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In the trenches: Strategies for effective work with troubled youth

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In the Trenches: Strategies for Effective Work with Troubled Youth

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Abstract

The overarching goal of this project is the compilation of a resource for those who have chosen to work with troubled youth. . Most workers in the field have a bachelor's degree or less, and even those with a solid education may find themselves ill-prepared for the practical challenges of working with this difficult group. For that reason, it was necessary to create a resource increasing the practical knowledge base of workers in the field. Within this text, I have compiled and reviewed literature concerning practical interventions with at-risk adolescents, combined it with professional experience, and provided a guidebook which is informative, easy to read, and, above all, useful in a practical manner. Included are sections on understanding the population, outlining useful interventions that have proven effective with this group, and reviewing the dangers of burnout, followed by preventive measures to avoid this pit fall. The end result is a manual designed to increase the productivity, effectiveness, and job satisfaction of those who have dedicating themselves to helping troubled children.

Introduction and Overview

"I'm going to kill myself!" Harold said, leveling half of a sharpened pair of scissors at me. "And if you try to put your hands on me, I'll stab you."

I was alone in the unit, dealing with a suicidal 17-year-old. Help, or support of any kind, was desperately out of reach. Harold looped a length of extension cord over his shoulder (presumably for hanging himself), and headed out of the unit into the nearby forest, still pointing those scissors in my direction. I worked furiously to recall how my training had prepared me for this situation. With a sinking sensation, I realized that it hadn't. Not in the slightest. I also realized that the only tools at hand to prevent this disaster were my relationship with Harold and the de-escalation skills that I had picked up over the years working at this residential school. I took a deep breath and followed Harold into the forest.

Luckily, this story had a happy ending. After about an hour in the forest, I managed to talk Harold down. After tearfully handing me the scissors and extension cord, he walked with me back to the unit. Harold later went on to graduate from the program and to return to his home community. However, I could not help but wonder how the story might have ended had I been less experienced or had less of a positive relationship with Harold. If I had been a brand new employee, fresh from my bachelor's degree, how might the story have ended?

Countless situations like the one just described have led me to the current project of compiling a resource for those who have chosen to work with troubled youth. For five years, I was a bachelor's-level case manager at a residential school for at-risk adolescent

boys. I found the work to be quite challenging, but also extremely rewarding. I was constantly astounded by the courage and dedication of my coworkers, but also recognized that, as humans, none of us had all the answers. Most workers in the field have a bachelor's degree or less, and even those with a solid education may find themselves ill-prepared for the practical challenges of working with this difficult group.

Unfortunately, the formal training offered by a bachelor's degree does very little to prepare students for the experience of working with troubled youth. For that reason, it is necessary to create a resource increasing the practical knowledge base of workers in the field. The purpose of this research project is to compile and review literature concerning practical interventions with at-risk adolescents. Furthermore, I hope to present the information in an accessible manner, and create a program based on the literature and on professional experience that will increase the productivity, effectiveness, and job satisfaction of childcare workers in this challenging arena.

Specifically, this project will deal with identifying and understanding the serious problems facing at-risk youth (physical and sexual abuse, neglect, low SES, parenting issues, crime, security, lack of trust in authority figures, insecure attachment, etc.). A strong understanding of the abnormal challenges facing at-risk youth is important for building empathy, forming strong relationships, and understanding the sometimes inscrutable behavior of this group.

Furthermore, the project will cover several interventions with proven effectiveness with at-risk children, as well as general tips for relationship and trust-building, providing structure, self-esteem building, and various other cornerstones of

successful youth programs. I will be looking at these techniques through the lens of a crisis and resilience perspective.

Crisis intervention is an unfortunately neglected area in most workplaces. For many, crisis intervention is synonymous with physical intervention. This project will outline several de-escalation techniques, and other approaches to crisis intervention in order to avoid using physical intervention, except as a last resort. In my five years working with this at-risk population, despite countless crises and confrontations, there were only three occasions in which physical intervention was necessary. I plan to outline the de-escalation techniques I developed, as well as reviewing the current literature on crisis de-escalation.

Finally, I will conclude with a section on professional self-care. This work can be challenging and rewarding, but also incredibly stressful and frustrating. Counselor burnout is a high risk. This section will deal with how to take care of yourself as a childcare worker, how to avoid burnout, and how to become energized by your work, rather than emotionally drained by it. After all, in this field of work, you are your own most important tool! If you allow yourself to become burned out, the quality of your work will suffer, as will your job satisfaction. This is an area that is unfortunately neglected in most workplaces, to the disadvantage of both clients and mental health workers.

In my research, I have found a great quantity of literature and resources dealing with these topics. However, most of the information I have found is of a highly clinical or theoretical nature, or concerning wide reaching social changes to address the problem. There seems to be a general lack of guidance for those who are face-to-face with troubled

children and adolescents as a career choice. Thus, the ultimate goal of this project is to provide a resource for those who are "in the trenches."

Having been there myself, I understand that mental health workers in this area can often feel overwhelmed, stressed out, and bewildered by the behavior of their clients. They have neither the time nor the inclination for extensive literature reviews. Hence, I will compile the literature, combine it with professional experience, and provide a guidebook which is informative, easy to read, and, above all, useful in a practical manner.

Understanding the Population

Having been caught smoking a cigarette earlier in the day, 16-year-old Tim was being punished. He was on a restriction, which meant he had lost access to some of his privileges, such as watching television or playing video games.

"I'm *bored*!" complained Tim.

"Well, you should have thought of that before you smoked that cigarette," replied Jeff, my team-mate. Tim responded to this judgmental comment by violently throwing the unit fire extinguisher through the window. As the result of this outburst, Tim ended up with a far more restrictive punishment (seven days of room confinement, plus seven hours of detention), worsening his predicament of boredom. Despite the fact that his actions repeatedly led to more and more restrictive punishments, Tim never seemed to get the idea, and incidents such as this one were repeated often. This pattern left us scratching our heads.

What was to be done with this child? How did such a mild rebuke draw such a violent and inappropriate reaction? What were the factors that motivated Tim to react in this manner? What was the best way to intervene to promote positive change? Unfortunately, events as confusing as this one happen often when working with troubled children, and often leave childcare professionals feeling confused, frustrated, and impotent. For this reason, it is important to explore the factors that contribute to dysfunctional interactions and antisocial behavior in at-risk youth. Furthermore, it is important to understand what an "at-risk" child is.

