

Resistant Behavior in Treatment

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The agency I work for is called Cayuga Centers, we are an agency managed by ORR (Office of Refugee Resettlement). The mission of this agency is to work with children and their families who migrate to the United States through the borders. Cayuga Centers proposed placing immigrant children in foster home settings where they could be in a home environment rather than in congregate facilities. The agency received funding through the Office of Refugee Resettlement to offer 900 short-term Treatment Foster Care beds for these children in New York City and its boroughs. These children are placed in Spanish-speaking foster homes as they await reunification with a family member or sponsor or return to the country of origin. We also provide long-term foster care for unaccompanied youth who do not have sponsors but can't be deported because their lives may be in danger in their home country, providing a safe, stable environment and a therapy-rich program as they work out their legal status (Cayuga Centers, 2016).

I work with the Office of Refugee Resettlement (ORR) and the major obligation of this agency has been to work with new populations coming into the United States. By working with these populations, ORR ensures that they not only exploit their full potential while in the country but that they are also connected to essential resources that will aid them with the social integration process. Since ORR is guided by the US' policies, this agency admits refugees that have been certified as meeting certain special humanitarian concerns, for example those experiencing civil wars, poverty or threats of war (ORR, n.d.).

Moreover, through this agency, the US has been globally perceived as a safe haven, a value that she prides in. Through the country's repatriation program, ORR extends loan facilities to eligible repatriated persons that have been referred by the US Department of State (ORR, n.d.). This agency has also been working with unaccompanied alien children. ORR not only assumes custody of these children but also connects them to appropriate social welfare services,

which includes care and placement. When these children are taken into custody, ORR ensures that they are placed in environments that are least restrictive thus preventing them from, being a danger to themselves and to the US community. Favorable settings also limits the danger of flight. It is essential to note that since every child that is in ORR's custody has had a unique journey and thus their situations and needs vary, this agency considers all this when undertaking clinical assessments, case management, release decisions and even placement (ORR, n.db).

At ORR, one of my roles is promoting the safety of unaccompanied children in foster homes. I also manage caseloads concerning placements and releases. Moreover, I coordinate unaccompanied children's intake process, manage the reunification process and thereafter update this information in the unaccompanied children's portal. At any particular time, I handle approximately 8 to 14 cases of unaccompanied children. Within 48 hours of these children's arrival, I ensure that their initial medical evaluations have been planned and confirmed. The medical evaluations are usually conducted by a family nurse practitioner.

Additionally, I also work closely with the clinician in ensuring that these children's admission and genograms have been completed in three days upon arrival. Working with the clinician, I ensure that within seven days of arrival, the unaccompanied children's psychosocial summaries and individualized service plans have been completed. It is also my duty to ensure that their identifying information and documents provided by their relatives are uploaded in their electronic file, UAC portal, and hard file upon discharge.

Moreover, working closely with the clinician and GDIT case coordinator, I review their progress, raise concerns, and make recommendations on children's release. I also manage the process of discharging and releasing unaccompanied children to sponsors. I conduct home visits to foster parents to monitor minor's safety while they are in placement. I also carry out other

duties as tasked by my immediate supervisor as well as the Chief Executive Officer (CEO). In all these undertakings, I always ensure that I work with my clients and colleagues in a respectful manner. I also acknowledge my clients' diversity and seek to promote social justice and the dignity and worth of every individual (National Association of Social Workers, 2017).

Case? →
Demographics: The minor was referred to the psychiatrist of the agency by the learning center based on the teacher's, and clinician's observations during class sessions, minor needed a referral for a psychiatric evaluation. Looking at the client's psychosocial history, he lacks empathy and it's not able to identify his emotions. It was not clear how the minor and the mother had been separated; however, his behavior could be connected to her absence while she was being prostituted by a pimp. The minor had displayed aggressive behaviors, both at the center and within the foster home which are documented in its significant incident report in his file. The client is eight years old and travelled from Honduras to the US. The minor had a guide, and this was how he had made it to the US. In Honduras, this minor's primary caretaker was the grandmother. As per the grandmother's report, after my agency reached out to her, the minor was molested by the maternal uncle. Since a clinical assessment was not conducted, this could not be verified. The minor was also exposed to marijuana by the maternal uncle and had even abused it.

The minor's mother also admitted to having been prostituted by a pimp and that she had also abused alcohol when she was pregnant with this minor. Assessments also indicated that the minor was defiant as he had difficulties adhering to laid down instructions and rules. For instance, he had difficulty with rules of engagement in the foster home. The minor was also aggressive as he frequently struck out at other minors and even the staff at the learning center. When the aggressive behavior set in, the staff often had a hard time calming down the minor. The minor also had a habit of screaming at the staff.

