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Child & Adolescent Mental Health

Supporting Young People Through Difficult Times

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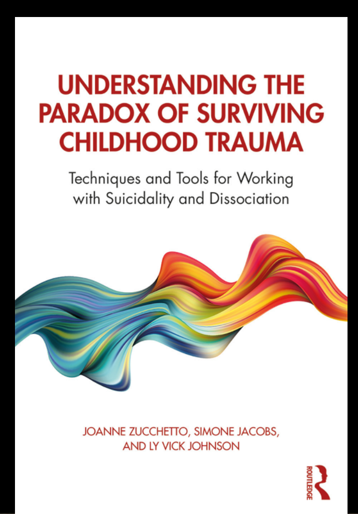

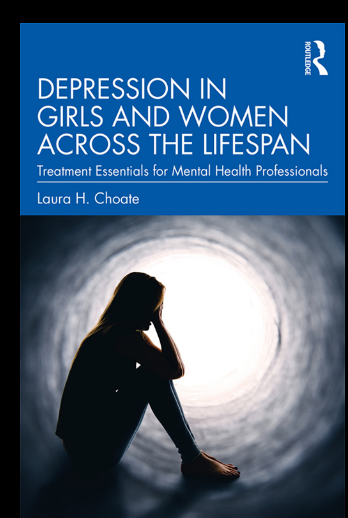

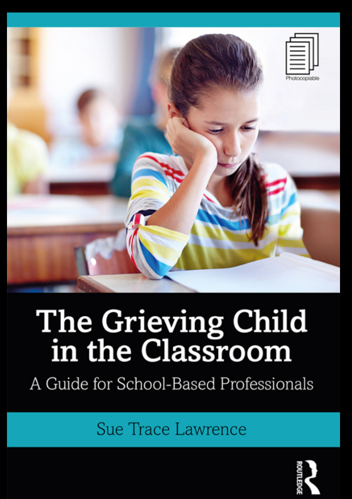

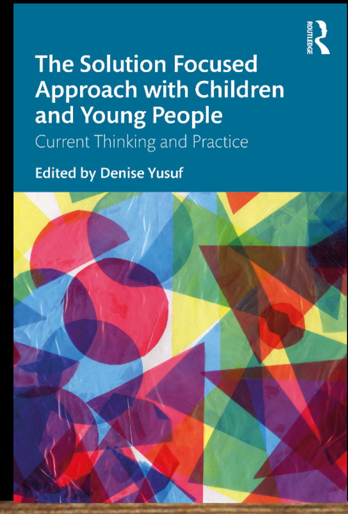

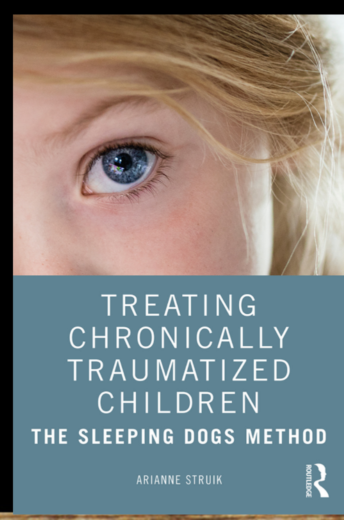

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Introduction

This FreeBook brings together international perspectives from psychology, family therapy, psychotherapy and counseling on treating trauma and grief in young children through to adolescence and beyond. Various topics and techniques are presented to give you a wide variety of research and case studies, written by esteemed professionals in the field.

In the first chapter, Joanne Zucchetto, Simone Jacobs, and Ly Vick Johnson discuss **Understanding Posttraumatic Symptoms Through the Eyes of a Child**. This chapter focuses on the process of being curious about your clients' experiences and behaviors and making sense of their lives in a collaborative way. From this more engaged and non-pathologizing position, we are led to a deeper understanding of the function and meaning of suicidality and many other challenges trauma clients bring to therapy.

In **Treatment for Depression in Adolescent Girls**, Laura H. Choate explores the experience of depression that emerges in girls as they transition to puberty and early adolescence. In this chapter, risk factors, including biological (e.g., timing of puberty), psychological (e.g., interper-sonal orientation, ruminative style), life stressors (e.g., abuse and trauma), and sociocultural risks (e.g., pressures, changes, and expectations for girls during this transition) will be explored, along with a review of evidence-based treatments for depression in adolescent girls, with a focus on Cognitive Behavioral Therapy (CBT) and Interpersonal Therapy (IPT).

What to Say, What Not to Say and What to Do for a Grieving Child is written by educator Sue Trace Lawrence. This is an amalgamation of three short chapters. The first makes specific suggestions on what to say to a child in emotional pain from a loss. Most people are uncomfortable in the presence of grief, and we are worried that we may become tongue-tied. The second section reiterates the need to express support and concern, not give advice or assurances that are unwelcome or unfounded. The final section discusses attachment theory and the neurological basis for this connection, as they have been described in recent neurobiological research, will be summarized within the grief context. It will emphasize the impact of the teacher's role and provide support in navigating a stormy path.

In chapter four, Chris Iveson will shows you that **there's more to children than meets the eye**. You will be introduced to Amir, Lucy, Aaron and Simon whom each demonstrate that they know a lot more than we give them credit for and teach us that we should always beware of closing down possibilities by believing in our assessments.

Introduction

Finally, chapter five looks at answering the question: **What is needed to overcome resistance?** Once children have started to use psychological defences, motivating them to process their trauma becomes more difficult. Very young children do not have these defences yet, which makes their trauma more easily accessible. The older children get, the more difficult it can be to access their memories, as their strategies to avoid become better and better. This chapter describes what processing of memories entails and how problems in the child's life can form barriers to engage in trauma treatment. Then the key principles of the Sleeping Dogs method are described.

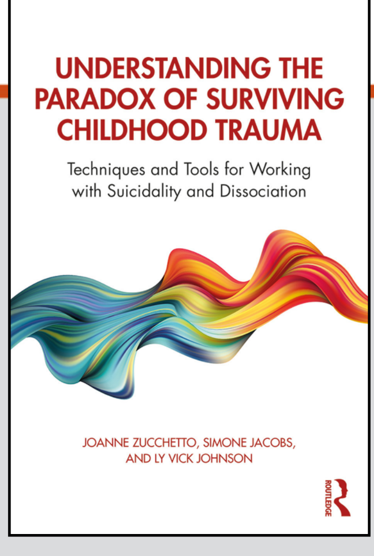
It is our hope that mental health professionals of all theoretical orientations will find value in the diverse treatment modalities presented here, and that you will be inspired to integrate some of these ideas into your own practice.

- The Routledge Mental Health Team

**As you read through this FreeBook, you will notice some excerpts reference previous chapters.Please note these are references to the original text and not the FreeBook.*

**Some references are not present in the chapters. Fully-referenced versions of the text can be purchased via the links on the chapter title pages.*

UNDERSTANDING POSTTRAUMATIC SYMPTOMS THROUGH THE EYES OF A CHILD



This chapter is excerpted from

Understanding the Paradox of Surviving Childhood Trauma: Techniques and Tools for Working with Suicidality and Dissociation

by Joanne Zucchetto, Simone Jacobs, Ly Vick Johnson

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UNDERSTANDING POSTTRAUMATIC SYMPTOMS THROUGH THE EYES OF A CHILD

Excerpted from *Understanding the Paradox of Surviving Childhood Trauma*

The Hidden Meaning of Symptoms

"Kim," who was hospitalized on the inpatient trauma unit, walked into Joanne's therapy office. They had met several times before over the course of two or three previous admissions. After greeting her, Joanne asked, "So, what's going on? Why are you here?" to which Kim responded, "I'm suicidal." She had been in the hospital with suicidal ideation before, but this time when she said it, something didn't ring true. Joanne felt Kim hadn't really answered the question. Not knowing quite what was going on, Joanne said something she'd never said before: "Given your story, I would be too." Joanne was as surprised as Kim by her response, yet something clicked. It was like a light bulb had turned on. They started to talk, really talk, about what was going on that led to the hospitalization. It was later, as Joanne took time to reflect on the session, that she realized why Kim's "I'm suicidal" statement didn't ring true. The issue wasn't whether or not Kim was truly suicidal. Joanne believed Kim felt suicidal, but the statement sounded rote. Joanne recognized that this was something Kim had said many times be- fore. In fact, Kim felt suicidal any time she felt overly stressed over the course of her life. It struck Joanne then that suicidality was Kim's default response. It was the language she used to get her needs met when she was feeling overwhelmed with emotions. Now that Joanne understood Kim's language, they could begin to have a different kind of conversation. Instead of only tracking the course of events and symptoms, they were able to explore Kim's long-standing relationship with suicidality. They could begin to make sense of the meaning that suicidality had for Kim instead of taking it for granted as a periodic inevitability of her PTSD diagnosis. This session marked the point at which the diagnosis started to lose its authority over Kim's treatment and she began to see herself more as a whole person instead of a just a PTSD patient.

The shift in Kim's treatment is representative of changes happening in the field of psychotherapy as well as in our larger society. Globally, cultural norms and values are in flux, and increased feelings of uncertainty and stress are affecting every arena of our lives. Trust in our institutions, from the religious to law enforcement and the government, has eroded. Young people are struggling with a lack of cultural structure that would otherwise provide boundaries and guidance.

UNDERSTANDING POSTTRAUMATIC SYMPTOMS THROUGH THE EYES OF A CHILD

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More and more people are turning to psychology and other therapeutic modalities to find meaning and self-understanding. The institution of mental health care itself is changing how it serves the public and is under greater scrutiny from society. For example, the widely accepted social science experiments, such as the Stanford Prison Experiment, have been discredited (Griggs, 2014). Unethical experiments led by renowned Harvard psychologist Henry Murray are thought to have contributed to the psychological demise of Ted Kaczynski a.k.a. The Unabomber (Chase, 2003). There was also the example of psychologists Mitchell and Jensen who oversaw the tor- ture of CIA detainees after 9/11 (Eidelson, 2017).

Well-established names and approaches in psychology are being questioned and there have been corresponding developments in the treatment room. The therapist is no longer automatically regarded as the expert on what's best for the client. Clients (quite rightly) expect to be heard, understood, and respected as unique individuals and not as textbook cases of mental disorders. There is a more informed and inclusive approach within the mental health field to serving clients who do not identify with the dominant white, European, hetero- sexual cultural narrative. Instead of imposing Western values and definitions regarding health upon the client, therapists are more open to understanding, respecting, and working with the cultural values and heritage that the clients bring to treatment. These are all ways in which researchers, educators, and clinicians are beginning to view mental health through a less pathologizing lens. In the field of trauma treatment, where, in the past, we may have regarded presenting symptoms from a clinical distance, we are now more willing to draw ourselves in closer to our clients so that we can better honor and respect what it means to have survived a childhood horror story.

This chapter expands on the ideas that were sparked by Joanne's transformative session with Kim. Therapy sessions such as this one have opened up our curiosity about our clients' point of view rather than seeing their experiences through the lens of our professional training. Our stance has become less distant as we sit with our clients and work together to make sense of their lives. From this more engaged and non-pathologizing position, we are led to a deeper under- standing of the function and meaning of suicidality and many other challenges trauma clients bring to us. Together, we trace the current suicidal crisis to its origins in the client's traumatic childhood, and we try to see the suicidality through the eyes of that child who is hurt and afraid. From this viewpoint, we can begin to connect the dots between the client's childhood experiences and their difficulties coping in the

present. When we approach trauma treatment in this manner, the client's symptoms, self-destructive behaviors, and relationship problems take on a different meaning. The therapy no longer consists of a sick person undergoing treatment by a mental health professional. There are now two people in the room working together to explore the origins of the client's difficulties as well as ways to build a more healthy and happy life.

Meaning Making Approach

When we approach our work from a non-pathologizing stance, we don't lead the treatment with an agenda but instead listen carefully to what the client is saying as well as what they are not saying in order to know what it is we should be focusing on. Therefore, the therapy does not unfold in the linear manner laid out in this book. Our approach is not meant to be a manualized process. In practice, an issue can present itself and be explored part way, only to be dropped because a more pressing matter arises. There are times when a topic comes up that strikes a chord that is too deep and upsetting for the client to deal with, and it has to be set aside for later. The therapist might introduce a concept that resonates with the client immediately, or it might only make sense at a later time, or never at all. In following the client's lead, we are continually assessing for shifts in emotion, a change in content, or a dissociative disconnect, which might need to be immediately addressed or not. So much depends on what the client is saying with her words and with her body as well as the emotional feedback we discern as experienced therapists.

All of these communications are clues about where to go in our exploration of the meaning of a client's experience. And while the concepts in this book are fundamental to the way we approach trauma therapy, we do not demand that our clients adopt our perspectives or terminology. We do not want to replace one imposed world view with our own. Instead, the ideas we offer create room for discussion as well as the opportunity for clients to understand and internalize the concepts in ways that make sense to them. Our clients make the concepts their own by metabolizing them through their experiences, their words, their emotions, and their perspectives. Therefore, the concepts in this book do not belong to us. Our approaches have developed through learning from clients like Kim and many other trauma survivors, who have opened our eyes to what they have lived through and how they have survived it. We have helped our clients to name their experiences and their survival strategies, and by doing so, we have co-created

a language that fits with what they have so courageously shared with us.

In this chapter, we lay out the framework we use to understand the difficulties that trauma clients have in their lives. We first ex- plain how a non-pathologizing perspective allows us to connect with our clients in a respectful and collaborative manner, and how this sets the tone for exploring the meaning of the clients' difficulties. We then explain how looking through the eyes of a child helps the therapists and the clients to understand these difficulties in the con- text of the impossible circumstances from which they arose. Finally, we describe how we connect the dots from the present difficulties to their childhood origins in order to understand the function and meaning of the difficulties.

A Non-Pathologizing Perspective

In an effort to be regarded as a legitimate area of study, the mental health field adopted the medical model. Psychological diseases have been categorized and codified with lists of symptoms that are meant to be clearly identifiable and measurable. Each diagnosis informs a particular treatment approach that has been created to reduce or cure the identified symptoms. These treatments have been researched and tested to be administered with a certain level of reliability. In addition, medications have been developed to support the management or eradication of symptoms, particularly for those whose conditions are considered resistant to change. What is consistent across many psychological theories and approaches to treatment is a perspective that views the adaptations and responses of trauma survivors as maladaptive or deficits of character, placing the pathology of unhealthy development squarely on the shoulders of the survivor. For example, research indicates that problems with attachment are rooted in the way the parent interacts with the child, and yet it is the child who carries the burden of having a disordered attachment style (Kobak, Zajac, & Madson, 1999). Looking back, we can see that a lot of harm has been done in the field of mental health. Moving forward, we have to hold on to the elements of psychological theory that re- main relevant while honoring those who suffered, and still suffer, as a result of harmful attitudes that still hold power over clients' care. In the present, there continue to be positive developments in the way individuals are regarded in the mental health field, in the wider field of medicine, and in Western culture. And yet the language of pathology still permeates much of the way we talk about health and illness. It remains pervasive in theory, the treatment room, and this writing, even as we work to shift perspectives.

UNDERSTANDING POSTTRAUMATIC SYMPTOMS THROUGH THE EYES OF A CHILD

Excerpted from *Understanding the Paradox of Surviving Childhood Trauma*

When survivors of childhood abuse and neglect enter treatment specifically for trauma, they often carry with them a long list of psychiatric diagnoses. This is true regardless of age; however, the length of the list tends to correspond with how much treatment they've had. Our trauma clients come to us with diagnoses such as depression, anxiety, substance abuse disorders, eating disorders, bipolar disorders, Posttraumatic Stress Disorder, and the "dreaded" Borderline Personality Disorder (Courtois & Ford, 2013). To accompany these diagnoses, many clients have an extensive list of medications that are meant to manage their symptoms as well as medications to manage the unwanted side effects of the medications. Doctors working in our inpatient trauma treatment program were often surprised and concerned about the number of medications patients were taking, many of which were contraindicated. This is not to say that the diagnoses are not valid or that the medications are not needed. Many clients meet DSM criteria for their diagnoses and benefit greatly from their medications. In addition to carrying psychiatric diagnoses, many of our clients also deal with physical illnesses. As the Adverse Childhood Experiences Study (Felitti et al., 1998) so carefully details, individuals with a history of trauma have physical problems resulting from living such a long time under stressful conditions. They struggle with issues such as gastrointestinal problems, cardiac illnesses, difficulty managing pain, autoimmune diseases and syndromes, and fertility issues. Long-term stress takes its toll, making every system in the body susceptible. In turn, dealing with medical issues can wear on psychological health (Briere & Scott, 2015; Felitti et al., 1998). Many of our clients are burdened with numerous roadblocks when seeking effective medical treatment. Some are not believed or are otherwise treated disrespect- fully. Many find that their physicians are unable to identify the cause of their ailments, or they are diagnosed with syndromes that are difficult to treat. There can also be struggles to get insurance companies to pay for treatments. Whatever the challenges may be, the experience of dealing with medical issues can be yet another traumatic, invalidating, and pathologizing experience for our clients.

For many clients, taking care of their psychological and medical issues are not the only challenges they deal with. It is common for our clients to also be in the midst of one or more life crises – a marriage in shambles, a long stint of unemployment, a pending court case, a divorce, a custody battle, a difficult family of origin that causes conflict and pain, having to drop out of college for the third time, losing a home. Many clients begin trauma treatment already overwhelmed by life and feeling hopeless about the future. How can they possibly get better? Many clients

begin trauma treatment already overwhelmed by life and feeling hopeless about the future. How can they possibly get better? All the evidence seems to point to a life half lived, whether they look to the past with all its pain and suffering, or they look at the present where there is so much difficulty and stress, or they look to the future where there is no end to the struggles in sight. Like the mental health and medical professionals they seek help from, all they can see are problems.

When traumatized clients walk into the treatment room, a therapist may hear either explicitly or implicitly any of the following:

> Help me to not care so much, feel so much, hurt so much. Help me to not die. Help me to manage, help me to care, help me to love, help me to connect, help me to disconnect, help me to cry, help me to feel less crazy, help me to understand. **BUT** none of that really matters, you don't understand, you can't help, don't look at me, don't get too close, don't try too hard. I'm crazy, I'm a liar, I'm a piece of shit, this is who I am, I don't trust you. I don't want to feel, I don't want to know, I'm so hurt, I'm so afraid, I'm so alone. I'm betrayed, I'm a victim. What is wrong with me? Why am I so defective?

These conflicting and painful messages carry a secret hope for as well as a limited expectation of trust, respect, and honesty. Traumatized clients come into therapy prepared for the blame, fear, and hurt they have internalized from being raised by people who inflicted or ignored pain, created confusion and chaos, and then refused to take responsibility. These internalized experiences are then compounded by encounters with mental and medical health professionals, who have provided them with numerous diagnoses, medications, and coping techniques. When there has been little or no improvement, trauma survivors can be made to feel unmotivated, resistant, or otherwise defective.

When clients come to us for treatment, they are taking yet another risk to ask for help. They arrive feeling overwhelmed, confused, suicidal, self-harmful, and stuck, and it is the therapist's job to figure out where to begin and which crisis takes precedent. But when confronted with the client's intensity of problems and feelings, therapists have to also effectively manage their own corresponding feelings of helplessness and hopelessness. Trauma survivors present many challenges to a therapist's sense of skill and competence. The clinician's training, experience, and title do not provide immunity from having their own defensive responses when faced with these challenges. The 'helper' may either pull back too

far and become disengaged or lean in too close and become the rescuer. In an attempt to create order out of chaos, the therapist may focus too heavily on organizing the client's problems and experiences into diagnoses, and then following the prescribed treatment plan. There is, of course, the need for a therapeutic framework from which to make sense of our clients' symptoms and behaviors, but there also needs to be room for the complexity of what the clients bring to treatment as well as the dynamics of the therapeutic relationship. Trauma recovery is incredibly hard work and the path does not always conform to the clinical structure of textbook treatment plans. When the inevitable surprises and side trips come up, therapists must be mindful not to manage their own anxiety and frustration by reflexively placing blame onto the client. If we can remain open and curious to the process as it unfolds rather than measuring success against specified treatment goals, there is more room to do this work, a greater sense of hope and energy.

