Walking a Tightrope:

WORKING WITH RISKY BEHAVIOURS IN ADOLESCENT CLIENTS

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Workshop aims and objectives:

Explore risk from the perspective of the young person and their development.

Develop our understanding of why risky behaviour is often a feature of adolescence.

Explore how we can identify risk behaviours and effectively work with them therapeutically.

Develop our knowledge of when risk can be contained therapeutically and when it requires implementation of safeguarding measures.

Explore how working with risk impacts practitioners.

Develop our understanding of how to practice self-care and support.

Why a tightrope?

This workshop centres on two ‘tightropes’ walked by practitioners:

- Identifying functional developmental risk behaviour alongside risk of significant harm.
- Therapeutic exploration and containment of issue(s) alongside the need to protect the client or others from danger of significant harm.

Part One: exploring risk and human development

1

Definitions of risk.

2

Risk as part of child development.

3

Risk during adolescence: three perspectives.

Origin of ‘risk’

- Classical Greek origin: meaning ‘cliff’, then Latin (root). Metaphor for ‘difficulty to avoid in the sea.’ (Homer’s Odyssey). Odysseus must take a ’risk’ to get out of danger without knowing if his safety is guaranteed.

See: http://research.dnv.com/skj/Papers/ETYMOLOGY-OF-RISK.pdf

- In common usage from mid 17th century, (Age of Enlightenment – people began to go further): from French *risque* (noun), *risquer* (verb), and from Italian *risco* ‘danger’ and *rischiare* ‘run into danger’.

- This concept of ‘risk’ is at the heart of the therapeutic process.

Risk: definition

- ***1*:** possibility of loss or injury.
- ***2*:** someone or something that creates or suggests a hazard.

- **at risk**
- **:** in a state or condition marked by a high level of risk or susceptibility, i.e. patients *at risk* of infection.

(Merriamwebster.com – accessed 11.7.2017)

Risk-taking throughout life: exercise

Consider the role risk-taking played in your life at:

- 0-5 years
- 5-10 years
- 11-18 years
- 18-now

Young children and risk-taking

- Exploration and risk-taking are an important part of child development.
- The baby crawling across the floor risks moving into the unknown to reach an interesting toy…
- The toddler taking their first wobbly steps has no guarantee that this will turn out well…
- …but this is how they discover new capabilities.

Risk-taking in middle childhood: going further

- School; new concepts, languages etc.
- Physical activities; sport, games, climbing etc.
- Social activities; forming more complex attachments, i.e. sleepovers, ‘best-friends’, etc.
- As children negotiate these challenges and their world expands, it may become clearer to what extent they have developed and internalised a secure attachment to caregivers.

Risk and attachment theory

- Children with a secure attachment are more able to take appropriate developmental risks:

'…the notion has been developed that an ordinary devoted mother provides a child with a secure base from which he can explore and to which he can return when upset or frightened.' (Bowlby, 1988:27)

- Children who are insecurely attached may either struggle with appropriate exploratory behaviour or move away from parents inappropriately due to an anxious and/or ambivalent attachment.

'This…includes children who are reckless and accident prone. They fail to use their attachment figure as a secure base, moving away without checking back with their caregivers when their attachment system ought to be aroused…Denying, excluding or disconnecting from feelings of distress, despair and fear is a defence against weakness and vulnerability. Thus, children deny danger: fearful situations are approached recklessly and with impunity.' (Howe et al, 1999).

Risk-taking in adolescence: what changes?

- **Separation from parents** – increased levels of autonomy along with less adult supervision of free-time/online activity etc..
- **Puberty** sparks significant changes physically, hormonally, cognitively and neurologically which may increase vulnerability to risk.
- Young people have more desire for and access to **'adult' activities**, i.e. drinking, smoking, sex, driving etc.
- **New expectations**, i.e. social, academic, can lead to pressure to 'perform' & be 'perfect' in order to gain vital love and validation. Such pressure can lead to increased vulnerability to risk.

