Keeping it Real: Overcoming Resistance in Adolescent Males Mandated into Treatment

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Abstract: Teenage boys who are mandated into mental health treatment through either probation or juvenile diversion are often reluctant to engage in treatment. These young men typically adhere to both rigid masculine gender norms and the code of the street, both of which discourage men to talk about their feelings or display any sign of vulnerability. However, if these young men fail to connect to supports they are at-risk for school dropout, incarceration and possibly significant injury or death. This article identifies barriers to engaging in treatment for systems-involved adolescent males as well as practical techniques for clinicians to help facilitate buy-in to treatment by reframing the treatment process for this population.

Keywords: Adolescent, males, treatment.

A 15 year-old boy comes into the office and sits slumped in the chair with a hood pulled up around his face. He has been mandated to therapy by his probation officer and it is clear that he does not want to be there. He responds to questions with monosyllabic answers or shrugs.

Our challenge as clinicians is to facilitate a shift or to reframe therapy so that a young man such as the one described above can come to view the clinician as trustworthy and to find therapy as worthwhile. How does this process occur? This article addresses this question through a review of the adolescent treatment literature and by drawing on examples from our clinical work with recalcitrant young men who are court-mandated to attend therapy.

Increasingly, adolescents are being mandated to mental health services through juvenile courts and diversion programs (Skowyra & Cocozza, 2007). The majority of these referrals are adolescent males with offenses ranging from truancy to assault to possession of drugs. Diversion or probation programs often seek to link young men with empirically supported treatments (e.g., cognitive behavioral therapy, multisystemic therapy) designed to address mental health problems that underlie delinquent behavior (Henggeler, Melton, & Smith, 1992; Kazdin & Weisz, 2003). If the treatment is effective it can prevent the young person from further involvement in the criminal justice system (Barrett, 2004; Kazdin, Whitley, & Marciano, 2006; Stephens & Repa, 1992).

There is extensive literature about specific treatments geared towards at-risk adolescent males, but there has been less focus on how to engage this population in a manner that ensures their "buy-in"—or participation— to the treatment process, or even how to ensure that they return to treatment after the first session. This article does not outline a novel treatment program for working with troubled adolescent males; instead it describes ways to reframe therapeutic techniques and concepts so that they are aligned with the needs of the target population, similar to what has been done in the fields of feminist therapy and multicultural counseling (Brown, 2004; Ridley, Mendoza, Kanitz, Angermeier, & Zenk, 1994). Using a case example to illustrate the complexity and challenges of making therapy relevant for young men, we will present our approach to working with a distinct population that would often rather take a punch than talk about feelings.

LITERATURE REVIEW

The struggle to connect with recalcitrant teens is certainly not a new challenge for clinicians. Adolescents often are brought unwillingly to therapists by their parents. However, boys who are court-mandated to treatment face specific obstacles to treatment engagement beyond those that one would expect from a teenager who is in treatment because of parental pressure alone. We will review briefly the literature that is useful in examining barriers to treatment engagement that are unique to boys who are mandated to therapy.

"WHY SHOULD I TRUST YOU?"

Many boys who have been mandated to treatment enter the clinician's office distrustful of adults (Kipinis, 2002). An unfortunate reality is that the histories of many of these boys involve exposure to trauma, abuse, or neglect (Digiuseppe, Linscott, & Jilton, 1996; Marans, 2000). The agents of these traumas are not infrequently parents or other caregivers. Those boys who were traumatized are likely to have been offended when lectured and reprimanded by judges, teachers or parole officers. By the time they enter into treatment they may look at the clinician as just another adult in the system who is going to tell them what they have been doing wrong and who could harm or deceive them.

Early child analysts such as Winnicott (1984) and Aichorn (1935) believed that antisocial youth in treatment

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often re-enact in the transference relationship with the therapist their anger and rage at the adults in their lives who have failed them. These boys feel the need to test whether, when pushed, the clinician will either retaliate or reject them. The testing commonly takes the form of verbal aggression. The challenge for the clinician is how to weather this initial barrage of hostility. If the clinician perseveres despite this resisistance, the youth will discover that the therapist is a trustworthy figure.

