HEALERS' HANDBOOK

Transforming Discord into Community Mental Health

A mutual aid mental health training handbook
by Joshua P. Aguayo

'Mire vuestra merced -respodió Sancho- que aquellos que allí se parecen no son gigantes, sino molinos de viento y lo que en ellos parecen brazos, son las aspas. [...]'

'Bien parece' -respondió don Quijote- 'que no estas cursado en esto de las aventuras; ellos son gigantes; y si tienes miedo, quítate de ahí y ponte en oración en el espacio que yo voy a entrar a ellos en fiera y desigual batalla.'

'Look, your grace,' replied Sancho, 'those that you see there are not giants, but windmills, and what seem to be arms are the sails. [...]'

'It is clear,' answered Don Quixote, 'that you are not that experienced in the matter of adventures; they are giants; and if you are afraid, move aside and say your prayers, while I engage them in fierce and unequal battle.'

From '*El ingenioso hidalgo Don Quijote de la Mancha* (1605)' by Miguel de Cervantes

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Introduction

Whoever you are, regardless of what skills you have or where you are in the world, this handbook contains everything you need to become an effective mental health support for your community.

Whether you're a professional looking to expand your toolset, a concerned citizen wanting to bring mental healthcare to your community, or a NEET (Not in Education, Employment, or Training) Clan Leader who can see the needs of their guild mates but has no way to support them: now you can change that.

This book provides the knowledge and guidance you'll need for a remote-first, disability-friendly work model that can be scaled according to the people and resources available in your community. The beauty of this approach is that it transforms what have traditionally been barriers—physical limitations, sensory differences, neurodivergence, chronic illness, or being homebound—into unique strengths in providing mental health support.

There are three domains you'll learn through this book: how to listen to people professionally; how to talk to people professionally; and how to not *tell* people what to do but instead help them figure it out by themselves. In other words, you'll learn Psychoanalysis and Psychology through the lens of Community Coaching.

I'm a Clinical Psychologist with a Master's Degree in Psychoanalysis and I've worked with people suffering from severe mental illness in Ecuador, the US, and Canada over the last 10 years. This handbook is a collection of key learnings from my formal education and the teachings of the many amazing mentors and supervisors I've had throughout my career, who really contributed the bulk of my formation. It's also a response to the unmet needs of the wonderful people I've met through my life as a life-long gamer.

This handbook leans heavily into Psychoanalysis and online culture, mainly because that's what I wrote my Master's thesis on: the therapeutic effect of Twitch.tv and its entertainers on their viewers.

Furthermore, I believe Psychoanalysis provides a more universal approach to working with and helping people while being experience-agnostic (meaning: it doesn't matter if you have previous knowledge or not) by teaching how to understand and listen to individual subjective experiences.

This handbook won't turn you into a Psychologist or a Therapist; instead it presents what I've called 'mutual aid mental healthcare': a community-based system where individuals trained in fundamental psychological concepts and therapeutic communication techniques (what this Handbook covers) provide accessible, non-clinical support to peers who have limited or no access to traditional services.

This remote-first, disability-inclusive approach transforms traditional barriers into strengths by leveraging both structured skills (active listening, thoughtful questioning, and collaborative problem-solving) and the lived experiences of providers and recipients alike. Operating within clear ethical boundaries that distinguish it from clinical intervention, this model democratises mental health support by creating healing spaces outside the professional healthcare system, particularly in underserved and online communities where clinical resources are unavailable, unaffordable, or culturally inappropriate.

If that sounds confusing: don't worry, that's what this book is about! In the process of working through it you'll learn how to help others figure themselves out, experience life more fully, and find peace— whatever that means for them. With some luck, you will learn a thing or two about yourself and find your calling in a sustainable job. Above all, I hope you will be inspired to join my quest of democratising mental healthcare.

If you would like to to support my work and help me continue creating free materials like this for people like you, please consider joining my supporters on Ko-Fi! It really helps keep me motivated and housed:

https://ko-fi.com/hgjosh

For consulting or training for your community, workplace, and other business enquiries please reach out to:

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You can also reach out to me on Bluesky. I'd be happy to answer your questions or provide support if I can:

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How to Listen Like a Professional

I'm going to use a lot of words to share knowledge with you, but this is what you need to remember from this book: there is no secret, all you need are the twin lights of curiosity and kindness to guide you.

Everything else can be learned, or trained, but the core fundamental trait needed for any kind of mental health work is being curious and kind.

It doesn't matter how many degrees you have on the wall or how many of Freud's books you've read: at the end of the day, the job is to sit down with someone and listen to them tell you about their lives for 45 minutes. If you're not curious about other people's lives and perspectives on the world, if you don't care about others, if you don't like gossip, it's going to be hell to hear people talk about ideas you might not agree with and people and places you don't know for hours each day.

Likewise, even if you are a social butterfly endowed with divine-like resilience and emotional fortitude, working with people is a demanding and eroding job. You will be meeting people at really low points in their lives, they will be angry, sad and scared and through their eyes you will see some of the worst humanity has to offer. You are not supposed to do this alone.

In an ideal world, anyone providing mental health services is themselves also a Client, whether it is therapy, counselling, coaching or spiritual aid. Please remember that healers need to be healed first, or everyone else also goes down. Self care is important, and should be a focus for you if you intend to apply anything I'm sharing with you in this Handbook.

With this in mind, professional listening is also different from just listening to a friend talking because the form (what it looks and sounds like) of a professional relationship is not accidental; on the contrary, it has to be well-defined and kept inside those boundaries. Meanwhile, the way we interact with regular people in our lives is generally dynamic and changes from time to time depending on our mood and feelings.

There are a few aspects that determine what a professional working relationship looks like:

Professional Boundaries: generally, boundaries are dynamic, and will shift and change as you continue to spend time with someone and you become more familiar with them. This is still true for a professional relationship—you're human after all—the difference is that there are some hard-limits that frame the relationship as a professional one:

Confidentiality: what is shared with you you must take to the grave, except when someone is in immediate danger or when commanded by a court of law.

Non-judgement: your role is not to determine what is right and wrong, nor to advise on ethics and goodness. your role is to listen and think together with your client the way THEY think, rather than the way you think.

Ethical limits: you can't date your clients, receive gifts, abuse privileged information, or add your clients on social media. They can't call you at 2am crying and you can't attend their birthday and hook up with their brother. **You are not friends, you are a friendly professional** providing a service and handling privileged information.

Most places will straight up fire you for breaching any of these. The logic is that being a listener, in a professional role, means there is always an imbalance of information and power in the relationship with your clients: they are encouraged to be vulnerable while you present a sterilized professional version of yourself; to pursue a romantic or business relationship would be to abuse a false perception that comes from that imbalance, to take advantage of someone who came to you for help, and would close the possibility of further work together.

As a general rule of thumb, you need to remember that the client is paying for the space and you both are at work. Let these two ideas mark the limits of your behavior: the discussion must remain focused on them and their problem at all times, and don't say to them anything you wouldn't say to your boss.

This doesn't mean you must assume the extreme 'empty' role of a Psychoanalyst where you deflect any questions and say nothing about yourself; on the contrary, your lived experience and intuition are powerful tools that might be useful for your client as well. Instead, strong boundaries allow you and your participant to be safe while using these tools to deal with delicate topics before, after, and during a session.

Depending on the context, you can use physical items to help strengthen those boundaries as well. This is why some institutions might ask their workers to wear a white coat, or even a uniform. The desk in between you and your client is another physical boundary, and the interface of a web call can be another. You can use these in different measures depending on your specific context, for example: if you work in-person and you have a quite sterile office, you might be more casual with your language or just generally more easygoing with your practice; likewise, if you are working in a phone call, where the only physical boundary is the phone, it might be important to be more strict with boundaries like punctuality or accountability.

Try to remember your own experiences with service providers through your life: what made you feel comfortable and what made you feel annoyed? Keep these things in mind as you present yourself and your physical/virtual space to your clients.

The keys are active listening and intentional choice of words. Look at the following statement and the possible responses below, pick the one you would use before moving on (or don't, I'm just a book):

Client: '[...] Yeah, I haven't been able to quit. I'm still smoking a lot, but at least it's medical now. I got a cannabis prescription last week, but I feel awful. It was a 5 minutes talk and they prescribed twice the amount I use in my worst months, you know what I mean? Have you ever smoked?'

Response 1: 'Oh don't even start, I get the medical too, it's amazing, two hits and I'm hitting the stratosphere. Don't worry, weed is not that addictive, you'll be fine if you just work out at the gym. I recommend 3 times a week: Check THESE guns out.'

Response 2: 'I have, and I see what you're saying. I've heard similar stories, not just with my clients but with close friends too, people who have had a lot of issues quitting weed. Maybe we could look for specialized help, like Cannabis Anonymous or something like that. Have you ever looked into groups like that?'

Response 3: 'It sounds like this provider wasn't really interested in listening to you, I'm sorry to hear that. What would be different depending on whether or not I have used weed before?'

If you thought: 'Number 1 is awful, but 2 or 3 could be okay depending on the context,' you are correct! Let's look at them closely:

Response 1 fails because:

- ➔ It imposes the speaker's worldview on the client (asserting weed is not addictive)
- ➔ It glorifies the very issue our client is trying to deal with (weed use)
- ➔ It closes the conversation and truncates the client's ability to reflect on the topic ('Don't worry bro, just go to the gym.')
- ➔ And obviously, don't show any parts of your body to your clients, no matter how proud you are of them.

Response 2 and 3 are valid, but under different circumstances.

Response 2 seeks to strike a balance of professionalism and warmth. The **information revealed has a purpose**: Building rapport, validating the person's experiences and exploring what they have tried so far.

Response 3 is an 'I don't know what to say so let's stick close to the book' kind of response. It is safe (minimizes the speaker's opinion and focuses it on the client), it validates the client's perception, it encourages self-reflection from the client and gives you some more information and time to work with.

Deflective responses like these are great when you've just started working with someone and that working relationship isn't fully defined yet or when the conversation needs to stick to a certain topic, like when you're doing an intake at an institution and there are specific questions or information you need to gather.

The idea behind an answer that doesn't reveal much about the speaker is that the space belongs to the client and we are trying to learn from them while helping them learn about themselves. There is no need to bring up ourselves unless it serves that purpose and, in fact, it can be counterproductive, by deviating attention from the topics at hand or communicating unintended misinformation.

While Response 2 would be closer to an 'ideal' intervention, it would only be appropriate in the context of an established working relationship. Having built some rapport with your client makes the difference in how they might interpret this response. It could go from 'Oh no, they're a stoner. I can't work with a stoner' to 'Oh, they're stoner. If they (seem) to have their life together, maybe I can do it too.'

Let's move on to the next important element of working with people:

Professional Linguistic Framework

You know how there are things you say with your friends or online that you would never say in front of your sweet grandmother? That's because those two groups of people have two different **linguistic frameworks: the words that make sense to use in communication.** This is not intentional; instead it is just the result of the way language works. Language is a chain: all words are connected to other words. In fact, that's the only thing they are connected to.

Let's look at more examples: one could probably explain the *Omegaverse* to my grandmother even if the word is not in the dictionary and she only speaks Spanish. Likewise, the word *'skibidi'* is *Ohio* in some contexts, but not in others. See where I'm going with this? These words only make sense *some* of the time and to *some* people. Does this mean these

words are fake? Well, they communicate information and they are used like all other words, so what makes them different? The dictionary is arbitrary: some person has to choose what goes into it. That's why *-ussy* is in the dictionary.

I'm trying to illustrate **one of the main characteristics of language**: not only **it is made up,** but it never refers to what's actually in your head. Instead, it refers to the words that describe what's in your head, which in turn you can only explain with other words. See the chain?

If I ask you to imagine an apple, you likely can, but I'm sure it's not the same one I imagined. Mine might be of a different color, size, or maybe mine is candied. Even if I were specific, and asked you to imagine a green, half-rotten apple: am I referring to a green skin or to green as in rotten? Did you include worms?

These examples illustrate this core characteristic of language: it is imperfect, limited. Words can only refer to other words. Think of it for a second: try to communicate a message without using words, not in your head either.

You can never communicate exactly what's on your mind. Not only that, but even if you could exactly put into words what's on your mind, interpreting those words once you say them depends on the other person, on the listener, who will interpret your words with a different set of experiences, understanding and context.

This is why miscommunication is an inevitable part of human interaction. It's normal, not a mistake or something to be ashamed of. We just have to plan around it instead of pretend perfect communication exists.

This is also where linguistic frameworks emerge naturally: as we spend time with someone the words we use change in meaning slightly, slowly, as we come to understand the people involved and we come up with more specialized words to communicate information inside that particular linguistic context.

'I'm hungry,' means something slightly different when it comes from your favorite sibling, than it does when it comes from your boss.

The collection of these minute changes mean that we effectively talk in different ways and use different words depending on who we're talking to. When done well, this makes communication more efficient and makes us feel connected, but it can also be the source of isolation. For example: when people, either professionally or otherwise, use only lingo and acronyms to communicate, it effectively creates an in-group and an out-group, even if unintended. Here's an example: '*RL says it doesn't matter if you're the GM's power bottom if you're not parsing high enough you can't roll on dps tokens at MC.'*

This is why it's important that you, as a professional listener, are aware of this framework as it changes and evolves naturally. You might begin the first sessions with someone in a more formal and structured manner, working from shared language and then naturally flow to match your Client's level of formality as a shared collection of words and meanings emerge.

If you speak a language that uses different registers depending on how formal or respectful the speaker is being, you can even see this happen in real time! For example in Spanish: a Client might straight-up ask you if it's okay to address you as 'tú' instead of 'usted', going from formal to informal registers as they feel more comfortable with you.

You, as a listener, are being invited to look at words the way your Client looks at them, and your job is just to do your best and try to see the world through their eyes for a moment and help them think about what they can see. Consider this example:

In a common interaction, it doesn't really matter if my meaning of 'love' doesn't match the meaning of 'love' of the other person. If they tell me they broke up with the love of their life, I get the general idea.

However, in a professional setting, if you're trying to help someone think, understand themselves better, and get new ideas, it makes more sense to ask: 'What does love mean to you?' Not only so that you yourself can understand the situation better—by inquiring you're also literally asking the other person to think about it more deeply; that is your role and why they are talking to you in the first place, but it is also why you must be careful and intentional about the things you ask. We all have things we just don't want to think about, ever or in a particular time, and that is ok.

For you as a Healer, getting better at your job means learning how to ask better questions, not necessarily coming up with answers, that’s the Client’s job. This is also where curiosity becomes an asset: if you're curious, questions will naturally come to you; you just need to select the ones that might be useful to your Client. Another thoughtful question in this example could be, 'what's the difference between the love of your life, and just someone you love very much?' Whatever you say, what matters is that you have a reason for saying or asking one thing and not another.

Remember, they already have the answers they are looking for: you just have to help them find them inside themselves. Your job is not to come up with answers; it is to come up with questions, and this is how you do it intentionally.

Motivational Interviewing (MI)

Motivational Interviewing (MI) is another tool that can help guide your active listening and professional posture (that's what I just taught you up until now). Motivational Interviewing is a collaborative, person-centered counseling technique designed to find and strengthen motivation for change (like quitting drugs or starting a work out routine). It's particularly valuable in community mental healthcare when working with clients who may be ambivalent about behavioral changes; this means they know what they want to change but struggle to put it into action.

You can probably think of some 'behavioral changes' you are 'ambivalent' about if you think about it for a second: consider things that you do, even if you know they are not that good for you, or maybe you know you shouldn't do it at all. It can be self-destructive habits, toxic relationships, lifestyle or diet changes you've been postponing, and so on. MI tries to help the other person find motivation inside themselves.

The core principles and skills taught by MI can be deconstructed and are excellent pillars for any kind of work with people, and in my experience as both client and therapist, it also resonates naturally with neurodivergent people.

I invite you to explore this topic further on your own, as training you in MI would require its own handbook. However, I want to share with you the principles and skills at the core of MI, since I believe these are ones you can learn and use most easily. These appeared for the first time in William Miller's 1983 publication *Motivational Interviewing with Problem Drinkers*

Sticking to these principles and mastering these skills ensures that 'client-centered', 'strengths-based', and all those SEO terms aren't just profit-increasing buzzwords, but actionable, practical items that you can incorporate into your practice.

Core Principles of Motivational Interviewing (R.U.L.E)

These four really extend to your entire professional practice. They are great recommendations that you can always rely on if you feel lost or unsure about how to act in a particular session.

- (**R)esist the righting reflex** (don't tell people what to do).
    - Our role is not to make choices for people. They are adults who can think for themselves and who know themselves better than anyone else in the world. As

helpers, there might be a natural impulse to offer solutions: DON'T. Remember, you are there to listen and ask questions; they have to do the work themselves, otherwise you might completely lose them, since you'd be just one more person trying to 'fix' them. Those are easy and free to find.

- **(U)nderstand the client's motivations**
  - Be curious, join them in their journey. Imagine you are an alien who just made a human friend or an idiot protagonist that just got reverse-isekai'd. Ask questions about words that seem mundane, such as, 'what do you mean you want to be less toxic?' Another illustrative metaphor could be to imagine you are tinkerers, looking together at a half-finished problem on the work table: you want to be able to see what is being fixed and what resources you have available as a team as clearly as possible before taking action.
- **(L)isten with empathy**
  - See yourself as human first and understand the humanity in others. You have to remember that nobody is perfect and that's okay, because sometimes you'll have to remind your client. Remember that no matter the choices your client has made there is nothing special about you that is preventing you from making the same mistake. Give them a break the same way you'd appreciate being given a break when you fail.
- **(E)mpower the client**
  - Help people grow, help them make choices and gain confidence in themselves. To do things for them is to make them dependent on you. Spare them such cruelty and instead believe in their own abilities, so that they can believe in themselves as well. Help them tame their light and give form to their shadow.

Essential Skills in Motivational Interviewing (O.A.R.S.)

These are as practical as it gets: these are ways of speaking that promote reflective thinking and help a conversation flow. They are weirdly great for making small talk in general as well.

- **(O)pen-ended questions:** when possible, ask the opposite of a yes/no question: a question that doesn't have a monosyllabic answer and makes you think. '
  - 'What can you tell me about the way things are right now?'

- ➢ 'What is the smallest step we could take to try and make this better?'
- ➢ 'What would success look like for us in this space?'
- ➢ *Advanced:* 'You said your Anxiety is at a 6 out of 10. What makes it a 6 and not a 5?'

❖ **(A)ffirmations:** don't assume people can read your mind or that they implicitly understand something. Make things explicit and communicate with your client. Let them know you understand what they are saying and that talking about some stuff is not easy.

- ➢ 'I appreciate your willingness to discuss death and suicide, I can imagine it's not easy right now.'
- ➢ 'That is understandable, I think myself and any other human would be sad about a loss like that too.'
- ➢ 'It sounds like you made the right choice there, even if you didn't have a lot of other options really.'

❖ **(R)eflective listening & summarizing:** these two are usually presented as separate, but I believe they serve the same function. They let you verify your own understanding of what the client has said so far. It shows them that you are actually listening and sometimes it lets them hear what they are saying but with different words. Both are indispensable skills to have when working with people.

- ➢ 'Let me make sure I understand what you've shared so far: your family is large but you only get along with your sister and this is why this fight is so bad, even if you normally don't get along with your family anyways. Because she is special. Is that correct?'
- ➢ 'Would it be fair to say that you tried your hardest, even if you didn't succeed? I understand you failed, but from what we've been talking it sounds like you gave it your all.'
- ➢ 'From what I'm hearing, this person sounds quite toxic, am I onto something there?'

Receiving (and giving) feedback

The final professional skillset you'll need for active listening pertains to giving and receiving feedback. This will be fundamental in all of your professional relationships. We'll focus on receiving feedback first.

Clients and supervisors will both have things to say about you and the way you work; not everyone will have read this handbook, and not everyone will be able to provide opportune, constructive feedback kindly.

There are two things you need to keep in mind:

First, there is always room for feedback, but that doesn't mean you're always wrong. Instead, since every person and case will be different, there is always a little bit of adjusting your technique to the new person.

Second, you need to be aware of your initial response. Don't let your emotions take over. Fight the natural defensive reaction and keep a cool head, especially when feedback feels uncomfortable.

With this in mind, especially when you are starting, it might be a good idea to simply ask your Clients for some feedback by your second or third session. This can take many forms, but here are some examples I have used in different settings:

'As we end our third session here, I just wanted to ask for your opinion on how things are going so far. Has this space been useful? Is there anything you think we should change to make it more effective?'

'Just so I get an idea of how to orient this space as we continue to work together: what is your impression of our work so far, are there any changes I should make or anything I should keep in consideration?'

Regardless of how you ask, you are likely to get an answer with two components:

An emotional component (e.g. I think it has been going well so far, I feel relaxed and safe.), and a practical component (e.g. maybe we could talk a bit more about codependency next time, I kinda get it but I'm not sure...)

The **emotional element** is important as a thermometer: it gives you an idea of how things are going, but emotions are fickle; they change from day to day and from session to session. Keep them in mind, respect them, but don't change your actions solely on emotions (yours or theirs). Remember they are talking about specific actions in the context of you providing a service; they don't know you as a person, and you must learn to make that separation. Don't take things as personal, because they are not. We'll go deeper into taking things personally in the Transference section of this book.

The **practical component** allows you to act intentionally. Nobody knows the participant better than themselves, so if they suggest a specific and concrete change, execute it, unless there is a good reason not to. Remember, you're a team trying to solve a problem together: they trust your knowledge and problem solving, you must trust their intuition and self-awareness.

Finally, remember that feedback has a scope. That specific Client is providing you feedback for a specific session or period, consider if there are greater lessons that you could add to your toolbelt for next time, but don't feel pressured to fundamentally change what you do, adapting your whole process every time. Small adjustments are just part of working with people and the way you do things will naturally change and evolve as you learn more and gain more experience. Just make sure you know and understand the reasoning and logic behind the choices you make.

When it comes to supervisors, follow the same logic when receiving feedback but remember: your role is to help people, not to serve the faceless, gluttonous maws of capitalism while maximizing the profit you extract from your Clients.

We will explore this further below in the section about meta-communication, for now, let’s move on.

How to Understand Like a Professional?

Work or family stress, grief, relationship challenges, living under capitalism while neurodivergent and trouble with major life transitions. These are the major non-clinical reasons people will come to you looking for help in the 21st century.

Add to these Anxiety and Depression and you've covered a good majority of what you would see day-to-day in most communities. These latter two are immense topics by themselves, and treatment entails both clinical (understood as services intended to diagnose and treat specific mental health conditions, provided by a licensed healthcare professional) and non-clinical interventions.

We will look at them in more detail further ahead, but generally speaking: there is a level of intensity or frequency where the symptoms of Depression, Anxiety (or anything else really) need a Clinical or pharmaceutical intervention. In that case our role is simply to know where to refer our Client and how to help them access the resources they need. This handbook is not intended to prepare you for Clinical Assessment or Clinical Interventions, however you are learning many of the tools and skills that would be used in a Clinical Setting and gaining the language required to communicate in these.