Risk-taking in adolescence: three perspectives

Neurological

Psychodynamic

Evolutionary

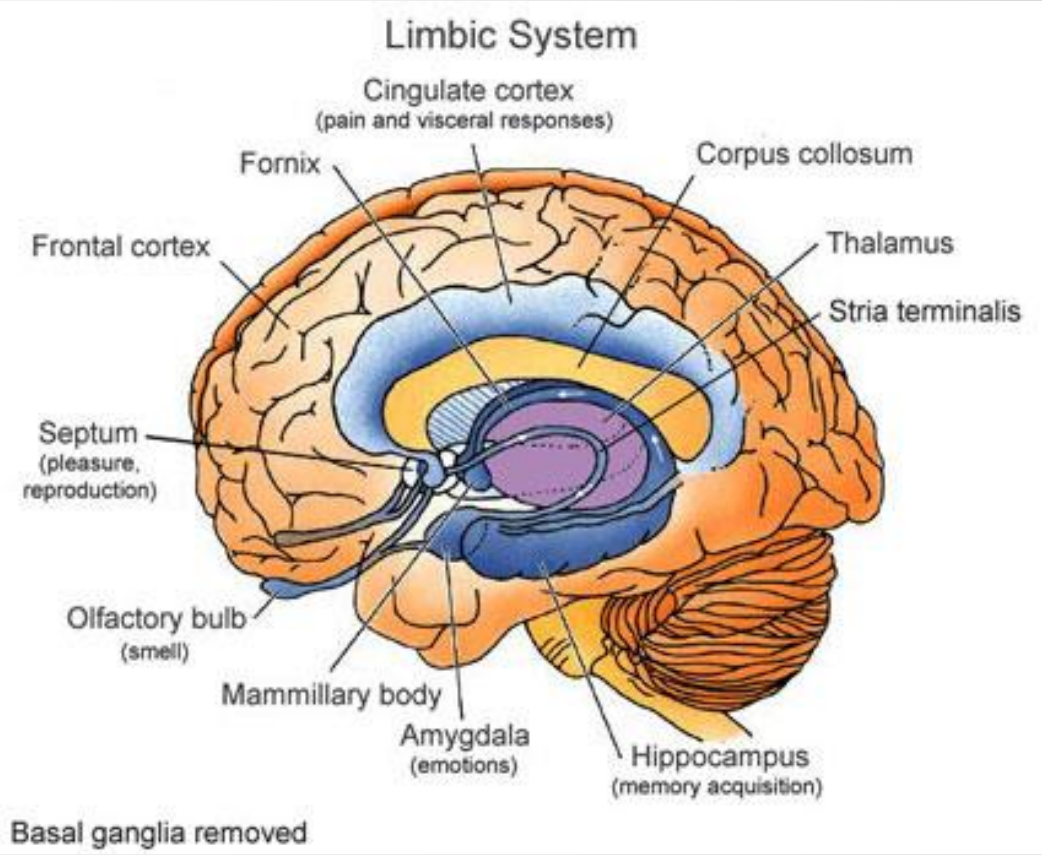
Risk in adolescence: a neurological perspective

- MRI scans suggest that puberty heralds significant change in the brain's volume and structure, vital for meeting the demands of independent adult life.
- This can lead to poor decision making capabilities and difficulties with impulse control:

'Though frontal-subcortical circuitry development is notable during adolescence, asynchronous maturation of prefrontal and limbic systems may render youth more vulnerable to risky behaviours such as substance misuse…'

(Bava & Tapert, 2010)

'These …shifts are no doubt connected to the many impending life transitions that lay ahead. Unfortunately these shifts are fraught with dangers related to an increased vulnerability to risky behaviours and addiction coupled with poor judgement and lack of adequate impulse control.' (Cozolino, 2006)

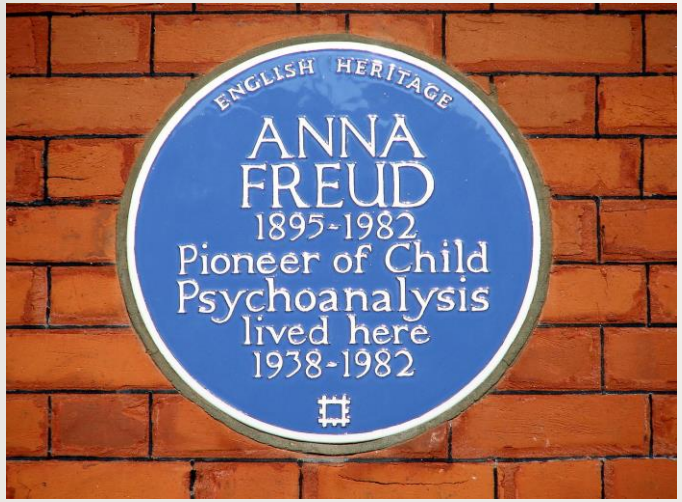


Self-harm and puberty

'The striking association of self-harm with puberty and affective symptoms might be related to emerging evidence of a period of particular neuro-developmental vulnerability around this time, with increased risk of emotional disorders and risk-taking behaviours. This vulnerability might be associated with particular developments in the cortical brain regions after puberty.'

