SW CEU_ How to Engage Highly Resistant Adolescents into the Process of Treatment-20250207_120012-Meeting Recording

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Andrews, Alexis, M LSCSW, LCSW started transcription

Andrews, Alexis, M LSCSW, LCSW 0:07

OK.
So we'll get started.
Umm.
So for everyone on today, we have Liz Jorgensen from Newport Healthcare.
And she is here to kind of go over how to engage highly resistant adolescents, which I know we all kind of struggle with.
And just different areas in the hospital. So I know this was one that when we sent out our.
Survey from the Professional Development committee.
This was one that.
That a lot of people ask you know about and had some was requesting just additional information about. So we just you know Kendra reached out from Newport and so we were just talking about this and this was one that they had.
A information about so we just figured this would be a good.
Ceu for all of us.
So I will just hand it over to Liz.
Liz, if you want to do an introduction about yourself, where you're from, because I know you're not from Kansas City.
And so if you want to just kind of talk a little bit about who you are kind of what you do and go from there?

Liz 1:24

Sure. Before that, if you don't mind if Kendrick could just say hello from Newport Healthcare and then will then I'll start.

Andrews, Alexis, M LSCSW, LCSW 1:28

Yeah.

KE **Kendra Eierman** 1:31

Just hello everyone.

I know I just saw probably several of you guys last month when we did a different virtual CEU, but my name is Kendra Ireman. For those of you who don't know, I am the local resource that covers Missouri and Kansas and the Kansas City and surrounding areas for.

Newport healthcare.

I support all of our programs throughout the United States.

So any clients who need that higher level of care residential treatment that fall within our age range of seven to 35.

You can always reach out to me, even if Newport isn't a fit.

I can help find a program that is best fit for that client.

Thank you guys for attending today.

L **Liz** 2:11

Thank you.

So I'm I'm very thrilled to be here.

My name is Luce Risco Jorgensen. I am speaking to you from Connecticut, and we're having a cold snap here. And it's a sunny out, though, so that's great.

And I have been in the field for 35 years.

And have learned a lot.

And when I was a lot younger, I didn't know what I didn't know. So to kind of give you a preface to what I'm going to share with you today.

Everything I'm gonna share with you, I learned from clients and I learned from trial and error and from some mentors and I mentioned some of them as well.

And I'm going to confirm for many of you things that you already know.

But I'm also really big on coaching therapist to have a more proactive stance and to be a guide and a good friend of mine who's a retired school Superintendent, he said.

He often says, like in a room full of 13 or 14 year olds, you only have to.

Be 15 or 16.

Like you don't have to be a genius to get them to do what you you need them to do.

And that actually I thought not only is that funny, but it's kind of what I'm going to teach you to do is to be the loving authority adult in the room.
And then I hope we have such a luxury of time today, we'll have time to do questions and answers, and Kendra's going to be looking in the chat and seeing if if you guys have a theme or questions or concerns.
And hopefully we'll have enough time to get to all of them.
So I just.
I've been starting on my presentations.
With this this the variation of this slide like listen, it's been a, it's been, it's been a rough few years. My first two years full time in the field were at the time of the AIDS crisis, which unfortunately the United States was denying.
But it was a worldwide crisis and I worked in two inpatient hospitals and I remember foolishly saying to myself, well, at least I'm coming into this field at a time.
Like this is the worst crisis, right?
And mostly it was.
It was hard because people were terrified.
They didn't know in the beginning with AIDS, the root of of transmission.
Pretty quickly we understood it was blood borne and harder to catch than we thought and but I was able to see some very, very brave healthcare providers that just said well, regardless we have to take care of these people.
These are our patients.
These they're our responsibility. And then other people, not so much.
Other people use kind of ignorance and prejudice to to not get involved and I I decided then what team I was gonna be on. I was gonna be on the run, into the burning building team. And if you work with teenagers and young adults, tweens to, you know.
The young adult age, like you're probably already in the run.
You're in.
Run into the burning building, personality versus runaway and and I'm not saying, listen, it's OK if somebody needs to run away and that's not their skill set.
That I understand, but I personally don't think teenagers are as hard as we.
Kind of make them out to be sometimes, as long as you get to what I'm going to be teaching you. Some of the Rosetta stones.
Like some of the ways to interpret their worst resistance so that you can get underneath.

But I do want to say that guys, it's been hard and it's it's it's it's not 100% easy right now.
We're all worried about federal funding.
Worried about Medicaid?
And we have good reason to worry.
And yet, here we are.
It's 2025.
You have these teenagers you're responsible for.
Let's keep calm and radically accept that there are certain things going on in our environment right now that we can't do much about, but we can all do our job to the best of our ability today.
At least that's how I'm coping.
And you know, remember the great Winston Churchill would say this over and over again to to Parliament. Mostly, but.
To the generals.
To the troops, if you're going to help, keep going.
Like what other choice do we have?
We just have to keep going, doing the right thing, taking care of the people that are are under our care, and this is a concept that I use and and I'd be interested to hear because I've gotten, I've gotten some real pushback on this sometimes from people, but.
The reason I'm actually known as an expert in engaging, highly resistant young people, and this is one of my key secrets.
I allow myself to love my clients and not love like weird.
Boundaryless love the Greeks had the idea of the four different types of love an agape, meaning a love for humanity, for the human being that's in front of you simply because they're a human being.
And you know, the Greeks would have said they had a a sacred soul. But you know, whether you believe in that kind of stuff or not, if you let yourself feel affection for.
Afu teenager.
Everything's going to go easier and I actually think that a few kids are pretty adorable.
I don't.
And I probably, I hope I don't drop the F bomb, but I might accidentally. I hope you all will tolerate me if I do 'cause I actually do some.

I do some acting and kind of act out a couple clinical scenarios later, but like the the kids who are really angry and resistant, they kind of tear at my heart because sometimes they really have been disappointed by the treatment field before. Sometimes the the most important adult.
In their life has have consistently disappointed them and hurt them.
And I feel like they kind of need to earn.
We need to earn their trust and if I start with the idea of agape, it just seems to go easier.
And you know we are.
We're seeing this not great COVID dip increase, although the the latest data, all the CDC website is dark right now, so unfortunately I I look to pull this up, I should have taken a screenshot of it before, but right now we are stabilizing with mental health. Mental illness.
Issues, but it's not good.
We're still at the worst rate ever, but but we are seeing increased suicidal ideation among our population 15 to to through young adulthood. We we're seeing this at Newport Healthcare, the the people coming into your programs, I'm sure, are sicker than they have been. We're seeing an incre.
In suicidal.
Attempts and completed suicide in in ethnic groups that had some protection before one of those.
Most scary ones is in among black Americans who had. I mean, not that there weren't suicides among black Americans, but as a cultural group, there have been some protection till recently and we're seeing that eroding.
So we have a big we have a, we have a lot of challenges ahead of us.
And kind of going back to agape 'cause, I'm gonna. I'm gonna cancel. You see my slides will be bad news. Good news, bad news. Good news, 'cause. Some of it's so dark, and I really am an optimist.
I'm a terminal optimist.
It's gonna kill me one day, but after 35 years.
In the field I I feel pretty strongly about the fact that this is a vocation and there's so much that we can do.
But take the agape idea and then add on top of it the idea, like your job, is to be a curious detective, right?
And each client is brand new and is a blank slate.