In the online era, people who come to you will most likely have an idea and some concepts to describe what they are going through:

'This last year I've been suffering from Anxiety.'

'I know I have to leave, but I can't stop thinking of our kids.'

'I'm not sure if I can keep doing this job, I think I'm burned out.'

'Nothing feels enjoyable anymore, I might as well be eating ash for lunch.'

However, you must remember that our eyes cannot see themselves. Someone who is depressed can only see themselves through the lens of Depression. Someone who feels defeated and exhausted can only see themselves from the point of view of someone who is defeated and exhausted.

This is why people look for help, because we all know instinctively that things can get better, but we're not always able to see the path forward. Therefore, a fresh set of eyes that can be trusted to act with utmost ethics and professionalism is sometimes needed to break the stalemate.

This is your roleL to see from a wider perspective, and then relay what you see to your Client, see if it makes sense to them or not and then repeat. In many ways you are giving them vocabulary to help put their feelings into words.

The idea is that it's difficult to work on something you don't understand. Something that you can't put into words is something you don't understand. And in many ways, understanding is simply the process of gaining more words to better describe an idea or aspect of nature.

These are high and abstract concepts, but they are just another way of saying that our job is to think together with the Client about the problem they are bringing to the table. In practice, sometimes you will be just remembering things your Client has said before and helping them organize their thoughts, and other times you will be pointing out contradictions in their own logic: not to 'fix' it, but simply so they can see it. It's up to them what they want to do with it, and you probably didn't have the whole picture anyway. A quick example might look like this:

Client: 'Nothing feels enjoyable anymore, I might as well be eating ash for lunch.'

Healer: 'That sounds rough, is there anything that's still kinda enjoyable? I think you mentioned you were looking forward to a new book last time we spoke, the one with magic and cyberpunk drama?'

Client: 'Cybernetic Mages, yeah… I haven't finished it, but maybe I will. I guess you're right. At least it helps time go faster, you know? Be less in my head.'

Healer: 'Is being up in your head good or bad?'

And so on. Sometimes remembering what somebody told you, being curious about their feelings or helping them be accountable to what they've said before is all you need to do. Sometimes your perspective will need to go a bit higher to gain a wider view, here is where formal knowledge about mental health comes into play.

Your goal is never to diagnose, but instead you can use your knowledge of mental illness to have a deeper understanding of the situation. For example if you are familiar with Depression and its most common symptoms, you can use that information to anticipate the challenges your Client might have and suggest more appropriate interventions or referrals.

The idea here is not to provide you with a secret recipe of things to try to suggest. Instead, I hope to show you the logic behind different interventions in a way that you will be able to use those core ideas to guide your own learning and practice and apply them to the specific needs of your community.

Finally, you must keep in mind that labels and diagnosis in mental health are descriptive, not prescriptive. This is the opposite of physical health. Let's look at this with an example:

If I catch Tuberculosis, medical personnel can identify what's wrong with me with almost complete certainty and then they can use that knowledge to anticipate what's going to happen to me and prepare accordingly. It gives them a clear therapeutic direction and steps to take. I don't even have to do that much really, a lot of the responsibility will fall on my service providers.

But with mental health it goes the other way around. First you have symptoms that may or may not be normal. As we'll see below, both Anxiety and Depression come from natural, normal mental processes. Then, at some point, you have enough symptoms or they become intense or frequent enough that they 'match' with the definition of some mental health illness, which itself has been defined over time by looking at groups of symptoms that often come together.

Notice how this is circular? We looked at the symptoms that often come together, called those symptoms 'Depression', and, if you match with those symptoms, that's what you have.

This is just an unchangeable limitation of mental health: you can't fully observe the object you are working with from the outside. There is no *Mycobacterium tuberculosis* to identify, there are no blood tests to run that will quantify the depth of the sadness you feel. We can observe the brain and how it changes, we can look at behavior and we can listen to the speaker, but in no way can we directly observe the experience the other person is having. So no concept or definition in mental health will ever be complete.

Think of it like this: we can agree that the sky is blue, but I will never know if the actual color we see is the same. We just agree to give that name to the color of the sky, whatever it looks like to me and whatever it looks like to you. We can agree I have Depression, but no one will ever know exactly what I go through, it's just incommunicable. This is part of the reason why mental health issues can be so isolating, keep that in mind.

Depression

You probably have an idea of what Depression is—if you're this deep into this Handbook, you're also likely to know somebody who has struggled with it, or perhaps you've experienced it yourself.

One of the core distinctions worth understanding about Depression is the difference between clinical Depression or depressive traits, and the normal processes of grief or sadness.

This is not a new question. While I'll combine it with modern perspectives, I think a great way to start understanding it is through Freud's 1917 book *Mourning and Melancholia*. Although 'Depression' as a concept didn't exist yet in his terminology, Freud describes this dynamic (paraphrased): when there is an 'object of affection' (which can be anything—a person, an idea, or a literal object) that we enjoy (for whatever reason, the simplest being that it satisfies our needs), we perform a sort of 'investiture' where we endow the object with special meanings and feelings. We make something special for us.

Freud would describe those meanings and feelings as a kind of 'psychic energy' connected to the primordial (and hard to put into words) drive that pushes you to stay alive and survive. This life-drive Freud initially called 'libidinal energy' since he connected it to sex, but later writers have come to understand it as separate, with sexuality being an expression of it.

This is a complicated way to explain what happens when you adopt a puppy, make a new friend, or fall in love with the characters in a book. In Antoine de Saint-Exupéry's '*The Little Prince*' the fox offers one of literature's most beautiful illustrations of 'cathexis' (the technical term for this process of endowing an object or subject with ‘emotional energy’):

'To me, you are still nothing more than a little boy who is just like a hundred thousand other little boys. And I have no need of you. And you, on your part, have no need of me. To you, I am nothing more than a fox like a hundred thousand other foxes. But if you tame me, then we shall need each other. To me, you will be unique in all the world. To you, I shall be unique in all the world.' - Antoine de Saint-Exupéry, ‘The Little Prince’, 1943

‘Mourning’ is the natural process that occurs when this special object, endowed with meaning and made unique, is lost. The process of sadness and grief are then literally what that process, of an object being de-invested from those emotions and meanings, feels like. Grief is what letting go feels like.

Freud contrasts this natural process with ‘Melancholia’, where these feelings get stuck for whatever reason and rather than grief completing normally, the emptiness from the loss outside becomes internalized, copied to the psyche of the person. Sometimes you can hear this when people say 'I feel empty since they left, nothing is fulfilling' or 'I feel like I died with them.'

Modern perspectives have gone on to identify these as the symptoms of Depression and would also allow us to describe this process in terms of neurotransmitters, pointing to an imbalance, a different level of neurotransmitters compared to the brains of people without

this issue. Along the same line, we could look at Depression in terms of learned attitudes and ingrained beliefs, that were set over time through life experiences and the actions of others, but that remain malleable, plastic. You can unlearn what you've learned; your neurons can unmake the connections they have made.

It is important to remember that all of these are perspectives on the same thing, like changing lenses under a microscope, or looking at a sign from the front and then from the side. Your entire experience of life is codified in neurotransmitters, but you can also only communicate it through words. Each lens allows you to see something new but also means losing sight of something else. See them as tools to different ends.

It's not that an imbalance of neurotransmitters causes Depression, or that Depression causes an imbalance of neurotransmitters. Instead, these are two descriptions of the same condition that has a physical component, that then gets translated under the light of awareness into your experience of being depressed. Pills change this because they affect the neurotransmitters in your brain, but talking, experiencing life, reflecting, listening to others, also changes the neurotransmitters in your brain, because your whole experience of life is just your neurons spitting neurotransmitters at each other and connecting to other neurons!

This is of course, just one example, connected to grief. In reality, Depression will take many forms, and can have many contributors to it: Adverse Childhood Experiences (ACEs), generational trauma, identity conflicts, genetics... This means that Moderate and Severe Depression usually will need a Clinical approach, focused on differential diagnosis (figuring out what's wrong) and that combines psychotherapy, provided by a licensed professional, and pharmacotherapy, considering it might take a few attempts to find the right medication. Usually this process will also include lifestyle changes where appropriate. In this case your role is simply to redirect to the appropriate professional.

Unfortunately, finding a therapist is often a challenge for a lot of people, whether it's a matter of access or money. Medication is usually available in different measures through public health programs in areas like Canada, Europe and most of Latin America, but in some places, like the US, any medication might be prohibitively expensive. This handbook exists precisely because of these accessibility gaps.

This means that inevitably people whose needs exceed your professional abilities will appear. It's important that you are aware of your own limitations and are able to point them in the right direction. Of special note, suicidal ideation should always be taken seriously and redirected to emergency service providers (ideally at intake). An irresponsible or unprepared intervention is often worse than no intervention at all.

Anxiety

Anxiety is complicated. There are many perspectives and theories on where it comes from and how it works, some of which I'll share with you, but I believe this complexity responds to the fact that 'Anxiety' is partly defined by the context and culture of the speaker. Is being nervous the same as being anxious? Is the Anxiety you feel before an exam, the same Anxiety someone with a Major Anxiety Disorder feels? Even the DSM-5-TR, the psychiatric manual that lists all mental health affections and their diagnostic criteria (you can check it out for free on archive.org if you're curious about it), steers away from providing a clear definition or etiology for 'Anxiety' as something you feel, and instead characterizes it as part of Anxiety Disorders or as a component for other clinical presentations. In your everyday life when people say 'Anxiety' they will often refer to the feeling we're talking about, but keep in mind some people might be using the word 'Anxiety' to refer to a clinical diagnosis, like Generalised Anxiety Disorder. Let's start with the things that most perspectives agree on.

The sensations you experience as 'Anxiety' seem to be part of a normal, physical, and evolutionary-advantageous adaptation in humans (and most mammals). Our ancestors were severely disadvantaged when it came to hunting and being hunted. To compensate, our ancestors gained the ability to enter a state of heightened alertness and attention: increased blood flow to extremities and muscles taken from non-vital functions and a flood of neurotransmitters and hormones make you stronger and slow down the passage of time (just for you, of course). Now you're ready to either run from the tiger or start chasing the mammoth.

Posed like this, it almost sounds like a super-power, and it probably was a key advantage that led us to where we are today. Even hyper-sensitivity makes sense in this context: a false-positive (running when there is no tiger) would be much less costly than a false-negative (not running, right before you're eaten by a tiger), so it would be selected for. Keep in mind that Anxiety also had in-group functions. For example, Social Anxiety serves a group function by encouraging homogeneity and harmonious behavior, and Health Anxiety serves a function by preventing the group from eating whatever poisonous thing they just found on the ground.

This idea is also connected to the individual variation that exists around the experience and intensity of Anxiety every individual feels. The idea is that all levels of Anxiety-sensitivity are valuable to a human group. You need low-Anxiety individuals to charge at wooly beasts ten times your size but you also need high-Anxiety people to set up

traps and keep watch, to ensure that the group is not poisoned by snakes in the middle of the night and that the rotten meat is thrown out in time.

Furthermore, the experience of Anxiety seems to have some common characteristics most people can agree on (including the DSM-5-TR):

- It is typically associated with muscle tension and hyper-vigilance, some people might describe this as 'being constantly on guard'. Some people might describe this as tightness in their chest or neck.
- It often includes avoidance/reduction behaviors. In other words, you are driven to do things to reduce that Anxiety, like going for a walk or taking drugs.
- It can be adaptive in certain contexts but becomes pathological when excessive or persistent.
- It differs from normal fears in intensity, duration, and interference with functioning.

Anxiety becomes problematic in our present-day because most of us don't experience life-threatening risks day by day. While our rational mind and environment can be easily adapted to this new reality, the physiological structures at play in the rest of our body can't adapt so easily. You can't really explain to your heart and supra-renal glands that, while you do need to take an action about your immediate concerns, they are not life threatening, and you certainly don't need to enter MAXIMUM OVERDRIVE mode to write a resignation email, go grocery shopping or to talk to the person you have a crush on.

This is confounded by the natural mechanisms we spoke of before. Anxiety is self-sustaining, you may hear this when people say things like 'sometimes the fear of having a panic attack gives me a panic attack.' The logic here is that it is much harder to know when 'the threat has passed' when the thing you're running from isn't as concrete as a hungry sabertooth tiger, but instead it is an abstract, nebulous, capital-first concept like 'societal expectations of success'. In many ways, the threat can never pass, instead work would be around re-symbolizing what those social expectations mean. (This is a fancy way of saying you'd try to help the person stop caring so much.)

As with Depression, moderate and severe Anxiety cases are best treated by a combination of psychotherapy and pharmacotherapy. Medication tends to be quite effective to quell feelings of Anxiety, but you must remember, medication only quiets down the symptoms: it doesn't resolve the underlying issue. This is why a combination approach is recommended. Medication makes it easier for the person to pull away from the entrapment of Anxiety, and helps them have a clear mind to work on whatever the core issue is in a psychotherapeutic

context. In other words, medication lowers the volume, and therapy changes the lyrics for the song.

If we focus now on the psychological experience of Anxiety, we can explore some ideas as to what happens in your mind when Anxiety becomes problematic: in other words, we can talk about what triggers our natural mechanism of Anxiety into hyper-activity. Just remember, looking at the psyche and looking at the brain implies looking at the same thing, just through different lenses (the lens of language versus the lens of biology). We are talking about the same thing.

We will be paraphrasing Freud's findings in his 1926 work '*Inhibitions, Symptoms and Anxiety*', where, near the end of his career, he proposed one last model for Anxiety, superseding the ones he had presented before. If you're a fan of attachment theory or object relations theory, reading '*Inhibitions, Symptoms and Anxiety*' will present you with a lot of familiar concepts and ideas. (Melanie Klein was a psychoanalyst after all.)

The key idea for your practice as a community Healer will be understanding Anxiety as a defense mechanism. The same way its biological characteristics are there to preserve your bodily integrity, Freud proposes that its psychic characteristics (what Anxiety does to you in our modern world) are also better understood as a defense mechanism. While this is one of the few defence mechanisms identified by S. Freud, it will be his daughter Anna Freud who deepens his work on defense mechanisms and identifies many of the mechanisms our minds use to protect ourselves when the demands of real life exceed our ability to cope. (Ourself understood as 'the Ego', you. The part of your mind that experiences life and can talk about it.)

With this in mind, S. Freud proposes the following model (simplified):

When we are born, we simply lack the mechanisms to deal with the influx of sensory information suddenly rushing into us as we leave the womb. This would be the first (of many) times we experience a sort of primordial Anxiety, an Anxiety that exceeds our physiological capacity to cope. Then, as we continue to grow, this primordial Anxiety fades to the background, but never disappears: it becomes a template for the Anxiety we feel as grown ups. Freud continues to explain that there might be other types of these 'primal' Anxieties as well. For example, Separation Anxiety would appear the first time the baby feels hungry, and the mother fails to feed them immediately. The reality of being a defenceless, potentially about to starve baby, then forms this original experience of separation Anxiety, of which grown up Anxieties are echoes.

Freud argues that if Anxiety has a primordial origin like this, then that would explain why other 'symptoms' (everything wrong with you is called a 'symptom' for Freud) can be so difficult to displace: Addiction, Depression, your toxic bf, a shitty personality… Under Freud's view, these are there to protect the Ego, you, the speaker, from that primordial and overwhelming Anxiety. You can think of your own death and the legacy you are leaving behind, if you'd like to feel what I'm talking about for a second, as a treat.

A full-on panic attack would be a moment where you experience this primordial Anxiety, unprotected by the defence mechanisms your mind can conjure. This is why a strong part of helping someone cope with Anxiety is showing them how to manage the aspects they can actually control. For example, by learning breathing exercises, meditation and attention redirection techniques.

Freud goes on to describe three forms of Anxiety:

- **Reality Anxiety:** that comes from perceived or imagined threats that have a basis in external reality. (Like knowing you live in bear country or a bad neighborhood.)
- **Neurotic Anxiety:** that comes from the desire of wanting to do something that we can't, aren't allowed, or shouldn't. Like being in love with someone that is not interested in you.
- **Moral Anxiety:** comes from the internalised notions of what 'you are supposed to do'. A common example is someone who grows in a strict family or culture and internalises those values, even if they don't match their own experience of the world and personal wishes. For example, some men are concerned they aren't manly enough based on their own (learned) version of manliness.

In practice, understanding Anxiety as part of a greater mental mechanism will help you and your Client know where to look and what questions to ask. The more practical way to help someone who is dealing with these challenges would be to help them replace those maladaptive defense mechanisms with ones that are better suited to modern life: instead of doing drugs in a dark room, let's try to go for walks by the river when you feel AAnxiety is coming. Instead of drunk-texting your ex when you drink because you feel lonely, let's do something when you start feeling lonely, rather than when you can't handle it anymore and end up drinking, and so on. We'll look at the practical side of finding and achieving goals further down in the book.

And while this sounds pretty easy, you have to remember that you're dealing with a mind that has had years to settle itself into its current dynamics, and that those dynamics are there

to protect the person from feeling even worse. Feeling anxious and not knowing why might be a more manageable feeling than wanting to end your own life, for example.

This is why we've explored Anxiety from many different perspectives, and it is why you must always let your Client be the one to lead the way: only they know what's the best way to go forward. Your job is to help them see what paths lie ahead, and what path they've taken to get where they are. It is up to them to choose when and how to move.

Finally, you must remember that talking about Anxiety will often uncover a mosaic of memories, feelings, and beliefs that are keeping that Anxiety in place. (These are the things defense mechanisms are defending from.) It is never your role to 'dig deeper' or find a capital T Truth: everyone can spiral on their own. Your role is the opposite: to ensure that they are ready and in a good place to do that thinking and feeling, and that the space where they are exploring those ideas is safe and comfortable.

Exploring and understanding each of these elements then helps the Client start making choices about how they take care of themselves, rather than reacting when things get out of control. Meanwhile, relaxation techniques, new learnings, medication, and practical lifestyle changes help create enough stability for us to be able to do the work of reflection and making intentional changes as needed.

We will explore this further down in the book, but it's worth mentioning for now that we also have a word for what happens when the stimulus and demands of the exterior world overwhelm the mind and its defense mechanisms. We call this ‘trauma’. Please note that while this book seeks to make you trauma-informed, working with and processing trauma requires special training and often multi-disciplinary approaches. If your Client wants to focus on trauma-work, it would be best to refer them to a mental health professional with the appropriate training and experience.

Addiction

Addiction is one of the most explored and well-studied areas of mental health, and it is the most visible side of a worldwide mental health crisis. It is strange then that it is also one of the most stigmatized mental health issues, mainly because there is this false perception that willpower or morals are involved, but as we'll see further down, the very definition of addiction implies a loss of control in the same way the definition of Anxiety includes involuntary physiological changes. To make it even more complex, addiction is often just one part of a mosaic of mental health challenges and rarely is it possible to treat addiction without working on the other aspects of mental health as well. I want you to understand why this is.

Let's begin with a working definition of addiction. Since it is a complex phenomenon, influenced by history and culture, exactly what is called an addiction can change. Is drinking every Friday a sign of addiction? It doesn't matter; we're not trying to diagnose the Client. Instead, look at what kind of help they request, listen to the details of how they are feeling and what they are doing, and try to help them think about what's going on and the path forward.

We can start with the concept of addiction as presented by the Canadian Mental Health Association, which is pretty dense but covers all the basics:

'Addiction can be broadly defined as a condition that leads to a compulsive engagement with a stimuli, despite negative consequences. This can lead to physical and/or psychological dependence. Addictions can be either substance related (such as the problematic use of alcohol or cocaine) or process-related, also known as behavioural addictions (such as gambling or internet addiction). [...] in Canada it is estimated that approximately 21% of the population (about 6 million people) will meet the criteria for addiction in their lifetime.'

Let's unpack this.

First, notice that addiction does not always mean addiction to drugs. One can be addicted to gambling, sex, videogames, shopping, adrenaline, work. Anything can become an addiction.

Another key element is the 'compulsive engagement with a stimuli, despite negative consequences.' It sounds alien, but this is referring to exactly what comes to your mind if you think of an addict: someone who keeps using drugs even when they see their teeth falling out. Someone who keeps gambling after they've had to remortgage their house.

But it is the word 'compulsive' that does the heavy lifting here: compulsive means that the behavior—using drugs, gambling, gooning—is driven by an irresistible internal urge or pressure; some people will describe this as a loss of control. Engaging in harmful behavior will often be aimed at reducing short-term Anxiety. Imagine a helium balloon that needs to be filled with helium again and again because it keeps floating down into sharp nails.

It is common, however, for addiction to start voluntarily: sometimes you even have to put up with discomfort, like the burning from cigarettes, or traveling to the casino in -20°C weather. This is what leads to the misconception that it continues to be voluntary as the condition progresses. But remember, if you can control it, it's not an addiction—that's the whole point of addiction; it's what addiction means.

Now, let's look at addiction from the perspective of a defense mechanism against primordial Anxiety. The modern way to look at this is the idea that addiction, especially at the beginning, can have a sort of self-medicating function. Not just substances, which are by definition drugs, but behaviors like shopping or even workaholism can change your brain in empirically observable ways, giving you shots of feeling-good when you engage in these behaviors even if they are being harmful to you in other ways.

This is not a metaphor; your actual physical brain changes, with some regions becoming more active, while others grow quieter. This is observable with modern brain imaging techniques. Remember, your mind and your brain are the same thing—your brain holds your awareness and understanding of the things that your mind and senses perceive, but it's still just your brain firing or stopping neurotransmitters (the chemicals that carry messages between neurons, the cells that make up your brain).

So, how do we help someone who finds themselves in addiction?

First, get rid of any judgment or ambitions to get them to change. If you want to help, be a human helping another human when they ask for help, before anything else and keep in mind that relapse is part of addiction; if it happens it's not a failure.

There are numerous clinical and non-clinical pathways to recovery: however, access to these resources and professionals can be limited or vastly over capacity (some waitlists can be months long). Furthermore, the wide amount of research and information on addiction means that it has its own specialized lingo that you will often hear when looking at services, so let's look at a few options and try to understand the principles behind them.

Clinical or Treatment-Based Recovery

This is what most people would think of first, it implies visiting a professional or a Clinic and receiving specialized help. Usually you'll be working with Social Work professionals but there might also be a team of others like Psychologists, Psychiatrists or Occupational Therapists. It has a few modalities:

Inpatient treatment: when the person goes to a Centre and stays there for some time, it can be anywhere from a few days up to several months.

Outpatient treatment: this is also Centre or Clinic based but rather than living there, the person is expected to visit the location to participate in groups, receive medication, psychoeducation, meet with their service providers, etc.

Mutual Aid Organizations

This refers to non-clinical services often provided by people who have gone through and recovered from addiction and have been appropriately trained to provide mental health services. (By reading this book and attending mental health first aid training, for example.)

They will generally use their first-hand understanding and lived experience to have a more human and personalized approach. 1-on-1 coaching and some types of counselling (that are provided by religious institutions, for example) are often at the core of this pathway.