Taking a more open and non-pathologizing perspective means being willing to face what lies beneath the chaos in our clients' lives. Managing posttraumatic symptoms is important and worthwhile work for survivors, but clients are more than the dysfunction that too often takes center stage in therapy. Diagnoses and symptoms do not tell the full story of what it means to grow up in a demoralizing and shaming environment, and so much of who they are and what they have been through can become lost, minimized, or pathologized.

Treating trauma from a non-pathologizing perspective does not mean we choose to address what might be considered "deeper" issues over present-day symptomatology. This is not an either/or situation. Deciding what to focus on in treatment is not even a both/and scenario. Using a non-pathologizing lens changes how the symptoms look. Instead of seeing symptoms as pathology, we see symptoms as information about how the client coped with trauma as a child. Therefore, PTSD symptoms cannot be disconnected from posttraumatic issues of identity and meaning making. The symptoms and self-destructive behaviors that are causing so much chaos in the present are components of a defensive structure that was the only chance the client had for survival. Therefore, a survivor of childhood trauma who is thought of as resistant to treatment might instead be someone who is not getting better because symptom management techniques do not get to the heart of why the symptoms exist in the first place. A symptom management plan will have more meaning, and therefore success, when we understand that the symptoms are clues to what the client's traumatic childhood

was like as well as the strengths and resources they marshaled for survival. The symptoms point the way toward healing. This understanding has the power to get the treatment unstuck, but it does not mean the work is easy. It is one thing to say that we see our clients as more than their symptoms; to be present with clients who are becoming more in touch with the horrors of their childhood trauma is another matter entirely. Trauma therapy is hard work that requires courage and compassion. When therapists approach this work from a more open and non-pathologizing stance, there is also more room to do this work with a greater feeling of hope and energy.

"Josefina" came in to outpatient treatment with Simone. In the past, she was hospitalized numerous times for suicidal ideation, and as with so many of our trauma clients, she had been diagnosed with multiple disorders over the years – Major Depressive Disorder, Anxiety Disorder, Bipolar Disorder, Posttraumatic Stress Disorder, Borderline Personality Disorder, and Dissociative Identity Disorder. Josefina was in middle age with three adult children and one high schooler. Her youngest son lived with her, and she had strained relationships with the rest of her family. Two of her siblings were dead and another was in jail for a violent crime. Josefina's life seemed to be a series of crises. She was unable to hold a job for long. She had been in several abusive relationships over the years and had had so many abortions that she was afraid to count how many. While in a dissociated state, she had carved the date of her last abortion into her arm as a reminder never to get pregnant again.

Josefina described a childhood that was immersed in pain. She and her siblings were raised by their mother, who was disabled. Her father's presence in the home was not consistent, and the memories Josefina did have of him were ones of verbal, physical, and sexual abuse. Josefina also recalled the easy violence with which her older siblings and kids from the neighborhood abused her as well as the fact that her mother did very little to stop it. When she became pregnant at a young age, Josefina's mother took her to get her first abortion. She remembered her mother being angry, and she knew she had done something wrong, but her mother never explained to Josefina what was happening. It was many years before Josefina understood what her mother must have known and seen but never put a stop to. And it also took a long time for her to consider how painful it was to have a mother who did

little to help or protect her when she was a child.

Josefina had a hard time sticking with therapy in the beginning of her work with Simone. She was afraid of facing the emotional and psychological damage of the abuse, which was compounded by the fact that she had essentially been abandoned by her mother. Josefina came to therapy for a few months and then left for over a year. When she returned, she stayed for another few months and left again after a having a flashback. After coming to therapy with Simone for the third time, she was able to make gradual and steady progress with internal communication – making sense, piece by piece, of the experiences she had minimized and dissociated from. Josefina learned that her "angry" self aspect was the one that carved the date of the abortion on her arm in an attempt to protect her from the trauma of another abortion. She learned that this aspect was angry because his job was to hold all the "bad" stuff, which included the abuse. This aspect was also angry because he believed the rest of the internal system was having a great time, thanks to his doing his job. There was also a childlike aspect whose job it was to hold the need for love but, because of the abuse, learned that pain was the price to pay for it. The aspect whose job it was to hold the sexuality tried to get love through sex, which was the only way she knew of experiencing anything that might resemble love or affection. In order for Josefina to survive in her youth, she had to not know what was happening. Therefore, it was paramount that these aspects of herself stay disconnected from each other. The dissociative barriers that were crucial for survival in childhood now meant that when aspects needed to communicate with each other, drastic measures were the only option – hence, the need to cut the abortion date on her arm.

Honoring

When we approach our clients' problems with openness and curiosity, symptoms that could easily be labeled as pathology are instead seen as defenses that are worth honoring. In Josefina's case, amnestic barriers between her self aspects can be honored as a means of protecting her from knowing and feeling things she was not equipped to handle. As Josefina began to learn about the realities of her childhood, she could thank aspects of herself for doing what they needed in order to survive. There is no need for judgment or condemnation. We can have

compassion for the childlike aspect of Josefina who seeks love but learned from the abuse that "love" comes at a price, one that was determined by the abuser. Honoring Josefina means honoring the fact that the dysfunctional pattern of Josefina's abusive relationships have, paradoxically, come from the healthy and fundamental human need for love and affection. Understanding the traumatic origins of Josefina's destructive relationships with men enabled her to work on developing healthy relationships in a way that was more meaningful and solid. Without insight into the meaning of Josefina's relationship patterns, any therapy work on relationships would continue to be derailed by a hurt and lonely self aspect that is stuck in the past, unheard and not understood. Josefina's work was to thank this self aspect for helping her to survive. Simone and Josefina can honor this self aspect for the predicament she faced when she was a child in a terrifying situation, and begin to change the association between love and pain. This work of honoring defenses allowed Josefina to begin to update and change the values for a healthier life in the present.

Curiosity

Donnel B. Stern (2003a) addressed the centrality of curiosity in psychoanalysis as an attitude that enables the exploration of dissociated aspects of experience. Being grounded is commonly thought of as the opposite of dissociation, but Stern (2003b) points out that the opposite of dissociation is curiosity. For complex trauma survivors, curiosity can have a destabilizing effect because it means asking questions for which the answers would have been too risky to know. When Josefina was taken to have her first abortion, it was better for her if she did not ask or wonder about what was happening. Being curious would have meant knowing things she wouldn't want to know and wouldn't have any guidance or support to make sense of. It would also mean feeling emotions for which there would be no comfort. Being unaware of what was happening to her as well as the reasons for the medical procedure was the best way for Josefina to get through it. It was only during a sex education class in high school that Josefina began to have an understanding of what had taken place. Even then, she could only allow herself to understand the physiological dimension of what had happened to her. The psychological impact and the meaning of what happened would have been too much for her to manage. Not being curious was a way for Josefina to protect herself from knowing the extent of the abuse. It was also a way for her to not know about being abandoned by her mother, which allowed their relationship to be preserved.

There is another factor that supports the abolishment of curiosity. The abuser maintains a family policy of secrecy that forbids the child from questioning what is happening and wondering if something could be done about it. Five-year-olds in healthy families have a lot of questions about how the world works, whereas a five-year-old living in trauma does not have the luxury of being curious. Josefina talked about the deafening silence that this secrecy imposed on all aspects of her life. She lost her voice, not just as a means of communicating with the outside world but also with her internal self aspects. As an adult in psychotherapy, Josefina was finally able to give herself per- mission to be curious by communicating with her self aspects and asking them questions. Before practicing internal communication, Josefina had assumed that her self aspects were intent on preventing her from having a stable and happy life. She was surprised to learn that they were trying to protect her, albeit in ways that caused more problems. The insight that Josefina gained through internal communication is an example of the therapeutic gains that can be achieved when we hold an open and curious attitude in our work. It is an attitude that allows the client to question long-standing assumptions they have held about why their lives are so challenging, thereby beginning an exploration into the origins of the ways they operate in the world. Curiosity and exploration would appear to be obvious features of psychotherapy. However, being curious also re- quires a willingness to accompany our clients to the dark places. A client who has the courage to be curious might learn that she loved the person who abused her and have to reckon with the shame that arises from this knowledge. Or she might feel the psychic devastation of betrayal upon discovering that her non-offending parent knew about the abuse and allowed it to continue. If “not knowing” has been the client’s best policy for survival, we have to be cautious when we invite them to join us in being curious.

Reality-Based vs. Strengths-Based

While a non-pathologizing approach to trauma treatment could be seen as being in line with strengths-based theory from social work (Saleebey, 2013), there is a difference between the two perspectives. The strengths-based approach focuses on the client’s strengths, not their symptoms. On the other hand, our approach focuses on the symptoms as clues about the reality of what the client has lived through and the strengths that have been used for survival. The adoption of the strengths-based approach has been an important shift within the pathologizing

culture of mental health treatment. However, the approach does not capture what it means to have survived a traumatic childhood. We do not see symptoms as after-effects of trauma that can be resolved by focusing on the positive but part of the story itself; rather, the symptoms are the lived experience or reality of the people who seek our help.

Listening for Subtext

Taking a non-pathologizing approach to working with Josefina means addressing the symptoms and sequela of her trauma without blaming her for the pervasive dysfunction in her life. We listen to Josefina without judgment, and we respect all that she has been through in her life. Most therapists do this naturally – we listen with openness and compassion, and take a sincere interest in the client's story. But, as we help Josefina to establish stability in her life, it is important to not only take a non-judgmental stance toward the in- stability, but to also listen for the meaning that the symptoms and problems hold for her. In Josefina's case, the cutting on her arm is a self-harm behavior that is symptomatic of PTSD. Internal communication revealed the meaning of this behavior – it was an attempt to protect Josefina from needing to have another abortion. Because of the protective dissociative barriers between self aspects, extreme means were necessary to get Josefina's attention. Trauma survivors can also communicate in extreme ways with people in their lives, including their therapists. It is helpful to remember this when a client's distress appears to be irrational, overly dramatic, or unresolvable. At these times, it is likely that they are unable to communicate the real reason for their distress. Our trauma clients survived by not being aware of their feelings and by not knowing what was really going on. So, it is our job as the "good enough" therapist to not get swept up in the drama, but to remain quiet within ourselves so that we can listen for the communication underneath the noise. For "Kim," the client at the beginning of this chapter, feeling suicidal was the only way she knew of getting help when she felt overwhelmed. However, the reasons for her very real suicidality could not be addressed until the treatment team recognized that there was meaning, a subtext, to her suicidality that had not yet been made known. A therapist who views the work through a non-pathologizing lens, who holds honor for the client's experiences, and who maintains an attitude of openness and curiosity is one who is able to cultivate this different way of listening.

As a new therapist practicing group therapy, Simone was often puzzled by how skillfully the senior therapists were able to respond to an angry client in group.

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It wasn't until she immersed herself in reading through the transcripts of clinical conversations with Joanne that it became clear how this was done. Simone was filling in for another therapist in a group one morning with another new therapist. A client, whom neither therapist had met before, began the group by expressing his anger about an unexplained and ongoing delay in having the psychiatrist approve his medication. When the other group therapist responded by promising to find the physician between group sessions to ensure the issue was resolved, the client's anger did not subside. He instead became more angry, and the other group members started to look like they were feeling uncomfortable. With no prior knowledge of the angry client, Simone stated, "This has happened before." The client turned toward Simone and angrily filled her in on his previous experiences with incompetent medical care during the time when he was supporting his mother over the course of her long battle with a terminal illness, which she eventually died from. As the client told his story, his emotion changed from anger to sadness. He tearfully recounted his experiences of frustration, hopelessness, and loss. The group members responded with expressions of sympathy and support. This was the first time Simone could clearly see how listening and responding to the subtext rather than the noise could have so much power. Dealing with the real source of the client's anguish opened a way through his anger and out of his isolation.

Simone had no way of knowing what was being stirred up in the client by his medication issue. But when his anger was not eased by the offer of a solution, she sensed there was something important hidden in the increasing noise. It was a risk to respond in this way to an unknown client, but it is also an example of how this work can be worth the risk. If Simone's statement turned out to be off the mark or if the client was not ready to deal with the pain of his mother's illness and death, he would have continued his rant, and the therapists would have tried other ways of helping him de-escalate his anger. We don't always get it right, but by stepping back and taking a risk to connect the dots between the past and present for this client, he was able to connect with the group, Simone included, and find healing in that connection.

Through the Eyes of a Child

It is easy to buy into the idea of a therapeutic framework that holds honor and dignity for our clients. What is not so easy is maintaining the framework in the face of the complexity and chaos our clients sometimes confront us with. There are

times when clients behave toward us in a manner that is thoughtless, hurtful, and intrusive, and during these storms it can be difficult to keep ourselves grounded in a non-pathologizing stance. As we work to maintain a tone of respect and dignity in the treatment room, we find it helpful to see the upsetting symptoms and behaviors through the eyes of the child who lived through the abuse. We have already explained that symptoms and behaviors represent the ways that the client has protected herself from feeling and knowing things that they are unable to bear. When we can also see these symptoms and behaviors through the eyes of the child, we allow for a deeper dimension to our understanding.

Looking through the eyes of a child gives us insight into the origins of our clients' relational patterns because childhood is when we learn how to be in relationship with others (Cassidy, 1999). Having insight into the traumatic origins of our clients' behaviors helps us to not take their attacks so personally, even when we feel hurt. When a client is ready, looking at their childhood together is an important component of making meaning of the way they struggle in relation- ships today. As therapists, we can begin by remembering what it was like to actually be five years old. To really put ourselves back there, we can think about or observe a five-year-old child in our lives. An- other option would be to watch videos online of a five-year-old at play, in school, or with family. We can reflect on the ways young children interact with each other, with their parents and teachers, and with their environment. It helps to really notice that the way they talk, think, and move in the world is different than adults. We hope you will see a keen curiosity, an easy ability to laugh at silly things, boundless imagination, and an interest in the world around them that is almost contagious.

Examining the world through the eyes of a five-year-old is to see a world in transformation. Five-year-olds have moved out of the toddler stage and are in the process of transitioning out of the preschool years and into the elementary school years. Toddlers play mostly alongside one another in what is called parallel play (Berk, 2013). A five-year-old is a much more social being and is actively engaging with both kids and grown-ups. Their grasp of the concept of time is becoming firmer and they are learning to tell time. Five-year-olds also have a sense of object permanence (Berk, 2013), meaning they understand that a parent who has left the room has not dematerialized but is elsewhere and will return. They also understand that if they leave an object in a particular location, they can return later with a reasonable expectation that it will still be there. Most five-year-olds have clear ideas about rules and a sense of right or wrong. Moral

reasoning is fairly black and white at this age and they have a harder time with the more complex grey areas (Berk, 2013). They have an understanding of how relationships are forged and maintained. Five-year-olds are also capable of showing empathy for others. They are learning more about emotions instead of just experiencing them, and they are capable of using words to name what they are feeling as well as ways to regulate them.

Now that we have remembered what it is like to be five years old, we can imagine what it must be like to be that age and live inside trauma. We can imagine what it is like for a five-year-old to live in a home where it isn't safe, where they are deliberately hurt or violated on a regular basis or ignored to the point of emotional and physical neglect. We can think about what it must feel like for that five-year-old to live in pain and uncertainty every day because a parent can't be trusted to show up sober, or put food on the table, or refrain from verbally assaulting them. Imagine being strangled by your parent until you pass out, and then being "saved" by that same parent when they remove their hands and not let you die. Imagine being dangled from a 10th floor balcony by your mother because you misbehaved in front of her friends. We can imagine the terror of waking up to the screams of a mother being beaten. Or the paralyzing fear of a child lying in bed at night and hearing the click of the door handle and the soft tread of their abuser approaching.

This repeated horror is too much for a five-year-old to cope with. There is the unrelenting fear and pain of being abused. There is the impossibility of making sense of a world in which the people you need for security and love are the same people who hurt you. The concept of betrayal, even, is not enough and at the same time too much when you are five years old and survival is at stake. All this is complicated by the fact that you love and need your parents so much that you don't want to leave them. Most abused children don't want to leave their parents, they just want the abuse to stop. Bowlby was right in recognizing the magnitude of the loss of attachment. The drive to attach is a much more powerful force than the pain, fear, betrayal, and loneliness of abuse. The abusers themselves know this and in fact manipulate the child's desire to stay with their parents so that they will keep quiet about the abuse. For children who do report abuse, the result is not necessarily a future of loving support and stability. The U.S. foster care system is flawed, and for many children, although the abuse may stop, life with a series of strange families does not begin to provide the kind of help they will need to recover from abuse and neglect. In many cases, their experiences in group homes

and foster homes solidify the beliefs abused children have about themselves and the world. When we hold the traumatized five-year-old child in our minds and consider the horrors they are confronted with, there is a shift in how we perceive our adult clients. Looking through the eyes of a child puts the troubles they have in their lives, and in therapy, into a different context. We have greater compassion not only for what they have been through but also for what they are going through in the present. We can better understand the unrelenting depression that manages all the pain they have endured and everything they have lost to the abuse. The persistent anxiety that positive coping skills and medications don't seem to touch makes sense in the face of a childhood lived in a constant state of fear. Substance abuse makes sense as a way to numb out the past and try to function in the present. Explosive emotions are understood in the context of the repeated trauma that brought on more emotion than any five-year-old could hope to manage.

Understanding posttraumatic symptoms through the eyes of a child does more than make a connection between a troubled adult- hood and a troubled childhood. Posttraumatic dysfunction is not only a sign of what someone did to our clients when they were children, it is a sign of what that child did in order to survive. We do not believe that children are passive recipients of abuse, but that they respond to the abuse with a strong instinct and an incredible will to survive.

The Predicament of Maintaining Attachment

The predicament of the child being raised in an abusive family is defined by attachment (Bowlby, 1988). For the child, survival and attachment are one and the same, and so their survival instinct is the instinct to preserve the attachment with the parents. Even if the parents are alive, without attachment, the child is an orphan. Children will instinctively avoid being orphaned at all costs. As Josefina's story shows us, in order to survive, children have to not know the abuse is happening. How else can a child get up in the morning and eat breakfast with a dad who assaulted her the night before? How can she focus in school when she is worried about what it will be like when she goes home in the evening? How can she make sure that the fragile relationship with the only parent she knows doesn't disappear? Abused children need to have a way of not knowing what is happening to them in order to re- main attached to a parent. Fonagy and colleagues (2003) address the issue of not knowing in their writing about how children are unable to know that their parent is both good and bad. In their need to maintain their

knowledge of the good, a young child will necessarily disconnect from the bad. Piaget's (1965) model of child development also addressed the issue of holding the good and bad together. He theorized that a child cannot hold the nuances of moral ambiguity until they reach adolescence. Therefore, throughout childhood, people and things are either good or bad; they cannot be both.

A child being raised in an abusive home does not have the re- sources to manage the pain and fear of being hurt, much less the impossible predicament of relying on the abuser for survival. Their minds are not developed enough to make sense of what is happening to them, and there is nowhere to go for help. Their only possibility for survival is to somehow not know about the abuse and not feel the feelings that come with it. The options a young child has for not knowing and not feeling are limited:

They can stop eating, They can stop pooping,

They can stop breathing (for a while), They can bang their heads on the floor,

They can want to cut,

They can disconnect,

And the ultimate escape mechanism, they can want to die.

The list is indeed bleak. These are the blunt and brutal tools in a traumatized child's survival kit. No family can guarantee constant safety for their children, but when a child in a good enough home experiences trauma, the aftermath is very different. A child in a good enough home has somewhere to go for help, comfort, and the possibility for the restoration of safety. This child may develop PTSD, but their family can provide the love, care, and understanding to help them recover. Their love and guidance also shapes the meaning the child will make of what happened to them. They will have the opportunity to believe in their goodness, innocence, and blamelessness for what happened. On the other hand, a child who relies on her abuser for survival does not have anywhere to go for help and must manage by taking extreme measures to not know the abuse is happening. With nothing and no one reliable in their lives, these coping mechanisms are the only things that stand between a traumatized child and annihilation. These are the only things between them and the loss of their "good" parents, between them and the knowledge of the horror of their lives, and the unbearable feelings that go with all of those experiences.

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When we understand our adult clients through the eyes of child- hood, our focus is drawn beneath the distressing symptoms and behaviors, and beneath even the horrors of the abuse, to the paradoxical core of the tragedy: The trauma survivor's self-destructive patterns come out of the intensity of the child's instinct to be attached in order to survive. As children, our clients lived within this terrible paradox. The only survival mechanisms available in childhood persist into adulthood where they are counterproductive and therefore pathological. It is only by looking at suicidality through the eyes of a child that we can understand that wanting to die and thinking about ways to die are a means for a child to survive the torment of being trapped within a traumatic paradox. It is as if the child is saying, "If I can die, then I can live another day." When there is no hope of rescue, suicide becomes the rescue plan. Suicidality is a metaphoric hope that gives the child something that is in her control, gives her some power. Focusing on suicide also provides a distraction from thinking about the abuse and from knowing that the people who were supposed to love and protect them, betrayed them.