In fact, a lot of times, especially when a chart is like this big, that comes to me before I even meet the person, I will read like the last notes from an emergency room or something.
But a lot of times I don't want to be.
I don't want my brain to get confirmation bias based on, although sometimes it's funny if you read someone's long charts, sometimes they'll have like all different diagnosis whatever. But these multi problem young people who tend to be resistant, they think they kind of deserve a fresh set.
Of eyes in you and in me.
So I try to just say like I'm a detective here and I'm it's a team effort.
It's me and you, the client, to figure out.
Why you're suffering and I purposely use the word.
Suffering as soon into the intake as I can.
And I know this sounds a little bit maybe glossy or as if I'm I'm.
What's the word?
I want to use making assumptions, but this is an assumption that'll always be true.
If a young person is, you know, angry, belittling, you won't speak. You know, sitting there like, you know, like a stone statue and won't talk. You can be fairly sure that there's suffering.
Big deal. And so as these, this is kind of the way I would talk to a client from this curious detective place.
I know that you must be really stressed and suffering to be in your current situation and you are absolutely free to disagree with me.
I just wonder what we can do together to figure out why you're suffering so much.
And that sounds like such a simple goofball thing to say.
But I've had.
I've had young men, you know.
6217 years old, full of muscle.
Ready to go?
Tell me you know what?
Over and over again.
Some of them were already telling me that.
And then you see like maybe a little tear comes to the eye, right?
And especially for young men, I mean, we really do have toxic masculinity in our culture. Young men are not allowed to be broken or feel broken.

And I run groups. Here we run groups, very powerful groups in Newport.
Academy and Newport Institute and all I have to do is gently ask a group with a lot of young men in it. Hey.
Guys, did you ever notice that you're allowed to be angry, but you're not allowed to be sad?
Boom, they jump right in.
They're like, Oh my gosh, it's not fair.
Like I'm jealous of my girlfriend. Her and her friends just cry with each other and you know whatever.
And I'm not allowed to do that.
So sometimes if you bring up the word suffering, especially with an angry young man.
They.
And if you allow them to disagree, you could see how I'm speaking here.
I'm not like you are suffering.
That's why you're being such a jerk to me.
You kind of get a customer, maybe that maybe that's all it'll take to have them come along. And then, of course, many of our clients, right, the clients that you see in your programs, well, nobody comes hopping and skipping into your waiting room like excited to be in.
Treatment, right?
They're there under duress and so I might say something like from this same foundational curious detective stance.
Hey, I know your parents.
Have been angry and threatened you, but I'm asking them to try another way to understand what it is that you cannot put into words because no one would choose knowingly the place you are in. There has to be a reasonable explanation for your pain.
So what I'm saying then again, is I'm not acting like a psychic, but I am making some assumptions that again, are almost always going to be true.
Now I've had young people roll their eyes and be like, oh, Kumbaya, you know, whatever.
But I got to say I see it also.
Maybe they're a little bit more open.
Into what I'm gonna say next, and I have to mention my mentor. Sadly, my mentor

died during COVID only two weeks after my mother died, and he had had a long life. He had a a debilitating stroke and then died soon afterwards.
Which those of us who loved him knew that was a blessing. But he was actually the first person in the 70s to say that people with severe compulsive disorders and addictions were suffering because.
The the theory up to then and in through the 80s.
I went to grad school in the 80s.
Was that anybody with compulsive severe compulsive disorder?
So gambling disorders, compulsive sexuality.
No, they didn't see it.
So much for people with OCD. But but but. But believe me, there was a paucity of any kind of research or any kind of anything. We still blamed mothers for autism back then, so I'll just tell you what was going on then.
But the prevailing theory was that people with these disorders.
Were character disordered and basically couldn't be helped.
And Ed suffered for years. Just saying, hey, I think these people are suffering and I think that's the way to go. And I think that's the way to get them to accept treatment.
And of course, he was right and actually research vindicated him for the last 20 years.
Of his life he had a he had a nice run where people stopped disagreeing with him, and I always think of his teaching to me of.
You might as well just suggest that the person suffering, if they won't talk to you and he said 80% of the time you have a customer then so that's where I.
Got my my ideas from. I'm gonna just go and let's this is a review. Cause of course you guys know the team brain, but I I just always wanna remind therapists like we're up against a lot when we're talking to an upset or angry teen brain. Right, because.
From the minute that puberty hits and we do, we know this data. The only thing that's changing about this data is the the timeline of how long it takes the, the entire neocortex to.
Develop, but so in this slide, obviously the blue areas, the neocortex.
And the red areas, the limbic system, it's about the size of a human fist, and it is intensely activated the minute that puberty start and the limbic system is the seat of all emotions and all instincts. And don't we know that teenagers tend to go.
Become very impulsive and very full of emotion.
I'm very blessed. My husband and I have raised four children to adulthood and they're all doing well.

And you know, couple of them had like, such easy going temperaments until, you know, they started getting a little hairy.
And hitting the hormones and then all of a sudden, you know, we were up against some pretty intense emotions. And this is just part of what we're dealing with. And if we kind of just see it as a norm, in fact, back to having great discussions in groups. We I talked to a bunch of teenagers that are like, I hate that I'm so emotional, like I don't.
I like it and I I really believe in Psycho Ed.
So I have a version of of a presentation about their developing teenage brain that I teach them, and the kids are very like, wow, that's great.
Oh, no wonder I do that.
Or like oh, that's why I overreact.
But I always just try to remind us to remember you're dealing with a very spicy limbic brain.
The teenager's emotions run their brain.
Not that they're not capable of.
Rational thought, but the prefrontal cortex, which is right here to right here.
The forehead of the brain, which is where all we believe the executive functions of the brain are housed, is logical analysis, time management, the ability to decipher what is the most important data from irrelevant data.
That's all right here and it's not fully online till 25. Although I always say like around 2021, you start to see that young person and not to say like listen.
They're using the prefrontal cortex all the time.
It just doesn't run the brain.
Until the mid 20s, if that makes sense and a way to think of it is the prefrontal cortex is the break of the emotional brain in teens and the the the gas pedal is the limbic system. And it just keeps pumping sometimes.
And that can make for a lot of conflict that can make for that intense reactivity that you see in your office.
So I actually tell clinicians, oh, by the way, we're going to send you these slides.
Some of them have hyperlinks to the research quoted.
So if you're the kind of person that wants to go back and read the research.
But I really.
I really tell you to teach your teenagers about their brain because they'll just stop fighting you and be like, Oh yeah, that's that's me.

I get really ornery. Oh, I I put a wall up when I first meet somebody, and that must be my limbic system.
And I mean, sometimes they try to use they they'll say to their parents. Like I didn't do anything wrong. Like tell, Liz tells me I have my limbic system, made me act crazy. I'm like, well, and you have to be responsible for sneaking out the window like you can't.
You can't blame that on the limbic system, but I think it's a very helpful way for teenagers.
Stand like what's going on in their brain.
And these these have hyperlinks on them.
The COVID states project.
I really encourage you to read that's still online, but we're we're looking at the highest rate peaking in 2024 of anxiety and depression of all time and young adults up up to 50% of young adults and teenagers would have a a anxiety and or M. Disorder and it's it's unfortunately not many of them are getting help.
In fact, it's it's interesting to me that so many treatment centers kind of compete with each other.
When really, if if we could only just get the young people into your programs into other programs that are out there suffering and not.
Doing well, that's really what we need to do.
And this is a hyperlink to the COVID states project which tells you all about the breakdown of which which age groups are most affected by COVID, what the mental health was before, during and after COVID.
Really helpful data.
So when we're engaging adolescents, first we're going to start with the assessment.
An assessment is initial and ongoing.
I never know the whole story in one session and I make sure that I have 120 minutes for my first session with somebody.
I know that you don't always have the luxury of that if you work in an agency, but really if you if you want to engage young person, you got to have enough time.
You know, we all have to get through the the electronic medical record and the drop down menu and all that, which I also.
So I hate it when people are assessing and they have the computer like that, I don't know.
That's just me.