Some classic examples are the 12-Step programs (Alcoholics Anonymous , Narcotics Anonymous), SMART Recovery, Secular Organizations for Sobriety (SOS), among many, many others. These groups are usually started by people in underserved groups and can grow to be pillars of their communities. My hope in writing this book is to lower the barriers to community mental health initiatives like that. I hope not only that this handbook will inspire you to be one of those people in your community: it should also have all the tools you need to have a strong foundation.

Natural Recovery

Some people just… do it. Without formal treatment or support groups. When the drug or behavior is there to escape from unwanted feelings and emotions, it makes sense that if the conditions in the real world that are bringing up these unwanted emotions were to improve, stopping an addictive behavior becomes much easier.

In many ways, this is where all the other pathways meet. At the end of the day, the best way to get rid of addiction is to improve your life to the point that it makes more sense to not-use drugs than to use drugs, and all the other pathways lead to that, to improving your life and your health, so that you can make that choice.

Cultural/Identity-Based Recovery Groups

Identity-based and cultural recovery approaches recognize that addiction and healing are experienced within specific social, cultural, and identity contexts. Similar to mutual-aid but these approaches leverage cultural strengths, collective wisdom, and shared identity as powerful recovery resources.

Some examples are: the White Bison/Wellbriety Movement; traditional healing practices (like herbalism, healing ceremonies); Buddhist, Catholic, Islamic recovery groups; LGBTQ2S+ (Lesbian, Gay, Bisexual, Transgender, Queer, Two-Spirit, plus)-specific programs and spaces; deaf recovery groups; veteran's programs; black, latino groups; and so on. If you are part of a community, online or physically, there might be a group that focuses

on the specific needs and challenges of your community. And, if not, this handbook contains all you and other concerned community members need to get started!

Medication-Assisted Recovery

If we are talking about a substance-use disorder, there are drugs like alcohol and opioids where stopping cold-turkey is dangerous, and it is recommended, if not required in some cases, to receive medical supervision while quitting. This is because the withdrawal effects are so severe that they can kill you. Meds in this case are used to lower those symptoms and make it possible for you to detox safely.

This one is more of a parallel to the other pathways. Medication won't fix your life, so it won't help you directly quit; however, similar to the principles of supporting talk-therapy with medication, the idea is that medication is there to give you a break, to make things easier for you, but you still have to do the work. It's just easier to talk to your sponsor, coach, counselor, or pastor if you're on meds than if you're not. They are meant to make it easier to think and reflect.

Some common examples of drug-assisted drug-treatment are methadone and suboxone, both used in the treatment of opioid-dependency. Dependency means your body adapted and now needs the drug to survive: this is why it's dangerous to stop cold-turkey. This is why drugs cause withdrawal.

By this point I hope you have a better idea of the kind of services and pathways to recovery that are available. While you can definitely work with addiction in a private setting, it is generally recommended to refer to a specialized service unless those are unavailable or have proved ineffective. The logic is that there are plenty of specialized service providers that will be better equipped to work with addiction, especially in complex cases.

Regarding our work, addiction is inseparable from other mental health concerns, and people who ask for your help often have an addiction of some sort—just ask if you're not sure.

The way addiction recovery works is by improving your life holistically and understanding the processes that are keeping that addiction in place, but that's not all; recovery often implies planning and implementing lifestyle changes (that we'll cover in the next section), along with exploration of the self and what makes you happy.

These are precisely the kinds of things I'm training you to do in this book; this is the kind of help you can lend. (We are getting there, don't worry.) Just don't bite off more than you can

chew, and, if you do, look for help. Remember that handling situations beyond your competence requires seeking guidance from qualified professionals.

Stress, Burnout and Life-changing Events

Up until this point, we've covered a large chunk of the people you may encounter (and realistically be able to work with) in a community mental health setting. What remains is what I would call 'discontent' based consultations. People who just need help with the typical miseries of being alive while Capitalism eats itself.

So let's go back to Freud, and his 1930 work '*Civilization and its Discontents*.' This is one of Freud's most pessimistic, but also most illuminating, works, and has become a classic piece of western philosophy. It proposes a worldview that can help you expand your perspective when working with someone, to go beyond their individual condition and see them as part of the greater community they belong to.

I recommend you read this book (or watch some YouTube videos, I'm not your boss) regardless of whether you're interested in working in mental health or not. It is not just a psychological treatise but a profound meditation on the human condition and the inherent limitations of social progress and freedom. Its insights into the psychological costs of civilization remain as relevant now, in a fragmented world led by madmen, as ever.

With that being said, let me share some of the ideas that I think will be particularly relevant for you and your work with people. Keep in mind the book is dense and I'm sharing only a few of its core ideas.

Freud defines civilization as: '*[...] the whole sum of the achievements and the regulations which distinguish our lives from those of our animal ancestors and which serve two purposes—namely to protect men against nature and to adjust their mutual relations.'* He then wonders why civilization is the way it is and what is our relationship to civilization.

Freud begins by proposing that when we are born, we aren't dissimilar from other animals and there is little separation between the Ego (the *you* that I'm speaking to) and the rest of the world. The idea is that a newborn wouldn't be able to initially tell the difference between internal sensations, like hunger and external sensations, like the perception of light.

Then he explains that as we start to realize that there are some things that are 'us': the things we can control, like our muscles and the direction of our senses, and there are things that are not-us, like food and mom, that are always outside and uncontrollable. Then, the satisfaction of hunger and other bodily needs becomes the task of the Ego (you) to handle. and the line between external and internal appears: anything the infant can't control is

‘external’. We can imagine this transformation as a bit of clay that is shaped into a drinking cup: it's still the same clay, but now it is also something more. Freud proposes then that the Ego (you, that sees the thoughts in your head) governs our actions as human beings, trying to avoid displeasure and bring stability to ourselves. He calls this 'reality principle'.

Now that we have people who can speak and think, he looks at how we come together to form society. If we were to behave like wild animals, driven entirely by instincts and needs, working together would be an incredible challenge. Cooperation would be a random occurrence, instead of our core survival strategy. Think of how chickens might try to eat other chickens when hungry and stimulated by the smell of blood.

In that effort to work together, then we have to agree to give up some of that freedom to blindly follow our carnal desires in exchange for the benefits and protection of civilization. In other words: humanity wouldn't have gotten too far if, instead of banding together to hunt mammoths, humans just murdered and ate whoever is the closest to them when they are hungry. Cannibalism is not a great survival strategy.

So now we have a problem. We gave up our freedom to make the dream work, but that sucks. It makes us neurotic. Literally, this is how Freud defines neurosis: as this fundamental state of discontent that permeates our experience as humans, because we have to give up part of our raw desires in the name of safety and connection.

For Freud, the base state of speaking humans is Neurosis, not as a disease, but simply as a condition of being, result of the social contract (giving up freedom for collaboration). Freud points out that we have made some collective efforts to deal with this discontent as well.

Religion and spiritual practices are one of those, but they are not universally viable: not everyone can become a monk. The pursuits of reason and arts are another option for Freud (probably labor and craftsmanship would also fall here, but Freud was a male neurologist who moved in Vienna's high-society circles, so he probably didn't think too much about manual labor).

But these also seem limited. The popular image of an artist is only sometimes one of happiness; misery and loneliness make for great art as well. You yourself might enjoy these things. Have they freed you from the suffering of the human condition?

What about drugs, love, and other deliriums of the unreal? He suggests that art, reason and religion are redirections of this discontent, while drugs (and psychosis, but he doesn't yet use this language here) make us insensitive to discontent.

Freud does place love on special ground. He suggests that romantic love is one of the few things that can genuinely overcome the sacrifices made in the name of society and become

more important than the rules of civilization. For a simple example think of a couple that displays public affection where it is frowned upon; for a more literary example think of the public charm in narratives like Bonnie and Clyde.

Freud also brings forward the idea of love, as presented by St. Francis of Assisi: a love that extends to include all living beings, including other animals and plants, under the golden light of care and compassion.

Freud discards this option, but I disagree: Freud begins this book making it explicitly clear that he is trying to fit religion and the experience of the divine under the umbrella of Psychoanalysis, and I think this is one of those places where he let his wishes get the best of his reason.

Abrahamic religions, Indian spiritual traditions and Buddhism generally agree that unconditional love for all of creation is a way to break with the suffering of the human condition. In this case I'm more inclined to give greater weight to thousand-years old traditions that continue to resonate with billions of humans even today. Rather than the single white dude in Vienna, from over 100 years ago, who clearly has an agenda.

If you're interested in more perspectives on religion and spirituality as pathways to peace and a fulfilling life, I'd suggest you check out Jung's works. He was one of Freud's disciples and eventually got kicked out over disagreements around this very topic (among others).

At the very least, however, Freud points out that you can't simply love your way out of paying taxes, or avoid stopping at a red light. This remnant of discontent then has to be kept under control, so Freud suggests that our conscience (as in Jiminy Cricket, not as in awareness), our internal sense of moral and social responsibility, of good and bad, is a simpler, internalized version of the greater laws of society. I don't know exactly the difference between murder and manslaughter, but I know killing people is wrong. What actually punishes you with guilt when you do something you shouldn't is this internalized version of the law, this Jiminy Cricket-conscience, that Freud calls the Super-Ego.

Freud and later Psychoanalysts will see the source of all misery in this conflict between the Super-Ego (this moral imperative internalized from society), the Ego (you, the speaker that makes choices and compromises) and the Id (our basic needs, animal instincts and desires that don't care about anything other than satisfaction and pleasure). To make life more manageable and enjoyable is to find a balance between these three aspects of ourselves:

- A super-Ego that is too strong becomes a tyrant, a voice of constant self-critique, a sense of inescapable guilt, a voice that tells you everything you do is wrong, flawed, imperfect. (Because it’s true, you’re only human and that's its job.)

- An Id that dominates the Ego and super-Ego eclipses reason with impulsivity and self-destructive behaviors, and, down the line, this lack of care about the concerns of others leads to isolation.
- Finally, the Ego, you, whose job is to mediate the demands of reality and the constantly-in-conflict mandates of your Id and your SuperEgo. You're the one that actually decides to get up and hit that bong, even if you don't always want to.

This is where we go back to the present day. If we keep in mind Freud's model, you can think of modern evidence-based techniques as means to operate this psychic machinery.

Techniques like ACT (Acceptance and Commitment Therapy), CBT (Cognitive-Behavioral Therapy), Family Systems Therapy, and many many others can be seen as means to redistribute mental energy between these aspects of ourselves. The goal of all of these is the same: to help you find peace and harmony between what you are, what you want to be, and what you can be.

What changes are the techniques used; different people respond better to different techniques, but all of these I mentioned (including Psychoanalysis) have had decades to develop and empirically demonstrate their effectiveness.

What I want you to see is the very human mechanisms that lie below (literally, as a foundation) to our modern evidence-based techniques. Because I can't train you in CBT with a singe book, but I can teach you to recognize the dynamics at play once your Client comes across them.

A way to think about this is to think of community and peer-led mental health supports as intrinsic-driven, they seek to find the answers every person has about themselves, while formal evidence-based practices seek to use the collective wisdom (embodied in the tools of science), to provide a buffet of answers for the person to pick from. Neither of these paths is more effective than the other, they answer to different needs in different people and communities.

One final idea I want to share with you in this section is the 'Death Drive.' I've left it to the end of this section, because it is super controversial and it seems to me that this is another concept where Freud finds an interesting philosophical idea, but then he tries to shoehorn his Psychoanalysis on it by using it to explain the origin of aggression.

Instead, I invite you to take this idea as a philosophical concept, use it to think about the world and people you see, and see what makes sense to you, what doesn't, and what other ideas it brings up.

Towards the end of his life, Freud was trying to answer the question: why do we do things that hurt us, if we dislike suffering and enjoy pleasure? Why aren't we driven entirely by pleasure like other animals, even when left to our own devices?

Think for example of drug use, where you know you're dying, literally killing yourself, but you continue to smoke. Maybe it doesn't even feel that good anymore, you know? What about that toxic relationship that lasted waaaay longer than it should? What about self harm, and eating disorders? Why do some people enjoy horror and gore, while others faint at the sight of blood?

Freud would ask you to look at nature. Not just animals or plants, all of nature: our planet and the countless stars above. Notice that most of it is not-alive. It generally doesn't change too dramatically in short periods of time, and complexity tends towards disorder.

Except for living things. They are the opposite, they are defined by change and move towards creating more and more complex arrangements every time. While it is easy to see that there is a push that drives life to… be alive, Freud points out that life is in a constant battle for self preservation, when we eat, breathe, sleep we stave off death for just a little longer.

But if this is the case, if life by definition pushes against the rest of nature, which is inanimate, isn't there also an intrinsic push-back towards an inorganic existence, that life is pushing against? Freud proposes that the base state of nature is inanimate objects and that therefore there must be a second push, a drive that leads back to this quiet state of inertness. He will call this 'Death Drive' or 'thanatos' and will place it in opposition with the 'Life Drive' or 'eros'.

One of Freud's great goals was to explain the unexplainable in human behavior, and while I don't think Death/Life Drive theory is the answer, I think it can be useful to think of death and aggression not as things to be avoided and discarded, but as part of a mind that has to deal with a natural world that is made of life and death. I will quote a modern analyst, who does a better job of explaining this idea., This is Christopher Bollas in his 1987 book '*The Shadow of the Object*':

'Whether we conceptualize it as death drive, enactment of traumatic experience, or the preservation of threatened self-states, we encounter in our consulting rooms the paradoxical human tendency to repeat painful experiences and undermine potential happiness. Our theoretical explanations may differ, but the clinical challenge remains.'

I have found it useful to see the psyche as being 'made' of some mixture of Death and Life Drives, leading to a spectrum. On one end is blinding life, uncontained by anything, it is scorching, devouring, it is complete dissolution into the external world, an Ego without boundaries that cannot filter the stimuli of life or take shape. On the other end is the absolute stillness of emptiness, calm death, a pure darkness that is unmoving, unchanging, unending, the quiet at the bottom of a frozen lake.

Neither allows for growth or progress. Instead, as the shadow and light mix, the darkness contains and directs the light, spreads it into color and endless possibilities, the light in turn puts shadows into motion and gives them shape, purpose.

Through life, dynamic motion is the goal, not to get stuck on one side or the other: a mind that has the resources to harden and overcome tough times, but also the levity to enjoy life and realize its ability to reshape the world and itself.

The task is then not to replace death with life, but to help people find the balance that feels the most like themselves at that moment in time; I've found that peace often comes precisely from understanding and accepting the mixture that each of us carry, and learning to take charge and responsibility over both, rather than only over the side we're culturally expected to enjoy.

For example, I probably wouldn't be too comfortable living with a stranger that shows no emotion at the sight of blood, but if I were going to have surgery, I would definitely hope the surgeon will be someone who is perfectly unaffected by the sight of blood and guts. It is the same trait but both the person and the context change the trait itself.

Depression sucks, but as symptoms improve, it's not like you just forget what it's like to be depressed forever. In many ways you learn to treat it as part of yourself, integrate it into the rest of what you are. Sadness becomes tranquility, pain turns into kindness.

Nobody can teach you what to do with every particular client every particular session. Human services are a lot like art, and you will develop your own styles and theoretical framework as you continue to grow through training, learning and experience. Therefore I hope you will instead understand the dynamics and forces that govern most people's behaviors (starting with the perspective of Psychoanalysis as a foundation), so that by being aware and understanding of those principles, you will be able to guide people in their search for answers about themselves.

Keep in mind that people study for years to become therapists or analysts. This book doesn't pretend to illuminate all there is to know about these topics. Instead, I hope it will act as a flashlight that will point you in the right direction and help you guide your own learning,

while also providing you the tools to literally be your own boss in an inclusive, disability-friendly, remote-first job.

Psychology has existed formally for a little over a century. Through most of our history, it has been elders, community leaders, healers and spiritual workers who take on the role of providing mental health care to their communities, and while there is a lot to learn and understand, remember as well that you already have the core fundamental requirements to support someone else: You are human and you're driven to help. You can start with that.

That's actually how Freud ended up inventing Psychoanalysis. He got a lot of things wrong because he was literally making things up from scratch (and railing medical-grade cocaine). There were no words at the time to talk about the phenomena he was trying to describe, but that didn't stop him from observing and asking thoughtful questions. In the process he helped a lot of people and made key discoveries.

The techniques and methods of understanding Freud developed continue to be at the core of any successful mental health practice. This is why I chose Freud to organize this text, because he started from zero, just like you.

I'm also preparing you to start from square one, because I hope that no matter your level of education, how old you are, where you are or who you are, you'll be able to become a Healer. I hope seeing the impact you can have will inspire you to help me make mental healthcare more accessible for everyone. I love the tools of psychology and psychometry, but the finest knowledge in the world is useless if it rests behind a sign that reads: '$250 an hour.'

100 years ago, Psychoanalysis arose as a counter-current to experimental psychology that sought to reduce the human experience to stimuli-response. Now I've called on Psychoanalysis once more, as a counter current to the modern barriers that limit access to mental healthcare.

Don't get me wrong. Institutions are there to help protect the public and ensure that services provided are ethical and backed by accountability. They exist for a reason, but nobody can have a monopoly on mental healthcare and it cannot be profit-seeking bureaucrats calling the shots around people's mental healthcare. Poor medical treatment risks death, poor mental health care risks fates even worse. Remember that, and let the weight of that responsibility inspire in you the wish to learn and grow, to act ethically, and to act always with kindness.

Research, Self-education and Resource Validation

The field of mental health isn't static—it's a living, breathing body of knowledge that constantly evolves as we understand more about the human mind. While this handbook provides you with fundamental tools to support others, and keywords to guide your learning journey, said journey is just beginning. In this section we'll talk about how to continue building your knowledge in a way that's both ethical and practical.

Think about it this way: if you were supporting someone with a physical health condition, you'd want the most current understanding of how to help, right? You'd need to know how the body works and what resources exist. Mental health deserves that same commitment to staying informed.

When someone shares their vulnerability with you, they're placing immense trust in your ability to respond appropriately. This doesn't mean you need to aim straight for a Ph.D. or even a Bachelor's degree, but it does mean committing to an ongoing process of learning and unlearning.

This isn't about perfectionism or becoming a walking encyclopedia—it's about ethical responsibility. The more accurately you understand various mental health experiences, the better equipped you are to respond helpfully rather than harmfully. To put it in the words of poetry:

'The range of what we think and do is limited by what we fail to notice. And because we fail to notice, there is little we can do to change until we notice how failing to notice shapes our thoughts and deeds.'

—Daniel Goleman, in '*Vital Lies, Simple Truths: The Psychology of Self Deception*' from 1985

Rather than approaching learning as a series of random online searches when issues arise, consider developing a consistent system that fits your life circumstances. This ecosystem might include:

Regular learning blocks: dedicate specific times—even just 20 minutes twice a week—for focused learning about mental health topics.

Diverse information channels: don't rely solely on one type of source. Mix academic articles, books, podcasts, webinars, discussion groups, and lived experience narratives.

Focus areas: while maintaining broad awareness, consider developing deeper knowledge in specific areas relevant to your community's needs, whether that's Anxiety in gamers, Depression in transgender folks, or burnout in student communities.

Reflection practices: after learning something new, take time to consider how it connects to what you already know and how it might apply to your support practice and the people you already work with. Maybe journal about it or, ideally, discuss with peers.

Resource library: create a simple system to save and organize helpful resources you discover—whether that's bookmarks, a note-taking app, or a physical folder.

Your learning ecosystem should accommodate your neurocognitive style, not fight against it. If you have ADHD and struggle with long reading sessions, maybe audiobooks and illustrated guides work better. If you're autistic and prefer deep dives into specific topics, embrace that approach rather than forcing breadth at the expense of depth.

Not all mental health information is created equal. The internet is simultaneously the greatest knowledge repository in human history and the world's largest repository of misinformation.

When you encounter mental health information, ask yourself:

'Who created this?' Information from established health organizations, academic institutions, or recognized experts generally deserves more initial trust than anonymous sources. However, remember that established institutions have their own biases too—they often underrepresent marginalized experiences and alternative approaches.

'What's their motivation?' Is the source trying to inform, persuade, sell something, or gain followers? Sources primarily motivated by commercial interests require extra scrutiny and are best left in the realm of anecdotes.

'How transparent are they about limitations?' Trustworthy sources acknowledge uncertainty and complexity rather than making absolute claims. Be wary of anyone claiming to have THE answer to complex mental health challenges.

'Do they cite their sources?' Can you trace their claims back to original research or established theory? If not, proceed with caution. Furthermore, verify the legitimacy of the sources themselves. Most of the authors I've named or recommended in the body of this text, I've done so because I know you can find their entire works for free online or in your nearest public library and verify what I've said firsthand. But what if I cited my own Master's thesis that is hidden behind a paywall? Not the same level of legitimacy, right? Different intentions as well.

'Is diverse representation evident?' Does the source acknowledge different cultural perspectives, neurodivergent experiences, and the impacts of systemic factors on mental health? Specially in the context of online-work in 2025, a western-exclusive perspective is not only limited, it might be harmful.

It is impossible to completely avoid bias, but you still must do your best to approach each person from a neutral perspective and without ambitions. Biases aren't a moral failure—they respond to a biological reality. Our brain is programmed to take shortcuts; it generalizes and catEgorizes to manipulate information more easily. When these catEgories erase the nuance of experience in other people, these become problematic biases.

We naturally gravitate toward information that confirms what we already believe (confirmation bias), but you can combat this by deliberately seeking perspectives that challenge your assumptions—especially from communities with different lived experiences than your own. Listen to people you don’t like. You don’t have to agree, just listen.

For example, if you believe Depression is primarily caused by chemical imbalances, seek out sources that explore social determinants of Depression or cross-cultural approaches. This doesn't mean abandoning what you've found helpful—it means expanding your understanding. For a simple exercise take a core belief, like the Earth being round, and read up on flat-earth theories, watch videos, look for first-hand accounts of flat-earthers talking about their beliefs and listen, try to understand their perspective and see the human being there, without passing judgement on the validity of the information. There are times to be human and there are times to be skeptic, they rarely occur at the same time.

Be wary of explanations that reduce everything to single causes: 'it's all trauma,' 'it's just brain chemistry,' 'it's the unconscious,' 'it's capitalism.' The most accurate understanding recognizes multiple interacting factors—biological, psychological and social. When you encounter simple explanations for complex experiences, ask yourself: 'what's being left out here? Who would disagree with this perspective?'

The strongest approach integrates both academic research and lived experience, recognizing that each has valuable insights and inevitable blind spots. It is impossible to completely avoid bias, but you still must do your best to approach each person from a neutral perspective.

Research and understanding evolve gradually. Be skeptical of sources claiming revolutionary breakthroughs that overturn everything we know (except the one you are reading right now, of course, I'm legit). Real advances in understanding usually build incrementally on existing knowledge.