As for the other options available, hunger pains from not eating can paradoxically provide some relief and comfort by distracting from the pain of the physical abuse and distracting from knowing that you are unloved. A child who finds a way to not feel the pain of the abuse can hope that they have not been hurt. If they can distract themselves from the fear of the next beating, there is the possibility that their life is not scary. These mechanisms offer hope that maybe the abuse is not really happening. Over time and with the continued lack of support and guidance from adults, these paradoxical coping mechanisms become the default mechanisms for handling emotions and stress that is too much. They are quick and effective "go to" ways of getting some form of relief. Over the course of their lives, our clients grow attached to these coping mechanisms, which become the only reliable and trusted companions in a frightening and unpredictable world.

A five-year-old child does not act on survival instincts with conscious deliberation. Small children are not aware that they are looking for a way to have agency in a helpless situation. They are unaware of their innocence, and many do not even know that they are being victimized. They may have sought out and cherished moments of relief, but they had little hope or expectation of happiness. Even in quiet interludes, they were on guard for the mood to shift, a fist to drop, the door to open, a voice to scream, and the quiet to end. This was the only life they knew, and exposure to other ways of growing up would have meant bearing yet another pain – the disappointment of knowing there was a better way of living that could never be theirs.

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"Maleya's" story is an example of the painful conflict traumatized children experience when they discover the possibility of a life different from theirs. The families in Maleya's low-income apartment complex seemed to have the same kind of life as her own. There were parents who shouted at and beat their kids, urine in the hallways, and dirty old men lingering in dark alleys drinking beer. One day, when she was in middle school, one of Maleya's teachers invited her over for dinner. The teacher lived in a nice clean house, with a nice husband who kissed his wife when he arrived home from work. They had a dog that played with them, good food on the table, and they laughed together. When it was time for Maleya to leave, she felt ashamed; for the first time in her life, she didn't want anyone to know where she lived. She almost wished she had never gone to her teacher's house because then she would not have known that there was a way of living that was clean, comfortable, secure, and loving. In her childlike way, Maleya had been content in her ignorance. Her life had been " just the way the world is." But now she knew different, and this meant that she was also aware of her shame, her pain, and her 'less than' experience of the world. Maleya's life had been unhappy, but this was not something she had to know before visiting her teacher's home.

Risk of Awareness

Gaining awareness is fundamental to the process of psychotherapy. However, the shame that Maleya felt when she discovered that there was another way of living shows us how risky this process can be for trauma survivors. We would like to think that it is empowering for clients to understand that their dysfunctional ways of dealing with life are not evidence of how sick they are, but instead evidence of their strength and resilience. But it is not that simple. This shift in perspective turns the client's world upside down, and so, we have to work slowly, with great care and sensitivity. Our clients have spent their whole lives defending against knowing how vulnerable they were and how necessary it was for them to be attached to their parents. When they understand what they did to maintain this attachment, they are empowered to begin healing and make different choices based on the updated context of their current lives. But paradoxically, this empowerment comes hand-in-hand with the pain of knowing and feeling the powerlessness of their childhoods. It takes great courage for our clients to face not only the story of their trauma but also the reality of the helplessness,

hopelessness, innocence, con- fusion, and hurt of their childhoods. These are not easy realities for the therapist to face, either. It is painful to sit with the hurt from our clients' childhoods. Trauma therapy is difficult and risky for both the client and the therapist, and we have to bear this in mind as we take on the work that has the power to change the worldview of our clients as well as our own.

Connecting with Dots

We make sense of our clients' experiences by connecting the dots between their current struggles and what happened to them in childhood. Many clients understand that their struggles have something to do with their childhood trauma, but they don't yet understand the manner in which the two are really connected. They may say things like "I start crying for no reason" or "I'm just an angry person." Some clients remember their childhoods as only idyllic, with summers at the beach, loving parents, and siblings who got along well. But they can't make sense of their depression, panic attacks, eating disorders, or their brother's suicide years ago. A client may tell her therapist that she has PTSD from childhood trauma and be able to identify the circumstances that trigger self-harm. But at the same time, she also believes that she is an inherently bad person and that the abuse was her fault. Connecting the dots means exploring how the client's beliefs came to be and understanding how these beliefs helped the client to manage the unmanageable conditions of her childhood.

When it comes to the client's symptoms and behaviors, we are curious about their meaning and origin, which is different than understanding them only as responses to triggers. Self-harm may be how one survivor has always released the pressure valve for built-up emotional tension. For another survivor, it might be a how she began punishing herself for making mistakes when she was a child. Self- harm can also be a way to not feel emotions. For example, when a client's best friend forgets to call her on her birthday, instead of feeling sad, hurt, and lonely, she reports that she is thinking about cut- ting herself. Or when the job they were hoping to get doesn't come through, their first thought isn't about disappointment, it's "I'm suicidal." For the client "Kim," from the beginning of this chapter, "I'm suicidal" was connected to taking away feelings about the stressors going on in her life. It is our job to help the clients figure out how the current thoughts and behaviors are connected to in the past, what meaning it has for them, and what emotions are associated with this default response. This comprehensive understanding of a client's suicidality will allow for the development of more meaningful and

successful coping mechanisms to reduce suicidality.

Fluidity of the Process

Connecting the dots is not a tidy or linear sequence that begins with "#1" and then finding "#2" until the picture of a rabbit or a house emerges. It is a complex process involving missing numerals, fragments of pictures we can't identify until we stumble upon another piece that we realize fits. Some pieces are blurry and will come into focus when viewed from a different angle. Processing trauma is a fluid process that responds to clinical material as it arises. When a client talks about having just exploded angrily at a co-worker, there is the opportunity to process what happened in the present moment. We can talk about the build-up to that moment, we can talk about the extenuating circumstances, and/or we can talk about other feelings that lie beneath the anger. With information about what happened and why, we can connect the angry explosion in the present back to its origins in childhood. It could be that there is something about the co-worker that reminds the client of something from their past. It could be a mannerism, or attitude, a style of communicating that activates the client's emergency response system. Helping the client make these connections provides insight into distressing experiences and patterns in their lives. If the co-worker was dismissive, the client might come to realize that he was treated dismissively and made to feel "less than" as a child. If we learn that the situation is a re-enactment of a toxic interpersonal dynamic from the past, we have an opportunity to explore that, and learn about why this scenario continues to be repeated in the client's life and how to address it differently in the present. Without connecting the dots, this scenario could focus on anger management, which can be effective but is somewhat limited. By connecting the dots, this situation becomes an exploration of patterns of behavior in the present that are being informed by experiences in the past. By connecting the dots, we open up a wider range of resources that can be used to manage the current situation in addition to offering the opportunity for healing from past hurts and betrayals.

In Conclusion

The work of connecting the dots is a process of puzzling together pieces of insight as they become uncovered. It is a fluid process that follows the clues as they present themselves, whether it is through a crisis, through the discussion of day to day issues, or by processing a childhood memory. Exploring the traumatic origins

of our client's dysfunction shifts the focus of treatment from the problems themselves to how the client came to be in their situation in the first place. This is work that requires us to think paradoxically, because the only way our clients managed to survive was to turn against themselves. As Jon Allen (2001) points out, clients don't see self- harm as self-destructive, they view it as self-preserving. The idea of cutting as a means of self-preservation may seem senseless, but this paradox speaks to the terrible senselessness of the child's traumatic existence. We hold the senselessness of what our clients have lived through and, paradoxically, believe that together we can make sense of what happened. It is difficult to fathom the instinct, strength, intelligence, will, and determination that it takes for our clients to have lived through their trauma. However, we see evidence of this in the treatment room every day, and it is by entering into the paradox that we are able to bear witness to the conditions that forced our clients to use these capacities to survive. It is within this paradox that we are able to understand that the dysfunctional way they deal with life today points to the only thing that stood between them and annihilation. As a colleague used to say in trauma therapy groups, "If you knew then what you know now, you wouldn't be depressed, you'd be psychotic."

Our non-pathologizing approach to trauma treatment sets a tone for the work that holds respect, honor, and dignity for our clients and all they have struggled with. We work under an "assumption of reasonableness" with regards to the symptoms and problems our clients bring to therapy. This means that although the ways the client is coping are counterproductive, they are reasonable considering the impossibilities a traumatized child is forced to "reason" with. This understanding forms the framework upon which we can begin to slowly and cautiously build a sense of trust and safety with the client. When clients feel safe enough, like a securely attached child, they can begin to take the risks necessary to work through their trauma and its devastating consequences. Being able to get underneath the language of pathology in order to honor the means by which the client has survived provides a little relief from being so tightly bound to their sense of shame. The client begins to feel a little less like a monster and a little more like a human being – one who is flawed and hurt. As the possibility of being human begins to percolate, so does the possibility of genuine connection with the therapist as well as others in a client's circle of support. It is through this genuine connection, not between a clinician and a client but between one human being and another, that the client begins to feel seen. They begin to internalize a

non-pathologizing view that holds respect for their humanity, honors their unique struggles, and treats them with a dignity they may have never experienced. It is always a privilege to be with clients as they begin to feel seen, and take the courage to peer with us into those dark places and make contact with their own humanity.

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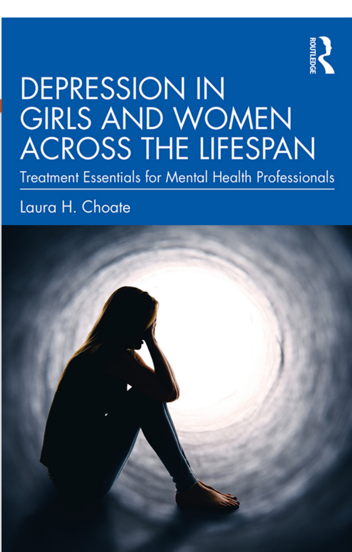
TREATMENT FOR DEPRESSION IN ADOLESCENT GIRLS

NAVIGATING PUBERTY AND THE TRANSITION TO ADOLESCENCE



This chapter is excerpted from

Depression in Girls and Women Across the Lifespan: Treatment Essentials for Mental Health Professionals

by Laura H. Choate.

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TREATMENT FOR DEPRESSION IN ADOLESCENT GIRLS

NAVIGATING PUBERTY AND THE TRANSITION TO ADOLESCENCE

Excerpted from *Depression in Girls and Women Across the Lifespan*

> People don't really see that depression can lead to dangerous situations. I faked smiles so people saw I was okay on the outside, but deep down inside, I felt numb and empty. It led to me not eating or drinking water, isolating myself from everyone, and having suicidal thoughts. I couldn't even leave my room. I still struggle with depression to this day, but going to counseling really helped me. Today, I'm about to finish my second year of college and I've published two poetry books.
>
> —Denise, age 19 (as quoted in Orenstein, 2018)

While Denise's struggle during her teenage years may sound extreme, unfortunately her story reflects the experiences of a significant percent- age of adolescent girls. Girls start to experience an increase in depressive symptoms at a surprisingly high rate during their transition into adolescence, and this rate has skyrocketed in recent years. As mentioned earlier in the book, girls' level of depression increased by 50% during the years 2012–2015, and increased by a total of 66% from 2007–2017 (Pew Research Report, 2019). Fully 41% of girls ages 12–17 reported persistent feelings of sadness and hopelessness during the past year (CDC, 2018). The most recent National Study of Drug Use and Health shows the rate of depression in adolescent girls has increased from 13.1% in 2005 to 20% in 2017, with most of the increase occurring in the years between 2010 and 2017 (Twenge, Cooper, Joiner, Duffy, & Binau, 2019). In another national study, the 2017 Youth Risk Behavior Survey also showed that 20% of all teen girls had experienced an episode of Major Depressive Disorder (MDD), and 22% said they had seriously considered suicide (CDC, 2018). So no, Denise is not alone in her experience with extreme sadness, hopelessness, and even thoughts of suicide.

It is noteworthy that these dramatic increases in depression during early adolescence are far more pronounced in girls as compared to boys. The male-to-female ratio during childhood is 1:1 (indicating no gender difference), but by age 13 it increases to 1:2 (American Academy of Child and Adolescent Psychiatry [AACP], 2007). This two-fold gender difference persists throughout adolescence and adulthood (Nolen-Hoeksema, 2001). As mental health professionals we should be concerned about these strikingly high rates of depression in girls during puberty and the transition to adolescence for several reasons. First, this is an issue that can affect girls regardless of race, ethnicity, and class. To date there are no consistent findings to indicate racial, ethnic, or socioeconomic differences in prevalence rates of depressive disorders in children

and adolescents, indicating that depression is an issue that cuts across race and class and that affects girls from all cultural groups.

Second, we should be concerned because depression onset at a young age is highly associated with recurrent episodes of depression and impairment throughout adolescence and adulthood. As stated in Chapter 1, adults who experience recurrent depressive episodes recall their first episode of depression as occurring in early adolescence (Weersing, Jeffreys, Do, Schwartz, & Bolano, 2017). Up to 72% of adolescents experience another episode of MDD within five years of their first episode, and are at two to four times greater risk for depression as an adult (AACAP, 2007).

Third, depression during adolescence harms the development of effective skills for healthy emotional, cognitive, and social development (Essau & Chang, 2009). When girls such as Denise in the quote opening the chapter begin to isolate from others and withdraw from life, they miss out on opportunities for social development. When depression interferes with the development of social skills such as communication, assertiveness, and boundary setting during adolescence, a girl may never learn these essential skills and have resulting interpersonal problems throughout her lifetime. In fact, compared with their non-depressed peers, depressed adolescents are more likely to have relational problems, experience more stressful life events, and have greater levels of marital and overall interpersonal distress as adults. In addition, individuals who experience depression as an adolescent are more likely to drop out of school and have higher levels of unemployment and job difficulties. Further, they are at higher risk for abusing substances in early adulthood, resulting in higher rates of substance use disorders and involvement with the criminal justice system (AACAP, 2007).

Finally, depression is of concern to mental health professionals because of its strong association with increased suicide risk in adolescents. Suicide is now the second leading cause of death in adolescents between the ages of 15 and 24 (Centers for Disease Control, 2017), and as rates of depression increase, so do rates of suicide risk. Up to 60% of depressed adolescents have experienced suicidal ideation, and 30% have made at least one suicide attempt (AACAP, 2007; Rohde, Lewinsohn Klein, Seeley, & Gau, 2013). Depressed adolescents are four to five times more likely to have a history of suicide attempts than non-depressed adolescents (Essau & Chang, 2009), and over 50% of suicide victims have a depression-related disorder at the time of death (Thapar, Collishaw, Pine, & Thapar, 2012). It is clear

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that experiencing an episode of depression during the adolescent years has the potential to lead to a chronic, recurring disorder that can result in academic, social, and serious psychological difficulties throughout a girl's adolescence and into her adult years.

Due to the serious consequences of depression, it is important for therapists to be aware of and to understand the biopsychosocial influences on girls that increase their vulnerability to depression during the adolescent years. It is also important to understand the differential impact of gender. Why does this transition often result in depression in girls but not in boys? Finally, how can therapists provide effective treatment and early intervention for girls during this window of vulnerability? To answer these questions, the purpose of this chapter is to (1) explore biopsychosocial risk factors including biological, psychological, cognitive, social, and cultural factors that make girls particularly vulnerable to depression and that contribute to gender differences during this developmental period; (2) consider assessment and diagnostic issues for depression in girls; and (3) discuss effective treatment options for girls, including Cognitive Behavioral Therapy (CBT), Interpersonal Therapy (IPT), and practice guidelines regarding adolescent use of antidepressant medications. See Box 2.1 to reflect on the themes in the chapter thus far.

Questions for Self-Exploration

1. Think back to your adolescent years. What do you remember about being age 13? Age 15? Age 17? How did you feel about your personality and appearance? What were your interests? What were your relationships like with family and friends?

2. Were you surprised at the increase in girls' depression rates in recent years? Is this spike in depression reflected in the individuals you see in your practice?

3. Have you ever worked with a client like Denise (quoted in the chapter opening)? Based on your personal and professional experiences, why do you think girls are vulnerable to depression during the transition to puberty? And why are they more prone to depression than are boys during this time?

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Risk Factors for Depression

There are multiple biological, psychological, and sociocultural factors linked to depression onset that can account for the large gender differences that emerge at the onset of adolescence (Hamilton, Hamlat, Stange, Abramson, & Alloy, 2014). These areas are discussed in terms of how girls experience the transition to puberty and to the adolescent years of her life.

Biological Factors

Family Influences The strongest risk factor for depression is having a family history of MDD. Having a depressed parent places a child at two to four times greater risk for developing MDD, having onset of MDD at an earlier age, and having a greater likelihood of recurrent episodes. Adoption and twin studies show that depression becomes increasingly heritable from childhood to adolescence (AACAP, 2007), and that the heritability for depression is higher in girls compared with boys. Depression in mothers is particularly related to the development of depression in adolescents, and children of depressed mothers report significantly lower self-esteem and a more depressive attributional style than do other children (Strauman, Costanzo, & Garber, 2011). Less has been studied about fathers' contributions to depression in girls, but one recent study found that both fathers' and mothers' psychopathology was related to depression and anxiety symptoms in adolescent girls (Rasing, Creemers, Jans- sens, & Scholte, 2015).

The strong link between depression in parents and their children is not only due to genetics but also to the way in which a depressed parent interacts with his or her child. This can include the negative impact of parental withdrawal from the child, poor parenting practices that could lead to safety concerns, an inability to attach appropriately, and a lack of ability to provide needed warmth and emotional support, all of which contribute to the development of depression in girls. Some of these impacts can begin to occur in the early postpartum period, and postpartum depression is linked to negative outcomes for children even into adolescence. The importance of treating maternal depression when it first emerges in pregnancy and early postpartum will be addressed in Chapter 4. Other family dynamics are known to contribute to depression in children, including chaos, hostility, abuse and neglect, and lack of parental approval. In particular, girls who have parents who use a harsh, punitive, belittling, or rejecting parenting style are more likely to become depressed as an adolescent (Gillham & Chaplin, 2011; Wang & Kenny, 2014).

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Twin and family studies with adolescent girls show that girls who are at high familial risk for depression demonstrate an increased sensitivity to family problems and stressful life events. This indicates that when a girl who has an inherited risk for depression is exposed to stressors like family chaos, harsh discipline, abuse, or lack of support and approval, she is more likely to become depressed in response to these stressors than would be a girl who did not inherit such a risk for depression. Further, this relationship between inherited risk, stressors, and depression is stronger for post-pubertal girls than for girls who have not yet reached puberty (Thapar et al., 2012).

Pubertal Changes Girls undergo drastic hormonal changes during puberty, and these changes are related to the onset of depression (DeRose, Wright, & Brooks-Gunn, 2006). Puberty and associated hormonal fluctuations contribute to depressive vulnerability in girls in several ways, including increases in sex hormones that affect the serotonergic system, the system that plays a strong role in regulating mood. At puberty there are also major physical and cognitive developmental changes. For example, puberty contributes to considerable growth in girls, resulting in weight gains primarily deposited in her breasts, hips, and thighs. A girl might dread these changes, especially if she perceives that she is gaining weight faster than her peer group. As her body changes in contrast to the thin ideal portrayed in the media, she may become dissatisfied with her body, perhaps for the first time in her life, and this dissatisfaction is associated not only with dieting and risk for eating disorders but also with depression. There are also cognitive developmental shifts in girls at this time that contribute to depression risk. As the prefrontal cortex matures at puberty, a girl is now able to think abstractly and to formulate long-term goals. However, this skill can actually contribute to depression when girls become frustrated if they are not able to achieve their newly formulated goals (Brent, 2013). Hormonal changes in the brain also lead to increased emotional intensity and reactivity, and strong emotional reactions are risk factors for depression (Frost, Hoyt, Chung, & Adam, 2015).