Court mandated young men frequently worry about keeping their own matters private as well as those of their families and peers, a product of the "stop snitching" mandate of street culture. This belief can be a powerful deterrent to opening up to a clinician. The "stop snitching" slogan was popularized by the Boston rapper Tangg da Juice in 1999, developed from a street campaign to reduce cooperation with authorities in their investigation of illegal activities. (For a history and chilling account of this culture, see Kahn, 2007). The term now is more broadly defined as any type of cooperation with systems (O'Ryan, 2008). Any young person who is seen publicly conversing with a police officer, probation officer, school official or counselor could be accused of snitching. Consequently, adolescent males mandated to treatment frequently come to their first session shut-down and do not want talk for fear of being labeled a "rat" or "snitch" (Rosenfeld, 2003).

"I DON'T NEED THERAPY"

"I don't need therapy" is a refrain heard from many court-mandated boys in treatment clinics. To them, therapy is something for the weak or even worse for "psychos." Pollack (1998), writes about the "boys code" wherein boys are socialized from an early age to believe that they should be able to handle problems on their own, to never ask for help or reveal weakness. Addis and Mahalik (2003) argue that men's reluctance to seek help for mental health problems stems in large part from a concern that going to therapy is proof that they are not normal. Many young men who are required by the courts or diversion programs to participate in mental health treatment struggle with shame around what it means that they have to see a therapist. This shame and worry can be intensified if during a preliminary session a stranger asks them about their feelings as well as private matters such as trauma, sex, and drugs (Levant, 1997; Mahalik, Englar-Carlson, & Good, 2003).

THE CODE OF THE STREET

Several of the boys who are mandated into treatment not only adhere to the boys' code but also to the "code of the street." According to Anderson (2000) the code of the street dictates that men must always look tough and be ready to fight or they will be labeled "punks" and risk being taken advantage of by others. These young men rely on their reputations on the street to protect them against rivals who may try to assault or rob them. The "street credibility" of a young man could take a substantial hit if it was discovered that he enjoyed talking to someone about his feelings (Rosenfeld, 2003). Consequently, court-mandated boys may view avoiding therapy as necessary to protect their reputation on the street.

In *Code of the Street,* Anderson (2000) also writes about how traditional therapies fail to account for the context in which many youth who are mandated to treatment live. For example, the author talks about how youth in an anger management group scoffed and laughed at the notion that they should just walk away from fights. They found this advice unrealistic knowing that if they walked away from a fight on the streets they would be labeled as a punk and others would try to victimize them.

In order to help young men navigate this cultural bind, scholars such as Townsend (2000) and Soriano, Rivera, Williams, Daley, and Reznik (2004) have written about the importance for young men of color developing bicultural self-efficacy or competence—meaning that they learn to navigate two cultures, their culture of origin and the dominant culture, effectively without compromising their own cultural identity. For example, some African American students are accustomed to performing multiple tasks at once at home (e.g., talking, eating, playing), but to be successful at school they have to learn to focus on one activity at a time (Townsend, 2000). Similarly, the posturing behaviors that young men use to earn street credibility can get them in trouble when they are confronted by an authority figure at school.

ADAPTATIONS IN PSYCHOTHERAPY

Kiselica (2003) posits that therapy is often structured in a way that is counterintuitive to how boys are accustomed to interacting and advises how clinicians can make mental health more "male friendly." For example, it's rare to see two boys or men sitting across from one another in close proximity having a conversation with no other activity occurring such as watching TV or playing a video game. The way that the physical space is arranged in the session can facilitate young men warming to communication with clinicians. Even small changes to the room—such as setting the chairs up in a manner so that the clinician and patient are sitting at an angle rather than directly face-to-face—encourages teenage boys to feel like they are not "under the spotlight." Since boys are accustomed to talking during an activity, it also helpful to have objects such as stress balls or puzzle games available for use.

"Playing with your Cards Face Up."

Owen Renik (2006) uses the term "playing with your cards face up" to describe his efforts to break down barriers between adult patients and therapists. Similarly, clinicians who are upfront and transparent about their understanding of court-mandated boys' misgivings about therapy have a greater chance of connecting with the patient (Black and Rosenthal, 2005; Thompson, Bender, Lantry, & Flynn, 2007). Clinicians can make statements such as "I know you don't want to be here and don't know who I am or if you can trust me and I respect that" or "You don't have to talk about anything that makes you uncomfortable and I know that it may take some time for you to get to know me."

