CHALLENGES ENCOUNTERED BY PRACTITIONERS WORKING IN THE MENTAL HEALTH FIELD

Stephanie Mendoza Linsao
B.A., University of California, San Diego, 2000

PROJECT

Submitted in partial satisfaction of the requirements for the degree of

MASTER OF SOCIAL WORK

at

CALIFORNIA STATE UNIVERSITY, SACRAMENTO

SPRING
2010
CHALLENGES ENCOUNTERED BY PRACTITIONERS WORKING IN THE MENTAL HEALTH FIELD

A Project

by

Stephanie Mendoza Linsao

Approved by:

__________________________________, Committee Chair
Andrew Bein, PhD, LCSW

__________________________________
Date
Student:  Stephanie Mendoza Linsao

I certify that this student has met the requirements for format contained in the University format manual, and that this project is suitable for shelving in the Library and credit is to be awarded for the Project.

_____________________________, Graduate Coordinator
Teiahsha Bankhead, PhD, MSW

_____________________________, Date

Division of Social Work
Abstract

of

CHALLENGES ENCOUNTERED BY PRACTITIONERS WORKING IN THE MENTAL HEALTH FIELD

by

Stephanie Mendoza Linsao

Practitioners working in the mental health field encounter many challenges when providing services to their clients. These challenges typically involve issues that clients deal with regularly or issues that mental health practitioners experience when working with this population. This study explores the experiences of mental health practitioners and challenges encountered when working with youth. A qualitative study was conducted using ethnographic interviews. Eleven participants were interviewed for this study, seven females and four males, who had a college degree and at least five years of experience working in the mental health field. Common challenges practitioners encountered working with youth are addressed. These challenges include trust, motivation, family involvement, resources, and culture. Practitioners also discuss practical ways to provide effective treatment. The implications for social work practice and policy relative to this study are included.

_______________________, Committee Chair
Andrew Bein, PhD, LCSW

_______________________
Date

iv
DEDICATION

I dedicate this project to Inda and Uncle Paul, my two angels who watched over me throughout this entire process. I love and miss you so much but know that you are always with me.
ACKNOWLEDGMENTS

I would like to thank God for His love and guidance, and for giving me the strength and determination to accomplish this project.

I would like to thank my mom and dad for all of their love, support and encouragement, and for always believing in me no matter what. Everything you have done in your lives has made me who I am today. Thank you for always teaching me to work hard and that I can accomplish anything I put my mind to.

I would like to thank my sister Libby, brother Don, nephew Donaldo, and niece Athena for their love and support, and for encouraging and motivating me to get my work done everyday.

I would like to thank my sister Cynthia and brother David for their love and support. Cynthia, thank you for always being there I really appreciate all of your help with everything you do. David, your strength and courage inspire me everyday, and your will to live encourages me to always do my best.

I would like to thank my TAP family for always being so encouraging and supportive, and teaching me what it truly means to work as a team. Thank you for helping me complete this project, I am extremely grateful.

I would like to thank my friend Balbindra for her time and love for research and for helping me read and edit my project.

I would like to thank my project advisor Professor Bein for taking me on as a student and guiding me throughout this process. I truly appreciate the time you took to meet with me and make sure I stayed on task.

vi
## TABLE OF CONTENTS

Page

Dedication ..................................................................................................................... v
Acknowledgments ....................................................................................................... vi

Chapter

1. THE PROBLEM ..................................................................................................... 1
   Introduction ....................................................................................................... 1
   Background of the Problem .............................................................................. 2
   Statement of the Research Problem ................................................................. 3
   Purpose of the Study ......................................................................................... 3
   Theoretical Framework ..................................................................................... 4
   Ecosystems Perspective .................................................................................... 4
   Application of the Ecosystems Perspective ...................................................... 5
   Definition of Terms........................................................................................... 7
   Assumptions ...................................................................................................... 8
   Justification ....................................................................................................... 8
   Limitations ........................................................................................................ 9

2. LITERATURE REVIEW ..................................................................................... 10
   Introduction ..................................................................................................... 10
   Stigma and Mental Illness ............................................................................... 10
   Culture and Mental Illness .............................................................................. 14
Chapter 1
THE PROBLEM

Introduction

Practitioners working in the mental health field often encounter many challenges when providing services. These challenges typically involve issues that individuals with mental illness deal with on a regular basis or issues that practitioners deal with themselves when working with this population.

In my experience working in the mental health field for almost ten years, I have encountered numerous challenges when working with my clients. Although each challenge was experienced differently with each client, these challenges often included problems around stigma, culture, countertransference, and burnout.

At my current place of employment, I worked with a client who was Filipino and diagnosed with schizophrenia. It was very challenging working with this client due to the symptoms of his mental illness, but even more so because of his cultural beliefs. His culture did not believe in mental illness, and the client and his family were often resistant to services even though they sought help. The client and his family had a difficult time accepting his mental health diagnosis due to the stigma and shame associated with it and struggled with accepting the services that were provided.

When working with this client, I often experienced countertransference due to the client’s situation and the lack of progress he was making over time. I often had feelings of frustration toward the client because I felt as if I was not helping him and did not know how to move forward. I began to question why I was working with this client given that I
did not feel like I could help. Working with this client was very challenging, and I often found myself to be emotionally drained and burned out.

Because of the challenges I encountered when working in the mental health field, I am inspired to learn more about how other practitioners face and approach difficult situations when providing treatment. This study explores the experiences of mental health practitioners and the challenges they encounter when working with youth with mental illness.

**Background of the Problem**

According to Overton and Medina (2008), “People suffering from mental illness and other mental problems are among the most stigmatized, discriminated against, marginalized, disadvantaged and vulnerable members of our society” (p. 143). They are faced with many challenges and often forgo services due to the hardship they experience because of the stigma and shame associated with mental illness. Tak-fai Lau and Cheung (1999) reported, “Nothing is more essential to the well-being of [people with mental illness] than acceptance and support given by the general public” (p. 431). It is important that practitioners take this into consideration when providing services and assist the client with normalizing their mental illness and value what they have to contribute to the world.

Clients with different cultural backgrounds often experience difficulties with receiving culturally competent services. Sue et al. (2009) reported, “Mental health services were not accessible, available, or effectively delivered to these populations, [and] compared to white Americans, ethnic minority groups were found to underutilize services or prematurely terminate treatment” (p. 526). If clients receive services where
they feel they are being judged or are misunderstood due to their culture they may choose to go without services. It is important that practitioners take a person’s culture into consideration when providing services in order to provide effective treatment. “In order to provide culturally competent care, knowledge of cultural beliefs, values and practices is necessary otherwise health practitioners can easily fall prey to errors of diagnosis, inappropriate management and poor compliance” (Bhui, Warfa, Edonya, McKenzie & Bhurgra, 2007, p.1).

Statement of the Research Problem

Although there is a great deal of information available on treatment approaches and the application of different theories to certain situations, there is very little information that reviews practical ways of providing services. This study will explore the nature of challenges for practitioners working with youth in terms of the dynamics of the youth-practitioner relationship and in regard to the personal and professional struggles of practitioners seeking to deliver effective services.

Purpose of the Study

The purpose of this research study is to examine the different challenges practitioners encountered when working with youth in the mental health field. The knowledge and understanding gained from this study will benefit practitioners, individuals with mental illness and their families, as well as mental health agencies. Hopefully, this study can help practitioners better understand how the client is affected on the micro, meso, and macro levels, and be able to provide them with effective treatment.
**Theoretical Framework**

This research study utilizes the ecosystems perspective. The researcher will explain the ecosystems perspective followed by a description of how this theory can be applied to this research.

**Ecosystems Perspective**

The ecosystems perspective emphasizes the importance of the relationship between a person and their environment. This approach defines the behaviors and strengths of the individual and identifies the support system that surrounds them. The ecosystems perspective focuses on how people and their environment fit together and adapt to each other, as well as identifies and assesses what is actually occurring between the systems and why. A key component of the ecosystems perspective is that it “strive[s] to understand the complex interactions between the client and other social systems” (Compton, Galaway & Cournoyer, 2005, p. 23).

The ecosystems perspective identifies the environment as “a complex environment-behavior-person whole, consisting of a continuous, interlocking process of relationships, not arbitrary dualisms” (Compton, Galaway & Cournoyer, 2005, p. 39). The mutual interdependence among person, behavior, and environment is emphasized.

The environment is described as four different layers that surround each person. These include the (1) situational, (2) micro, (3) meso, and (4) macro levels. The situational layer is the part of the immediate environment perceived by a person at any given moment. The micro layer includes the person’s experience with his or her family, at school or work, or during leisure time. “The microenvironment is largely specific to
the individual, in that no one else experiences the same environment in the same way” (Compton, Galaway & Cournoyer, 2005, p. 54). The meso layer includes groups, organizations and institutions that people encounter in their daily lives, such as school, work, religion, recreation, and community resources. The meso layer influences and determines the character and functioning of the microenvironment. The macro layer includes the physical, social, cultural, economic, and political structure of the larger society, including technology, language, housing, laws, customs, and regulations. Each layer influences the person-in-environment and affects their potential by providing or limiting access to resources and opportunities. The ecosystems perspective helps social workers to consider new change strategies for old problems, and to identify different points for intervention. By thinking systematically, social workers are able to collaborate creatively with clients in identifying a range of change targets and strategies as part of the problem-solving process.

Application of the Ecosystems Perspective

When working with individuals with a mental illness, it can be beneficial to apply the ecosystems perspective in order to create change. When applying this theory to practice, it is important to consider the client’s situational layer. Each person is an individual and often has their own unique perception of the immediate environment surrounding them and what is occurring in that environment. It is important that the practitioner try to understand this layer when working with a client in order to gain a better perspective of where they coming from.
The micro layer is very important because the client typically interacts with the members of this layer on a regular basis. The members of this layer are often very influential to the client and impact the way a client might respond to services or interventions. The members of this layer and their interactions with the client helps form their outlook in life and how they respond to people and situations. When practitioners are working with the client, it is important for practitioners to involve the members of this layer in the treatment plan in order to successfully make change happen.

When looking at the meso layer surrounding a client, it is important to recognize how the client and the members of the micro layer are influenced by the meso layer. For example, if the client is a minor and attends school, the social worker would evaluate how the client feels about going to school, how the client feels they are doing in school academically and socially, their relationship with the teacher and other school staff, the relationship the client has with peers, as well as the perceptions of the client’s parents and other family members and how they think the client is doing and how it impacts them and their relationship with the client. There are so many other aspects that could be taken into consideration depending on the client’s situation and what they perceive as needing to be changed. The impact of the meso layer is crucial and the social worker must explore how the client, as well as their family is influenced by it.

Lastly, the macro level must be evaluated in order to see how the client has been impacted by it. It is important to evaluate the client’s physical, social, cultural, economic, and political structure of the larger society, and understand the role each plays in the client’s life. For example, it is important to recognize if a client is homeless and
figure out how that affects the client and whether they perceive it as a problem. If the client does not perceive homelessness as a problem and it is not causing harm to them or others, the focus for help should be concentrated elsewhere. It is important for social workers to work collaboratively with their clients and help them identify problems and strategies as part of the problem-solving process.

**Definition of Terms**

**Mental Illness** is a condition that affects a person’s brain and causes difficulties in his/her normal cognitive, emotional, or behavioral functioning.

**Stigma** refers to “any condition, attribute, trait, or behavior that symbolically identifies[s] the bearer as culturally unacceptable or inferior with consequent feelings of shame, guilt and disgrace” (El-Badri & Mellsop, 2007, p. 195).

**Culture** is a person’s beliefs, traditions and way of life which helps shape the way they perceive and interpret situations and events.

**Cultural Competence** refers to “the behaviors, knowledge, skills, attitudes, and structures that are required to work effectively across groups from diverse backgrounds. It encompasses a set of congruent behaviors, attitudes, and policies that comprise a system by which an agency or practice is enabled to work effectively in cross-cultural situations” (Whealin & Ruzek, 2008, p. 320).

