Engaging Marginalised Men in Enhancing Family Relationships: Synthesising Theories And Models Into Practice

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Abstract

"Me & My Family" is a twenty-four hour psycho-educational program designed to enhance the family relationships of marginalised men. It was developed as part of a larger project aimed at improving men's family relationships by increasing their ability and inclination to use conventional family relationship agencies. Its goal is to bridge the gap between marginalised men and family relationship services.

In the first phase of the project, five pilot programs were run in Victorian prisons. The aim of these pilot programs was to develop a program which family relationship services could use as a “man-friendly” gateway to their other services. At the same time, it was intended that a model would be developed for how to engage men in the processes of exploring the place of family relationships in their lives with a view to taking action to enhance the quality of these relationships and to increase the men’s stake in the important relationships in their lives.

An independent evaluation of four of the five pilot programs showed that 85% of participants achieved the personal goals they entered the program with, and 77% achieved at least one other unexpected gain from their participation in the program. Self-efficacy was strongly affected with mean reported confidence that relationships could be improved increasing from 6.3 to 8.9. In addition, participants reported to the evaluation team that the program was beneficial, should not be changed and should be provided more often in prisons.

This workshop will firstly outline the theories on which the "Me & My Family" program and its facilitation approach was based. Then the components of the program will be detailed. In the second half of the workshop, participants will have the opportunity to practise some of the interviewing and facilitation methods utilised in the program. Finally, participants will be invited to identify ways of incorporating what they have learned into their own programs or practices.
Introduction

In 2000, Jesuit Social Services Men & Family Relationships Program was funded by the Commonwealth Department of Family and Community Services to develop an innovative program for engaging marginalised men in the processes of accessing family relationships services. The project was conceived in 1998 while the author was employed by Caraniche Pty Ltd, a Victorian psychological services enterprise which, amongst other activities, is a major provider of offender rehabilitation programs to Victorian prisons. While there are many groups of men that can be described as “marginalised”, it seemed clear that with regard to both accessing family relationships services and maintaining viable and supportive family relationships, imprisoned men are at a great disadvantage.

Moreover, it was clear from other sources (Gee & Melvin, 1998) that these men represented the archetypal “difficult client” for family relationships service providers. At the risk of stereotyping, they are aggressive to such an extent that they raise the fears of workers, they are unreliable, lack empathy, are self-centred, often lack both the cognitive skills to understand the counselling process or articulate their emotions, and are impulsive so rarely persist when therapeutic process become emotionally challenging. It seemed to us that if we could develop an approach for engaging these “hard cases” in attempting to improve their family relationships, then we might learn some principles that would be useful and applicable to other agencies working with other groups of marginalised men. In the second and current, phase of the project, we are training family relationships agencies in the principles we identified as contributing to the success of the pilot programs we ran earlier this year. Today I will be introducing you to some of these. We believe they are applicable to other ways of working with marginalised men, not just in running the “Me & My Family” program that we developed.

Although it was not stated in the original submission, an important part of our intent was the desire to develop a program that could be used in other correctional contexts so as to generate two further preventative outcomes. The first of these was to begin the process of reconciling the prisoner with his family. It is generally recognised that the presence of support from family after release is a major factor in reducing recidivism (Montgomery, Torbet, Malloy, Adamcik, Toner & Andrews, 1994). The second outcome we hoped to generate was to reduce the likelihood of the children of the men who participated in the pilots becoming offenders themselves. It has been shown that the most significant factor predicting the likelihood of a boy being incarcerated is his own father’s incarceration. Mind you, I must add that measuring these outcomes was neither a part of the original submission or the project as it is being conducted, so our hopes remain in the realm of good intentions unless one of our “graduates” lets us know what impact we’ve had!
Later, if we have time, I’ll show you some charts that demonstrate what a tremendous early intervention opportunity this sort of program can be.

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The Me & My Family Program

Slide 3 shows the design of the project. We’ve completed the first three steps and are now implementing the last three steps.

