Prime Forensic Psychology

Phone: 0430 530 125

Shame, blame and nothing to gain? Forming therapeutic partnerships with young men and adolescents as involuntary clients

Dr Russ Pratt, DPsych, MAPS, ATSAF

Wednesday 13th November 2019 9am – 10am

ManNewScript – Rewriting the way we work with men: One-day Conference

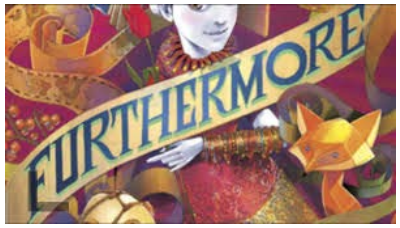
Shepparton, Victoria

Today

Let's do some work around:

- Working with adolescent males and young men (both voluntary and involuntary clients),
- The presenting challenges for services and therapists alike.
- Getting the client in the room but then doing something with them,

Furthermore:



- How can we give ourselves the best chance of meaningful connection with our young male clients, and thus provide the client with the opportunity to do something meaningful during their time with us (but…who should decide what is meaningful anyway?),

- I will provide *some* strategies and ideas that take into account the theory of what we know about young males, as well as what I have learnt over the past 20 or so years of working with young men in involuntary and voluntary settings (e.g.; youth in residential settings, young people who sexually abuse others, youth with impulse control issues),

- I will tell *some* practice stories, and thus practice strategies, will be presented and discussed.

Hey you – yep…you!

Audience input and participation is not just welcomed,

but is expected!

Responding to treatment: Indicators of risk in young people

There are few actual 'indicators of risk' identified within the literature related to abusive youth.

- *Early onset behaviours of concern:* the fact that any concerning behaviour occurs as an 'early onset' behaviour is an indicator of risk. Generally, the term refers to behaviours occurring before the age of 12 years, however the term could also be associated as occurring prior to the onset of puberty.

- *Persistence of the behaviours:* This term refers to a behaviour that continues regardless of punishment, treatment, redirection. It is not the same as having numerous offences/victims prior to detection. A question to ask that may be related to this issue is: *To what extent has the behaviour persisted and under what circumstances?* A young person who persists with the behaviour despite families having knowledge of the prior behaviours, despite legal sanctions and despite treatment is likely a greater cause for concern than a youth who persists despite parental awareness alone.

- *Patterns of deviant arousal: This in regards to sexual abuse/assault.* Unusual in youth however clearly established deviant preferences need to be taken seriously, and require careful and proper exploration of the behaviour.

Your clients

Our clients: Robbie

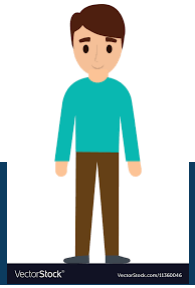
13-years old,

Since age 10, Robbie has resided in therapeutic residential care after mother convicted of drug offences and jailed for 4 years,

Robbie has very poor vocabulary, heavily influenced by “gangsta rap” in which he is exposed to ongoing swearing, degradation of women, and sexual terminology,

Three years ago, Robbie was placed with a couple with a view to long-term foster care. Shortly after being placed with them, the couple found out they were expecting and eventually a girl was born. She is now 2 and a half years of age.

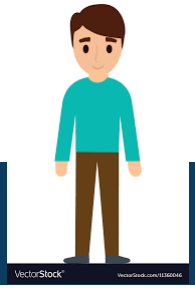
Robbie’s placement recently broke down due to his poor language and constant swearing, physical aggression to his foster parents (but not his foster sister), and refusal to comply with any house rules.



Robbie: Gansta rap

[Int ro: Murder Mike & *Du-Rag*]

[Verse 1: Du-Rag & *Murder Mike*]
Ni##a, ni##a, ni##a, ni##a, ni##a, ni##a, ni##a
I'm one-hundred-percent ni##a
Ni##a, ni##a, ni##a, ni##a, ni##a, ni##a, ni##a
I'm two-hundred-percent ni##a
Ni##a, ni##a, ni##a, ni##a, ni##a, ni##a, ni##a
Why do police hate ni##as?
Ni##a, ni##a, ni##a, ni##a, ni##a, ni##a, ni##a
They hate us 'cause our dick's is bigga



Our clients: Billie

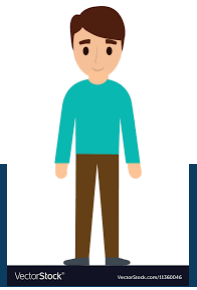
19-years old,

Resides with father whom he describes as a "…room mate",

At 10, witnessed his mother being beaten by her then-boyfriend, Joe. Joe had locked Billie inside house with his little brother, leaving Billie with feelings of rage, anger and aggression.