**Countertransference** is defined as “all the reactions a clinician has toward a patient, regardless of their source” (Satir, Thompson-Brenner, Boisseau, & Crisafulli, 2009, p. 511).
Burnout is defined as “a negative psychological experience that is a reaction of workers to job-related stress. Burnout refers to a cluster of physical, emotional, and interactional symptoms, including emotional exhaustion, a sense of lacking personal accomplishment, and depersonalization of clients” (Acker, 1999, p. 113).

Professional Dissonance is “a feeling of discomfort arising from the conflict between professional values and job tasks” (Taylor, 2007, p. 89).

Assumptions

Assumptions that need to be considered in this study include: 1) practitioners working in the mental health field encounter challenges; 2) individuals with mental illness experience stigma; 3) people from different cultures have different beliefs regarding mental illness; 4) practitioners experience countertransference; and 5) practitioners experience burnout.

Justification

The information found in this study will benefit the social work profession by helping to identify challenges practitioners encounter when working in the mental health field. This study can help practitioners recognize possible challenges they might encounter when working with clients, and in particular youth with a mental illness and encourage them to utilize the treatment approaches the study participants believed were beneficial to them. This study can help remind practitioners to be more mindful of countertransference and encourage them to use countertransference positively as a tool to teach clients new skills. This study can also help clients learn new self-care strategies to avoid burnout.
Limitations

The researcher will be interviewing eleven mental health practitioners to explore challenges they encounter when working in the mental health field. All study participants work for the same agency which is located in one specific geographical location.
Chapter 2

LITERATURE REVIEW

Introduction

This literature review will be organized in four sections. The first section will provide a history regarding stigma and mental illness and the effects it has on the individuals who have a mental illness. The second section will discuss culture and mental illness and why it is important to take culture into consideration when trying to provide mental health services. The third section will examine the role of countertransference and how it affects the client, the practitioner, and their therapeutic relationship. The fourth section will discuss burnout, the factors that contribute to it, and the effect it has on workers.

Stigma and Mental Illness

“People suffering from mental illness and other mental problems are among the most stigmatized, discriminated against, marginalized, disadvantaged and vulnerable members of our society” (Overton & Medina, 2008, p. 143). People with mental illness are faced with many challenges and experience hardship due to the stigma and shame associated with it.

People with mental illness are affected by stigma on many levels and are presented with different challenges in each one. People with mental illness often struggle with their social identity and how they are perceived in society. Social identity is socially constructed and usually gives society justification to label people who are seen as different. Societies, or large groups within a society, evaluate people to determine
whether or not they fit the social norms. If it is determined that a person does not fit the social norms, they are considered to be outcasts. Outcast-oriented labels causes people with mental illness to feel bad about themselves and often creates self-stigma.

Self-stigma is an internal assessment where people judge themselves and decide whether they are good enough to meet social standards. Overton and Medina (2008) asserted that “this judgment decreases self-esteem as a person tells him- or herself that he or she does not fit in or is not good enough to live up to the expectations that others impose on a person and his or her environment” (p. 144). When a person does not feel like they fit in or live up to what society deems as acceptable, they often have feelings of inferiority, shame and self hate. These negative feelings can cause a person to have self doubt and to feel as if they are incapable of holding a job or living independently.

People with mental illness also encounter structural stigma. Structural stigma “is an external evaluation of a person that is based on societal norms” (Overton & Medina, 2008, p.144). Structural stigma works as a system and creates barriers for people with a mental illness. As reported by Overton and Medina (2008), “One third of all states restrict the rights of people with a mental health diagnosis to hold elective offices or sit on juries, and one half of all states restrict child custody rights of someone with a mental health diagnosis” (p.144). These stigmas create barriers for people with a mental illness and assume that they are not competent enough or able to do what “normal” people can do. Structural stigma limits people with a mental health diagnosis and affects the assessment regarding whether they are capable or not and creates unequal opportunities that might cause them to feel less worthy.
People diagnosed with mental illness face many challenges in recovery and integrating back into society. Norman, Sorrentino, Windell and Manchanda (2008) asserted that “although the intrinsic symptoms of such disorders can contribute to these difficulties, they are greatly compounded by the social stigma associated with mental illness” (p. 848). The media plays a large role in social stigma and contributes to the portrayal of people with mental illness as being scary and violent. El-Badri and Mellsop (2007) reported, “Beliefs that those with mental illness are dangerous, hard to talk to and unpredictable are prevalent among the public” (p. 198). In a study that reviewed discriminatory attitudes toward people with intellectual disability versus mental health difficulty, Tak-fai Lau and Cheung (1999) reported that “the public held a more negative perception and attitude towards people with mental health difficulty than towards people with intellectually [sic] disability” (p. 439).

Stigma experienced by people with mental illness greatly affects all aspects of their lives and can often hinder them from getting a job, housing, and even treatment. Employers often assume that people with a mental health diagnosis are less dependable, unpredictable, and could be a danger to others. Due to this stigma, employers repeatedly dismiss applicants that disclose they have a mental illness instead of looking at their education, experience, ability or qualifications for a job. El-Badri and Mellsop (2007) reported that “twenty-three percent [of the individuals in their study who have a mental illness] reported they had been turned down for a job [and] fifty-eight percent avoided indicating on written applications for jobs . . . that they had a mental illness for the fear that the information would be used against them” (p.196).
When individuals with mental illness are unable to obtain employment, they often have to rely on Supplementary Security Income (SSI) as their main source of income. The amount individuals receive from SSI is very small and does not allow them to live a good quality of life. If individuals with mental illness are living independently, they typically only have enough money to pay for basic necessities and do not have enough money to participate in leisure activities. Many are left with no choice but to stay home and remain isolated due to their financial situation.

When looking for housing, people with a mental illness are often overlooked or rejected. Landlords typically look for renters that are going to be responsible, pay on time and take care of the property. Landlords often assume that people with a mental illness are unable to do this, and are hesitant to lease to someone that they see as unfit to take care of themselves let alone an apartment. Overton and Medina (2008) noted, “[Landlords] are less likely to lease apartments to someone who has been labeled mentally ill” (p. 146).

Due to the stigma associated with mental illness, people who have been diagnosed often avoid seeking services. El-Badri and Mellsop (2007) reported that “stigma can cause stress and create barriers to seeking psychiatric treatment . . . for fear of further stigmatization” (p.199). People with mental illness not only have a fear of stigmatization by the public but by professionals as well. Kirby (2008) reported, “Some of the people most able to help those with mental health problems appear to hold negative attitudes toward them” (p. 1321). This stigma is often caused by a professional’s lack of knowledge and past negative experiences.
In rural areas, seeking treatment can be very difficult due to the lack of availability and accessibility of services. Due to the nature of the community, it is often challenging to keep things confidential. This can cause greater fear that others will find out about their mental illness and cause them to become outcasts. Boyd et al. (2008) reported that “rural adolescents who received mental health services within the context of a rural community . . . indicated that rural gossip networks and social visibility within rural communities compounded their experiences of stigma and social exclusion and . . . affected their on-going utilization of the mental health service” (p. 3). It is important that people with mental illness are able to utilize services confidentially in order to avoid being stigmatized and get the help they deserve. Tak-fai Lau and Cheung (1999) reported, “Nothing is more essential to the well-being of [people with mental illness] than acceptance and support given by the general public” (p. 431).

Culture and Mental Illness

Culture influences many facets of a person’s life, including their psychological well-being, and must be taken into consideration when discussing mental illness. Culture is an integral part of a person. It is their beliefs, traditions and way of life which helps shape the way they perceive and interpret situations and events. If a person’s culture is not taken into consideration when trying to provide them with mental health services, the help being given might not be appropriate and can cause the person to underutilize services or forego them altogether.

Providing culturally competent services to members of ethnic minority groups has been discussed for over forty years and continues to be an important topic of discussion.
in the mental health field. Sue, Zane, Hall, and Berger (2009) noted, “Multiculturalism, diversity, and cultural competency are currently hot and important topics for mental health professionals” (p. 526). Due to the growing diversity of the U.S. population, there is a desire for culturally competent services to meet the different needs of multicultural populations. Many studies have shown that there is a lack of culturally competent services being provided to ethnic minority groups leading to enhanced resistance to services. Sue et al. (2009) reported, “Mental health services were not accessible, available, or effectively delivered to these populations, [and] compared to white Americans, ethnic minority groups were found to underutilize services or prematurely terminate treatment” (p. 526).

Kung (2001) reported, “Studies have indicated that cultural differences exist in the conceptualization of mental disorders by different ethnic groups” (p. 2). Some ethnic groups view having a mental illness negatively and are often resistant to services due to the stigma and shame associated with mental illness as well as lack of cultural sensitivity by service providers. In a study investigating the use of services for Vietnamese with mental illness, Phan (2000) reported, “Vietnamese-speaking patients sought help from mental health services only when their behavior was quite extreme . . . such procrastination in help-seeking was a result of their fear of being stigmatized” (p. 412). Due to this fear of stigma and the belief that personal and family problems should remain private, underutilization of mental health services among Vietnamese and other Southeast Asian cultures is common. According to Phan’s (2000) study, some of the major concerns that were encountered when seeking mental health services were: language and
ethnicity matches between therapists and clients, concerns with medication and their effects on the metaphysical balance, difficulty in trusting service providers, communication, and fear of physical and psychiatric examination (para. 418).

“In order to provide culturally competent care, knowledge of cultural beliefs, values and practices is necessary otherwise health practitioners can easily fall prey to errors of diagnosis, inappropriate management and poor compliance” (Bhui, Warfa, Edonya, McKenzie & Bhurgra, 2007, p.1). It is important to recognize that within the culture of many minority groups, the family is of central importance in the mentally ill patient’s life. For example, some Asian American cultures believe the family is supposed to take care of each other when someone is ill, and seeking external help might suggest that the family is inadequate in taking care of its own. Kung (2001) noted, “To a culture that cares so much about the ‘loss of face’, this may aggregate families’ tendency to deny the illness or carefully guard against its disclosure to people outside the family, causing greater burden and isolation” (p. 2). Due to this belief of inadequacy when seeking help, it is important for mental health service providers to acknowledge and take these beliefs into consideration when working with ethnic minority groups.

In the African American culture, studies have shown that African American women have a high prevalence of mental illness but only a limited number of them seek or accept help from mental health service providers. Because of their social, cultural, and economic status in the United States, African Americans are at higher risk for mental illness. Copeland and Butler (2007) reported, “They are more likely to be exposed to mental disorders, less likely to seek treatment, more likely to use hospital emergency
rooms when seeking treatment and more likely than Whites to receive inpatient care” (p. 36).

When working with African American women, it is important to utilize this information and try to understand the reasons behind their being underserved. According to Copeland and Butler (2007), “The lower use of mental health treatment services by African American women is attributable to high cost and lack of insurance coverage, a resistance to inequitable treatment services, stigma associated with obtaining mental health services, attending a clinic dominated by White therapists and clients, perceived racial discrimination, cultural beliefs, and faulty expectations of treatment intervention and outcomes” (p. 40).

It is fundamental for therapists to assess the cultural backgrounds, health beliefs, values, and informal support systems of African American women, as well as explore their experience with discrimination and socioeconomic differences. Therapists should have a good understanding of these different areas and be able to portray themselves in a genuine, honest, trustworthy, empathetic, and non-judgmental way in order to engage African American women in the therapeutic process. Copeland and Butler (2007) reported, “Both the interpersonal and intrapersonal dynamics that contribute to the mental health status of African American women must be understood for therapeutic engagement” (p. 47).

When offering mental health services to a diverse population, it is imperative to acknowledge the important role culture plays in their lives and provide culturally competent services. According to Whealin and Ruzek (2008), “Mental health practices
that lack cultural competence prevent diverse clients from receiving the care they
deserve” (p. 326). If clients receive poor quality care, they may not return for services
and may suffer unnecessarily from an untreated disorder.

