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Interview with a Clinical Mental Health Counselor

I. Professional Overview

Settings. Deborah Williams, a licensed mental health clinician practicing in Gig Harbor, Washington, agreed to sit for an interview. She began her career in Alaska, first earning an undergraduate degree in psychology, then a Master of Science in clinical psychology from Alaska Pacific University. She did this while raising young children. Deborah said this was a difficult time, going straight through school with no break while tending to children as a single mom. Shortly after graduation, she went into community mental health. Part of her decision to go in to community mental health was to qualify for student loan forgiveness; unfortunately, due to failing to consolidate her loans, she wasn't able to take advantage of that program. However, Deborah continued working in community mental health for 13 years. During this time, she worked in two different facilities. Her clientele was predominately the Alaskan native population, middle- and lower-income individuals, both male and female clients. She then switched to substance use disorder as a chemical dependency counselor working in an inpatient facility. Most of the individuals she worked with had a dual diagnosis, consisting of both males and females. She also worked in the attached detox center. The substance use disorder groups she led consisted of same-sex individuals, one group of women, one group of men.

Deborah never questioned her decision to work as a mental health counselor, and she said she has worked with some difficult clients. When she first came to Washington, she worked with men in the penal system. She said this was difficult as they were sex offenders and

pedophiles, and she had to develop a way to understand their points of view, bringing empathy and listening without disgust. The men under her care would complete the program to shorten their sentences.

Current Employment. Deborah's current scope of practice focuses on middle- to upper-income clients, mostly adults with some adolescents, and her clientele is predominately female. Deborah finds working with people the most rewarding part of her job. She said even when she was working with challenging populations, she got to know them so well and she can always find the good in people. She finds her biggest challenges are when her clients have low self-awareness and the paperwork involved, having to justify all decisions made. She said many stakeholders, from the employer to the insurance company, make demands and she feels she needs to justify all decisions. Deborah mentions the time element is so difficult to measure because two people diagnosed with the same disorder are most likely going to progress at different paces. The paperwork, especially in chemical dependency, is intense, and many times her treatment plans would span six pages.

When she moved to Washington, Deborah said even though there wasn't reciprocity between Alaska and Washington at the time, and Washington made her jump through hoops to get licensed even though Alaska is on par with Washington when it comes to required classes and hours. Washington also required Deborah to take additional courses to validate her chemical dependency certification. She said this took a lot of time and money, and she felt it was redundant. She was certified as a CDCII (chemical dependency counselor) in Alaska and had to start over in Washington, working to get her CDP (chemical dependency professional) certification. Deborah stated chemical dependency focuses on risk reduction presently, especially in our area, and she is on board with that—many people are in the

precontemplation stage and aren't going to quit. She sees other counselors now working to mitigate the damage caused by substance use: damage to the individual's health, their family structure, and even the community.

When Deborah was just starting her practice, she said her most difficult clients were those who suffered from social anxiety and were closed off, and she once referred out a client who reminded her too much of her daughter. The countertransference was strong, and she knew she couldn't be unbiased. She now knows how to deal with these types of clients after receiving therapy herself. She realized her low comfort level with social anxiety clients was due to her own insecurities; she stopped trying to direct the sessions and learned to read body language and not be so "pushy" and put people on the spot—less combative. She went on to take additional training in trauma, counseling sex offenders to understand motives, anxiety; basically, anything she didn't know a lot about, Deborah took more training regarding those topics.

Insurance & Sources of Funding. Deborah feels she had just as much paperwork before and after the rise of HMOs and managed care, especially in chemical dependency counseling. She has found many clients through specific insurances, choosing to become part of their networks. All the insurance companies have different contractual limits, requirements, and fees. She must agree to the requirements if she wants to be in-network, and charge only the fee they set. Some reimburse such a small amount; she doesn't take those insurances anymore. For example, Deborah worked with ComPsych, an EAP, early on in her practice to gain clientele. At first, the $35 an hour was worth it to get clients. However now, Deborah does not work for such a low amount as she has enough clients to support her practice, and many other EAPs pay more.