I'm old school.
I'm 61, so that's just me, but you really need to take your time, especially with a resistant teen and you.
You going to barely get the what's answered in an hour.
And then maybe you can get to the wise if you have enough time.
And one thing that I want to say is that it's and I'd love to see a show of comments if you're seeing this or not.
We're seeing a lot.
Law of resistance and nationwide. In fact, there was an article in the New York Times this morning.
Of a Canadian study of how bad the mental health effect of the high potency THC products has been, and we really are seeing more young people showing sequelae of serious mental illness.
That's either secondary to using these high potency THC products or is embellished or augmented.
So in other words, they already have anxiety or depression.
Excuse me.
What their use of these high potency THC products are augmenting the symptoms of the mental illness quite intensely, and the weed that was available in the 90s in the naughts was about 3 to 5%.
THC this stuff starts at 60% THC going all the way up to 90% THC and the residual.
Components are generally fluids that are.
Solvents. So there's all these chemicals.
Sometimes gasoline is used in the in the the procurement process to make these substances. It's really bad news.
The the use of substance use and and I don't.
I didn't have a chance.
Actually you can't access this data right now, but hopefully that'll change the monitoring the future.
You can get it broken down by state, so you may have your data up in Kansas City by the state, by Missouri State site cause a lot of the states are still showing the data, but.
But basically, we're looking at a third of the 10th grade, and if you're in a more affluent area, these numbers are higher.
This is an average of the monitoring the future NITA study. That's done every two

years and here.
I skipped a slide but but back to this.
Almost all of these use and they only started asking about high potency THC, the last two two times they did the monitoring the future.
And it's a one to one correlation.
So kids that admit to using cannabis in any form are admitting to using the high potency THC, and it's kind of like the The Dirty little unknown secret of how intense these substances are in terms of rapid addiction, potential triggering psychosis, including something called cannabis.
Cannabis.
Oh, I'm gonna get it wrong.
I'm gonna get it wrong.
It's not intoxication syndrome or that we do have that too.
So it's acute psychosis, just while the person's under the influence of it.
It'll come to me.
But what we are seeing, and it really can't be explained by anything other than these high potency THC products, maybe turning on one copy of the gene of psychosis because you know, thank God 6.
Psychotic illness is a recessive gene. Or that? Or the.
The predisposition to to psychotic illness is a is a recessive gene, we believe, but you need.
So you need 2 copies of recessive gene right to have the illness. Well, but you still carry that one copy in your genome and we think this high potency THC may turn on that gene.
And I'd be interested to hear from this team, since you're all experts working with young people, you've probably seen more psychotic breaks that.
You know, you gotta ask very directly of the patients. How old were you when you first started using plant weed, right. And then you go to how old were you when you first started using?
Dabs or well, the names keep changing.
Right now they call dabs and carts and if you ask it like laissez faire, like, oh, how old were you when you did it?
Like kids will say, like, Oh yeah, that's what I first started using.
That's what I use most of the time.
In the problem is very few young people understand.

Stamp the risks of this. You probably have seen cyclical vomiting syndrome or cannabis Hyperammersis syndrome.
That's when it's not from smoking to high potency products.
It's when the person tries to cut back on the THC, the hypothalamus gets kind of hyper triggered and starts the person starts vomiting and vomiting and vomiting and vomiting. And the reason I really bring this up is you're not going to have a customer that's interested in in.
Abstinence, if they.
Are having these horrible sequelae symptoms when they try?
Sorry to quit, so we really do need to understand what's going on.
And actually I need to update this slide because of this study today, we have some pretty good reporting data now on the number of cases in the emergency room.
Sure you have it at the hospital there of people coming in with.
Sequelae of psychosis and these other physical problems that are absolutely connected to the high THC product.
And there's absolutely no stigma against smoking cannabis.
Weed carts are what most kids call the highly concentrated THC.
I don't know if you guys are the same, but on the East Coast here kind of looks like schools who have given up on.
Disciplining because the carts have no scent.
They don't smell so like, you know, if you lit a joint in a bathroom or were doing bong hits or something, the whole hallway would know.
It's pretty easy for people to use this or the kids to use it and go undetected, and it's sad 'cause I run groups here, sobriety groups and and the kids are like we get them permission to go to the nurse's office or the guidance office to go.
To the bathroom because of how much they're exposed.
Just going to the bathrooms at various schools. I don't mean to be a Debbie Downer, but I do think if we're working with highly resistant teenagers, we need to understand how many of them may be under the influence of.
The high potency THC because you saw by the data we're talking about.
40% of high school seniors are using it, so on a regular basis. So let's just.
Going to extrapolate from that of how many of these young people may be in your office? Of course, alcohol is still the most frequent drug of choice for teens, and we all know alcohol use a regular basis can exacerbate depression and anxiety.
But but it feels good when they're under the influence.

So it's such a hard sell.
And always, always, always when we're talking about resistant teenagers. We got to remember the famous Kaiser Permanente CDC study.
Oh, have to see.
Maybe this is on the Kaiser site now. 'cause you can't get it.
On the CDC.
That your clients, even if they're from affluent families, if they are really resistant and angry and have that long psychiatric history, they have multiple adverse child experiences.
They just do.
And you know, Poooore families or families of different ethnicities, non dominant ethnicities often get called out for some of these aces where the more affluent you know.
Caucasian families don't, but that doesn't mean that those risks.
So not happening.
All the time and one of the things that is so interesting to me and one of the reasons we we take it both at Newport in my own office, we take family history, a variety of different ways, and we repeat kind of assessment for family history because you.
Have a lot of denial at first, and obviously so many of your families are going to be like scapegoat this kid, right?
The kid is the big problem.
He the big fu problem in our family.
But then you do.
You start to get to that. Why?
Of why is this child so?
You know, so resistant. I can't tell you how many using the techniques I'm teaching you. How many kids will say like, Oh my God, this is the first place that I've gone where you cared about what was wrong with my family, that you cared about the fact that.
My mom has a serious mental illness.
It would.
All the focus was on me and my behavior.
So again, back to why a kid might be like this or like this in front of you. If they've had other treatment experiences where the the clinicians for whatever reason were not able to get to the average child experiences that the kid feels.

Devalued, and they feel like their experiences don't matter.
So then they're just not gonna tell you much.
And I do have to call out.
I'm not trying to be extra woke or anything, but young men of color back-to-back to the fact that the suicide rate is much higher for them.
We are seeing many more mental illness symptoms in young men of color and it seems to be related to high hypervigilance and high levels of cortisol in the bloodstream over time.
Black males are more susceptible than black females, although.
There's some effect there too.
There's some very good data that teases out all other variables to show that a young person feeling like they may be a threat in their own culture really does do a number on them over time. Just biologically 'cause if if you're high alert all the time, whether you.
Started off with Pdsd or not you. You you're going to erode the nervous systems efficiency in terms of making using and recycling.
Neurotransmitters and and this is just.
Just a fact.
And I and I spend a lot of time making sure that everything that I share is factually based. And again, I'm giving you the research to to look at it yourself.
So. So let's all just stay based on science, you know, because the cool thing about science is it's true whether you believe it or not. You know, as Neil Tyson degrasse, he says.
And I think we need to.
We need a big, deep breath of society and come back to the fact that don't we all want?
Say our family member had terrible brain cancer.
We will all want a brain surgeon and an oncologist that believes in science, don't we?
I mean, it's just a fact.
And if we could get past all the the divisions and all of the things that are going on here and agree that and not to say some, some research studies are biased, that's true.
They they can be.
So you always have to see who funded the study, etcetera.
But we do have to start trusting experts again, who hopefully won't won't misguide