At-Risk Youth

Sagor and Cox (2004) defined "at-risk" as, "Any child who is unlikely to graduate, on schedule, with both the skills and self-esteem necessary to exercise meaningful options in the areas of work, leisure, culture, civic affairs, and inter/intra personal relationships" (p. 1). Although the term "at-risk" has applied to many different populations over the years, this succinct definition will do for the purposes of this paper. Most children in this population have been referred for services by the school system, the justice system, or the department of social services. As a bachelor's level child-care worker, this is most likely the work situation in which you find yourself. You may be working as an intensive in-home counselor, as a staff member in a residential facility or day treatment center, a human services worker for the juvenile justice system, or any of a number of other positions in this rapidly widening field. Regardless of your particular situation, the goal will be the same: to intervene in the life of a child who seems destined for failure, and redirect him or her toward a more hopeful path in life.

Most students at risk of academic failure are of low socioeconomic status, are living either with only one parent or in foster care, have been held back in school or had below average grades, have older siblings who dropped out of high school, or suffer the effects of negative peer pressure. Many at-risk children have been exposed to violence, racism, unstable care arrangements, economic deprivation, and community insecurity. Children in poverty also have a higher rate of physical and mental health problems, and juvenile delinquency (McWhirter, 2007). The majority of students with whom I have worked have had one or more of these risk factors. In addition, coexisting with the risk

of academic failure were the risks of incarceration for illegal activity and the many health risks associated with drug abuse, gang involvement, and a violent lifestyle.

These children have faced every imaginable hardship. Domestic violence, suicides of close family members, severe familial alcohol and drug abuse, neglect, abandonment, serial foster placements, and sexual abuse are only a few examples. The previously mentioned Harold once related to me tales of his mother burning him with an iron, and once striking him with a belt so hard that part of the buckle became lodged in his head. I could fill this entire paper with such stories of horror, but suffice it to say, children in this population have suffered hardships that most of us cannot imagine.

In many cases, these are children who have suffered at the hands of adults and authority figures. They may have been incarcerated, expelled, beaten, sexually abused, verbally abused, emotionally abused… the list could go on. The point is, in most cases, the self-esteem of these children is so fragile that even the mildest criticism is too much to handle, and may provoke a violent lashing out. In addition, they have learned to protect themselves by keeping others, especially authority figures, at a distance. A threatening demeanor is a good way of accomplishing this goal. When framed in this way, it is a little easier to understand the unpredictable and often volatile nature of this group.

Attachment and Empathy

When children receive adequate care and affection from their primary caregivers (normally parents), they form secure attachments. Securely attached children grow up to be more well-adjusted as teens, young adults, and adults. Close and secure family relationships have been shown to be strongly predictive of a better ability to be empathic

and responsive to the emotions of others as adults (Ainsworth, Bell, & Strayton, 1971). Unfortunately, troubled children from troubled families often have had little opportunity to develop secure, long-term, deep attachments. As the result, just the opposite is true: they are often less empathic, less understanding of their impact on others, and less able to trust and predict the behavior of others. For these reasons, it is likely that the child's first encounter with a youth worker who is willing to create a caring relationship may be strange and frightening. However, within this frightening relationship is the potential for a corrective emotional experience, and the capacity for healing. The child may learn, through his relationship with you, that not all interpersonal relationships are painful, but that some can be deep, caring, and rewarding.

It is important to remember that, as a child-care worker, you represent an authority figure. In most cases the relationships that these children have had with authority figures are not good. They may not trust that you have their best interests in mind, and they may not trust *you* as a person. They may suspect that your intentions are to impose your will upon them, and interfere with life in general. Therefore, any intervention you offer may be met with resistance, passive resistance, or outright hostility. This is normal! Rather than becoming offended or frustrated at this, see it as an invitation to get to know the child better, and understand where they are coming from. Earning their trust can be challenging, but it can be done. Tips for relationship building will be discussed in the next section.

The best way to empathize with the plight of your clients is to attempt to understand the world from their point of view. You will need your imagination for this

exercise, but, once completed, you will have a much better understanding of the behaviors and motivations of the children you serve! Let's begin…

Imagine that you are completely incompetent at shooting basketball free throws. (Imagining this may or not be a challenge for you.) Imagine that despite your efforts, you were never very good at this task, and were often told that you were not good at it. Now imagine that ability to shoot free throws is the sole determinant for success in the world. No matter how much you practice, you don't seem to be getting any better. Your teachers and peers often shake their heads in disbelief that you cannot master something so "simple." Eventually, they decide to take you away from your friends, and isolate you in a small room in which you can practice free throws all day long. You may improve slightly, but you are still well below average, and your teachers and family begin to wonder what is to be done with this person who can't shoot free throws. You begin to wonder what is wrong with you, that you have such trouble with this activity. Your self-esteem begins to suffer, and you begin to wonder what is so damn important about being able to shoot free throws. Meanwhile, your friends have all moved on, leaving you to socialize only with other students who can't shoot free throws. You are now extremely lonely, and feel out of place in your own school. Your teachers, parents, counselors, are all telling you that you will never amount to anything if you don't apply yourself and learn free throws. After all, your peers are successfully shooting nine out of ten free throws, so why do you continue to struggle to shoot a meager five out of ten? Now you feel incompetent, alone, useless, and hopeless that things will get better. Would anyone wonder why you have started to withdraw psychologically and emotionally from the classroom? Why not give up entirely and just sell drugs for a living?

This scenario may seem silly, but it is very similar to the dire situation that our at-risk youth find themselves in as part of the education system. Success in society depends, in large part, upon our abilities to succeed in performing the specific academic tasks of focusing, thinking, and problem solving in the classroom.

Situations such as this have often led these children to a state of "learned helplessness." (Abramson, Seligman, & Teasdale, 1978) Being behind their peers academically, and lacking the skills to catch up, they often begin to see themselves as "dumb" rather than unskilled. Unfortunately, the adults in their lives often begin to see them the same way, and give up on them. It is easy to see how these kids begin to see school as demanding, threatening, confusing, and unresponsive. It is still easier to see how they will begin to look for ways to avoid being in this situation, such as truancy, purposeful acting out behavior, malingering, etc. Being the "bad kid" means that adults will begin avoiding interactions with the child, which, in this situation, is exactly what the child wants!

Some kids struggle with math, some with reading, some with social skills. Everyone struggles in some area of life. For kids such as the previously mentioned Tim, the struggle is with adaptability, flexibility, frustration tolerance, and problem solving skills (Greene, 2010). Unfortunately for these kids, there aren't many situations in the day that *don't* require flexibility, frustration tolerance, and problem solving. Being able to interact with others and handle the challenges of everyday life requires all of these skills. In order to have healthy interpersonal relationships, we need to be able to be flexible, solve disagreements cordially, and manage our emotional reactions to the frustrations we feel. These skills are generally lacking in troubled children. It is not that

they are “bad,” but rather that they are “unskilled.” As the old saying goes, when your only tool is a hammer, everything begins to look like a nail.