Personal Questions. When Deborah was in 8th grade, she interviewed a social worker, and the social worker told her to find a different occupation. She loves being a counselor and would not change her career. If Deborah were forced to pick a new occupation, she would do something outdoors—maybe a park ranger or similar career. She said she doesn't like that most mental health counseling takes place indoors. Although Deborah doesn't miss the low pay and long hours, she does miss having coworkers to discuss treatment and research. Although she is in an office with other counselors, she does not get many chances to see them, or meet with them to discuss approaches. Deborah mainly reaches out and bounces ideas off her retired colleague who started the practice with her.

Deborah has an eclectic toolbox of theoretical orientations: CBT, DBT, EMDR, MBCT, person-centered, relational, and strength-based to name a few. She mostly focuses on what the client needs and structures her approach after reaching a consensus on goals with the client. She refers

II. Work Environment

Organizational Structure & Clientele. Deborah works in a for-profit, private practice, outpatient, in an office setting with four other counselors. She avoids telehealth when counseling people with trauma and will only do telehealth with individuals she knows well. Deborah requires individuals to see her in-person at her office. She occasionally offers a sliding scale to referrals, but she has enough clients now to charge her normal fee. She will do house calls if someone is too sick to come in to her office but won't make house calls to those with anxiety problems—she doesn't want to enable avoiding behaviors. Her clients have diverse mental health needs such as schizophrenia, bipolar, personality disorders, really the full gamut, she said. Currently, her clientele mainly suffers from anxiety and depression.

Deborah said she refers individuals with schizophrenia and personality disorders to community mental health centers due to their complex nature, the demand placed on the counselor, and her lack of resources. She mentioned these types of clients need holistic treatment: medications, groups, and other specific needs. Her main objective is to help clients become self-sufficient with short-term therapeutic goals. She used to offer more free community psychoeducational groups when she was younger. Now, in her advanced age, she tends to keep a consistent schedule and focuses on her small group of clients, working part-time. Most of her clients now are middle-aged White women, in the middle- to upper-socioeconomic status, presenting with anxiety and depression.

Services Offered & Agency Demographics. Deborah occasionally does prevention and outreach, but mostly gets referrals through insurance and EAPs now if she does need clients. Her agency markets only through Psychology Today now and gets maybe a couple a month. Most of her referrals come from other clients. She works in a small setting, with other counselors who are women, somewhat diverse (three White women, one Hispanic woman), with two of the counselors specializing in pediatric counseling. Deborah's expertise is a bit different, having a background in chemical dependency and working with incarcerated individuals.

Prior Settings vs Current. Deborah said the pay working at a community mental health center (CMHC) was abysmal, but the benefits were great. She said the CMHC took advantage of students and those who are early in their careers. It is stable money, but it was still difficult to pay bills. She enjoys working for herself, the pay is much better although she must pay for benefits herself, she likes that she has the autonomy to do so. It was difficult for Deborah to complete all of the paperwork that was required of her when she worked at the

CMHC, and the amount she does now is merely a fraction. She was paid with a salary at the CMHC, and she would always take work home with her. She was not reimbursed for this, being told she couldn't work overtime, and she worked tirelessly to get things done.

Future Challenges in the Mental Health Field. Deborah feels more clinicians will move toward private practice quicker due to low pay and excessive demands. Especially after COVID, the stress and mandates that are placed on counselors working for institutions will continue to burn out counselors at a higher rate. She hopes that due to the increased need for counselors, work conditions at community mental health centers and other state and government organizations improve.

Deborah was easy to speak with and very conversational; she brought so much knowledge about the precise area of counseling I'd like to go into. She did confirm many of the things I've heard about community mental health centers; however, I am not swayed. I still feel drawn to the area in counseling that needs people, even if for a little while. Deborah gave me some great ideas on how to interact with certain clients, and tips for remaining calm and composed in difficult situations. My biggest takeaway is that even though mental health counseling is a demanding and tiring field, it is also a rewarding one.