choice[ix], I say, "I would be happy to work with Nick." As part of his discharge plan I am to meet with Nick for one hour per week. His discharge plan also includes weekly team meetings with professionals from family and children services, the local department of disability services, representatives from the local school system, a big hospital in the neighboring metropolitan area's autism clinic, and a couple of other councils related to the welfare of children about which I am still learning.

In the week or so running up to meeting with him I am visited by various staff members within our agency to let me know what to do in the event of an emergency and generally to commiserate. I try to focus as little as possible on all of this, and to stay open for meeting this young person as open heartedly as possible. I am reminded of previous sports coaches who would tell me to "keep your eye on the ball."

When the day of my assessment with Nick comes, I am honestly quite nervous and desperately trying my best not to be. When he and his mother sit down in my office and we exchange our greetings I start the way I have come to start most of my assessments, by asking, "So, what have you heard about the purpose of our time together today?" I then give them a heads-up about having to fill out a mountain of paperwork and that we will probably be talking for about an hour and a half. I make sure they know where the restrooms are. Early on I try to engage the identified client, the child, as much as possible. In this case, I look directly at Nick and ask him questions, make observations about a toy he has or what's written on his shirt, etc. Also, by giving him a task to do that is important for the assessment I let him know that his voice matters. I ask him to draw

me a picture of what it was like for him living in the residential facility. I give him the option of using colored pencils, crayons or paint. He chooses colored pencils. He does not begin to draw a picture of what this was like for him, but rather, of a superhero. He is walking around my office throughout the assessment, looking at virtually everything. As I often do, I wish that I did not have to do the most boring stuff with the child client there. I empathize with mom's feeling like she is under a microscope as different service providers are in and out of her home on a daily basis. As it turns out, Nick is being evaluated for autism and the local family and children's services agency is involved with the family stemming from allegations of the molestation of Nick and his brother by an older kid who lives nearby. Nick's father is in prison and mom expresses a couple of times how much her son misses him. She has recently had another baby and looks and sounds exhausted.

Here I am reminded of the difference between *identification* and *empathy.* Identification is hearing someone's pain or trauma and feeling it as if you *are* that person, with all the typically accompanying emotional stew. Empathy is to hear the trauma and to put yourself in that person's shoes, while maintaining your essential selfhood as a separate being. As we have all been taught in our graduate program, it is here that *I* meets *Thou*. I mention this because not overly identifying has been one of my greatest challenges in this work. Nick is a good example. When you work with children their lack of power and control over their own lives is starkly apparent, and their capacity to trigger old wounds from your own childhood is significant.

When you work with children their lack of power and control over their own lives is starkly apparent, and their capacity to trigger old wounds from your own childhood is significant.

The assessment ends as most do. I feel like I have been hit by a truck and have about fifteen pages of forms to fill out, and must land on a diagnosis for billing purposes.

After our first encounter Nick strikes me as a polite, articulate, hyper, heavily medicated child. It is also clear that he is what is colloquially referred to as "in his own world." He has so many people in his life watching him, evaluating him, and putting him in restraint holds after his behavior escalates in response to an environment that seems terrifying in its inconsistency and judgment. Thinking about him from a Gestalt perspective, he clearly has not had a stable environment upon which to build an integrated life. He is fragmented. What parts of himself does he need to reconnect to? He was telling me about a violent fight with his mom in such a nonchalant way. It is like he expects that violence of himself, or he is living up to expectations from others. To use my initial metaphor, he is on shore, away from any adults on the boat reaching out to him and maybe even walking the other direction. To him this seems like the most sensible of reactions to a life where the ability to trust in caregivers has consistently been broken.

I bring this case up at my next weekly supervision session. My supervisor tells me not to worry about diagnosis too much, that, "There are enough people trying to diagnosis this kid." I had chosen an adjustment disorder diagnosis (the adjustment being from residential care back home) and he supports this. He encourages me to strive to be a steady place where he can come express himself. He agrees with me that working with child clients is more poetry than prose. By this I mean that you cannot so readily sit down and talk with a child about what is going on in their psyche. You must provide them with opportunities to give you, and hopefully themselves, a window into their inner worlds, and then validate what you see. Nick has enthusiastically identified drawing as

one of his coping strategies and so we start there. My supervisor is also a big fan of puppets, and Nick eventually takes to these as well.

One day at school Nick refuses to participate in class. His teacher then sends him to the office. He becomes increasingly emotionally aroused and begins walking around the administration office touching everything he sees, the sensory experience feeling quite necessary. School staff asks him to stop and to calm down; they ask him many different things. He seems to feed off of this and increases in his agitation. He ends up kicking a behavioral aid, a police officer is called, and Nick ends up kicking him as well. When his mom shows up to take him home he is sitting in the back of police cruiser, handcuffed.

When I meet with Nick the following week he starts the session with, "I hope my brother and sisters can come to visit with me when I go to jail." He tells me a story in the sand tray with superman, in which his special powers make everyone scared of him. Later, in the waiting room with his younger brother, I am able to witness one of what he calls his "meltdowns" firsthand. It was definitely like a switch flipped, he was in his element, all smiles. It was as if he did not know me or anyone else, all of the adults were simply enemies. It started over him throwing snow at the aid placed in his home to help with mom. She forcefully told him to stop and he saw things getting worse and his fear over being sent to residential manifested into the instinct to fight.