In the troubled child’s experience, they have likely not felt the comfort and security of an adequate caregiver. They may not have ever had someone respond consistently to their needs, notice that they are happy, sad, angry, etc., and communicate with empathy about the feelings that they are experiencing. At first, they may be frightened or “weirded out” by your ability to empathize with them, and your desire to offer a caring relationship. This seems strange to them, because it is not what they are used to. They may be insecurely attached as the result of a weak bond with their primary caregiver, and may be unable to experience the nurturance, care, and security that you are offering them. Don’t be discouraged. Healing takes time.

Learning new tools is often a slow and painstaking procedure, but it is not that these children don’t want to learn. It is simply that they aren’t learning these skills as fast as expected. It may be helpful to think of it as a developmental delay related to the skills of problem solving, flexibility, and frustration tolerance (Greene, 2010). When framed this way, it is easier to tolerate and understand Tim’s explosive behavior. When Tim doesn’t have the skills necessary to deal with the demands he is facing, he falls apart, and resorts to his oldest coping strategies, rage and violence.

It becomes still easier to understand if we imagine ourselves in a situation where we do not have the necessary skills to deal with the demands placed upon us. Any new hire knows the stress of being out of his or her element, and feeling ill-equipped for the challenges we face. We all know how stressful this can be. Difficult children are no

different, except that they fall apart more easily, more often, and in a more problematic manner than the rest of us.

So now we have covered the population, and framed their needs in a way that is growth-oriented and strength-based. This perspective will help give hope to your work, and decrease feelings of frustration when your clients don't learn the "skills" as fast as you would like. Now we will look at some useful strategies for "hands-on" work, and examine a few of the risks native to this work and how to cope with them.

Useful Strategies

So, now that we have a basic understanding of the population we are dealing with, we must ask ourselves; "What is the best way to intervene?" What works, and what doesn't? How do we go about building trust and forming close relationships with those who have had little reason to trust anyone?

Unfortunately, behavioral problems have a spiraling effect on human relationships. Behavioral problems can cause others to become distant, frustrated, and emotionally cold. This, in turn, can cause the insecurity that worsens the behavioral problems, and so on and so forth. On the other hand, adults dealing with difficult kids can sometimes become so frustrated and irritated with the child that they start responding to *everything* the child does. This over-reactivity is a form of attention, which actually ends up rewarding the child (negative attention is still attention) and reinforcing the behavior that you, as the adult, are trying to stop. This creates a feedback loop in which the child continues to escalate, and the adult continues to respond with more frustration, and so on (Turecki, 2000). It is important that these dynamics do not play out between you and your client. So, we will begin by examining some of the most troublesome behaviors exhibited by this population, and how you can avoid falling into the traps they often create.

Defiance

Let us begin by discussing defiance. Few things will drive an ordinarily calm and collected adult to distraction faster than being openly defied. Take the following example:

Me: "Tim, I need for you to get this room cleaned up before dinner. Thanks."

Tim: "Fuck you! I'm not doing that shit!"

At the time I was angered by this response. It seemed totally out of proportion with what I had asked of him, and I didn't think I deserved to be talked to that way. While this was true, responding in an angry or vengeful manner would have only locked me into a pitched power struggle that I had no way of winning, and recapitulating countless previous encounters that the child has had with other authority figures. Herein lies the sticky nature of defiance. When faced with a defiant, nasty response such as the one just described, anger is a very natural reaction. You may feel your pulse quicken, the blood rushing to your head, your judgment becoming impaired. "He's not going to get away with that!" you may say to yourself. However, this path of thinking is not going to help the child, and if you respond in anger, you will have fallen into the trap.

Intuitively, it may feel very natural to "crack down" on a defiant child, but in reality this only feeds the problem. You can inadvertently worsen defiance by being too intrusive, too "in-your-face," and imposing your will too vehemently. Those angry emotions must be bracketed in order to properly deal with the situation. The best way to do this is to understand where the defiance comes from, and deal with it in a way that fosters growth and security, rather than reinforcing and escalating the behavior.

So, where does defiance come from? Among its many uses, defiance is a coping strategy that allows the child to have some measure of control over his life (Greenspan, 1995). In many cases, these are children who do not feel safe or secure, and who do not

feel they have much power in their environment. A defiant "No!" is a way of exerting power and feeling less helpless. Not only that, but it often will divert a stressful situation into one that, while unpleasant, is familiar to the child, and gives him the upper hand. While it may be an ineffective life strategy, defiance is one coping strategy that helps troubled teens gain some measure of control in a world that often feels overwhelming (Greenspan, 1995). Often, when a child responds in a defiant, nasty manner, what he is really saying is "This interaction is too much for me to handle right now."

Often, defiant children can give the impression that they are antisocial, and aren't interested in connecting with others. However, this isn't so. Rather, children who feel unsure of themselves in social situations may cope by playing it safe and keeping others at a distance (Greenspan, 1995). Through practice, we can help them to feel more confident of themselves, and enjoy interacting more.

When viewed in this light, the defiant, self-centered, obnoxious child becomes a frightened and fragile creature, desperately wanting help, but with no idea of how to ask for it. Any attempt to get close to this child may be met with verbal abuse, nastiness, and downright aggression. So how is it done?

The first step in effectively managing difficult children is to effectively manage yourself. Before you can deal with the challenging behaviors on display, you must adopt an attuned and empathic attitude. Keep your emotions out of it, and respond with your thinking, not with your feelings. Take an emotional step back from the situation, and remain professional, focusing on the actual behavior, and not on any suspected motives you think the child has for the behavior. If you take it personally ("He's not going to get away with this!") then your angry emotions are clouding your judgment, and you are on

the wrong path (Turecki, 2000). The attuned empathic approach will allow you to examine the behavior, remain calm, and avoid making rash decisions because you are angry or frustrated.

If you find yourself constantly confronting the child for even the smallest behaviors, take it as a warning sign that you have been drawn into an unhealthy dynamic with your client. Constant confrontation will take its toll on your energy level, frustration tolerance, and psychological well-being, and it will have a similar effect on your client. Instead, try to use restraint, and respond to fewer situations. Take a step back, and ask yourself if confronting this behavior is really important, and question what you could lose by doing nothing. In these high maintenance situations, it is often better to have a list of the most relevant behaviors which *must* be challenged (i.e. hitting, biting, etc.) and come back to the small stuff (room cleanliness, loudness, etc.) later, when the situation is more stable (Turecki, 2000).