us when it comes to the most important things.
So this comes from Dewey's.
Work on on risk and one of the reasons I think it's very hard working with a high risk teenagers is the anxiety that you may feel knowing you know the outcome. If a child has too many of the the distal risk factor, distal is distant from the lat.
Dis so distant long standing proximal means recent acute within a short period of time.
And you basically can.
And predict which teenagers are going to be at risk for the most volatility.
To maybe violence towards others and or.
Self harm based on a combination of the distal risk that's along 1 axis and then proximal events.
Now here's the hard part, I said.
This might calm you down.
If you have a kid who's telling you they have some suicidal ideation but they really don't have a lot of adverse child experiences, they're not psychotic.
They haven't just been hospitalized. You can work with that as a symptom in a different way.
Then someone who has a suicidal ideation and a long history of adverse childhood experiences, and what we really want to be acutely aware of, if the child has distal risk factors and then proximal events like sudden loss of a relationship, loss of their home or security a sudden.
Death, suspension, expulsion, intense humiliation. These things will set them on a course of often self destruction or destruction of.
Property or.
Or other things. And it's very sad looking at many of the school violence episodes.
Do you know what?
A lot of times, one of the things that's the last, the last straw will be expulsion or intense humiliation, and that child has really no one to turn to.
It's very, very sad.
And I want to get back to the foundational skills.
So if you have a hot potato kid who may be at risk for self harm or maybe violence, you still want to use the same.
Language that I brought up before, right?
And I have a little school language in here.

Hey, I know you jammed up with unexcused absences. It may seem like you can't get cut off, caught up on all the work you've missed. Would you be open to letting me help you find another way out? So you go on it?
Depending on what the kids, so this would be if a kid is failing in school, which it happens a lot and you know we're in third quarter now, you know this is where kids start to panic and they're not going to graduate and all that.
Sometimes they just need our loving authority to be like, hey, there's a way.
Yeah, could.
Will you let me try to help you with the school counselor?
Find a way out and of course add whatever.
Thousands of different situations where you could use similar language and then I'm just gonna bring this up because you are all dedicated good humans. If you've chosen to work with teenagers and children.
So remember, our job is to just get the young people to the next stage of willingness to change, right?
You're not gonna have somebody in an intake, and for a few sessions go from.
Pre contemplation of any anything's wrong with my life that I could possibly change, right?
And I do have to say our field really could use a wake up call with us.
We need to help young people focus on the things that they can change and kind of get away from the overly.
Culturally sanctioned victimization kind of mindset, where obviously we validate their pain and their suffering, but we want them to get to the point where they may be willing to make changes.
And this isn't just for drug addiction.
This is for you know, lifestyle changes for taking care of depression, lifestyle changes for taking care of bipolar.
But remember, you're going to feel less stress as a clinician if you remember your job is just to get your client from one mental state to another state.
And often if if you can get a client to the preparation state of our, would they be willing to accept more help and change? People don't need a whole lot of support after that.
I mean, we still offer them support, but I just think it's a good way to feel like better about what you do because especially for those of you that are young clinicians, you may not know that your work was extremely helpful with a young person because

they may.
Bounce out of treatment, especially parents that are.
If if they have multiple.
Risks and poverty, they're they're moving.
They go out of the area. Whatever. I'm old enough. And now, because of the Internet, I have clients look me up. Who I saw 25 years ago, 30 years ago.
Who will say I always wanted to say to you now I have 12 year sobriety.
I just got my chip.
I'll get pictures of the chip, you know.
What I did remember, like you helped me get from thinking I had no problem at all to thinking I might have some power to change my life situation.
But you, young clinicians, don't you just don't have that experience yet?
Yeah, but you will.
OK.
This is the only original idea that I've ever had.
Everything else I've told you today is derivative and and stolen and borrowed. And even though I do try to credit all of the people that I've learned from, you know, you can't really credit everyone.
Many teenagers will be angry and resistant in your initial sessions because they're worried about being punished if they tell the whole truth.
This is especially true for a kid who comes to you.
I.
I don't know if you guys have school mandated assessment stuff like that, like I always.
I mean, I'm grateful that we get those kind of mandated assessments, 'cause we get juvenile, you know, justice, mandated assessments, etc.
But at the same time, you know the team is not going to be a happy partner coming in there.
So what is the amnesty proposal you say to the teenager in front of the parents that you want them in and out accounting as quickly as possible?
That's a big sell right there. 'cause. Sometimes kids think you're going to, you know.
If they come and see you, they'll be seeing you for five years, and that's definitely Debbie Downer. If they're not going to want to keep coming back.
Back to that one.
But amnesty means if they have the guts to tell you what's really been going on.

Well, first of all, you say most of it I can keep confidential, but if it's something that we can't keep confidential or something that's pretty vital information that your parents need to know.
Mom, dad, grandma Foster. Mom, would you be willing to have complete amnesty or forgiveness for everything Liz tells me?
Because, you know, she's in some big trouble here. She's up for expulsion.
And I'm not going to be able to help Lizz unless I get the whole story.
Do you know in 30 years of using this idea which a teenager gave me after he survived a fatal car accident where his two best friends died in the front seat, he came up with this idea?
This is when I was working in an inpatient long term psych unit.
So there you go.
I told you everything I learned. I learned from my clients, but I have only had one parent say no.
And this dad was probably the most rigid, angry man I had ever met.
Like with a hair on the back, my neck would go up when he came in.
All the other parents.
And and grandparents and foster parents are like, of course, we know there's more to this story.
We just want you to get better, like tell this nice lady everything and a lot of times, as soon as if the kid really believes what the adults have said, as soon as they leave, the parents leave the room. The guardians, they're tearfully telling you the whole story.
So you don't even have to do multiple tricks to engage them.
They're like, oh, somebody understands I'm a teenager and I'm scared that I'll be grounded for life.
Or that my parent, you know, my parents will never forgive me.
But even then, they don't tell you the whole story.
Right away.
But they do tell you a lot.
So, OK, you gonna do this? So now I'm assuming you're with your resistant teenager, and maybe you've gotten them past the first hurdle.
Did the language that you use in asking questions is absolutely crucial.
You always say. How old were you when you first drank alcohol?
How old were you when you first vaped nicotine.
How old were you when you first smoked weed? And then how old were you when

you first smoked dabs?
Or wax. And you also say, how old were you when you first thought of suicide?
How old were you when you first had a panic attack?
And the reason that's really important to never ask binary questions is it gives a comfort it gives.
It gives a almost an acknowledgement that you know they may have done some of these things that they're not proud of, that they don't want to admit to, and generally you're going to get some high yield if you use the how old were you when?
Versus have you ever done that 'cause? If you ask a teenager? Hey, have you ever done cocaine?
What do they say? No, of course they say no.
Adults will say that too.
And you know, if you think of it this way too, I'm kind of back to the prochaska, decamente stages of change.
There's going to be if you have a child in front of you that has many distal risk factors, your relationship with them is going to be one of the chapters of their lifelong maybe journey with the mental health system, right?
And you want to think that that you're looking at, you know, as Martin Luther King, Doctor Martin Luther King.
Junior said that the arc of history is long, but it bends towards justice will.
The arc of healing is long, and it bends towards growth, but your teenagers that are resistant, they're going to be up and down. They're going to be up and down.
They're going to be up and down. As a therapist, you going to feel better about your day to.
Day work.
If you remember that you're keeping your eyes on that prize, right, that the child will eventually be growing and self actualizing and and feeling some autonomy and maybe hopefully God willing, getting out of a difficult family situation.
Either living in a group home or.
Or maybe going to college or other things like that because it can be very demoralizing.
I believe me, I know I've gone through several periods of burnout in the field when things were just very, very difficult and it was very hard for me to get.
Traction with a lot of very multi problem, angry teens, OK.
Now I'm going to teach you something that blew my mind, that I only learned five