This, at least, is how I see it. I am beginning to attend his team meetings when I have the time. The tension I feel, relevant to work with other children, is between seeing Nick's actions as conscious and malicious versus seeing them as instinctive (or frontal vs. limbic to use neurological jargon). Coming largely from an attachment orientation I fall

He is teaching me that how we see a client is perhaps the most important thing

into the instinctive camp. The difficulty here is that by seeing them as conscious and malicious the emphasis is on changing Nick's behavior, whereas if we see his actions as instinct the onus is on us adults to change (work with children in a CMHC always involves so many other adult actors). There is a practical consideration here too. As developmental psychologist Gordon Neufeld is often pointing out in his work, if Nick is as defended against feelings of vulnerability and sadness as he seems to be, consequences are simply not going to work with him. It seems to me that seeing things this way in a CMHC is very much swimming upstream. But that is what I try to do in my work with Nick. I have him for individual counseling and his "team" encourages me to modify his behavior. In addition to what I have described above, I am trying to provide him with experiences of calm (key word here, as he is very sensitive to the arousal of others around him) positive regard. I am trying my best to pay attention to what is going on with him as he flits around my office, and to help him to do the same. He is teaching me that how we *see* a client is perhaps the most important thing, because it is inevitable that when I try to *do* anything with him it never goes as I had it planned, or goes at all. He is teaching me to let go of my plans.

The treatment team and I are clearly at cross-purposes, and as I work with him I very much wish I could focus on building relationships with all of the adults in his life, and talk about how we can court him back into relationship with us, because without that we have nothing. Because of the limits of my job I can only do very little of this and it kills me.

II. "Right relationship and soft hearts[x]"

Moms stand at the door when their kids come home from school and want to know how they did on their math test that day…but we don't provide the space or container for that kid to come home and tell you or not tell you what their day was like.

- Adolescent psychotherapist Madeline Levine

The Davis kids are transferred to me from another counselor in our office. It is reported that neither one of them have been showing up for counseling regularly, and that when they do they do not say a word. Their case manager sees them frequently and has known them for a long, long time and seems to have a pretty good relationship with them. They have both been mandated to attend counseling as a condition of the probation they are serving for fighting. Their mother also died unexpectedly recently. I call their father and schedule a home visit to introduce myself as their new counselor and get some paperwork signed, after their case manager puts in a good word for me.

I show up at the house toward the end of my day, around 5 p.m. I take a seat on their couch and adjust to the thick cigarette smoke wafting through the air. The T.V. is on loud and two kids sit on the couch, one the younger brother, Sam, who I will work with and the other his friend. His sister comes down the stairs after a shower. Their dad is sitting in a chair by the couch, avoiding eye contact with me. These situations are always difficult. I try hard not to show how uncomfortable I feel, intruding upon their space, because there is a good chance that they are nowhere nearly as uncomfortable with it as I believe they are, or as I am. I start with, "So, I know you all have been seen by folks at [our agency] for a long time. While I can look at a bunch of papers with your names on them, I'd love to get to know you myself. Tell me what your experience has been like in counseling." They say they did not like it. I get enthusiastic. "What didn't

you like about it the most?" Here they start talking and I can feel a pulse of pride, *I got these two to talk* (in general I find pride to be a good bellwether for the need to take a look at the shadow side of my motivations). The sister, Amber, mentions that their previous counselor stared at them, asked uncomfortable questions and judged them. I say, "OK, so you don't want me to stare at you (I kind of ham this up, looking away from them while speaking), ask you uncomfortable questions or judge you." I tell them that I will keep a close eye on the staring and judging, and that we will check in on it together at the end of each session. I then explain that counseling can get uncomfortable sometimes but that we will take it slow. I only ask that they commit to three sessions with me and if it does not work they can find someone else to finish out their required counseling (I find this helps a lot with mandated youth, as it sends a clear message that you are not going to take their view of you too personally). At this point their father says, "I think this might work for them." They agree to meet with me the next week.

After they come in and sit down in my office I ask them to close their eyes and imagine themselves when weak. What they see, what it feels like, etc. I rush through this a little faster than I would like. When I do any kind of guided imagery I always feel like the client is smirking to themselves (this is clearly my own issue) and so I rarely do the set-up as well as it deserves. I am also nervous because they are in high school and really might think this is silly. I just knew they were not that into talking so thought I would try something different. They both engage with the activity pretty readily and when they are done, Amber has drawn a cactus and Sam has drawn a picture of some woods with a person in the center. Amber explains that she is the cactus, protecting herself from others with her thorns. We explore the properties of the cactus together and

she points out that the water inside is her tears that she cannot let out (in a later session with Sam not there she shares that she does not cry because of how it might affect him). Sam shares that he drew himself lost in the forest, and when I ask, "What were you doing in the forest?" he says, "Looking for someone to talk to" as if he could care less and is giving me an answer to get me off his back. I err on the side of interpreting this as meaningful for him and where he is at right now – desperate to connect but feeling totally lost. After telling me that they hate talking about their lives and what they have been through, they start to talk a bit (I am finding this to be a common occurrence with adolescents with broken attachment to adults, if you are able to give them enough space and show genuine interest in what they do have to say or otherwise express). Their father and his girlfriend were recently violently arrested in the middle of the night by the police for opiate distribution; police searched both Amber and Sam's rooms with guns on full display. Amber has nightmares about her mother's death often and cannot be away from her father for more than a day. Sam is much quieter. It is obvious they have been clinging to each other as their primary support. I try not to show how excited I am that they are talking to me or to scare them off with too many "uncomfortable questions."