Additionally, it is important to choose the time and place for teaching carefully. These "teachable moments" are most effective when they occur away from the heat of battle (Turecki, 2000). If your client is having an emotional meltdown, it is not the time to lecture or try to reason with him. I like to imagine this approach as trying to teach someone math while they are on fire. Later, when the dust has cleared and your client is calm, it is the perfect time to have a discussion, inform them of the consequences, and make a plan together about how to avoid the behavior in the future.

The key to this is an authoritative interaction style. You must set limits on behaviors, but not on empathy. Understanding and empathy are some of your greatest tools, and feeling understood can resolve a lot of the temperament related issues that

punishment cannot. (Turecki, 2000). Some children may be intimidated into behaving by a confrontational, authoritarian style of interacting, but they will lose respect and trust for you in the process. Punishment alone results in resentful obedience under the best of circumstances (Greenspan, 1995).

Defiant children will simply draw you into a power struggle that you cannot win, and which will leave you exhausted, angry, and frustrated. This is hardly the psychological state in which to offer empathic support! However, you can also not let the child run all over you with no limits. They key is a delicate balance of firmness and gentleness. Be consistent and firm, but also communicate to the child that you have not lost empathy, and explain your rationale for confronting or punishing. This approach will impart the structure they need to feel safe and have success, but also reinforce that you care about them. If warmth and appropriate limits are increased together, the child will become motivated because he or she *wants* to behave better, and understands the reasons behind the limits (Greenspan, 1995).

This sounds simple, but in reality it can be quite challenging. It requires patience, a cool head, and the best interests of the child in mind. It may seem counter-intuitive, but after all, if defiance is a coping strategy that develops as the result of feeling powerless, then taking away a child's autonomy by being too overbearing would simply worsen the problem (Greenspan, 1995). By looking at the problem from this perspective, it is easy to see how many parents and child-care workers fall into this trap! However, as professionals, it is our job to provide support and empathy despite the nastiness and defiance. This leads me to my next point: Don't take it personally! These children are used to not trusting others, and lashing out to keep others at distance. You will be no

exception! You will have to earn their trust, and convince them that you are capable of providing support, warmth and empathy! This is where the patience comes in. Over time, as the attachment bond deepens and grows, the child may begin to see you as an ally, rather than just another adversary.

Children in Crisis

At the time when troubled teens come into contact with you, the child-care worker, they have most likely been through the proverbial wringer, and are likely in a state of perpetual crisis. Adults in their lives have been unfair, unresponsive, emotionally and/or physically abusive, and untrustworthy. It is your somewhat daunting task to prove to them that you are not simply another adult in a long string of adults who have not been there for them (Conrath, 1986). While this task may seem quite difficult, it is also where our greatest opportunity lies. Understanding the opportunities and dangers presented by crisis is a big step toward working effectively with this population. As we all know from countless seminars, the Chinese character for crisis is a combination of the characters for danger and decisive movement. In the case of your clients, the decisive movement is the opportunity for personal growth. While students will often come to you in crisis mode (which will no doubt increase the energy and stress of your work), this state presents a profound opportunity for positive change.

Unfortunately, what often happens is that teens become labeled by their behavior. It is all too easy to judge a teen based on their irritable mood, violent outbursts, and negative behavioral history. It is far harder to see the person in pain behind these behaviors, and to find the survivor within the victim (Echterling, et al. 2005).

As you read in the previous section, these teens have often been through every imaginable hardship in life. While this is a terrible thing, it also presents the opportunity to mine resilience. Children and teens are remarkable resilient creatures, and this is often an overlooked strength that you, as the helping professional, can help point out. Often these teens feel hopeless, helpless, and at the mercy of the world. Through empathic listening and reflecting, you can slowly but surely illuminate the fact that they have been through some extremely trying times, and are still standing.

The goal is to slowly build confidence that they are, indeed, resilient, and they have the ability to take some ownership in their lives and get through this hard time. This is done by connecting with your client by listening, understanding, and validating his or her feelings. Rather than attempting to talk them out of their negative feelings, the goal is, conversely, to listen to their story, understand how they are feeling and why, and let them know that their emotions are *valid*. This is an opportunity to be with your client, validate that they have been through a tough time, empathize with them, encourage, and ask reaching out questions that will demonstrate your desire to help (Echterling, et al. 2005).

As you are listening to your client's story, make sure to pay close attention to any strengths or demonstrations of resilience that you hear along the way, and use them as encouragers as the conversation progresses. Many clients in crisis may feel very demoralized and helpless, so offering accurate encouragement can help them to frame their story from a more positive perspective. As an example: "You've been through some really hard times! Most people wouldn't have been able to handle that situation as well as you did. How did you summon the courage to make it through?" From this

perspective, the client is not the victim of circumstance, but a survivor who has been through the fire and is trying to make it to the other side.

The Risk of Assault

The Occupational Safety and Health Administration (OSHA) has created guidelines for preventing workplace violence for health care and social services workers (http://www.osha.gov/Publications/OSHA3148/osha3148.html). According to statistics from the Department of Justice included in these guidelines:

> The average annual rate for non-fatal violent crime for all occupations is 12.6 per 1,000 workers. The average annual rate for physicians is 16.2; for nurses, 21.9; for mental health professionals, 69.2; and for mental health custodial workers, 69.

You will quickly notice that the rates of violent crime among health care and social workers are higher for mental health workers. *Much* higher. In fact, OSHA estimates that the rates are actually even higher than reported. In many organizations, there is the mentality that assault is "just part of the job," and many incidents of assault go unreported.

It is true that the risk of assault is part of the job in most mental health settings, but that does not detract from the serious nature of these occurrences. It would be nice if all of our clients were rational people, capable of controlling themselves and working through conflicts in a calm matter. However, if this were the case, they would likely not require our services! When dealing with teens and children, this is particularly true. Few children are admitted for residential care unless they have serious impulse control

problems, or are in some way a danger to themselves or those around them. Tully, Kropf, and Price (1993) found that 81% of their surveyed psychologists had experienced an attack, either verbal or physical, at work.

It is not my intention to frighten you away from this type of work, but it is important to recognize the dangers, understand that these risks *do* exist, and take the necessary precautions to protect both yourself and your clients. During my time as a residential worker, I was attacked on several occasions, sometimes with dangerous weapons (a shard of glass from a broken mirror, a fire extinguisher, a large rock). In each of these cases, I was able to avoid injury by following the safety precautions set forth by my organization. This is a practice that I cannot endorse enough. If you are a new staff, learn the safety precautions put in place by your organization, and *follow* them. It may seem that these rules are put in place for the safety of the clients. While this is true, you will also find that these precautions also protect you as a mental health worker, not only from physical harm, but from liability as well.

