

## **ENGAGING THE ADOLESCENT AND FAMILY**

**Presented by Kenneth Minkoff, M.D.**

### **OVERVIEW**

This workshop emphasized the clinical application of treatment principles to the process of engagement. It focused specifically on engagement that occurs during the development of an initial treatment relationship and during assessment. It also included strategies for motivational enhancement with individual adolescents with their families, adolescents within their families and the adolescent and their family within the larger systems in which all of those are embedded.

### **INITIAL ENGAGEMENT**

Engagement begins with the initial assessment. One of the challenges with adolescents can be the actual system that brings them in for treatment. As such it is important to establish a relationship in which you as the clinician can position yourself comfortably to move forward in the process of dealing with the myriad of issues. A set of mutual goals must be created that can be both supported by the individual and endorsed by the system. This process begins the very first time that you meet people, even before you have gathered information about the nature of what is going on. The process of establishing how to position yourself and engage people around their own individualized goals is an intimate part of the assessment process.

### **KEY ELEMENTS OF ENGAGEMENT DURING ASSESSMENT**

#### ***WELCOMING/DETECTION***

The first order of business is to hold a high index of welcoming for all persons for all their issues. You want to create a sense that whatever you hear is something that you expect and welcome. This proactive welcoming stance is critical to information sharing and gathering.

#### ***DIRECT INTERVIEW***

Information should be gathered in a direct interview. When we are working with systems, figuring out whom we directly interview first is an important part strategically about how we approach the engagement process. The general rule is to identify who is the decision-making authority who established the treatment connection. The initial contact should be with that

person. If the parents are initiating the treatment contact, I am interesting in hearing from the parents about what their agenda for the treatment is so I have an understanding of their goals. The parent's goals may in fact be quite different from the goals of the adolescent who is being referred. This applies as well to adolescents who are engaged, not only with their family system, but also with other multiple systems of care. It can be that there is a system that is making the referral that has a set of agendas for how the goals of the treatment are and how they are established. I want to understand how those goals are articulated. Based on how those goals are articulated, I will try to follow a process for figuring how who to talk to, in what order, based on what people are asking. Directly interviewing the adolescent is an essential part of that process.

### ***COLLATERAL SOURCES***

It is routine as part of the evaluation and positioning process to have contact with all additional collateral sources. Information on their potential goals, viewpoints, and leverage is gathered using the same model for gathering information from each of them. The interview approach is non-judgmental, empathic, and detached.

### ***INTERVIEW APPROACH***

#### **Empathy**

Establishing the empathetic connection in this engagement process involves the recognition that all of the players in this drama which is presenting to you, the adolescent, the family, the divorced parents with their respective remarried spouses and children, the correctional officers and the school people, everyone in this drama including the adolescent is probably somewhere other than where you would like them to be. Part of your empathic process is to recognize that they all are in fact doing the best job that they can do within the context of who they are. All of them are experiencing challenges and dilemmas that in one way or another are painful. Some of the challenges and dilemmas involve the idea that there is a better way for them to be and yet there are resistances and difficulties getting there. It is fully empathizing with this position, recognizing the painfulness of this dilemma that is an important first step in creating a treatment connection.

## **Non-Judgmental Detachment**

The second aspect of engagement is maintaining non-judgmental detachment. Detachment is a challenge for clinicians on either side of the system, mental health and addictions. We all are pulled in these treatment situations in different directions that undermine our detachment. One of the ways in which our detachment gets undermined at the individual level is that we experience a sense of wishing to be in control of things that we cannot be in control of. We wish to have the power to make this adolescent stop using because he/she is going to die or get into terrible trouble and we feel the need to rescue this person. Sometimes our detachment gets pulled in the other way. We are trying so hard and these people are just not listening to us and we want to blast through their denial. That also mitigates our detachment. Sometimes our detachment gets pulled with one aspect of the system or another. We totally accept and empower the choices the adolescent makes or we totally sympathize with the parents. Either way we get drawn into feeling that the solution is that there is something out there that we have to be in control of in order to have a successful outcome. Detachment implies that we become able to acknowledge both to ourselves and to the people we are dealing with the true limits of our own power. Not to do this, leads the people you are trying to engage to react against you.