Sue et al. (2009) reported, “Culturally competent care has been defined as a
system that acknowledges the importance and incorporation of culture, assessment of
cross-cultural relations, vigilance toward the dynamics that result from cultural
differences, expansion of cultural knowledge, and adaptation of interventions to meet
culturally unique needs” (p. 528). In order to provide culturally competent services, it is
important to look at both individual and organizational levels. At the individual level, a
culturally competent person should be able to acknowledge, accept, and value the cultural
differences of others, as well as have the knowledge and skill to appreciate similarities
and differences between culturally diverse groups. At the organizational level, “cultural
competence . . . must be embedded in the infrastructure and ethos of any service
provider” (Bhui et al., 2007, p. 8). The organization should actively plan and implement
services that are developed purposely for the needs of their clients in order to provide
culturally competent care.

Countertransference

Working in the mental health field can be a very challenging and difficult place to
work. Many people have their own reasons for wanting to work in this field but some
people feel compelled to do so because they have been affected by mental illness in some
way. They often want to help others who have experienced similar things because they
can empathize with what their clients are going through and truly feel that their personal experiences provide a base of wisdom for assisting their clients.

People who have a good understanding of their life experience and how it affects them emotionally and mentally can be very helpful in working with this population. Their experience can be valuable in helping clients understand the challenges they encounter and with what they are going through. This is a very valid reason for wanting to work in this field. When a person is able to truly empathize with a client, a strong bond can be formed in the therapeutic relationship and assist the client in making significant progress toward their goals.

Although a person’s experience can be helpful, there is a need for caution. In fact, some people might argue that having prior experience in what a client is experiencing can be more challenging than helpful, and can do harm to the client, the practitioner, and the therapeutic relationship. Individuals often have concerns about countertransference which can be defined as “all the reactions a clinician has toward a patient, regardless of their source” (Satir, Thompson-Brenner, Boisseau, & Crisafulli, 2009, p. 511). When a clinician’s personal experience is similar to a client’s, it might bring up unexpected negative emotions while working with them. It can be challenging to continuously experience those negative emotions and separate past experiences with what is currently being felt and distinguish the cause of those feelings. Some clinicians might unintentionally retaliate toward the client and be completely unaware of what they are doing. This reaction can be very detrimental to the therapeutic relationship and cause conflict between the therapist and the client.
If clinicians have to deal with these feelings on a regular basis, it can be emotionally draining and consequently affect the way they conduct therapy with their client. According to Horowitz (2002), “There is a serious risk that the reawakening of painful recollections may lead to emotional distancing, a protective retreat from intolerable feelings where therapist and client engage in silent collusions” (p. 236). The therapists’ response to the way they are feeling can cause a huge void in the client-therapist relationship and really hinder the client from building trust and allowing the therapist to help them with their problems.

It is important to note that countertransference, like transference, is everywhere and unavoidable and generally unproblematic (Clarkson & Nuttall, 2000, p. 363). As long as therapists are aware of how they are feeling and are able to control their emotional responses toward their client while they are conducting therapy, they should be able to build good rapport with the client and a good therapeutic relationship. Therefore, it is important for therapists to acknowledge and address their problems with countertransference so it does not negatively influence the therapeutic process and treatment outcomes.

People with schizophrenia deal with a lot of loss in their lives when they are first diagnosed. Over time losses mount as people face what they are not going to be able to do because of their illness. It can be very difficult for therapists to listen to the stories of clients diagnosed with schizophrenia and how their illness has affected them in such a negative way. It is a therapist’s job to listen to these stories and to help them process and problem-solve. This can cause therapists to experience their own memories of grief and
loss and cause them to react negatively toward the client. Therapists might feel inclined to withdraw emotionally or avoid certain topics a client may want to discuss during a therapy session.

Schizophrenia can be a very debilitating illness and clinicians can often work with clients with schizophrenia over a long period of time. Horowitz (2002) noted, “Practitioners regularly enter into long-term work spanning many years, sometimes without easily discerning signs of improvement” (p. 235). Due to the lack of progress seen at times when working with clients with schizophrenia, it can be very frustrating for clinicians because they might feel like they are not helping the client at all. When a therapist feels like they are unable to help a client, they are unable to validate the work they are doing and might begin to doubt their ability as a therapist. These feelings of doubt can cause the therapist to feel strong negative emotions toward the client, causing countertransference. Therapists like to help others and often validate their work through a client’s progress, but working with a client with schizophrenia can cause them to feel incompetent.

In many instances, due to the severity of the client’s illness, countertransference is going to be experienced when working with a client with schizophrenia. During the experience of countertransference, it is important for the therapist to recognize what they are feeling and address it at a later time during supervision. With supervision, therapists can learn to be more aware of how they are affected by their clients and be more empathetic instead of taking things personally. It is important for therapists to explore and understand why they are experiencing certain feelings so they can better handle
similar situations that arise. Horowitz (2002) stated, “Empathy then becomes a way of seeing, understanding and ultimately of connecting with the private world of persons who have lost their sense of stability and rootedness” (p. 241).

If a clinician is unaware of his or her countertransference, it can lead to an unhealthy therapeutic relationship and do serious harm to the client as well as to themselves. When practitioners are unable to recognize countertransference or acknowledge the feelings they are experiencing, it can cause more stress and strain on the therapeutic relationship. If the clinician is experiencing negative feelings toward the client, it may cause them to retaliate toward the client for making them feel badly.

Once the clinician reacts negatively toward the client, the damage is done and the clinician cannot undo the harm that they might have caused to the client. The clinician then has to worry about rebuilding trust with the client once again and must deal with the effects they have caused from their own countertransference reactions. If a clinician reacts negatively toward a client, it can cause the client to be more guarded and less trusting, and keep them from sharing with the clinician or even working with the clinician at all.

According to Clarkson and Nuttall (2000), “The countertransference that is likely to cause trouble is the unconscious one on the practitioner’s side” (p. 363). It is important to acknowledge that countertransference exists and that the clinician and the client are both affected by it. Even if countertransference can be negative at times, it is typically when a clinician is unaware of it, chronic and repetitive, detrimental to the therapeutic relationship, and persistently distressing to the therapist. So, in order for
countertransference to be positive and contributing to the therapeutic relationship, the clinician must be aware and open to acknowledging the countertransference that is occurring, address the countertransference so it does not become chronic and repetitive or damaging to the therapeutic relationship, and does not become stressful to them.

*Burnout*

Working as a professional in the mental health field can be very fulfilling as well as stressful. Acker (1999) reported, “The direct contact with clients in clinical practice and the continual responsibilities of meeting their emotional as well as their physical needs offer both intrinsic satisfaction and stresses for the providers of the services” (p. 112). In a profession that is client-centered, it is not uncommon to have emotionally drained and chronically frustrated workers. Since these workers encounter challenges on a regular basis, it is not surprising that many of them might experience burnout.

According to Acker (1999), “Burnout is defined as a negative psychological experience that is a reaction of workers to job related stress” (p. 113). Workers who feel burned out and frustrated with their jobs are more likely to have higher turnover and be absent from work. Kim and Stoner (2008) reported, “Social worker turnover is a serious problem for social work administration because [it] negatively affects the quality, consistency, and stability of client services” (p. 6). Worker turnover can also cause psychological distress in remaining staff members as well as new inexperienced workers who have to fill those positions. These conditions could lead to client mistrust of the system and financial problems for the organization.
Burnout can be attributed to several factors however role stress, job satisfaction, social support, and professional dissonance seem to noticeably affect worker burnout when working in human services. According to Kim and Stoner (2008), “Comprehensive reviews of the burnout literature have consistently suggested that social workers are more likely to feel burned out when they perceive higher levels of role-related stress, which is characterized by a workers’ high role conflict, role ambiguity, and role overload” (p. 8). Since role-related stress is directly related to emotional exhaustion, a worker who is experiencing a high level of emotional exhaustion is also more likely to have a depersonalized attitude toward his or her clients and lack of personal accomplishment at work.

“Role ambiguity is the perceived dearth of important job-related information or lack of clarity at work” (Rubino, Luksyte, Perry, & Volpone, 2009, p. 291). Because uncertain situations are innately stressful, role ambiguity often interferes with workers’ capacity to accomplish their objectives at work. Workers must put forth additional time, energy, and effort into looking for information they are unsure about which causes their energy level to diminish. Workers who are unsure about their roles at work are also likely to expend valuable resources on information-seeking before they even begin the task. Eventually, all of the worker’s resources will be depleted and cause them to be emotionally exhausted. If an employee continually experiences emotional exhaustion and does not feel like they are succeeding at their jobs, they are likely to experience negative feelings toward the workplace for their wasted efforts and even feel like a failure due to their lack of accomplishment.
A person’s job satisfaction plays a significant role in decreasing employee burnout. According to Acker (1999), “The work-related satisfaction of helping people, achieving change and improvement, and promoting their growth has important implications for social workers’ behaviors at work, their desire to continue in their work, and their involvement in the job and with their clients” (p. 112). If a person’s job is unfulfilling or not the right fit, it can provoke emotional exhaustion because they are doing a job that poorly matches their personal abilities, values, or goals. A worker might put forth more time, energy, and effort into trying to prove that they actually fit the job or in performing tasks that do not come naturally. Furthermore, if a worker is doing a task that is not intellectually stimulating or intrinsically satisfying it might cause them to feel more exhausted than if they were genuinely interested in their work.

A poor fit between a person and her job can cause the employee to feel unhappy and ultimately leave her dissatisfied in a job found to be uninteresting. When a job is not suitable to a person’s interest or values, it can often lead to a negative attitude. According to Rubino et al. (2009), “When people must perform duties every day that are not compatible with their values or interests, they likely become dissatisfied and cynical about the importance of their effort and their job... [and] are likely to become increasingly frustrated with the way they find themselves spending each day” (p. 291).

This problem of fit also affects a worker’s professional efficacy. When a person is uninterested in the work they are doing, it is less likely that they will make effort towards becoming an expert in it. This can cause a worker to feel inadequate and unproductive when doing the job. A worker might struggle with how to accomplish
goals or take longer to produce results because he or she has not tried to learn how to do
the job more efficiently or effectively due to lack of interest.

Social support plays a large role in diminishing stress and negative attitudes in the
workplace. Although social support can generally be defined as the supportive
interactions or exchanges between people in both formal and informal relationships, the
definition is different when applied in the workplace. Kim and Stoner (2008) reported,
“In the context of job settings, social support has been found to be a working condition
that reduces the negative effects of job-related stress” (p. 9).

When working in a stressful environment, it is important that workers feel they
are being supported by their co-workers, supervisor, and the organization they are
working for in order to be productive. In a study done by Gibson, Grey, and Hastings
(2009), they noted that therapists who worked with children with autism showed that
perceived supervisor support played a central role in the prediction of reduced therapist
burnout. Gibson et al. (2009) reported, “High levels of perceived supervisor support
were associated with reduced emotional exhaustion, reduced depersonalization, increased
personal accomplishment, and increased perceived therapeutic self-efficacy” (p. 1029).

When working with clients with severe mental illness, it can be very emotionally
demanding and slow to show progress toward accomplishing goals. Because of these
factors, it can be very challenging to work with this population without feeling burned
out or ineffective, especially when working with clients with more chronic and complex
problems. In an effort to prevent burnout and employee turnover, it is important that
people who work with clients with severe mental illness have strong social support in the
workplace and a supportive working environment to maintain their attachment to the organization. Acker (1999) noted, “It is important that mental health organizations find solutions to the problems of job-related stress. If they do not, social workers who work with clients with severe mental illness may become burdened and exhausted emotionally and show other symptoms of burnout – a serious problem for these social workers, their families, their clients, and the quality of their services” (p. 117).