Understanding the motivations for violence can also help you to predict when violent interactions may occur. Sometimes violence is a reaction to anger. At other times, it may be a reaction to fear, or to feelings of frustration and helplessness. Sometimes it is simply a strategy that the client has used in the past to successfully control others. Your reaction to this behavior is the most important part of controlling and de-escalating the situation.

When dealing with someone who is acting strangely, or escalating toward violence, feelings of fear or anxiety are natural reactions. It is important to examine your own reactions to these emotions. Often, feelings of fear or anxiety due to the

unpredictable nature of these types of situations can provoke a counter-aggressive or authoritarian response from mental health workers, in an effort to "control" the situation and manage the anxiety. Unfortunately, this often only serves to exacerbate the client's feelings of anger, frustration, and helplessness. The result is an escalation of the violent behavior, rather than the desired *de*-escalation (Dubin, 1989).

If you are new to this field, the behavior of your clients may seem strange and troubling to you. Don't worry! This is normal. I remember my first day on the job as a residential worker. My first thoughts were "Gosh, some of these kids are *big*! Also, some of them seem pretty confrontational. I wonder how dangerous this job is?" I admit that I had unpleasant visions of being beaten up by angry teenagers. However, as I became more accustomed to the work, I grew more comfortable with the population. Soon, I was laughing at myself that I had been so worried. While unpleasant, aggressive, or even violent interactions did occasionally occur, they were extremely rare. In fact, the relationships that I formed with some of these "intimidating" teens became some of the most rewarding of my career. With experience, you will also begin to feel more comfortable, and you will see that strange behavior, while sometimes unpredictable, does not always indicate a risk for violence. In many cases, the therapeutic relationship you build with your clients may leave you wondering how you ever found them to be strange or intimidating in the first place.

You will likely find that in cases where the motivation for violence is anger, frustration, or fear, that a calm reflection of accurate empathy will do the trick in helping to de-escalate the situation. Not "Calm down right now!", but "Wow! You are really angry right now. Tell me what is bothering you." This approach tells the client that you

can see how they are feeling, and that you want to understand them. I found that this approach of calm understanding was sufficient to defuse the majority of tense situations. It is important, however, not to overestimate your relationship with a client as well. Regardless of how well you feel you understand your client, there is the possibility of unpredictable violence due to circumstances you may not be aware of. Those who are afraid, overwhelmed, or extremely angry do not often make rational decisions.

However, in some cases, the motivation for violence is manipulation. Some clients have learned that violence is the way to get what they want from people, and they don't mind using it on you, others, or on themselves to get their way. Past behavior has been shown by quantitative research to be the best predictor for future violence (Mossman, 1994), so if your client has a history of violence toward staff, it is good to take that into consideration. In these cases, the approach of calm understanding will be less effective, and you may find yourself in a situation where physical or other more extreme types of interventions may be necessary. In these cases, again, it is best to closely follow the safety regulations put in place by your organization. Most organizations have meticulous guidelines about the types of clothing that should be worn, escape routes (should they become necessary), how to summon support from other staff members, and how to safely use physical interventions as a last resort. Use support whenever possible, and don't try and handle a dangerous situation on your own.

The basic point is to be empathic, but to be cautious as well. Use your empathic skills and relationship, but don't get cocky. Good clinical skills will lessen your likelihood of being assaulted, but they don't make you immune!

Finally, it is important to appropriately deal with the emotional effects of being involved in an assault or other dangerous situation. Fear, anxiety, and anger are all normal reactions to violence, and it is important to manage and process these emotions before you get back into the fray. Aftercare for the victims of assault is extremely important (Gately & Stabb, 2005). Debriefing is an important part of this process. Talk about the incident with your supervisor, or with another colleague, and explore what important lessons may be gleaned from the incident for both you and your agency. It may be useful to think of some ways you could have handled the situation differently. Hindsight is always 20/20, and while processing the elements of the incident will not change what happened, it may help you or others to be more prepared in similar future incidents. Your organization may want to revise policies and procedures in light of what was learned from the incident. Using supportive debriefing can help you tap into your own resilience after experiencing violence, which is an important part of taking care of yourself after the event. In addition, the lessons learned by your experience may help avoid similar situations in the future, which may help you ascribe meaning and derive some positive benefit from the incident. If you continue to feel traumatized by the event, and can't seem to get over it, you may want to talk to the clinical staff, or seek some counseling of your own.

In summary, you should not be afraid of interacting and forming therapeutic relationships with your clients, but you *should* be cautious. Hone the clinical skills that will help you de-escalate situations, understand your own limits, and seek help from those around you. These three points will help you and your clients remain safe, so that you can enjoy the rewarding experiences that this work can bring.

Coping with Suicide

When I first met Joseph, he was a deeply depressed young man. The symptoms of his depression were so strong that he could not get out of bed most days. He was failing school because of refusal to attend, and had no meaningful relationships with either peers of staff at the school.

Being fresh out of school, and full of passion, I made it my mission to "save" Joseph. I began by simply sitting quietly in his room with him while he stared blankly at the ceiling. Occasionally I would try to start a conversation, but most of my attempts were ignored. However, I made it a point to sit with him for a whjle each day, hoping that my presence might comfort him, and bring him out of his shell. After a time, he started to become accustomed to my visits, and would make small talk. I eventually coaxed him out of his room by offering to play some video games with him. This soon became our ritual, and a relationship started to form. Joseph was starting to come out of his shell, and I felt pretty proud of myself for helping him do it. Soon, Joseph was attending classes again, and doing remarkably well. He even got a part-time job off campus at a fast food restaurant. Joseph went on to earn Level 6 (the highest behavioral level at the school), and graduate from high school. His smiling face in cap and gown adorned the campus newsletter, and posters were made to hang around campus. He was a real success story. He returned home to his family, no longer a troubled child, but a confident young man.

Six months later, Joseph's mother called to inform us that Joseph had committed suicide. This news wounded me deeply. Even now, six years later, I can feel tears welling up as I write about it. Hadn't I saved him? I had tried my best, and felt like a

failure. It came close to ending my career in mental health. I doubted my abilities to handle such tragic events, and my abilities to intervene effectively. I also felt a crippling sorrow for the child I hard worked so hard to help. Luckily, I decided to talk to the unit clinical counselor about my feelings. What he told me was this: "You have to just do your best. It is ultimately up to the client whether they succeed or not."

This is a piece of advice I have carried with me ever since. This tragic event, potentially career ending, instead became my impetus to become better, and eventually led me to enroll in a counseling program.