Rolling with Resistance

Even when playing with their cards face up clinicians can anticipate active resistance from the patient. Angry

declarations from these teenagers such as, "This is not going to help" or "It's a waste of time to come here" are not uncommon. Rather than provide direct counterpoints to negative beliefs about treatment it is recommended that clinicians "roll with resistance." Rolling with resistance is a technique that was popular30ized by Motivational Enhancement Therapy with substance abusers in an effort to circumvent their resistance to change their substance use behaviors (Miller & Rollnick, 2002). This technique can be straightforwardly applied to boys court-mandated to treatment in that their protestations are met with acceptance of the boy's perspective rather than resistance: "I might not be able to help but I am going to try" or "I don't believe that you *need* therapy either but since you have to be here we may as well work on ways that you can avoid further trouble with the law." Because these boys can be so accustomed to getting nowhere in arguments with authority figures they are often surprised when their resistance is met with passive acceptance.

Validating the Need to be Tough

Teen boys may also feel the need to brag about how tough they are as a defense against feelings of vulnerability that come with seeing a therapist. It is common to hear boys boast about how they could take anyone in a fight or that they fear no one including the police. The clinician can validate these proclamations by saying, "I hear you, you don't back down from anyone" or "Clearly, you are not someone to mess with." The clinician is demonstrating respect for the client's need to show his toughness and is not dismissive of his bravado, which can be adaptive for boys. The young man's posturing is more likely to diminish in subsequent sessions if he feels that the clinician respects him and does not pose a threat to his masculinity.

Dealing with Provocative Behavior

Court-mandated boys are often well-versed in antagonizing adults and may test clinicians with provocative language, insults or taunts. Clinicians can understandably struggle with the question of how much resistance should be tolerated as the teenager's defense against trusting a stranger and when the behavior becomes a personal attack. While one can expect bravado from this population, any direct threats against the clinician, especially of physical harm, should not be tolerated and are counterproductive to forming a therapeutic relationship. In these instances, the clinician can provide a firm limit such as, "I understand that you do not want to be here. I want to work with you and want to do what it takes to make treatment helpful and relevant to you. However, threats against me are not acceptable and so I think it is best that we stop at this point. I am willing to try again if you feel that you can agree to not make threats against me."

SETTING THE FRAME FOR THERAPY

We suggest that the clinician avoid using terms like therapy or counseling when addressing these teenagers so as not to arouse feelings of shame. Instead, the clinician can explain that the meetings you have together will focus on practical goals such as getting into less trouble in school or complying with probation. A therapy session can become much more appealing if framed as an alternative to lock-up. Indeed, for many of these young men complying with therapy means a discharge from probation or diversion. If the courts require a certain number of sessions, that timeframe can be presented to the client as a trial period after which the two of you can evaluate whether the work has been helpful. "The court requires that you come for at least six sessions. At the end of six weeks, let's take a look together at when we have done. If it is helpful we can go on and if not, we can stop." This kind of message gives the young person a sense of agency and can relieve anxiety about treatment being a never-ending process.

"Warm-Up."

After the clinician explains and discusses treatment goals, a warm-up by the clinician is recommended, for example, asking the teenager about his interests. This helps the youth acclimate to the back-and-forth verbal exchanges of treatment before revealing deeply personal or potentially threatening material. Boys are usually more comfortable talking about activities or interests (e.g., video games, music, athletics, computer programming, etc.) than they are disclosing personal details of their lives. Accordingly, the clinician should not move too quickly to ask about the teenager's emotions or feelings. Boys have a tendency to convey their feelings in a physical manner and it is not uncommon to see young men clench their fists, fidget, or sink into their chair when a clinician starts to ask about anger, pain, or sadness in their life. By staying attuned to these physical cues the clinician can get a sense of when it is better to back off and steer the conversation to less personal or intrusive subject matter.