**Design Of The Project**

- Run 1 pilot program while writing manual
- Run 4 prison-based pilots
- Evaluation (Prof Tony Vinson, UNSW)
- Rewrite manual
- Write training workshop & train interstate services
- Disseminate program

*Slide 3: Project Design*

Slide 5 shows what we are aiming to achieve through the process of the group program...
**Action: The Program**

- Problem recognition
- Goal creation
- Developing a relationship plan
- Initiating the relationship action plan
- A treatment component (DV, Parenting, Marital relationship)

*Slide 5: The Program’s Actions*

...and Slide 6 shows the program’s structure.

**Action: Program Structure**

- 2 pre-group interviews
- 1 x pre-group R&E interview
- 10 x 2-hour sessions
- 2 x post-group interviews
- 1 x post-group R&E interview

*Slide 6: Program Structure*

In this slide, “R&E” stands for research and evaluation which was a component of the pilot programs, but is not a mandatory part of the "Me & My Family" program per se. Note the two intake interviews and the two exit interviews. Both sets of interviews are intrinsic to the functioning of the program and shouldn’t be considered optional. In the section on theories I’ll discuss their purposes and why they are important.
Today, I’m not going to talk about the content of the program. There are copies of the program here and I can email the most recent draft to those interested. But slides 7 and 8 give a thumbnail of what’s in the program. In the “Practice” section of this presentation we’ll deal with the “how” of the program, but the manual contains the “what”.

### Content Details....

- **Session 1:** Intro
- **Session 2-4:** Defining Relx (ideal versus achievable)
  - Psycho-Ed, MI, TA, Jenkins
- **Session 4-8:** How Relx go astray (beliefs versus experiences)
  - Psycho-Ed, CBT, TA, MI, Jenkins

**NB:** From Session 2 to 10, a Relx Action Plan will be formulated by all participants.

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**Slide 7: Program Content – Sessions 1-8**

### Content continued....

- **Session 9-10:** From goals to action
  - RET, CBT, Triaging
  - Agency presentations
  - Help-seeking skills training
  - Referrals

**Slide 8: Program Content – Sessions 9-10**

Now let’s look at what was achieved in the programs we ran as pilots.
Results

Professor Tony Vinson of the University of NSW evaluated four of the five pilot programs we ran, and again, I can email his report “Repairing Relationships Behind Walls” to those who are interested. Today though, I just want to show you what the key findings from his evaluation were.

Firstly, I want to remind you of the importance of the client’s feelings of hope and confidence in the approach and in the therapist in conventional psychotherapy. Jerome Frank in his landmark book Persuasion and Healing (1971) said that people come to us with a problem and the first way in which we can help them is to give them hope that the problem will be solved. This is relevant to our project because we were asking or expecting the prisoners in our pilot programs to identify goals for their family relationships and to work towards them. In other words, to make changes in attitudes and behaviours. But in order to make those changes, you have to believe that change is possible and achievable. This is good, because the most significant result we achieved was to increase the participants’ confidence that their family relationships could be improved (see Slide 9).

85% ACHIEVED THEIR PERSONAL GOALS FOR THE PROGRAM

77% ACHIEVED AT LEAST ONE OTHER GOAL

CONFIDENCE (OUT OF TEN) THAT RELATIONSHIPS COULD BE IMPROVED:
BEFORE : 6.3 - AFTER : 8.9

32/39 MEN COMPLETED. ALL 7 WHO LEFT WERE MOVED OR RELEASED. NONE VOLUNTARILY LEFT.

Slide 9: Results from the Evaluation Program

I’d like to give you one example of the kinds of changes these men have achieved. Our partner in the project, Caraniche, has delivered two instances of the program through Community Corrections Centres in Victoria. I visited one of the later sessions in the program which was run in Ballarat. During the session I asked the men what changes they had made as a result of the program, and one man announced that he had recently negotiated with his
ex-wife to relieve her of some financial obligations. As a result of this, he was
going to have increased contact with his children, a goal he had been trying to
achieve for some two years previously. This was the first time he had
successfully negotiated anything with his ex-wife outside the Family Court
system.