years ago, and it's one of the main reasons that some of your patients are highly resistant and I can never pronounce it correctly. In fact, my.
Friend, who's a scholar of Greek and Latin, gave me a way to pronounce it.
It's called a negrocia, a negrocea, and it is present in about 50% of people with serious mental illness.
And what does it mean? The inability of a patient to see their own symptoms?
So sometimes your psychotic young person is not lying to you.
They really think they're talking to Elon Musk on the phone or they're really thinking that God the father is telling them what to do.
It's a neurological condition and many people with I don't know if you've read any Oliver Sachs. Great work.
You know the man who mistook his wife for a hat.
That but.
This this syndrome, that Nagosia syndrome happens a lot with brain damage, but it also happens with psychiatric illnesses.
Especially with substance abuse and people think that denial is lying, but honestly, people will be smoking on a weed pen all day long and you'll do a timeline and say like, hey look, it looks like you started to fail out in school, like once you started smoking. Oh.
It had nothing to do with that.
I feel so much better now that I'm smoking.
I just.
I hate my teachers this semester, you know, and the young person is not lying to.
They actually can't see the connection.
Between their symptoms, behaviour and the consequences in their life, does that make sense? And this is his book.
And I right before COVID when I first read this book, I wanted to get him to come and speak.
I I helped run conferences every once in awhile.
I still have never heard him speak.
I know people who have seen him for consultation and this is one of the best books I've ever read in our field.
I can't recommend it more, but what? What Doctor Amanda or does is teach you very simply if you're dealing with someone with complete denial of deficit of their illness, what you can do is.

Is find a goal and the language that I showed you in previous slides is really borrowed from his thinking.
I mean, I was already thinking like that and working like that because it's effective, but if if somebody's not willing to get sober, you say, hey, you know, it sounds like you had RSP and pneumonia for like, a month, you know, you know?
A couple months ago, would you be willing and maybe cutting down on the amount of stuff that you're putting in your lungs?
You have to kind of find a a goal that the that the.
Client will be willing to work with you on if that makes sense.
You can't come in with the blunt object.
They just do not listen.
And here's an actual quote from a person that I was seeing, and a person that I'm still working with.
I know you're angry that your psychiatrist put you in the hospital for no reason.
So my client thought it was no reason he was psychotic and he wanted to stay.
He wanted to live in a church, a local church, to be near God all the time. So.
Kind of had to put him in the hospital.
I understand that.
Can we work on helping you find a job?
You've also said that this is a big goal for you now. Obviously this young man couldn't get a job because of his psychotic symptoms.
Which eventually led him to be more willing to work on the psychotic symptoms.
Recently I had a young man with cannabis induced psychosis who did not believe he was psychotic.
In fact, he had been hospitalized four times, and when the psychosis and was every time he smoked weed again.
The psychosis would come back and in between episodes he would be like, Oh my God, I get psychotic.
Every time I smoke weed.
Why do I smoke weed again? And it's been at least four times he's been back and forth, so at at the last time that he was psychotic, he told his parents that he was firing me and firing his psychiatrist.
And no, I'm not having any more interaction with that field because they put me in the hospital against my will and it's ****** ******** and blah, blah, blah, blah, blah and.

All right. So mom and Dad did something pretty wise. They said. OK, you don't have to.
To do what they say, but in order in this kids already 24 years old.
But he's been struggling with this since he was 19.
You don't have to see Doctor Morgan and Liz, but if you don't, then you do have to move out of the house. You can move in with your friend and, but my friend's a junkie.
Well, we all we we don't.
You don't need to do everything that Doctor Morgan and Liz say, but you have to see them.
And then I was able to convince this young man, hey, David, can we talk about meeting with Doctor Morgan, psychiatrist just to reassure him that you're fine?
You may be right.
Maybe he does worry too much.
And maybe your parents worry too much as well, and maybe me as well.
But maybe he has some good ideas.
To help.
Well, that, I mean it was a much longer conversation than that obviously, but that got him in the door with the doctor that got him willing to take a medicine for anxiety.
Vraylar, which does help with anxiety but also helps with psychosis.
And he's fully functioning again now.
So just to remind yourself too, as you're seeing a, a really resistant patient in front of you, remember the median onset for many of the biologically driven illnesses are adolescents, right?
Bipolar one and two, the median age of onset 17 to 25.
Schizophrenia, schizoaffective disorder.
Most show symptoms age 13 to 29.
I mean, you almost never have someone have a full break with either bipolar one or or schizophrenia after the late 20s. This is this is a very interesting statistic for major depressive disorder. The median age 50%.
Of people with the disorder is.
Get it by 25 years old, but but with that 50% of people who get it, 25% have their first episode on or or younger than 17, right?
So when you have an irritable, angry patient, maybe have a high index of suspicion for the beginning of a bipolar disorder or a major depressive disorder.

And let's not forget, sometimes the disorders are so slow.
And onset that the person.
Doesn't know that they are depressed, right?
They, and they may have had some of the symptoms we used to have.
Cyclothymia was a diagnosis that I think made a lot of sense, but they may have had a low level depression for a really long time. That's just gone into a major depression.
So just have a high index of suspicion for that, and of course, borderline personality disorder.
You know you're going to see, honestly a lot of times you see signs of that right around puberty.
I personally think there's a strong biological component to that.
But I haven't seen.
I have not seen discerning research to back that up.
It's part of the biopsychosocial theory, of course, but we do see it hit around adolescence very often, OK.
And then when you're working with families with resistant young people, make sure you ask about primary relatives having serious mental illness over and over and over again.
And and you can't just have a checklist saying, do you have any family members with bipolar, with schizophrenia, whatever you have to ask behavioral questions like, do you have any blood relatives who, despite intelligence and education, could not sustain employment? Are there any relatives who had trouble leaving?
The house or were erratic and they're functioning.
Any abandonments of children?
Or disappearances from the family. So you'll have a family. Who says? Oh, no, we don't have any mental health illness in the family.
Ask the questions that way. Like Oh yeah, two of my uncles still live with.
My grandparents and like it's it's terrible.
We don't know what they're going to do.
They're in their late 80s and it's just awful.
You really want to see what primary relatives to the adolescent that you're trying to treat may have had in terms of biological mental illness.
I hope that makes sense.
OK.
So now I'm going to say I made-up these categories.

And I'm getting towards the end of the presentation. So say you have just a normal ornery teenager who doesn't want to be there.
OK.
That's primary resistance.
It's it's probably related to the adolescents need for autonomy, privacy.
Teens are going to lie to you initially.
All teens are going to be a little resistant.
Oh, those some are pretty treatment savvy these days.
And if you're not the first therapist, but they had a good experience before, then they may not be be there.
And then you know, I just validate them.
I go. Yeah. Who wants to go to counseling?
You know, really it's kind of like going to the dentist. You just don't want to lose your teeth.
You know, nobody wants to go.
And then sometimes they laugh.
Sometimes that's all that it takes, and so primary resistance. You do the amnesty agreement I've already taught you that you ask questions.
Hey, tell me what you love about weed. You know, you get in there, you screen for underlying risk factors.
The kid may not need a lot of follow up care, you know, but you just want to get them talking to you. And then sometimes what?
Instead of pushing ongoing sessions, if a kid really isn't is low risk, I say to the kid with the parents I go listen, Johnny's got a few things going on.
Mary's got a few things going on, but they really don't want to come to counseling right now.
Let's talk about what you would have to see at home to that would make you bring Johnny back if you catch him again with drug paraphernalia.
OK.
Let's write that down. If he continues to miss days at school, OK, let's write that down. And I believe in making a behavioral contract that says, OK, we're not going to force you to come back. But if you show us any of these.
Behaviors you'll be telling us by your behavior that you need to come back to counseling.
Does that make sense?