According to Taylor (2007), “Professional dissonance is . . . defined as a feeling of discomfort arising from the conflict between professional values and job tasks” (p. 89). Social workers are often presented with challenges when helping their clients but also have to consider the effects their actions might have on others and society in general. Social workers encounter situations where they are required to make decisions that the client does not like because it impedes their progress. However, these decisions may be inevitable whether the social worker is comfortable with them or not. This conflict and decision-making process can be emotionally exhausting and eventually lead to burnout if one is not aware of their professional dissonance and does not process why they are feeling that way.

It is important to understand how professional dissonance applies to clinical practice and to explore how clinicians make use of dissonance resolution strategies in order to alleviate their discomfort. For example, when a clinician feels dissonant about having to hospitalize their “favorite” client they should process those feelings of dissonance in order to reduce them. Taylor (2007) reported, “There are four ways in which dissonance can be reduced: (1) by removing the dissonant cognition: “I had no
choice”; (2) by adding new consonant cognitions: “I’m helping her”; (3) by reducing the importance of dissonant cognitions: “She doesn’t really mind being in the hospital”; and (4) by increasing the importance of consonant cognitions: “Her safety is the most important thing” (p. 97). Professional dissonance is experienced by human service workers in a variety of workplaces, and it is important to address the discomfort they feel and apply dissonance resolution strategies no matter where they work.

Although work has never been easy for human service workers, it became more difficult after welfare reform took place in 1996. According to Abramovitz (2005), “Welfare reform has placed the lives of clients, the jobs of social workers, and the mission of agencies in jeopardy” (p. 175). Welfare reform caused agencies to shift a large amount of staffs’ time and resources from social services to managing the impact of welfare on the lives of clients and the mission of agencies. Abramovitz (2005) reported that “as a result, workers had less time to provide services and faced an intensification of dilemmas resulting from less control of their work, mounting ethical conflicts, and burnout” (p. 177).

Since welfare reform was established, many agencies have been presented with new challenges and have been affected in a negative way. Agencies are conflicted about the type of services they are providing and what they feel they should really be working on with clients. Abramovitz (2005) showed that “seventy-five percent of the agencies reported that workers spent more time helping clients understand new and typically unclear welfare rules” instead of addressing the actual problem at hand (p. 178). Due to the professional dissonance these workers experience, it is important for them to
acknowledge and process those feelings and apply dissonance resolution strategies in order to help prevent burnout.

Summary

In this chapter, the literature relevant to this project was reviewed. Some of the topics discussed in this chapter included history regarding stigma and mental illness, the importance of considering culture when addressing mental illness, the effects of countertransference on the client, practitioner and their therapeutic relationship, and the factors that contribute to burnout and how burnout affects workers. In the next chapter, the methods used to conduct the study are described.
Chapter 3

METHODOLOGY

Introduction

This chapter will describe the research design and methodology used for this research study. The sampling procedures, data collection procedures, instrumentation used to collect the data, and data analysis approaches will be discussed. This chapter will also describe the steps taken to protect human subjects.

Research Design

This study investigates the following research question: What challenges do mental health practitioners encounter while working in the mental health field? The researcher conducted an exploratory qualitative study and utilized ethnographic interviews for inquiry, as well as content analysis to identify emergent themes.

Sampling

The research study participants consisted of eleven mental health practitioners who were working at a community mental health agency in Sacramento. All participants had at least a bachelor’s degree and five years of experience working with individuals with mental illness.

The sampling method used for this study was convenience sampling. For this study, it was important for the researcher to interview mental health practitioners who had some experience working with this population. The program manager of the community mental health agency was contacted to obtain consent to recruit mental health practitioners to participate in the research study. Once consent was obtained to recruit
participants and conduct the study, practitioners were contacted in person and asked to participate in the research study. Participation in this study was completely voluntary.

Data Collection Procedures

All interviews were conducted in a secure location. Prior to the interview, each participant was given a description of the research study, informed the interview would be audio taped, and asked to sign a consent form to participate. Each participant was asked a total of eight standardized questions, which lasted between forty minutes to one hour in length, and follow-up probes were asked as necessary.

Instrumentation

Face-to-face, standardized, open-ended interviews were conducted with eleven mental health practitioners, lasting between forty minutes to one hour in length. These interviews were conducted at the convenience of the participant and held in a secure location. In preparation of the interviews, the researcher designed a standardized questionnaire consisting of eight questions (See Appendix B). This standardized form of questioning ensured all eleven interviews were conducted in the same manner using a consistent and thorough process. This standardized form of questioning also assisted the researcher in organizing and analyzing the data.

Open-ended questions allowed an unlimited number of different answers to the same question and permitted the participants to express their point of view in their own words. Open-ended questions allowed the participants to answer complex questions in a creative manner and use their own expressive format.
Data Analysis

After the interview process was complete, the audiotapes for each interview were transcribed and the raw data was analyzed. During the analysis of the data, the researcher determined the similarities and differences of this material and made codes based upon the relevant ideas, themes and/or concepts that emerged. After two interviews, the researcher debriefed with her Project Advisor to develop the codes. Codes were further refined and individual interviewee comments were subsequently sorted.

Protection of Human Subjects

As required by California State University, Sacramento, a human subjects application was submitted to the Committee for the Protection of Human Subjects from the Division of Social Work. This committee approved the proposed study and determined the project as “minimal risk” to the mental health practitioners. The human subjects approval number is 09-10-057. The approval was received prior to the collection of any research data.

Participation in this research study by the mental health practitioners was completely voluntary. In addition, the practitioners were told they had the right to decline to answer any questions or stop the interview at any time, for any reason. To protect the identity of their client, participants were instructed not to use their client’s name during the interview. Clients were referred using a “pseudo” name or by the use of the word “client”. All information received during the interviews was held strictly confidential. The audiotapes and all transcribed materials were stored in a locked cabinet and destroyed after completion of the research project. This information was described in
the participant’s consent form, which was signed prior to the interview (See Appendix A).
Chapter 4

FINDINGS

Introduction

This study examined the perceptions of mental health practitioners who provide service to youth. Areas of inquiry involved provider ideas about challenges encountered. In gathering the data for this study, several themes emerged from the questions that were examined (See Appendix B). Themes that emerged from these interviews included: 1) challenges to successful treatment, 2) providing effective treatment, 3) countertransference, and 4) burnout. This chapter will focus on each theme and highlight quotes from the interviews when discussing the themes. This chapter will also discuss the demographics of the study participants. To protect the identity of the clients and the mental health practitioners, all study participants were given a fictitious name.

Demographics

Interviews were conducted with eleven mental health practitioners at a community mental health agency in Sacramento. Practitioners interviewed included one program manager, one clinical supervisor, one nurse, four mental health therapists, and four community mental health workers. Nine practitioners identified their ethnicity as Caucasian, one practitioner was half Caucasian-half Nepalese, and another practitioner was Mexican American. Seven of the practitioners interviewed were female and four were male. Eight practitioners have a master’s degree and three have a bachelor’s degree. The practitioners’ ages ranged from twenty-eight to fifty-nine years old. All
practitioners who participated in the study had at least five years of experience working in the mental health field.

Challenges to Successful Treatment

Trust. Six practitioners reported trust as a challenge to providing successful treatment. Based on their past experiences, trust is often difficult to develop with a client when they have been previously mistreated by adults. Paul, one of the practitioners, shared, “Some of their abuse or Post Traumatic Stress Disorder issues stop them from creating a strong trust. They let you in to a certain level and kind of shut off and won’t let you past that, or some live in a fantasy world.” When the practitioner encounters a client who experiences difficulties trusting, the practitioner will often struggle with building rapport and helping clients accomplish their goals.

Many clients often participate in multiple programs and have different experiences in each one. Some clients might have experienced practitioners who genuinely care about them or just do their job and focus on their need to be paid. Some clients might even have a skewed perception of practitioners due to their mental illness and may feel as if they have been wronged even if they have not. These past experiences influence how clients form their perception of a practitioner and have a huge impact on how they will respond to treatment. Monica reported, “A lot of our clients have been in different programs and so they tend to think that this is just your job and you don’t care about them. [Clients] come in with the attitude that you’re just somebody else that is going to come in and out of my life, why am I even going to connect to you. So, it’s hard for them to trust you or to really feel connected to you and I think it takes time [to form a
Since they don’t feel that connection with you, they are less likely to work on goals and feel connected to the program.” If a client does not feel connected to the program, they might not feel motivated to participate and, thus, terminate services.

Regarding trust, one of the mental health therapists talked at length about the repetitive negative reactions clients have experienced overtime from people they trusted and the effects that these experiences had on clients. Mary stated, “It’s hard when our clients have had such a long history of mental health issues and stigmas and family reactions and school reactions to their behaviors, I think they lose trust in people.” It is difficult to create trust with strangers and share personal information with them when your experience with your family and teachers, people who typically try to help you and better understand who you are, react negatively toward your behaviors. These negative reactions can cause clients to be more guarded; therefore it takes longer to create trust and begin working on goals.

Diane, a mental health therapist, also recognized trust as a challenge to treatment because of the way clients have been treated in their past. Diane reported, “Kids who have been in the system have been mistreated by adults their whole life and have no reason to trust me.” Cindy, another mental health therapist, also agrees trust is a common challenge when trying to provide services. Cindy stated, “There is often a distrust of adults [when trying to form relationships with clients].”

Tony, the program nurse, shared, “A lot of our clients have a psychiatric diagnosis and they don’t like to deal with the doctor and they kind of look at me as being like an adjunct to the doctor. So, it takes them a long time before they actually open up with me.
There will be clients who are here for years and years that will tell me a mistruth because they don’t want it to get back to the doctor. In order for me to nurse them, I have to always assume they are telling me the truth and when I find out it’s very frustrating.” When a client is unable to trust the nurse, it can really hinder a client’s progress in treatment due to their inaccurate reports.

**Motivation.** Lack of motivation was a common challenge that some of the practitioners encountered when working with clients. Practitioners who experienced this challenge expressed that the lack of motivation often stemmed from different sources but in the end caused clients to not want to work on their goals. Monica shared, “Clients not wanting to work on their goals is the biggest issue I have as a barrier [to providing services]. They come up with their own goals but they don’t want to work on their goals. Their lack of motivation and the diagnosis they have themselves and all the different behaviors and symptoms that come with that is a challenge.”

Another practitioner felt his clients’ lack of motivation to work on their goals stemmed from their dependence on their Supplemental Security Income (SSI). Paul expressed, “[Clients] would rather just have a buddy and goof around. They’re happy with their SSI money. They feel like they don’t have to go to school or work and create a lifestyle around the money they have.”

Three mental health therapists felt clients’ lack of motivation stemmed from having services for so long that they become tired of participating in a program. Lisa said, “The biggest barrier I encounter is clients who have been in the system for so long and being in a place where [the program] is voluntary but not really because there’s a
stipulation causing them to participate in the program. Such as, parents saying you have
to be part of the program or you have to move out.” Mary said, “[Clients] have had
services for so long that they’re kind of burned out [from participating].” Cindy shared,
“There’s a weariness of having been in therapy for most of their lives and have been
looking forward to not having it once they’re eighteen.”

Mary and Cindy also felt clients’ lack of motivation could be explained by their
level of maturity and differing priorities in life at this age. Typically, when working with
clients who are ages fourteen to twenty-one years old, whether they have a mental illness
or not, they want to be independent and make their own decisions in life as part of their
basic needs. Cindy stated, “Clients are at the developmental stage of individuating and
moving away from parental figures. When they come to our program, especially those
who are nearing eighteen, their focus is to push away so they’re not invested. They’re
looking forward to making their own decisions.” Mary said, “One of the biggest barriers
with our population right now, with them being teenagers, is that a lot of the times they’re
not ready for services. A lot of our clients, I don’t feel like, they really understand or
grasp yet cognitively the kind of support we can offer. So, it’s frustrating when we feel
like our program is helpful for independent living skills and some sort of therapeutic
goals and they’re not ready to go there yet.”