(Hawton et al, 2012)

Risk in adolescence: a psychodynamic perspective



Changes in internal drives and libido:

Adolescence heralds an increase in drive activity, including qualitative and quantitive changes to the sexual drive which can be overwhelming for the individual:

'…the sexual and aggressive drives may overwhelm them so that separation evokes helplessness, futility and despair'

(Marks Mishne, 1986).

'…a relatively strong id confronts a relatively weak ego'

(Freud, A., 1936).

This corresponds with a limited capacity for sublimation of the internal drives:

'The resultant impulse-ridden behaviour and the low self-esteem arising out of lack of struggle to master, commonly create feelings of emptiness, boredom, and depression, frequently dealt with by drug usage today.' (Marks Mishne, 1986)

Risk in adolescence: a psychodynamic perspective

Changes in object relations:

Psychoanalytic theory suggests that during this phase the young person must separate from their original 'love-objects' in order to form new partnerships and romantic connections.

'**Nothing helps here except a complete discarding of the people who were the important love objects of the child, that is, the parents.'** (Freud, A. 1969: 8)

Risk in adolescence: an evolutionary perspective

‘One needs to engage in high-risk behavior in order to leave the family and village to find a mate. This risk behavior occurs simultaneously with an increase in sexual hormones, resulting in adolescents seeking sexual partners and is seen in other species. In conjunction with this novelty-seeking behavior, there would need to be some mechanism for detecting cues of safety or danger. The increase in emotional reactivity during this period may allow adolescents to be more vigilant and aware of threat, to ensure their survival as they move from a safe environment to a novel one’

(Casey et al, 2008).

Risk in adolescence: an evolutionary perspective

This can leave the young person vulnerable as they prepare to leave the relatively protective family environment:

'From an evolutionary perspective, adolescence is the period in which independence skills are acquired in order to increase the success of separating from the protective influence of the family. It is also a period when there is an increase in the likelihood of harm such as injury, depression, anxiety, drug use, and addiction' (Casey et al, 2008).

Summary: Appropriate functional risk vs. dysfunctional risk

- What all three perspectives seem to suggest is that the changes, internal and environmental, taking place during puberty pave the way for functional risk and exploration whilst also leaving the adolescent vulnerable to dysfunctional risk-behaviours and acting-out.

Part Two:
risk in the room

1

Introduction to risk presentations and the shift from ‘functional’ to ‘dysfunctional’ risk behaviours.

2

Significant therapeutic factors in working with risk

3

Risk assessment and safeguarding

Examples of risky behaviour in the room

Examples of potentially dysfunctional risk behaviour:

Substance/alcohol misuse	Unprotected sex/risky sexual behaviour	Compulsive gambling
online activities	Anti-social/criminal behaviour	Political or religious extremism
Disordered eating	Self-harm/injury/para-suicide	Compulsive video-gaming

Examples of ways in which young people may be at risk from others:

- Abuse (physical, sexual, emotional) includes bullying/domestic violence/coercive control (Can take place online or irl).
- Grooming i.e. for sexual abuse/exploitation, gang activity, to take part in terrorist activities, (can take place online and in the community).
- Exposure to pornography/unsuitable and/or graphic images of violence etc.
- Female genital mutilation (FGM)
- Forced marriage

Disordered eating and adolescence: key concepts

- An example of when developmental issues can be exhibited in dysfunctional risk behaviour.
- Definition: **'…a disorder …in which there is an excessive preoccupation with weight or shape, and/or food intake, and accompanied by grossly inadequate, irregular, or chaotic food intake'** (Bryant-Waugh & Lask, 1995). (See DSM V for current criteria)
- Onset common during adolescence. (Bryant-Waugh & Lask, 2013)
- Collaborative assessment is crucial to get a sense of the client's eating and exercising behaviours, as well as any concurrent issues such as anxiety, depression, and/or self-harm; presentations commonly found alongside ED's.
- Risk assessment is a continuous process. Practitioners need to be alert to signs that symptoms have worsened and are no longer manageable through counselling alone.
- Depending on the severity of the problem, therapy may involve family members and/or other agencies.
- Often therapy for ED's involves supporting the client in finding a sense of self and identity in order to be able to move towards appropriate separation and individuation.