I speak with their father a number of times on the phone to schedule appointments, and to generally check-in. I get the sense that he is intoxicated when I talk to him and stories that I hear from Amber and Sam seem to reveal the same. When they begin getting more comfortable with me, it is painstakingly obvious that even Levine's parent standing at the door to ask about math homework is not a reality for them, much less someone to

This highlights a central conundrum in working with child clients. The line between being a counselor and being a parent becomes tricky to navigate.

really take interest in their inner lives. This highlights a central conundrum in working with child clients. The line between being a counselor and being a parent becomes tricky to navigate. Often they ask for advice, implicitly or explicitly. Even more importantly, they have a hunger for knowing about your life, who you are, etc. I have felt it would do them a disservice to deny them this completely, while keeping myself in check as much as possible about trying to take on a role that I am truly unable to take. I have shared more about my life with some of these kids than I ever thought I would. I do not want to be another adult in their lives who wants to take without giving. I simply have to be careful that I am not giving so much so that a session in any way becomes about me. I have failed here already. I know that. The key is this – these kids are longing, somewhere inside themselves, to give up their guise of independence and find adults they can count on. A professor in my training program once said, "If a client comes to you and says, "I couldn't have done it without you," then you didn't do your job." This is complicated working with children, because developmentally they are not intended to do it "without you." I am clearly still figuring this out, but it makes for a dance that hopefully rewards as it challenges.

One of the really great things about working at the agency where I work is that there is a lot of support for nontraditional counseling (as I mentioned above, as long as we can use the right language to bill for it, a key skill in a CMHC, they are satisfied). Amber and Sam expressed a real desire to just drive around the countryside rather than going to the office to meet with me. So I pick them up at their house and we drive around. The first time we do it I make them give me a tour of the area. I frequently ask them, "What do you remember about this place?" and the memories flow. It becomes the

best assessment technique I have come across. Amber says, "This is the hospital I go to when I get ulcers from stress," and Sam commands, "Run that guy over, he got us kicked out of our last apartment." Another time we take a silent walk in the woods. I wonder about what makes this counseling; in what ways am I drawing from what I have learned? For one, while walking through the woods I was good at letting the silence be, and frequently made use of immediacies, such as "You're waiting for me to catch up," to make the walk a different way of being with others than they may be used to.

As it stands, the Davis kids seem to have started to lose some interest in counseling. I have felt the need to tell them that this makes sense, as the more we get to know each other the more uncomfortable things are likely to get. Not all of my adolescent clients are nearly as defended against adult attachment. But all of them benefit from counseling that puts right relationship front and center, and strives to give space for hearts to be soft when everything in their lives is telling them they have to be hard.

III. "The growth of a child's imagination is a good marker for their progress in counseling[xi]."

Sometimes after an assessment I have a hard time going on with my day. That is the way it was with George.

A mother brings in her seven year-old son for counseling because she is worried that he is having a hard time with her separation from his father. I start by saying, "From either one of you, what has brought you into counseling." George responds right away, "I am here because I want to help my parents." After a few questions it is obvious that mom is not going to be very forthcoming with George there. His cousins are out in the waiting area so I ask if he could sit with them and draw me a picture while I talk with his

mother. Immediately following his exit she opens up, in distress about her marriage and primarily wanting to talk about that. It comes out that George was violently raped by an adolescent family friend, who he still has to see on occasion. His mother asks if I think this is a problem. It is amazing how easy it would be for me to answer that question in writing, or to a friend asking with no personal investment. However, when a concerned mother asks you that question about her son, whose sweet face you have just seen, it is equally amazing how clogged it seems the words can become in your mouth. I tell her that ideally he would never have to see this young man again. I say that yes, even if his father is spending time with this young man while George is not there it could affect his sense of safety and security. Later on in the assessment George brings up the assault and I can see that mom does not like this. When I bring up this case to my clinical director later, she hands me a book on treating sexually abused boys. I do glean a couple of insights from this text, things to pass on to his parents, but mostly I wonder when I will have time to read this.

When the assessment is finally over (I have a hard time keeping them under two hours for a variety of reasons) I am quite despondent. My own parents divorced when I was in high school and I was the child entirely preoccupied with taking care of my mother and hoping beyond hope that my parents would get back together. This case brings all of this to the surface. I want to help George find his own feelings and to help his family build him a secure enough container so that he is not driven by the anxiety to keep his parent's crumbling marriage in tact.

As we walk down the school hallway for our third or fourth session together, George says, "Aren't you supposed to come on Tuesdays?" I reply, "Well, school was

cancelled yesterday and I wanted to make sure I saw you this week." He smiles broadly. It is all about making these kids feel special. We enter the unoccupied music room (which the school has made available) and I waffle between taking the Alpha role[xii] in the burgeoning attachment relationship and giving him the choice of where to sit and piece of furniture to use as a desk. I start making my judgment here based on my assessment of him as a dependent in his relationships primarily, but I think he is actually developing something of an Alpha complex so it would make the most sense to take the lead with him. We chat a bit, he tells me about the new apartment he lives in with his mother, how he loves it and has already made a new friend through his dog. I feel the need to self-disclose here, and I tell him that I would want my dog to be with me too if I were to move. I do this because of a conversation with his mother in which she shared that he said he was "a greedy boy" for wanting to take the dog with them to their new apartment when his dad would want her too. I want to give him every opportunity to hear from adults that this was a valid thing for him to have done. It is hard for me to see a seven year-old so utterly focused on taking care of those who should be there to care for him. Most of my male clients are really into comic books so I tend to carry around printed, blank comic templates that we can use to create our own. I ask George to tell me a story. He is very preoccupied with the type of story I am requesting and the purpose of the activity. As I thought when doing other activities with him, he is all business. We end up drawing different emotions he has felt and situations in which he has felt them. They all involve fighting with his brother. I am thinking to myself, "There is so much going on with kid, I want to do something that helps him deal with it." And of course the voice of my supervisor is in my head as well, telling me to focus on how to *be* with kids rather