I will not discuss assessing suicide risk in this project. It is a larger subject for a different paper. Instead, I will now discuss the impact of client suicide on mental health workers.

Unfortunately, client suicide is thought to be the crisis most often experienced by mental health workers (Bongar, 1993). Because we work with troubled people, the risk for client suicide is somewhat of an occupational hazard. In the wake of client suicide, clinicians have reported frequent feelings of guilt, sadness, anger, and fearfulness when dealing with suicidal patients (Sacks, Kibel, Cohen, Keats, & Turnquist, 1987; Schnur, & Levin, 1985). Even years later, most mental health workers who have experienced client suicide still remember the name of the client, and vivid memories of the event (Brown, 1987a).

In a recent survey of 1000 professional counselors, it was found that 23% had experienced the suicide of a client under their care (McAdams & Foster, 2000). These counselors reported having unwanted intrusive or avoidant thoughts about the crisis, and stress symptoms. These negative effects were greater in younger, more inexperienced

counselors. The reasons for this are twofold: novice mental health workers are more likely to feel that they have failed when a client commits suicide, whereas more experienced workers have learned to separate personal failure from the limitations of the therapeutic process. Additionally, inexperienced workers do not have a broad base of experience with clients, which may make it more difficult to process what happened (Brown, 1987b).

The effects of client suicide can be devastating, both personally and professionally. If you are unfortunate enough to face it during your work, it may have profound effects on your self-concept and confidence. It may make you fearful of working with other clients who are depressed or suicidal. Conversely, you may find yourself purposely avoiding thoughts and feelings associated with the event. Regardless of your reaction, it is important to cope constructively with the effects. Talk to your colleagues, supervisors, and clinical staff about the incident, and if this doesn't seem to help, seek out counseling of your own.

It is unfortunately the "nature of the beast" that we will come face to face with suicidal clients. It is therefore necessary to become educated on the risks, learn how to intervene effectively, and be able to cope with the fact that our best efforts will sometimes not be enough. Whether you are a novice or a veteran, the therapeutic process has limits. You cannot "make" someone heal, and you cannot "save" someone without his or her permission. The choice for healing lies with the client. You are there to help them along the path to growth and healing, but it is the client's choice to walk with you or not. Do your best.

We have now established that this is a hard job. Thank you for sticking with it. The logical next step is to discuss how to cope with some of the things that make this job hard, so that you can continue to do it well, and enjoy this rewarding profession.

Taking Care of Yourself

Thus far we have covered some aspects of the population with whom you are working, and some effective strategies for working with this group. Now we will embark upon the final, and in my opinion, most important section. Here we will discuss strategies for helping you manage your own stress, keep yourself sharp, and thrive in your work. While there are many jobs that are more physically taxing than the mental health profession, there are few that are more emotionally challenging. If you are a bachelor's level professional, you are probably well versed in the various schools of thought and theories associated with psychology, but you have likely had very little training in the practical side of the work and the many hazards associated with the helping professions. The point of this section is to provide some basic and applicable tips about the nature of the beast, provided by those who have spent many years working in the field where you now find yourself.

Much of the literature concerning burnout applies to counselors and psychotherapists, who most likely spend several intense fifty-minute sessions a day with individuals, families, or groups. However, the dangers and strategies presented in the literature also apply to you as a "frontline" helping professional. In fact, most of the pertinent information applies to you in an even more salient fashion. While therapists may spend an hour at a time working with troubled individuals, as a residential worker, you are likely to find yourself working with troubled individuals for eight to twelve hours a day, seven days a week, and with 8-12 clients at a time! If you are an in-home counselor (as I currently am), you may spend three to five hours working within a chaotic home environment, only to move on to your next client and spend another three to five

hours working! Make no mistake, the work that you do is every bit as intense as traditional psychotherapy.

As you do this work, you will likely hear terms such as "burnout," and "compassion fatigue." These are conditions that will negatively affect your mental health, decrease your interest in your work, and make you an unhappy and ineffective mental health worker.

Burnout refers to a level of emotional exhaustion in which one is either incapable of continuing to work, or continues to work poorly. Maslach (2003) defined it as "a response to the chronic emotional strain of dealing extensively with other human beings, particularly when they are troubled or having problems" (p. 2). The burned out caregiver is likely to suffer from decreased energy, a lack of interest in previously compelling work, and a feeling of dread and loathing associated with the idea of going to work. Burnout often results in compassion fatigue, which refers to a state of being so overwhelmed that one ceases to care or feel empathy for one's clients. As a counselor, of course, this is unacceptable, but it is a very real danger.

Burnout will occur at differing times and intensities for most people who work in the mental health field. All will likely experience it at some point along their professional careers. There is a misconception that burnout only affects those who have been in the field for a long time, but this is not so. Burnout affects those who are new to the field as well, and it is normally related to feelings of emotional overload due to the sudden intensity of the work (Zur, 2008). New mental health workers also tend to suffer from feelings of inadequacy as they embark upon this career path. This is normal, but it is also a significant contributor to new hire burnout.

Burnout Hazards

Several hazards of the profession contribute to burnout for all levels of mental health workers, be they frontline staff or licensed professionals. The first and most obvious is simple emotional depletion (Zur, 2008). Mental health professionals often spend long hours working with people who are in psychological pain and crisis. They are expected to be empathic, caring, and professional, and give heavily of themselves without any expectation of that sentiment being returned. This is the strain of being leaned on constantly, but of having no one to lean on. Constantly dealing with people suffering through loss, pain, suicidal thoughts, or other forms of trauma can eventually take a heavy toll on the caregiver. Sometimes caregivers can become overwhelmed, and start to feel the client's sadness as their own. This is what Carl Jung referred to as "psychic poisoning." More recently, it has been referred to as "vicarious traumatization," and describes a state in which the caregiver's world becomes negatively impacted by too much engagement with client trauma. Without proper support, it can be easy for even a beginning mental health professional to become emotionally drained and begin to suffer from compassion fatigue.

In addition, many mental health professionals (especially residential and in-home) work many long and odd hours, such as evenings and weekends, when most other people are off from work. Free time normally occurs in the mornings or afternoons, when most other people are at work. This often creates a sense of isolation (Zur, 2008), when the mental health professional is alone during free time, and working when others are having family and social time. Coupled with the aforementioned emotional depletion, this can create a real crisis!