By the way, one outcome we had expected to produce through the pilot
programs was an increase in the men’s knowledge of and willingness to use
family relationship services. We couldn’t really measure willingness, because
most of the men were still in prison when we completed the pilots and we
don’t have the resources for long-term follow-up. But when we measured
change in their knowledge of agencies, we found that we had made no impact
at all. In most cases, they couldn’t name one family relationship services
agency when the program started, and nor could they when it ended. Still, I
think the story I’ve just told illustrates that these clients are often able, and
probably prefer, to solve their problems without the need for assistance from
an agency. Certainly, we didn’t achieve that result by teaching him better
negotiation skills. I think we motivated him, by increasing his confidence and
hopefulness, to do things he was already capable of but had either not tried or
had given up trying. These issues of motivation and hope fit in with the
theories that underpin the program so let’s look at those now.

How Does It Work I: Theories

Again, for a more complete explanation of how these theories relate to the
program, I’d refer you to our manual, and for a proper understanding of the
theories themselves, go to the original sources in the reference list. This will
just be a quick look at the theories, before we get into how they’re applied in
practice.

The three main theories are Stages of Change, Narrative Therapy – especially
Alan Jenkins’ ideas on restraint and invitation, and therapeutic common
factors combined with motivational interviewing.

Stages Of Change

This model was developed as a result of a large public health intervention
during the 1980s in the United States aimed at nicotine addiction. The
originators of the Stages of Change or trans-theoretical model, Prochaska and
DiClemente found that in giving up a drug of addiction, people reached
different stages of change at different times and the stage dictated what
change strategies were successful with each individual.

Table 1, which comes directly from Prochaska, DiClemente and Norcross,
shows how the client’s behaviour varies in each stage, and what the therapist
needs to do at each stage. Perhaps you can understand more easily though,
how these stages are manifested in client behaviour, if I overlay another
model, Steve de Shazer’s simpler Customer-Complainant-Visitor model over the Stages of Change one. This is what I have done in Table 2. Now, I’m sure if you’re like me, you all love working with Customers (Action stage) and do your utmost to avoid working with Visitors (Pre-contemplators). But look, isn’t that description of a Visitor similar to the description of marginalised men that I gave at the beginning? These men often only approach services because they have been mandated to do so, or are expected to by some external authority (that often includes their partners and parents).

<table>
<thead>
<tr>
<th>Stage</th>
<th>Characteristic behaviour</th>
<th>Therapist Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contemplation</td>
<td>Realises and acknowledges possibility of problem existing, yet minimises. Appears to “seesaw”, realises and then discounts.</td>
<td>Tip decisional balance. Evoke reasons to change in order to reduce dissonance. Strengthen confidence in change as possibility.</td>
</tr>
<tr>
<td>Action</td>
<td>Adheres to program of action. Applies program actively.</td>
<td>Help client to take achievable steps toward change.</td>
</tr>
<tr>
<td>Maintenance</td>
<td>Sustains change through application of strategies consistently. If change is achieved, then exit from program.</td>
<td>Help client identify and use strategies to prevent lapses and relapse (problematic relationship behaviour).</td>
</tr>
<tr>
<td>Relapse</td>
<td>“Slips” into unhelpful thoughts or destructive relationship behaviour (lapse) leading to relationship difficulties (relapse) – return to pre-contemplation stage.</td>
<td>Help client to renew the process of contemplation without becoming “stuck” or demoralised. Reinforce what has been achieved.</td>
</tr>
</tbody>
</table>

Table 1. The Stages of Change Model
<table>
<thead>
<tr>
<th>De Shazer category</th>
<th>“Problem is…”</th>
<th>“Solution is…”</th>
<th>Therapist actions to promote change</th>
<th>Stage of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visitor</td>
<td>“What problem? They’re the ones with the problem!”</td>
<td>“Get you/ them off my back. Leave me alone.”</td>
<td>Align with client about how unreasonable “they” can be. Invite him to find the easiest way to “get them out of your life”</td>
<td>Pre-contemplator</td>
</tr>
<tr>
<td>Complainant</td>
<td>“Not my fault. It’s genetic, the environment, my partner, my childhood…”</td>
<td>“Resign myself to it” OR “if they/ it would change, then I could”</td>
<td>Outlines choices even-handedly, finds small areas that client does have influence over and “casually” points these out to produce dissonance</td>
<td>Contemplator or preparation</td>
</tr>
<tr>
<td>Customer</td>
<td>“Something I need help with and want to change”</td>
<td>“Is not clear to me, but I’ll know it when I find it”</td>
<td>Coaches, encourages, tells client what to try, finds resources, teaches skills</td>
<td>Action or maintenance</td>
</tr>
</tbody>
</table>