than what to *do.* I want to push the imaginative envelope with him, take a bit of a risk. I ask him to describe his dad's new house to me and in doing so he ever so briefly says that he misses his old house, where he grew up. I ask him, "Would you like to play an imagination game with me?" I pull up the chair and place it across from him, getting ready for the Gestalt chair technique. I ask him to imagine his home sitting in that chair. George smiles but is all game. Even in cases where the imagination has been forgotten as a disposable luxury, children are generally so much more willing to engage in these types of techniques than adults. Or at the least, I feel less self-conscious introducing them to children because of this assumption. So George begins talking to the chair, saying goodbye to his home, and apologizing for not taking better care of it. I ask him to switch places and respond as his home. He giggles a little bit and then switches seats. After a pause he says, "I will miss having you around too, but I understand." When he responds for the last time to his home as himself, I see George at a loss for words for the first time, staring at his feet. After a moment or two he says, "Wow. I actually felt something there. It was emotional." We process what he is feeling, I do some simple reflecting, staying pretty close to what he is giving me. Then it is time for him to return to class. I bring him back to that world, asking what class he has next, what he is excited about happening during the rest of the day. He starts to perk up again and by the time I walk him back to his classroom he seems ready to join recess.

I felt something there as well. I felt a glimpse of the feeling that I may know what I am doing. I have to appreciate these because they are rare in coming.

IV. Talking to parents

I ask Joshua about his getting in trouble at school after his mentioning it himself

(though I already knew), and I ask how is parents reacted. He says, "My mom got mad" and "My dad whooped me." He says both nonchalantly but I ask him about the "whooping," which then seems like it was a pretty typical spanking. He says that he deserved it and I make my best attempt at eliciting the hurt and identifying with that aspect of it, acting baffled by his belief that he deserved it. I am very reluctant to report this though I believe I may have to. My reluctance is primarily about losing the family's trust and about the father not seeming to do this regularly or from a place of violent loss of control. A part of it is also my not wishing to confront the issue with the parents, not knowing how to confidently answer the question, "Well, what do we do instead?" Though in thinking about it I do think I could answer that question relatively well. I could talk about his impaired self-regulation and ways to help him improve this. Time-ins (when he is required to do something with a parent), chores with a parent, eliciting good intentions, and that when it comes to discipline it is parents, not children, that really need it…I guess I don't have too much in mind to quickly give them. When I get back to the office I consult about this. As soon as he said, "whooped," I felt so helpless. It is a day of feeling overwhelmed. Paperwork, and now the reality of my vocation, confronts me. One day at a time. That's all I can take on.

After talking to my clinical director and a colleague I am encouraged not to make a report. Spanking is essentially legal in Ohio and the sense is that a call to the local children's services agency will serve no therapeutic end. I agree with the decision, and am relieved.

Joshua's parents do come in for a session and the issue does come up. Mom mentions the spanking after Joshua brings it up and follows with a hasty, "…and I don't

know what you think about that." This is in the middle of a conversation in which I am trying to find the words to describe my take on ADHD and medication. Like other meetings with parents I find myself lecturing and their eyes glassing over. Before I know it the time is up and I never said a thing about spanking. What would I have said - "It's just that the risks of it outweigh any potential benefits, because it might take him further away from you and will confuse his trust in you," or something like that? I have Minuchin's voice in my head, that we must be soft with parents, so as to not subvert their authority[xiii].

Later on they come in for another session, without Joshua. It has come to my attention through Joshua's case manager that his mother's husband adopted him at a young age, and he does not know that this man is not his "real" father. They expect me to bring this up with them. Toward the end of the session, after talking about attachment-based strategies to address his misbehavior at school, I bring the issue up, essentially being transparent about the fact that I know and asking them if they knew how they are going to treat the issue. They are relieved in my bringing it up it seems, telling me straight up, "We don't know what to do." Having thought about this before meeting with them I tell them that there are certainly no simple answers here but that one thing I would want to be clear about is the importance of their son hearing from them about the adoption. We discuss the many complications – Joshua's biological half-brothers might attend his same school, and they very much want to keep him away from his biological father because of past abuse and neglect. We discuss how this puts a lot of Joshua's current behavior into perspective. We discuss ways to tell him, coupling it with some other rite of passage with his father. His father says to me, "I just can't stand the idea of

him screaming at me, 'You're not even my dad.'" I tell him he will probably do that at some point and the challenge is preparing so that he can take it when he does. I assure them that I am willing to talk this through with them more when they feel ready to tell him, if they would like. As I drive home that evening (the session went about 30 minutes past what I had planned for and I need to get home) it occurs to me that Joshua's dad was not so much worried about the impact of the knowledge that he was adopted would have on his son, but rather on how telling his son this would impact his identity as a father. The risk of Joshua losing the sense of having a "real" father may be much smaller than the risk of his father losing the sense of having a "real" son. During the session I missed this, too nervous and too concerned to get it "right" with what I told them. It also occurs to me that what parents need when I talk with them is not instruction but a chance to find their own feelings, their own tears as it often turns out to be, as they are given that permission as rarely as their children.

Talking to parents is becoming the hardest part of my job, and while I am grateful there are opportunities, I often dread them for the nerves that accompany them. This is where joining a family system becomes so useful, though this, like reading a book on a new presenting issue or approach, takes time. My agency invites families together once a month for a big homemade meal at a local church. I have decided to make these a priority to attend.