Mental health professionals also have the disadvantage of rarely getting to see the fruits of their labor. I spoke once with a counselor who had been in the field for many years. He told me that he often fantasized about doing manual labor for a living, because at least he would be able to see what he had accomplished in the day. This is unfortunately not so in the mental health field. The work is often slow and difficult, and very rarely are there any tangible results at the end of the day (Zur, 2008). As a mental health caregiver, you will experience a constant cycle of meeting new clients, connecting with them in strong and empathic manner, then disconnecting and discharging, often to never hear from your client again. Residential workers are often haunted by the thought that their clients will likely return to negative behavior patterns once they return to their home communities. If clients are unable to take their learning experiences with them when they return home, it gives the whole endeavor a sense of futility. With no objective way to measure success, it can become hard to tell when you are making a difference. This can lead to feelings of helplessness, and doubts about your skills in your chosen profession.

A related hazard is over-emphasizing your importance as a helping professional. Beginning mental health workers have a tendency to see themselves as personally responsible for any change that may happen in the therapeutic relationship. This leads to a self value judgment based on whether the client succeeds or fails. If the client fails, the professional feels like a failure. If the client does not change, the professional may feel accountable for this. The truth is that, while you are there to help, the client is the one that is responsible for change. As a wise supervisor once told me, "You cannot take credit for your clients' successes, *or* for their failures." This bit of advice has sustained

me through many hard times, and has made it more bearable when my clients have not done as well as I hoped.

On a similar note, constant worry is another roadblock that wears upon mental health professionals (Zur, 2008). You may find yourself thinking about your clients long after you have left work. "Will Johnny follow through on that suicide threat?" or perhaps "I wonder if Susan is doing ok?' or even, "I've got a weird feeling about Frank. I wonder if he's dangerous?" Taking work home with you is a problem in any job, but is seems especially troublesome for mental health professionals. You may feel responsible for the mental well-being of your clients, or worry that one of them may harm themselves or others, or do something that might cause you to be sued. There are a number of valid worries with which to contend, and it is no wonder that mental health workers often suffer sleepless nights. In fact, some mental health workers become so distracted with the problems of their clients that they neglect to attend to their own! Our problems often seem less pressing than those of our clients, and it is easy to become wrapped up in the problems of our clients while neglecting our own.

In addition to these threats to the emotional and mental health of caregivers, there are also profession-specific dangers to the mental health worker's personal relationships. As one who works in this field, you will often find yourself on the receiving end of the most secret and intimate parts of the lives of your clients. In return, it is sometimes only therapeutically appropriate to share those parts of yourself that will be beneficial to the client. Self-disclosure can be a powerful tool in building rapport, but it must be used very carefully. If you over-disclose, clients may use it against you, or feel you are wasting their time and money. And they may be right! The therapeutic relationship is *necessarily*

different than a normal relationship. However, the danger is that this pattern of one-way intimacy can carry over into your other relationships (Zur, 2008)! You may begin to interact in a "therapeutic" manner with friends, family, and loved ones. While this approach is very appropriate in the mental health setting where you are plying your trade, it is weird, frustrating, and off-putting for the people who love you.

This brings me to my next point. When you spend many (in some cases *very* many) hours a day interacting in a therapeutic manner with your clients, it can become very difficult to "turn it off" when you come home. You may find yourself using counseling or behavioral modification techniques on your friends and family, or using technical jargon to describe their behavior. Don't do it! In the words of one of my graduate professors: "Don't try this at home, kids!" It is important to remember that your loved ones are not your clients. They need to you to be yourself, share your feelings, and show a full range of human emotion. I have personally found it useful to make a conscious mental shift (use whatever ritual you find useful) before I walk in the door in the evening. As mentioned earlier, this can be a very difficult profession to "leave at work."

Confidentiality, although an essential policy for the well-being of our clients (and for the ethics of our practice), can inadvertently create strain in the lives of mental health workers as well (Zur, 2008). In order to preserve confidentiality, mental health workers are often inclined to not discuss their professional lives with anyone outside the secret world of supervisors and co-workers. This can create a gap between the family and the mental health professional, as they are not aware of the challenges faced in the field, nor the joys and successes. They are essentially blocked out of a large portion of the

worker's life, which can be quite difficult for both the worker, and for the family members and loved ones. In some cases there can even be jealousy that the worker is willing to give so much time and energy to these mysterious clients. Additionally, some mental health professionals will begin to avoid doing activities in the community that may result in running into their clients. This may include avoiding social events, parties, fitness clubs, etc. Some even choose to do their shopping in different communities in order to avoid running into clients when they are not in "professional mode." This has the double-edged effect of not only isolating the mental health worker, but his or her family as well.

Burnout Prevention

All of the previously discussed issues can contribute to burnout and compassion fatigue. So how are they avoided? What strategies and techniques will decrease the risk of burnout and compassion fatigue? In this section, I will outline several tips and strategies that will help you be a healthier, happier, more effective mental health professional. The strategies compiled here are gleaned from professional literature, from the experiences of colleagues, and from my own personal experiences working with troubled children. My intention is to provide a practical guide for those who are new to the field, containing strategies developed by those who have felt the pressures of burnout and the attrition of empathy, and have learned how to deal with them.

First, it is important to know that burnout *is* preventable. The first step is to be aware of the previously mentioned hazards, so that you will be able to recognize when one of them is impacting you negatively. Forewarned is forearmed, as they say. There

are also a number of approaches you can use that will help protect you from burnout, both on the personal and professional fronts.

Many mental health professionals find that it is useful to have therapy of their own. This can give you an adequate space to vent your frustrations, process difficult emotional situations, and talk about things that your family, friends, and co-workers might have a hard time understanding. Having a "shoulder to lean on" will help keep you empathic and sharp, and will mitigate the negative effects of emotional depletion. In addition, the confidentiality of the counseling relationship will allow you to blow off steam in a safe environment, without fear of reprisal from your boss or co-workers!

Speaking of bosses, it is also important to take advantage of the resources your supervisor can provide you. In a recent study, it was shown that perceived supervisory support plays a central role in reducing counselor burnout (Gibson, 2009). It also plays a large role in mitigating the effects of a high workload on feelings of personal accomplishment. Therapists who have a high workload and low perceived supervisory support had lower personal accomplishment scores on the Maslach Burnout Inventory. The bottom line is that a supportive supervisor will go a long way toward decreasing your risk for burnout.

It will decrease your job stress to use a team approach with your supervisor to formulate interventions for particularly difficult cases. It is in your supervisor's best interest that you work effectively and don't become too stressed, and you will find that most of them will use their years of experience to benefit you. As a residential worker, I relied heavily upon the advice and input of my supervisor, as well as that of the clinical staff in my unit. They were able to provide interventions that had been effective for

them, as well as the theoretical orientations to back them up. This team approach made each of us more effective, less stressed out, and feeling more supported in our work. This type of collaboration is invaluable. While it is possible to "tough it out" on your own, your brain by itself will never be as good as several experienced brains put together, and trying to be a "lone wolf" will only leave you susceptible to burnout.