Table 2. De Shazer Categories, Therapist Actions and Stages of Change Model

I want you to notice that the De Shazer and Stages of Change “therapist actions” column isn’t labelled to “produce cure”, but rather “to promote change”. This is crucial because it has a lot to do with what I call our “stance” in the work we do. We assume that the most important part of the changing that will happen is going to be done by the client in the environment in which he needs and wants change to happen. Therefore it is vital that he changes as much as, and only as much as he is ready to right now. This means we’re happy with a little change – sometimes as little as not leaving the room during the program – with Visitors, but with people in the Action stage, we’ll ask for or expect a bigger change. The point is, they are changing themselves, we are not “fixing” or “curing” them.

**Narrative Therapy**

Alan Jenkins is most well known for his book on counselling and running group programs for male perpetrators of sexual abuse and family violence, *Invitations to Responsibility* (Jenkins, 1992). While we state explicitly in the "Me & My Family" manual that our program is not designed to address such issues, there are some similarities between the tasks required of men in violence perpetrators programs and in a program like "Me & My Family". Both groups may be reluctant to admit there is a problem. So often the first
task is to help someone move from the pre-contemplation to the contemplation stage. Next, both groups may suspect that they could, under the “right” circumstances have some influence on potential improvements in their relationships. Furthermore, in both groups, the men may be doing something to stop the situation getting worse although they may not perceive this as being effective or worthy of comment.

Jenkins’ techniques generally achieve one of two outcomes. Some of them increase the cognitive dissonance between who the man would like to be – someone strong and loving - and who his actions show him to be – weak and out of control, a victim of his emotions. Others focus on increasing the man’s sense of agency and responsibility in his relationships – something which highlights the first of these two dissonant self-images. In the practice section, we’ll talk in some detail about how this is achieved.

Motivational Interviewing And Common Therapeutic Factors

William Miller’s (1983) Motivational Interviewing approach, like the Stages of Change model was also developed for substance-abusing or addicted clients. It is an interview style originally described by Miller (1983) that aims at creating an atmosphere for change based on accurate empathic understanding, mutual trust and acceptance, in an attempt to understand the construction of the world from the client’s perspective. The responsibility for change is “owned” by the client and not imposed by the therapist. This approach suggests that change is in the client’s best interests and is their personal choice. A risk-reward analysis of the advantages and disadvantages of the behaviour is explored, with the intention of producing a sense of dissonance, conflict, discrepancy and psychological ambivalence about the rewards and consequences of problematic behaviour. The “decisional balance” (Orford, 1985) is tipped toward contemplating the altering of the problematic behaviour. Strategies are persuasive rather than coercive, with the overall goal of increasing clients’ intrinsic motivation to change and their ability to give reasons for potential change. I think you can see how this approach blends with the Stages of Change model.

The Common Therapeutic Factors model refers to the findings by a number of researchers (Lambert & Bergin, 1994; Miller, Duncan, & Hubble, 1997) that regardless of the theoretical orientation or therapeutic techniques used by therapists, there are certain factors common to all forms of psychotherapy that account for successful outcomes. The most important two categories of these factors, accounting for 70% of the variance in treatment outcome, are therapeutic alliance and client or extra-therapeutic factors. Let me explain what these are. “Therapeutic alliance” refers to the client’s perception of the relationship between himself or herself and the therapist. A highly rated alliance is a relationship where the client perceives the therapist to be motivated to improve the client’s situation, to be optimistic that the client will improve and where the client perceives that they and the therapist are working towards the same goals. Client and extra-therapeutic factors refer generally to resources either internal or external to the client which are perceived to have some
positive effect on treatment outcome. Again, I don’t have time to go into all the details of the research on these factors, so I refer you to the reference list. But I want to now move on to describe how these models apply to what we did in conducting the pilot groups. It’s time to start synthesising the theories and models.