Cries and Joys

I. Assessment and diagnosis

This is guaranteed to be a challenge for most new counselors in a CMHC. Most of our programs do not put too much emphasis on diagnosis and yet we are expected in a

CMHC to come up with one after a relatively short amount of time with a client. I do feel that I was well prepared by my program for the technical side of this, but the ethical side still looms large. I find that I try for the least restrictive of diagnoses while respecting what is going on for someone, usually an adjustment disorder (though my clinical director does not like this one because we can only use it for a year for billing purposes). I also diagnose clients with ADHD frequently. I often use the line, "My job is to help you find out about yourselves as individuals and as a family, and to live the fullest lives possible." This is the short and simple statement that I rely upon until I get relaxed enough to not feel any need to script. I always err on the side of transparency and explain why we diagnosis (for billing) and that it is a very small part of how I see a client (here I usually put my fingers in a "pinch" position to show how small) and that the diagnosis can change.

I always err on the side of transparency and explain why we diagnosis…and that it is a very small part of how I see a client…and that the diagnosis can change.

I have also printed out DSM IV criteria to show clients where my thinking came from and to ask what they think of it. Many who come in with a previous diagnosis, never explained to them, seem to really appreciate this. I have also once or twice used the metaphor that diagnosis is, at its best, a kind-of rough map. It says nothing about what it is like to be a person in the place being mapped or about the journey we have to take. What it does tell us is that we all have choices about which direction to go and our lives have given us different geographies, so it can be harder for some than others to get to certain places – like vulnerability, intimacy, self-regulation, etc. This is even hard for me to say because of all the limits and hubris in the DSM IV. I find that no one else in

my agency really talks to clients much about diagnosis, other than to explain why medication might be necessary. But regardless of how I feel about it, rigid assessment (I am expected to ask clients as young as three whether or not they have smoked peyote, though I usually skip this part) and diagnosis is part of the job and if it is happening I think it is only fair to really let clients in on the process.

Going into this I do wish that I had had more background on the Mental Status Exam (MSE), the GAIN short-screen and other simple assessments we are expected to perform. The assessment classes in a graduate program are usually not favorites, but I would love to take one again. I was too concerned with whether or not I thought they were valuable and not concerned enough with the empowerment I would feel with more information. In some ways it may not be the role of a counseling program to bow to whatever trend begins to dominate the field in assessment and diagnosis. But it is incumbent upon those of us planning on working in a CMHC to become familiar with these trends so that they do not sweep us away as soon as we walk in the door.

II. Supervision and consultation

Another counselor said about his experiences with supervision and consultation in a CMHC, "At no point…did I have an authentic peer relationship with another clinician; interactions with like-minded case managers were the closest I could get. I found about 20% of my supervision sessions really helpful. To deal with all this, I tried to focus as much as I could on a. spending time with my clients and b. leaving as soon as I was done each day, often to do something physical to literally shake off whatever weirdness I had encountered that day." My experiences have been similar. Meaningful consultation with other clinicians seems like a foreign concept in most settings. At my agency we had a

lunch meeting once, on my and another counselors initiative, but there was distinct paranoia that our clinical director was going to stop it from happening because we are not suppose to "staff" cases without her present. The paranoia was for naught but I got the clear impression during the meeting that no one was too comfortable talking openly.

Personally, even if the clinically useful information is minimal, I love supervision. I think it is mostly having someone pay direct and constant attention to me for an hour. It is a delightful break from my hectic routine. The biggest hold up for acting in this work with absolute integrity is lack of time – it is a set-up – get as many in and out and let appropriate care fly out the window. There often feels like no way to do this job without turning to easy answers. This is why I recommend trying to get one-on-one supervision first and foremost. My supervisor does not seem to bring much deliberate preparation to the task but I feel comfortable with him and he is a solid rock to rest on and reflect in a stormy sea. There may not be too many at your CMHC.

Regardless of other affinities, find the calm people as soon as you can, and hang out around them.

III. Medication

I believe that one of the main efforts of neurobiology and medicine should be directed at alleviating suffering…But how to deal with the suffering that arises from personal and social conflicts outside the medical realm is a different and entirely unresolved matter. The current trend is to make no distinction at all and utilize the medical approach to eliminate any discomfort.

-Antonio Damasio, M.D., Ph.D.

Instead of asking why a disorder or illness develops, we ask why a fully self-motivated and self-regulated human personality does not.

- Gabor Maté, M.D. [xiv]

This is a sensitive issue for many of us. We have lots of anecdotal evidence that psychiatric medications help. It is past time that we reassess this evidence, because the research that has been done paints a very different picture – one where the neurophysiological origins of psychological phenomena are far from established and where longitudinal studies assessing pharmacological intervention for the treatment of DSM IV-classified disorders are far from promising[xv]. However, I have worked in half a dozen CMHC's now, and in each one the general understanding was that counselors were to enforce "medication compliance." Some of this is Medicaid policy and a lot of it is simply dominant thinking (not the most accurate or even pervasive, just the most loudly broadcast). This is another instance where with information there comes more empowerment. I believe every new counselor should be required to have a background in pharmacology. This could be done academically but could also involve independent study. Clients will be coming to us with questions because in many cases prescribing doctors do not have or take the time to answer them. I am straight forward about the limitations of my expertise but I do share what I know, which generally means sharing that *we* know a lot less than is often professed when it comes to what psychiatric medications do in the brain and how they impact the mind.

While our psychiatrist is relatively humane (for example, she never tells clients they will have to be on medication for the rest of their lives and is good with kids and collaborative in nature) her background is in working with adults, where the concept of

something causing a problem in one's life is more straightforward (an adult saying "I don't like that I'm like this" is different than a child whose parent's say, "I don't like that he's like this."). She also evinces the terrible gulf that exists between what has been researched and what has trickled down into practice. I asked to meet with her and she was very accommodating. When confronted with her authority, I feel like I buckled. In the agency it is her diagnosis that trumps all others and in general the agency sees her work with us as a great gift in a region where there are few psychiatrists. I specifically wanted to ask her about some of my clients that seemed, to me and to them, overmedicated. For example, I have a number of clients who continually increase in symptom expression after stimulants for ADHD are prescribed or augmented in dosage. I wanted to share my concern over their long-term impact in cases where symptoms seem to decrease in the short-term.