Pubertal Timing Recent research indicates that the age of onset of puberty has fallen (up to two years earlier) during the past 40 years (Greenspan & Deardorff, 2014). Currently the average age for breast budding (considered the onset of puberty) is 9.8 years for White girls, 9.3 for Hispanic girls, and 8.9 years for African American girls (Greenspan & Deardorff, 2014). This is concerning, as early puberty is a risk factor for depression. This is due not only to actual hormonal fluctuations that occur at puberty but also with how the timing of puberty coincides with

social factors—when a girl appears different from her later maturing peers, she can feel objectified, excluded, and self-conscious, placing her at risk for depression. This is not the case for boys; early maturing boys are at no higher risk for problems or depression. In contrast, research indicates that early puberty places girls at risk for many problems, all of which are also related to depression.

One of the primary risks has to do with a girl's appearance. Puberty is accompanied by increases in body fat and weight, and many girls who mature early develop negative body image, placing them at risk for low self-esteem and eating disorders. Because they appear different from other girls, they are also likely to be teased and bullied by peers because of their changing body shape and early breast development. This can cause them to experience negative labeling and social exclusion, and as a result they often become disengaged from school. Their early development also causes them to appear older than they are, so they are more likely to experience sexual harassment.

Another primary risk for depression is that early maturing girls experience problems when they begin to spend time with older friends who are already part of the adolescent subculture. Because they appear older than they actually are, they are likely to draw the attention of an older group of peers and partners. Girls typically display the physical changes of puberty one to two years before boys, so an early maturing girl might look up to three to five years older than boys her age and will also appear much older than her on-time or later maturing peers.

If girls don't fit in with peers and potential romantic partners of their own age, they might be drawn to spend time with an older peer group where they feel more accepted. This can cause them to become included in social situations in which they are pressured to participate in activities for which they are not socially, cognitively, or emotionally mature enough to handle, such as parties that include smoking, drinking alcohol, and using other substances. They are also more likely to be pressured into sexual activity before they are developmentally ready to make these types of decisions about their sexual identity and behaviors, and unwanted and coerced sexual experiences are linked with depression (DeRose et al., 2006). They are also more likely to experience verbal and physical abuse in their dating relationships (Graber, Nichols, & Brooks-Gunn, 2010). Overall it is difficult for a younger girl who lacks emotional maturity to be able to remove herself from unsafe situations, assert herself in a dating relationship, stand up to peer pressure from older peers, and say no to risky or harmful behaviors. As a result of these

many risks and stressors, studies show that girls who experience early puberty are also more likely to report a history of suicidal ideation and suicide attempts (Graber et al., 2010).

Psychological Factors

Attributional Style With the emergence of abstract thought in adolescence, cognitive vulnerabilities also emerge, through which girls can develop a negative attributional style—attributing negative events to internal, stable, and global causes (e.g., "I'll never be invited to any parties again; I will always be rejected"). Girls are more likely than boys to develop this negative style, which is strongly linked with depression. Girls are also more likely than boys to respond to negative events with avoidant coping rather than cognitive reframing or active problem solving, two strategies that help protect against depression (Schmidt-Gies & Laessle, 2014).

Emotional Clarity and Regulation As stated previously, brain development in early adolescence leads to sharp rises in levels of emotional intensity, and this is especially the case for adolescent girls. Girls have greater overall emotional intensity than boys and feel higher levels of almost every emotion (Frost et al., 2015). While emotional intensity and expression can be a positive quality for girls, it can also lead to depression if a girl experiences more negative emotions than positive ones, or if she does not know how to regulate these emotions. For example, research indicates that children and adolescents who are vulnerable to depression experience high levels of negative emotions, strong negative emotional reactivity, and high sensitivity to negative stimuli. They tend to avoid and dislike novel situations and are hesitant to approach others due to sensitivity to rejection. They also tend to have poor coping skills for managing these intense emotions (McLaughlin & Nolen-Hoeksema, 2011).

In addition, poor emotional clarity is also a risk factor for depression. Emotional clarity refers to a girl's ability to understand what she is feeling and to label her feelings appropriately. When she is able to understand and label her emotions, she can think about situations more clearly, logically, and rationally. She is then better able to focus on goal-oriented, problem-solving behavior. In contrast, when girls experience an increase in emotional intensity at puberty, they may have trouble understanding and managing these feelings, placing them at risk for depression. One study of early maturing girls found that girls with a negative coping style and poor emotional clarity were the ones most likely to develop depression at the

transition to puberty (Hamilton et al., 2014).

Interpersonal Orientation

> You kind of let go of yourself. In the mind of a teenager, it's all about your friends. So sacrificing a part of yourself to have friends is nothing. You have to have friends. . . . If you sit back and let people take control, then you'll have lots of friends. You don't even realize what you're doing. You just know you can't be alone.
>
> —Anonymous (Machoian, 2006, p. 58)

Another factor that puts adolescent girls at risk for depression is that they begin to experience a heightened need to be close with others and to feel a sense of belongingness to a peer group. When girls are highly invested in friendships, this closeness can serve as a double-edged sword: it can bring increased social support, but it also causes girls to become vulnerable and distressed when there is conflict in their relationships. For example, inter- personal stress is associated with increased levels of depression and lowered self-esteem for girls but not for boys (Hankin, Wetter, & Cheely, 2008). This is because girls and women are more likely to base their self-esteem on the quality of their relationships, so that their self-esteem is based on whether their relationships are going well or not. This seems to be happening with the girl in the previous quote; she is sacrificing part of herself in order to maintain her relationships, but she realizes that there is a cost that comes with this sacrifice. When a girl displays high levels of *sociotropy* (i.e., is highly concerned with others' opinions of her and her standing in current relationships), this can cause her to sacrifice her own needs and desires in order to please others, to avoid conflict, and to maintain the security of her relationships. Sociotropy can cause a girl to neglect the development of an authentic self-concept during the important years of identity formation in the adolescent period (Gilligan, 1993). When self-esteem is contingent upon interpersonal success, a girl is vulnerable to depression. Sociotropy is more present in girls than in boys (Cambron, Acitelli, & Pettit, 2009), and interpersonal stress, peer rejection, and poor relationship quality are predictors of depression in girls but not in boys (Hankin et al., 2008). In addition, because girls can be overly invested in the success of their relationships, girls are also more likely than boys to minimize their feelings of anger and to inhibit their expression of assertiveness, and both of these qualities are linked to depression (Gillham & Chaplin, 2011).

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A related issue is when a girl's need to gain the approval of her peer group extends to her overvaluation of her appearance as a way to gain others' approval. Because peer approval is so valued, girls may become overly concerned with their appearance, weight, and shape in meeting cultural values for beauty and for gaining social success with peers and potential romantic partners. In fact, for girls, confidence in appearance is the most important contributor in determining her self-worth, whereas for boys it is his confidence in his abilities (Gillham & Chaplin, 2011). When girls internalize the message that the most important part of their identity is their appearance, they will compare themselves with others and with media ideals for beauty, and believe they can never measure up to these standards, leaving them vulnerable to depression. Conversely, when a girl is depressed, she is more likely to have a negative body image; girls who are depressed are more likely to experience body image dissatisfaction, self-blame, and disappointment than are boys who are depressed (Gillham & Chaplin, 2011).

Another factor related to girls' interpersonal orientation and investment in relationships is girls' inclination to display excessive empathy for others. Excessive empathy is a term that refers to girls' tendency to experience feelings of guilt due to others' difficulties, taking on others' problems as if they were their own. Girls who experience excessive empathy, high levels of compliance (over-concern about meeting the demands of others), and overregulation of emotions (working hard to keep her emotions in check) are also vulnerable to the development of depression (Hankin et al., 2008).

Rumination and Co-rumination Rumination refers to the process of engaging in repetitive behaviors and thoughts that focus a girl's attention on her symptoms of distress and of all of the possible causes and consequences of her symptoms. It involves dwelling on her problems in a way that keeps her stuck in her negative cognitions (Rood, Roelofs, Bögels, Nolen-Hoeksema, & Schouten, 2009). A girl who ruminates is focused on the past, going over events in her mind and trying to figure out what went wrong, blaming herself for her words or actions in a self deprecating way (e.g., "I was so stupid in school yes- terday! If only I would have said . . . I can't believe I did . . ."). It is clear to see how rumination can interfere with motivation and problem solving, keeping a girl stuck in her negative mood instead of brainstorming possible solutions and actively trying to solve the problem. Rumination has a well-established link with depression (Rubenstein et al., 2015). Women are twice as likely as men to engage in rumination, and when they experience a negative mood, women are more likely to ruminate in an effort to

"figure out" what is wrong, while men are more likely to turn to distracting activities as a method for coping. These gender differences in rumination start to appear at age 12, around the same age that gender differences emerge for depression (Rood et al., 2009).

A related concept that affects girls more so than boys is co-rumination. Co-rumination involves ruminating with others, rehashing the details of a negative event, and discussing negative feelings related to the event with others in one's social circle. Girls are far more likely to co-ruminate with friends than are boys, and it appears to be a gender-specific risk factor for depression; co-rumination predicts greater depressive symptoms in girls but not in boys (Barstead, Bouchard, & Shih, 2013). Co-rumination is both a protective and a risk factor for depression; while it can cause a girl to feel closer to her friends as she processes her feelings with them, co-rumination actually makes her problems worse and can exacerbate her existing depressive symptoms (Rood et al., 2009). Instead of helping her move forward with problem solving, talk- ing excessively about negative feelings can make them only increase in intensity. Unfortunately, even listening to others ruminate can also be harmful for girls. As stated previously, because girls are likely to use *excessive empathy*, taking on their friends' problems as if they were their own, girls can be negatively affected by listening to their friends' ruminative dialogue over time.

Stressors and Negative Life Events

The biological and psychological factors described previously will not necessarily lead to depression unless a girl also experiences a stressor or negative life event (McLaughlin & Nolen-Hoeksema, 2011). Girls experience more frequent stressors and are more likely to respond to stressors with depression than are boys, particularly if that stressor is related to problems in her relationships (Essau & Chang, 2009).

Major life stressors like abuse and trauma can be strong risks for depression onset (see Chapter 1). However it is also possible for minor stressors and daily life hassles to accumulate and become stressors that trigger depressive symptoms (Avenevoli, Knight, Kessler, Merikangas, 2008). It is important to under- stand and validate all stressors according to the client's perspective; an event the therapist perceives as a relatively minor mishap could be experienced by the client as an insurmountable problem. This is particularly relevant to keep in mind when

working with young adolescent girls because they are likely to experience many life changes simultaneously; consider some of the following changes and stressors that often occur at the onset of adolescence:

- Physical changes of puberty, timing of puberty
- Changes in peers, cliques, bullying
- Social media use, cyber bullying
- Increased parent–child conflict
- Transitions to larger schools with increased academic challenges
- Increased media messages emphasizing appearance
- Increased attention from others about her appearance while weight and shape are changing at puberty
- Emerging sexual identity and questions/confusion about what this means
- Concerns about romantic relationships, dating relationships, potential onset of abuse in relationships

As girls transition to early adolescence, these many hassles and stressors can accumulate across life domains and become highly challenging to navigate (Rudolph et al., 2008). In contrast, because they reach puberty later, boys not only have fewer vulnerability factors to begin with, they are also less likely to have to deal with the multiple stressors of early adolescence simultaneously.

Social Media Use and Depression

> This [social media] resulted in me not eating properly and losing a lot of weight and becoming very depressed, I finally recovered which was hard for myself to be bullied online again in year 8. Overall I would say social media has caused me many issues and has caused me to be depressed many times.
>
> —Anonymous girl, age 14–16 (#StatusofMind Report, 2017)

> iGen'ers look so happy online . . . but dig deeper and the reality is not so comforting. iGen is on the verge of the most severe mental health crisis for young people in decades. On the surface, though, everything is fine. Social media posts highlight the happy moments but rarely the sad ones: everyone is smiling in their selfies, unless they are doing a duck face.
>
> (Twenge, 2017, p. 94)

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One emerging stressor I would like to highlight is a girl's use of social media. There is a significant line of research that links social media use (e.g., use of sites such as Instagram, Snapchat, Twitter, and Facebook) with depression and other negative mental health outcomes (Hunt, Marx, Lipson, & Young, 2018; Twenge, Joiner, Rogers, & Martin, 2017; Twenge et al, 2019), and this link is particularly strong for adolescents. While clearly most adolescents are engaged with social media at some level, girls are more absorbed in frequent, daily social media use than are boys, and the more time they spend on social media, the more likely it is to have a negative effect on their mood and relationships. The risk for negative out- comes is highest for any adolescent who uses social media more than two hours per day, and teens who use social media five or more hours daily are the most likely to report unhappiness, depression, and suicidal ideation (Twenge et al., 2017).

Other research also suggests that teens who spend more than two hours per day on social media sites are more likely to report poor mental health, including symptoms of anxiety and depression. In fact, a recent study of 14- to 24-year-olds conducted by the Royal Society of Public Health in England (who reported the quote the opens this section) examined the impact of social media use on mental health (using measures of anxiety, loneliness depression, sleep disturbance, body image, "fear of missing out" (FOMO), and bullying). Results showed that use of Twitter, Facebook, Snapchat, and Instagram each had a negative net overall impact on mental health (meaning that the negative impacts outweighed any positive impact associated with use), with Instagram having the most negative impact.

One of the primary mechanisms through which social media use is linked to depression is that increased social media use is related to loneliness. Adolescents who visit social media sites every day are more likely to agree with the statements "I often feel lonely," "I often feel left out of things," and "I often wish I had more good friends." The adolescents who are the most lonely report spending more time on social media than others and also are more likely to report spending decreased time in face-to-face interactions with friends (Twenge et al., 2017). Refer to Box 2.2 for findings of a recent study linking social media use directly with depression and loneliness.

Study Spotlight: How to Reduce FOMO

Findings from a recently released study conducted with college students demonstrate that social media use can directly impact mental health, causing increased levels of depressive symptoms and loneliness. In an experimental study, researchers at University of Pennsylvania followed college students over the course of three weeks, asking them to send nightly screen shots of their battery usage (which reveals how much time they spent on social media per day). The experimental group was asked to limit their social media usage of Facebook, Instagram, and Snapchat to 10 minutes per platform per day (no more than 30 minutes per day total). The control group was told to continue social media use as usual. Researchers found that all students in the study showed decreased anxiety and "fear of missing out" (FOMO) scores over baseline, presumably due to self-monitoring throughout the three weeks. It seems that just being aware of how much you are using social media each day helps you use it less and actually feel better in terms of worries over missing out on what others are doing. But interestingly, the experimental group (students who limited their social media use to only 30 minutes per day) had significantly lower depressive symptoms and loneliness than did the control group by the end of the three weeks (Hunt et al., 2018).

Most relevant to the discussion in this chapter, social media use affects the youngest users the most negatively. In studies that compare 8th, 10th, and 12th graders, it is the 8th graders who report the highest levels of social media- related loneliness, depression, anxiety, and FOMO. 8th graders who spend 10 or more hours a week on social media are 56% more likely to be unhappy than those who spend less time on social media. Further, 8th graders who are the heaviest users of social media have a 27% increased risk of depression com- pared to adolescents who do not use social media as often (Twenge et al., 2017).

Why might this be the case? Younger girls are in the process of starting to develop an identity, to determine who they are and what they believe apart from the opinions of their parents and families. They are starting to become more concerned about standing out and forming a unique identity ("who am I?") while also trying desperately to fit in with peers ("where do I belong?"). If they learn to measure their worth by the number of "friends" or "followers" they can accumulate or by the number of "likes" they can accrue for a particular picture or post, they will learn to

become more concerned about how they are being evaluated by others than what they personally think or feel. Second, at the transition to adolescence they do not have the life experience to be able to critically sort through comments and determine what is accurate or helpful; they do not have the cognitive capacity to understand the importance (or irrelevance) of the constant flow of images and information. They also do not yet have the maturity to be able to rationally think through what to post or share online (and what the potential consequences might be). Further, at the transition to adolescence, a girl is already experiencing increased egocentrism, focusing on the "imaginary audience"—feeling like everyone is focused on her every move and on all of her perceived flaws. In an online environment, this "imaginary audience" becomes all too real as she can see how gossip or negative comments about her spread rapidly to hundreds if not thousands of others. She can feel pressure as if she is under a microscope, and most adolescent girls do not know how to manage this level of scrutiny. As she posts a picture or comment, she also opens herself up to criticism and cyber bullying.

In addition to these pressures that can impair her authentic identity development, social media use is linked to depression because the more time a girl spends on social media, the more likely it is that she will also have fewer face- to-face interactions. We thrive when we have positive, face-to-face interactions with other people; social support is foundational to positive mental health, and online interactions do not provide this type of necessary emotional connection with others (Shakya & Christakis, 2016). If a girl's primary social contact is online, she misses out on potentially beneficial social interactions and might not develop needed social skills during adolescence. One caveat to this is when girls use social media to enhance their existing friendships (e.g., using social media to plan face-to-face activities and support their ongoing friendships); this type of use does not seem to contribute as much to loneliness and depressive symptoms.

When girls use social media frequently, they are also more likely to compare themselves with others (both with those people they know as well as with celebrities, "influencers," and models). This can lead to decreased self-esteem as girls start to believe they can never measure up in terms of appearance or social life. An adolescent girl does not yet have the critical thinking skills to recognize that everyone posts only "highlight reels" of their lives and that their posts do not represent reality. They fail to perceive that the carefully selected pictures and posts only represent what participants want others to see, not what their lives are

actually like. This has been termed a "compare and despair" attitude among girls, who feel negatively about themselves as a result. As girls scroll through others' feeds, they can also feel rejected and excluded as they view the events and activities their peers are attending, feeling like they are missing out on life.

Finally, social media use is related to depressive symptoms in adolescents because it contributes to a lack of quality sleep. As discussed in Chapter 1, sleep disturbance contributes to and is a symptom of depression. Using social media at night before bed is linked to poor quality sleep in adolescents. Not only does viewing social media before bedtime contribute to going to bed later than intended, it also disrupts sleep—as is the case when a person has trouble falling asleep after being on social media sites for several hours. Further, it is hard for adolescents to turn their phones off at night—up to 20% of adolescents report that they wake up during the night to check messages on social media (#StatusofMind Report, 2017). In sum, social media use is a growing trend among adolescents and is a risk factor that needs more study and consideration for how to best moderate use. For now, it is helpful to consider the quote by Jean Twenge:

> If you were going to give advice for a happy life based on [these data] it would be straightforward: Put down the phone, turn off the computer or iPad and do something—anything—that does not involve a screen.
>
> (Twenge, 2017, p. 78)

The Case of Elise

Elise is a 13-year-old girl in the 8th grade. She has one older brother, age 16. Her parents have been divorced for two years and share joint custody of both children. Elise and her brother alternate every other week living with her mother and then her father. Before the divorce (around age 11) Elise was an outgoing, confident girl who excelled in elementary school. She had a group of friends and was involved in soccer and art club outside of school. At age 11.5, Elise experienced significant pubertal changes, started her menstrual cycles, and developed breasts and a curvaceous figure. These changes caused her to appear much older than she was, and now at age 13 she appears to be an older teen. Due to these changes and the fact that she had to alternate between parents' houses each week, she began to feel distant from her friends. During the 7th

grade many of her peers teased her about her appearance and started calling her a "slut" even though she had never even shown a romantic interest in anyone. She entered the 8th grade with no close friends and dreads going to school each day. Her older brother's high school friends, however, stare at her when they come over to visit her brother, and several of them start asking for her text and social media contacts. One particular boy messages her frequently on Snapchat and asks her for pictures of herself. His requests become increasingly aggressive in asking for nude pictures. She is flattered by his interest but does not know how to handle his pressured requests for provocative pictures. When she tells him no, he dramatically "disappears" from her social media world, and she does not hear from him again. She is devastated by this rejection but tells no one. She feels totally alone at school and at home. She thinks that her mother is too stressed with her new single life to be bothered with her problems and she believes that her father would not care. All she can do is think about how stupid she is, how ugly she must be, and how hopeless her situation is. She believes she will never have friends at her school and that she will be an outcast for life. Slowly she stops caring about her schoolwork, she loses interest in eating or in going out with her parents, cries for no apparent reason, and she wants to sleep all of the time. In fact, she goes to sleep as soon as she comes home from school and only comes out of her room if either of her parents make her have dinner with them (which is only 3–4 nights per week). Her parents do not seem to notice; she guesses that they are relieved that they do not have to spend time with her. Over a period of several weeks, she is at the point where she begs her parents to let her stay home from school because she does not have the energy to make it through the day.