On a similar note, it will actually be of benefit to follow the rules and regulations of your organization as closely as possible. Sometimes rules and regulations may seem silly, or unnecessarily complicated. However, they are put in place to not only protect your clients, but you as well. As a new staff member, I once made the mistake of giving a child a privilege that he had not earned. We were on an activity in the community, and all of the boys I was supervising had earned the privilege to be unsupervised by staff for up to thirty minutes, allowing them some freedom and space that they had earned by good behavior. One boy in the group (I will call him Carl) had not yet earned this privilege, but since he was well behaved and with other responsible boys, I decided it would be fine to let him have some social time rather than forcing him to stay at my side for the activity. This was a big mistake. Carl took the opportunity to escape from the activity (we called this going AWOL). Luckily, Carl was recovered shortly after, unharmed. However, during the time when he was missing, I was panicked. I knew that I had bent the rules to allow Carl to enjoy the activity, and that I was ultimately responsible for his safety. I kicked myself for making such a foolish decision, and doubted my abilities to do this type of work. Back on campus, I got a stern talking to from my supervisor, and a disciplinary letter in my file. This was not a mistake I would make twice. Had I simply followed the rules, I could have saved myself a lot of stress

and heartache. Mistakes like this are pretty common for new (and sometimes even veteran) staff. While it is important to not beat yourself up too much, it is also vitally important that you follow the rules put in place by your organization. It protects your clients, and also protects you from liability and unnecessary stress.

On the personal front, it is a good idea to have some hobbies and activities that are not related to psychology or mental health work (Zur, 2008). Painting, cooking, and joining a soccer league are all things that have helped me to manage stress, although the possibilities are endless. Just find something that you enjoy that will let you forget about work for a while, and remember that you are a human being and not just a professional. Being involved in community activities will also help to mitigate some of the feelings of isolation that often accompany this work.

Do not undervalue the benefits of vacation. Most organizations that work with troubled youth offer decent vacation hours, because they recognize the importance of allowing staff to "recharge their batteries." Take advantage of this! I know that it can sometimes be hard to leave your clients without your support for a week, and sometimes vacation plans can be hard to arrange. However, it is worth the effort. When things are rough, try and take some time away to remember who you are outside of work. This will make it easier to handle the job when you return. Oh, and don't count professional conferences as vacations. That is cheating.

In a recent study, job satisfaction and self-esteem were shown to be good predictors of burnout in the helping professions (Sang Min, Seong Ho, Kissinger, & Ogle, 2010). Counselors who have high self-esteem and good job satisfaction were shown to be more resistant to burnout. This may seem like common sense, but beginning

mental health professionals are often plagued by feelings of inadequacy and inefficacy. It is important to process these feelings with supervisors, peers, and clinical staff in order to prevent the downward spiral that can lead to burnout. Poor self-esteem leads to poor job satisfaction, which contributes to burnout as well. If there are other issues that are preventing you from being satisfied with your work, it is also important to problem solve to see what may be changed to improve your overall satisfaction. A healthy amount of job stress just goes with the territory, but some organizations are better than others. If you find yourself highly unsatisfied, and there is no feasible remedy, it may become necessary to find work with an organization that is a better fit for you.

Making friends outside of work is also important. If all of your friends are mental health workers, you will likely find yourselves talking about work, even when you are trying to have fun. I know that mental health professionals are very interesting folks, but it is also important to broaden your perspectives on people, and maintain a little distance from the work you do every day.

Where this is most important is in being with family. Some of the knowledge you gain as a mental health professional will also be useful in dealing with your family, but it is important to draw a distinct line between your professional life and your family life. As I discussed earlier, it is all too easy to come home in "therapeutic mode" and drive your family to distraction. Having a therapeutic presence works wonders in the mental health setting, but we must remember that this setting is time-limited. In other words, your clients will likely not have time to grow tired of you. Your family, on the other hand, will hopefully be around you for many years, and the therapeutic stance will quickly grow old for them. As a professional, you will be rational, methodical, not

disclosing too much of yourself, avoiding judgment, seeking understanding, not getting upset or losing your cool, and focused on maladaptive behavior. These are all great for the therapeutic relationship, but surprisingly not for personal relationships.

In personal relationships, mutual sharing and vulnerability are important parts of intimacy. Showing a full range of human emotion, including anger, frustration, despair, happiness, love, etc. is not good therapy, but it is vital to your personal relationships. This applies to friends, spouses, and children. Believe it or not, your teenager does not want to hear "I understand that your need for personal freedom and fun motivated you to take the car without permission." Instead, they would rather hear "You took the car without permission?! You are GROUNDED!" What I am saying is: Be a friend, be a lover, be a parent, but don't be a therapist at home. I have been as guilty of this as anyone, and I have found it useful to make a distinct mental shift before I walk in the door at night. I always imagine a childhood hero, Mr. Rogers, walking in the door as he did at the beginning of every episode, and changing his work clothes and shoes into more comfortable attire. I do this in my head before I come home in the evening, changing out of my professional identity and into my personal identity. I then try my best to not think about work until the next day. This may work for you, and it may not. The important point is that you find some way to turn off the therapeutic mode in your personal life.

Which brings me to the next item: balance. All of the previously mentioned dangers and interventions boil down to this. A happy and effective mental health worker is a balanced mental health worker. By this I mean balance in all parts of life. Not always giving, but giving and taking in equal measure --a balance between your needs and those of your clients. Not too involved, not too detached. A balance between work

and family, between work and alone time, between work and every other important part of your life. This is *the* human profession, and it is ironic that we can easily forget that *we* are human in the course of our work. We have needs for love, intimacy, fun, freedom, and all the other normal human needs, but we can easily forget this because the needs of our clients seem so much more *urgent.* If you forget you are human, you will forget what makes you a great mental health worker, which is your essential humanity. So take care of yourself, and you will be better able to care for your clients.

Conclusion

Whoever you are, dear reader, I sincerely hope that this project has been helpful to you. You have chosen a noble and challenging profession. You have willfully chosen a life dedicated to helping others, to changing lives, to fostering growth and healing. You have chosen this over material wealth, over prestige, and over power. What could be more noble?

We have discussed troubled youth, how to help them, and how to take care of yourself as a mental health worker. There are many other books and articles out there that will be informative, but I hope that this brief introduction will be useful to you as you carry out your work "in the trenches". This work is hard, but rewarding in a soul-nurturing way that few other jobs can be. You have chosen this work in order to be important in the lives of suffering children, and to help them get through some of the hardest times in life. For that, you have my eternal respect. Thank you, and keep doing what you do.

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