Resources. Nine practitioners reported that the lack of resources is a challenge to
successful treatment. Five practitioners felt that the lack of resources was due to funding
while the other four practitioners felt accessibility to resources was the key issue. In
regards to the effects of budget cuts and lack of funding on resources, the five
practitioners shared their experience. Cindy stated, “Clients are often excited about working on independent living skills but the process is arduous because six months to a year pass by before anything happens because resources are evaporating.” Diane said, “A lot of programs aren’t funded well so I don’t know if they’re still open or serving our population. Or there is a huge waiting list, especially for shelters.” Paul reported, “Programs being cut due to funding [is a barrier to providing services]. [There are] a lot less resources. For example, the Department of Rehabilitation typically sets clients up with jobs but they don’t do that anymore.” Celia shared, “Our clients are aging out into a system that doesn’t exist. We provide them with services from age fourteen to twenty-one and then all of a sudden we are throwing them out into a world of absolutely nothing.”

Celia also discussed how lack of funding has affected Child Protective Services (CPS) and communication with other agencies. Celia reported, “CPS has lost so much of their workers so clients don’t have a worker. Playing phone tag and not getting calls back [is also a barrier to providing services].” Carol also commented on how communication between agencies has been negatively affected by budget cuts. Carol shared, “With budget cuts, a lot of programs aren’t able to return phone calls right away and that can be frustrating getting clients the services they need to move forward.”

In regards to the accessibility of resources, one practitioner expressed his frustrations and discussed how clients are affected when resources are not easily accessible. Tony, the program nurse, explained, “Things change so quickly in regards to resources. The problem with the Medi-Cal system is that there aren’t a lot of resources
that are readily accessible. You can’t find them right away and have to spend a lot of time looking into it. There isn’t a Medi-Cal provider list in the state of California for physicians that take care of Medi-Cal patients that is current. There’s one that is three and a half years old but many of those physicians have changed to not taking Medi-Cal because of the budget. One of the barriers [to providing services] is there just isn’t a lot of information. You have to find it and it takes a while, and by the time you’ve found it for the client sometimes their clinical conditions have worsened or they just lost interest in it.”

Don reported, “Finding resources is difficult because it’s not centralized.” Lisa said, “Lack of information about resources and finding requirements for programs [is a barrier]. Monica stated, “Resources are not updated and not knowing about resources that are available [are a barrier].”

*Family Involvement.* All of the participants in this study were able to recognize the important role parents/caregivers play in the treatment of the client. The practitioners expressed that the role that the parent/caregiver plays really depends on whether the client lives at home with their parent/caregiver and how involved the parent/caregiver is in their everyday lives. Eight of the eleven practitioners felt parents/caregivers could be a challenge when trying to provide treatment, but were open to involving parents/caregivers in working together as a team to help the client accomplish their goals.

In the study, practitioners talked about the different ways they felt parents/caregivers could contribute or be challenging when providing treatment to clients. Celia shared, “In certain situations [the role of the parent] is extremely helpful and they
play a pretty active role in doing a lot of encouraging. To get the parents on board is beneficial and even necessary because some of our clients have this learned helplessness and they need that push outside of us, especially since their parents are around them more often. I think in other situations, in cases that come from extremely unhealthy and abusive family living situations, [the role of the parent] is extremely hindering and actually makes things worse and prevents [clients] from achieving their goals and therefore the goal and the treatment plan is more focused on individuation and separation and independence from that unhealthy situation.”

Diane shared, “[If the parents/caregivers] are supportive and somewhat educated in what their child’s diagnosis is and what their symptoms are, and they are able to distance themselves enough to implement interventions that I may give them, then clients may have a better time of translating what we talk about in therapy and interventions that I’m asking them to give a try to being at home. Communicating with the family that this is what I’m asking them to do and why is sometimes difficult because sometimes parents don’t care and just want you to fix [the client] and don’t want to be a part of the fixing. Sometimes parents don’t understand it or agree with it and sometimes they sabotage treatment so it’s difficult.”

Tony reported, “I think parents and all family members, if they’re any type of active role in the client’s life, they’re really very crucial. They can be a very important part of the treatment team. You have to follow confidentiality but you also have to respect that this is their loved one. This is somebody they care for. They may not want you involved because they’re afraid there may be some horrible secret that might come
out. But the most that you can get them involved the best because they feel like they’re part of the team and they feel like they’re contributing. And that’s what nursing is about, to get everyone involved so that you can get [the client] to have the most functional life as possible whether it’s a mental illness or physical illness. Families are crucial.”

Lisa shared, “If the family is involved, they can either play a positive role and be encouraging and supporting and wanting not only positive change in the client but themselves as well, can be positive or they can be discouraging telling [the client] there’s nothing wrong with them and they don’t need meds. Lack of parental involvement is not such a bad thing depending on the dynamics of it.”

Monica stated, “Depending on where the client is living, I think [parents/caregivers] can add to [the progress of the client’s goals] and help, or they can be a huge disadvantage and almost work against you. Our goal is to get our clients to be independent, so we teach them stuff to make them independent, but if they go back home and mom is still driving you to the store and buying you groceries and taking you to doctor’s appointments and doing everything for you, everything I try to teach them is not going to be successful.”

David expressed, “I think [parents/caregivers] play a huge part in [the progress of a client’s goals] but I think it’s our job to work with parents. I think often times it’s a little manipulative where you’re trying to convince the parents what’s best for their child because they don’t want it to be their fault that their kid struggles. So trying to convince [parents/caregivers] to change their point of view by allowing them to believe that some of the ideas you’re giving them are their ideas and just making sure that they’re an active
participant in the client’s treatment plan because if the parent is not supportive of [their treatment] and they’re spending the majority of the time at home then the work that we do with them, four to five hours a week, doesn’t really do that much if the other hours of the week are being reinforced in a different way. I think definitely convincing the parents to be on board is really important unless the goal is to get the client out of the house and on their own and more independent, like separating from the parent.”

Mary said, “Some clients have family members or caregivers that are very involved who have been able to be big supports sometimes in their life so it’s always important to get them on board because if there has been a certain behavior or family structure for so long you can’t just change it working with individual clients. You have to bring in the family structure to get them on board and to create more independence for the client at home because we can’t just work on independent living skills here [at the agency] or working on growing more to adulthood if their parents want them to stay children and want them to not have any money management skills and not get any money or any responsibility in the home. There are some clients too that don’t feel like their family has been a support or they don’t feel it’s worthwhile to have their family involved because that’s not going to help them. Sometimes what helps them is focusing on what they’re working on and their goals and going from that angle and not always involving the family as much besides check-ins here and there.”

Don explained, “Getting [parents/caregivers] involved is extremely important. It’s a way into the entire system which is more powerful than any individual intervention
because the system goes on day and night and our clients’ own personal growth is sort of limited compared to how the whole system influences them.”

Cindy stated, “[Parents/Caregivers are] absolutely the primary thing. I’ve been really encouraging [clients] to increase doing family therapy because we can’t do therapy and teach them then [they] go home and not follow through. When young adult children or children see their parents or family being unhappy, they often feel very responsible for them. A lot of my work with family therapy is to help parents begin to take a look at how they’re living their lives and help them to try and do things that will help them feel better about themselves. It takes a lot of pressure off the family system and off the adult child and [they] can move on from there.”

Culture. All study participants recognized and acknowledged the important role culture plays in a person’s life. Many of the participants reported they did not encounter a lot of problems with culture and mental illness, but were open to learning about the different cultures that were presented to them in order to provide treatment. Five practitioners were able to identify challenges they encountered in regards to culture while trying to provide services and discussed their experience. Celia, one of the mental health therapists, discussed an intake interview she conducted and encountered parents who did not agree with their child’s diagnosis due to their Vietnamese culture. Celia discussed how the client and his family were impacted by their culture. Celia shared, “There’s a client whose parents come from Vietnam and he was born here. He has a psychotic diagnosis and started developing that at age twelve. And despite having to be taken to the hospital by police because he laid out in front of the street to get run over by a car and
was officially diagnosed, his family wasn’t agreeable with that and that led him to getting worse in a lot of ways and there was CPS issues due to medical neglect.” Celia also talked about the culture of upbringing as a more prominent challenge due to the role of the parents and the influence they have on their children. Celia reported, “I’ve dealt more with the culture of upbringing. I have a client with a significant marijuana abuse problem and a psychotic diagnosis, and it is unknown whether the diagnosis is valid or if it’s the response to being ‘stoned’. His father condones and minimizes the marijuana use and sees it as a therapeutic thing. If he’s stoned then he’s not aggressive.”

Carol, one of the community mental health workers, also encountered challenges when working with a Vietnamese client. Carol explained the difficulty she had when trying to provide services to the client due to the client’s own cultural conflict. Carol shared, “A Vietnamese client wanted the service but did not want it. She didn’t want us to talk to her parents because they didn’t believe in mental illness and they thinks spirits are guiding her. It was difficult to maintain the respect for her culture but also trying to give her the treatment. She was continuously conflicted. She was in the center. She had one foot in our culture and one foot in the other and a diagnosis of Schizoaffective Disorder so she wasn’t really doing much. She ended up stopping treatment all together.”

Diane, a mental health therapist, discussed her experience working with Hmong clients and how their cultural beliefs and spiritual ceremonies could be misinterpreted as mental illness. Diane shared, “I had some Hmong clients that, historically in this country, their cultural beliefs or spiritual ceremonies sound an awful lot like hallucinations. So, if
I didn’t know those things, I might be diagnosing somebody with symptoms they don’t have and maybe a diagnosis they don’t have.”

Mary, a mental health therapist, discussed her experience working with an African American client who has, what she termed, a culture of poverty and gang violence. Mary discussed the importance of understanding the client’s perspective when providing treatment. Mary explained, “I have an African American client who’s bipolar and has a culture of poverty and gang violence and other things. I consistently ask him to explain his perspective because I might not always get it culturally and [how the] family perceives something. It’s important to constantly ask the client what they think or how they think their family perceives it, or how he/she perceives it, instead of how I might create interventions because I think it’s this blanket. [For example], this is how they’re going to react because they’re Asian or African American. Even if they’re African American, they might not always identify with that culture.”

Cindy, a mental health therapist, discussed her experience working with the gang culture. Cindy shared, “Currently, a culture I’ve had to learn to work with is clients immersed in the gang culture and how to be non-judgmental about that, and understanding how this is their culture and what the meaning is for them at the same time coming to terms with not having to be stuck in that culture.” Cindy also talked about her experience working with a family where the parents only spoke Spanish. In this case, both language and the culture were barriers to providing treatment. Cindy reported, “I’ve worked with one family where the parents were Spanish speaking and we had to have an interpreter to help me understand. The father did not have language for sadness or
depression so he said it was like having a chicken in his throat. [The client was diagnosed with] Schizoaffective Disorder and there’s a lot of shame about that. They are very supportive of each other but there isn’t this acceptance, so they felt they couldn’t share it with other family members so that was difficult for them. [There was also] the belief that somehow they caused this for their child.”

Providing Effective Treatment

Practitioners are faced with many challenges when working with youth due to lack of trust and worries of wanting to be accepted by peers and society in general. In this research study, practitioners discussed practical ways to approach working with youth in order to provide effective treatment, as well as address the challenges encountered.

Building Trust. When participants were asked about challenges to providing services, issues with trust was a common barrier they experienced, especially when working with a new client. Individuals who are referred to this agency for services often have a history of being mistreated by adults which makes it difficult for a client to share personal information with an adult they do not know. In this study, participants shared what they do to help create and maintain trust with a client, as well as what their strength is in building trust with a client. David shared, “I think treating a client like anybody else [helps create trust]. You treat them like a person, you treat them with respect and overtime [trust] develops. I think you can use different ways to do that like you can share generalities about yourself that don’t cross boundaries or share things about friends that you have that you can relate to their lives. Being able to listen to them and not judge
them [also creates trust]. You always want to think they can get better and that we’re here to help and that’s why they’re here. I’m a good listener and have a good sense of humor. I think I know when it’s okay to joke around and put myself down. I think my style of listening facilitates them sharing more and I think I can give them good advice and reinforce it by remembering what they talked about later. I’ll remember to ask about [what we talked about] which reinforces that I’m listening and that I care and want to make sure they are headed down the right path.”