Case Example: Mira

Mira is a 13-year-old girl who has been referred to a counsellor working in private practice by her parents. They are concerned that she has recently lost weight, is experiencing low-moods and seems to be struggling to eat during family meals.

During the assessment, Mira admits that she 'hates' her body and wants it to be different. She thinks she is bigger than her friends and doesn't 'fit-in'. When asked how long she has felt like this, Mira says she has been unhappy ever since a family holiday just before she started year 7. She remembers feeling uncomfortable wearing her bikini on the beach and then thinking her stomach looked huge in photos when she looked at them afterwards. She had to ask her mum not to post them on Facebook, as she usually did after a family holiday. When the counsellor asks if anything else was happening around that time, Mira remembers that the holiday came shortly after she had her first period. This was during the last term at primary school when she was taking her SATS. Mira remembers feeling embarrassed and ashamed that she was the only one of her friends whose periods started this early.

Mira admits that she skips meals and has been trying to eat as little as possible and exercise more frequently. She says she knows this is 'silly' but there is a voice in her head which tells her she is fat and this is what she must do. She says she has had lots of compliments from friends about looking slimmer.

Mira tells the counsellor she has been looking at Instagram posts related to eating healthily and losing weight. She says sometimes she is shocked by what she sees and thinks some of the girls she follows 'take things too far'.

- **What does the counsellor need to consider <u>at this stage of the work</u>?**
- **What are the risk factors to be considered?**
- **What protective factors might there be in this case?**
- **How might Mira's relationship with food and her body be explored therapeutically?**

The risk presentation tightrope:

Balancing containment and therapeutic exploration of the issue(s) alongside the need to protect the client or others from danger of significant harm.

Significant factors in working therapeutically with risk-behaviours:

- Therapeutic relationship including working alliance.
- The therapeutic frame and boundaries.
- Knowledge of legal and ethical frameworks relating to confidentiality.
- Good relationships/communication with family and/or other agencies, as appropriate.
- Cultivation of resilience, autonomy, and communication skills.

The therapeutic relationship: key factors

01

Therapeutic attitude of non-judgement and curiosity.

02

Core therapist-provided conditions of acceptance, empathy and genuineness.

03

Trust-building so the young person feels safe enough to explore difficult thoughts and feelings.

04

A relationship built on clear & realistic guidelines regarding confidentiality and its limits.

Developing Resilience: using therapy to help the client find the resources they need

- Capacity to express and articulate emotions appropriately and effectively.
- Capacity to make choices whether or not to engage in a harmful/risky behaviour or to allow another to harm them or place them at risk.
- Capacity to identify/form close relationships with others who understand and appreciate them.
- Ability to find perspective. They may feel like hurting themselves right now but is this how they will feel at another point.
- How will they feel if they do/don't use a behaviour or coping strategy they are trying to avoid or refrain from. What would be an alternative?

safeguarding:

Risk assessment, crisis plans, and breaching confidentiality

Assessing for risk of significant harm

Definition of significant harm (Children Act, 1989, 31:9 and 10):

- "harm" means ill-treatment or the impairment of health or development [including, for example, impairment suffered from seeing of hearing the ill-treatment of another];
  - "development" means physical, intellectual, emotional, social or behavioural development;
  - "health" means physical or mental health; and
  - "ill-treatment" includes sexual abuse and forms of ill-treatment which are not physical.
- In considering whether harm is significant to a child's health or development, the child's health and development must be compared with that which could reasonably be expected of a similar child.
- The meaning of 'significant' in case law has developed to mean enough to justify state intervention. (Thomson Reuters Practical Law, 2017 – accessed at uk.practicallaw.thomsonreuters.com 14.9.17)

BACP (2014) competences: risk assessment

The ability to conduct a risk assessment to gauge:

- How likely it is that a harmful/negative event will occur.
- The types of harmful/negative events.
- How soon a harmful/negative event is expected to occur.
- How severe the outcome will be if a harmful/negative event does occur.
- The likely mediating impact of any protective factors (BACP, 2014).

Risk factors: (Reeves 2015, Stewart & Bell, 2015)

Previous suicide attempt/current suicide plan. Self-harm behaviour/ideation, current or historic.