Discussion Questions

1. What are the risk factors for depression that Elise possesses? What are the biological and psychological influences, and what stressors and negative life events likely contributed to depression onset?

2. If you were Elise's therapist, where would you start in your treatment with her? What do you see as her strengths, and what are her obstacles to change?

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Excerpted from *Depression in Girls and Women Across the Lifespan*

Assessment and Diagnosis

There are some distinctions, however, when conducting assessment with children and adolescents. Adults can overlook depression at this stage because the vast majority of adolescents experience dramatic increases in irritability and mood reactivity during puberty, and these symptoms can be misinterpreted as simply a normal part of a child's development. The difference is that while most adolescents become sad and irritable at times, MDD is diagnosed when symptoms last two weeks or more, are intense, and significantly interfere with relationships or with the performance of typical activities (APA, 2013). When MDD occurs in children and adolescents, the most common symptoms are low mood, loss of interest in previously enjoyed activities, difficulties with concentration and motivation, changes in appetite and sleep, irritability, physical symptoms, and in some cases, thoughts of suicide (Cox et al., 2014). In addition, 40–90% of depressed children and adolescents experience other comorbid disorders such as anxiety or disruptive behavior disorders (AACAP, 2007).

Another complicating factor in diagnosis is that while symptoms are similar to those seen in adults, there are a few notable differences: While adults are able to verbalize that they are experiencing a depressed mood, children and younger adolescents have difficulty in describing what they are feeling. They tend to display more mood lability, irritability, low frustration tolerance, temper tantrums, or somatic complaints like stomachaches or headaches than do adults who are depressed. Another difference is that their symptoms may be interrupted by times when they will have an elevated mood. This mood shift occurs because young adolescents are more influenced by their environments than are adults, so they can still find occasional enjoyment from life events (Stark et al., 2006). However, by later adolescence, the cognitive symptoms of depression (e.g., hopelessness, low self-esteem) are more pronounced, so that a client's negative thinking patterns pervade her attitude towards all aspects of her life and inhibits enjoyment of almost all activities which she might have previously found to be enjoyable (Stark et al., 2006).

Finally, assessment of depression in adolescents must include questions to determine suicide risk. Counselors should assess for suicidal thinking when working with any adolescent girl with depressive symptoms, because depression is so highly associated with both suicidal ideation and behavior. Counselors should continue to assess for suicide risk not only during the initial assessment but

also throughout the course of therapy, especially when the client is also taking antidepressant medications (AACAP, 2007). The Federal Drug Administration (FDA) has issued a black box warning about the risks of suicidal ideation and behavior associated with antidepressant use in children and adolescents. This warning was released after the findings of the Treatment for Adolescent Depression Study (TADS), a large-scale randomized controlled clinical trial to evaluate the effectiveness of psychotherapy (CBT) alone, anti- depressant medication (Prozac) alone, and combination therapy (both CBT and medication). In the 36-week study, adolescents in the combination group had the greatest recovery rates. Combination treatment reached maximum benefit at week 18 with a response rate of 85%, reaching peak effectiveness earlier than either treatment alone (Prozac only, 62%; CBT only, 48%). Significantly, those adolescents who only received medication (and no psychotherapy) were twice as likely as clients with combination therapy or CBT alone to report suicidal ideation (TADS Team, 2009). This study and other findings (Spirito, Esposito-Smythers, Wolff, & Uhl, 2011) led researchers to conclude that therapists should continuously assess for suicidal thoughts and behaviors in depressed adolescents, especially when antidepressant therapy is first initiated, noting that the risk of suicidal ideation is highest during the first three to five weeks after medication onset (AACAP, 2007). In addition, findings high- light that combination therapy (medication plus psychotherapy) is the best treatment option for moderate to severe depression (Cox et al., 2014).

Assessment for Severity and Recommendations for Treatment Approach

According to practice guidelines, for mild depression that is causing only minimal impairment in a girl's life, therapists should provide supportive counseling—active listening, providing psychoeducation to the client and her family about the nature and course of depression, teaching general coping and problem solving skills, and monitoring ongoing symptoms. She might also benefit from self-care strategies such as exercise, relaxation, and improved sleep routines. After four to six weeks of supportive counseling with no improvement or if there is worsening of symptoms, CBT or IPT is recommended for clients who are non-suicidal and still in the mild range of depression severity (AACAP, 2007). Overall, medication is not recommended for clients experiencing mild depression.

At the moderate to severe range, however, treatment should begin with CBT or IPT and then include a referral to a medical professional to evaluate for possible antidepressant use (AACAP, 2007). There are two reasons that medication is not

recommended as a stand-alone or first-line treatment: First, there is an overall lack of strong evidence for the effectiveness of antidepressants in children and adolescents. In a meta-analysis, the quality of evidence for antidepressant efficacy was rated as very low, and only fluoxetine (Prozac) was statistically significantly more effective than placebo (Cipriani et al., 2016). Second, as reviewed previously, there are serious risks associated with the use of antidepressants in children and adolescents, including a risk of increased suicidal ideation.

Treatment of Depression in Adolescent Girls

There are therapeutic elements essential to include with adolescent girls who experience depression. First, the therapist should involve the client's family, particularly her parents or guardians. Ideally, families can be viewed as facilitators of the client's treatment rather than antagonists or obstacles to recovery (Weissman, Markowitz, & Klerman, 2018). Families can be educated that depression is no one's fault; as explained in this chapter, depression occurs through a complex combination of genetic, biological, environmental, social, and cultural factors and therefore no one is to blame for the disorder, including the client. When families are knowledgeable about depression and its treatment, they can also become advocates for their daughter at school, possibly communicating with the school counselor or administrators to make possible accommodations to her workload or schedule (Brent, 2013).

Another key treatment element is working with the family to make decisions about the course of treatment, including decisions about the use of antidepressant medication. Guidelines reviewed previously are summarized in Box 2.4.

Practice Parameter Guidelines for Depression in Children and Adolescents

- For uncomplicated or brief depression with mild psychosocial impairment, provide psychoeducation about depression (causes, courses, treatments, and risks associated with each treatment), provide supportive management through the use of active listening skills and instillation of hope, teach general coping and problem solving skills, collaborate with the family and school, and conduct ongoing monitoring of symptoms.

- After four to six weeks, if there is no improvement, then a trial with CBT or IPT is recommended for clients who are non-suicidal and whose symptoms remain in the mild range.

- For clients who have more moderate to severe depression, it is recommended that treatment should begin with combination therapy to minimize the risk of medication-induced suicidality (TADS Team, 2009).

(*Source*: Adapted from American Academy of Child and Adolescent Psychiatry, 2007)

Whether or not a client is referred for medication, ongoing evaluation for suicide risk and the development of a safety plan should be an essential part of any treatment approach. Adolescents who are at the highest risk include those with increased baseline suicidal ideation, drug and alcohol use, family conflict, poor treatment response, and a history of non-suicidal self-injury. Therapists can collaboratively develop a safety plan to help the client learn how to identify triggers, replace destructive urges with positive coping strategies, and reach out for support (Brent, 2013).

Through the initial stage of treatment, the therapist is also working to establish an alliance with the adolescent client. This can be challenging due to her developmental stage when she is likely starting to individuate from parents and other adults, resisting their efforts to control her, and trying to establish her own sense of personal power. Since she is likely feeling dismissed by adults in her life whom she perceives as telling her what to do without listening to her or validating her feelings, it is important that therapists refrain from becoming yet another threatening adult who is trying to take over her life or dismiss her opinions (Choate, 2013). Instead, the therapists can take time to listen to her, validate her concerns, and share power with her, rather than power over her during therapy. By sharing power, therapists can seek to establish a synergistic, empowering, collaborative relationship with adolescent clients (Enns, Rice, & Nutt, 2015). Even while the therapist has to respect the legal rights of parents/ caregivers to make treatment decisions on her behalf, the therapist can fully explore her preferences for treatment and inform her of the choices she has in the process. Instead of serving to only further silence her inner voice, the therapist can empower her to begin to share her needs and opinions openly.

As the relationship is established and the therapist has provided initial steps of treatment (e.g., basic psychoeducation, considering whether a referral for medication might be warranted, and assessing for suicide risk), a therapist must then consider the treatment approach that is most likely to be effective for the

client. In the sections that follow, I outline Cognitive Behavioral Therapy (CBT) and Interpersonal Therapy (IPT), the two treatments that have the strongest evidence base and that are recommended by national practice guidelines.

Cognitive Behavioral Therapy Approaches for Depression in Adolescent Girls

CBT is the most widely researched therapy for treating depression in adolescents, and has the strongest evidence base of any psychotherapeutic approach (Curry & Hersh, 2014; Spirito et al., 2011; Weersing et al., 2017). In a major meta-analysis of the evidence base for psychosocial treatments for adolescent depression, CBT was labeled as a well-established intervention, with evidence of efficacy in multiple trials by independent research teams (Weersing et al., 2017). It is most studied and effective for adolescents aged 13–19 but is not as consistently effective for children (Cox et al., 2014; Weersing et al., 2017). It is a structured approach and works best when the client is committed to longer- term treatment; in several studies, depressed adolescents who had greater than 9 CBT sessions were 2.5 times more likely to have a positive treatment response than were those who had less than 9 sessions (Kennard et al., 2009), and the clients who received therapy for 6–9 months had the greatest benefits (TADS Team, 2009). Practice guidelines indicate that the best way to prevent relapse is to continue treatment for up to 12 months, even offering monthly, quarterly, or "booster" sessions after primary treatment has ended (AACAP, 2007).

According to cognitive theory, depression results from an interaction between a pre-existing cognitive vulnerability to depression (as described in previous sections) and a stressful life event. Under typical conditions, girls with a vulnerability to depression might never experience an episode of depression. It is when she is faced with triggering life stressors that an at-risk girl will subsequently develop depression. According to Beck's schema construct (Beck, Epstein, & Harrison, 1983), a girl is cognitively vulnerable to depression when she possesses a negative attributional style (tending to make global, stable, and internal attributions for negative life events such as blaming herself when things go wrong) and when she develops negatively biased beliefs, leading to a highly negative view of self, others, and the future (termed the cognitive triad of depression). Therefore, when a girl possesses such negative views of herself (e.g., "I am so stupid"), others (e.g., "Everyone always judges me"), and about the future ("I will always be such a loser"), she will likely become depressed when she

experiences a negative life event (Reinecke & Ginsberg, 2008).

In addition to the cognitive triad, girls with cognitive vulnerability to depression are also likely to possess perfectionistic standards, pessimistic cognitive styles, negatively biased information processing, and poor coping and problem solving strategies. Once she develops a negative view of herself and views the world through a pessimistic lens, her resulting thoughts and behaviors will perpetuate and even exacerbate depressive symptoms. For example, if she already thinks negatively about herself, she will tend to emphasize negative feedback from others and discount any positive feedback she might receive as a way to confirm and reinforce her existing negative self-concept (Remmel & Flavel, 2004). Further, when she believes her attempts to make things better for herself will only be futile, she will become less likely to implement active coping and problem solving skills. In addition, when she believes that others will respond to her in a rejecting or negative manner, she may push others away to protect herself from rejection, yet this behavior only serves to increase her sense of social isolation (Abela & Hankin, 2008).

Components of Effective CBT Programs

CBT interventions emphasize cognitive, problem-solving, and coping skills deficits by assisting the client to change negative beliefs, attitudes, and thoughts about herself, others, and the future that will in turn promote positive mood. CBT also helps clients increase behaviors that boost positive mood and that help the client to re-engage with life and to enhance her social sup- port system. Most research-based CBT intervention programs include similar elements. In the following section, I synthesize seven of these components identified across research studies (see Brent, Poling, & Goldstein, 2011; Reinecke & Ginsberg, 2008; Kennard et al., 2009). I also weave in examples from the case of Elise, presented earlier in the chapter.

Psychoeducation As stated previously, an important component in the early stages of treatment is the provision of psychoeducation for both the client and her family about the nature of depression and the likelihood of positive treatment outcomes. The therapist provides a rationale for CBT techniques; emphasizes the importance of consistency in attendance, monitoring, and behavioral practice; and discusses helpful resources to read outside of session. For Elise, both parents need to be educated about the nature of depression and her need for increased support during this time. They may need to find ways to support her so that she does not

spend so much time alone when she is at either of their homes.

Therapeutic Collaboration Through Goal Setting and Monitoring CBT emphasizes a collaborative working relationship with parents/caregivers as well as between client and therapist, working together to define clear, measurable goals. The client will be encouraged to monitor her thoughts, behaviors, and mood, helping her to identify that certain beliefs or activities can cause her to either feel better or worse. Homework is also assigned each week to give clients opportunities to track thoughts, mood, and behaviors, test out the validity of a particular belief, or practice a new behavioral skill. In this case, Elise agrees to monitor her moods and thoughts on a tracking app on her phone. She also agrees to come to therapy weekly and to complete homework assignments because she believes that therapy will help her feel better if she follows the plan.

Cognitive Restructuring Cognitive techniques are used to first identify automatic thoughts and cognitive distortions about self, others, and the future. Next, the client is encouraged to develop more realistic counter thoughts by asking herself a series of questions to help her recognize errors in her thinking and how a particular belief may be contributing to her depression. For example, Elise has developed a belief, "I am an outcast for life. I will never have friends." She can ask herself, "What is the evidence for this belief ?" (e.g., *"I currently don't have friends, but I did have good friends in the past."*) "Is there another way to think about it?" (e.g., *"Yes, the kids at my middle school are mean and I can't wait to move on to high school in a few months. I will have the chance to make new friends and have a fresh start. In the meantime, maybe I can text one of my old soccer friends who goes to a different school. Maybe she will want to go to a movie with me."*)

Behavioral Activation Behavioral activation is an essential component of CBT and can also be used as a stand-alone behavior therapy (without using the cognitive components of CBT). It is a solution-focused intervention based on the idea that individuals who are depressed do not receive enough positive reinforcement in their lives because they are avoiding the very people and activities that would provide this reinforcement (Curry & Hersh, 2014; Ritschel, Ramirez, Jones, & Craighead, 2011). The therapist assists a girl to first monitor her behaviors and moods, and to determine which activities contribute to a more positive mood, and which activities tend to make her feel worse. The therapist then helps her create a menu of activities that she can use to boost her mood (e.g., "What are things you do that make you feel better, that bring you pleasure, or that bring you a sense of accomplishment?"). Elise's therapist asks her to track her moods for a few days, and

she realizes that she feels the worst when she spends time at her dad's house, because he lives in a more isolated area and she spends most of her time alone when she lives with him. She also feels worse when she spends too much time on Instagram and Snapchat. She realizes that she feels best when she gets her homework done and when she hangs out with her older brother watching movies. She agrees to try to do more of the activities that boost her mood and spend less time alone and on social media. Her dad agrees to help her find more things to do while she is at his house.

In addition to mood-enhancing activities, the client is also encouraged to establish and follow a regular routine (e.g., going to school, doing home- work, engaging in self-care). Getting up in the morning and going to school (or having some planned structure for the day) increases the likelihood that she will interact with others and will start to feel better as she completes activities. This straightforward approach is helpful for children and younger adolescents who are not yet cognitively sophisticated enough to engage in the abstract thinking requirements of cognitive restructuring. It is also helpful for severely depressed clients who can't focus on cognitive change but who are able to try basic behavior changes that can promote a more positive mood (Ritschel et al., 2011).

Social Skills and Communication Training Because girls are not often socialized to express their opinions and needs in an open, direct manner, they need skill development and practice in social skills. This component consists of practicing skills in areas such as assertiveness (e.g., avoiding passivity and aggression), compromise (e.g., active listening, reflection, negotiation, conflict resolution), and social interaction skills (e.g., starting conversations, joining groups, listening, using I-statements). Because girls who are depressed have a tendency to isolate and feel rejected by peers, it is important for her to start with small goals (e.g., to smile at three people at school; to say "hi" to at least one person in the cafeteria) in order to build self-efficacy towards more advanced social goals. The therapist might also need to work with parents/ caregivers and the client on family communication styles that increase trust and promote more effective communication (e.g., reducing blame, clearly labeling problems without name calling, validating one another's perspective) (Ken- nard et al., 2009). In the case of Elise, family sessions are indicated to improve communication between the mother, father, and their adolescent children, and also to provide more structure and support for Elise during her recovery.

Problem Solving Along with social skills training, this component has been

identified as one of the most effective for decreasing depressive symptoms (Kennard et al., 2009). It involves teaching clients a five-step model for solving problems: (1) defining/operationalizing problems, (2) defining goals, (3) generating potential solutions, (4) evaluating consequences, and (5) implementing action and evaluating results. Clients are encouraged to use problem-solving strategies instead of engaging in rumination and co-rumination, cognitive styles that keep the negative feelings at a high level of intensity and only exacerbate depression.

Emotion Regulation These strategies help clients learn to (1) increase awareness of the chain of events that lead to depressed mood so that the cycle can be interrupted before her mood spirals downward, and (2) learn to cope when she finds herself in distressing situations that cannot be changed, at least in the present moment. These skills include mindfulness, progressive muscle relaxation, deep breathing, guided imagery, seeking social support, or connecting to religious and spiritual resources. For example, one study found that girls who used positive coping resources such as religion and spirituality were less likely to have depressive symptoms (Durbin & Shafir, 2008).

These components cut across CBT treatment programs, although they are packaged and presented in varying ways depending upon the treatment modality, setting, and particular client population. I will highlight two CBT interventions designed specifically for adolescent depression: Adolescent Coping with Depression (CWD-A) program and the ACTION program.

Program Snapshot: Adolescent Coping With Depression Program

Program Summary: CWD-A is designed for adolescents ages 13–17, and sessions are conducted in eight weekly 90-minute group meetings. At least two family sessions are also incorporated, and continuation sessions are included monthly for six months following the end of the eight weekly sessions.

Research Support: CWD-A is among the most studied and effective CBT programs for adolescents, with strong support for its efficacy (Kaiser Permanente Center for Health Research, 2015; Garber et al., 2009).

Unique Features: The client workbook and group curriculum are available online for free use by mental health professionals (www.kpchr.org/acwd/acwd.html).

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Program Components:

1. Cognitive restructuring to address negative beliefs, guilt, hopeless- ness, and worthlessness by identifying and implementing challenges to negative thoughts

2. Behavioral techniques to address social withdrawal and interper- sonal interactions by increasing pleasant activities

3. Problem solving, communication, and negotiation skills to address poor problem solving and ineffective interpersonal interactions with family and peers

4. Relaxation training to ease social anxiety and tension

5. Goal setting to identify short- and longer-term life goals

Program Snapshot: ACTION Points

Program Summary: The ACTION CBT-based treatment program is specif- ically designed for adolescent girls ages 9–13. Treatment is based on the conceptualization of depression as resulting from negative thinking and skill deficits. The program helps girls learn to recognize their negative thoughts or mood and then to use these as cues for implementing either coping skills (for situations in which they don't have the ability to change the outcome), problem solving (for situations in which they can take active steps to make things better), and/or cognitive restructuring skills (for times that could be improved by thinking differently about the situation). Leaders teach these skills in groups of four to six girls, meeting twice weekly for 11 weeks.

Research Support: Multiple studies indicate strong empirical support for program effectiveness (Stark et al., 2008; Stark, Streusand, Krumholz, & Patel, 2010).

Unique Features: The single sex group format is deemed important for its instillation of universality, hope, for reliance on other members as sources of emotional support and for assisting in countering negative beliefs.

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Program Components:

In the first few group sessions, girls learn coping and problem solving strategies and how to determine what is needed based on a given situation.

1. If I decide to use coping skills . . .

Girls are taught to recognize situations in which they cannot change the outcome as opportunities to use a coping strategy. Coping strategies are categorized in five areas:

• Do something fun
• Do something that uses energy
• Do something soothing and relaxing
• Talk to someone
• Change the way you think about it

If a girl decides to change her thinking about the problem, she can use cognitive restructuring skills:

To learn cognitive restructuring, girls are taught to counter negative thoughts by learning how to be "thought judges." Girls learn talk back to the "muck monster," a vivid symbol through which a girl's negative thoughts are visualized as keeping her "stuck in the muck." Girls are encouraged to dispute the muck monster ("What is another way of looking at it?" and "What is the evidence?") and to replace the muck of negative thoughts with more positive and realistic thinking.

2. If I decide to use problem-solving skills:

Girls learn to use problem solving for situations in which action is needed in order to improve the situation. The steps are as follows: (1) problem definition, (2) goal definition, (3) solution generation, (4) evaluating consequences, and (5) self-evaluation.