In order to enhance the possibility of establishing a dialogue in early sessions it is recommended that the clinician ask very specific questions and use closed-ended questions to begin. Young men who are uncomfortable in therapy may respond to open-ended questions with frequent shoulder shrugs of "I don't know." For example, if you ask "What do you like to do for fun?" you will probably not get a detailed response. However, if you ask a specific question like, "Can you name your top 3 bands?" or "What video game are you playing the most this week?" you will more likely get information and keep the conversation flowing.

An example that highlights the importance of this warming up process comes from Trevor, a 17 year old, who was mandated to therapy multiple times as a youth. He said that in previous encounters with therapists his guardian told the therapist in their first session about Trevor's abuse history. Trevor said he refused to talk with any person who knew within 15 minutes of meeting him the most painful details of his life. As clinicians, we may make the tacit assumption that we are given privileged access to information without earning these patients' trust. We may inadvertently alienate these wary teenagers if they experience these questions as an invasion of their privacy.

Using Humor

Bringing humor into the session is another way to "break the ice" and normalize the process of therapy (Florsheim, Shotorbani, Guest-Warnick, Barratt, & Hwang, 2000; Mannes, Roehlkepartain, & Benson, 2005). After all, boys

are accustomed to socializing by teasing and humor (Pollack, 1998; Kiselica, 2003). Tim, a 15 year old referred by his school for swearing at teachers, was resistant to coming to weekly sessions. The therapist found that the best way to foster a connection with Tim was to use humor and to engage his competitive nature by saying, "Do you mean to tell me that you cannot come down to the clinic for one 45 minute meeting once a week, is that really more than you can handle?" or, "Are you saying that one teacher has so much power of you that any little thing she says causes you to lose it?"

Channeling Competitive Behavior

Boys' competitive nature can be funneled into creative pursuits, such as music or athletics. The foundation of hip-hop music is based on "battle-rapping" as a means to settle feuds in a non-violent manner (Chang, 2005). Many young men use hip-hop as a means to develop a sense of competency and express frustration and anger in a way that promotes building a narrative - a key element of resiliency (Hauser, Golden, & Allen, 2006). One adolescent's lyrics were particularly compelling. His song, "Stop, Look and Listen," started by describing how he was born to a teenage mother and felt desolate but then came to understand that "knowledge would send him to college." This rap song became part of an introductory video for advising program in his high school and channeled his sense of marginalization into engaging other adolescents to be invested in school (Rappaport, 2001).

For many teens the athletic fields or a martial arts studio offers a release for angry feelings while at the same time providing discipline and a sense of accomplishment (Stevenson, 2003). For those young men who are not artistically or athletically inclined, competencies can be encouraged in areas such as academics, computer programming, web design, and automotive repair. Regardless of the specific activity, the clinician can serve as a catalyst to help young men invest their time and energy in prosocial activities which ideally will lead to reduced involvement in delinquent activities (Benson & Scales, 2004). The clinician can also advocate with the school to adjust a student's schedule so that he can participate in classes or activities that are aligned with his talents. Concurrently, the teenager begins to view therapy as not just a place where he talks about his problems, but also an arena where he can explore and foster talents and interests.

Omari Walker, a former star football player at Boston College and now a program director for a youth development organization, is a testament to how a helping adult can use humor and an "outside the box" approach to engage disaffected young men (MetroWest Community Health Care Foundation, 2002). Walker was frequently suspended from school as a teen for fighting and refused help from teachers. One day his high school teacher challenged him to an arm wrestling contest with the condition that if the teacher won, Walker would stay after school for extra help. This was the turning point that helped him to feel connected to a trusted adult and subsequently to get on track to attend college.

NAVIGATING THE GREY AREAS OF CONFIDENTIALITY

Most clinicians are trained to review carefully with the adolescent and his parents the limits of confidentiality in sessions. Imminent threats to self or others are obvious reasons to break confidentiality in any therapeutic setting, but in the work with court-mandated youth. there are "grey" areas outside of these relatively clear-cut situations that may require the therapist to share information with others. This complicates the therapeutic alliance. One of the dangers inherent in trusting a therapist for court-mandated boys is that the therapist mightdisclose information that could get them in more trouble. As a result, the youth may feel the need to censor important conflicts or occurrences in his life. They have an understandable concern that anything they say in sessions could be used against them in court. The youngster is in the office because he has done something illegal, whether it is stealing, fighting, selling drugs, using drugs, or truancy from school. If the courts, probation, school or his parents find out about further infractions, the consequences could be expulsion or incarceration.