When Paul was asked about creating trust with clients, he shared about the importance of listening, being present and expressing interest as a way to build trust with the client. Paul stated, “Listening and being as present as I can so they feel like they’re being heard. Express interest in what they’re all about, what their beliefs are, their interests are, and actually care about it. Be truly interested in the person. Follow through in what you say you are going to do, be really consistent, have good boundaries, and let them know you care about them and care about their life and their goals and wish the best for them.” Paul also shared that his strengths in creating trust is being “approachable and friendly.” Paul said, “I know when to clown around and when not to. My clients know I do care about them and I’m not just here to make money and go home. I care about them and love what I do and appreciate them for who they are.”

Celia shared, “I think I come from a definite place of openness and nonjudgmental and I don’t probe for information right away. I start off by it being a relaxed environment and ask how I can help them and what do they want to achieve. As far as gathering information and assessment, I feel like that comes from conversation.
I’m able to gather information based on what they say and then probe based on what they say. I also ask them if there’s anything they want to know about me. I also mention a few times in the first month or two the idea of wanting to have an open communication with them and that I validate the fact that there are going to be things they’re not going to want to tell me or feel comfortable talking about and that they can tell me that and I’d be cool with it, and no matter what they tell me, even if it’s a complaint about me, that I would never respond or react poorly. A casual development builds trust.” Celia shared that her strength in creating trust is that “I come across as a genuine person. My clients recognize that I like them even the ones that drive me crazy. I also call them on their bullshit which I think they appreciate.”

Tony stated, “When a person agrees to let you nurse them, they already trust you. Touching people during nursing procedures or listening to a client tell you ‘I really want to hurt myself’ that indicates an incredible amount of trust for someone to admit that to you. The way you get that is show them and teach them and you reshown them by example that you do care and that you can be trusted. I make it very clear to [clients] that if you tell me something where you’re going to hurt yourself or hurt somebody else or maybe you’re doing something that’s really dangerous and is eventually going to hurt you, I do have to talk to people about it but it’s only within the treatment team and we’re not going to talk about that with anybody else. I find that’s worked to continue to build trust.” When Tony was asked about his strength with building trust, he explained, “I’m very firm and very clear but I’m the way I present, I’m not gonna go behind their backs. What you see is what you get in my nursing and you’re gonna get the best nursing
regardless of what’s going on. I think they initially say Tony comes on kind of firmly but they also know that if [they] have a problem [they] can tell Tony and he’s gonna figure a way to get it done to help me out and that matters. I think that helps.”

When Mary talked about creating trust with clients, she focused on the importance of building a foundation and being strength based. Mary shared, “Building rapport [helps create trust]. I try to really learn about [the client’s] interests and understand them. The first couple of months [in therapy], I let them totally direct the sessions and what they want to check in about and talk about, and they get to figure out what they want their goals to be. I think those build a foundation and I continue to build that trust by supporting them in their strengths. I think the more we can identify what’s going right and the more we can point those out to [clients] instead of what they’re doing wrong, I think that helps build a trust and helps them understand that there is someone they can share stuff with who won’t discipline them and listen to them and support them. I always try to believe my clients will do better next time.” When Mary was asked about her strengths in creating trust with clients she identified being honest with her clients as her strength. Mary explained, “I always tell my clients I will be honest with them because I expect them to be honest with me in our therapeutic relationship. I’m forthcoming with information I know about and tell them I would like to talk about it and process it and they can share what they want about it. And when I’m feeling something in session too, when I’m conflicted or maybe even upset in a session, I’ll be honest. [I’ll tell them] I need to stop for a second and I need to let you know this is my internal reaction to what you’re saying. This is a place where you can talk and vent but it’s also a
place where you can learn new behaviors and learn new responses to what has happened. Having an open conversation because I always want to be honest with them and genuine with them about how I’m feeling in session and what’s going on in real life [helps build trust].”

When dealing with creating trust, Don stated that he likes to “take an active interest in the client’s world, noting similarities and using use of self in the process. If I have anything in common, I bring that in, it really helps.” Don noted several things he felt were important to be aware of and to present when trying to create trust with clients, which included “being relaxed; present myself as a just person; use of sense of humor; self-deprecating stories to a mild degree; [being] goofy; keep clear and mind boundaries; you’re like everyone else; you’re human, and experience and training is the only difference between you and I, which points to the respect in terms of myself as a human being and as a professional not having more value than them and communicating clearly by actions that we are the same, we’re both people of equal value and merit.” When Don was asked about his strengths in creating trust, he listed, “Use of humor, taking an interest in subculture, such as music, bringing treatment to their level, language use, vernacular, and ways to connect and understand their culture in moderation.”

When Lisa discussed creating trust with clients, she said, “It’s important to be able to recognize a client’s pace. You can’t have higher expectations for that client if they’re not capable at that point and be patient. Use basic trust building skills like honesty, follow through, compassion, reliability and dependability.” Lisa shared that her strength in creating trust is that “I have a good ability to join the client with where they
are and be compassionate towards them and listen to them a lot and validating their feelings and giving a lot of empathy to their own personal situation.”

*Dealing with Stigma.* In this study, participants were asked about how they would help a client if they were experiencing stigma around their mental illness. All practitioners acknowledged that stigma was a common challenge that their clients experienced and shared how they addressed the issue to help clients rise above it. Several of the practitioners focused on normalizing the client’s mental illness and discussed how they would do that. Don shared, “I try to normalize [their mental illness]. I try to reframe it and let clients know that a lot of people have mental illness but don’t share it because it’s a stigma. So, you’re actually in a large section of the population that has varying degrees of mental challenge and that would make it more normal and not so different from a medical illness or other things people deal with. We want to help them see their experience as normative as similar to other people, not strange or ostracized.”

David expressed that he likes to normalize a client’s mental illness and focus on the client’s uniqueness as a positive characteristic when they are dealing with stigma. David said, “Normalizing it to the fact that there’s a lot of people that have challenges and struggles and that’s what makes us unique. Unique isn’t a bad thing and being weird is only being different and that’s not a bad thing either and trying to get them to embrace the positive parts of themselves and reinforce that. Reduce the negative parts through socialization and talking to them. Just letting them know that we all have challenges to overcome and that’s a part of life and if you can overcome the challenges and still have a love for yourself then you have a lot better chances at happiness.”
When clients experience stigma around their mental illness, Tony shared that he likes to make sure clients understand that they have a lot of value in the world and that they are important people. Tony stated, “A lot of our [clients] are young and most of them know they look different and act different, and people their age see that and a lot of times will have a very negative judgment toward them. I think what you need to do is [tell them] you have a lot of value in this world and you’re a very important person. People aren’t always going to say what a great guy you are. But overall most people, especially people here [at this agency] that are taking care of you, understand that you have a value and that what you are going to contribute to this world is important. It might not be exactly what they want but it is important. By telling them that and showing that you really do care in firm, very fair ways, it does work.”

Cindy shared that she likes to talk about the client’s experience with stigma directly and help them realize they are not their mental illness. Cindy expressed, “Talking about it directly and how [the clients] experience the stigma and what they’re doing to cope with [stigma]. Help them to realize that they are not their mental illness and it is just one component and there is far more to them. I try to take out of the equation that [their mental illness] is something that is bad. I’ll explain it’s challenging. It’s similar to having diabetes and you just have to learn to manage the symptoms. I want to validate how they feel and how they interpret the stigma. Psychoeducation, psychoeducation, psychoeducation.”

When dealing with her clients’ issues with stigma and their mental illness, Diane likes to use statistics and metaphors to help address the problem. Diane reported, “I’m
pretty honest with them and I will tell them there are a lot of jerks in the world and that unfortunately there is still stigma around mental illness. Then I’ll transition into the statistics, which are ninety-eight percent of people have someone they know that is close to them that has suffered from a mental illness and sometimes [clients] won’t even realize that depression is a mental illness. They don’t think of it like schizophrenia or bipolar, so sometimes that can help them feel a little better about it. I also compare [their mental illness] to cancer or diabetes and help them understand that if they had diabetes they would take insulin because their pancreas doesn’t make it and explain that their brain doesn’t make a specific chemical and that’s why they need to take meds to help get brain chemistry normal.”

Paul shared that he likes to explain to clients that everyone has their own issues and that nobody is perfect and that they need to learn how to deal with the stigma so they can have a productive life. Paul explained, “I would talk to them about how you can’t really change people’s viewpoint of things and throughout your life people are going to judge you on whatever they feel like judging you on because people are human. So, I help them realize that everyone has their own issues and we’re all working on something and nobody’s perfect. And explain people have different issues and to learn to accept that this is the hand they were given in life and to figure out how to best deal with it so they can have as productive and happy a life as they can. And part of that is to go through life and not worry about what others say because you can’t change it and only change the view you have and have a harder shell.”
Working with Families. All of the participants in this study were able to recognize the important role family members play in the client’s treatment. Some of the participants acknowledged the importance of respecting the family culture, providing support, not being confrontational, being client-centered, as well as understanding how to balance family involvement when working with families that are hindering a client’s progress. Practitioners shared their treatment approaches when working with clients and their families. Don shared, “Respect the family culture. Respect the experience of the people who have spent potentially the child’s lifetime with them and all the coping mechanisms the family has built up to work the system and get the things they feel are really important for the client. To join and connect with the family and talk about their strengths and let them know that we appreciate the strengths they have. Help them feel like part of the treatment and they’re appreciated for the work they’ve done. Then gently helping them understand the background and the context behind our point of view and how maybe the family system is kind of toxic with whatever they are doing, and help them understand other points of view without telling them how to parent or not telling them how things need to be done but working side by side. [Explain] we’re both stronger together and here’s our point of view and lower resistance any way we can.”

Mary, one of the mental health therapists shared that she likes to call a family meeting and gather everyone involved in the treatment of the client to discuss what they can do as a team to help the client accomplish their goals. Mary said, “[I] call a family meeting to have family involved, client, and community mental health worker [present]. Instead of a confrontational approach, I refresh everyone on the client’s goals, and
encourage and ask them how they can help in the home to work on goals so we’re all on the same page. The whole meeting is about being on the same page, being connected, and having a structure set up at home that is similar to what we are trying to help the client do here at the agency. Building rapport with the family and client are important.”

Monica, one of the community mental health workers, expressed that she does a lot of collateral work with parents and likes to make sure that the focus is always on the client. Monica explained, “I would discuss the client’s goals with the parents so they’re aware of what [the client] is working on and what [the client is] supposed to be doing. [I would explain to the parents.] this is your child’s goals and this is what they wanted to work on then they’re a lot more open to it because they know it is not coming from us. If that doesn’t work, then we have a team and we can meet with the therapist, myself, the parent and the child, and all meet together and get everything out there. I think it’s really good that we can all meet together and working together is our goal. It’s not I’m doing this and the therapist is doing this and the parents are doing this. We can all get together and have the client there, which makes a huge difference for them to hear what [everyone] is saying. It’s not said behind their backs and they’re part of that and they can say their piece in it. Open communication and working together [helps when working with families].”

Celia, one of the mental health therapists, shared that there are precautions that need to be taken when working with families who create an unhealthy environment for the client. Celia shared that she likes to do “collateral, family therapy or individual therapy with the parent where therapy is about individuation on their end and self care”
when working with families who are hindering a client’s progress. Celia shared, “In situations where it’s been unhealthy to the point of being abusive and harmful psychologically and emotionally [to the client], it’s been a very careful balance between not involving the caregivers at all to fielding and manipulating, not being judgmental, and validating even if the view is skewed.”