And in we got to remember that we have to teach parents to discipline kids.
It's OK to set limits parents.
It's essential.
I would have 4 gangsters instead of four. Lovely wonderful adult children. If I wasn't the meanest mother in Redding, CT.
Like they lost the car, they lost their cell phone, curfew, cash, credit card, computer console. Depending on the crime.
And I also rewarded them and praised them for good behavior. Right. We give it these privileges to our child and we may taketh them away.
And I find like the young generation of parents really need a lot of like of our strong, you know, positive influence to say like, no, no, no, no, no.
You got to sometimes if the kid is on the computer all hours of the day and night, and they're failing in school and their symptoms aren't getting better because they basically are not sleeping.
You've got to take that.
Computer where you've got to shut down the Wi-Fi in the house. You know, at a certain time, etc.
And you know, I really don't understand parents giving a credit card to a kid, but that that's just not the culture I was raised in. But, you know, if a kid is using drugs or they're acting out or they're sneaking out, all those privileges need to be shut.
Down until the child is in a better state of mind.
Secondary resistance.
So this is going to be, you know, energized by need to self medicate and.
Self Medicaid. I don't necessarily mean drugs.
I mean, like pushing away behaviors means like I'm just keeping myself safe. 'cause I'm pushing you away, right?
Staying in bed, you know, doing things to self, Sue that are non functional or or or maladaptive. Generally there's there's higher pre-existing risk factors back to that distal access that I showed you before.
Generally, there's a longer history of substance use or self harm.
Compulsive behaviors, possible neglect, abuse.
Comma, so you use all of the techniques that we already talked about, but for this group I like to do a sequential evaluation of the risk factors.
And and underlying learning disabilities kind of back to the XY axis. So you do like all of the the the risk factors and kind of the historical changes and the historical dips

down and maybe improvements and then you do it on a timeline and you see like oh.
Is in this interesting. Like you said, it didn't really bother you that your dad remarried. To move to California and now you only see him in the summer, but that seems to be when you started smoking dabs every day and whatever.
Because again, Agnes knowsia.
A lot of times the client doesn't like you would honestly know right away what the risk factor is.
But you have to be able to visually show them a timeline. Does that make sense?
And then they go, oh, yeah, I guess I I did get a little worse when my dad moved to California with his new family.
And then you really want to do if the if the kid is more resistant, you got to do an assessment of the family function.
The boundaries, the rules and supervision at home.
And then you want to be more aggressively treating comorbid depression, bipolar, ADHD, get them in for a psych console, even if there's nothing that you can do, right.
Then you know you want to have a higher, you want to have a high index suspicion of more serious psychiatric stuff going on.
And this is what anybody who's a young therapist online. Please, please, please use some loving authority with the teenagers.
It doesn't mean bossing them around, but I think you've already.
Understood by my the way I speak to the teenagers, I don't boss them around, but I do.
I do think there are times where we're a little bit too much nurture and validate and not enough push to change because young people will do what you say. In general if you say, hey, I really would like you to check out this once a week, group that.
We run.
There's a lot of teenagers your age in there.
They're they're. Many of them have stopped smoking the high potency THC and they're feeling so much better.
Would you please just try it?
I tell you what I'll ask the group leader if I can meet you there.
And introduce you to the group like. Would you please just try one group please?
So that's what I mean by loving authority, right?

Kendra Eierman 53:16
Liz, we had a question come in.

Liz 53:17
Yes.
Sure.

Kendra Eierman 53:20
They were understanding about the limit setting from parents, but what about those kids who are violent in response and are runaway and place themselves at risk?

Liz 53:24
Yeah.

Kendra Eierman 53:30
I see this as a pattern of parents feeling like they have no control and not being able to limit send.

Liz 53:36
Well, first of all, I think that I was gonna in my tertiary resistance. That child needs residential care.
And the other thing is often there's a behavioral dynamic where the teen has trained the parent to back off unreasonable limits.
So so you really need.
It's hard to just answer that question without the details of the case, but a parent will need to be coached by you as the therapist to understand. Like, OK, every time you've taken something away from them before, including cash.
Or whatever which said they couldn't use drugs in the house.
They ran away.
They destroyed property.
Are you ready to call EMS and have them seen at the local emergency room?
'Cause that's what it's going to take to to change this pattern.
Are you ready to maybe have them spend some time in the hospital short period of time in the hospital and or residential?

You got to break the pattern.
You got to bring in the big guns for that because often what happens is especially if the kid keeps coming back, if they run away and they're gone.
That's a totally let me put that in a different category. But if they run away and come back, they've trained the parents to back off on reasonable limits, and it really is a it's really a terrible scourge in our current environment where it listen with my patients it.
Only takes one trip to the emergency room.
Sometimes they do need residential, by the way, they really need it.
But sometimes it takes one visit to the emergency room. As long as the parents aren't punitive, where they realize, like, oh, it is not worth breaking a desk or doing.
Something because I sat in an emergency room for 14 hours.
I saw a resident at 40 clock in the morning.
I slept on a pediatric bed for two days.
That's not worth it.
And I know that sounds like a punitive response, but the truth is the could really, they're either they, they still do have psychiatric issues to behave that way.
Don't get me wrong, but sometimes there's two categories. Sometimes the child is bipolar or has complex PTSD, and they're just acting out, acting out, acting out.
Well, that child needs more containment than you can do.
And outpatient therapy, they need to be in a residential, but then there's the other category of kids who behaviorally are just they're the Energizer Bunny.
They're just poking poke and poking, poking, and they have the parents pretty well trained by what they say or what they threaten to do, that the parent gives in.
Does that make sense?
I'm sure there'll be more questions at the end about it, but.
And that kind of gets to my next. Oh, sorry.

KE **Kendra Eierman** 55:59
Yeah, she she had just commented again.
She just said thank you.
She knows it's complex. Many of these kids do not then end up screening in for inpatient psych or residential.

L **Liz** 56:09
Yes, right.

Kendra Eierman 56:10
Maybe the ER visit itself is a deterrent.

Liz 56:13
Yes, that's what I'm saying.
So sometimes the ER visit itself is a deterrent, and I've had families have to call the EMS 2-3 times and then the kids find like, OK.
I'm grounded.
I got it because.
No one on Earth changes their behavior until the pain of continuing.
The their their current pattern of behavior outweighs their perceived benefit.
Right. And you almost don't have to worry about their underlying illness to understand. There's always a behavioral.
Level of this as well.
So yes, this this the therapist got got it like it's not a punishment that they can go see the ER, but if they're saying I'm going to kill myself if you don't let me see my boyfriend. Well, then the the appropriate response to that is not to give.
Him the car keys. It's to say, well, we have to have you seen at the emergency room because what if your boyfriend can't see you one night if you're suicidal? Whenever your boyfriend is not available?
Well, that's really serious and we need to get your help, right?
The problem is most parents.
They need a lot of coaching. The parents for this because they'll say spiteful things like, oh, see, it wasn't really an issue anyway.
No, no, no, no. You have to let the kids sit with the consequences if that makes sense.
And I really believe.
Counselors because in therapist, you guys are such lovely people. But we tend to error on the side of trying to bond too much with the teens or being too validating every once in a while. You have to say honey.
I.
I adore you, and you're gonna wind up in penitentiary in a year. 'cause you 17 years old and the juvenile system is almost done for you. And we gotta help you. Like we have a chance right now. You could go to residential and make up all your school.