At age 15.6 years, Billie had commenced sexually assaulting his two female cousins, aged 12 and 14 years of age. He stopped about 9 months later when he entered into a romantic relationship with a girl aged 16 years.

He tells his therapist he has completely changed from "…the guy who did that shit" and cannot understand why no-one will recognise his 'amazing' change.



Our clients: Toby

11 years old,

Indigenous,

Resides in a therapeutic unit,

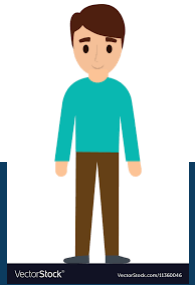
Removed from mother at age 17-months due to extreme neglect and environmental issues,

Diagnosed with *Reactive Attachment Disorder,*

Has resided in residential care ever since, however recently moved to a foster-care placement,

Several weeks into the placement, it broke down after Toby held a knife at female carers throat and threatened to have her raped and killed.

Foster carers continue to see him, believing that he now realises what a great opportunity Toby missed by not settling with them.



What might our clients want from us in therapy? I

- In the following slides, I consider what treatment goals might be desirable in a therapeutic journey, in particular from a developmental perspective,

- However, prior to moving towards those treatment goals, lets have consideration to what Robbie, Billie and Toby might say about this……

- Let's put ourselves in their shoes and think about what they might ask for?

A cohort of your male clients will also present as the ‘good client’. What does the good client look like?

- In the therapeutic space, you and he will have wonderful, insight-filled conversations together,
- Always has interesting insights into his own condition,
- Holds your attention and the sessions simply ‘runs by’,

What’s the problem for this client?

Two different therapeutic areas to pay attention to with male clients

1. **Psycho-education:** The provision of information to the client that one could get out of a text-book, or from Dr Google. Might be information about his condition, information about trauma, anything….

2. **Cognitive component of therapy:** This is therapeutic. Not providing information from text book, but discussing the client's condition with him and assisting with ways to manage the condition. Might include cognitive restructuring, the provision of strategies to the client for when life is impacted by whatever the psychological condition might .

FOR A LOT OF MALES, THIS IS THERAPY

FOR A LOT OF MALES, THIS IS COMFORTABLE THERAPY

The third therapeutic area that ***must*** play a part in therapy for it to be truly successful with male clients

3. **The affective component of therapy:** This is what *makes therpay actually* therapeutic.

For the client to actually utilise 1. and 2. in psychologically loaded situations, we must assist him to practice using them under *affective load.*

Here's an exercise:

HAVE YOU EVER…

A LOT OF MALES DON'T LIKE THE AFFECTIVE COMPONENT OF THERAPY

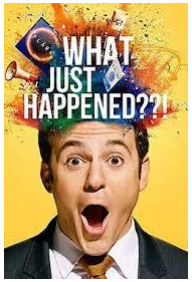
FOR A LOT OF MALES, THIS IS *UN*COMFORTABLE THERAPY

Pay attention to:

Micro-tells

Don't be afraid to use:

What just happened?



Make sure you:

Follow-up on questions.

All of these will ensure you practice in male-specific ways

What might "get in the way" in therapy

<u>What the therapist might see as getting in the way:</u>

- Client has poor commitment to therapy; either turns up late or not at all,
- Lacks motivation when at therapy, lots of "I don't know's" and "yes/no" answers,
- Story the client told is not really believable; I challenged him on it.

What might “get in the way” in therapy

<u>What the client might see as getting in the way:</u>

- I am doing the best I can to get there, I have no money, and poor transport options, but I am criticised by my therapist when I am late or unable to attend (repeat of past experiences)
- My therapist asks lot’s of questions – and I feel bombarded, feel like I have to defend myself, and the language is too hard to understand. Anyway, asking questions is not therapy,
- The therapist treats my story with contempt from start, challenging me rather than listening and being on my side – I’m not trusting him with the truth.

The “Poor Me” effect perspective: Guys are quite good at it

- Can be a particularly male phenomena – the “Poor Me” presentation,
- Often goes hand-in-hand with a trauma response,
- ‘Poor Me’ can be a real block to the development of what might loosely be called empathy (In next slide I call it “awareness of impact of one’s behaviours on others” as a starting point).
- Did you know that research shows that men struggle to link ‘obvious’ external events to ‘obvious’ internal emotional states? For example:

“My dog died, my wife left me and I lost my job. Why do I feel so bad/sad?”

- ‘Poor me’ can also moonlight as “stoic me” which is an obvious block in therapy.