Understanding Culture. When participants were asked about their challenges with culture and mental illness, most participants reported that it was not a common occurrence and had only encountered it a few times while working in the mental health field. Although participants did not encounter many challenges with culture, they all recognized the importance of understanding a person’s culture in order to provide treatment. Practitioners discussed their treatment approach when dealing with challenges in regards to culture and mental illness while providing services. Don, one of the practitioners, shared, “Be a student and try to remember all you can in a humble way about this is not my culture and I just need to know without judgment and a supportive approach to be a student of the culture or background of what’s going on that’s coming up. Get some more formalized help with someone that knows the culture that can be a resource, a consultant in a sense to fill in the details with the understanding that every family, every culture is unique and you can’t stereotype just to be guided and understand. [Also use] interpreting services and community organizations that are more knowledgeable about the subject.”

When Tony was asked about working with clients who have different cultural beliefs about mental illness, he shared that it is important to try and meet the client half
way and try to find a treatment approach that works best for the client and still respects their culture. Tony, the program nurse, shared, “You basically have to figure out what they believe, what they want from you, and then try to find a middle of the road like I’ll work with you and accept that but if you’re gonna come here and accept help from me I’ve got to be able to do what I have to do under the standard of care. So, it’s a fifty-fifty, I’ll give you this, you give me this, and then we’ll see what’s the best we can do because when they come here they are definitely entitled to the best care they can possibly get regardless of their cultural experience. I’ve used interpreters a lot, talked to some of the holistic backgrounds of some of the Native American people, and I’ve worked with healers about approach. If you work with them and show them that you honestly really respect their background, you can work with even the people that you think are the main blocks to the client accepting you.”

When working with clients from a different culture, Diane expressed the importance of educating the client about their mental illness, as well as understanding their culture and identifying the barrier to services. Diane shared, “I try to do a lot of education. I try to do ‘research says’ statements, sometimes I use the internet and look up research, I use books and handouts things the client can read and that it’s not something I’m making up. It’s something in print. I try to learn more about [the client’s] culture and what it is that is the barrier. Being trained and really being up on as much as I can and validating.”

When Celia encountered challenges with the culture of upbringing, where the father felt the client using marijuana was therapeutic, she discussed the importance of
educating the parent and being nonjudgmental. Celia explained, “I’m dealing with it in a psychoeducational place and nonjudgmental way. [I] explain concerns ‘based on research’ and that it’s shown that marijuana can exasperate symptoms and even create them.”

When Mary discussed her experience with working with different cultures, she emphasized the importance of psychoeducation and understanding the client’s perspective. Mary reported, “I would provide a lot of resources in psychoeducation about the direct terms. A lot of our clients, even though they’ve been in the mental health services for a long time, they don’t know their own diagnosis. I think it’s really important to talk to them and the caregivers about that language, bringing direct concrete language about what’s going on, explaining about the actual diagnosis, and what are some of the symptoms. And then caring about them and listening to how they might interpret it or what that might mean to their culture and what that might mean especially as a family structure to admit that there’s this stuff going on with their son or daughter. I think it’s important to check-in with that as well when working one-on-one with a client because how their family reacts to their mental illness is a huge part in their stressors or triggers and how they understand their mental illness as well. It’s important to be culturally competent. With my schooling, we looked a lot into different cultures and cultures within those ethnic groups and how they might perceive spirituality and other things. Joining and understanding from the client’s perspective is very important.”
Countertransference

In this study, participants were asked about how they address countertransference when working with clients and whether they felt there was a population that was more difficult to work with. All participants reported being very aware of their countertransference when working with clients and understood that it was normal to experience it. All participants had a system in place to keep their countertransference in check and expressed that they did not feel it was a challenge for them when providing treatment. Five of the eleven participants acknowledged that addressing their countertransference when working with a client, depending on the therapeutic relationship, is a good way for clients to learn. Practitioners shared their experiences with countertransference and the population they felt would be more difficult to work with. Monica, a community mental health worker, shared, “The first thing for me is just being aware that it’s happening. I’m really good at knowing when I feel it. I can’t control what I feel, but acting on it is something else. I think for me, just being aware and reminding myself it’s not personal and trying to separate the two prevents me from acting on it or treating [the client] a certain way or looking at them a certain way. Just getting everything into perspective and realizing a lot of what they do is due to their diagnosis and it’s not about me or my beliefs and they’re not my children.”

Paul shared, “I try to stay neutral and not take anything personally. And [remember] that they are who they are and they say and do things, and to not take things personally but also have good boundaries. [I] try not to be judgmental but try to teach them some of the skills they are here to learn.”
David shared, “I think it’s important to check yourself. I try to be more positive with [clients] and make sure whatever I’m feeling about things that they’ve said doesn’t necessarily come across, but giving them what I think is the appropriate direction and making sure their therapist knows what’s going on in their head and reinforcing when they make strides in the right direction. I believe each person is an individual and as long as they’re here get as many chances as they need to succeed. Even though they’re terrible one week, the next week you’re just as positive as you would’ve been otherwise. You can be as negative as you want with your coworkers and complain and get that kind of stuff out, but with the client you need to go into every interaction one hundred percent pure like they’re a new person each time.”

Don shared, “Knowing that it exists and that you are going to have it with lots of clients, and identifying and keeping a certain account on what is going on with yourself as you process your session work, and look at your notes and review what’s going on in your session plan and pick out certain parts that really hit a button for me and work on my own issues and process that. Keeping account of that and monitoring yourself and running it by others who mentor you or fellow co-workers you can talk to and vent and get some perspective on it.”

Tony shared, “You’re warned against countertransference and you’re told it happens to everybody and it does but it’s only bad if you don’t know it’s happening. It’s normal and that’s fine as long as you recognize it’s happening and you can do something to control it. You keep aware of what’s going on and you know that it’s going to happen and the more you’re in the field the more quickly you’re going to recognize it.”
Celia shared, “By being totally aware of it. I have a good awareness that was
developed over time. I’m pretty good about keeping myself in check and being aware of
what’s going on inside me when I’m with a client. I process afterwards and ask what is
this all about? I process it and talk about it and sort of deal with it and really keep it in
check.”

Carol shared, “In the moment I try to catch myself and not react to it. If my bond
with a client is strong enough, I might address my countertransference straight on and
allow them to take some time and process about it. Sometimes I do a lot of self talk when
I’m with them to get through it to keep me calm then I like to vent to coworkers after.”

Lisa shared, “Being aware of it. I use my co-workers or peers to process through
it or look at it in different ways. And just be aware of it and think about whatever issues
that are within myself that might be brought up and deal with those personal issues. But
in session with a client, be aware that it’s going to be there and not let it have a negative
impact on the session. Sometimes it can be a positive thing to acknowledge it to the
clients but there is a fine line.”

Mary shared, “In session, I stay very neutral and straight-faced if there’s
something that produces a reaction out of me. If there is something that I’m listening to
and feel uncomfortable about that I want to respond to, I’ll say ‘I need to tell you
honestly that this is my reaction’ and talk about it in a neutral way that’s a discussion
because I can’t expect them to trust me and grow from therapy if I’m just another adult in
their life telling them what to do. I help them process what they think is right and wrong
from their situation and what they can do differently. I have colleagues and supervisors I
bring it up with and learn how to handle it better and understand it better, and always come back to trying to see the world in my client’s perspective because I need to know what it means for them.”

Cindy shared, “I have an image in my mind of countertransference. I recognize what is happening in my body and ask myself: Is my jaw tense?; Am I trying to make my case with the client more than I should be?; Am I trying to be a hammer to this client? If I feel fear that I’m not doing things right, these are cues. Recognize what feelings are occurring inside myself and remind myself that other people experience these feelings when interacting with this client. Depending on my relationship with my client, I will address it with my client.”

Diane shared, “One of the ways I experience countertransference is also a strength that I have with working with clients, is that I have a brother with Schizophrenia. If I know the client well enough and it’s therapeutic for them, I will self-disclose to them that I have a close family member who’s been through that. I have a family member who has been in the hospital, or that’s taking medication, or doesn’t want to believe they have this illness. Sometimes self-disclosure can be good as far as building a relationship with them and getting them to trust me. Countertransference is huge. You’re human, it’s going to happen and you just really have to be aware of what’s going on in your own life, what your buttons are. I often ask myself why am I saying this, is it because it’s going to make me feel better or because it’s going to help [the client] therapeutically, and that usually can wake me up to is this my countertransference or is this something that therapeutically they need to hear.”
When considering countertransference, practitioners shared populations they felt would be more difficult to work with. Five practitioners identified individuals with Conduct Disorder or Antisocial Personality Disorder as a challenging population. Don stated, “As a professional it’s discouraging because the outcomes are not great and relating to their point of view is difficult. It seems not as hopeful, a bit discouraging, and just distasteful to some degree.” Four practitioners recognized older adults as more challenging to work with. Lisa shared, “I feel like they’re more resistant to change and they can be more difficult because things are more engrained.” Two practitioners felt individuals who are severely developmentally disabled would be difficult to work with. Paul expressed, “I realized I wanted them to achieve much higher than they were capable of and that was hard for me.”

Burnout and Self-Care Strategies

Ten out of eleven practitioners acknowledged that they, at one time or another, experienced burnout and their performance was negatively affected by it. Most practitioners identified paperwork as the main contributing factor to burnout but were able to recognize other factors that played a part as well. Practitioners shared how they are affected by burnout, factors that contribute to their burnout, and their self-care strategies. Monica shared, “The patience is a lot less and just being tired. Not being as active as you would have if you had more energy. If I feel like I’m up to where I’m supposed to be and I get enough sleep and don’t feel overwhelmed, I might encourage clients a lot more. But when you’re just at that point and they don’t want to do their goals, I say that’s fine and they don’t have to. Almost sometimes not wanting to meet
with clients, it’s ok if they don’t want to meet with you because you’re tired and you just need a break because you get overwhelmed working. I’ll be okay with them not meeting with me, or being with them and not really paying attention exactly to what they’re saying and being in my own world. I don’t have the option to prevent it, so I accept it and realize that it’s going to be a struggle, I’m going to be tired and overwhelmed and not be in the best mood. It’s easier to accept it and deal with it and take a day off here and there.”

Paul shared, “I’m less patient, remove myself a little more, and don’t listen as well to the client and try to tune them out. [Factors that contribute to burnout are being] overworked, too many projects on my plate, and too busy in my personal life. I know really well when I start getting to that level and take a few days off, long weekends, do less work, take a long lunch or play on the computer a little. Take a break today and do more tomorrow.”

David shared, “The burnout comes from paperwork and sometimes coworker negativity. I feel like I get a lot of energy from the clients. If I’m having a bad day or something bad’s happening in my personal life, going to meet with clients can give me a lot of energy and make me feel more positive about myself and about them. I’ve definitely had specific burnout with specific kids where I’d feel like they’re kind of stuck, and I feel like I’ve tried everything to get them out of a rut and help them move on, but I don’t usually feel burnout towards the clients. I feel burnout towards the job at times as far as the paperwork and getting out of bed in the morning. . . . [For self-care,] getting enough sleep at night is helpful and making sure I’m being open with co-workers that I
care about, that share the experience that I do, being able to talk to them or listen to them is helpful too.”

Don shared, “Taking on the burden of your client’s problems on yourself and feel like you have to fix it. That can be overwhelming and can feel like a huge responsibility, and it’s my fault because I couldn’t figure out their problem. That kind of thinking really creates burnout along with life being out of balance. Way too much work, not enough balance in your personal life. Overtime, realizing that my client’s problems would be there whether I’m there or not. It’s really not my burden or responsibility but what if I helped a bit. What can I do today that helped what I can do in the future that might make a little difference? Focusing on the positive side and taking off the burden psychologically really helped. It also let me to have a more balanced whole life because I could leave it at work. In terms of boundaries as another aspect of not being burned out, during my commute, there is a point where I unpack things in my mind and close the suitcase and put it away because I have a home life. Psychologically put it away, exercise, friends and other relationships, and other interests, timing vacations and using them well, connecting weekends when you can, being strategic about how you look at the process and making sure you really monitor yourself and really plan and see it as part of your process [of self-care]. Part of my job is making sure I don’t burnout. When I’m at work, I go out and have lunch, get out of the office, take little breaks and refresh.”