But ultimately this is another issue of great divergence. I do not believe children should be prescribed psychiatric medications, or as a step in the right direction they should be approached with the utmost transparency, caution, and thrift. I am still figuring out my role here, and I believe the profession is doing the same. Regardless of where you stand I believe new counselors need to be thinking more critically about this than ever before.

IV. Why and how we come back

Truly, it is…great. Once you're in a room with a door that closes with your 38-year-old client, and you are the first person he ever comes out to as gay, and he leaves the room ten thousand times more relaxed, and over the next month becomes one hundred thousand times more self-loving. Or when you're in the middle of a game with your child

psycho-educational group, and they're yelling and paying attention and not calling each other names. These moments happen all the time. I could give you a long list.

At times I have felt like a salesman, going out into the field in hopes of bringing in the company the most profits depending on how many hours I've worked with my clients. The work can at times feel like "putting in your time" as a new counselor, and the burnout rate is no doubt high. But it is what it is, and as long as you know that going into it, you'll be alright. The clients need the help, and it's meaningful work.

- From two other counselors with experience working in CMHC's.

I have a thirty-minute commute to and from work. I have learned to treasure this time and I would almost recommend it. On the way to work I ride without the radio on, gearing up for the day and trying to calm my mind and my sometimes tightening stomach as I approach my agency's door. On the way home I sometimes ride in silence as well, treasuring those rare-to-find moments when reflection is possible. More often I listen to loud music or shout and shake off the stress and secondary trauma from the day.

One of my primary struggles is how hard it is for me to hear the stories my clients tell me and keep them inside. This is a struggle because our work is truly sacred and to respect it as such we must carry around the stories we hear like fancy glassware; I am often dismayed by how clients are talked about when they are not around. On the other hand, while I want to maintain the dignity of the children I serve I also want to process what I have heard, part for selfish reasons, for it makes for good storytelling – humorous tales abounding in resilience – but also because I know that if they all stay inside me I will cease to hear them, I will clog.

As writer and poet David Whyte puts it[xvi], "When had I erected a barrier inside me that let things out but did not allow them back in? (As good a definition, perhaps, of stress and burnout as could be made)." I have found no better way to describe the phenomenon of "burnout" that is much discussed and witnessed in CMHC's. I see it in other clinicians and in myself. I know that if it feels like I am not letting things in, letting them affect me, that I need to make space for some unclogging or reassess my commitment to this work. So I write after almost every session, as long as I can. I talk to my wife. I know I need to do something more, and I encourage you to think about what your unclogging practices might be before taking this work on.

Another counselor told me that, "…Even as I get more clinical training and clinical work, I match it with client advocacy and community activism. It's the best self-care I can give myself, particularly in the absence of decent vacation time, etc. that characterizes community treatment work." For her, this does it. For me, in a similar but very different fashion, my son is my client advocacy. My close friend asked me one evening about whether some aspect of my fatherhood transfers over to the kids I work with, their pain striking some deeper cord with me. It feels a little different actually. When I come home to my son I see them in him and want to give him what many have not had – a strong, consistent family that fosters a sense of wonder about the world. Having someone smile at you when you walk in the door goes a long way.

I also come back because of what I learn from my clients. I learn something every day through my reactions to them. They pull a nurturance from me, which I have often wondered where it had hidden itself. Especially with child clients, they are surrounded by many adults who react in negative ways to their understandable, but oftentimes

annoying, behavior. I feel a need to care for myself so that I can be something different for them. There is a common acronym from substance abuse recovery literature, H.A.L.T. (Hungry, Angry, Lonely, Tired). It fits here as well – I cannot be the best counselor for these kids if I am feeling any of these.

A professor once told a class I was in, "You are your best tool." I am realizing that I am sharpening my tool with my tears. I go for runs and have cried thinking about my clients. I once stopped dead in the road on the way home from a movie and bawled like a baby. Even writing this I feel self-conscious, that I am feeling it too much or that these are really tears pent up from my own wounds. What I know is that each time I cry I feel like I have expanded and can take more in. I feel more able to be present. Perhaps this will change as I continue to do this work. But I fear how I would be if none of it came out in this way.

Finally, in talking with other counselors and thinking about this for a while myself it comes down to two things. As long as I a) stay curious and b) expect surprises and mistakes, I will be able to succeed in this work, or find my soul nurtured by it. For a good friend of mine it is was his dynamic of "constantly forgetting to make client or other provider phone calls, and *forgiving* [himself, and my emphasis] for not being able to do everything or see everyone" that made coming back possible. I am coming to appreciate that my graduate training just got me started. We must set up our counseling work so that we are always in a learning environment. This requires a paradoxical combination of utter confidence in what we are doing in the moment so that we can take risks, and the more general awareness that our task is to fall and to get back up again, over and over.

Resources

In my humble opinion, these are the resources that each of us should make use before and during work in a CMHC.