When you read about 'groundbreaking' discoveries, look for confirmation from multiple sources before significantly changing your approach. There's a tendency in mental health discourse to translate all human suffering into diagnostic catEgories. While these catEgories can be useful frameworks, they can also obscure the role of normal human responses to abnormal circumstances. Remember that distress often represents a reasonable reaction to difficult experiences rather than pathology. Being frustrated at the state of a world that has some humans defecating and sleeping on the street, while others have summer and winter mansions, is perfectly normal.

On the same line, academic research provides crucial systematic knowledge, but lived experience offers equally valuable wisdom. Both have blind spots. Research might miss important realities that don't fit measurement tools; individual experience might overgeneralize from personal patterns. The strongest approach integrates both:

Read the research, but ask: 'whose experiences might be missing from these studies? Who conducted the research and for what purpose?'

Value lived experience, but ask: 'how might other people experience this differently? What patterns emerge across many individuals' experiences?'

This integration is especially important when working with communities whose experiences have been marginalized in formal research—including BIPOC communities, LGBTQ+ people, disabled people, and neurodivergent individuals. As an example, go ahead and try to find research on bisexual people: choose any topic you fancy.

The ultimate test of knowledge isn't how much you know—it's how you apply it to support others. Offer information as possibilities, not prescriptions: 'some people find meditation helpful for Anxiety. Would you be interested in exploring that?' rather than 'you should meditate for your Anxiety.' Acknowledge your limitations: 'I've read about this approach, though I'm not an expert on it. Would you like me to share what I understand?'

Another good idea is to translate technical concepts into accessible language but without oversimplifying: 'when we experience trauma, our brain's alarm system can become more sensitive—kind of like a smoke detector that goes off from cooking steam, not just from actual fires.'

Respect that what works generally may not work for this specific person: 'research suggests this helps many people, but everyone's different—what matters is whether it helps you.' It's okay to use your lived experience too! 'Full disclosure: I tried those meds and they made me incredibly dizzy. That doesn't mean it will be like that for you, but don't be

discouraged if they do, that effect helped my psych figure out the right meds for me. So it sounds like you're on the right path.'

The more you learn, the more you realize how much you don't know. This growing awareness isn't failure—it's intellectual growth. It allows you to remain humble, curious, and open to the complexity of human experience.

It is also normal to find the sheer volume of mental health information available overwhelming. If you find yourself paralyzed by too much conflicting information, remember:

You don't need to know everything or be perfect to be helpful. Presence, empathy, and basic support skills go remarkably far.

Instead, focus first on core knowledge that applies broadly, then gradually add specialized knowledge as needed. When uncertain, return to the fundamentals: listen deeply, respond with compassion, and recognize your limitations. The goal isn't perfect knowledge, but resourceful learning—knowing where to find information when needed and how to evaluate it thoughtfully.

How to Coach Someone

Now that you have experienced the existential dread of learning Freud, let's get down to applying this. The thing closest to what I'm teaching you to do would be mental health consulting, with psychoanalytic spice.

Remember how I told you addiction treatment is one of the best developed areas of mental health? It is precisely there that we find examples of the most effective types of non-clinical intervention. So let's put this together with the principles and ideas we learned before and look at how an average session would be organized. Whether you work independently or under an institution, generally you will be looking at some variation of the following. Let's assume for now that all sessions last 45 minutes:

First Session

Sometimes you might need more than one, but I think it's disrespectful to take more than one session strictly gathering information. Time is literally money, and the economy isn't great. Unless there's information required by an institution, the main question you need to focus on is:

Healer: 'what brings you here today?'

Sometimes it takes 45 minutes to answer that question, sometimes it takes 5. To make it worse, people don't always know what they are talking about and very commonly people will have an 'easy' answer, and then the real answer. Your first job is to help them figure it out. Remember that people aren't stupid: the world is confusing and we're all exhausted. Let's continue the example, and assume we have a client named Tank:

Tank: 'Hey man, my wife wants to divorce me so I need help making her stay.'

Before you keep on reading, re-read the example above and see what comes to your head. Remember, you're not looking for answers: push away the instinct to reach conclusions and offer solutions. Instead, see through that reflex and focus on what you (and therefore the Client as well) need to ask to really understand the request they just made.

My first reaction is to say: 'you can't MAKE someone stay, what's wrong with you?' But in the role of a Healer, I am embodying a different perspective on things. Furthermore, I gave my word I would help this person so I push away that reflex and look for a question.

'Making his wife stay' is probably not the path to happiness anyway. Instead, you could ask yourself, 'what is the need that he is trying to satisfy by making his wife stay?' Keep that question in mind, but for you. It might be too personal for some people and it might not even make sense to them if it's not the right time to hear stuff like that. Never lie to your participants, but be kind, and remember that sometimes truth hurts.

Another possible question would be: 'what do you mean, make her stay?' Remember how I told you words only refer to other words, so we can't really communicate exactly what's in our head? Well then what immediately came to my mind when he said 'make her stay' might be wrong, maybe he means that he wants to change himself to see if she stays, we don't know, so we ask. But he just came in, so it's important to be polite and delicate until you know a bit more about his temperament, his current mental state and how emotional this topic is for him.

The best 'secret' I can give you to make this easier: try to imagine you're an alien, your transgalactic-spacecraft crashed on Earth and it's your first time with a human. You're smart, you understand how everything works, except for humans: you've never seen one and they are completely different to you (except for how they look). Try to really get into that role when you're listening. Let's say even then you can't think of any other question, that's fine too. In that case, that's your question:

Healer: 'I see. Could you tell me a little bit more of the story? So I can have a better overview of what's going on?'

Let your curiosity and knowledge guide you at the beginning, then with practice you will get more used to thinking in questions rather than answers. Remember that you two are on the same side working to solve a problem. Imagine asking questions like putting things on a table, so that you two can look at them, and the more things you put on the table, the easier it is to see how they fit together. So don't be afraid to ask questions, they are the meat and potatoes of your job. Let's look at his response:

Tank: '**She says I've changed** *since we got the cat*, and I think she's right, I just want to go back to the way things were before.'

You can think of your questions as a way to follow a path of thought or the chain of words we spoke of before. There are many paths we could take here, many chains to follow, I've colour coded and formatted them so that you can see where they come from:

'Interesting. What is the role of the cat in all this?'

'What does she say has changed?'

'Is it okay if I ask you what the past was like?'

Since we're still getting to know this person, it's important to maintain some professional distance. Try to err on the side of too much caution, rather than too little. A way to maintain this distance is by using 'object-oriented questions'. Notice how the three questions above are directed to an object? That's what I color—and format— coded in the Client's speech.

An object-oriented question reduces tension by taking attention away from the Client's inner experience. You're essentially distracting their awareness with something less stressful than whatever is going on in their heads. But, obviously, they are not random questions: they still have the intention of helping the Client explore a line of thinking.

The opposite of an object-oriented question would be an 'Ego-oriented' question, one that directly asks the Ego (the thing that speaks from inside the other human body, like you) about its internal state. I've marked this one in red and highlighted it, because you generally don't want to do this.

'What makes you want to go back so badly?' This question demands the Ego to scan its wants and emotions, and that can be pretty overwhelming to someone who is in a vulnerable position looking for your help. It would be problematic, if not harmful.

Most of the time you'll be using object-oriented questions to reduce tension; this will be true for most sessions. Occasionally, in later sessions, after you have built some trust and rapport, you might consider it useful to encourage your Client to think about their mental state or feelings. It's a possibility, but most people can do a good job winding themselves up on their own, so increasing tension is rarely needed.

If and when you visit a mental health professional yourself, pay attention, and you may notice that now you can see these tension-controlling patterns in their speech, like using object-oriented questions. Notice how they are using these patterns to balance the level of emotional intensity through the session. Let's go with the following question:

Healer: *'Interesting. What is the role of the cat in all this?'*

And let's imagine a somewhat ludicrous answer as an example, but that illustrates something you will encounter often. You'll find below an example of what I mean when I say that sometimes your job will be to help the person figure out exactly what they need help with, because people don't always know how to ask for help or put their feelings into words.

These challenges in communication are especially common in men, whose super-Ego might tell them things like 'asking for help is a sign of weakness' or 'men don't cry.' There is cultural variance, but in most cultures masculinity doesn't include learning the vocabulary and self-awareness needed to talk about your feelings and ask for help; worse, it might include the notion that that's somehow a weakness.

The super-Ego, as mentioned in the previous section, is that internalized sense of what's right and wrong, copied from a perception of what society expects from us, and it is really the super-Ego that punishes us with guilt when we break those rules. Tormenting yourself is bad for you, but the super-Ego doesn't care about that—it cares about order, because it serves the social order; it is civilization's enclave in our minds.

Let's look at this example answer:

Tank: 'Well, ever since the cat came, things have been different. We got him a couple of days after she miscarried our baby.'

It should be super obvious what I mean now. The cat has nothing to do with this, but it will be much easier for some people to say the cat is breaking the marriage than for them to admit they are broken-hearted and they are acting differently because they are incredibly sad.

Still, remember that your role is not to offer answers or wild interpretations of other people's internal lives. Your thoughts are for you, and keep in mind you are for sure wrong about some things, due to the limitations of language. You will never know everything, and that's okay—when you can sit in peace with not knowing, you'll know you've learned everything I have to teach you in this book.

So instead of saying 'well, it sounds like you're actually sad about your baby, and I know this because I learned the very basics of psychoanalysis and psychology from some guy who

clearly spends too much time online,' be human, be empathetic, and realise that you're not looking at 'severe dysthymia inside a normal pattern of grief.' You're looking at a broken man who just needs another human to be there and remind him he isn't alone.

The coaching and fixing the marriage can come later, when he's ready to talk about the real problem, and only he can tell you when that time comes.

Let's assume he spends the rest of the first session catching us up to date with his life story, broken marriage, and cursed cat. Let's assume we've also learned that his wife has already moved out of the house, and his plan is to get physically and mentally 'swole' to get her back. Let's move on to:

General Session:

So far I've been teaching you to use psychoanalysis to understand the mind and the modern tools of Psychology to actually provide assistance, so your basic 45-minute session is going to reflect that.

I suggest you start your sessions with an open-ended (the opposite of yes/no) object-oriented question. You might feel the impulse to bring up whatever you spoke about last session and try to get back on that topic, but you have to respect the Client's autonomy and empower them to take responsibility for their inner conflicts. Enter each session without ambition, like you're an alien ready to help your human buddy.

Furthermore, by the second session they'll have had a whole week to think about the last session, so the topic might not be that important anymore. Perhaps they're having a rough day and would rather talk about that than the divorce, or maybe they've already figured out what to do and instead want help with the next step. You don't know, so don't pretend you do. Instead, consider asking something like this:

'So, where should we start today?'
'How did things go this week?'
'Is there anything in particular we should talk about today?'

I like to think of this first stage in a regular session as you and your Client putting tools and ideas on the table. The goal is to get an overview of the current situation along with the resources you have available.

If you haven't yet worked one out yet, make sure you have a clear goal that you and your Client are working toward. It doesn't have to be super specific, but there needs to be some

direction—you're not doing pure Psychoanalysis. Even if we know 'get my wife back' is probably going to change, we will stick to it for now since that's what the Client said and that's all we have right now.

The core of each session is the talking and thinking part. I usually try to spend 30 minutes in this part, and they are pretty free-form. Essentially, you're looking at a problem and thinking together about ways to resolve it. Whether or not it can be realistically solved is a conclusion that the Client will have to find on their own; you can only give them ideas and information.

While thinking, people will often stray into different topics or follow their own train of thought into unrelated territories. These might seem disconnected, but don't be fooled. If they were truly disconnected, they wouldn't have come up. You don't randomly think about pink elephants throughout the day, but if you're at the Zoo, you might remember a picture of a pink elephant.

Psychoanalysis would look at this in terms of connected concepts and linked ideas, but I think it's interesting to consider it from a biological perspective. Neurons that fire together link together—the more one neuron communicates with another, the stronger the connection between them becomes: their little neuron arms, called axons, physically change, growing or shriveling as these mental connections change. Concepts and ideas that are connected together by language are also literally connected in your brain. A 'chain of thought' is literally a chain of neurons. The same thing through different lenses.

If your Client brings up topics that seem unrelated, don't stop them, don't steer them, instead be curious and try to figure out why these ideas are connected: why are these neurons linked? What happened, what did they hear, what do they believe, what is not being said? Keep those questions in mind while you listen. If you choose only one question, ask yourself: 'what is going on here?' as you continue to listen.

The final 15 minutes of the session are the practical side. We've thought of a lot, we've talked about a lot, then it's time to bring it back to the here and now and look at what actions you two can take to move closer to the goal. (Which let's say is still to get his wife back.) Again, you don't need to overthink this—just communicate openly and clearly. You can say something like:

Healer: 'Alright, I noticed we have around 15 minutes left. Usually I like to use this time to take everything we spoke about today and try to turn it into something we can actually do to get ourselves closer to the goal we have. Should we try?'

If your Client agrees (maybe they don't know yet and want to keep talking, that's okay too), a good question to guide this part, especially during the first stages, is:

Healer: 'So what do you think would be the smallest, simplest step we could take to get your wife back? An action that you could take between this week and the next.'

Generally, your job will be just to help the person define those goals and be accountable to them. You can ask them if they'd prefer you to be on their case every session or a more relaxed laissez-faire approach. You want to make sure that goals are realistic, dependent only on your Client, and well defined in time and space.

For example:

Goal: *'I want to work out at the gym 3 times next week.'*

Good! It is defined in time (3 times next week), defined in space (the gym) and it depends on him (work out).

There might be people for whom 3 times a week to the gym might be a challenge, but that's the magic of letting your Client lead the way: Either they already know 3 times a week is achievable, or they are about to learn if it is. It's progress either way.

More commonly you'll have the opposite problem—over-enthusiastic participants might want to write down a laundry list of tasks to complete. Here your role is to manage expectations. Don't tell them what they can or cannot do; we don't know.

Instead, just let them know it's okay if they don't complete anything, or ask them to pick one that is the priority, while the others will be bonus objectives. The idea is to help them avoid setting themselves up for failure—that's what having realistic expectations means. Something that gives us all confidence is having done something before, so it can be a good idea to ask if they have gone to the gym with that frequency before, and highlight how that is a show of strength. (Pun intended: this is what having a strengths-based approach means.)

Remember that your focus should be on what's achievable rather than what's ideal. Look to your Client for guidance on what's realistic for them personally.

Contrast this to an impossible objective:

Goal: 'I want to lose enough weight for my wife to take me back.'

Everything is a problem: it doesn't depend on our Client. We don't know how long it will take or even if he plans to take drugs, diet, or go to the gym. Just a terrible goal all around.

I'm a naturally delicate speaker but sometimes you just have to give it to them straight (I do my best considering I'm bi), in this case you could say:

Healer: 'About the objective, I said I'd help you achieve your goals, but we can't control your wife. I can't in good faith tell you that is going to happen. Maybe we could focus on the weight part, if that is something that you care about, and hopefully that'll change something? Knowing that she is a free human being that we can't predict or control. What did you have in mind?'

Again, your role is not to judge them or tell them what to do, but always be honest and don't set them up for failure. Manage their expectations. If they want to get their wife back, they want to get their wife back, and we're gonna do our best. But be real.

Let's continue the conversation a little bit, and let's assume he instead gives us a more complex answer when we ask what our goal should be:

Tank: 'Well... She said I'm not the man she married anymore, so I've been thinking of getting back in shape. I signed up for the gym.' *grabs his dad-belly* 'I want to try to get rid of this.'

This is where you'd help him assess his current status compared to his goals, then work together to determine realistic first steps. 'What are you doing right now, if anything, to lose weight and what would you like to be doing?' Once you've identified those steps, you'll help him execute planned changes with a focus on sustainability—going to the gym is great, but ensuring the habit sticks is what matters.

Continuing with the theme, you might think there are a few issues with his proposed solution:

We're ignoring that clearly his ex's words have been hurtful. His solution doesn't address what is likely the real issue (the miscarriage and its consequences) and even if we assume he has suddenly found the discipline and interest needed to actually get buff at the gym (which is unlikely to happen suddenly when he isn't feeling great), it is going to take time.

Freud would call these observations 'wild interpretations' and they are more about you than about the other person. You can't read people's minds, you don't know what's good for them, their life history, or what's going to make them happier. Stop pretending you have answers, and focus on listening. Trust that each person is capable of figuring out what they need to heal, even if they can't always put it into words.

If they are telling you that what they need right now is physical activity and not thinking too much, your job is to help them with that, not to overwrite that with your own ideas of what would be good for them. It's not that you're wrong, your interpretations are useful for yourself as tools of observation, but they are not in any way the answer your Client is looking for. That answer can only come from inside themselves.

In other words: this is what it means to move from a 'problem solving' position into a 'listening' position. The same way you can't lift weights in their name and expect your Client to get buff, you can't do the thinking for your Client and expect them to grow.

It might seem like I'm exaggerating with these examples, but take a moment to think about yourself, and all the times you were unable to see something that was just SO OBVIOUS for someone else. This is just part of being human. To reiterate, people are not stupid, the world is confusing and emotions are scary. Be kind and compassionate.

Closing Sessions Effectively

The final element of every session is, well, closing the session. Sticking to the scheduled start and end times is important, especially in the context of remote working, because the boundaries of time are one of the few 'practical' boundaries you have when working online. It is an implicit reminder that this is a professional space of work, and not a space of chilling with a friend.

Ending the session on time is a challenge for a lot of new professionals, nobody likes interrupting someone else, even less if they are talking about something emotional or meaningful, and even less if you're curious and want to hear the end of the story. However,

you and your Client are working, and the same way you'd expect to clock in and clock out on time, you must be disciplined about the duration of a session.

This will likely stop being an issue as you gain more experience and confidence in yourself, but I've already set you up to make it easier as well. Having a transition from freeform to practical planning 15 minutes before the end of the session will make it easier to end by making you both aware of the time and bringing attention back to present and objective matters.

This applies to the matter of a Client being late or not showing as well. The Client has selected a specific slot in your day; you are expected to spend that time in the space or call with your Client. If your Client arrives 15 minutes late, the session still ends at the appointed time. If Client doesn't show up with no notice, that session still has to be paid for. If they arrive 5 minutes before the end, they still get those 5 minutes.

Psychoanalysis has a lot to say on this, but I think the simplicity of modern Psychology offers more concise reasoning: this is a disruptive behavior you don't want to encourage. Furthermore, you want to ensure that your time has explicit value, not to mention that proper scheduling is part of professionalism.

A top tip is keep it simple and quick: 'it seems we have to stop for today.'

The Final Session

Just like the first, the last session will usually have a different form. Generally your Client will let you know when they consider things have improved to a point where they no longer need help, or it might be obvious from having achieved the overall goal you set up. They might say also something like:

'So for this week… I don't have much to say, things have been going pretty well.'

Generally you want to make sure you ask two main questions at some point in this session. I actually picked these up from working a minimum-wage retail job:

'Have we solved the issues we set out to solve or is there anything left we should work on?'

'Is there any feedback you'd like to share about me and the way I work?'

The logic here is simple. You want to make sure the person is actually ready to close this episode of care, and you are not perfect, so you want to learn from your mistakes and grow.

And, finally, let them know that if they ever need help again, they are welcome. The future is always uncertain, and that's okay.

How to document your work

After every session you will have to write notes. You have to do it, it doesn't matter how good of a memory you have. You also have to make sure you're saving these notes under lock and key or properly encrypted. If you're employed, it's the institution's role to figure it out, but otherwise you have to ensure that the information entrusted to you is safe and private according to local laws.

There are many ways to write notes, but I like the SOAP format as a catch-all guide. It sounds like something new, but it really is just organized journaling. SOAP is just a common format and nobody will complain if you write notes like this. SOAP stands for:

(S)ubjective: write a short observation of the mental state of the person at that time.

'Client presented a quiet and shy disposition when he joined the call, however as the conversation continued and I reiterated my role isn't to judge, he seemed much more engaged with our work.'

(O)bjective: note the objective, tangible facts of what happened that session.

'We spoke about the challenges in his married life. He recounted the early years of their marriage, and how the situation deteriorated. Towards the end he mentioned a miscarriage, but was quick to change the topic. Considering this is our first session, I chose not to inquire further.'

(A)ssessment: this is your take on the matter. So far we've focused entirely on what our Client did and said, and that's the point, your notes should be Client-centered, not about you, but here you can add what you see:

'I believe he is highly motivated and has the tools to make changes. At the moment he seems to be directing that energy towards his ex wife, but he has started to direct it towards self-development, with time this will probably help him find peace. The topic of his divorce seems complex, but we agreed that focusing on physical activity and health would be a good starting point.'

(P)lan: what you and your Client agreed for the next session. Sometimes there is a plan, sometimes the plan is 'we agreed to follow-up next week at the same time.'

'Client's goal is to attend the Gym near his home at least 3 times this week. He seems confident in achieving this goal and I don't anticipate any issues either. We also agreed to think of more ideas on how to bring his wife back. Hopefully they will be centered around self-development.'

You can use headers when you first start writing notes but they aren't necessary. When I learned this from one of my supervisors I wrote the acronym on a post-it on my screen so I could just glance at it when writing my notes. The final note all together would look like this:

'John Healersguild | Preferred name: Tank
February 14, 2025

Client presented a quiet and shy disposition when he joined the call, however, as the conversation continued and I reiterated my role isn't to judge, he seemed much more engaged with our work. We spoke about the challenges in his married life. He recounted the early years of their marriage, and how the situation deteriorated. Towards the end he mentioned a miscarriage, but was quick to change the topic. Considering this is our first session, I chose not to inquire further.

I believe he is highly motivated and has the tools to make changes. At the moment he seems to be directing most of that energy towards his ex wife, but he's started to direct it towards self-development, with time it might help him find peace.

The topic of his divorce seems complex, but we agreed that focusing on physical activity and health would be a good starting point. Client's goal is to attend the Gym near his home at least 3 times this week. He seems confident in achieving this goal and I don't anticipate any issues either. We also agreed to think of more ideas on how to bring his wife back. Hopefully they also will be centered around self-development.

S. Joshua A.'

And that's it. You have (vicariously) seen your first Client. The reality is that none of your sessions are gonna be like this, because each is unique. At the same time, every soccer match is different, but you only need to learn the rules once to become a player. Think of that!

How to meta-communicate

The final core competencies you'll need revolve around meta-communication. This means going up one level, from talking about something, to talking about what is being said. To look at the system as a whole, at the underlying mechanics. At some point in your life you must have received or have been asked to provide feedback on something. That is meta-communication. You might have looked up the solution to a puzzle online or the walkthrough for a game, that is meta-cognition, you are meta-gaming.

Receiving Feedback

You won't always be able to choose when to receive feedback, and spontaneous feedback tends to be on the negative side. You are human, and sooner or later something is going to get to you. So, instead, just get used to handling feedback professionally every time, and it'll be easier.

First you need to be aware of your initial response. Don't let your emotions take over, keep a cool head. Fight the natural defensive reaction; if it is an asynchronous interaction, give it some thought before answering, if at all. Sometimes all you need to say is thank you. Remember: useful feedback often feels uncomfortable initially. I told you earlier that truth sometimes hurts, that's why it's important to be kind and mindful of the way you communicate.