Celia shared, “All my paperwork and phone calls get on bottoms of lists because I’d rather do face-to-face stuff or I don’t have time to do it or it’s the last thing I want to do. I’m tired. Paperwork goes more with burnout, [especially] when there’s changes in
paperwork. Running into barriers [also] creates burnout. [For self-care,] I have great relationships with people I work with so I do a lot of socializing, joking around, and venting. I go out to dinner and watch movies. I talk about exercise as a good way for self care. I make to do lists.”

Carol shared, “There’s a lot of weight on productivity and wanting paperwork done within a seventy-two hour period. We absorb so much of our clients’ needs and diagnosis that it finally gets to us. We give, give, give, and then we hit a point where we need a timeout. [For self-care,] venting with co-workers is a huge release. Before I even leave work, to be able to vent a little, I get the support or sometimes I’m able to get another perspective outside of the situation. Once I leave, I take time for myself, family support, and spa days. Do something you enjoy doing.”

Lisa reported, “Burnout goes in waves. Unrealistic job demands, not doing enough self-care, not being able to separate work from personal life [contribute to burnout]. If you don’t have healthy boundaries it can increase burnout. [For self-care at] work, being able to use co-workers to process when I’m frustrated or overworked or overwhelmed that’s helpful to get support from other people. Using supervision sometimes is helpful. Being more realistic with myself and making a cognizant effort not to overwork myself or take on too much. At home, do things that are enjoyable to myself. Don’t bring work home. Try to incorporate more fun stuff and relaxation into my personal life.”

Mary explained, “I constantly feel like I get more burned out by progress notes than working with clients. I mentally don’t take my work home. If I feel stressed out, I
verbally process it with another therapist or with my supervisor and vent about how I’m feeling. There’s a lot of paperwork in mental health when working for an agency that works through Medi-Cal. I think that the time we spend on paperwork and with doing it a certain way and the details of it, I think there is valuable time that can be spent on direct services that we waste on paperwork. [It’s] less stressful when I take paperwork home then [I’m] not as stressed or anxious thinking about getting more behind. Time management [helps].”

Cindy shared, “The hellacious amount of paperwork [causes burnout]. The paperwork burns me out terribly. Loss of sleep worried about not getting paperwork done [affects me]. [For self-care at] work, I play FreeCell on the computer, talk to my supervisor if [I’m] feeling overwhelmed, go out to lunch, and drink tea. At home, exercise, yoga, aerobics regularly has really helped me. [I like] reading, hiking, doing things with family, planning vacations, and having my own personal checklist of what I want to do outside of my job [for self-care].”

Diane shared, “Bigger burnout is paperwork. I don’t see myself doing this for very much longer. I don’t think I can be ruled by bureaucracy and paperwork of course. There is a need to document but not to the point that Sac County wants us to. The pay isn’t very good. Everything that is expected of us goes so much beyond just being a therapist that it’s almost impossible. I’m scheduled forty-three hours a week but I routinely do two to three additional hours a week at home. [For self-care,] I try to be aware of when I go to bed, what I’m eating and how much water I’m drinking throughout the day. I will stand at the window. I go to the movies and spend time with my family.
It’s a balancing act. I do what I tell my clients to do. I use Cognitive Behavioral Therapy on myself. I try to practice what I preach as far as making mentally good choices for me.”

Summary

In this chapter, the data from the study was analyzed and discussed. Chapter 5 is a description of the conclusions and recommendations. The limitations of this study and the implications for social work practice and policy are also discussed.
Chapter 5

CONCLUSIONS

Introduction

This chapter summarizes the study’s conclusions. This chapter will discuss some of the challenges encountered by practitioners working with youth in the mental health field, as well as their treatment approaches. This chapter will also discuss recommendations, limitations of this study, and the implications for social work practice and policy.

Conclusions

In this study, participants reported an array of challenges they encountered when working with individuals with mental illness. These challenges included trust, low client motivation, family distress, inadequate resources and cultural barriers, as well as practitioner experiences with countertransference and burnout. One of the most common challenges that practitioners encountered in this study was with resources. Due to budget cuts in the state of California, it was not surprising that resources were a major challenge to providing successful treatment to clients. Interestingly, practitioners identified two reasons why resources were a challenge: lack of funding and accessibility. Some practitioners reported that resources continue to degenerate and, for those that exist, they do not have enough staff to operate their agencies efficiently. Other practitioners reported difficulty with finding and accessing resources due to not knowing what resources exist, not knowing what to look for, and resource information not being centralized or updated. Diminishing resources and accessibility to resources have a
major impact on providing services to clients because of the negative effects it has on practitioners. When workers have to put forth additional time, energy, and effort into looking for information they are unsure about, it can lead to burnout and affect how services are provided.

Participants in this study worked specifically with clients ages fourteen to twenty-one and identified low client motivation as a common challenge. Practitioners reported that clients often times lacked motivation due to their maturity level and not really understanding cognitively the services the program has to offer. Practitioners recognized that clients were at an age, developmentally, where they want to be independent, make their own decisions, and have different priorities. Practitioners also shared that many clients have received services for such a long time that they are burned out and just don’t want to receive services any more. It is important that practitioners take these factors into consideration when working with adolescents with a mental illness in order to help motivate clients to participate in treatment and accept help.

Another major issue that practitioners identified as a challenge was trust. Practitioners reported the difficult time they had with working with clients who are new to the program due to lack of trust. Practitioners reported that many clients they work with have a history of being mistreated by adults and struggle with sharing their personal experience with someone they do not know or trust. Practitioners emphasized the importance of creating a casual environment when trying to engage clients in treatment, genuinely taking an interest in who they are and what they like, and truly caring about them as people and treating them with respect in order to develop and maintain trust. It is
very important to take these approaches into consideration when trying to provide services because these elements create a foundation in the therapeutic relationship from which you can build on. Practitioners also expressed the importance of maintaining trust by continually showing that you care and that you will follow through on what you have said.

Even though many practitioners identified clients’ families as a common challenge they encountered when providing treatment to a client, many of them recognized the important role family members play in a client’s life and were open to working with them. Both mental health therapists and community mental health workers acknowledged holding family meetings as a helpful intervention to make sure everyone involved in the client’s treatment is on the same page and understands the client’s goals. One practitioner noted, “Getting [family] involved is extremely important. It’s a way into the entire system which is much more powerful than any individual intervention because the system goes on day and night, and our clients’ own personal growth is limited compared to how the whole system influences them.” All of the mental health therapists also stated that providing family therapy and individual therapy for family members often assists the client in reaching their goals.

Surprisingly, culture was not considered a significant challenge in this study. Practitioners reported having very little encounters with challenges with culture in regards to race/ethnicity, but did express experiencing more challenges with the “culture of poverty”, the gang culture, and the culture of upbringing. Although these were not cultures specifically addressed in the literature, these cultures must also be addressed in a
culturally competent way in order to truly engage clients in treatment and not feel as if they are being judged for their cultural background. A possible explanation for the minimal encounters with cultural challenges could be the resistance to services, and thus client self-selection, due to the stigma and shame often associated with mental illness.

Countertransference was regularly experienced when providing treatment but was not really seen as a challenge. All practitioners acknowledged that countertransference exists and were aware and mindful when they experienced countertransference when working with clients. Burnout was also a common occurrence that mental health practitioners experienced but did not necessarily identify it as a challenge when providing services. Practitioners did not so much attribute their burnout to working with their clients but instead placed responsibility on the cumbersome amount of paperwork required by the county. Some practitioners also reported experiencing professional dissonance due to the amount of time it takes to complete paperwork when they felt their time could be better utilized providing direct services that were greatly needed.

Recommendations

Based on the findings of this study, recommendations can be made to both practitioners and researchers. This researcher recommends that practitioners utilize this study to help them assess similar challenges they might encounter when working in the mental health field. Practitioners can also use this study as a tool to help them identify additional treatment approaches they can use when they encounter similar challenges that were reported. Practitioners can use this study as a guide to address possible issues they
might encounter in future practice and provide trainings to address these challenges proactively.

Future researchers can use this project as a guide to doing further research that explores challenges working with youth. This researcher recommends that future researchers expand the study across different agencies in different geographical locations in order to enhance its generalizability.

Limitations of the Study

Limitations of this study involved the size of the study and the nature of the sample. Due to the small number of participants and convenience sampling method, the study cannot be generalized to the larger population. Since this was a qualitative study, the study is also difficult to replicate. The face-to-face process of collecting data may have resulted in eliciting a biased response. The bias of the researcher may have affected the design of the study, data collection and interpretations of the research. In addition, all participants were selected from the same community mental health agency. The responses may have been different if the participants were selected from different mental health agencies.

Implications for Social Work Practice and Policy

This study can assist helping practitioners to better anticipate the challenges they might encounter when working with youth in the mental health field. The common challenges founded in this study can help practitioners to be more proactive regarding these topics and possibly utilize the study participants’ treatment approaches when addressing similar challenges. In regards to social work policy, the county could utilize
the findings in this study as feedback to help create new policies that increase funding for social services. The findings from this study can also be reviewed as a means to help the county create new policies that would help decrease the amount of paperwork required when providing mental health services. This study could help the county recognize that the large amounts of paperwork they require contributes to practitioners’ burnout and quality of services provided.
APPENDIX A

Consent for Participation in Research Project

My name is Stephanie Linsao and I am currently a Masters student in Social Work at California State University, Sacramento. I am conducting a research study that will examine the challenges practitioners encounter when providing services to individuals with a mental health diagnosis. My research will explore the various challenges that practitioners experience when working with individuals with a mental health diagnosis and how they approach those situations.

In this research study, I will be conducting tape recorded interviews that will last approximately one hour. Participants will be asked several open-ended questions about their experience working with individuals with a mental health diagnosis, the challenges they have encountered when working with those individuals and how they approached those challenges.

This study is considered “minimal risk” which means the probability and magnitude of harm or discomfort anticipated will not be greater than what might be encountered in daily life.

If there are any concerns or problems arise, the following resources are available:

Catholic Social Services of Sacramento
5890 Newman Court
Sacramento, CA 95819-2608
916-452-7481

Employee Assistance Program-Manage Health Network
(800) 888-4024

Your participation is greatly appreciated, and I would like to reassure you that participation is entirely voluntary. You have the right to refuse to answer any question at any time, and are free to withdraw from the study at any time for any reason. The interview tapes are kept strictly confidential. Interview tapes and consent forms will be kept safe and private by the researcher in a locked box and will be destroyed after the research study is completed. The data collected from the interview tapes will be reviewed and documented, and under no circumstances will any names or identifying characteristics be used at any time.

Your signature below indicates that you will participate in this study.

Thank you for your participation.

If you have any questions or concerns, please feel free to contact me at slinsao@hotmail.com or (916) 752-8611 or Andrew Bein, PhD, LCSW, Project Advisor at (916) 278-6170.

______________________________ ____________________
Participant’s Signature      Date
APPENDIX B

Interview Questions

1.) Can you tell me what you do (your role) with mental health clients at this agency?

2.) What barriers do you encounter as a practitioner when trying to provide services? What are some of the challenges in terms of forming relationships with the clients and providing resources?

3.) When confronted with a problem regarding a client’s culture and their beliefs on mental illness, how do you approach the situation? What interventions do you use?

4.) What role do you think parents or caregivers play in the progress of a client’s goals? How do you work with parents or caregivers if you feel they are hindering your client’s progress?

5.) How do you help a client when they are experiencing problems with stigma and mental illness?

6.) How do you deal with creating trust? What are some of your strengths in terms of connecting with clients?

7.) How do you address counter transference when working with clients? What may be a population that is more difficult to work with?

8.) How are you affected by burn out when working with this population? What do you do for self care so you do not burn out?

Demographics

- Years of experience working in the mental health field?
- Race/Ethnicity?
- Degree of Education?
- Gender?
- Age?
REFERENCES