On Medications:

- Take These Broken Wings: Recovery from schizophrenia without medication AND Healing Homes: An alternative, Swedish model for healing psychosis, two films by Daniel Mackler. *Mackler was a practicing psychotherapist in New York City for about a decade before deciding to make these films. Like a number of the resources I recommend here, they are important perspective to consider in counterpoint to the mainstream we are expected to uphold in CMHC's.*
- Anatomy of an Epidemic: Magic bullets, psychiatric drugs, and the astonishing rise of mental illness in America, by Robert Whittaker. *Whittaker was a journalist writing for the pharmaceutical industry, setting out to write an investigative book on the effectiveness of psychiatric drugs. What he found was not we expected. This is a recent book, with an impressive review of some of the most research done on the subject.*
- The Epidemic of Mental Illness, Why? - A series of two articles in the New York Review of Books by Marcia Angell and, stemming from the articles, a letter exchange with the American Psychiatric Association and Angell entitled "The Illusions of Psychiatry": An exchange. The first article and subsequent links can be found at www.nybooks.com/articles/archives/2011/jun/23/epidemic-mental-illness-why/?pagination=false. *With a limited amount of time to invest, this series*

of articles and exchanges is critical reading. It is the best review of the issue in a condensed format that I have found.

- Basic Psychopharmacology for Counselors and Psychotherapists (2nd Edition), by Richard S. Sinacola and Timothy S. Peters-Strickland M.D. *This is straightforward information on the most common psychiatric medications, what we know about their activity in the brain, side effects, etc. I reference on a weekly basis.*
- Psychotherapy Medications, published by the Addiction Technology Transfer Center Network (www.attcnetwork.org). *This is a free, downloadable publication found on the ATTC website, similar to the Sinacola and Peters-Strickland text.*

On clinical practice:

- Hold Onto Your Kids: Why parents need to matter more than peers, by Gordon Neufeld and Gabor Maté. *More than any other book this has influenced my thinking about human development. Many of the concepts will resonate with anyone coming from an attachment orientation. There are many practical examples and illustrations of the concepts and I turn to it frequently.*
- How to Talk so Kids Will Listen…And Listen so Kids Will Talk, by Adele Faber and Elaine Mazlish. *A great one to use with parents. Much of it is in comic format.*
- Windows to Our Children: A Gestalt therapy approach to children and adolescents, by Violet Oaklander. *Filled with therapy techniques for all ages. A gem of a book.*

- 101 Play Therapy Techniques, by Heidi Kaduson and Charles Schaefer. *Similar to the Oaklander text, but with far less theoretical grounding and context given.*
- Working with Families of the Poor, by Patricia Minuchin, Jorge Colapinto, and Salvador Minuchin. *A common complaint that I hear from other counselors working in a CMHC and trying to find a book with case studies is that very rarely do the clients look like the clients we work with. There are case studies included here that do something to remedy that. More importantly, working in a CMHC means working with a vast array of other human service agencies and this text is a terrific introduction to the instituions of beaurocratized poverty and mental health treatment in this country. It also provides good guidelines for how to work in one of these institutions in a way that most protects that integrity and dignity of those it serves.*
- Coyote's Guide to Connecting with Nature, by Jon Young, Evan McGown and Ellen Haas. *The best book I've found on nature-based interventions, with all ages. Also provides an intriguing and helpful conceptualization of mentorship in general. For the way I want to work moving forward, I find this text essential.*

On self-care:

- The Three Marriages: Reimaging work, self and relationship, by David Whyte. *I have found this book a very helpful companion in examining how I ended up where I have, and crafting a meaningful, sustaining life. I need reminders of what this means while facing the demands of work in a CMHC.*
- Care for the Soul: A guide for cultivating depth and sacredness in everyday life, by Thomas Moore. *Similar in function to the Whyte text.*

- Good Will Hunting, a film by Guz Van Sant. *Kind of a funny entry, but I watched this film one night and felt really inspired to keep being a counselor. We desperately need this kind of inspiration after our graduate studies conclude. I encourage you to find your own Good Will Hunting.*

Appendix A

Sample cover letter

This is an actual cover letter that I sent off, and the general format that I usually followed. We all find what works best for us but I know I would have appreciated someone else sharing what they have used. It took me a while getting used to "selling" myself so explicitly. I guess it worked because I got a number of interviews.

To whom it may concern,

I am writing to apply for the position of School Based Mental Health Therapist at [CMHC]. In addition to this letter you will find a copy of my resume attached. Thank you for taking the time to consider me for employment with [CMHC].

When I read the description for this position I felt that I had found the job I have been working toward for many years. I doubt that you will find someone whose experiences and skills better match the demands of this position.

Back when I was first doing school-based social work with the Migrant Education Program in the Shenandoah Valley, I most enjoyed the opportunities to provide active mentorship for my clients. For example, a colleague and I once coordinated with local schoolteachers and community leaders to develop and instruct a summer class on muralism. At the end we had over twenty at-risk youth finishing a beautiful mural depicting their vision of community for the surrounding region. In Washington, D.C. I facilitated violence prevention groups for young men and gained a deep understanding of motivating preventative changes. Over the last few years, I have been in graduate school in the Clinical Mental Health Counseling Program at the CACREP-accredited James Madison University. Here I have gained the clinical skills necessary for this challenging

work. During my clinical practicum I especially enjoyed my child and adolescent clients. I received excellent supervision for these clients on such interventions as play therapy and treatment strategies for youth diagnosed with an autism spectrum disorder. Currently, I am working as a Therapeutic Day Treatment counselor in a middle school, providing school-based therapy every day to SED children and their families from a diversity of backgrounds. I love being in a school environment and coordinating with other adults to set up the most effective strategies for maturation to take hold for our young people. I have a strong desire to continue on this vocational path, humbly working to facilitate transformative changes in schools, families, and communities.