Psychological/emotional ill-health, i.e. depression/anxiety. Social isolation/bullying.

Poor school attendance/lack of employment.

Loss, i.e. Bereavements/Relationship break-up.

Issues with gender identity/ sexual orientation.

History of sexual abuse.

On the 'at risk' register.

Parent/carer with mental illness, current or historical.

Alcohol and drug misuse.

Age/gender/cultural background.

Protective factors

Coming for counselling/ the quality of the therapeutic alliance.

Ability to engage in exploration of their inner world including difficult thoughts and feelings.

Support of family and/or friends/other agencies.

Involvement in interests and activities, particularly those which build self-esteem and positive connections with peers and adults.

Capacity to develop and use self-care/appropriate coping strategies.

Safeguarding resources:

- UK Government guidance. i.e. (alternatives available for Wales, Scotland and NI.)
  - *'What to do if You're Worried a Child is Being Abused: Advice for Practitioners'* (HMG, 2015).
  - *'Working together to safeguard children: A Guide to Inter-Agency Working to Safeguard and Promote the Welfare of Children'* (HMG, 2015).
  - *'Information Sharing: Advice for Practitioners Providing Safeguarding Services to Children, Young People, Parents and Carers'* (HMG, 2015).
- BACP or other professional body
  - **When the safeguarding of our clients others from serious harm takes priority over our commitment to putting our client's wishes and confidentiality first, we will usually consult with any client affected, if this is legally permitted and ethically desirable. We will endeavour to implement any safeguarding responsibilities in ways that respect a client's known wishes, protect their interests, and support them in what follows** (BACP, 2015: 5).
- Supervisors and line managers.
- Agency protocols where relevant.
- Other resources, i.e. NSPCC (www.nspcc.org) , Barnardos (www.barnardos.org), MindEd (www.minded.org.uk).

Safeguarding: courses of action

1

Urgent and immediate referral to another emergency service, i.e. when young person discloses that they are in immediate danger.

2

Possible involvement of third parties/other agencies alongside counselling, e.g. eating disorders, substance misuse, early intervention for psychosis.

3

Formulation of a risk management plan. Plan to be drawn up collaboratively between client and counsellor covering aspects of how they will manage potential areas of risk. This can operate alongside the previous two options or be used as a stand-alone response.

Risk management/crisis plan

Exploring ways to ensure adequate support between sessions/over breaks/when work comes to an end.

Exploring healthy coping strategies, i.e. talking to a trusted person, walking, drawing, writing, using telephone or online crisis support.

Identifying resources for support. Who can I talk to?

Keeping safe. Safe places, people, activities etc.

Ability to recognise when something is helping and when it is exacerbating situation, i.e. listening to music, watching movies, etc.

Part Three: the impact of working with risk

1

The risks of working with risk.

2

The experience of working with risk.

3

Protective factors for practitioners working with risk.

The risks of working with risk:

Development of 'compassion fatigue' (Figley, 2002).

Safeguarding decisions: Anxiety re 'getting it wrong' or letting the young person down/not keeping them safe.

Exposure to traumatic stories: therapist, '…runs the risk of developing symptoms of 'secondary traumatic distress disorder' (Figley, 2002).

Potential triggering of memories of traumatic events/experiences in therapist's own history (Marks Mishne, 1986).

Lack of effective support in working with risky presentations and/or professional isolation.

The experience of working with risk: exercise

1

Think about a time when an 'at risk' client had a particular impact on you.

2

Why do you think this was?

3

What might have helped?

Protective factors when working with risk

- Figley (2002) suggests two key factors in lowering or preventing compassion fatigue:
- Sense of Achievement: **'…is the extent to which the psychotherapist is happy with his or her efforts to help the client.'**
- **'…demands a conscious, rational effort to recognise where the psychotherapist's responsibilities end and the client's responsibilities begin.'**
- Disengagement: **'…the extent to which the psychotherapist can distance himself or herself from the ongoing misery of the client between sessions…'**
- These can be challenging for therapists working with young people and risk behaviours.

Protective factors when working with risk

- Clinical supervision – decision making, reviewing actions, etc.
- Peer support; peer supervision, support networks, etc.
- Personal therapy.
- Professional support with child protection issues, i.e insurance company, BACP, UKCP etc.
- Reading/training/cpd activities to develop skills and confidence.
- Self-care activities away from work, i.e. hobbies/activities with friends/family not connected to life as a therapist.!