Moreover, these teenagers often associate with other youth who are engaged in illegal and/or dangerous behavior. Therefore, the clinician can hear about drug deals, gang behavior, fights, and criminal activity, placing the therapist in the precarious position of trying to support autonomy and help the youngster with decision-making, but at the same time needing to protect the safety of the adolescent and others. At the outset of treatment the clinician should talk in detail about what is comfortable and appropriate to keep confidential and what the clinician feels may pose a safety risk and compromise confidentiality.

For example, probation or the court will typically want to know if the young person is attending. Often, it is part of the probation or diversion contract that the young person regularly attend therapy; more than one or two missed sessions will be considered a violation of the contract. Consequently, it is important that the teenager understands that the clinician will be informing the referring party of his attendance. At the same time there must be some assurance of confidentiality. If the court-mandated adolescent believes that anything he discusses in session will be reported back to the authorities, he will have little investment in treatment. The clinician can say, "the specifics of what you say in this room stays in this room unless you are talking about hurting yourself or someone else or doing something that puts you in immediate danger. In those cases an adult needs to know and it is my duty to tell an adult to make sure you get the help you need. The only thing I will be reporting to the court is whether or not you are coming to session and whether or not I feel our work together is helpful."

In one instance, a gang-involved student said that when he left the office he would either be killed or he would harm someone else. He was vague about the details and there was not enough information to inform police of a direct threat. However, he was sharing enough of his sense of danger that the clinician felt that she needed to take steps to remove him from his environment, where he could think through his options safely. The therapist talked about how they needed to

slow things down and that being killed or killing was an irreversible decision. A hospitalization was presented as a way to get him out of danger long enough for him to plan his next move and to consult with someone who had experience about exiting gangs. She discussed how he was in a potentially deadly standoff and that he was brave to ask for help because the stakes were so high. The therapist and patient also explored together whether his parents were aware of how much danger he was in and that it might be better for them to find out while he was in the hospital, as he didn't want them to panic. With his cooperation, she initiated hospitalization and informed his parents of his concern about being killed or killing someone else. This intervention afforded him adequate time to negotiate an exit from the gang that did not involve a violent confrontation.

In another situation, a student talked about an imminent fight planned near school because he had "pissed off a drug dealer because he owed him money." In this case, the clinician limited her intervention to exploring the pros and cons of having the fight so close to school grounds, hoping that the student would use this information to make a wise decision. The drug dealer had approached him in the school hallway when other kids were around and berated him. His only alternative, he felt, was to fight in order to show him that he and his friends were not intimidated. The therapist examined how the benefit of fighting would be to establish who was dominant but the down side was that drug dealer and his friends may come by his home and hurt his sister. They wondered together if there was a way to smooth things over without conceding his sense of honor. There was a risk involved in this approach, as there was no promise that this student would avoid the conflict even if he were exploring alternative steps.

Of course, these kinds of agonizing instances where adolescents reveal actions that fall into the grey area of confidentiality are not unique to patients involved with probation. The prediction of future violence is notoriously difficult. Many of these adolescents do have histories of violent behavior, and the knowledge that past violence predicts future violence can heighten the clinician's sense of foreboding when hearing of the potential for high risk behavior (Rappaport & Thomas, 2004). Sharing the information with other adults allows for some sharing of responsibility for helping to contain the teenager's behavior. It can be useful for the therapist to delineate the process of deciding when to inform other adults and to share responsibility. In addition to providing important feedback, this sharing can serve to illustrate how adults try to make responsible choices, something that these boys may not have had the opportunity to experience or witness.