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**How Does It Work II: Practice**

Before we look at what our practices in running the group programs were, we need to have in place principles derived from the theories or models. Once we have those principles laid out, we know what to do in practice. So the derivation of group process techniques is theory-principle-technique.

**Stories must be heard before they can be re-authored**

This is one of the commonly recognised principles in the field of narrative therapy, a tradition in which Jenkins for one, was trained. One of the simplest and most powerful things I believe we did was simply to respectfully listen to what the men had to say about how they had come to be the people they are. Frequently, they told us in the context of a group session, “This is the first time

**Include everything and everyone**

This is derived from the common therapeutic factors model. Since it is extra-therapeutic and client factors that consistently account for around 40% of the variance in treatment outcome, it makes sense to include them in the group facilitation process. A secondary benefit of taking what the group members offer you is that you’re not yourself setting up to be in conflict with the group and thereby negatively impact the therapeutic alliance.

**The group, not us, manages the rate of change**

This principle is related to both the Stages of Change model and to motivational interviewing. The Stages of Change model clearly states that people won’t change until they decide they are ready. Now, assuming our group process methods successfully promote change, in a group of men who are disclosing sensitive and personal information about family relationships that they value highly, what do you think will be the factor that restrains that disclosure? It’ll be their perception of the safety of doing so, won’t it? So if we push them, they’ll clam up and nobody makes progress.

Okay, so how does this relate to motivational interviewing? I said earlier that motivational interviewing aims to have the client own the problem, and therefore the solution, in part by producing a discrepancy between the client’s ideal and actual behaviour. Having the group guide us as to when they’re ready for change ensures that members of the group own what happens in the
Individual calibrates the group, group regulates the individual

This is similar to the previous principle. The first part of this principle applies to the requirement for increasing levels of trust to permit increased levels of self-disclosure – and therefore relatedness and growth – among members. The second part combines aspects of all three models. We found that when participants expressed anti-social or counter-productive views, other members would often call them into line. This happened more so later in the program once members had identified goals in common and had “formed and normed” as a group. The Stages of Change model suggests that people need different forms of motivation at different stages, but it doesn’t say the motivation has to come from the therapist, so we have an example here of people having the therapeutic response supplied by other participants rather than by the group leaders.

We often observed that in listening to each other’s stories, the men realised how little excuse they had for “maintaining their problems” as problems. In fact, this is something Tony Vinson commented on after the post-program interviews with participants, to the effect that he was hoping to meet the poor fellow whose family situation everyone else’s was better than! This was another form of cognitive dissonance – one that fits both the narrative and motivational interviewing models – which raised participants’ motivation to improve their family relationships.

Finally, by reinforcing the group’s ownership and agency in moving towards individual goals we are strengthening extra-therapeutic factors. Now it’s time to move on to the techniques.

Invite

I should mention that many of these techniques are more in the nature of an attitude or stance taken towards the group, rather than something you just do. Because we start from the stance that the unsatisfactory aspects of our clients’ relationships result from their restraining beliefs, the most successful likely strategy is to invite them to examine and challenge those beliefs. There are three main ways to do this. Firstly, when a participant professes a belief or point of view which restrains them from enhancing their relationships, we can explicitly invite him to challenge it. An explicit challenge can be along the lines of “What makes you say that?”, or “Has that always been true for you?”. Secondly, we can implicitly invite him to examine it. An example of an implicit invitation would be for example, “Thanks for that input, Mark. Now, I want to hear others’ perspectives on this. Bob, how does that fit with your experience?” [knowing that Bob’s experience is quite different, and that when he tells his story, the difference will prompt Mark to re-examine his beliefs.] Finally, we can covertly invite the participant to examine their beliefs. This is
done by exposing the participant to an experience which is likely to be a poor fit for their beliefs. For example, if their expressed beliefs suggest that their experience of women is that they are either submissive or harshly punitive, we ensure that they observe and participate in interactions with our female co-facilitators who are neither of those things.