Work from two quarters that you've missed, like the loving authority has to come in to really, really help.
OK.
This is the last category.
It's one the the person kind of to this to the the person that asked the question.
It's when the person is most severely affected by.
Psychiatric issues and substance use. They're acting out.
They have the whole household up in arms. They may have had a couple placements already.
And basically you have to have absolute empathy, non judgmental stance. You do need supervision to create a treatment plan.
Usually I still even though I'm the boss at my own office, I go next door, ask my colleagues, hey, I'm thinking of doing this.
What do you think?
Because kids that are this resistant and have this much going on.
Oh, it's.
It's brutal.
It is brutal.
It you really need some help to decide what to do.
Often family members need their own psychiatric help.
I'm dealing with a case right now that, thank goodness Mom and Dad, listen to me.
They're both in their own treatment because interestingly enough, there was a undiscussed trauma.
They have an adopted son who's acting out like crazy.
Sweetheart, I love them.
I love them, but he's a big fu kid. But such a sweetheart.
I know that sounds like an oxymoron, but.
I think you know what I mean.
And it turns out that before he was adopted, the parents had a biological son who died at birth, and it was like an emergency thing where the mom almost died as well.
And they had had so much trauma from that that they indulged this kid from day one. And once the family secret came out and the son was like, oh, no wonder you let me push you all over the place.
That's what the kid said in that family therapy session.
Oh, no wonder. 'cause my brother died. OK, I didn't know that.

Now the family still has a long way to go, but thank God mother and father are in their own therapy now. That makes a huge difference.
And I'm not saying that they always need residential care, but if they're, if they're compulsively cutting, if they, if they're using the dabs daily and can't stop if they're using cocaine daily, cocaine is back. Now the opiates were in.
You know how there's usually 1015 year patterns of opiates versus stimulants?
Right now we're in a stimulant phase, and sometimes the kids get really sick from that and kind of have to go away or not kind of have to go away for a while.
And back to remember, make your decisions based on the proximal in the district distal risk factors.
The only problem is we don't have any control over the proximal things, right?
We don't have control over up. The boyfriend breaks up with them or the girlfriend breaks up with them or oh, they're humiliated online or something like that.
But again, if you know if you've done your homework kind of easy, what I'm explaining to you today and you know the kid has severe, you know, proximal risk factors, you can be right on top of saying to caregivers, foster parents, parents, you call me as soon as.
There's a crisis.
Please call me because we know your child is high risk if they have, you know something, you know something happened in the present moment that's really overwhelming to them.
And as effective clinicians, we have to provide structure, education and hope and young people do respond to science.
It's. I teach some of this brain stuff to teenagers. I told you they kind of eat it up.
They love it.
They're very curious about their bodies and they're curious about hormones and all kinds of stuff.
And I think it's all about the science.
But you know what? We have to teach science, not bias, right?
So sometimes we could be surprised that the science goes against our bias on the right or the left.
I'll tell you. And to me, as I said before, I'm a science girl.
But I'm weird.
I'm a Jesus girl and I'm a science girl.
Is that weird?

I don't know.
Somehow I've been able to do both. That was a little that was a little bratty, sorry.
And of course, we need to do what we do for some spiritual reasons.
What you do is a sacred vocation, guys.
You don't have to believe in a God or a higher power to know that what you do has meaning beyond the 50 minute you know session.
You have to take care of yourselves. Oh my goodness.
Especially today, with the number of patients that you may have to see the all the electronic medical records.
Requests all this stuff. You've really gotta get good peer support.
You have to have your clinical supervision, your own therapy, and you've got to to have fun and take care of yourself and find a little tribe of people. I call my tribe.
Oops, sorry. I call my tribe my holy **** ****. I have 5 or 6 therapists that I can just call at any time to just like I'm going crazy and we all help each other out.
And some of them work here, but some of them are just from different jobs that I've had and that I've hold on.
2:00 you got to have a bit of a sense of humor.
Otherwise, the the resistant teenagers are just going to do you and you know, and everyone's used to humor with a teenager.
My mentor, Doctor Kansian, really believed in the the carefully curated use of charisma and humor with a client.
You don't do it to dramatize yourself.
You don't do it to make yourself funny. You use it to try to like, get get that connection.
Going and get and the good thing about humor is it disarms people and for the moment you're both laughing.
You're equal.
You're sharing something.
It's a way of showing that we're safe, right?
And read some data on compassion strain because and post traumatic growth like we've all been in states of compassion, strain and post traumatic.
Cultural I don't know. With COVID and everything, we've all been through a lot.
All of us, and we, we deserve to spend some time thinking about not how we can be more productive, but how we can be well and do this work.
And I wanna say the the hardest thing about setting boundaries as a therapist is

setting them with ourselves. First deciding I need more time to rest.
Like yesterday was a snow storm here and normally I would have just been zooming all day, but I had eight clients lined up.
I picked the four that I wanted to see and I took a nap.
I made some soup 'cause I really needed to rest.
I wasn't feeling great, but the what I mean by first you have to decide what the boundary is. Then you'll be able to communicate it to your supervisors.
To the clients, to the families.
Et cetera. And I understand that you know the reality of working in a hospital or an agency is there's certain things that we just have to do right.
We just have to do them.
That's their non negotiable, but there are other things that maybe we take upon ourselves.
I used to joke around that I needed to join volunteers anonymous and I used to have to sit on my hands and staff meetings because a really interesting project would come up and I'd be like, oh, I want to be part of that project. Well, self-care means saying.
No, sometimes right.
Self-care means saying to a boss. Listen, I know I've always run the holiday party.
I used to run the holiday party.
For a hospital like I know I've done it every year for 10 years. Can't do it this year, but I'm letting you know in July.
Oh, come on.
No, I'm letting you know.
No matter what, I'm not running the holiday party.
I can't do it this year.
I won't do it.
I used to start every staff meeting.
Hey, I I hear no one else has been nominated yet to run the holiday party till my boss was finally ready to hear.
So we can use humor even too with our supervisors to to take care of ourselves.
'cause you ain't no good to anybody else.
If you're not taking care of yourself.
And back to agape.
I hope you guys kind of like that idea now. I think you are already doing it.

You're already doing it.
And again, what you do is a vocation.
I have just a little little sayings from all over the map here.
You know, because we we, you know, all of the world's great faith traditions have so much in common, much more in common than they have not in common.
And this too shall pass.
And if you think you're too small to make a difference, the Dalai Lama says, try sleeping with a mosquito.
You are making a difference with your your resistant adolescent clients.
They they may not be showing it yet, but if you just keep showing up and trying to do your best and trying to use your best knowledge of the situation, you are making a difference.
And I just want to say thank you so much for everything that you do for the young people and the families that you care for.
And now we have time for Q&A.

Andrews, Alexis, M LSCSW, LCSW 1:06:10
Thank you so much, Liz.

L

Liz 1:06:11
Hello. Oh, there we go.

Andrews, Alexis, M LSCSW, LCSW 1:06:19
You don't see any questions yet, but does anyone on have any questions?

L

Liz 1:06:38
Or comments or or ideas I'm sure.
I'm sure many of you have ideas that could even extrapolate on what I'm saying.
And like I said, we, oh, someone raised their hand.
Oh God.

Ramphal, Areli 1:06:59
Yeah, it's aureli. Hi.
And perhaps you mentioned this.

I received a phone call, so I got a little sidetracked.
Do you guys also offer or do you have any support for parent coaching?