PROBLEM-SOLVING

If clinicians can help young men to problem-solve the situations that could result in a violation of probation then patients may perceive therapy as being worthwhile. For example, one condition of probation or diversion usually forbids the client from associating with peers who are also involved in the legal system. The literature highlights the danger of the contagion factor with youth violence (Dodge, Dishion, & Lansford, 2006). However, for many young men their peer group is their main source of social support and it is unrealistic to expect them to walk away from life-long friends. Instead, the clinician can suggest that the client impress on his friends the serious consequences he faces if he is caught engaging in delinquent behavior. Often, peers will understand that when one of their own is on probation he should be given a warning when there is increased risk of something illegal occurring (e.g., a fight, receiving stolen property, etc.) so that he can leave before trouble occurs.

Clinicians can also help young men recognize that talking back to teachers or police officers in an effort to appear tough is likely to have negative consequences (e.g., suspension, violation of probation) that are disproportionate to any peer credibility they may earn. One young man, Sam, reported in session that when he was tempted to tell a teacher off, he thought about the fact that school was ending soon, while a confrontation could cost him his freedom. Sam didn't want to give the teacher the satisfaction of sending him to lock-up because he could not keep his cool when confronted. Sam used this self-message as a way to calm himself before he acted in a way that he would later regret.

The patient should ideally identify the clinician as a person he can confide in about the pressures to fight, deal drugs or violate curfew to attend a party. The clinician can help the teen act less impulsively and assist him in making decisions that will keep him in the community and out of lock-up (Greene, 1998). By recognizing that the patient is not likely to avoid all possible risky behaviors by staying indoors all of the time, the clinician's primary focus can be helping the patient avoid behaviors that are likely to lead to lock-up (e.g., fighting, stealing, dealing drugs). Following is a case example that illustrates how the above techniques can be weaved into the process of therapy to facilitate treatment engagement with a court-mandated young man.

CASE EXAMPLE

Denny is a 16-year-old Latino male referred to one of us (JB) for treatment by his probation officer. He was on probation for an assault and battery charge stemming from a fight with a cross-town rival. Denny associated with a "delinquent" peer group, and relied on few adults in his life. He lived in a housing project with his mother and two younger siblings and had no contact with his biological father. Denny was a sophomore in a public high school and receiving poor grades due to truancy and lack of effort in class. Denny's probation officer was frustrated with his noncompliance and threatened to lock him up at his next court date.

Denny was resistant to come to regular appointments but he knew that it was a requirement of his probation and he was motivated to stay out of lock-up. His probation officer agreed that if Denny attended regular counseling sessions she would allow him to remain in the community as long as he did not commit another violation. JB showed Denny the letter from the probation officer detailing the terms of the agreement and said, "I know it may seem like I am just another white guy in the system trying to tell you what to do, but I promise I will do my best to understand what you are up against and work with you to figure out realistic ways that we can keep you safe and out of court. You can meet with

me for 45 minutes every week and we can try to figure out ways that work for you to keep you out of lock-up, or you can try your luck in court." Denny agreed to the deal and began to show up on time for sessions and participate actively as to him it was a means to an end of staying out of court and possibly jail.

As Denny began to open up, he revealed that he was an avid hip-hop fan, liked to play basketball with friends and had a budding interest in cars. He often had his iPod with him when he came to sessions and allowed the therapist to scroll through his music library and introduced him to his favorite artists. JB asked Denny about the places he hung out the most with his friends and asked him to describe where they were in relation to sections of the city with which he was familiar. (It is often helpful to have boys "teach" about their neighborhoods and interests as it puts them in the driver's seat and often eases them into more comfortably talking about themselves). As the work together progressed, JB learned that Denny's father died of a drug overdose when Denny was young and his mother was hospitalized for a suicide attempt because of depression. Denny was fiercely loyal to his cousins who lived close to him, and while they were not in a formal gang they were associated with and seen by other youth as representing a neighborhood that was frequently in conflict with other neighborhoods in the city. In fact, the fight that led to Denny's probation was part of a long-standing "beef" between his friends and a group of peers from another neighborhood. While Denny's probation officer forbade him to associate with peers who were also court-involved, it was evident that Denny would rather be locked up than stop hanging out with his friends. They "had his back" (would look out for him and protect him) and were the only people in his life that he trusted and who gave him a sense of belonging.