Suggested Reading and resources

Therapy with Children: Children's Rights, Confidentiality and the Law. (2010) By Debbie Daniels and Peter Jenkins. London: Sage.

Working with Risk: In Counselling and Psychotherapy. (2015) By Andrew Reeves. London: Sage.

Counselling Children and Young People in Private Practice: A Practical Guide. (2015) By Rebecca Kirkbride. London: Karnac.

Counselling Young People: A Practitioner Manual. (2018) By Rebecca Kirkbride. London: Sage.

Legal Issues Across Counselling & Psychotherapy Settings. (2011) By Barbara Mitchels and Tim Bond. London: Sage/BACP

Confidentiality & Record Keeping in Counselling & Psychotherapy 2nd Edition. (2015) By Tim Bond and Barbara Mitchels. London: Sage/BACP.

Good Practice in Action 031: Safeguarding Children and Young People in England and Wales. (2015) By Barbara Mitchels. Lutterworth: BACP.

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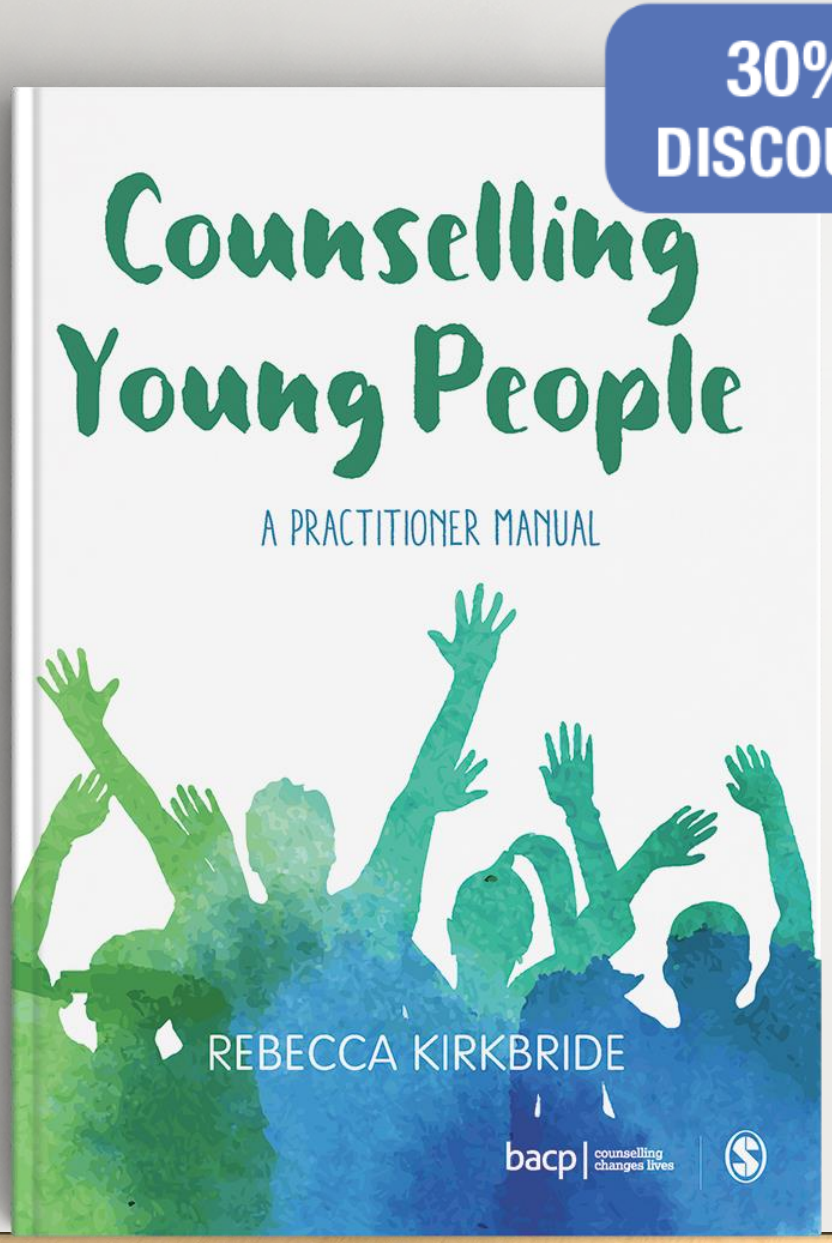

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