Liz 1:07:15
I think that that that's a great question and I I'll just direct that to Kendra.
What we do is we have the ability for all of our.
Our regional representatives, our clinicians, right.
Kendra you're a clinician.
So you do.
Parent coaching when someone's really considering residential, right?
Is that what you're saying?

Kendra Eierman 1:07:39
Yeah. So I guess in terms of like parent coaching, like in my role, really if parents are considering residential or higher level of care, they can reach out to me and I can always take them through like the different levels of care that I know in the area.
For that, Newport provides in terms of truly like one-on-one coaching when clients are in Newport's residential treatment program, we do family therapy weekly.
That's required in our programs.

Liz 1:08:07
Yes.

Kendra Eierman 1:08:07
So they're gonna get that.
At while they're with us, but the other thing? Yeah. The other thing is we have parent support groups, so they're able to join those, you know, forever, like even two years after client sleep Newport or from then on however long they wanna be a part of them. But.

Liz 1:08:09
Intense family coaching that way. Yeah, yeah.

Kendra Eierman 1:08:24
They're able to get a lot of coaching through those as well. Another service that I

often like refer out like if maybe a client isn't coming to Newport and is interested in parenting coaching.
There's a parent support group in my classes called.
Other parents like me, they're all done virtually.
It's out of a group based off of New York.
It's a mom that founded it while her son was going through different treatment programs.
So you could always look into them or share that service with parents.


Ramphal, Areli 1:08:55
Thank you.

KE **Kendra Eierman** 1:08:57
Welcome.

EB **Edmonds, Maureen, B** 1:09:01
I do have a question for lit, sorry.


Stallbaumer Rouyer, Jennifer, S 1:09:02
I just up.

L **Liz** 1:09:04
Sure.


Stallbaumer Rouyer, Jennifer, S 1:09:06
No, that's OK. I was.

EB **Edmonds, Maureen, B** 1:09:06
I don't know if.


Stallbaumer Rouyer, Jennifer, S 1:09:07
Yeah, that's fine.
Can I just say one thing, 'cause? I got to pop off Liz.
I really appreciate your use of the term of being curious detective and like not just with adolescents, but with other people as well.

All of our clients as social workers and as clinicians to approach with as a curious detective.
So thank you so much for sharing that language.

Liz 1:09:27
Oh, thank you.
Well, you get a lot more data that way, don't you?

Edmonds, Maureen, B 1:09:35
I was just gonna say so.
I am in a high school setting and and providing therapeutic support to young people and often I don't have access to parents and caregivers for whatever reason and so.

Liz 1:09:46
OK.

Edmonds, Maureen, B 1:09:50
Wondered your perspective on, you know, I do a lot of like radical acceptance work, you know, accepting what is right now and focusing on what we can control.

Liz 1:09:56
Yes.

Edmonds, Maureen, B 1:10:02
And I heard you speak to that a little bit.
I don't know if this is necessarily a question as much as just it's really hard.
Sometimes when we have parents that are disengaged and young.
There's so many factors outside of the young person's control.

Liz 1:10:17
Test so in one of my previous lifetimes I supervised a team of like 10 school based therapists and we were it was like a hospital setting like yours at our local hospital.
And you know the goals are different when you're doing school based care because you really can.
Do the kind of intense uncovering work, and I love that.

I love that you teach some radical acceptance.
I I you know, the other thing is it's kind of good old fashioned social work. You can teach them about all the resources that are available to them.
Outside the time you have with them and I still believe what you do is really valuable.
I mean working with the family doesn't always lead to to change, because sometimes families are intractable like they're not going to change. But then you get the sense like, OK, now, like, a lot of times, even in my private practice office, families will bring the child in and.
They're paying for care and they're not willing to change.
Then you come back to what you just said.
The radical acceptance and helping the child to find.
A community outside of.
You know their parents that can give them support.
Aunts, uncles, godparents, grandparents, mentors, music teachers.
You know, getting creative, helping them find other adults that can be there 'cause the the literature is pretty clear. If a young person has mentors, they if they have very dire family situation, but they have mentors, they do quite well, especially if they have one mentor that'll stick.
With them through the whole journey into adulthood.
So I I don't know if that helps, but you're.
In a tough position, because especially if you've been used to doing treatment outside a school setting, the the level of depth you can do really does go down.
I think I think it's tricky.

EB **Edmonds, Maureen, B** 1:12:01
Yeah. Thank you.
I struggle sometimes 'cause I feel like a young person.
You know, there's 1718. They have maybe a trauma history and.
They're they seem ready to really do some of that deeper trauma processing.

L **Liz** 1:12:16
Yes.

EB **Edmonds, Maureen, B** 1:12:16

And yet there are barriers to them accessing that level of therapy support, and my time is so limited here.

Liz 1:12:20
Yes, yes.

Edmonds, Maureen, B 1:12:24
So I wanna be able to provide that safe space, because clearly they're expressing to me that they're ready for that.
And also because I can't always provide that consistent, you know, care to them. It just makes me nervous.
Like how far into this do I go?

Liz 1:12:40
Yeah.
That's a. That's like Occam's razor.

Edmonds, Maureen, B 1:12:42
There's a lot of resource.

Liz 1:12:43
That's a hard question.
I appreciate that you're asking that.

Edmonds, Maureen, B 1:12:45
Yeah.

Liz 1:12:46
It's that's tough, yeah.

Edmonds, Maureen, B 1:12:49
Yeah. Thank you.

Liz 1:12:51
Really tough.

Well, this was delightful.
I I'm glad that it was helpful to some of you.
I'm surprised there weren't more objections, but that's good. 'cause. You know, I'm.
I'm known to be a little bit mouthy and difficult.
Depends on where you stand, but you know also.
Can I speak to some of the young people here?
Hard times come and hard times go.
OK, remember I told you. I walked into this field when we were denying AIDS.
All right.
And look at where we are with that and I'm reading it.
Fabulous book right now about the fact that the history of protest movements is never reported and in history it's just the outcome of the movements, right.
So if there's something that you believe in and you're feeling, you know, upset right now or stressed or you don't know where things are going, find a way.
You know, what do we say?
Take your broken heart.
Turn it into art.
Find something that you can do to make a difference, because.
I've been up and I've been down and I've been sadly protesting some of the stuff since.
Same stuff since 1981, but that's neither here nor there.
But, but things have been flow right and funding ebbs and flows and we've been here before and.
It always turns around and and you know what?
Often even a stop clock is right twice a day.
Sometimes things will happen that will surprise you.
That'll benefit in the long run, our society.
So just don't with COVID and everything else.
I'm just so worried about the younger generation getting too fried instead of realizing like, no, no, no, no, you have.
You have autonomy.
You have the ability to to make a difference in the world. You really, truly do.
And don't let anybody tell you that that you don't is they're lying, basically.
And you know what?
I still think lying is wrong.

I know I'm old school with that, but I just don't think.
I don't think it's a good look to lie.
You know, it's just me.
I see nobody's laughing, but OK.
That was a joke, but.
All right guys.
Well, this was delightful and I'm so glad that there's this partnership with Newport Healthcare and your your work is very, very valuable to us. And I know that Kendra is available to any of you for follow up. We'll get the slides out. I think. Didn't you say, Alex?
With the with the oh, someone's laughing out there. Thank you.
I can.
I can only see a couple faces so.
I'm gonna. You're gonna send the the slides out with the evals, right where the.

Andrews, Alexis, M LSCSW, LCSW 1:15:33
Yes, yes.

L

Liz 1:15:33
The knowledge test OK sounds great.
Unless there's any other questions, what do you think, Kendra?
Wait a little longer, I think.

Andrews, Alexis, M LSCSW, LCSW stopped transcription