While Denny would not completely separate himself from his friends and would never want to let them down, he did acknowledge that he would like to avoid lock-up. He recognized that if he got into one more fight the odds were good that it would cost him his freedom. Denny explained that he could not back down from a fight with a peer from a rival neighborhood and especially not one who had "dissed" him or one of his close friends. Denny said his last fight occurred after school with a boy who he heard had been "talking shit" about him. Denny said he dropped the boy with two punches and left quickly before any teachers or other adults knew what happened. He admitted that when he fights he can get angry very quickly, and once he is "heated" he has a difficult time walking away.

I talked to Denny about fighting and the associated risk of losing his freedom. Using cars as a metaphor, we talked about the importance of not going from "zero to sixty" in terms of anger because once his "engine is revving," he will not back down. Denny agreed that sometimes his friends could get him "hyped" and ready to fight. I asked Denny if he could let his friends know that he was one fight away from getting locked up so they could look out for him. Denny came back to the next session and said that his friends understood his predicament and would give him the heads up if they knew a fight was planned.

The progress Denny made was put to the test when he heard from his friends that a boy started "talking to" a girl that Denny was dating and that this boy was "badmouthing" him to the girl. Denny was on his way to our session when he called his cousin to inform him of what was happening. Denny told me that his cousin asked it if he "wanted to take care of it right now"—meaning that they would find the boy and beat him up. After commending Denny on coming to the appointment despite this crisis, I asked him what he was going to do about the situation. Denny said that he felt the boy had "put his name out there" by talking about him and that he had to "show him what's up." When asked if getting back at this boy was worth suspension and lock-up; Denny replied that it was not. He added that he did not think the boy was a real threat rather, he was just someone who liked to talk. Subsequently, Denny approached the boy and the two "squashed their beef," verbally allowing both boys to save face without resorting to violence.

A challenge in working with boys such as Denny is understanding that adolescence is often a dangerous time for boys and if they can get through these years safely the pressure not to back down begins to abate. While Denny was able to reduce the number of fights he participated in, there were times when he did fight, especially when it meant standing up for a friend. Knowing that he was not going to walk away from all potential "beefs," the therapist made the difficult decision to tolerate the risk that Denny could get hurt or incarcerated, or hurt someone else. Additionally, Denny continued to write rap music and enrolled in the auto-body repair program at his high school. As he began to understand that his interest in cars could earn him a living, he associated less with a delinquent peer group and devoted more time working on fixing cars.

DISCUSSION

Although the focus of this article is on youth who are court-mandated into treatment, it has relevance for therapy with many of the adolescents we see in other clinical settings. Many of these young men are like Denny: initially resistant to treatment efforts and involved in risky behavior. However, clinicians who persevere and strive to connect with this population can be rewarded with both small and large successes. This article is meant to be a starting point of a discussion around techniques and ideas for engaging adolescent boys in treatment. It is critical to formalize this approach to treatment and evaluate its effectiveness through systematic research. Examples of possible outcome indicators for systems-involved adolescent males in treatment include a reduction in disciplinary actions taken by the schools, the number of youth involved in fights, the number of probation violations and legal infractions, as well as increased involvement in pro-social activities, such as organized sports.

CONCLUSION

The young men we work with demand a sustained, concerted effort from us to help them identify systemic barriers to their success and build a sense of self-worth and dignity. We can help them realize that with hard work and dedication they can surmount the daunting challenges in

their lives. Setbacks will invariably occur and these teens may lose faith in the belief that their lives can be different. They may violate probation or diversion agreements, drop out of school, or get locked up. Nevertheless, it is crucial as clinicians to maintain our inspiration and hope and to keep inviting these young men into relevant treatment. We need to encourage the kind of reflective discourse that challenges teen boys to question the assumption that life is a series of chances or that "the game is fixed" for frustration and incarceration. They need to know that they matter and can contribute in profound ways. We want these young men to find a way to overcome their sorrow, whether it is losing a mother to an overdose or seeing a brother incarcerated. It is important that they find a way to persevere in a manner that allows them to take responsibility for their future and to avoid over-reliance on externalizing the blame for their current circumstances onto others. We have a duty to gain our their trust, encourage them to share their stories, and help to catalyze a change in a direction that allows them to find their way.

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