Detachment does not come easily, so for myself, I use a detachment mantra. For substance abuse issues, it goes something like this. It is perfectly okay with me that you use substances as much as you want. Does this mean that I am recommending that you use substances, absolutely not? My recommendation to you, if you were to ask me, is probably that you don't use substances at all for a whole variety of reasons that you probably already know. What is most important is that I recognize that I can't make you do anything that you don't want to do and I am respectful of your choices, I will care about you the same whether you make the choices I think you ought to make or you make choices that are different from what I think you should make. Ultimately you are the one that needs to live with the consequences of your choices. My job is to help you to understand those consequences as clearly as possible and help you to articulate your choice making process as best as I can.

It is not sufficient to get yourself just in this detached position. In order to engage people, you have to find a way of communicating your detachment to them. Simple being neutral is not enough to let them know that we actually experience this non-judgmental, empathic, detachment. I find ways of trying to communicate this to people proactively and I try to do it early on. I want people to know that I am interested in how they think and what their choices are right at the beginning. Some of the things that I may say to a kid are, “many people in your situation find that using substances is helpful, is that true for you? If you are drinking and drugging, and you like it, why don’t you do it even more than you do? I genuinely want to know.” I am assuming that at any point in time, people are making a variety of decisions about what they do and what they are not doing and I want to get a clear idea of their decision-making process. The same kind of decision-making processes apply to any member of this particular drama and knowledge of this is important as we try to determine how to position ourselves in relationship to a complex system.

## **Hope**

Another aspect I try to establish at the beginning during the assessment process is the communication of hope. One of the things that we frequently encounter, particularly with adolescents who are in very complex and difficult situations is a sense of pervasive despair for both the adolescent and their families. The reality also as we approach stopping the substance use, is that they will continue to experience pain or perhaps more pain. The dilemma is that we may feel that they are right, there is no hope, and so we wind up contributing to the charade. However without being able to talk meaningfully to people about hope, a lot of the rest of what we do gets lost. So how do we deal with the provision of hope? It is the provision of empathy and hope simultaneously with detachment that forms a powerful engagement hood for each of the members in this drama.

## **Acknowledge the Reality**

From my point of view, providing hope is a three-part process. The first part of hope involves having the courage to acknowledge the reality of the individuals despair. One of the things that I try to do is to put the unspoken horribleness of the situation right out on the table. I put it into words, based on my feeling about what that person is sitting with. When we

communicate that we understand the reality of someone's despair, we are communicating a couple of things. The first is that we are saying I understand how you really feel and I am not afraid to say it. Two, you feel the way your situation is, is unbearable, but I'm letting you know it isn't, because I'm willing to bear it with you here and now. Three, you feel that there is no way out, but I'm saying that there is, we may not know what it is at the moment but I'm willing to join you in your despair and sit in it with you until we find a way out.

### **Entitled to Help**

The second aspect of hope is help. One of the reasons people often feel helpless is that the things they have already tried have not worked and that they feel like the act of getting help is more help than they should have asked for in the first place. We need to both acknowledge how terrible the problem is and at the same time acknowledge that because it is such a terrible problem, people are entitled to receive as much help as they possibly can for as long as they possibly can to sort it out and have a solution.

### **Vision**

The third aspect of hope is being able to create for people a vision of what a hopeful outcome can be in the face of the horribleness of their existence. You support the possibility that one day they will feel really proud to be a person, not only in spite of but also because of their adversities, and they can overcome each and everyone of these adversities on a daily basis. Their vision of who they can be is open-ended, any possibility remains possible. You support that possibility, however impossible it may be that they can achieve that goal or the feeling equivalent of that goal.

## **HISTORY**

### ***LONGITUDINAL STRENGTH BASED HISTORY***

The next aspect is how to move forward to develop a strategy to engage people in treatment around their own perceptions of what is going on and how treatment can be beneficial. However, the initial part of that process is organizing the assessment data into an integrated longitudinal strength based history. Longitudinal implies the data is chronological. Adolescents

and families tend to be poor historians, especially in relating cause and effect, so by using a longitudinal sequence time line some of the connections can be discerned.

The history is also integrated. Integrated implies in this context that the mental health and substance abuse information is combined at each significant time point in the longitudinal sequence. This is important because we are interested in gathering information about how mental health symptoms and substance symptoms interact. Often we feel like we do not have sufficient diagnostic data because people usually come to us when both sets of symptoms are more or less out of control and we do not have much information going forward. We do have information going backwards and gathering that data interactively in the past can be very helpful diagnostically in the future. The other reason that it is important is because routinely our history taking instruments do not encourage us to integrate this data. Integrating the information in the time sequence will give you more data about how the actual process moves forward and how these symptoms move together and the person's perception of how these things moved together.