On a more logistical note, I completed all requirements for my master's degree last spring and am working toward licensure as a professional counselor. Also, I am already approved for Counselor Trainee (CT) status through the Ohio Counselor, Social Work and MFT Board. I would more than happy to answer any questions you may have about my qualifications. I assure you that I am a gifted therapist and dedicated to providing sensitive and comprehensive treatment to children, adolescents and families. In addition, as an experienced speaker, trainer and community advocate I can guarantee you would not regret bringing me onto the team of professionals at [CMHC].

My wife and I have been excited to relocate to Ohio for some time. Thank you for taking the time to consider my interest for this position.

I look forward to talking to you more about my vision for working with youth and their families, and how I am a great fit for this position.

Sincerely,

Patrick Lincoln

Appendix B

More thoughts from other counselors

Below are comments gleaned from conversations with three other counselors working in CMCH's:

- *Each one of [the transformative moments in counseling] took me completely by surprise, because I spent so much time writing notes, avoiding my undiagnosed bipolar supervisor, or trying to track down no-show clients.*
- *Some of the other treatment staff were extremely client-centered, others were often condescending particularly towards clients in the substance abuse program.*
- *It meant constantly (unintentionally) violating HIPPA, at one clinic site, because everyone violated HIPPA all the time -- for instance, by leaving medical record schedules open on their monitors, or getting bizarrely punished at another clinic (that takes corporate culture in general too seriously) for requesting access to YouTube, an off-limits website with enormous therapeutic value (I showed one client yoga videos in Spanish, for example).*
- *So, clearly, it could also be obscenely frustrating, particularly when coming up against the limits of our managed care system -- knowing that your client couldn't be referred to an autism specialist because they didn't have the right insurance, or knowing that this teenaged client who had experienced some S-I would be referred to a psych hospital, which would proceed to hospitalize her for a week, medicate her, and refer her for a weekly follow-up visit, thanks to ridiculous clinic S-I liability policies. Or when you realize that the people who have been doing community clinic therapy the longest are by far the most*

unstable/unreliable professionals you've ever met. They are supposed to be my mentors?

- *I desperately tried to invite any therapist I came across last year to lunch/drinks/whatever. The most helpful "resources" were books by Yalom, etc. that included actual cases, but those also weren't that helpful given that the cases that make it into these books rarely look like my clients.*
- *Doing community work is tough, unglamorous and honest. With in-home work you will see in a most unfiltered way the inner workings of that home and how your client reacts within it. On the other hand, you lack the safety of your own office, chair, and closed door. The therapy happens along the way, and often in subtle ways, such that the client doesn't quite know that the therapy is happening. If you come from a program that trains you to do traditional therapy (i.e., 50 minute talk therapy), you may be surprised at the disconnect between these types of work. Community agency work can be largely behavioral based and for some clients their activities of daily living come before their mental health needs. In other words, clients may be too low functioning to even do "real therapy" in the first place. In the office, there may be multiple programs running at once and you may only work with some part of the staff. In some ways, community agencies may view the work as a large business, with smaller branches within it.*
- *Working in a community mental health setting is a constant juggling/balancing act, and that goes beyond the usual multitasking under-resourced aspect of things. It means constantly toggling between a "how can I best support this individual" mindset to "how can I support communities I work with (which may or*

may not be my community too)." Keeping both central to my work is the only way I can do it, because focusing exclusively on one leaves me feeling paralyzed or ineffective.

Notes

[i] For the sake of this primer, "community mental health clinic" will be defined as any agency that receives public funding to provide mental health treatment to Medicaid insured and uninsured individuals. In Virginia, these are typically hospitals and non-profits known as community service boards. Where I work, in Ohio, the system is similar, but public funding is managed by a board that then doles out state monies to a number of different non-profits in a jurisdiction (the board providing no direct service themselves). From my first impressions, this leads to a little less coordination in any given region as in Virginia, owing in part to an increased competition for resources.
[ii] Included in this paper is a resources section. There you will find the appropriate information on this and many other places I have turned to for guidance and support.
[iii] Thomas Merton, Thoughts in Solitude
[iv] The clinical reflections are all experiences from my first year working as a professional counselor. Inspiration has been taken from my personal psychotherapy notes. **Identifying information has been altered**. **In all cases this means names have been changed, but in some cases I have also changed gender, age, etc.**
[v] This will be explored more in-depth when I address supervision.
[vi] Paperwork will be addressed more thoroughly later, but I will say here that my internship instructor summed it up nicely by saying, "There is paperwork, and then there is Medicaid paperwork." This is a primary reason why many of those in private practice find it more than simply inconvenient to see clients with Medicaid.
[vii] I have included a sample cover letter in Appendix A, below.
[viii] From my former professor, Dr. Ed McKee.
[ix] This highlights one key difference between doing counseling in a graduate program and doing counseling in an agency. In an agency, there is the obvious need to keep your job. This makes admitting to uncertainty or doubt more difficult, especially as a new employee. At least for me, I feel the need to impress. The scrutiny is real, and I rarely feel comfortable saying that I cannot do something.
[xx] From a talk given by Gordon Neufeld. He is talking about what it takes to unmake a bully, but I find the two concepts as important cornerstones to working with young people in general. See the resources section of this document for where to find more information about his approach.
[xi] As told to me by my supervisor during one of our sessions.
[xii] This language comes from the "Alpha Askew" concept of Gordon Neufeld, as to how attachment relationships are intended to function.
[xiii] From Minuchin's book, Working with Families of the Poor.
[xiv] The Maté quote is from his book, Scattered: How Attention Deficit Disorder originates and what you can do about it. The Damasio quote was found in the same text but is from his book, Descartes' Error.
[xv] In the resources section you will find a few sources for these assertions.
[xvi] In his book The Three Marriages: Reimagining work, self and relationship.