Treatment objectives from a developmental perspective

1. Understand, identify, and interrupt thoughts, feelings, beliefs, and behaviours that contribute to problematic behavioural patterns,

2. Develop responsibility for personal choices and behaviours, without minimisation or justification,

3. Assist clients to understand and overcome the impacts of prior adverse experiences on self-image, psychosocial functioning, emotional responses, and interactional behaviours,

4. Develop awareness, sensitivity, and compassion for others (often referred to as *empathy,* can we call it *awareness of impact of our behaviours on others?),*

5. For sexual abuse cases, understanding the nature of both healthy sexual interest and deviant sexual ideation,

Treatment objectives from a developmental perspective

6. Learn and use adaptive coping and social skills,

7. Build and engage in non-coercive relationships,

8. Develop and use a relapse prevention/safe behaviour plan,

9. Development of relapse prevention and safe behaviour plans that recognises situational, emotional, and cognitive factors that might contribute to further offending behaviours, and the development of defined methods to avoid high-risk situations and escape patterns of antisocial behaviour,

Treatment objectives from a developmental perspective

10. Improved family functioning in which family dysfunction, communication, attitudes, or roles contributing to or that help maintain violence, aggression and antisocial behaviours are addressed and remediated,

11. Victim recognition and awareness, with a focus on the development of empathy and clarification of the harm caused to the victim and others,

12. Victim and community restitution in which the youth who harms undertakes reparation and makes amends.

Phase oriented treatment: Working through an issue

Phase oriented treatment: Building relationships

What you might see:

- YP feels unsafe, may display fear masked as anger or rejecting behaviour (The “F--- Off” scenario),
- YP may act unsafely; through aggression to others, self harm, absconding, risky behaviour,
- YP displays dysregulation, doesn’t manage intense emotions, may appear up-regulated, hyperactive through to flat, numb, depressed,
- YP tests your commitment to them (“I knew this wouldn’t last”),
- YP too aroused to take in anything – all energy managing anxiety.

All this slide: From isolation to Connection: Child Safety Commissioner: 2009

Phase oriented treatment: Safety

What you might see:

- As YP feels safer, relationship difficulties appear, let guard down, real connection can commence,
- YP may be resistant to genuine connection (challenges their view of self and others),
- YP avoids intimacy, as leads to possibility of rejection – you may move on soon so why bother?
- YP has issues with peers/family members,
- YP relationships conflictual, intense ups and downs.

All this slide: From isolation to Connection: Child Safety Commissioner: 2009

Phase oriented treatment: Safety. What you could do

- Build relationship through honesty, reliability, following through,
- Understand trauma, link it to their behaviour and treat the behaviour as a symptom of trauma (I know – repetition, repetition, repetition),
- Help them feel safe through nurture, support and structure,
- Use clear boundaries and logical consequences,
- Stay calm and well-regulated. Set limits on aggression and avoid power battles,
- Co-regulate with YP – use your calmness to soothe them,
- Don't take it personally,
- Use PACE,
- Engage at all times – increase your understanding of this child's situation and background.

All this slide: From isolation to Connection: Child Safety Commissioner: 2009

Phase oriented treatment: Telling the story

What you might see:

- YP responding to a safe environment,
- Relationships are building,
- As anxiety lessens, more info able to be taken in and learnt,
- YP beginning to make sense of their own story,
- Opening up/trusting may result in perceived vulnerability and you may see an escalation/return of risky behaviours.

All this slide: From isolation to Connection: Child Safety Commissioner: 2009

Phase oriented treatment: Telling the story. What you could do

- Expect both progress and regression,
- Use PACE,
- Help YP to talk,
- Help YP work manage extreme emotions,
- Help YP tell stories about day-to-day, interests, activities, hopes and desires (strength based work),
- Develop stories with them,
- Read to and with them,
- Challenge them to think,
- Insist on respectful behaviour (give it – expect it back),
- Celebrate skills and achievements.

All this slide: From isolation to Connection: Child Safety Commissioner: 2009

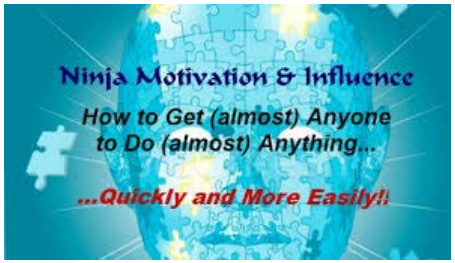
Phase oriented treatment: Connection and empowerment

What you might see:

- More settled behaviour, some good decision making by YP,
- Greater capacity for self-regulation,
- More empathy for self and others,
- Greater capacity for positive peer relationships,
- Safer connection with unit staff,
- Enjoyment of talents and skills,
- Connection to community and culture,
- YP can speak up for themselves in positive ways.

