Maintaining hope in the face of hopelessness: applying lessons from Rogers, Klein, and Crittenden in providing psychiatric care in a juvenile justice setting

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Overview

- Too hard, too complex, too disruptive.
- Lesson 1: Rogers - Unconditional Positive Regard
- Lesson 2: Klein - Object relationships
- Lesson 3: Crittenden - Attachment can change
- Conclusions
Nothing I am telling you today is information you don’t already know.

It’s not rocket science – I keep things simple so that I can understand them.

PS: this is why brain surgery was never my thing.
Who has seen Tyrone before?

- 12 years old, ? Aboriginal heritage, lives in residential care.
- ? ADHD, average intelligence, complex trauma presentation
- Lived in 10x placements from age 7, usually breaking down because of unmanageable behaviour or absconding and self-restoration to his mother who has since died.
- Charged for the first time with punching a carer who was restraining him after he was refused permission to visit his Aunt and started throwing objects at staff and threatening to “burn this place down an everybody in it.”
- Bail refused - seen in a custodial health clinic... but could just as easily been a GP clinic, or your community paediatric clinic.
- And if he’s lucky, he might have even been referred to a CAMHS service that is not overwhelmed with dealing with crisis presentations.
- Does this case sound familiar?
Complex problems across multiple domains

- We know that these young people have significant:
  - Psychosocial disadvantage.
  - Primary health needs.
  - Mental health needs.
  - Developmental needs.
  - Child protection needs.
  - Educational needs.
  - Carer needs.
  - Family needs.
Sociological-Ecological Systems Model: Bronfenbrenner (1979)
What Tyrone needs is a parent who can also be a case manager...

- It’s easy for professionals to be overwhelmed.
- How do you think Tyrone’s aunt was going to manage the systems, especially as she probably has multiple children like Tyrone in her care?
- How many young people do you think get good case collaboration?
Is it any wonder that Tyrone ends up hanging out with Nelson and friends...
How do you begin to unpack the too hard basket?
… when it feels so hopeless?
What can you, as an individual, do?

- Sisyphus kept turning up despite the hopelessness of his task.
- We know that young people disproportionately account for offending, and that young people who have contact with the law is that the majority of young people eventually stop getting into trouble by the time they hit enter their late 20’s.
- My suggestion: Go back to where you came from!

Farrington (1986)

**first principles**

*noun*

the fundamental concepts or assumptions on which a theory, system, or method is based. 
"I think we have to start again and go right back to first principles"

Translations, word origin, and more definitions
Barnardo’s Life Story
Carl Rogers: A Client-Centred Approach
Lesson 1: Unconditional Positive Regard

- How was Tyrone’s experience of receiving care from his parents?
- What do you think Tyrone’s experience of contact with health and social services professionals is like?

- Rapport is the foundation of all therapeutic relationships.
- Young people are generally pretty good at sniffing BS from a mile away.
- Language is exceptionally important, not only for the young person, but for the people in the systems around the young person.

**Conclusion:** Ultimately, you cannot begin to engage with a young person unless you can bridge the gap between the young person’s lived experience of being ignored, disregarded, abandoned or invalidated, and your genuine attempt to build a human relationship with them, before you can even begin to have a therapeutic relationship with them.
Kleinian Object Relations
Lesson 2: Healthy object relationships requires attachment security over time

- Tyrone’s attachment representations are informed by pathological object relationships with his own caregivers over his life so far, and his integration of split-off part-objects has been arrested by his prejudicial beginnings.

- Why are you going to be any different to the last caseworker, doctor, police officer, or teacher?

- Consistency and presence is key – i.e. just turning up. Again. And again. And again. And again. And sometimes again. And then the young person disappears off into adult services.

- You, just as the many object-relationships who have been formed and tested before you, are probably a part-object – where the good and the bad are split off and irreconcilable.

- Integration of the split off part-objects cannot occur without predictability.

- **Conclusion:** Keep turning up. You may well be the first professional person the young person is able to integrate as a whole object.
Crittenden’s Dynamic Maturational Model of Attachment

**FIGURE 2**
The Dynamic-Maturational Model of Attachment.
1) Patterns of attachment are self-protective strategies.

2) Self-protective strategies are learned in interaction with protective figures (attachment figures, most often one’s parents).

3) Symptoms are functional aspects of dyadic strategy (e.g. acting out, inhibition) or consequent to a strategy (e.g. anxiety behaviours).

4) Strategies will change when individuals (a) perceive that the strategies do not fit the context (b) have alternative responses to offer, and (c) both believe and feel that it is safe to behave in the alternative ways.

5) Therefore, the focus of treatment should be on enabling individuals to reflect upon the conditions surrounding their behaviour, to practise new responses in safety, and ultimately to learn to fit strategy to context to yield maximum safety and comfort.
Lesson 3: Attachment styles can change

- How does the system around Tyrone help to establish or maintain the conditions necessary for his attachment strategies to adapt to a less hostile?
- Is this even possible in a youth justice setting?

- Much of the work is not only with the young person, but with the system around the young person. As a clinical leader, your behaviour and willingness to think well of the young person in your care and to model that behaviour, inevitably influences the behaviour of your peers.

- **Conclusion:** Every contact you have with a young person is an opportunity to create the safety of a therapeutic frame to encourage the adoption of different strategies to manage their attachment trauma.

- You can’t know if your intervention today is the one that makes the difference, and you most likely won’t know how much of a difference it has made until 10-15 years down the line.
Putting it all together...

Guest Editorial

Will the real psychiatry please stand up?

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May I have your attention please? May I have your attention please? Will the real Slim Shady please stand up? I repeat will the real Slim Shady please stand up? We’re going to have a problem here

Eminem: The Real Slim Shady

May I have your attention please?

Children are the future. Nothing has reinforced that more than being a father to my own children. Yet in Australia and New Zealand, suicide remains the leading cause of death in children (aged 5 to 17) and young people. We know serious mental illness often emerges between the ages of 12 and 25, 14% and 27% of adolescents and youth respectively experience psychiatric problems, and these ages are least likely to access general practice and psychiatry. Treatment delays are common and only 25% receive professional help. Among youth with severe mental illness, only half receive professional help and fewer receive optimal evidence-based care. Headspace may have slightly improved access, however much better access is needed across the board.

excluding conduct disorder in over 1829 adolescent offenders, 60% of males and 67% of females met diagnostic criteria for one or more psychiatric disorders. Young offenders with schizophrenia are much more likely to experience rapid reincarceration compared with other youth offenders. We cannot ignore it: there is a relationship between aggression and mental illness, for both children and adults.

When child psychiatrists confirm conduct disorder and adult psychiatrists confirm antisocial personality disorder, mental health services often look no further. However, research shows that an overlap of disruptive behaviours and mental illness is the rule rather than exception. The evidence base exhorts child and general psychiatrists alike to look beyond aggression and to ask, ‘Is mental illness behind this?’

Too many times, the author and other adolescent forensic psychiatrists witnessed adolescents with psychosis declined from child and adolescent mental health services and inpatient units due to aggression. Frequently, aggression is driven by untreated or poorly treated psychosis. Adolescents with severe psychosis deserve prompt and effective treatments not a dismal one.
Each young person you see is a starfish...

Loren Eiseley (1969)
The Star Thrower
Closing remarks (i.e. my cheat sheet)

- Lesson 1: Rogers = Be nice
- Lesson 2: Klein = Keep turning up and be nice.
- Lesson 3: Crittenden = Turn up and ask everybody else to be nice too.

- And most importantly of all:

  Don’t fake it and keep it real.

  Hope starts with you.
...and finally, the lanterne rouge...

...THE END.