Action Kits:

In final sessions girls are given Action Kits that consist of color-coded cards

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that are used as reminders of skills learned throughout the program. These include (1) when do I use coping skills, problem solving skills, or cognitive restructuring? (2) how do I identify my emotions? (3) a copy of the five categories of coping skills (listed previously), (4) a copy of the steps for problem solving, and (5) the two questions used to evaluate a negative thought: "Is there another way to look at it?" and "What is the evidence?"

Elise and ACTION Treatment

To help Elise overcome her depressive symptoms, Elise enrolled in a small counseling group that followed the ACTION model. While she was reluctant to join a group at first, her individual therapist believed that she would benefit from the interactions with other teens going through similar problems. In the first few sessions, Elise began to trust the lead- ers and members as she realized that they cared about her feelings and what she had to say. They helped her to recognize her negative thoughts and triggers for her sad moods. She learned to recognize these as cues to alert her to the need to implement problem solving, coping skills, or cognitive restructuring. To develop her problem-solving skills, she chose the most pressing problem—no friends. She then learned the steps for problem solving, eventually coming up with two strategies (e.g., join an after-school group away from school, call some of her friends from soccer). Within the group, she also identified coping skills for when she is in situations that cannot be changed (for example, she has to live in two separate homes due to her parents' divorce, and she must remain in her current school until the end of the academic year). She agreed to try some new pleasant events (go to a yoga class, watch a movie with her brother), some energy-producing events (ride a bike while at her dad's rural house, which provides lots of trails), self-soothing strategies (light a candle and listen to relaxing music), talk to someone (she agrees that maybe her mom would be more open if she was more aware of Elise's struggles). She also learned to change the way she thinks about herself, others, and the world. For example, she learned to visualize her negative thinking as a muck monster and her thoughts as keeping her stuck in the muck. She learned how to talk back to the muck monster by evaluating her thoughts and replacing them with less harsh, extreme thinking.

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Interpersonal Therapy for Adolescents

As with CBT, Interpersonal Therapy for Adolescents (IPT-A) has strong research support and is effective for girls (Mufson, Dorta, Wickamaratne et al., 2004c; Jacobson & Mufson, 2010). IPT-A is particularly effective when the client is experiencing parent/child conflict, social role impairment, and displays high levels of sociotropy (Brent, 2013; Gunlicks-Stoessel, Mufson, Jekal, & Turner, 2010). Three randomized controlled trials (RCTs) have been conducted to conclude that IPT-A is more effective than treatment as usual, clinical monitoring, and wait list (Jacobson & Mufson, 2010). IPT-A has been successfully modified for a group format (IPT-AG; O'Shea, Spence, & Stark, 2014) and shows promise with girls from Latino populations (Mufson, Yanes- Lukin, Gunlicks-Stoessel, & Wickramaratne, 2014), pregnant adolescent girls (Miller, Gur, Shanok, & Weissman, 2008), and delivery in school-based mental health clinics (Mufson, Dorta, Olfson, Weissman, & Hoagwood, 2004b). It has also been successfully modified for preadolescents and to include the family in weekly sessions (FB-IPT; Dietz, Mufson, Irvine, & Brent, 2008). This format specifically addresses family–child conflict and improvement of social impairment with peers (Dietz, Weinberg, Brent, & Mufson, 2015).

Theoretical Conceptualization of IPT

IPT was initially developed to treat depressed adults. It is based on the assumption that negative interactions and dysfunctional communication patterns in early relationships contribute to internal working models of relationships, and these models are activated during times of relational stress (Mufson, Dorta, Moreau, & Weissman, 2004a; Weissman et al., 2018). For adolescent girls these stressors can accumulate in multiple life domains and occur simultaneously, including dealing with complex peer relationships, dealing with victimization from bullying, conflicts in romantic relationships, and increased conflict in parent–child relationships (O'Shea et al., 2014). According to attachment theory, a girl's earliest relational experiences will influence her expectations of and behavior within her current relationships. Until her maladaptive inter-personal patterns are changed, her relational problems and vulnerability to depression will continue. IPT also posits that when a girl is depressed, she interacts with others in ways that only serve to elicit negative feedback and continued loss of social support, both of which will perpetuate the depression. In contrast, as the client improves her interpersonal relationships, builds sup- port, and enhances interpersonal competence, her depressive symptoms will be reduced (Mufson et al., 2004a). There is some overlap

in the areas addressed with CBT; IPT targets areas such as family conflict, affective expression, peer problems, effective problem solving, and communication skills, as well as developmental issues such as individuation, emerging romantic relationships, and managing peer pressure.

IPT-A Treatment Approach

IPT-A is described in a treatment manual (see Mufson et al., 2004a; see also Weissman et al., 2018 for a guide to Interpersonal Psychotherapy). According to IPT-A, there are four tasks for the therapist: (1) to create a therapeutic relationship with the client and her family; (2) to conceptualize the adolescent depression through an interpersonal context by identifying interpersonal problems in one of four areas: grief, interpersonal role disputes, interpersonal role, transitions, and interpersonal deficits; (3) to assist the client in becoming more aware of maladaptive communication patterns and change them so she can more effectively meet her relational needs; and (4) to help the client to develop a stronger social support network.

Initial Assessment The therapist meets with family members to explain the counseling process and to obtain an interpersonal history. It is important to involve the parents/caregivers in at least the first phase of treatment so that they can collaborate on the treatment plan. Part of the purpose of this initial session is also to determine if the client will likely benefit from IPT-A. Research indicates that she is most likely to have treatment success if the family is supportive, if she can establish a therapeutic relationship, and if she is motivated to decrease her depressive symptoms. Finally, IPT-A is recommended as a short-term treatment for adolescents ages 12–18 who meet criteria for acute onset Major Depressive Disorder or persistent depressive disorder (formerly termed *dysthymia*). It would not be appropriate if the client is actively suicidal, has psychotic symptoms, or if her primary diagnosis is bipolar disorder, sub- stance abuse, anxiety, or conduct disorder (Mufson et al., 2004a).

After meeting with the family, the therapist then meets with the adolescent alone to discuss confidentiality and to assess goals for therapy. The counselor conducts an assessment to collect the following information:

- Collect information to make an accurate diagnosis of depression
- Obtain information about current and past depressive symptoms

- To ascertain a history of the current depressive episode, including a possible precipitant
- To collect a psychosocial history including past episodes of depression or other disorders
- To assess current psychosocial functioning
- To ask about family/personal medical history

With adolescents it is also important to discuss associated problems such as suicidality, non-suicidal self-injury, substance use, antisocial behavior, or other comorbid problems. It is recommended that the counselor also meet with the parents separately to confirm the results of this part of the assessment and to attempt to reconcile any discrepancies between client and parent reports. This additional information is helpful in conceptualizing the client's problems and how the depression is being perpetuated.

Sessions 1–4

Initial sessions include providing psychoeducation, collecting an interpersonal inventory, and the presentation of the case formulation.

Psychoeducation

The therapist helps the adolescent to understand that her symptoms are part of being depressed, and that depression is a treatable disorder with a positive prognosis. She and her family members should be encouraged to provide her with some relief from the pressure of performing at same level as prior to being depressed. Parents' concerns should be validated, but they should try to refrain from expressing frustration at their daughter's lower performance quality while she is depressed. While she might need some extra support at this time, she should still be encouraged to go to school, compete tasks, and to do as many of her usual activities as possible.

Collect an interPersonal inventory

The Interpersonal Inventory helps to examine the client's relationship problems and history of relationships. For example, the therapist asks general questions such as:

- Do you think you have problems in your relationships with people? What are the problems?
- Who in your family do you feel closest to, who you could count on and go

to for help? What makes the relationship special to you?

- Who can't you count on? What makes it hard for you to be close to that person?

For adolescent clients who have difficulty in answering these questions, an examination of current relationships through a "closeness circle" exercise is recommended. The client is asked to draw a series of concentric circles, with an X in the center to indicate the client. The client is asked to name others in her life and place them on the circles according to the level of closeness she feels with each of them. The counselor can then discuss the most important relationships in greater depth. For example, for each person who is closest to her on the circle, she can examine:

- What activities do they do together?
- How frequently do they interact?
- What are the expectations for the relationship?
- What are the positive and negative aspects of this relationship?
- What changes do you want to make?
- What happens when you have conflict?
- What happens when you try to talk about it?
- What have you tried already that was or was not helpful?
- How has your depression affected your relationship with this person?

The next part of the Interpersonal Inventory is to assess for life events that occurred around the time of depression onset. These events might include problems with friends, changes in family structure, transitioning to a new school, moving to a new location, death or illness in the family, sexual identity development, and onset of romantic/sexual relationships.

Present the case Formulation As the client begins to link the onset of depression with these problems or changes, the therapist can explain the connection between the relational stressors and the depression. She can begin to recognize that as changes are made in her relationships, she will subsequently have more energy and begin to feel better, and will develop relationships that are more mutually satisfying. At this point the therapist will help the client select one or two problem areas for treatment focus: grief, interpersonal role disputes, role transitions, or

interpersonal deficits. (Mufson et al., 2004a).

Sessions 5-8

Based on the problem area(s) chosen, the therapist approaches strategies for improving that area, using such techniques as education; clarification of feelings and expectations; encouragement of affect; clarification of her roles in the family, peer, group, and community; facilitation of social competence through communication analysis (impact of words on others, feelings they convey, feelings that are generated, and how they can modify these exchanges); and decision analyses (basic problem solving skills, compromise, negotiation skills, modeling, and role playing) (Weissman et al., 2018).

Four Interpersonal Problem Areas

Grief

If the adolescent is coping with the loss of a relationship, such as the death of a parent or other loved one, the IPT-A approach to grief resolution is helpful for adolescent girls who are currently experiencing depression. It can also be beneficial for those who are at risk of depression following a loss. This may be particularly important for adolescents who have been depressed in the past and who might be vulnerable to its recurrence given the stress of the loss. It might be also helpful for girls who lack an understanding of death, have lost significant others due to multiple or sudden deaths including suicide or homicide, have a conflicted relationship with the decreased person, or have an overly dependent surviving parent, as these are all risk factors for developing depression during the bereavement period (Mufson et al., 2004a).

To assess the impact of the loss, the therapist can examine (1) the nature of the relationship with the deceased person, (2) her current support system, (3) her coping skills and psychological maturity, and (4) any signs of distorted grief including behavioral problems such as acting out, drug or alcohol use, or sexual promiscuity. It is also helpful for counselors to know that with adolescents, the grief response may appear to be more episodic than pervasive across time. The first step in working with grief is to assist the client in connecting the particular loss with the onset or increase of depressive symptoms. Once this link is made, it is helpful to provide her with education about normal bereavement patterns. She might be experiencing a range of feelings, from sadness, excessive guilt, anger, fear, or a belief that she is responsible or could have prevented the loss. It is important

for her to understand that her feelings are normal, that grieving takes time, and that grief is experienced differently by each individual.

It is also helpful for her to learn that it is normal to fear being overwhelmed and unable to control her emotions. This is the reason she might have avoided facing the loss until now, because her feelings are so powerful. She can be reassured that while feelings can be intense, they are not dangerous, and that they do subside as you express them. The idea is to process the feelings surrounding the loss rather than continuing to avoid them, which actually makes them worse (Weissman et al., 2018). The therapist can assure her that they will move slowly at her own pace and only discuss aspects of the loss as she feels ready to do so.

Next, the client is encouraged to actively mourn the loss by thinking about and describing it in detail. Some exploration questions to consider:

- What happened right before, during, and after the loss?
- How was her relationship with the person around the time of the loss?
- What types of things did they do together?
- If the loss was a death, how did she find out about it? How did she react to it?
- What was the funeral like for her? How did she grieve during the funeral?

Next, she can explore her current feelings about the relationship and how the loss is affecting her daily life. For example, what is she struggling with most now that the person is not present in her life anymore? It is especially helpful for her to create a realistic, three-dimensional picture of the relationship, recalling both the good and bad qualities, because exploring a balanced view of a lost relationship helps to facilitate the mourning process. The client should be reassured that it is normal to have both positive and negative feelings about the person, and the counselor can validate these conflicting feelings (Weissman et al., 2018).

Finally, the therapist can examine the client's need for strengthening existing relationships or establishing a new social network that will provide support. This is important because she might be experiencing social isolation. Her peers might be avoiding her because they don't know what to say to her or how to discuss the loss. It is also common for grief experiences to put a strain on existing relationships in her life, resulting in an increase in conflicts. This type of avoidance or conflict can in turn increase her vulnerability to depression at a time when she needs

increased support. A further need for additional support occurs if she is in a relationship with a parent or loved one who is overly relying on her to help him/her cope with the loss. Because of these problems, the client might need to practice new styles of communication, learn to set boundaries, practice ways to develop supportive relationships, and be encouraged to become involved in activities that might strengthen her support system (Mufson et al., 2004a).

Role Disputes

This is a relevant area when the client and significant others have conflicting expectations in their relationship. Many girls will have experienced conflicts as a result of unmet expectations, mistreatment, and betrayals in their relation- ships with parents, friends, teachers, or significant others. Such interpersonal conflict can cause an adolescent girl to feel helpless, powerless, out of control, and misunderstood. In turn, she might increase social withdrawal and engage in poor communication with others, furthering her inability to communicate her feelings and expectations with the other person. The goal in this problem area is to assist the client in successfully resolving a conflict with a person (or persons) with whom she is in conflict. To assess the history of the dispute, the counselor might ask such questions as:

- When did you first become aware of the dispute?
- What are your expectations of this person and how have they changed?
- What do you fight about?
- How do you communicate your needs?
- How do your fights end? How do you feel when this happens?
- How do you wish the other person would respond to you?
- How do you think your relationship can be helped or improved?
- What have you already tried to do to resolve the dispute?
- What prevented these attempts from working? (Weissman et al., 2018)

To begin to address a particular conflict, the counselor can first determine the stage of the dispute:

- *Negotiation* (e.g., there are ongoing attempts to improve the relationship)
- *Impasse* (e.g., neither individual is attempting to change)

- *Dissolution* (e.g., the relationship is beyond repair)

The client's plan will be dependent upon the stage of the dispute. For example, if she is at the negotiation stage, she may spend time closely examining her patterns of communication with the person with whom she has a conflict. She can receive feedback about the ways she communicates her needs, how she expresses anger, and how she responds to the conflict (Weissman et al., 2018). The therapist can assist her in problem solving and in practicing new ways of communicating, or work to change her expectations with the relationship if these have been unrealistic. She may also benefit from role-playing with the therapist and observing modeling of appropriate communication (Weissman et al., 2018). She might also benefit from having the person attend a session with her to practice the skills and to try to decrease the conflict.

If she is at the impasse stage in her relationship, she can decide what is best for her: to move the relationship back towards negotiation, or to facilitate its movement towards dissolution. To facilitate negotiation, she might have to invest more energy in the relationship and take risks in sharing her feelings; in other words, she needs to open up the conflict in order to resolve it. If she decides that dissolution is the best solution, the counselor can assist her in taking action to end the relationship. In this case, she may need to spend time mourning the loss of the relationship, incorporating aspects of grief work, and accepting the loss as a role transition (as described in the next section; Weissman et al., 2018). If the dispute is with a parent, she can examine the most effective ways to cope with the situation, try to reconnect with the parent, develop more realistic expectations about what the relationship will actually be like, or increase her involvement in pleasurable activities that do not involve the parent. She might also try to identify an alternative family member who might be able to provide the support and caregiving that this parent is unable to give (Mufson et al., 2004a).

Role Transitions

Like role disputes, role transitions are common in girls with depression. Role transitions occur when a girl has difficulties in releasing a previous life role and in embracing a new one. Examples can include when a girl is uncomfortable with the changes in her body at puberty and is ambivalent about moving from girlhood to adolescence—a process that involves sexual identity concerns, decision making about dating and sexual behavior, and taking responsibility for her future in terms of academics, college, and career (Mufson et al., 2004a). Transitions might also

occur unexpectedly due to a change in the adolescent's role in the family due to a move, separation/divorce/change in family structure, or family illness. An adolescent girl might also experience problems with transitions when she or her parents have difficulty accepting the inevitable changes that occur with adolescent development, such as increased independence and responsibility (Mufson et al., 2004a). This is the problem area that would most likely take precedence in the case of Elise presented in this chapter.

The first step in this area is to assist her in clearly identifying the nature of the roles involved in the actual transition. Once the roles are defined, she can focus first on her old role, fully validating and exploring her feelings about it, and mourning the loss of a role that is comfortable and familiar. She can also explore how the loss affects her sense of identity and relationships with others. The therapist might also provide parents with education regarding normal adolescent developmental transitions.

The client can then begin to examine her feelings about the new role. For example, what is causing her to experience anxiety or ambivalence about her new role? What are the potential benefits and opportunities that the new role may yield? How does the new role fit with her overall life goals? It may be helpful to assist her in creating a chart, comparing and exploring the pros and cons of both the old and new roles in an effort to create a balanced picture of the transition (Weissman et al., 2018).

Example of Elise's Pros/Cons of Role Transition Chart

Old Role Pros	**Old Role Cons**
Oldest grade at school Know what to expect Teachers understand me and my depression	Tired of mean girls at school Bored by current school subjects Bullied at school, called a "slut" Everyone knows I've been depressed
Old Role Pros	**Old Role Cons**
Chance to start over No one knows my history, not labeled Chance to take new classes Chance to meet new friends Will be able to get away from the mean girls	What if no one talks to me and I'm lonely? Don't know what to expect What if I make no friends? Classes might be really hard People might bully me

The next step will be for her to examine the specific demands of her new role. What does it require? Are there things she needs to learn? How can she go about developing these skills? What are the strengths she already possesses that she can bring to the new role? Finally, she can examine her support system and the ways in which she may need to ask for help in transitioning to the new role (Mufson et al., 2004a).

Interpersonal Deficits

This problem area is identified when a client has a history of difficulty in initiating or maintaining close relationships. When an adolescent girl has trouble developing and maintaining relationships with peers and becomes socially withdrawn, then she is less able to overcome her social deficits because she has fewer opportunities to interact with others. This pattern contributes to depression and subsequently leads to further withdrawal. Social isolation and a lack of a network of peers are particularly problematic in adolescence because the successful establishment of social relationships is an important aspect of many of the developmental tasks of adolescence (Mufson et al., 2004a).

To make improvements in this area, the counselor can assist an adolescent client in assessing her interpersonal problems by discussing her current relationships, past relationships, and even her relationship with the therapist. As part of this review, the therapist can provide the client with specific feedback about her communication style and how it might be improved. To help reduce her social isolation, establish new relationships, and strengthen existing ones, the client may benefit from basic social skills training exercises that can be practiced both within and outside of counseling sessions. Family members may also be involved so they can encourage the development of these new skills. For example, the client can identify people who can be a support to her, practice ways to express her feelings more clearly, role play a conversation with peers, and identify activities in which she can participate that will enable her to meet peers with similar interests. Mufson and col- leagues recommend that it is most helpful to be specific, and to stay focused on improving one relationship or building one particular skill set in order to make progress during the limited time frame of therapy. This approach is similar to the CBT social and communication skills training described earlier in the chapter. Group therapy (e.g., Young et al., 2016) is also recommended as a way of receiving interpersonal feedback and for practicing new social skills.

Conclusion and Maintenance

The last phase of therapy helps the client plan for how she will manage interpersonal stressors after therapy has ended and to review the progress she has made during treatment. Some ending tasks include (1) How do you feel about ending treatment? (2) What are some warning signs that your depression is returning and that might indicate the need to return to counseling? (3) What are your interpersonal strengths and skills you have learned in therapy? (4) What are some areas where continued work is needed? (5) What is your plan for the steps you will take once counseling has ended? (6) When do you need to return to schedule a maintenance or booster session for the near future? (once-per-month maintenance sessions are suggested in the treatment manual).

Adaptations of IPT-A

IPT-A has been adapted to a group format (IPT-AG) with promising results (Mufson, 2010; Mufson et al., 2004b). Belonging to a group provides adolescents with a place where they can practice the communication and relational skills they are learning and provides them with an experience of universality that they are not alone with their problems. The current format of IPT-AG includes 2 individual pre-group sessions with adolescent and parent in order to conduct the interpersonal inventory and to determine areas of focus, fol- lowed by 12 consecutive group sessions. It also includes 1 mid-treatment family session with each adolescent. The IPT-AG model has also been modified to include family members in every session. In this newer format, weekly sessions are divided into two parts: meetings with adolescents followed by joint or dyadic meetings with parents. Additional studies are needed to establish effectiveness of incorporating parents into all weekly sessions (Dietz et al., 2008).