You also want to make the best out of it. If you're going through that awkward moment, you might as well get your money's value out of it. Ask for examples if something's unclear. Ask about their perspective: how did they reach their conclusions? Do not excuse or explain, listen instead.

Another key is to distinguish between the delivery (which might be flawed) and the content (which might be valuable). Sometimes you'll get good feedback from people you don't like. Be professional, own your mistakes, and give credit where credit is due. A useful question to guide this part might be:

'What part of this, even if small, might be true?'

Finally, just choose what to do. Some feedback prompts immediate action or change, while others will be useful ideas to keep in mind moving forward. Discard the ones that aren't useful: some people have trash taste, we can't do much about that. Thank everyone

anyway—all feedback represents someone sharing their time with you, they care, even if not expressing it in a nice way.

Giving Feedback

Sometimes you have to provide feedback. If you are teaching others you might have to provide feedback on their learning. If you are working in a team your opinion is valuable and you might want to share it. And obviously your Clients, if you're several sessions in and they're still fixated on unrealistic goals, might need some gentle redirection. So let's look at how to do that:

First, be direct. Do not mince words on the main message (you can mince words everywhere else):

'I noticed you have missed every other session we scheduled last month' works better than vague hints. You also need to be timely and specific. 'Sometimes you say weird things' tells the other person nothing compared to: 'you keep mentioning that last Friday you…' *checks notes* '…'lost the will to live when your purple-maxed druid wiped raiding Molten Core hardcore', but I have no idea what any of that means.'

Anytime you provide feedback there must be a reason why you are providing said feedback. Generally it is also a good idea to ask if the other person would like feedback at all to begin with. Sometimes we like lying to ourselves, and that's okay too.

Finally, be empathetic with the other person. Praise in public, but correct in private. Positive feedback is great for a meeting, anything else is better discussed in confidence. **Discussed**. Feedback is not a one-way line; if you wanted a one-way line you should have sent a form. Instead, ask for feedback on your feedback: was it useful for them? Is there anything you could do to help them make the changes you suggested?

Regardless of how good you get at it, sometimes feelings will get hurt. Which brings us to our next critical concept in the meta-dynamics of a professional relationship.

Transference

This is the technical term for the feelings that emerge while working together and that go from your Client towards you. They have a special name because they are different from regular feelings. They aren't 'yours' the same way your regular feelings are.

Freud's 1912 book '*The Dynamics of Transference*' is deep Psychoanalysis. It is one of his dense texts, full of the psychoanalytic lingo he has been making up and defining for the last few decades and he is still trying to convince us (some would say himself) that everything is

sexual energy one way or another. However, the dynamics he finds in the consulting room is what gets distilled and remains until today, at the core of mental health practices.

As work continues and you get to know each other, your Client might suddenly express anger or unexpected critique, they may feel sorry or sad for you, they might think you are the best therapist that ever lived and get a crush on you. None of these feelings are about you.

They don't know who you are, they have no connection to you outside that meeting once a week when they talk 80% of the time, and, when you talk, you're talking about them. Freud uses sexual love as his example (because of course he does) and suggests that these feelings that are being invested onto the analyst (remember? Like taming a fox?) are reflections of the feelings they have experienced towards other people instead. They are experiencing an unconscious 'Transference' of feelings.

Ever been angry (maybe at yourself) and taken it out on someone who had nothing to do with it? That's Transference too. It is part of being human, not just of mental healthcare. Freud notices that in the consulting room this can be a form of resistance, a form of sabotaging the process of getting better. We do that sometimes because the suffering you know can be more comfortable than the pain of growth or the promise of something better. That's kind of okay; it's important to keep trying to suffer less. It might take a few tries sometimes.

A more modern example of Transference are parasocial relationships. The viewer in a livestream doesn't really know the streamer and yet some people might experience intense feelings, that often include a bit of fantasizing, towards that person.

Freud suggests that it is important to talk about these feelings while working together. If after some time your Client tells you they have a crush on you, don't panic, remember they don't actually know you (and Freud would say it's inevitable). Then talk about it, for example:

'This is a professional relationship, that can only achieve its goal if we stick to the boundaries we've had so far. Did something happen that triggered these feelings? Did I do something different?'

Remember object-oriented questions? You're an object too. If you can't think of anything else because you are nervous, you can use yourself. Just don't do it too often or you'll come off as narcissistic. Freud suggests having that conversation and trying to connect it to the topics being discussed in that or previous sessions. Try to convert that resistance into a tool of thought. Freud even offers a taxonomy of Transference:

Positive: Client projects positive feelings (admiration, affection, trust) onto therapist.
Negative: Client projects hostile feelings (anger, distrust, resentment) onto therapist.
Sexualized: Client develops romantic or sexual feelings toward therapist.
Parental: Client relates to therapist as they would to a parent figure.

'Negative' in this context refers to the hostile feelings, but all types of transference are equally problematic, and potentially useful. I haven't mentioned it so far, but remember that there is a certain inertia to mental health recovery and Transference can be part of that resistance.

The same way people generally don't go from well-adapted people to psychiatric patients from one day to the next, recovery also takes time, mental resources, and there is a natural resistance to getting better.

Progress is a line that snakes upwards, what matters is not how many times it falls, but that it falls a little higher every time. Please understand that sometimes being unwell is more comfortable than taking on the monumental task of getting better.

Countertransference

This is your baggage, the unresolved issues you have that might be unconsciously projected into your Client. Maybe there's a Client that you really like, every time you work together is a blast and you look forward to it every week. That's Counter-transference. There might be clients that you flat out can't connect with—you even catch yourself drifting off during sessions; perhaps they remind you of someone difficult from your past. That's Counter-transference as well.

Counter-transference isn't inherently problematic or something to eliminate—instead, it provides valuable information, it is a form of communication. The key is to observe your emotional reactions as a form of communication from your Client. If you find yourself feeling unusually bored every time they come in, treat that boredom as data rather than a personal failing.

Ask yourself: if making you feel bored were a message, what might they be trying to communicate? Could it be that they're creating similar reactions in other relationships and that's contributing to their isolation? Could it be that they too feel stuck and aren't sure how to express it? Maybe they've internalised criticism about being 'boring' and are unconsciously seeking confirmation.

Turn the lens inward as well: why exactly do you feel bored? Is it the content of what they're saying? Their communication style? The pace? Do they remind you of someone from your own life? Your Countertransference can reveal both your Client's patterns and your own unresolved areas.

These reflections are for your internal processing—tools for deeper understanding as you continue to listen attentively. You don't necessarily share these observations directly (at least not immediately or without careful consideration). Various theorists have expanded on this concept since Freud, and I encourage you to explore Counter-transference more deeply as you continue your learning journey.

Consider the work relationship itself creates a unique dynamic field where both transference and Counter-transference operate simultaneously, creating that complex space where healing can occur.

Counter-transference is simply the result of an imperfect human trying to help another imperfect human. And that imperfection, when approached with awareness and compassion, becomes not a limitation but the very soil from which connection and healing grow.

Let’s start getting practical and apply this knowledge with some practical examples in the next section!

How to Work With Neurotypical People

Everything we've discussed so far is actually the difficult part of the job. This is on purpose. The people who really need your help are going to be the most challenging, they are also going to be the most interesting and human people you'll ever meet.

This last part pertains to the easy part of the job. Working with people who are more typical. There is a checklist of fundamental lifestyle conditions that will make any other work much easier. These are not strict requirements, and there is a certain feedback loop between feeling better and being able to do more of these things. Keep in mind that serpentine movement upwards, rather than the illusion of a line that only goes up. To be at peace and grow most humans will need:

- Appropriate physical activity
- To eat and sleep appropriately
- A sense of purpose and community

As hard as it may be to believe, some people really just haven't thought of organising their life intentionally, and it is really just a matter of pointing it out and helping them achieve those goals or develop the skills needed.

Just keep in mind those are vague on purpose. There is no universal; people's own lived experiences and their knowledge of their limits means that these aspects of self-care will come more easily to some people than others, that is okay. The idea is not to balance them out, but to strengthen the areas that come naturally and learn to compensate for the ones that do not. In other words: maybe you don't like working out, but enjoy being meticulous about a balanced and delicious diet. Take advantage of that.

Let's look at a simple example of how to work on these lifestyle aspects. Generally, any improvements you want to make will follow the same dynamic cycle:

First, assess current status and compare it to your Client's goals in that regard. For example, if we're at 0 physical activity, we need to have some, that's your input. Then it's up to the Client to figure out what the first step would be. Remember we spoke earlier about setting realistic, achievable goals? You'd apply that knowledge here as well.

Then you have to execute the planned changes. Here, the focus is on making sure these plans are sustainable. Going to the gym is great, but if you know every time you sign up you

only go two times, maybe stop trying to go to the gym and start with 10 minutes of walking around the block. Focus on what's achievable, rather than what's ideal. Look to your Client for advice.

Finally, assess the changes that have been made, and return to the beginning of the cycle to focus on the next things. This model I'm sharing recognizes that human flourishing emerges from the development of physical vitality, physiological regulation, and psychosocial fulfillment, but not all of them can be developed or needed at the same time. Instead, see them as components that come in different proportions.

Again, you need to explore the topics of sleep hygiene, physical activity, and sense of belonging to gain a toolset that helps you understand what you're hearing. But remember that people are not stupid, everyone has the capacity to figure out what's wrong with them, and, most people, especially in the information age, have an idea of what needs to change to get there. Give priority to what your Client has to say, remember they are the experts on themselves, we are just helping them realize that.

Of course, you don't need to be a paragon of self-care to know what to do. Instead, it is important you have theoretical, logical reasons for the choices and recommendations you make. With this in mind, I want to share with you Abraham Maslow's *Hierarchy of Needs*, which provides a way of understanding and prioritizing human needs. It comes from his 1943 academic paper titled '*A Theory of Human Motivation*'.

Maslow comes at a moment where psychology is polarised between the followers of Psychoanalysis concerned with the abstract of mental dynamics and the adherents of behaviorism focused on the observable components of behavior.

Maslow in many ways pushes both fields forward by coming up with this combinatory perspective, that becomes a third large school of thought in Psychology: Humanistic Psychology.

His hierarchy sees human needs as 'bio-psycho-social'. This is a shorthand way of saying that human needs are of three natures:

- Bio- (From Greek 'bíos' (βίος) meaning 'life'): the physiological aspect that comes from the needs of the body as it tries to sustain its mortal existence. Other animals have these as well.
- Psycho- (From Greek 'psūkhē' (ψυχή) meaning 'soul'): the psychological aspect, that comes from the mind's goal of protecting the Ego against the stimuli and unspeakable existential dread of human experience.

- -Social (From Latin 'socius' meaning 'companion, ally, associate'): the communitary aspect that arises from the Ego's need to collaborate with others to ensure everyone's continued, comfortable existence.

As the name implies, Maslow considers some needs are more important than others. Securing something to eat is more important than expressing your creativity. Not because art is less valuable, but simply because you can't be a great painter if you're dead from starvation.

So while they are not necessarily steps that have to occur one before the other, it is very difficult to fulfill the needs in a higher tier without fulfilling the needs in a lower tier. Furthermore, people make choices around the satisfaction of their needs for external reasons as well. For example, someone might temporarily sacrifice physical comfort (level 1) by moving to a foreign country, to achieve something meaningful (level 5) like finding a community they feel a part of.

Likewise, different levels might be satisfied in different areas of life simultaneously: improving your physical health makes it easier to go out and buy the guitar you've been wanting to buy, or the example I gave you long ago: taking meds makes it easier to go to therapy. Think about that one for a second before reading on.

Maslow's Hierarchy of Needs

Now let's look at the hierarchy itself, starting from the base (level 1), the most fundamental of needs.

1. Physical Survival Needs

The basics we need to stay alive: food, water, shelter, sleep, and warmth. When these aren't met, they become our main focus and they are so ingrained in our nature that we might even break the social contract to fulfill them. For someone experiencing housing insecurity or chronic illness, these foundational needs often consume their entire psychological bandwidth.

2. Safety Needs

Once our physical needs are satisfied, we seek security and stability. This includes physical safety, mental and physical healthcare, job security, and resources for the future. Remember that for many, particularly those with disabilities or chronic conditions, safety needs might require different accommodations or approaches than what's typically assumed.

3. Belonging Needs

After feeling safe, we look for connection with others. This is a spectrum that includes friendships, romantic relationships, family bonds, feeling part of a community or maybe just feeling seen. This is where your role as a Healer often begins—creating that space where someone feels truly heard and understood.

4. Esteem Needs

Next, we want to feel valued and respected. This includes self-respect, recognition from others, seeing the results of our effort, and feeling competent in what we do.

5. Self-Actualization

At the top of the hierarchy is the desire to become our best selves—to grow, be creative, pursue our talents, and reach our full potential. This might seem distant for someone struggling with Depression or Anxiety, but even small steps toward personal fulfillment can provide meaningful progress.

Just to emphasize, these levels are not rigid boxes—it's just difficult to work on the higher tiers if the more basal needs aren't met. Furthermore, these change over time. The needs of someone just starting their marriage are not the same as someone living on their own for the first time.

This is why it is your Client who has to tell you what their needs are at the moment, then you can use your knowledge to suggest a plan that takes into account future or unconsidered needs as well, and see if they agree. They might not, and that's okay—remember people are woefully unpredictable. That's not an issue, it's just part of being human. Try to assume the alien position we spoke about earlier and be curious, rather than judgmental. Your goal isn't to diagnose their place in Maslow's Hierarchy, but to understand their unique experience and help them recognize their own capacity for growth and healing.

How to Understand Different People

If there's one thing the internet makes evident, it's that humans naturally form communities with their own unique folklore, vocabulary, and norms. Whether it's different nations, ethnic backgrounds, neurotypes, or even Revolt (Discord) server subcultures—each group develops its own perspectives on mental health, communication styles, and healing practices. These are all cultural traits, so I want to tell you about another stock-raising buzzword that I hope you will actually apply.

Cultural competence

Cultural competence is the essential skill of recognizing and navigating differences with respect and curiosity. In mental health work it means developing an ongoing awareness of your own cultural position while cultivating a genuine curiosity about the cultural frameworks of others. Think of it as another expression of that twin-light system I mentioned at the beginning: curiosity and kindness. The curious mind asks about differences rather than assuming understanding; the kind heart approaches these differences with respect rather than judgment.

Let me be clear—cultural competence is not about memorising facts about different groups or having a mental encyclopedia of cultural practices. That approach actually leads to stereotyping and risks reducing complex individuals to cultural caricatures. Instead, true cultural competence is about developing a stance of cultural humility—recognizing that each person's cultural experience is unique, intersectional, and constantly evolving. Ask people first-hand about their own cultures.

This matters profoundly in online mental health support because culture shapes every aspect of how we experience and express psychological distress. Depending on where you live and the beliefs of your family, you ask for help differently than your parents do, for example.

Consider how Anxiety might manifest differently across cultural contexts: in some Western frameworks, Anxiety is often described through psychological terminology and internal feelings. In other cultural traditions, the same underlying experience might be expressed through physical sensations or spiritual frameworks. For example, what a clinician might diagnose as 'generalized Anxiety disorder' could be described as 'thinking too much' in some Southeast Asian communities, 'heart distress' in Middle Eastern contexts, or 'soul loss' in various indigenous healing traditions.

When you're listening to someone, you need to tune into both the content of what they're saying and the cultural framework they're using to make meaning of their experiences. Questions like 'what does Anxiety look like in your family?' or 'how do other people in your church typically handle these feelings?' can reveal important insights about cultural meaning-making. This isn't just about ethnic or national culture—it applies equally to online communities, gaming subcultures, religious groups or neurodivergent perspectives.

Neurodivergent communities have developed their own cultural frameworks, language patterns, and norms that differ from neurotypical society. For instance, the direct communication often preferred in autistic communities can clash with neurotypical expectations of social nicety. Similarly, ADHD communities often develop unique time management concepts that don't align with conventional productivity frameworks. Understanding these differences isn't about pathologising either approach—it's about recognising different but equally valid ways of experiencing the world.

Online communities add another layer of cultural complexity. Internet language evolves rapidly, and current expressions like 'brain rot' or 'schitzo' carry emotional meanings that might be incomprehensible to someone unfamiliar with digital communication patterns or even just in a different moment in time.

When someone says they're 'doom scrolling' or feeling 'parasocial attachment' these aren't just slang terms—they're culturally specific descriptions of psychological experiences that wouldn't have made sense even a decade ago and its significance might be difficult to grasp by someone unfamiliar with these communities. (There is no monolithic ‘online community’.)

In more actionable terms, developing cultural competence requires both self-reflection and active learning. First, examine your own cultural assumptions. What aspects of mental health do you take for granted? What communication styles feel 'normal' to you? What metaphors for psychological experiences resonate with you? What kind of heroes and villains do you like? These preferences aren't universal—they're shaped by your cultural positioning, including your professional training if you have it.

Next, approach each person as a cultural guide to their own experience. This means listening for cultural frameworks rather than imposing your own. When someone describes feeling 'possessed by negative energy,' don't immediately translate this into 'they must mean Depression.' Instead, explore what that metaphor means within their worldview. Ask questions like: 'what does that experience feel like for you?' or 'how would someone in your

family typically address negative energies like this?' Try to be an alien figuring out their human guide.

Language and communication patterns vary enormously across cultures as well. This includes not just spoken language but nonverbal cues, storytelling traditions, emotional expression, and comfort with silence. Some cultures value direct communication while others emphasize harmony through indirect approaches. Neither is inherently better—they're simply different strategies for human connection.

Some cultures see direct eye contact as a sign of respect, cordiality and connection. Others see direct contact as a sign of irreverence and a disrespectful signal of having the upper hand in a power dynamic.

Some Spanish speakers prefer to be addressed in a more formal manner by younger people, regardless of station. I could offend a Client if I used the wrong register.

Speaking of Hispanic cultures, time orientation and its significance also differ significantly between cultures. Western psychological frameworks often emphasise future planning and goal setting, but this approach may conflict with present-oriented or cyclical time concepts in other cultural traditions.

Family structures and relationship expectations are deeply cultural as well. The autonomous individual at the center of much Western psychology doesn't reflect the interdependent self that many cultures prioritise. Questions about family involvement, privacy expectations, and decision-making processes should be approached with cultural awareness.

For example, it is more common to find elder adults without family support in North America than in South America, because cultural norms and economic differences promote that Hispanic households incorporate senior citizens into multi-generational households. Each approach has its strengths and drawbacks.

Religious and spiritual frameworks offer healing pathways in many cultures. Rather than dismissing these as 'superstition' or 'opioid of the masses', recognize that spiritual practices have provided mental health support for millennia before modern psychology existed. When someone frames their experience in spiritual terms, honor that framework even if it differs from your own.

In the same vein, consider that historical and intergenerational trauma shapes communities in profound ways. Many marginalised groups carry collective wounds from historical oppression, displacement, or violence. These experiences create specific mental health contexts that require acknowledgment and sensitivity. This applies to ethnic minorities,

LGBTQ2S+ communities, disability communities, and other groups with histories of systemic marginalisation.

In practice, this aspect of cultural competence means remaining flexible in your approach while maintaining ethical boundaries. It doesn't mean abandoning your professional judgment or core values—confidentiality, non-judgment, and ethical limits still apply across cultural contexts. But it does mean recognizing when your usual approaches need adaptation to better serve someone from a different cultural background.

Let me give you a concrete example: a client mentions they see themselves as 'lazy' and a 'bad worker' because they can't focus at work. An approach lacking cultural competence might immediately reframe this as 'you're not lazy, you just have executive function challenges.' While well-intentioned, this response invalidates the Client's cultural framework for understanding their experience.

A more culturally responsive approach might be: 'I'm curious about what laziness means to you. Did anybody say this to you?' This opens space to explore how cultural expectations are shaping their self-perception without imposing your own framework.

Online and gaming communities deserve particular attention here. These spaces have more fluid cultural norms, values, and communication patterns that influence mental health experiences. Because people constantly come and go, they are ever-changing and renew themselves often, but that doesn’t mean the emotional value of these relationships is any less than the emotional value of flesh-based relationships.

When someone describes their guild leader as 'toxic', the psychological impact of that relationship can't be fully understood without appreciating the specific cultural context of guild hierarchies and online social structures. In other words: You might not realise how serious that is if you don't take into account that online relationships are the only genuine relationships some people have. Similarly, concepts like 'grinding', 'malding', or 'noob' carry emotionally laden meanings in gaming contexts that might be missed without cultural understanding.

For neurodivergent communities specifically, cultural competence means recognising and respecting neurological diversity as a valid cultural framework, not just a collection of diagnostic categories: it is important to see people as people and not as a collection of things to fix.

This includes understanding community-specific language (stimming, masking, etc.), respecting communication preferences, and recognising neurodivergent strengths rather than

focusing solely on challenges. You have a bit of a leg up here, as I've spent this entire book teaching you to think in a more neurodivergent way.

Cultural competence is particularly important when discussing sensitive topics like addiction, trauma, or sexuality. Cultural backgrounds profoundly influence how these experiences are conceptualised, the language used to describe them, and appropriate approaches to healing. What constitutes 'recovery' or 'healthy relationships' varies significantly across cultural contexts.

Finally, remember that cultural competence is an ongoing journey, not a destination. No one achieves 'complete' cultural competence—the goal is continuous growth and learning. You will make mistakes, misunderstand cultural references, and occasionally cause offense despite your best intentions. When this happens, respond with humility, apologise sincerely, learn from the experience, and adjust your approach. This willingness to acknowledge cultural missteps and grow from them is itself an essential component of cultural competence.

Realise that most misunderstandings come from ignorance, not malice. A sweet old lady once told me my name can't really be Josh. 'It must be José, right?' Because I'm Hispanic... Turns out I was literally the first Hispanic person she ever talked to.

Inclusion & Accessibility

There are two people I'm hoping this handbook will help: your Client and you. We'll talk about self-care in the section below, but I'd like to provide you with an overview of what I mean when I say this is disability-friendly, remote-first work. While many of these points might be evident from the rest of the book, I want to make them explicit.

The role of a Mental Health Healer represents a profound opportunity to transform what have traditionally been barriers—physical limitations, sensory differences, neurodivergence, chronic illness, or being homebound—into unique strengths in providing mental health support.

Disability scholar Rosemarie Garland-Thomson, in her 2014 paper '*The Story of My Work: How I Became Disabled*,' proposes that: 'disability can be an occasion for suffering, but it can also be an occasion for joy, knowledge, and connection.' This exemplifies 'embodied knowledge'—insights gained through navigating a world not designed for diverse bodies or minds.

This experiential knowledge creates a foundation for empathetic understanding that transcends theoretical training. Not only is this something that can seldom be taught, it is often unique and connected to local contexts: it is not the same to be blind in Ecuador as it is

to be blind in Canada. This first-hand expertise becomes invaluable when supporting others through psychological challenges.