### ***STRENGTH AND FUNCTIONAL BASED HISTORY***

Strength based and functional based history is also part of the foundation for determining treatment needs. The more impaired a person may be the more important it is to develop interventions that build upon their existing strengths rather than focus on correcting all their "deficits." In approaching people in a situation that is inherently judgmental, being able, to talk to people about what they have done well becomes incredibly important. In addition, looking at symptoms in isolation without looking at people's functional capacity gives a misleading impression. A person's functional capacity in relationship to their symptoms as they are negotiating the normal life tasks and sequence gives a clearer assessment with which to build a treatment plan with interventions that are built upon behaviors that have been successful.

During this assessment process, engagement with the individual occurs getting details about their situation. One of the things that people tend to do that creates distance and disengagement is to ask fewer questions about the things you know least about or the things that make you the most anxious. This is the time to push yourself to ask more questions, more details about people's substance using experiences or the efforts of different family members to deal

with or develop different interventions. The less I feel like I know exactly what is going on, the more detailed information I want, not that I will necessarily know at the end of getting all this detail what to do about it. In fact, part of the detachment is feeling comfortable gathering a lot of information and having the people look at you and say, “and?” You have to say that this is a big, serious, messy problem and I don’t know what to do about it right now, but we’re going to try to figure it out. Getting details allows me to have a clearer idea about the contingencies that operate in people’s environments and begin to help formulate a picture of interventions that are specific to the details of their real life circumstances.

## **DETERMINATION OF TREATMENT NEEDS**

### ***MOTIVATIONAL ASSESSMENT GUIDE FOR INTERVENTION WITH CLIENTS (“MAGIC”)***

Determination of treatment needs occurs not just on your own formulation of what you think the recommendations but most importantly from what the people you are working with think is going on. There is a tremendous risk of presuming you know what is going on without having any idea of whether that is connected at all to the adolescent or the family's decisions about treatment within the context and contingencies that are presenting themselves to them. In addition, in adolescent systems it is typical for people to have many different ideas and different perceptions about what is going on. Those different perceptions between different members of the system and the persons own presentation is viewed as an “informational inconsistency,” versus lies. "You said that you haven’t used for three months, your mother said you’ve been using every night. Why is she saying these terrible things about you behind your back?" Always try to deal with the dilemma as it is presented. In the MAGIC model the focus is on continually asking questions and engaging the adolescent and the family around the possibility that there may be something that they can learn to do differently without challenging the idea that they have done anything wrong and without implying that there is something wrong with what the are doing. The focus is simply trying to help them to try to decide whether or not if there is something they can do that might help and it might be in their interest to learn what it is.

The challenge of developing motivational interviewing is that we are looking for opportunities within this structure where things can actually go wrong, so the challenge of a detached stance is that when you present people with motivational possibilities, the choices they

may feel free enough to choose may or may not work. The key of a motivational enhancement strategy is that you position yourself empathetically with people and then you leave it to them to make those decisions and choices and bear the consequences of those choices in the context of some kind of ongoing relationship.

An example of this technique for the adolescent who is returning home to parents who are actively using is the following. You approach all of the people in that dilemma with the set of choices that they are going to make regarding their substance use or not and figure out whether that is a reasonable strategy and work with the kid to say, what are the things that you can do to deal with the fact that your parents are using. Would you choose to live elsewhere, do you think you would be better off in a more sober environment? If you want to try to do this, what are the supports that you need in order to be successful and then you are developing an intervention that says you can try to do it this way but if it doesn't work then you will probably need more help or more structure to proceed.

In groups, motivational enhancement strategies operate by enlisting the group processes and involving members of the group in listening to each other's decisions and choices. Members of group begin to recommend and apply choices to others that they may not initially choose for themselves. In the process of doing so may begin to internalize those choices. The group becomes a very powerful strategy for facilitating motivation in people who are resistant.

### **About the Presenter**

Director of Integrated Psychiatric and Addiction Services for Arbour Health System, Kenneth Minkoff, MD, is a board certified psychiatrist with a certificate of additional qualifications in Addiction Psychiatry. He is nationally known for his expertise on co-occurring disorders and integration of mental health and substance disorder services. Dr. Minkoff has authored and edited numerous works on co-occurring disorders and is an experienced psychiatric administrator with considerable expertise in developing public and private managed care systems.

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