IPT-AG has been studied in a group of primarily Latina female adolescents ages 12–18 in a school setting, and results demonstrated that IPT-AG group is effective (as compared to a control group who received primarily supportive psychotherapy); however, the results were strongest for those who were in highly conflicted relationships with their mothers or with friends (Gun- licks-Stoessel et al., 2010). There is also some initial evidence that IPT-AG was effective in reducing depressive symptoms in a group of adolescents who were displaced survivors of war in northern Uganda, and the effects were stronger for girls than for boys (Bolton et al., 2007).

TREATMENT FOR DEPRESSION IN ADOLESCENT GIRLS

NAVIGATING PUBERTY AND THE TRANSITION TO ADOLESCENCE

Excerpted from *Depression in Girls and Women Across the Lifespan*

Conclusion

It is clear that girls face many challenges as they transition to early adolescence. First, a girl's body is changing rapidly as she undergoes a drastic physical and cognitive transformation. Not only does she look different on the outside, she also feels emotions differently and thinks about the world in a more cognitively complex way. With these physical and cognitive changes as a backdrop, she is also facing the many stressors mentioned in this chapter— including cultural pressures about the importance of appearance, attention, and accomplishments; increased academic pressures; friendship upheavals; sexual identity and sexual decision-making concerns; navigating social media; and family conflicts. In addition, she might be facing all of these changes and challenges simultaneously, which places her at risk for depression. This vulnerability is exacerbated when a girl has an inherited risk for depression and possesses the psychological risks described in this chapter (e.g., negative and intense affect, negative attributional style, interpersonal orientation, excessive empathy, and tendency to ruminate and co-ruminate). It is important for therapists to be aware of these risk factors so they can provide early detection and intervention for depressive symptoms. As reviewed throughout this chapter, when depression develops in adolescence, it can cause impairment in the development of healthy emotional, cognitive, and social skills, often leading to significant interpersonal problems that will follow girls into adulthood. By providing assistance when symptoms first emerge, a girl may be protected from not only the development of a current depressive episode but also from a lifetime of recurrent episodes of MDD.

Because this is such a high-risk time for girls—and risks only seem to be increasing according to current statistical trajectories—therapists need preparation to recognize the risks and to be informed of effective treatment options. Therapists can develop the knowledge and skill to provide evidence-based interventions such as CBT and IPT when girls experience MDD, particularly because depressive episodes in adolescence are associated with increased suicide risk and so many other problems. As stated by Zalaquett and Chatters-Smith (2016, p. 205), "Treating depression (in chil- dren and adolescents) is a professional responsibility and matter of social justice for practitioners" because untreated MDD can lead to so many adverse outcomes later in life. When girls receive treatment in early adolescence as they first become vulnerable to depression, they not only benefit from symptom remission, they also develop the resilience to cope effectively with future challenges.

TREATMENT FOR DEPRESSION IN ADOLESCENT GIRLS

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Note

This chapter was adapted from the author's previously published work regarding counseling interventions for depression in adolescent girls: Choate, L. H. (2018). Depression in girls during the transition to adolescence: Risks and effective treatment. Journal of Child and Adolescent Counseling, 4, 50–66. Copyright © Association for Child and Adolescent Counseling, http://acachild.org/ reprinted by permission of Taylor & Francis Ltd, www.tandfonline.com on behalf of the Association for Child and Adolescent Counseling.

While many of the headings remain the same, the current chapter has been expanded and updated to reflect current issues and the most recent evidence base for studies in this area.

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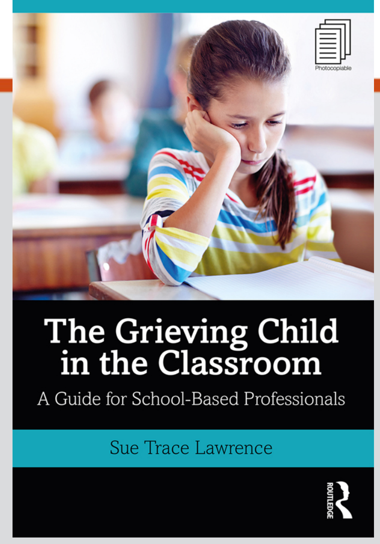
WHAT TO SAY, WHAT NOT TO SAY AND WHAT TO DO FOR A GRIEVING CHILD



This chapter is excerpted from

The Grieving Child in the Classroom: A Guide for School-Based Professionals

by Sue Trace Lawrence.

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WHAT TO SAY, WHAT NOT TO SAY AND WHAT TO DO FOR A GRIEVING CHILD

Excerpted from *The Grieving Child in the Classroom*

What to Say to a Grieving Child

The question everyone invariably asks is "What do I do or say to someone who is grieving?" There are comments that are not helpful. When we consider individual differences in mourning, constructing an itemized list of supportive, or at least appropriate, comments is a daunting task for sure. Nonetheless, I will offer a handful of guidelines and suggestions gathered from research and responses from the bereaved themselves.

It is important to keep in mind what your goal as a support person is. As Megan Devine suggests in her book, It's Ok that You're not OK (2017), losing a loved one is not a fixable dilemma. Death is final. It cannot be reversed. Things will not be "OK." A child will intuitively know that any statement that implies otherwise is an empty promise. True, the intense pain of an immediate circumstance may dissipate, but as Devine so poetically suggests, grief is something we "carry," not "get over." We learn a new normal, a way to exist in a drastically changed world. When we love someone, we miss them when we no longer can see, hear, or touch them. The finality is painful to accept, and no words of encouragement can alter the facts. To a mourner, comments implying that patience is all that is necessary for life to "get better" are dismissive at worst and missing the point at best—regardless of the true intent of the person delivering the statements. The best course of action is to communicate to the child you recognize her feelings and are available for support. Although it may be awkward to mention the loss to a child who is just returning from bereavement leave, ignoring the issue is usually worse. Many of the respondents in our interview study broached this topic, saying that the lack of acknowledgement from educators and peers was painful. To the grieving child who has experienced a major life change, the fact that others do not mention the event implies a lack of caring or recognition of the seriousness of the child's feelings. Teachers should be sensitive to a child's privacy, and they should recognize that comments should be made privately. Educators can take a minute and speak to the child quietly to make a brief acknowledgment of the child's grief. Even a simple "How are you?" can be enough to express concern and validate the significance of the issue.

Like adults, children will vary wildly in their need to talk over their feelings and tell their stories. This is true not only from person to person but can vary within a single individual. As a teacher who may have a solid understanding of a student's personality and behavior patterns, you may guess which a pupil will be willing to

share and who will keep thoughts to herself. Do not be surprised if your predictions are incorrect. Grief often changes the usual responses, so be ready to "go with the flow." If a child shows a desire to talk, let them do so. It might be best to find a quiet time when the student can speak privately. This will allow you to understand what information the child wishes to share and evaluate the appropriateness of expressing these ideas to the other children. A few pupils may ask to speak with the class, and the instructor should be prepared to handle the nature of the child's comments. Other times, a child may not wish to speak even in a private conversation. You might take the student's lead, allowing him to share as he wishes. Acknowledging grief is not the same as forcing conversation. Even if a child responds to a simple "how are you?" with an obviously untrue "fine," the message of caring and concern will be conveyed.

Why do we, as supporters, find bereavement so uncomfortable and awkward? When a youngster falls and skins a knee or shows up in a class with a cast on a broken arm, no one hesitates to ask the hurt child about the physical injury. When a student returns to class after a long illness or recovery from surgery, most people, even peers, find it easy to inquire about her health. After a loss, however, the case is very different. This is true for several reasons. First, watching someone in emotional pain can trigger similar responses in us. Their grief may remind us of our own losses. We have an underlying worry that death is contagious; "there but by the grace of God go I." Most people fear losing their loved ones to the point of disassociation. We ignore the possibility by avoiding the subject at all costs. Observing others mourn is painful, not only because of our ability to emphasize but because of our need to pretend that grief cannot happen to us.

Second, the emotional part of grief is hidden from view, leaving well-meaning supporters clueless to the effects of their helpful attempts. Opening the door for Jimmy, who is on crutches as he recovers from a broken leg, is an obvious course of action unlikely to have negative consequences. When we say the wrong thing to a grieving child, we worry we will create more pain and suffering. Our fear of saying the wrong thing leads to our silence.

Third, our society holds the view that death and grief are failures of sorts, problems that need to be fixed (Devine, 2017). We may consider a crying person to be weak-willed, and we want the grieving individual to "get over it" as soon as possible. We crave normality for ourselves and for everyone else who touches our lives. Their pain and discomfort disrupt us, too, and we may do whatever we can to

fix the glitch in our everyday existence. One way we act on this motive is to offer advice and practical solutions to those who are hurting (Devine, 2017). Most of us are kind-hearted, and we wish to ease suffering. We are sincere in our efforts to mend their broken hearts, and our comments and advice are intended to lessen their pain. But grief is not fixable, and although we may have useful ideas, we cannot solve the "problem" of losing a loved one. The perception of futility and ineffectiveness generates learned helplessness, which most of us will go to great lengths to avoid. As a result, we may unconsciously "blame the victim," assuming that the bereaved individual is at fault for their own distress. This scenario unfolds through avoidance of the mourner or insensitive comments like "suck it up" and "be strong." More- over, a grieving person knows that the loss will not resolve. Suggestions on courses of action, such as cleaning out the deceased's clothes or going to a movie to distract oneself, are likely to be interpreted as unwanted commands that miss the mark. At worst, these types of comments may isolate the mourner further, forcing them into silence to avoid further unsolicited advice. However well-intentioned and practical this advice may be, a person in the throes of new grief is in no real position to hear or accept it.

Connection is most helpful and desired by a person who has suffered a loss. Grief isolates us and generates loneliness. It denies us the opportunity to believe that others empathize with our pain. Sometimes we may even doubt that concerns voiced by others are genuine. While the details of grief are unique to personal circumstances, all of us can relate to the pain of loss. Supporters should be available to listen, to help with mundane tasks, to give a hug, to just "be present and sit with grief " (Devine, 2017). As helpers, we must first acknowledge of the loss. Ignoring reality does not erase the grief. A next step is showing support through a simple statement such as "I am here if you wish to talk." This comment requires follow-up in terms of action. Check in with the bereaved and offer opportunities for the grieving child to seek help. Be sensitive to the potential for overextending the offers. Your job is not to commiserate. Student in our study reported that too much attention by school staff, especially in front of other children, was extremely unhelpful. Our grieving kids want their distress to be accepted but not in public or dramatic ways, and they certainly do not want pity. Children are intuitive and will balk at comments that appear condescending or patronizing. Pity and fake sympathy are to be avoided. If you are sincere in your questions, then be prepared to hear the answers and respond with honesty.

Active listening is a technique used in humanistic therapies and taught to

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laypeople. Psychologists teach this technique in trauma coursework, giving class attendees ways to broach sensitive topics with people who are trauma-impacted. To be honest, active listening is a skill we can use in everyday life. Concern and empathy are conveyed through this method. This technique allows for communication and support Active listening is a technique used in humanistic therapies and taught to laypeople. Psychologists teach this technique in trauma coursework, giving class attendees ways to broach sensitive topics with people who are trauma-impacted. To be honest, active listening is a skill we can use in everyday life. Concern and empathy are conveyed through this method. This technique allows for communication and support without asking probing questions or pressuring the respondent to divulge details that are too uncomfortable. Sometimes referred to as reflection, the goal of active listening is to concentrate on a person's comments and then "reflect" their essence. The goal is to clarify, affirm, and validate what the individual has said without judgment or elaboration. This technique requires the listener to pay attention, and by reflecting the ideas, misunderstandings are eliminated.

One way to learn this technique is to become familiar with common sentence starters that promote its goals. Here are a few examples of reflective responses:

- "It seems like you are thinking…."
- "It sounds like you are saying…."
- "That must make you feel…."
- "You would like to…."
- "That might make anyone feels…."
- "It must have hurt when…."
- "You did not expect…."
- "You might want to change…."
- "You don't know why…."
- "You wish things would be different about…."
- "You are upset about….."
- "You are scared about…."
- "You are angry about…."

- "You are sad about...."
- "You seem confused about...."
- "It must seem unfair to you that...."
- "A solution you seem to be considering is...."
- "It must be challenging to deal with...."
- "It is tough when...."

Through active listening, an educator shows compassion by engaging with a student in need. When you reflect the student's comments and feelings, you supply acceptance and validation. The child not only learns that his emotions are acceptable, but that others recognize and appreciate his hardship. Since no judgment is made, the stage is set for an individual to share freely, without fear of condemnation. The listener offers no advice, since the speaker can perceive this as criticism. Therapists focus on allowing grievers to access their emotions. This method demonstrates to the griever you can handle their pain and are not intimidated by their reactions to the loss.

Active listening is an excellent way to create a safe space for kids to share their experiences. It can promote an empathetic bond between the communicants. Obviously, some discretion is needed, since there are times when this technique may be inappropriate. For example, if a child asks a specific question that requires a definitive answer, reflecting the question could be inappropriate. ("When should I turn in this late assignment?" is not answered by "It sounds like you are wondering about the due date.") If a child's comments are self-destructive or violent, mere paraphrasing the aggressive intention may be insensitive. ("It seems as if you'd like to cut yourself " may be empathetic but may be interpreted as granting permission.) In these cases, we can use active listening to acknowledge the pain behind the threatened behavior while suggesting a more appropriate way of expressing the negativity. Frequently, a child may genuinely need reassurance, and active listening may just sound placating. (The anxiety of a student who asks, "Am I going to die, too?" will not be ameliorated by a comment such as "I hear how worried you are about your own health and safety.") Of course, when a child is asking for reassurance or a boost of confidence, adults must not lie. In the previous example, for instance, stating definitively that the child will not pass away is a claim no one can make with 100% certainty. A child who has suffered the death of

a loved one will recognize the lie, having proof positive that deaths can and do occur. What the caring adult can say, however, is the actual truth: although no guarantees exist in life, chances are small that a child will die in her early years. Practical information, such as reminding the child that she sees a doctor regularly and wears a seatbelt, can also provide some reassurance—assuming those facts are true. Hollow promises and blanket reassurances will only reinforce to a child that adults are not being honest with them.

Reflecting conversation requires the listener to focus on the speaker, setting aside one's own issues, opinions, and values. This is easier said than done, and the technique will be ineffective if the listener interjects too many ideas or expresses an arrogant attitude. A novice might invoke the sentence starters in such a way as to sound scripted or phony. The method takes practice until the responses can flow naturally and elicit open reactions. The technique can be utilized almost anywhere, anytime, and with any person, allowing for a multitude of opportunities for honing this skill.

When speaking to a grieving child, be careful about the use of too many questions, resorting to lecturing, or providing too many suggestions. When the pain of a loss is new, the bereaved individual first requires connection and validation. By asking for details, the listener may encroach upon personal space and trigger more pain. Using the event as a topic for an information-disseminating session avoids the emotional aspect of the situation, and by offering advice or coping strategies, the listener implies that the griever just needs to "get better" soon. Avoid the human tendency to share too much of one's own personal experiences. It is natural to com- pare and relate others' circumstances, and it may appear helpful to commiserate by sharing similar events. In these cases, a blanket statement such as "I've been there" or "I lost my mom, too," may promote empathy and help the listener understand that she is not alone in her grief. But too many details divert the focus from the grieved to the listener. No two losses are identical, and these comments create the implication that comparisons are being made. The point to communicating with a grieving child is to express empathy and concern through acceptance of pain and emotional suffering. By keeping that goal in mind, an educator can approach this student with compassion, humility, and respect.

Children and adults both yearn for permission to feel their own emotions. One of the most helpful actions a support person can take is merely to be present and witness the person's grief (Martin & Ferris, 2013). Kids may be embarrassed to cry

or express emotions, and they may be suppressing their reactions at home. Giving students a safe space in which to unload and express themselves may be the best thing you can do for them.

Humor can be helpful in adjusting to loss, too. In studying individuals who have been coping well with bereavement, Bonanno (2009) reported that the majority retained their ability to laugh and smile. In certain instances, these reactions related to positive memories of the deceased. Other times, the interviewees had managed sadness enough to find respite in laughing. Naturally, adults should not find humor in anything directly related to the death or loss. However, many adults fear it is inappropriate to focus on anything humorous while someone is in the midst of grief. This is usually untrue, and the majority of people use laughing as a way to feel better or distract themselves momentarily from their pain. While humor may not be well-received immediately after a loss occurs, with a little time, grievers might jump at the chance to find something funny in their lives.

It is helpful to remember that you are not required to offer answers to every child's questions, and it is OK to admit that you do not know everything (Granot, 2005). No correct way to grieve exists, and none of us always knows what to say. Although kids may look to you for knowledge, advice, and solutions, the better choice is to acknowledge an uncertainty rather than to lie or feign insights with which you have little confidence. You might consider using your own lack of answers as an opening to honest discussions or a guidepost on the path to further learning you and the student can do together. Perhaps the class, as an entity, could benefit from a group project designed to explore issues that grief can generate. Children need your strength and wisdom, and they can learn from you how to search for answers to the tough questions.

What Not to Say to a Grieving Child

Even though most of us have suffered through a loss in our lives, connecting to someone else who is grieving is often awkward. Sometimes we shy away from the bereaved, afraid that what we say might upset them. Being a witness to someone in intense pain is uncomfortable and often mortifying; we cannot help but think "there but for the grace of God." A great number of us will try to avoid any contact, rationalizing and concocting excuses for not attending funerals or visiting the houses in mourning. Although this behavior may be insensitive, it is understandable that others' grief hits a nerve with us, reminding us of our past

pain or creating apprehension about the future. Sometimes, we can keep the bereaved at arm's length, sending along a condolence card or submitting a message to a social media page. Teachers of grieving children cannot avoid face-to-face contact. The child may look to you for comfort and consolation. As a role model, you may have a major influence as the bereaved student turns to you for stability and healthy reactions. Although there is no perfect thing to say, many comments are decidedly unhelpful. Here are statements that create pain and discomfort in students on the receiving end.

- "I know exactly how you feel." It is fine to commiserate and acknowledge that you have lost loved ones too, but since every relationship is unique, you cannot know exactly how anyone else feels. You can empathize, however, and share in someone's pain. But it rings false when you claim to comprehend the nuances of another person's emotions. This is particularly true when you have not lost a similar person in your life. For instance, we can distinguish between losing a pet and losing a parent. Even if you have experienced a similar loss, avoid sharing too much of your experience when the mourning period is new. People immersed in grief do not have the emotional time or energy to listen to your stories. Children are not prepared to hear too many details of another's losses. The educator-child relationship presumes a level of emotional distance. Be careful not to divulge intimate details.

- "Everything happens for a reason." This comment has several flaws. First, it is not a fact. This opinion is a matter of faith for those who hold specific views. Second, whether we can find a grand purpose life is a subjective point. For some people, happenstances seem to be part of a master plan. For others, events occur randomly. This statement triggers guilt and incompetence, implying that the listener does not understand meanings in his own life. Listeners may perceive this statement as presumptuous and self-righteous.

- "Your loved one is in a better place." Again, this comment stems from faith, not a fact. Everyone holds different religious views, and you may have no clue if a child or her family subscribes to this belief. This claim does not diminish the pain of loss, anyway. Although it may reassure us to have faith that a loved one is safe in a happy afterlife, the pain of living without him or her is still real. A child who hears this may experience guilt for missing

their person when that individual is potentially happy, safe, and secure in an afterlife. Young kids may not even be considering the fate of the object of their grief; they are focusing on their own experience. To the child, the egocentric effects of the loss are most salient.

• "You will be reunited someday." Be cautious when suggesting this idea, even if you sincerely hold this belief (Hone, 2017). As a child's teacher, and not a family member, you are not familiar with the details of your students' spiritual views. This statement can backfire when a guilt-ridden child harbors doubts regarding his own goodness and frets over his potential eternal fate. None of us have factual knowledge of what awaits us after death, so do not make comments that suggest that you know better. Acknowledge the child's beliefs and be respectful of differences.