If you appreciate my rebellious yet bridge-building writing style, I recommend reading Garland-Thomson's paper. It offers an excellent academic perspective on contemporary Disability Studies and presents many principles that build the theoretical foundation for the handbook you're reading now.

Looking at the job itself, the core competencies of listening, reflective questioning, and holding space require no physical mobility. This flexibility creates a more sustainable practice for the Healer while offering clients a model of compassionate adaptability. Remote mental health support leverages technology not merely as a substitute for in-person connection, but as an accessibility enhancement. It allows for real-time captioning and transcription, multiple communication modalities (video, audio, text) and enables session recording for review (with appropriate consent).

Disability Studies remains one of the least explored and researched areas of mental health. There is often limited knowledge about available resources, and even when resources exist, communicating needed accommodations can be challenging. By being aware of possibilities, you can make more appropriate recommendations and guide your own learning based on the specific needs of your community.

A Healer with disability experience offers Clients several unique benefits, such as witnessing a helping professional who navigates challenges daily, demonstrating that valuable contributions aren't contingent on conventional abilities. This implicit modeling can be transformative, particularly for Clients who struggle with feelings of inadequacy. This approach also represents one of the core tools when working with addiction, which is why there are so many peer-supported initiatives around substance use recovery.

If you have a disability, you've likely developed sophisticated functional skills when navigating the world. You might have created innovative ways to deal with capital-first bureaucracy, learned to self-advocate, or identified structural institutional issues rather than focusing solely on personal deficits. These skills transfer directly to supporting Clients through their own obstacles.

Lived experience navigating healthcare, accommodation systems, and social bias provides insight that can help clients contextualise their struggles within broader systemic issues rather than viewing them as personal failings or irremediable fates.

The remote-first, disability-friendly Healer model I'm proposing doesn't simply accommodate disability—it recognises the unique value that disabled practitioners bring to

mental health support. By centering accessibility, we create opportunities for meaningful work among those often excluded from traditional employment while simultaneously addressing the critical shortage of mental health support globally.

The Mental Health Healer role, when implemented through this lens, becomes not just accessible work but transformative practice that enriches both practitioner and client through authentic connection across difference.

Creating Therapeutic Spaces at Home

Remote therapy requires intentional environmental design that mirrors professional standards while accommodating home limitations. These spatial considerations aren't merely aesthetic preferences—they represent psychological boundaries that significantly impact therapeutic efficacy and the therapeutic alliance.

Research in environmental psychology demonstrates that consistency in work settings helps establish what Winnicott (1965) referred to as a 'holding environment', where clients feel secure enough to engage in vulnerable work. The symbolic space serves as a container for the work relationship and helps to distinguish it from ordinary interactions.

Designate a dedicated workspace that minimises both visual and auditory distractions. While a separate home office is ideal, this isn't accessible for everyone. Instead, prioritise consistency and professionalism by selecting a specific location that can be reliably arranged for sessions. A simple table positioned against a neutral wall can suffice, and virtual backgrounds (when stable and professional) offer an alternative when home environments cannot be fully controlled. If you’re a bit media savvy, a greenscreen is also a good choice. The predictability of your setting communicates reliability to clients who may have experienced environmental unpredictability in their lives.

Sound management represents another crucial boundary layer. Implement strategies like noise-cancelling headphones to minimise your distraction and white noise machines placed outside your workspace to prevent sound leakage—particularly important for neurodivergent clients who may experience heightened auditory sensitivity.

Lighting and positioning significantly impact nonverbal communication—essential for therapeutic attunement. Arrange lighting that illuminates your face rather than creating backlighting, ensuring clients can clearly read your facial expressions and microexpressions. If it is a voice-only call, you don’t need to put on pants, but also don’t work while laying in bed.

Visual clarity supports facial mirroring, useful for co-regulation and emotional attunement, particularly beneficial for neurodivergent clients who may already experience challenges with social cue interpretation. Consider the opposite might also be true, some people will benefit from an audio-only set-up, as video or being seen might be too stimulating.

These environmental considerations collectively establish the foundation for ‘talking professionally’, allowing both you and your clients to focus on the psychological work rather than environmental distractions.

How to Take Fun Seriously *(Examples of modern healing communities and art as therapy)*

Art has always been a powerful vehicle for human expression, but, historically, not all art forms offered equal accessibility across different abilities and needs. In recent years, tabletop role-playing games like Pathfinder and virtual performance spaces like VTubing have demonstrated remarkable potential for inclusive participation. These creative domains exemplify disability-friendly expression through their inherent flexibility, community-focus, and capacity to transform traditional barriers into unique strengths.

Role-playing games create accessible creative spaces through their fundamental structure. Unlike performance arts that demand specific physical capabilities or traditional social skills, RPGs are inherently adaptable systems that abstract physicality completely and take it out of the equation. Their pacing can be adjusted to allow for processing time and energy fluctuations, making them accessible to people with chronic illnesses, cognitive processing differences, or attention variations. For example: a player experiencing fatigue can take breaks without disrupting the collaborative experience, while someone with processing differences can take the time they need to formulate responses while attention is directed at other players.

From a psychological perspective, these games create what Winnicott might call a 'potential space' where internal reality and external experience intersect through shared imagination. A Dungeons & Dragons campaign is a real construct, a narrative story (like a novel) built collectively, that brings together real and imaginary aspects of each participant to create a space almost mythic: a space that is neither part of our collective reality, but undeniable in its effects on the real lives of the players. In other words: you never 'really' purged the ancient evil from under the vampire's castle. Except that the imaginary experience created real bonds of camaraderie and friendship. The bravery you discovered in yourself doesn't vanish at the end of the sessions. The talents that flourish from the enjoyment of fantasy make it part of yourself. Aren't those very real things?

In terms of inclusion, the multiple modes of engagement available in RPGs create various entry points for participation. Some players excel at strategic elements, others at character development, and still others at collaborative storytelling. This variety allows participants to engage through their strengths while navigating around challenges. A person with social Anxiety might initially focus on the mechanical aspects of gameplay while gradually

developing comfort with in-character dialogue, building confidence in a structured environment that feels safer than unmediated social settings.

The structured social interaction of RPGs (Role-Playing Games) provides clear parameters that make connection more navigable for neurodivergent individuals, who might find typical social environments overwhelming. The explicit turn-taking, clearly defined roles, and transparent rule systems create what psychologists call 'scaffolding' for social engagement. This structure reduces the cognitive load of interpreting unspoken social rules that often makes unstructured interaction exhausting for neurodivergent people.

In terms of physical disability, with the rise of online play platforms RPGs have become increasingly accessible to those with mobility limitations, chronic illnesses, or geographic isolation. Someone who might be homebound due to disability can fully participate in these collaborative storytelling experiences, connecting with others through shared creativity rather than being excluded by physical barriers.

Along these lines, VTubing represents another innovative intersection between art, technology, and accessibility. By using digital avatars rather than showing their physical selves, content creators interact with audiences through animated characters that closely mimic their movements and expressions. This creates accessibility through what psychologists call 'strategic disclosure'—allowing creators control over when, how, and whether to share aspects of their identity rather than having disclosure forced upon them by what's visible.

For individuals with fluctuating conditions, chronic pain, or visible differences that often draw unwanted attention, the avatar provides consistency in self-presentation while accommodating behind-the-scenes variability. A creator might be managing pain, using mobility equipment, or experiencing symptom flares while their avatar maintains consistent presence (this sounds almost like the therapeutic consistency we spoke about earlier, huh?). This separation between physical state and social participation allows for meaningful connection without the exhaustion that often comes from managing others' perceptions of disability.

The modified production demands of VTubing compared to traditional content creation also lower barriers to participation. While conventional video creation requires managing lighting, background environments, physical appearance, and camera presence depending on the limits of what's physically available, VTubing significantly reduces these sensory and physical demands. This frees up energy for creative expression and makes it accessible to

those who might find the requirements of traditional content creation prohibitive due to physical differences, executive function challenges, or energy limitations.

These art forms support core elements of mental wellbeing identified throughout the handbook because they inspired this handbook. They address multiple levels of Maslow's Hierarchy of Needs simultaneously—from belongingness through community connection to self-actualisation through creative expression. They incorporate the principles of Motivational Interviewing naturally: respecting autonomy, understanding individual motivations, listening with empathy, and empowering participants through collaborative creative agency.

What makes these art forms particularly valuable for inclusion is their capacity to transform what might traditionally be seen as limitations into sources of creative strength. This truly comes to life when disabled game masters create worlds informed by their unique understanding of power dynamics and accessibility, or when neurodivergent VTubers bring innovative communication approaches based on their distinctive cognitive styles, or just plain fun weirdness.

The psychological value extends beyond individual participants to broader cultural impact. When disabled creators visibly participate in these spaces, they challenge limiting narratives about disability and demonstrate the quality and humanity found in creative contributions that emerge from diverse lived experiences. This representation itself becomes a form of mental health support for other disabled individuals who rarely see their experiences reflected in mainstream culture.

As we work toward truly accessible mental health approaches, these creative communities offer valuable lessons about creating multiple pathways to meaningful engagement. They remind us that accessibility isn't merely about removing barriers but about actively valuing the perspectives that emerge from diverse lived experiences.

How to Self-Care

The final key learning from this book regards self-care. I don't want to repeat what you'd find in a social media post. Instead, I want to leverage my lived experience to use the symbols of videogames as a metaphor to explain why you can't do anything without first taking proper care of yourself.

In multiplayer online games, there's a classic team dynamic. The 'Tank' is a character who stands at the frontline, absorbing damage and protecting the team. Meanwhile, the 'Healer' stays slightly behind, constantly monitoring the health of others and casting spells to keep the Tank (and others) alive through difficult battles.

Imagine a Tank stands facing a hell-beast, fire deflecting against his shield while trying to hold the monster's attention. Behind them, a Healer frantically works, watching both the Tank's health bar and their own 'mana pool' (their magical energy resource that powers healing abilities). The Tank needs constant attention—but what happens when the Healer runs out of mana?

Everyone fails. The entire team is defeated.

In mental healthcare, you are the Healer, and your clients are the Tanks facing their own demons. The emotional labor of supporting others through their battles is your healing magic. But your ability to offer that support depends entirely on your own resources—your psychological, emotional, and physical reserves. Research consistently shows that the quality of care practitioners provide directly correlates with their own well-being.

Just as a skilled Healer in a game needs to understand the mechanics of their character's energy systems, as a mental healthcare provider, you need to understand your own internal resources and what replenishes or depletes them. Here are some examples of these 'critical resources':

- Physical Energy: your body's capacity for activity, alertness, and endurance—the foundation upon which all other resources depend
- Emotional Capacity: your ability to process, contain, and respond to emotional content without becoming overwhelmed
- Cognitive Bandwidth: your mental clarity, focus, and processing power (now you can use that word and say you don't have enough bandwidth for stuff)

- Compassion Reservoir: your ability to genuinely care, empathize, and remain present with suffering
- Existential Stability: your sense of meaning, purpose, and groundedness in your work

Each session with a client draws from these resources in different proportions. A particularly intense session dealing with trauma might heavily tax your emotional capacity while leaving your physical energy relatively intact. A long day of back-to-back sessions might primarily drain your cognitive bandwidth, making it difficult to focus and remember details by the end of the day.

Think of these resources as interchangeable—when one becomes severely depleted, others can be used to compensate, but that depletes them even faster. For instance, chronic physical exhaustion eventually impacts your emotional capacity and cognitive bandwidth. In neurobiological terms, your prefrontal cortex—responsible for empathy and decision-making—requires adequate physical resources to function optimally. In other words: it's hard to work with a migraine.

However, just as our bodies give us hunger signals when we need food, your mind and body also offer warning signs when your helping resources are running low, these come in four categories:

- ❖ Physical warning signs:
  - ➢ Tension headaches, neck/shoulder tightness, jaw clenching, or digestive issues
  - ➢ Changes in sleep patterns (insomnia or excessive sleeping) or in appetite (loss of appetite or emotional eating)
  - ➢ Increased susceptibility to colds and minor illnesses due to stress-related immune suppression

- ❖ Emotional warning signs:
  - ➢ Irritability or impatience over minor issues
  - ➢ Emotional numbness or detachment ('I don't really care anymore')
  - ➢ Heightened emotional reactivity to client stories (tearing up more easily)

- ❖ Cognitive warning signs:
  - ➢ Difficulty concentrating during sessions

- ➢ Forgetting important details about clients
- ➢ Decreased creativity in your approaches to helping

- ❖ Relational warning signs:
  - ➢ Avoiding Client contact or dreading upcoming sessions
  - ➢ Growing cynicism about Clients' capacity for change
  - ➢ Decreased patience with Clients' progress pace

When you notice these warning signs, consider it the equivalent of flashing indicators on a dashboard, or a screen turning red at the edges. They're alerting you that your resources are running dangerously low. It's time to replenish before breakdown occurs. You might be fine for a little bit, but if nothing changes, you'll be wiped. Let's look then at some practical examples of what to do once you have an idea of what needs you need to satisfy. (Remember? This is the same as Maslow's Hierarchy but applied to you!)

For physical needs:

Sleep

Establishing consistent sleep patterns forms the foundation of physical resources renewal. Create a dedicated sleep routine with consistent bedtimes and wake times, even on weekends, to regulate your body's natural rhythms. If you wake up at noon, try to always wake up at noon.

Develop a 30-60 minute wind-down ritual before bed, incorporating dimmed lights, reduced screen exposure (or at least turn on night mode, come on), and relaxing activities like reading or gentle stretching.

Your sleep environment deserves careful attention—aim for a cool temperature where you won't be waking up to add or remove covers. Try to reduce noise and increase darkness, that signals your brain that it's time to rest.

If data-inclined, consider tracking your sleep patterns through an app or journal to identify what helps or hinders your rest. Remember that persistent sleep difficulties warrant professional attention, as quality sleep underpins all other self-care efforts.

Eat

Next are your eating patterns. They directly influence your capacity to support others. Focus on nutrient-dense meals that provide sustained energy rather than the quick spikes and

crashes that come from processed foods and excess sugar. The last thing you want is a sugar crash while you're working with your client.

Hydration plays an equally crucial role—keep water accessible during sessions and develop the habit of drinking regularly throughout your day, especially since the cognitive work of helping is often a great excuse to distract you from your own physical needs.

On the same vein, be mindful of your relationship with stimulants like caffeine, which can mask fatigue rather than addressing the underlying need for rest. If you are a data enjoyer, pay attention to your unique responses to different foods by temporarily keeping a food/mood journal—many people discover surprising connections between specific dietary choices and their energy, focus, and emotional resilience.

Move

Physical activity also serves as one of the most reliable ways to replenish depleted resources, but this doesn't necessarily mean intense workouts. Focus on movement you genuinely enjoy rather than what you believe you 'should' do—sustainable practice depends on pleasure, not obligation.

Another strategy for more chaotic people is to look for opportunities to incorporate movement naturally into your day, such as walking meetings, active commuting when safe and feasible, or brief stretching sequences between client sessions. Remember that even short movement breaks—a five-minute walk, a few yoga poses, or simple stretches—can significantly shift your energy and mental state. Pay attention to how your body feels before, during, and after different types of movement, allowing this feedback to guide your choices rather than following arbitrary external standards.

Feel

In the same spirit, environmental psychology research consistently demonstrates that exposure to the other parts of nature that aren't humanity, restores attention and reduces stress hormones—even brief interactions with non-human natural elements can significantly replenish cognitive and emotional resources.

Try to spend time outdoors, knowing that even 20 minutes can produce measurable benefits. Find a favorite plant and a favorite non-human animal if you don’t have them and enjoy learning about them.

If that is not feasible and you work primarily indoors, bring elements of wild nature into your space through plants, natural light, nature sounds, or images of natural scenes.

Technically your brain can't even tell the difference between real and fake. You can, but not your brain, strangely enough.

Consider adopting practices like 'forest bathing' (mindful time in wild settings, not related to green-washing) as a regular restoration practice. Urban environments still offer opportunities for nature connection—seek out parks, gardens, riverside walks, or even single trees in your neighborhood.

For emotional needs:

The emotional labor of mental healthcare work requires intentional processing channels to prevent accumulation (of negative energies, some would say) and overwhelm. This is another way of saying that people will share their psychological burdens with you, and you need effective ways to process these secondary experiences rather than internalising them. This is a form of 'emotional contagion'—the tendency to absorb and mirror the emotional states of those we work with intensively.

Consider maintaining your own therapy or counseling relationship—even experienced healers benefit from having dedicated space to explore their reactions to helping work. Regular peer supervision or consultation provides another valuable outlet, allowing you to discuss challenging cases with others who understand the unique demands of this work.

In terms of what you can do on your own, you can try to develop new personal reflective practices like journaling, meditation, or artistic expression that help you process absorbed emotions.

One of your first goals for yourself must be to develop healthy outlets for the full range of emotions that arise from your work—not just the difficult feelings, but also the joy, satisfaction, and meaning. Consider creative expression through art, music, writing, or movement as ways to translate emotional experience into tangible form. Practice allowing yourself to feel what arises, including the emotions that seem 'unprofessional' or uncomfortable.

Self-compassion becomes particularly important when you're struggling—treat your emotional responses with the same understanding you would offer a child, a dear pet or client. Normalising your reactions, literally talking to yourself like you’d talk to a Client, reduces the secondary stress that comes from judging your own emotions, creating space for authentic expression and release rather than suppression that ultimately depletes your resources further.

In the face of others' suffering, many Helpers unconsciously restrict their own joy and pleasure. It feels wrong to be happy when you spend all day hearing about people who aren't. Yet, paradoxically, this tendency toward 'empathic distress' actually diminishes your therapeutic effectiveness rather than enhancing it. Counteract this tendency by intentionally scheduling activities that bring you genuine enjoyment and satisfaction. It’s harder to bail out of that Habachi afternoon if you scheduled it as an afternoon with the boys than if it’s just a note in your calendar.

Try to maintain interests and hobbies completely unrelated to your professional role—these separate spaces allow different parts of your identity to flourish beyond your helper role. As you go around enjoying these, develop the practice of noticing and savoring small moments of joy throughout your day, perhaps keeping a physical or mental record of these experiences.

Positive psychology research calls this 'savoring' and identifies it as a key practice for sustaining wellbeing in difficult work. Resist the common urge to postpone enjoyment 'until the work is done,' recognising that helping work is never truly complete.

Keeping the personal and professional in balance

Especially when working independently, one of your main responsibilities with yourself is going to be creating an intentional physical separation between your work and personal spaces whenever possible, particularly if you operate from a home office.

This spatial delineation supports cognitive and emotional compartmentalisation: it helps you step in and out of the role. To this end, you’ll need to develop personalised transition rituals that explicitly mark the shift between your professional and personal identities—whether changing clothes after sessions, taking a specific route home that symbolises 'leaving work behind,' or cueing a playlist that signals 'work is done' during your commute.

You must also learn to say no to yourself. Decline requests that exceed your current capacity and recognising that setting appropriate limits now prevents the greater harm of overextension later. Remember that well-maintained boundaries protect not only your wellbeing but also the integrity and sustainability of your practice itself.

Growing as a professional

Professional development represents a double-edged sword in mental healthcare—while growth fuels engagement and prevents stagnation, not all development activities affect your

psychological resources equally. Focus on continuing education opportunities that generate energy rather than depleting it—topics that activate your genuine curiosity and connect to.

Regarding day-to-day practice management, adopt a realistic perspective about client capacity—how many individuals you can effectively support without compromising either quality of care or personal wellbeing.

This sustainable number may be lower than institutional expectations or capitalist greed suggests, particularly for neurodivergent practitioners managing additional cognitive load. Build deliberate administrative intervals between client sessions (minimum 10-15 minutes) to process emotional content, complete documentation, and reset your attentional resources before the next therapeutic encounter.

Structure your weekly schedule to include varied types of professional engagement to prevent the particular exhaustion that comes from cognitive and emotional monotony. This might include balancing individual therapy with group facilitation or integrating work with communities you personally identify with. Consider not just the quantity of clients you serve but also the qualitative emotional intensity of your caseload when making decisions about new client acceptance.

Remember that effective workload management in mental health practice inevitably involves making difficult choices between competing priorities, guided by both ethical commitment to client welfare and sustainable practice for yourself. Neither should be sacrificed in pursuit of financial gain or institutional metrics. Some Clients are more demanding than others, and it’s okay to recognise that difference and consider it when setting up your schedule.

For social needs:

Professional isolation dramatically increases vulnerability to burnout and compassion fatigue, while meaningful connection provides both practical support and emotional sustenance. In this regard, you can try to cultivate and maintain relationships with colleagues who understand the unique challenges of mental health work—trusted professionals with whom you can communicate in shared language (remember linguistic frameworks?) about experiences that those outside the field might find difficult to comprehend.

For example, when working with complex Clients, general people might not understand why you put so much effort when it’s so emotionally draining, but a colleague will probably understand that the most challenging, or annoying, people are the ones who need help the most.

Simultaneously, you'll want to develop and nurture friendships outside the mental health domain to broaden your perspective and provide cognitive relief from constant immersion in helping concerns. Schedule connection with individuals who consistently energize rather than deplete you and approach these relationships as essential professional sustainability practices rather than indulgences.

Receiving Support

This dimension warrants particular attention, as mental health professionals—especially those with neurodivergent traits—often excel at providing support while struggling to receive it, yet this reciprocity remains essential for sustainable practice.

You can systematically practice requesting help when needed, starting with small, low-risk requests with trusted individuals if receiving support triggers vulnerability or discomfort. Consciously allow others to provide emotional containment and validation, recognising that receiving care strengthens rather than diminishes your therapeutic capacity. You can even be honest with your loved ones, and just tell them what you're trying to learn, most neurotypical people will be eager to help.

Examine any internal resistance to receiving support and try to identify the underlying beliefs, past experiences, or neurodivergent masking patterns that may contribute to this difficulty. Remember that appropriate vulnerability in selected contexts strengthens rather than weakens interpersonal connections, often deepening the very relationships that sustain your helping work.

By developing comfort with receiving support, you also model healthy interdependence for your clients, many of whom struggle with similar challenges around accepting care from others—creating a powerful parallel process that enhances therapeutic outcomes.

Meaning and Purpose Connection

Meaning serves as a powerful protective factor against burnout and secondary trauma, but the daily challenges of mental health work—especially within systems prioritizing productivity metrics and money over therapeutic outcomes—can sometimes obscure the deeper purpose that initially drew you to this role.

We spoke earlier about creating rituals, and this is another area where it can be useful to create personal rituals that anchor you to your sense of purpose—perhaps a brief intentional reflection before beginning the clinical day or a structured gratitude practice focusing on moments of meaningful connection with clients.

A simple practice I picked up from volunteering with Jesuit friars is to close your eyes and try to remember the faces of all the people you saw that day. That's it, it's simply about being aware of the lives you touched that day.

You can also incorporate physical reminders of your professional purpose within your workspace—symbols, quotes, or meaningful objects that ground you in your values during difficult clinical moments. You can try to engage with inspirational narratives, theoretical texts, or philosophical teachings that resonate with your professional ethos and renew your sense of vocational meaning.