All this slide: From isolation to Connection: Child Safety Commissioner: 2009

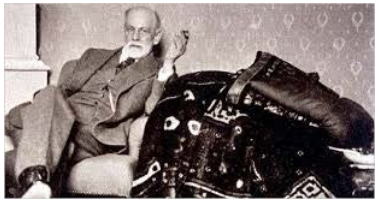
Phase oriented treatment: Connection and empowerment. What you could do



- Assist them in healthy choices,
- Assist them to develop empathy,
- Assist them to connect with talents, interests and skills,
- Help them connect to positive peer systems,
- Help them connect to safe family, community and culture,
- Assist them to make sense of their family,
- Encourage them to speak up and advocate for themselves,
- Build hope and celebrate it,
- Inspire them through your commitment.

All this slide: From isolation to Connection: Child Safety Commissioner: 2009

In therapy 1



For a client to move on in therapy (being successful) in therapy:

- The client must be able to listen in to what he actually experiences and report it back. If he cannot hear his own body or his own mind, then he cannot change anything in a conscious way.

This phase of therapy is about opening up the mind.

- The client must be able to remember some of what he has experienced in the past and in the recent past. He has to be able to report it and analyse it. If he can't remember, especially the way his mind and body works when he does dangerous things, if he can't consciously pinpoint what to change. This phase of therapy is about remembering.

This phase can be tough – remembering what you did to people both recently and long ago.

- When the client can remember and analyse their memories, they can move to the next goal. This is remembering what he has done and experienced, how it felt to him and possibly to others around him. All that must be remembered and processed. If he can begin to feel what others around him may have felt at his hands, he may well not want to hurt others like that.

This phase of therapy is remembering and feeling.

In therapy 2

- When the client has begun to sense his own feelings, and feel what he has done to others, he is ready to think about what others mean to him. Often he has a deep mistrust of others. It comes from the past and lives on in the present. It means, in real life, he has an inability to attach, to connect and to be intimate. If he cannot attach, he might not be able to practice feeling, learning and changing. He is at risk.

The objective of this phase of therapy is attachment.

- The client practices attachment. The process should lead to a new phase of therapy. This is considering what he really wants out of life. For example; connectedness, meaning, purposeful independence. This phase is crucial. It gives meaning to the "why" of change. If he cannot find purpose in his life, he may find change very hard to contemplate.

This phase of therapy focuses on human needs.

- The client must give up the old and practice new ways of connecting and feeling. He has to experience what it means to: manage well rather than being abusive, assertive not aggressive, peace-minded rather than anger-filled. If he cannot practice and do the new, the previous therapy phase objectives are almost without value.

This phase is about changing.

In therapy 3

- He practices intervention strategies. He practices relapse prevention mechanisms and expands his new world of connectedness. He practices not letting control and life skills slip from his grasp. He attempts to maintain mastery of the objectives learned from all his therapy sessions.

The objective of this phase of therapy is maintaining and moving.

"It goes back to being pulled out of the hat."

Soothing trauma: A culture to aim for (I)

When working with youth who have experienced trauma, your work must impact at an *affective* rather than *cognitive* level. In other words the logic of the situation has little chance of making an impact. The depth of feeling is often palpable and thus your intervention must be at this affective level. Think about how you can do the following:

- Know the young person – get together and talk,
- Be available – helps young people to trust,
- Be sensitive – helps young people to manage feelings and behaviours,
- Be accepting – builds the self-esteem of the young person,
- Form a cooperative relationship – helps young people to feel effective,
- Nurture household membership – helps young people feel like they belong.

Adapted from Schofield & Beek (2009)

Soothing trauma: A culture to aim for (II)

Additionally, think about how you could be successful with this.

Spend a couple of minutes in your groups talking about this. WE will come back and discuss.

Try these:

- Regulate your tone, speed and volume.
- Use P.A.C.E. (Hughes),
- Get down (or up) to the same level as the youth,
- Use your body language to appear both safe and engaged/interested,
- Be yourself.

A developmental treatment model

- Loosely follows the four pillar model of trauma-sensitivity (sanctuary) model:

- Affect regulation and emotional awareness: clients learn to recognise emotion through role play, experiential exercises and games, and to manage their emotionally charged moments and issues. Through breathing, simple yoga style methods, and connection to others (caregivers/family),

- Good Way Bad Way: uses narrative therapy techniques and sets up a dichotomous situation where clients can look at how their 'bad' side has been able to overcome their 'good' side. At the end of this section of the work clients are then able to undertake 'offence-process' work,

- Healthy change: If you take away something unhealthy, you must replace it with a healthy something. In this case, work focuses on healthy and legal models of being a man

- Future: moving on from treatment – practice, and celebrating success.

Contact details

Russ Pratt

Russ@primeforensicpsychology.com.au

Ph: 0430 530 125