The other presenting problem that this client had was that he was experiencing cognitive delays. For instance, this minor has problems identifying and reciting the seven days of the week. The other problem, which led to the aggressive behavior, was that he liked being in control. He also liked the attention that he was receiving as a result of his behavior, which gave him a sense of control. Given the client's presenting problem, the initial diagnosis was ADHD. However, after undergoing sessions and interventions within the emergency room, he was diagnosed with fetal alcohol syndrome. This diagnosis was influenced not only by his behavioral issues, but also by the client's abnormal facial features (a small head), below average height and the biological mother's admission to having abused alcohol when pregnant with the minor.

In a bid to facilitate a harmonious reunion, the client had been prompted to talk to the biological mother, but after initial refusal, he agreed. The call had gone well, but after ending it, the minor threw tantrums after this call a psychiatric evaluation had been planned. There was no prior history of attempts to obtain help because of everything the minor had experienced the agency had made attempts to seek assistance for the minor. For this minor, the risk factors included child abuse and parental substance abuse and neglect.

Although clients' resistance to therapy is a major challenge as it impedes treatment, it also provides the therapist with a substantial amount of information about the client in question (Newman, 1994). With the collected information about a client, the therapist can be able to tune into their clients thus improving the therapeutic relationship, identifying existing impediments to change and developing interventions that will suit their client needs. Working with this minor, it is evident that his resistance was being influenced by culture, gender, ethnicity and identity.

In my work with this client, resistance is manifested in his behavior. During the first session, one of my goals was to build rapport with my client to ease the process of engagement.

in what ways did he demonstrate resistance?

in what way?

Part of this went well, but when we delved into the presenting problem, the client became fidgety and maintained his silence. He thereafter started singing. I changed my tact and enquired of what this song reminded him of, but this did not help. He even yelled at me since he could not remember part of the words. We had made progress; initially, and therefore this was a little frustrating for me. At some point, my client even pointed out that he had been the man of the house when he was living with his grandmother and thus did not need my help. He even stated that he had set out in search of being reunited with his mother as he felt that he was man enough to face her.

Although the common goal that we had was to work through my client's aggression, he was of the observation that aggression was essential for his manhood. At times, I felt stuck with this client since the available information was not sufficient to work with and the client was not open to talking. In some instances, I was stuck because professional code of ethics requires that I protect my client's confidentiality, but there were instances when this was in conflict since I had to report that which my client had spoken in confidence. The reason why I did this it's because between the clinician and myself was determine that some of his past history of trauma was necessary to be disclosed in other for all departments understand how to work with this minor. All the departments involved in the minor's daily activities should know a bit of his history in order to understand him, and better served.

For this client, what was getting in the way was his belief that men were not expected to ask for assistance as this belittled their manhood. He had been brought up to believe that men that asked for help to deal with the problems that they were facing were weak. In this case, my client was torn between what his culture held as true manhood and his desire to participate in the therapy process. By being male, my client felt that he did not have to be assisted. He felt that

working through his aggressive behavior with me was weakening him and thus those of his culture would view him as not being a true man. Oppression played into my client's resistance since he felt that the presenting problems that he had were his to handle and thus by being helped, he was being looked down upon. This made him feel weak and thus vulnerable to oppressive sociocultural forces.

For my client, one of the ego defenses that were visible ^{identification with the aggressor} was acting out, as evidenced by his yelling or aggressive behavior. While this was an immature mechanism, my client used it as a way of reducing or coping with distress. The other ego defense that this minor exploited during therapy was blocking. My client exercised this, for example through singing, as this was aimed at keeping me out. For this client, he had found these ego defenses effective as coping strategies. As part of the presenting problems, acting out and blocking enabled this client to feel in control while at the same time drawing attention to himself. Despland, Roten, Despars, Stigler and Perry (2001) were of the view that if a therapist's interventions were developed in a way that they addressed the ego defenses, this was essential in the development of therapist-client alliances.

While working with the minor, transference played an essential role in the development of the therapeutic alliance. This enabled therapy sessions to proceed after the initial resistance. It was also through the therapeutic alliance that it became easier to communicate and thus relate with my client. To address instances of countertransference, the therapist set therapist-client boundaries as this would ensure that the existing relationship was well understood. Even though I have gained some progress with this client, in some instances transference was present. The client could see me as a female, around his mother age, and trying to make a connection were at times redirection was present, and he didn't like that. The client in numerous opportunities

repeated that myself could not tell him what to do, what was not right because he is a man, and knows very well what to do.

To address my client's resistance, I will explore the genogram exercise. Through this exercise, I will seek to understand how the concept of helping and the helping behavior is experienced. Equipped with this exercise, it will become apparent how the helping behavior in this family was influencing my client's resistant behavior. However, the experience that the minor had at the hands of his maternal uncle will also be taken into consideration since my client's molestation and exposure to marijuana had negatively impacted him.

Wanda -

you write well + clearly and provide important psychosocial data about your client + his presenting problem. That said, a minimum of five references from our class syllabus is required for this paper. Let's discuss what's needed for you to resubmit.

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