Remember that mental health work inevitably brings practitioners face-to-face with profound questions about suffering, resilience, and the human condition. A common strategy to deal with this existential dread is to establish a regular meditation, prayer, or contemplative practice that creates psychological space for integration and perspective beyond immediate clinical concerns.

Likewise, you can engage with communities that share your values and existential orientation, whether spiritual traditions, philosophical collectives, or service-oriented organisations where collective wisdom offers support for processing the deeper questions this work inevitably raises.

In many ways, I'm encouraging you to identify ways to connect with something larger than individual experience—whether through nature immersion, artistic expression, spiritual practice, or social justice movements—that contextualise individual suffering within broader patterns of meaning.

If You're Starting With Your Needs Depleted

What if you're reading this while already in a state of significant depletion? What if your resources are almost completely exhausted?

First, recognize that recovery is possible. Then, try to implement any of the strategies I've shared with you in this entire Handbook. I know it's harder than it sounds, but it's also a feedback loop, and if you can get in motion it will be easier to stay in motion. There are some things you can do to make that first step towards self-care a little easier. (See how I'm coaching you now?)

You can begin doing a triage, an assessment that seeks to prioritise your needs. Consider what is draining your resources: what absolutely must continue, and what can be temporarily paused?

It might also be useful to reach out to your personal or healthcare network. Receiving support firsthand will help you learn a lot now that you know what to look for. I'd also hope you now have a wider vocabulary to advocate for yourself and ask for help.

If you can stabilise things a bit, prioritise sleep, nutrition, hydration, and movement, like we discussed earlier, and build back slowly, rather than immediately returning to previous patterns. Pay attention to yourself as things change: remember your lived experience so that you can better understand the lived experience of others.

Once you've stabilised, you can spend some energy propping yourself up in a way that makes this less likely to happen again, even if it does recur. Try to figure out what systems or patterns led to this depletion, and looking at the warning signs above, ask yourself: what signs did you miss or ignore?

Remember that being temporarily depleted isn't a personal failing—it's information about the sustainability of your current approach. Some of the most valuable insights about effective self-care come from these difficult experiences.

Self-Care as Professional Responsibility

Here's the most important truth about self-care for mental healthcare providers: taking care of yourself isn't separate from taking care of clients—it's an essential component of it.

When you maintain your own resources, you model healthy self-care for your clients (many of whom struggle with basic self-care). This provides hope and makes self-care seem less alien and distant. (It’s also easier to respect someone who not only talks the talk but also walks the walk.)

By ensuring you're in top shape, you bring your full presence and capacity to each session. It's not about being perfect, by any measure; it is about feeling like you're doing your best, so that you can inspire the same in others, no matter how much or how little that is.

These ideas will also help you sustain your practice over the long term, helping more people overall. Any way you see it, taking care of yourself pays dividends. One of my favorite ways to put this comes from Uncle Iroh, a character from the 2005 animated series '*Avatar: The Last Airbender*': 'Sometimes life is like this dark tunnel. You can't always see the light at the end of the tunnel, but if you just keep moving, you will come to a better place.'

As a final argument (what a crazy world where I have to use the tools of rhetoric and persuasion to convince you to take care of yourself), imagine two scenarios from your client's perspective:

Scenario 1: your Client faces a difficult emotional challenge. They look to you for support, but find you depleted, distracted, and barely able to focus on their needs because you're physically exhausted. Your responses are automatic, by the book, rather than thoughtful, and your emotional presence is limited. How supported would they feel?

Scenario 2: that same Client looks to you and finds you well-rested, focused, emotionally available, and fully present. You have the capacity to listen deeply, respond thoughtfully, and hold space for their pain without being overwhelmed by it.

Which helper would you want supporting you through your hardest moments?

Your Clients deserve the helper from Scenario 2—and so do you. So let’s look at some common excuses, or, as they are technically called:

Barriers to Self-Care

Don’t worry, these are my specialty. The challenges and excuses you'll often find around self-care:

'I don't have time for self-care.'

This is perhaps the most common excuse—and the most deceptive. The truth is, you don't have time NOT to practice self-care. Without it, your efficiency decreases, your cognitive processing slows, and you ultimately spend more time accomplishing less. In the long term, your body will pass you the bill too and force you to slow down by getting sick.

Here are some actions you can take:

Start with small but integrated practices (5-minute meditation between sessions, stretching, grab a granola bar, take a slow shower). Remember that self-care isn't always 'one more thing'—it can be doing current activities more mindfully. Maybe you already read, it's ok to read more and intentionally. Consider self-care as part of your job, not separate from it. A good institution will offer self-care benefits as part of its benefits package.

Most importantly, schedule self-care activities with the same commitment as client appointments: be ‘serious’ about taking care of yourself.

'Caring for myself feels selfish when others need me (or in this time of crisis).'

Many helpers carry an unconscious belief that self-sacrifice equals virtue. This martyr mindset is both culturally reinforced and deeply harmful. Let's focus on what to do if this is what comes to your head:

Recognise that putting yourself last actually limits your helping capacity. If there was a numeric total, it would be lower, simply because you're giving less if you have nothing to give! It is important to challenge the false dichotomy between caring for yourself and caring for others. I've said this a million times already, but it's because capitalism hates this one simple trick: taking care of yourself is part of your job.

It might also be a good idea to explore the origins of your self-sacrifice beliefs (ideally in therapy). Sometimes it's a family thing, sometimes it's a cultural thing, sometimes it's a sexism thing. Then reframe self-care as resource management, not indulgence. Yes, you're having fun, but it is serious fun. Like this book.

'I should be able to handle this without special accommodations.'

This excuse often stems from perfectionism and unrealistic expectations about human capacity. There is no magic trick, we just have to acknowledge (with actions, not with thoughts, prayers or pizza) the real psychological impact of helping work and normalise our human limitations rather than fighting them. Practice self-compassion for your very human needs.

'I don't know what actually helps me recharge.'

Sometimes the barrier isn't conceptual but practical—you simply don't know what works for you and maybe never had the time to figure it out. This is common in people with rough childhoods that had to grow up fast and take on responsibilities inappropriate for a child. But it's never too late to figure it out. It's just a bit awkward when you're bigger, nothing more.

You can try experimenting with different self-care activities while methodically observing their effects on your mental and physical well-being. This approach, rooted in behavioral psychology's principles of self-monitoring, allows you to build personal evidence for what genuinely replenishes you. Take time to reflect on past experiences when you felt renewed and identify common elements—search your memory as far back as childhood or adolescence, as these early patterns often establish our core restorative needs. Family members may also provide valuable insights about activities that historically energised you, offering perspectives outside your conscious awareness.

Trusted others in your current life can also provide objective feedback about when you appear most energised or balanced—just ask them. This multi-source approach to understanding your needs aligns with contemporary models of psychological well-being. Remember that effective self-care often evolves throughout your lifespan—neuroplasticity ensures that our brains continue changing, meaning what worked in previous life stages may not serve you now, and current preferences may shift as you develop.

For those living with chronic illness, disability, or other health challenges, self-care transcends conventional practices and becomes an essential component of identity integration. Honor your body's unique needs and limitations without engaging in comparative thinking with providers who have different capacity—a cognitive distortion that undermines self-compassion. Instead, advocate for accommodations that support sustainable practice within your profession and seek communities of other helpers with similar health challenges. This collective approach not only generates more diverse perspectives but creates solidarity networks that buffer against the isolation often experienced by healthcare providers with disabilities.

For those in historically underserved communities, focusing on no-cost/low-cost self-care activities acknowledges the socioeconomic determinants of wellbeing without pathologising resource constraints. When choices must be prioritised, concentrate on the most essential forms of self-care—research consistently demonstrates that small, consistent practices generally produce greater long-term benefits than occasional elaborate interventions: take yourself out on a park-bench date every Friday, rather than saving up for a 1 week vacation every year.

Remember that effective self-care is highly individualised, reflecting unique psychological, physiological, cultural, and spiritual needs. The specific practices that replenish your resources may differ significantly from those that work for colleagues, which is why standardised self-care recommendations often fall short. The key is developing

metacognitive awareness of your resource states and implementing intentional strategies to maintain them—what psychologists refer to as emotional regulation and self-management competencies.

In the gaming world, the most valuable Healers aren't those who deplete their mana pools fastest—they're the ones who understand their resource mechanics so thoroughly that they can sustain their group through even the longest, most challenging encounters. This gaming metaphor parallels psychological concepts of energy management and allostatic load (or stress-induced adaptations) in healthcare providers.

It follows that the most effective mental healthcare providers aren't those who sacrifice themselves on the altar of service—they're those who understand that their own wellbeing constitutes the foundation upon which all their clinical effectiveness rests. Research on provider burnout consistently demonstrates that depleted clinicians show reduced empathic accuracy, increased cognitive errors, and diminished therapeutic presence.

Carl Jung astutely observed in his autobiographical work '*Memories, Dreams, Reflections*' (published posthumously in 1963): 'The doctor is effective only when he himself is affected. Only the wounded physician heals.' This concept doesn't advocate for suffering alongside clients; rather, it emphasises maintaining authentic human connection and emotional responsiveness—capacities that require conscientious self-care to preserve in challenging clinical work.

As you continue your journey as a community Healer, remember that every moment invested in maintaining your psychological and physical resources represents a direct investment in your therapeutic capacity. When you practice meaningful self-care, you ensure that those seeking support encounter not merely a willing helper, but a truly resourced one—a healer with sufficient reserves to offer the attunement, presence, and containment that effective helping relationships require.

Your self-care isn't selfish or peripheral to your professional identity—it constitutes the most fundamental and generous contribution you can offer to those you serve.

How to provide Mental Health First Aid

This area isn't the focus of this handbook, but it might be valuable in under-served settings. While this handbook doesn't replace professional training, I'll do my best to equip you with some basic mental health first aid skills. Think of it like a physical first aid kit—it can help manage a situation until professional help arrives. Your role is to assist, not to treat.

1. Warning Signs

First, learn to recognise potential mental health challenges. You know your community and the people in it, so pay attention to how people are doing. The first step is realising who might need help. Here are some common red flags in different aspects of our personality:

- Mood: persistent or sudden sadness, irritability, Anxiety, or apathy.
- Behavior: withdrawal from usual social activities, changes in sleep or appetite without clear reason (someone might naturally eat less in the summer, for example), difficulty concentrating, increased substance use.
- Thinking: keep an eye out for uncharacteristic difficulty making decisions, paranoia, or suicidal thoughts.

2. Action Plan (A.L.G.E.E)

The ALGEE method provides a structured approach to assisting someone experiencing a mental health crisis and guides you on what to do if you ever find yourself in such a situation:

- (A)ssess for risk of suicide or harm. Ask directly if they are having thoughts of harming themselves or others. If so, seek immediate professional help (just call 911 or your local emergency number).
- (L)isten non-judgmentally. Create a safe space for the person to share their experiences without interruption or judgment.
- (G)ive reassurance and information. Let the person know they are not alone and that help is available. Provide information about local mental health resources.
- (E)ncourage appropriate professional help. Support the person in seeking professional help from a therapist, counselor, or psychiatrist.

- (E)ncourage self-help and other support strategies. Help the person identify coping mechanisms, such as exercise, mindfulness, or connecting with supportive friends and family. (We talked about this, remember?)

3. Communicating Effectively

Use the skills we've been talking about to create an effective path of communication. You will use many of the skills we've already covered in this book:

Active Listening: pay attention to both verbal and nonverbal cues. Reflect back what you hear to ensure understanding.

Empathy: try to understand the person's perspective and feelings. Validate their experiences.

Non-Judgment: avoid offering opinions or advice. Focus on creating a safe and accepting space.

Open-Ended Questions: encourage the person to share their experiences by asking questions that require more than a 'yes' or 'no' answer (e.g., 'What's been going on for you lately?').

Finally, remember mental health first aid is not a substitute for professional help. Recognise your limitations and seek guidance from qualified professionals when necessary. Remember, you are not expected to be a therapist. Your role is to offer initial support and facilitate access to appropriate care.

Suicide and Risk Assessment

Assessing suicide risk is one of the most important responsibilities you'll face as a mental health supporter in any role. While this doesn't replace professional training, these tools can help you recognise warning signs and respond appropriately when someone may be in danger. When in doubt, err on the side of caution and call 911. Every suicide is an unnecessary death that occurs when humanity as a whole fails to protect its most vulnerable members.

The framework I'll share with you is inspired by the Columbia-Suicide Severity Rating Scale (C-SSRS), adapted for non-professional community supporters. It follows a 'stepped' approach that helps determine level of concern.

Begin with a straightforward, compassionate question about thoughts:

'Sometimes when people are feeling overwhelmed, they have thoughts about death or not wanting to be alive anymore. Have you had any thoughts like this recently?'

If they respond affirmatively, continue exploring further; if they say no but you still have concerns based on other warning signs, consider asking how they've been coping with their current challenges.

When someone acknowledges thoughts about death or suicide, gently explore their intent and any potential plans. Ask whether they've been thinking about acting on these thoughts, if they've considered how they might hurt themselves, whether they have access to means to harm themselves, and if they've decided on a timeframe. These questions help distinguish between passive thoughts ('I wish I wasn't here') and active planning, which represents significantly higher risk.

Recent warning signs that should raise your level of concern include talking about wanting to die, feeling hopeless, or being a burden; increased substance use; researching methods of self-harm; withdrawing from activities and relationships; giving away possessions; saying goodbye to people; sudden mood shifts, especially from deeply depressed to seemingly calm or resolved; increased aggression or reckless behavior; and dramatic changes in sleep patterns. Your concern should heighten when multiple warning signs appear together.

The only person who ever committed suicide in my care was someone I saw that morning when getting to work. He seemed unusually happy and in an uncharacteristically positive mood. I didn't think much about it, but made a mental not to ask him later. My supervisor explained later that night: 'wouldn't you be pretty happy as well if you knew all your problems and suffering are going to be over by sundown?'

Historical factors that increase risk include previous suicide attempts, family history of suicide, recent personal loss or trauma, social isolation, chronic illness or pain, and access to lethal means such as firearms or drugs. These factors, particularly in combination with current warning signs, suggest a need for emergency professional intervention.

Risk Level Response Guide

When assessing lower concern situations, you might observe occasional passive thoughts without intent or plan, few warning signs, good social support, willingness to discuss feelings, and the ability to identify reasons to live. Your response in cases like this should include attentive, non-judgmental listening; helping them identify coping resources while assisting with connecting to support systems like family or friends and always providing crisis resources in case feelings intensify.

Moderate concern situations present more frequent thoughts of death with vague thoughts about suicide without specific plans, some warning signs, ambivalence about getting help, and limited coping strategies or support. In these cases, stay with the person or ensure they're not alone; help them connect with their support network immediately; actively assist with reaching out to a mental health professional; create a simple safety plan; schedule a definite check-in within 24 hours; and consider suggesting they speak with a crisis line together during your session.

High concern situations are characterised by a specific suicide plan with access to means, stated intent to die, multiple warning signs, previous attempts, impulsivity or agitation, hopelessness about the future, and few protective factors. Your response must be immediate and decisive: do not leave the person alone; remove access to means if possible and safe to do so and contact emergency services or a local crisis team. If in a remote session, get their exact location and stay on the line until professional help arrives. Focus on getting through the immediate crisis by emphasising just the next few hours.

Creating a Linguistic Framework That Allows Talking About Suicide

Many community supporters worry about bringing up suicide, fearing they might plant the idea. Research consistently shows that asking directly does not increase risk and often brings relief. You might open the conversation by saying: 'I've noticed you've been saying things that make me concerned about your safety. It's important for me to ask—have you been having thoughts about hurting yourself or ending your life?'

If they disclose suicidal thoughts, respond with validation rather than panic. Thank them for trusting you with this vulnerable information, acknowledge how difficult their situation sounds, and express that you're glad they told you.

Ask them to tell you more about these thoughts and how frequently they're occurring. Inquire whether they've thought about how they might hurt themselves—this isn't suggesting methods but rather assessing the specificity of any planning.

When focusing on safety, ask what has helped them manage these thoughts before, who in their life knows about these feelings, and what would help them feel safer right now. These questions help identify existing coping resources and support networks while conveying that safety is a collaborative process between you both.

When someone is experiencing suicidal thoughts but doesn't need immediate emergency services, work together to create a safety plan. Begin by discussing what thoughts, images, moods, or situations tell them a crisis might be developing—these are their personal warning signs. Then explore internal coping strategies by asking what they can do independently to take their mind off problems or help prevent acting on suicidal thoughts.

Next, identify people and social settings that can provide distraction during difficult times, and specific people they can ask for help during a crisis. Make sure they have contact information for professional help, including local crisis lines, and local emergency services. At the end of this book, you'll find a list of international resources put together by TheLifeline Canada Foundation. Keep in mind some of these might have changed, depending on when you're reading this book. Finally, discuss making their environment safer by removing items they might use to hurt themselves.

Documentation Guidelines

After conducting a risk assessment, thorough documentation is essential. Record the specific questions you asked and the person's responses in their own words whenever possible. Note the risk level you determined, actions taken, your follow-up plan with timeline, resources provided, and any consultation sought. A note might read:

'Client expressed having thoughts about 'not wanting to wake up anymore' but denied specific suicide plan or intent. We discussed coping strategies and developed a safety plan. Client agreed to contact crisis line if thoughts intensify and scheduled follow-up for tomorrow at 3pm. Provided resources for 988 crisis line.'

I'm not a stickler for paperwork except in cases like this. You document EVERYTHING when it comes to crisis and incidents. You can never document too much.

Always err on the side of caution when assessing suicide risk—it's better to respond with more concern than needed than to underestimate danger. Never promise to keep suicidal thoughts secret, as this creates an impossible ethical bind if the person's safety requires involving others.

If you yourself struggle or have struggled with suicidal ideation, working through it and finding peace with yourself turns that crisis experience into useful lived experience that can inform your practice and work with others. It's easier to hear someone wants to kill themselves when you know what that's like and have worked through it.

Remember that successfully connecting someone to professional help during a crisis is a meaningful accomplishment by itself, even if you cannot resolve their underlying issues. Your role is to bridge the gap until professional intervention becomes available, not to single-handedly 'fix' complex psychological struggles. Document everything carefully for continuity of care and your own protection. Throughout this challenging work, take care of your own emotional health by maintaining appropriate boundaries and seeking support when needed.

Self-Care After a Suicide Risk Assessment

Supporting someone through suicidal thoughts is emotionally demanding work that requires intentional self-care afterward. Take time to process your own feelings about the interaction, and consult with a supervisor or trusted colleague about the situation. Most people go their entire lives without ever meeting death intimately.

Remind yourself of the boundaries of your role to prevent taking on inappropriate responsibility. Use grounding techniques if you feel overwhelmed by the emotional weight of the conversation. Consider your own need for professional support, especially if you find yourself repeatedly involved in crisis situations or if the circumstances resonate with your personal experiences.

How to Respect the Limits of Mutual Aid

This handbook has provided you with a foundation in understanding mental health challenges and equipped you with basic tools for offering support within your community. However, it's crucially important to recognise the ethical and practical boundaries of peer support work.

You are not a therapist, psychologist, psychiatrist, or licenced counselor. Your position is that of a community helper—offering support and guidance within clearly defined parameters that complement, rather than replace, professional care.

❖ What You Can Do

- ➢ Offer a listening ear and empathetic presence: by providing a safe and non-judgmental space for individuals to share their experiences and explore their challenges.
- ➢ Facilitate self-reflection and exploration: by utilising motivational interviewing techniques to help individuals identify their strengths, values, and goals.
- ➢ Encourage help-seeking behaviors: by supporting individuals in accessing appropriate professional mental health services when needed.
- ➢ Promote self-care and healthy lifestyle choices: by guiding individuals in developing strategies for managing stress, improving sleep hygiene, engaging in physical activity, and building social connections—all evidence-based components of mental wellness that complement formal treatment approaches.
- ➢ Offer practical support and resources: by connecting individuals with relevant community resources, such as support groups, educational materials, and social services that can address social determinants of mental health like housing, food security, and economic stability.

❖ What You Cannot Do

- ➢ Diagnose mental health conditions: you are not qualified to assess or diagnose mental illness. Attempting to do so violates professional boundaries and could lead to misdiagnosis, delayed appropriate treatment, and potential harm. Diagnosis requires extensive clinical training and standardised assessment techniques.
- ➢ Provide psychotherapy: therapeutic interventions require specialised training, supervised clinical experience, and adherence to professional ethical practices.

Offering therapy without proper qualifications is not only unethical but potentially dangerous, as it may inadvertently reinforce maladaptive patterns or trigger psychological distress.

- ➢ Prescribe or recommend medications: only licenced medical professionals can prescribe or offer specific medical advice. Psychotropic medications have complex mechanisms of action, contraindications, and potential side effects that require specialised medical knowledge to manage safely.
- ➢ Offer guarantees or promises of cure: mental health challenges are complex and often require ongoing support and management. Offering false hope or unrealistic expectations can be detrimental to an individual's recovery journey and may damage trust when improvements don't materialise as promised.
- ➢ Handle situations beyond your competence: recognize your limitations and seek guidance from qualified professionals when faced with complex or high-risk situations. This self-awareness is not a failing but an ethical strength in community support work.

If you find yourself in a situation where you're out of your depth, feel uncomfortable, or simply recognise it's best to refer your community member to professional services. When making a referral, provide the individual with specific and accurate information about available resources, including:

Contact information: provide current phone numbers, email addresses, and website links for mental health professionals, agencies, and support groups. Consider the accessibility needs of the individual, including language preferences and geographic proximity.

Referral process: explain the steps involved in accessing services, such as making an appointment, completing intake forms, and navigating insurance coverage. For many, especially those experiencing mental health symptoms, these administrative hurdles can be overwhelming without guidance.

Warm handoffs: when possible, facilitate direct connections rather than simply providing information. This is called a 'warm handoff'.

Support and encouragement: offer to assist the individual in navigating the referral process, such as rehearsing the initial phone call, addressing concerns about stigma, or accompanying them to their first appointment if appropriate and welcomed.

Non-Negotiable Referral Situations

Certain circumstances require immediate professional intervention. In these situations, referral is not optional but ethically mandatory.

Suicidal thoughts or behaviors: if an individual expresses thoughts of imminently harming themselves or has a plan to attempt suicide, immediate referral to emergency services or a crisis hotline is necessary. Always take such expressions seriously and prioritise safety over confidentiality in these circumstances.

Risk of harm to others: similarly, if someone expresses intent to harm others, especially with specific plans or targets, this requires immediate professional intervention and potentially mandated reporting depending on your jurisdiction.

Severe mental illness symptoms: individuals exhibiting symptoms of psychosis, mania, or severe Depression require professional assessment and treatment.

Child abuse or neglect: any suspicion of child abuse or neglect must be reported to the appropriate child protective services agency. As a community Helper, you are likely a mandated reporter under most state laws, meaning you have a legal obligation to report suspected abuse.