**Validate Their History**
This is essential. This is done by simply permitting each member the opportunity to tell the story of his life and his relationships. The reason we do this is that even if the individual telling the story learns nothing new others might. But frequently the “narrator” learns something simply because it is the first time the story has existed in the “real world” of conversation, rather than in the “ghost world” of his memory and emotions.

**Minimise Or Undersell**
Here don’t mean “minimise” in the sense of the participant minimising his responsibility for his actions or trying to minimise their effects. Rather, we mean that we often aim to minimise or undersell the benefits of change. I’m sure you’ve all been subject to the attentions of pushy salespeople or telemarketers. And what’s the response? Right, you’ll usually refuse their invitations to buy. In a way, we are trying to “sell” the participants a new image of themselves as capable and responsible for improving his family relationships. So it’s better that he feels it’s been his decision to take the actions necessary to make that improvement. Robert Cialdini’s (1993) book outlines the principles at work in these sorts of influencing strategies for those of you interested.

**Model And Attend To Relationships**
This partly means we simply practise what we don’t preach. That’s right, we don’t preach (oh, alright, I do – on the wrongs of corporal punishment of children), because as we know from developmental psychology, children pay more attention to what adults do than what they say. This is basic social learning theory (Bandura & Walters, 1963). Of course, how the facilitators treat each other and the participants is the most important part of this modelling.

**Attribute Positive Intentions And Resources**
This is something I learnt from Alan Jenkins’ 1992 book and from workshops he’s been doing more recently (Jenkins, 2000), but it’s also used any time you’re working with clients suffering from either shame about something they have done or inadequacy generally. Obviously this applies to the men Alan works with, but the second qualification, inadequacy, also applies to marginalised men with regard to “relationship know-how”. In all our interactions, we aim to “discover” a positive intention in their either their deeds or in their emotional reactions to their situations. For example, when a
participant expresses anger or frustration about the difficulty in getting contact with his children, we’ll highlight the positive motivation – love of his children and the outcome he wants to achieve for them. From there we can proceed to talk about what he can do in the near future to get on the road to that outcome. So you see, we link the positive intention to finding a resource and exploiting it in action. We want to get some kind of action happening quickly.

Praise & Emphasise Competence & Courage
This is similar to the previous technique. Again we’re increasing hope and confidence by drawing participants’ attention to their successes or to courageous attempts to change – even attempts that result in “failure”. We recognise that change is not easy and we need to reward and encourage movements towards it. Without making a big deal of it, we want the men to realise that taking emotional risks is a “manful” thing to do.

Assume “Final” Success And “Already” Motivation
One of the major findings of the common factors researchers was that the proportion of psychotherapy outcome accounted for by therapist technique or model was equivalent to that accounted for by placebo and expectancy effects. A major contributor to expectancy effects is the therapist’s ability to communicate to the client that the therapist believes and expects that the client’s situation will improve and that the client has at least some resources that will influence this outcome. There is no “technique” as such here. It’s more that in the questions we ask during the group sessions, we are constantly communicating to the participants that we see their current relationship problems as temporary setbacks on the road to satisfying relationships, rather than as a permanent state of affairs.

Conclusion
I suspect some of you may have found this presentation somewhat frustrating if you were looking for concrete “hands-on” techniques that you can take back to work and use with your clients on Monday. If that’s the case I’d urge you to take part in our training workshops when we come to Hobart, Adelaide and Perth early in 2002. We haven’t been funded to provide any training beyond that, although the program materials will still be available from Jesuit Social Services, Caraniche and from the Department of Family and Community Services. But the workshops are definitely the way to learn because you can actually watch us demonstrate the approach and try it out yourselves. If you can’t get to a training workshop, email or phone me because I’m quite prepared to talk at length about how this model can be applied with the men and communities you work with.
References