Remember that effective community support creates bridges to professional care when needed, rather than attempting to substitute for it. Your role in the mental health ecosystem is valuable precisely because it offers something different from—but complementary to—professional clinical services.

How to Create a Sustainable Pay-What-You-Can Practice

Establishing a financially viable practice while giving capitalism the middle finger requires some savvy economic planning. A sustainable pay-what-you-can (PWYC) model starts with calculating your 'sustainability number'—the baseline hourly rate needed to keep your practice afloat while meeting your financial needs to actually thrive, not just scrape by in a hellscape economy.

This calculation must be brutally honest and comprehensive. Up until this point I've been asking to be kind and compassionate. Explicitly, only for this part and never again, I'll ask you to do the exact opposite and think like a ruthless sociopathic robber baron.

Thorough financial planning creates the foundation for career longevity, particularly important in therapeutic work where the system burns practitioners out at alarming rates. For this specific aspect of planning, adopt a ruthlessly pragmatic approach to account for every ounce of value you contribute—your labour deserves full compensation even while dismantling barriers to care. The capitalist machine expects you to undervalue yourself; don't play into its hands.

Consider these expense categories when calculating your sustainability number, I'll make up numbers so we can look at the math as well:

Office space ($800 monthly) is more than just a physical location. This acknowledges that dedicating space to professional purposes deserves compensation, even when working from your bedroom. The psychological concept of 'boundary setting' applies to physical spaces as much as emotional ones—your personal space has quantifiable value that the system would love for you to donate for free. Be generous with people, not with institutions.

Professional insurance ($150 yearly) provides essential protection in a hyper-litigious society. You can seek out non-profit insurance providers or worker-run cooperatives that aren't feeding the corporate insurance beast while still keeping you protected.

Supervision (variable) isn't optional—it's mandatory upkeep for your clinical brain. Regular consultation on cases with more experienced practitioners improves clinical outcomes and reduces your own psychological wear-and-tear. If formal supervision is inaccessible of prohibitively expensive, you can try to create a structured peer consultation group with ironclad confidentiality protocols—mutual aid in action.

Continuing education (~$100 monthly) directly impacts your service quality and keeps you from becoming a relic in your field. Professional bodies insist ongoing education is an ethical requirement, especially when working with specialised populations where best practices evolve faster than capitalism can commodify them. It doesn't mean you have to spend $100 every month: you can save up and use that money to attend seminars or register for more expensive certifications.

Administrative costs ($300 monthly) recognise the soul-crushing invisible labor of practice management. Client communications, scheduling, record-keeping, and technological infrastructure maintenance require time and expertise. If you're performing these functions yourself, compensating yourself appropriately for this administrative labor is an ethical imperative. If you want, you can exploit yourself a little here, as a treat, and use your local minimum wage for this calculation, along with an assessment of how much time you're working outside your time with Clients.

Retirement planning ($100+ monthly) addresses future financial health. This is especially relevant for neurodivergent practitioners navigating career trajectories in a system designed for neurotypicals. Remember: most financial institutions allow retirement funds to serve as collateral for preferred-interest loans.

Extended healthcare coverage ($250 monthly) must include comprehensive mental health services. Demand policies providing actual therapeutic services rather than 'psychoeducational services' or the artificially capped session limits insurance companies love to peddle.

Marketing and networking (~ $500 monthly) ensures your expertise reaches those who need it most, not just those privileged enough to know where to look. Research shows service availability alone doesn't ensure utilisation—potential clients must know you exist and understand your work. This covers initial branding costs and ongoing community engagement that builds solidarity rather than just client acquisition.

Personal salary (local living wage +10%) should reflect both the specialised nature of your work and realistic local economic conditions. Research the living (not minimum) wage in your region as a starting point, then take that hourly rate and multiply it by the number of hours you'll work with Clients every week. E.g. $25 an hour, times 20 hours a week means $500 a week in your own salary in this role.

Regarding caseload, we need an estimated amount of hours you'll be working each week. In my experience, the maximum realistic number people can handle while still providing the best quality of service is an effective-caseload of 20. That means you'll be in the office for 20

sessions every week, for 45 minutes. This effective number represents the total of the people you see regularly, plus newcomers and people you talk to infrequently.

This number also allows for some flexibility upwards if there is the need and professional availability, while also offering flexibility downwards if you simply let Clients transition out of care naturally while not taking on new ones. You might want to do this if you yourself need to slow down your rate of work or if the Clients you are working with require more frequent sessions.

Sliding scale adjustment (+20% flat of total) creates financial sustainability within an accessible practice. This percentage markup is strictly dedicated to covering the cost of the sessions with people who can't pay full price. Adding 20% flat effectively means that for every five full-rate sessions, you can provide one no-cost session or two half-cost sessions. This structure operationalises mutual aid while ensuring your practice remains viable without exploiting yourself.

If your business grows large enough, consult with an accountant and see what recommendations they have for your specific situation. It is a bit of a hassle, but it is a good issue to have: it is a sign of growth. Let's look at an example table of what expenses could look like:

Monthly Expenses			
Monthly Cost	**Amount**		
Office Rent	800	**Weekly Hours**	20
Administrative Costs	300	**Hourly Rate**	25
Retirement	100		
Extended Healthcare Insurance	250		
Marketing & Networking	500		
Own Salary	500		
Sliding Scale Fee	400		
Total	2050		
Sustainability Number	102		

Once you've established your sustainability number, you can design your fee scale structure considering a profit margin for your business (typically 15% to 25%).

Alternatively, some practitioners prefer a percentage model, where clients self-select their fee as a percentage of the standard rate. This approach is particularly effective in online practices, where modern platforms have been designed to make sliding scales easy to implement.

Regardless of the specific method, sustainability in a PWYC model absolutely requires setting firm limits on yourself. Consider implementing a cap on lower-fee slots (I used the math to make you reserve 20% of your practice for reduced-fee clients already), creating time-limited arrangements that are reassessed quarterly, and intentionally balancing your schedule with higher and lower fee clients throughout your week to maintain both emotional and financial equilibrium. If a lot of people need help, it might be better to have a 1 to 2-hour support group meeting with everyone, rather than trying to see everyone individually for free. It doesn't matter how kind and compassionate you are if you're at risk of being homeless because you can't pay the bills or if you're out of business in 6 months. Don't put yourself in that situation.

When it comes to clients, transparent communication about your fee structure builds trust and effectiveness. Your website might state: 'I believe mental health care should be accessible to all. My standard fee is $100 per session. I offer a limited number of sliding scale spots based on financial need. Please inquire about current availability.'

During initial conversations, approach the topic with sensitivity and take the initiative. Nobody likes talking about money, but you're the one that starves if you don't charge, so take responsibility for it.

You can say things like this: 'I'd like to discuss fees. My standard rate is $100, which reflects the care I provide for you and others in our community. I do offer sliding scale options for those experiencing financial constraints. Could you share what might be manageable for you at this time?' Many practitioners find it helpful to provide fee information in advance, saying, 'here's information about my fee structure. You don't need to decide immediately—please review it and we can discuss it at our next contact.' I'm a big fan of just straight up putting it in your marketing materials, but I'm also a mental health worker, not a marketing expert.

Implementation of a variable rate scale requires keeping close track of the amount of money coming in and being expended. Utilise practice management software or spreadsheets to track the distribution of full-fee versus reduced-fee clients. Many public libraries offer free

office software training, and you can find plenty of free courses online for all kinds of learning styles and abilities; optionally you can get addicted to EVE Online and learn spreadsheets like that as well, which is what I did.

Once you record and look at your numbers, schedule quarterly reviews of your client fee distribution to ensure alignment with your sustainability goals. Sometimes you'll say yes to everyone that asks for a reduced fee but then realise you don't have enough to cover your own operating expenses. It is important to look at the big picture once in a while to avoid this scenario. If you're finding it challenging to find a balance, it can help to create separate waitlists for standard and reduced-fee openings, so that you are forced to respect your own limits.

When deciding, try to guard against unconscious bias by ensuring that everyone gets treated equally, regardless of how much they pay. These sessions are only different in the spreadsheets; for all intents and purposes, all sessions are exactly equal in time, quality, and your availability.

Reduced fees are accessibility measures, not charity. Consider them the same way you would consider the cost of building a ramp in your building as part of the costs of operating the business. This is a way to phrase it in communication terms: 'I present my sliding scale as promoting equitable access to care rather than as me 'helping out' clients with financial needs.' It is a matter of principle, not of character.

Maintain consistent boundaries by not adjusting fees based on therapeutic progress or personal feelings about clients. I've asked you to trust your clients about everything else; this goes here as well. Nobody tries to 'steal' therapy: ask them to be honest and check in every once in a while.

Consider: aren't you happy to pay for the things that you enjoy and find useful? Would you try to steal your doctor's stethoscope or try to doc-and-dash a nutritionist? Why would someone try to steal your help, of all things?

Instead, regular reassessment keeps your pay-what-you-can model viable long-term. Every six months, conduct a practice audit assessing the current distribution of fee levels across your caseload, whether your financial needs are being met, if adjustments are needed to your fee scale, and whether you need to modify the number of reduced-fee slots. If you did the math well, you will only need small adjustments over the years.

Hopefully now you've learned the last piece of information I had for you: how to coerce the bloody machinery of capitalism to serve a sustainable practice that helps those who need it the most.

Final Words

I sincerely hope this handbook has ignited something within a genuine desire to connect with others, to offer support, and to contribute to a world in desperate need of healing.

This isn't about transforming you into a fully-fledged therapist overnight. It's about rediscovering that fundamental human capacity for empathy, connection, and the ability to help mend the emotional wounds we all carry. Some wounds are paper cuts; others are deeper, so much so that you can see the scars in the body. Each deserves attention and care in its own way.

What's the next step? Go out there, engage with those around you—listen to your friends, family, online communities, even the stranger you pass on the street. Learn more, ask questions, be genuinely curious about the world through their eyes, and offer a kind word or listening ear when appropriate. Remember, even the smallest act of kindness ripples outwards, extending far beyond what you might initially see. This is half of the Healer's Guild project. The next half covers how to build an institution that serves its workers and community based on the principles presented in this Handbook—the next step in nurturing this movement from a spark into a flame.

I'm still working on it and I need your help to be able to keep on with this project. If you feel moved to support my mission of making mental healthcare more accessible and guiding people toward becoming a new generation of healers, consider supporting me on Ko-fi. Every contribution, no matter how small, is indispensable to sustain this work and remain independent from profit-centric financial interests.

Thank you for coming on this journey with me. Now, go forth and contribute your unique brand of healing to the world, one conversation at a time. You've got this! I believe in you,

~Josh

Extra Example

Here is a completely fabricated example that illustrates the principles and dynamics we've been discussing in greater detail, with only short notes in between:

Context

'The Healer's Guild' began as a mutual aid initiative within a Revolt (Discord) community for neurodivergent adults navigating work and relationship challenges. Maya, a 32-year-old graphic designer with ADHD and experience managing her own Anxiety, completed Mental Health First Aid training and studied this handbook. Having benefited from therapy herself but recognising the barriers many community members faced in accessing professional care, she established a structured peer support system within the existing community.

Setup and Characteristics

A pinned post explained: 'I am not a therapist or counselor. I offer supportive listening and collaborative problem-solving based on lived experience and mental health education. I cannot diagnose conditions or provide treatment, but I can help you explore options and connect with resources when needed.'

Sessions were offered via text, voice, or video depending on participant preference. Flexible scheduling accommodated different time zones and energy levels. No fees were charged, but community members could contribute to a resource fund that helped subsidise professional care for members in crisis.

With consent, Maya kept brief session notes using the SOAP format described in the handbook. She also arranged monthly consultation with a licensed therapist who volunteered to provide guidance on boundaries and appropriate referrals.

Client Journey: Jamie's Story

Now let's follow the journey of one community member. Jamie (they/them), a 28-year-old software developer who reached out after experiencing increasing burnout, relationship difficulties, and what they described as 'probably some Depression and Anxiety' but had no access to affordable therapy in their rural area.

Initial Contact

Jamie messaged the Support Circle channel: 'things have been really rough lately. Work, home and the like. I tried therapy a few years ago but can't afford it now. Would talking help?'

Maya responded: 'I'm sorry things have been difficult. I'd be happy to schedule a time to listen and think through this together. Just to be clear, while I have training in supportive listening and personal experience with similar challenges, I'm not a therapist. Would you still like to connect?'

Jamie agreed, and they scheduled a voice call. Here are some excerpts from the following work sessions.

First Session

Maya: 'Hey Jamie, welcome! So what brings you to reach out today?' (Open-ended question)

Jamie: 'Everything. Work is overwhelming, my relationship is strained, and I just don't have the energy for anything anymore. I wake up dreading the day. All I have to look forward to is playing with you guys every once in a while.'

Maya: 'I can imagine it’s not very nice to wake up if there’s nothing to look forward to.' (Reflection)

Jamie: 'Yeah, and I don't even know where to start fixing it. My partner says I'm distant and irritable, but I feel like I'm just trying to survive each day. I’m just… out of it. You know?'

Maya: 'Mhm. Sometimes all we can do is take one day at a time. When you think about how things might have changed, have you found any patterns on what makes things better or worse for you?' (Object-oriented question exploring patterns)

Jamie: 'It's been building for months, but got much worse after our team lost two developers and I started working 60+ hour weeks. My sleep is terrible now—I'm either working late or doom-scrolling because I'm too wired to sleep.'

Maya: 'So there's a connection between the increased workload, sleep disruption, and how you're feeling? How has your sleep pattern changed?' (Following the chain of associated factors with specific focus)

Over the next 20 minutes, Maya uses reflective listening and object-oriented questions to help Jamie explore the interconnections between their work situation, sleep disruption, relationship strain, and emotional state. Rather than interpreting or diagnosing, she helps Jamie see these connections themselves.

Maya: 'From what you've shared, it sounds like the increased work demands started a chain reaction, a bit like dominos: disrupting your sleep, affecting your energy and mood, which then impacts your relationship. Would you say that matches your experience?' (Summarising to check understanding)

Jamie: 'That actually makes a lot of sense put that way. I hadn't really connected all those dots.'

After a bit more intense thinking, they move to the last part of the session.

Maya: 'We have about 15 minutes left in our session. Would it be helpful to think about one small, concrete step that might begin to address any part of how you're feeling? We started talking about home but it sounds like work might be a root issue.' (Transitioning to action planning)

Jamie: 'Yep. I think I need to set some boundaries at work, but that feels impossible right now.'

Maya: 'What makes it impossible?'

Jamie: 'I don't know. I don't want to get fired, I guess?'

Maya: 'Hm… Setting workplace boundaries can be challenging, especially when we're already exhausted, but we don't have to go straight to slapping your boss, you know? What would be the smallest thing that could make things at work better for you?' (Scaling the challenge, emphasising client agency)

Jamie: 'I could start tracking my hours accurately. My team lead doesn't actually know I'm working this much.'

Maya: 'That's an excellent first step—gathering data makes it easier to stand your ground too.' (Affirmation) 'Would you like to check in next week to see how the hour tracking went and explore next steps?'

Jamie: 'Yes, that would be helpful. This conversation has already helped me feel less alone with this.'

Maya: 'I'm glad. Before we end, I want to check in about something you mentioned earlier—you described possibly experiencing Depression and Anxiety. Some of what you're sharing could be situational stress or could be clinical symptoms. Would it be helpful if I find some resources about that? I can give you a hand finding a therapist if you want too if you're ever interested. There are usually places with scaling fee scales or pay-what-you-can.' (Appropriate boundary acknowledgment)

Jamie: 'Maybe eventually, but I'd like to try making some changes first and see if that helps. Professional help isn't very accessible where I live anyway.'

Maya: 'Right, you mentioned Moose Jaw. Let's focus on what's in your control now, and I can share some telehealth options to keep in mind if needed later. How does that sound?'

Follow-up Sessions

Over the next six weeks, Maya and Jamie met weekly for 45-minute sessions. Following the handbook's guidance, these sessions maintained a consistent structure while allowing flexibility in content:

Session 2-3: Situational Improvement

Jamie successfully tracked their hours and had an initial conversation with their team lead about workload. They also began implementing a 30-minute wind-down routine before bed. Maya used Motivational Interviewing skills to help Jamie recognise their strengths and explore barriers to maintaining these changes.

Session 4: Crisis Point

Jamie arrived distressed after a major argument with their partner. Maya listened empathetically while maintaining appropriate boundaries:

Jamie: 'My partner threatened to leave. Said I'm not the person they fell in love with anymore.'

Maya: 'That sounds incredibly painful. Why would she say that?' (Object-oriented question rather than advice-giving)

Jamie: 'Part of me knows they're right. I've been irritable and distant. I just don't know how to fix everything at once!'

Maya: 'I see. Do you need to fix everything at once? Is there anything that seems more important than the rest right now?' (Reflection followed by priorisation)

This conversation led to Jamie deciding to be more transparent with their partner about their struggles and consider couples communication strategies.

Sessions 5-6: Integration and Growth

Jamie began seeing gradual improvements:

Reduced work hours after setting clearer boundaries

Improved sleep with consistent wind-down routine

More open communication with their partner

Still experiencing low mood but with less intensity

Maya used these sessions to help Jamie recognise patterns, celebrate progress, and develop sustainable self-care practices aligned with their values and constraints.

Final Session: Transition and Closure

By the seventh session, Jamie reported significant improvement in their immediate situation. Maya facilitated a closure conversation:

Maya: 'Looking back over our time together, what changes have you noticed in yourself or your situation?'

Jamie: 'The biggest thing is feeling like I have some control again. I'm still overworked, but setting boundaries has helped. My relationship is much better since we started having weekly check-ins. My mood is still up and down, but the desperate feeling is gone.'

Maya: 'Those are meaningful changes, take care of yourself so that they stick! What do you think helped most in our conversations?'

Jamie: 'Having someone listen without judging and help me break things down into manageable steps. And not feeling pressured to 'fix' my mental health immediately.'

Maya: 'As we discuss wrapping up our regular sessions, do you feel there are areas where additional support might be helpful, either through our community or other resources?'

Jamie: 'I still think I might benefit from therapy eventually, especially for my Anxiety patterns. But for now, I'd like to continue applying what I've learned and maybe check in occasionally.'

Maya: 'Alright. That sounds like a thoughtful plan. I'm happy to provide occasional check-ins, and I've updated that resource list we discussed with telehealth options that might work in your area when you're ready. Would you like to schedule a follow-up, or prefer to reach out as needed?'

They agreed on a one-month check-in with the option for Jamie to participate in the community's weekly group support sessions in the meantime.

END

International Crisis Centres

If in crisis, call 911 or the Mental Health Crisis Lines provided below.

ENGLAND

The Samaritans: 08457-90-90-90

FRANCE

National crisis line: 01-45-39-40-00

NETHERLANDS

National crisis line: 0900-1450

BEIJING

Befrienders 03-5286-9090

HONG KONG

The Samaritans HK: 2896-0000

SHANGHAI

Life Line 021-6279-8990JAPAN

OSAKA

Befrienders Osaka: 81-066-260-4343

Befrienders Osaka: 81-066-260-4343

Children & Families: 03-4550-1146

Counseling Center: 03-4550-1146

TOKOYO

Life Line Tokyo: 03-5774-0992

NORTHERN IRELAND

1life: 1-800-247-100 or text the word HELP to 51444

Bodywhys (help for Anorexia and bulimia): 01-283-5126

Childline: 1-800-666-666 -0800-1111

Contact Youth (counselling for young People): 028-90457848

Eating Disorders Assessment (NI): 90618299 or 90621627

Nexus Rape and Incest Counselling

- Belfast Centre – 028-9032-6803
- Londonderry Centre- 028-7126-0566
- Enniskillen – 028-6632-0046
- Portadown – 028-3835-0588

Community addiction service, alcohol, drugs addiction: 028 90664434 or 90330499 or 90731602

Child Protection Helpline: freephone, 24 hrs – 0800-800500

Rape crisis and sexual abuse centre: 028-9024-9696

Victim Support Belfast – 028-9024-4039

Samaritans:1-850-60-90-90

Young Persons Advice line: 0808-808 5678

Youthline: 0808-808 8000

Zest suicide/prevention Londonderry: 028-71266999

SRI LANKA

Bandarawela: 0572222662

Kandy: 081-2234806

Katunayake: 011311020

Kohuwela: 5780153

Kurunegala: 0374931731

Lunugamvehera: 0475781200

Matale: 0662223521

Mawanelle: 035-5788330

Panadura: 038-2235291

Panduwasnuwara: 0372291718

Panduwasnuwera: 0375715815

Sumithrayo – Colombo: 2692909 / 2696666 / 2683555

UNITED KINGDOM

Alcoholics Anonymous: 0845 769 7555

CHILDLINE: 0800-1111

Cruse Bereavement Care: 0870-1671677

Family Line: 0808-800-5678

Farmers in Difficulty: 07002-326326

National Debt Helpline: 0808-084000

National Drugs Helpline: 0800-77-66-00

Papyrus Hopeline: 0870-1704000

Sexuality: 020-7837-7324

The Samaritans: 08457-90-90-90

Violence & Crime: 0845 30 30 900

Woman's Aid Domestic Helpline: 08457-023468

SCOTLAND

Age Scotland: 0845-125-9732

Alternatives Crisis Pregnancy Trust: 01382-221112

Angus Women's Aid Supportline: 01241-439457

Anti-Social Behaviour Helpline: 0800-1691283

Breathing Space Scotland: 0800-83-85-87 – For young men who may be feeling suicidal

Caithness & Sutherland Women's Aid: 01955-606971

Central Scotland Rape Crisis & Sexual Abuse Centre: 01786-471771

Chest, heart & stroke: 0845-077-6000

Child Protection Line: 0800-0223222

Debt Line Scotland: 020-7553-7640

Dementia Helpline: 0808-808-3000

Drugs Action: 01224-594700

Edinburgh Crisis Centre: 0808-801-0414

Epilepsy Scotland: 0808-8002200

Families Anonymous: 0845-1200660

Fife Independent Disability Helpline: 01592-203993

Glasgow Battered Women's Aid: 0141-553-2022

Interactions Counseling & Support Services: 01592-262869

Inverclyde Women's Aid: 01475-888505

Lothian LGBT Helpline: 0131-556-4049

NHS 24 HR Helpline: 08454-24-24-24

NHS INFORM Scotland Helpline: 0800-22-44-8

One Parent Families Scotland: 0808-8010323

Parentline Scotland: 0800-028-2233

Perth & Kinross Drug & Alcohol Team: 01738-474455

Rape Crisis Scotland:08088-01-03-02

Scottish Domestic Abuse Helpline: 0800-027-1234

Scottish Women's Aid: 0800-027-1234

Shelter Scotland: 0808-800-4444 housing advice

The Samaritans: 08457-90-90-90

The Scottish Prisoners Family Helpline: 0500-839383

Women's Aid Edinburgh: 0131-315-8110

Your Call: 0808-801-03-62 for the physically challenged across Scotland