• "It could be worse." In saying this statement, the speaker is diminishing the child's right to be upset. The implication is that the student is grieving in a manner disproportional to the event. Grief is subjective, and no one may challenge whether a person is sufficiently or excessively sad. Pointing out how circumstances could be more traumatic not only sounds like criticism, but this comment feeds on fears. Telling a child whose dad died in a car accident that "at least his mother survived" not only triggers a sense of guilt for grieving too much and not being grateful for mom's presence, and it may remind the child that his other parent could die, too. It is fine to remind a bereaved child of the positive aspects of her life, but not in a way that minimizes the current feelings.

• "You must be brave for…" It is not a child's place to buck up and be strong for the adults in their lives, or even for their siblings. Remaining stoic and holding oneself together is a taunting task for grown-ups, so asking this of a child is unfair. This comment might cause a child being pressured to support those around them, along with pangs of guilt and failure and if they stumble in this endeavor. Children are learning how to grieve and repressing their feelings is not a good lesson for the present or the future.

• "Everything will be OK." Some things in life are never "OK." Although the stabbing pain of a recent loss may recede and become less sharp over time, the deceased is not coming back. There is a hole in the child's life that cannot be refilled. People are not replaceable, and no one "gets over" grief.

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Excerpted from *The Grieving Child in the Classroom*

As Devine (2017) says in her book, we carry grief. It is important for a grieving child to realize that life continues and that there will be a new normal, but the missing piece remains absent. Grievers of any age will sense that this comment is intended to comfort but rings hollow.

• "It was their time." This, too, is an opinion, and an irrelevant point to a griever. The loss is painful, regardless of whether the loved one was ready, prepared, or cosmically destined. This presumptive idea is unhelpful to a bereaved person. This comment is abstract and hypothetical, and young kids are not cognitively mature enough to contemplate this idea.

• "…. would want you to be happy/cheer up/move on." Do not speak for the deceased individual. This comment, even if true, will make a loved one bristle, even a child. This statement intrudes on the child's relationship with their loved one and assumes that you know what that person might want. It is impossible for someone to cheer up on command. There is a danger that the child may believe this comment and feel even worse for suffering. Grief does not disappear just because we wish it away.

• "Are you still sad?" This question sends the message that the griever is abnormal or weak for continuing to grieve. It also forces a person to deny their feelings (Hone, 2017). Rather than promote healthy communication and connection, this comment encourages repression of emotions and slams the door shut on conversation. Death is a sad event for those left behind, with no deadline for feeling better.

• "Time heals all wounds." This claim is a common response, but most of us recognize its inadequacy and inaccuracy. Although the intensity and frequency of our pain may lessen over time, losing a loved one hurts for the long haul (Dyregrov, 2009). While we may find it easier to remember the deceased with joy with time, good thoughts are often tinged with at least a hint of sadness. Typically, time alone is insufficient; we must also work to express our emotions and deal with unfinished business (Martin & Ferris, 2013). If we assume that love never ends, then sadness over losing it persists, too. The wound may no longer be in an acute condition, but the scar is permanent.

• "Just think happy thoughts." Asking a bereaved individual to ignore or repel negative thoughts and feelings is not only impossible when grief is

intense, but it might actually encourage negativity. While focusing on positive memories may be a good strategy eventually, trying too hard not to think about some- thing usually results in greater attention being drawn to it (Cacciatore, 2017). Distraction is fine, but do not pressure a child to cheer up.

• "God does not give us more than we can handle." Although the truth of this statement depends on one's own faith and experience, this remark is not comforting to most people in pain. They are aware only of their distress. It may even depress confident people to hear this comment. Moreover, the implication of this statement is if you are strong, you will receive more pain. This is a frightening concept! Although meant to compliment and encourage, kids can interpret this remark negatively.

• "Let it go." Grief does not just go away. While we need to cope and move on with our lives, asking someone to release their pain prematurely is useless (Cacciatore, 2017). This well-meaning piece of advice may be popular because of Disney's movie, Frozen, but a bereaved child may interpret this comment as dismissive and insensitive. We need to experience grief fully in order to process it, and although the intensity may lessen with time, memories and love do not sail away like a released balloon.

Many adults have the mistaken idea that children will forget their losses, or perhaps they do not care as much as adults do. Likewise, grownups assume that kids do not need facts and are better without complicated information (Granot, 2005). Although we must recognize a child's developmental maturity, hiding the truth or neglecting to recognize the impact on a young person can only deprive kids of the support they need during stressful times. Information should be age appropriate, and adults would be wise to check for an accurate understanding.

Euphemisms are never a good idea, since it is too easy for a child to misinterpret them. Some, such as "sleep forever" or "put to sleep," may scare the child into equating death with actual slumber. Others are confusing, such as saying the love one "departed" or "expired." Trying to make the situation sound positive by saying the loved one went to this "great reward" creates inaccurate perceptions and does nothing to lessen the sting of loss (Wass, 2000). Kids need to hear the truth, since a fact of this magnitude can never be completely hidden from them. Be clear in the

language you use without providing unnecessary details.

Avoid asking too many questions, especially about the death itself. Refrain from preaching or sounding like you have all the answers (Hone, 2017). Limit questions to general inquiries, especially about the family. Follow the child's lead and do not tread into areas with which you are uncomfortable. Comments that hit a raw emotional nerve may not generate an overt reaction, but students remember how they sting, despite the best of intentions.

What to Do for a Grieving Child

Besides listening, an educator can do more to support a grieving child in the classroom. Some appropriate responses involve a direct acknowledgement of the loss, while others can aid in academic and social ways. Cacciatore (2017) suggests that traveling the road of grief is a learning experience. If this sensitive situation is ripe with teachable moments, who better to navigate this journey but an educator? We might find it useful to have specific goals in mind. What are we trying to accomplish? Baker, Sedney, and Gross (1992) described the major tasks a grieving child will need to tackle when coping. In the early days, the focus is on understanding what has occurred but with protection from unnecessary or age-inappropriate details. The middle phase involves accepting the reality of the loss and adapting to the resultant changes. Last, the child will need to reestablish a sense of identity and continue to develop within the framework of the loss. If we are mindful of this grief map, we know where the child is heading on the path while remaining aware that the speed of the journey varies from person to person.

When preparing for working with the grieving child in your classroom, the overarching principle is to establish a sense of safety. Death creates instability, but we need to feel secure in our surroundings. There are many ways to build a stable environment, such as through routine, openness, empathy, and reassurance. Maintaining trust is essential, along with providing a nonjudgmental environment (Corr, 2010). By keeping our eyes on the ultimate goal—being a solid support for the child—we direct our good intentions in helpful ways.

Communication with the child's home is essential to understanding how the child is coping and expressing concern to the family. As educators, we must incorporate teamwork when working with students. For kids to learn, teachers and parents or guardians must cooperate. Adults must share essential information for the benefit of the students. Instructors may find these discussions awkward and worry they are

intruding on a family's privacy by making a phone call. If so, an email or letter to the home is appropriate (Cohen & Mannarino, 2011). The goal is to con- nect, and any method of communication can work. Although a few parents may initiate the contact and reach out to their children's schools soon after the loss, at other times speaking to school personnel is the last thing on their radar. It does not hurt for a teacher to send off a quick note expressing condolences and asking how the child is doing. Educators should keep in mind that the adults are grieving too, and sensitivity to their reactions is essential for helping the affected child by the reactions of adults in his life (Granot, 2005). This empathy opens the door for the adults to express any concerns and offer a heads-up regarding any problematic behaviors. Practical matters such as absences and late assignment and then agree upon solutions.

If staff members have built a solid relationship with the child's family, it may be reasonable to offer direct help beyond the school setting. Besides the phone call or a condolence note, willingness to help with the grieving child will be welcome (Cohen & Mannarino, 2011). Do not make empty promises, however. Many people will make blanket statements such as "Call me if you need anything," and they may be sincere in the offer. A bereaved child rarely asks for help directly. A mourner may be embarrassed or needy and answering the phone may exhaust him. He may not know what to say or ask, as grief has a way of alienating us from our own needs. Therefore, try to make specific offers. "I can bring dinner tonight for your family" is a more concrete and palatable offer rather than a vague "Let me know if I could bring you food." The same thing goes for a student in your class. If you can make a helpful offer, such as providing homework help, be sure to follow through.

Teachers and other school personnel may wonder whether they should attend the funerals when a student's loved one dies. There is no hard-and-fast rule for this circumstance. Factors such as closeness to the family and the student must be considered. Keep in mind your own comfort level with such action. Let us be honest: no one enjoys going to funerals, and many of us find that these ceremonies make us uncomfortable and may trigger our own history with grief. If you believe that your reaction and discomfort may be too extreme or obvious, it might not be the best course of action for you to attend. If you are close to the child and think your presence might be comforting, then it is appropriate to attend a funeral as a sign of caring and support. Be open and show emotion; kids learn by watching others cope with sadness. Be mindful, however, that intense expressions can challenge a vulnerable child.

WHAT TO SAY, WHAT NOT TO SAY AND WHAT TO DO FOR A GRIEVING CHILD

Excerpted from *The Grieving Child in the Classroom*

When the child returns to school, adhere to a normal schedule as much as possible. Although acknowledging the loss is important, special treatment should not be overt. Many of our student respondents admitted that in their time of grief, school became a welcome distraction. Routine and structure provide a sense of familiarity that is comforting (Samuel, 2018). Many reported that they preferred school to home for a while, as they found it helpful to get a reprieve from the grief-saturated atmosphere on the home front. Many claimed that they threw themselves into school-based activities to distract themselves from their pain. Sometimes, a child may welcome a special project or other concrete task in which to engage (Granot, 2005). Although too much preoccupation with tangential activities and other forms of avoidance may not be the best course of action all the time and in every case, the need to have a semblance of normalcy is reassuring. The child's performance in the classroom and in extracurricular activities may not be up to par, but educators should recognize the desire for life to remain the same, despite the contradictory signals a child may give. Loss is confusing, and mixed emotions and irrational behaviors may be normal in the immediate wake of the event.

Educators can help a grieving child by giving them time to regroup following the loss. If they miss several days of school, be sure to give them extensions on the work they need to complete. Remember, even when the child returns to school, he will be distracted. Many of the comments made by our interviewees related to this issue. Students in the Ursinus study reported that their teachers were not flexible in accepting late assignments and did not offer sufficient catch-up time. Many interviewees admitted that they had substantial difficulty concentrating and paying attention for weeks or months after the loss, but their teachers were unaware and unaccommodating. One astute respondent stated that the grief process is "not linear, and teachers need to stop acting like it is." Remember that children grieve uniquely, and their mourning will ebb and flow. Be cognizant and flexible regarding the difficulty many kids have in focusing on schoolwork. It may be next to impossible to study vocabulary words when thoughts of a missed loved one intrude into consciousness. Perspectives change after a trauma or loss, and the small things become unimportant (Cacciatore, 2017). Students may be unmotivated, avoiding studying and putting forward little effort. Be patient with the grieving child and offer support. Do not judge the child's journey through grief and do not assume he "should be over this by now." Grief has no established timetable, and none of us are qualified to tell another when he should be back to "normal." There could be times when the grieving process is taking a negative turn,

and they may require outside help. Even in this case, understanding and leniency regarding schoolwork may be necessary. This may be a good opportunity to offer extra tutoring or help with homework, either from you or perhaps a trusted, empathetic peer. Flexibility with assignments and school performance were the most common needs suggested by our respondents when asked how teachers can help a grieving child.

Some bereaved children may wish to recount their experience and share memories of the deceased. Staff may resist hearing their stories and feel awkward listening to personal information. But allowing the bereaved to express their thoughts and emotions can be positive steps in coping. One task of grief is maintaining a bond with the loved one, although in within a new context. Sharing our stories is useful in this regard (Kosminsky & Jordan, 2016). Teachers should be sensitive and encourage appropriate conversations. The discussion can shift to a private talk and counselors may be included. These talks may be uncomfortable for the adults, but we should not discourage children from sharing their narratives.

Play is helpful to a child who is struggling with grief. For kids with limited vocabularies, play allows for acting out and expressing feelings. Stressful events can be reenacted, helping the child to process what has happened. Because of stigmas surrounding grief and intense emotional reactions, older children can use games and dramatic play to adjust to loss. Play may be distracting, too, and kids may find it easier to discuss their problems while busy rather than through a direct conversation (Gonzalez & Bell, 2016; Hooyman & Kramer, 2006). Simulations and role-playing exercises have been shown to work well in allowing children to practice their reactions to dilemmas and problems related to death and loss (Klingman, 1983). Physical activities are outlets to dispel energy healthily. (Bazyk, 2007). And of course, recess and other free time periods are refreshing and calming, allowing kids to reset before returning to serious work. Creative projects, whether visual and literary arts, musical expression, or dramatic endeavors, can allow for catharsis of emotions that are difficult to express directly (Hilliard, 2001). Nonverbal means of expression are extremely useful when working with a special needs child who has a limited vocabulary or poor communication skills (Zakreski, 2017).

Bereaved pupils have reported that school staff acted as if they had forgotten the loss after a time. For instance, one student recalled how her teacher asked the class whether anyone had lost a loved one. This occurred only two weeks after the

death of the student's brother! (The instructor was aware but oblivious to the potential pain her question might generate.) The girl inferred that her instructor forgot the loss, implying a lack of significance that hurt her deeply (Dyregrov, 1991). Stu- dents in the Ursinus study indicated that staff expected them to be back to normal quickly, refusing to extend any flexibility after a limited time. While we should not patronize a grieving child, patience, compassion, and understanding are crucial.

A few children may resist a teacher's attempts to reach out. Sometimes, the student does not know how to accept this help, so they may act disinterested. Pupils may reject new attachments to avoid the risk of losing them. Other students, particularly older ones who crave of peer acceptance, may fight against any sign of perceived weakness or reaching out for help. No one can force a child into an attachment. But the realization that someone loves them may motivate them to cultivate new relationships. And outright avoidance or ignoring the elephant in the room can send the message of disinterest. Even when they put up a brave front, kids notice how those around them respond. Do not be fooled into thinking otherwise! Classroom teachers can offer support in ways that involve the rest of the class. When a student experiences a death in their family, this reality will affect classmates vicariously. In today's world of social media, information passes at a rapid rate, and even if a child does not share details herself, it is a safe bet that rumors and other bits of news will soon make their way around the school. When the grieving student is absent, the instructor has an opportunity to discuss the topic openly. Without offering too much personal or confidential information, the instructor or school counselor can clarify the facts and make sure the other students at least know of the plight of their peer. This may be a good time to dispel any misconceptions of death without being too graphic or providing unnecessary details. It might be a good idea to inform the students' families of the upcoming discussion to allow for parents to voice concerns. In a public school setting, refrain from too much religious-based talk, although students may broach this topic. Be receptive to diverse ideas and express a tolerance of various views. The point to this open conversation is not to preach but to ensure that rumors are not rampant and encourage empathy toward their class- mate. One helpful activity is role playing, as pupils can practice ways to approach and talk with the grieving child. Take advantage of teachable moments so the group can learn hard life lessons, building the foundation for their own future coping.

Another valuable idea is to incorporate relevant topics into actual lessons. For

example, learning stress-relieving behaviors such as deep breathing, guided imagery, and relaxation techniques will benefit any student. Teaching healthy coping skills is a vital part of any wellness curriculum. Instructors can introduce cultural ideas and varieties of social customs in academic coursework such as social studies. Teaching tolerance for strong emotions and support for mental health problems are additional ways teachers can help any child who is struggling with tough issues (Cohen & Mannarino, 2011).

When a teacher starts a class discussion, she should be mindful of triggering fears and anxieties. It is natural for children, young ones in particular, to internalize information and relate it to themselves, in a typical self-centered fashion. Their first reactions and thoughts may not be for the well-being of their classmate but may relate to possibilities in their own lives. Hearing the news of Billy's dad may create concern for one's own father. Learning that Sally's sister died from pneumonia may create fears that one's own cough predicts the same fate. To an adult, comments that reflect this egocentrism may appear inappropriate and insensitive, but these are normal thoughts and feelings. Try to be reassuring and nonjudgmental as you acknowledge these worries and yet steer the conversation back to the child who experienced the loss. We can quell students' fears and encourage empathy at the same time.

Teachers should take special care when involving the class in group activities or discussions when a particular group of students has a history of being unsupportive, or if the issue at hand is divisive. The point of including the class is to allay fears and allow positive expression of feelings. If the classroom has a hostile atmosphere before the traumatic incident, the heightened emotions of the stressor will not improve things (Johnson, 1998). In these cases these, an educator might separate the class into smaller groups to address concerns effectively. While not every negative reaction can be predicted, good judgment is needed regarding specific students' ability to respond appropriately.

Unfortunately, a minority of kids may use the information of a classmate's loss as fodder for bullying the griever. Though unbelievable, cruel treatment can and does occur. This possibility has a greater likelihood in cases of suicides and drug- related deaths. For example, one child related how a peer told her that "if her mother wasn't already dead, she would kill herself because of having a child like you." Although students often become adept at hiding bullying from the view of their teachers, educators need to pay close attention to nip any such behavior in the

bud. By establishing a strong rapport with a grieving child, teachers can create an environment in which the victim of bullying agrees to share such actions with you. Staff can prevent this behavior through honest communication with the class, a no-tolerance policy that involves swift consequences for the perpetrator, and positive role-modeling from the adults in the school. Teachers should encourage interactions and try to minimize attempts to ignore or ostracize the griever.

Other times, hurtful comments may be inadvertent. Students have reported that uninformed children may ask about a parent they do not know is deceased, putting the grieving child in the awkward position of having to explain the situation. Young children naturally exhibit morbid curiosities and ask for details about the death or the funeral, triggering painful memories and requiring difficult responses. The likelihood of these types of dilemmas is why honest discussion with a class prior to the child's return may be beneficial.

If such conversations take place after the child returns, try to be transparent in addressing the issue. If possible, include the grieving child in plans (Dyregrov, 1991). Many of our student respondents stated that they did not wish to be the subject of rumors and secret conversations. Although this behavior will undoubtedly take place to some degree, and may even serve a useful purpose (teachers collaborating on ideas to help a child, for example), no one wants to overhear others talking behind her back or observe people hush as soon as they enter a room. Tact is the rule of the day.

Teachers should be mindful of their own comments, too, after a pupil returns to school. For instance, reminding students to ask their mothers for help with a bake sale may present as insensitive to the motherless student. These statements are not intentionally hurtful and may be unavoidable. At a certain point, a grieving child will need to learn how to deal with comments that hit a nerve. A level of sensitivity can go a long way, particularly when the child has not yet built up defenses and refined coping skills.

One concrete suggestion for teachers is to involve the class in a project designed to show support to the grieving child and her family. My first-grade teacher did just such an activity, and the effect on me was so positive and so strong that it remains a vivid memory to this day, over 50 years later. My class had been preparing to make a Christmas mural for the classroom before my absence. During my days away from school, the teacher directed the students to decorate the mural for me, and each child made a personal card which they affixed to the giant sheet of paper.

Later, the teacher hand-delivered this to my home. Even as a 6-year-old, I remember being in awe that this elaborate work of art was meant for me. Every one of the individual messages written by my classmates in the typical scrawl of beginning writers touched me. Not only have I preserved the mural, I still recall the sense of love and compassion expressed when I felt isolated and misunderstood. I am forever grateful to my teacher for having the foresight to know how meaningful this act was. I realize she helped not only me, but she also performed an invaluable favor for the class by allowing them the opportunity to express empathy and concern. Creating cards or pictures takes little time and effort, but the rewards may last a lifetime.

Online platforms are another vehicle to honor the deceased and empower students to express their feelings. This project can take many forms, from simply commenting on established pages or creating a unique memorial site. The nature of the endeavor and level of involvement by children will depend on their ages and appropriateness of the sites involved. If the pages are public, hurtful comments and posts are possible, so be mindful. However, done responsibly, online memorials can be effective ways to share grief, receive support, and honor the loved one (Mitchell et al., 2012).

Your class may find it therapeutic to raise money or gather donations to help the family. Projects that raise awareness for causes may be relevant, if the age, level of maturity, and circumstances call for this. Physical action can be cathartic and help the other students believe they are doing something constructive. Death and loss make us powerless; concrete action can mitigate this helplessness.

On a larger scale, educators can opt to offer support group services or to acknowledge the loss in ways that involve the entire school. Educators can create ways to incorporate death education into curriculum designed to encourage social and emotional learning. Specific courses of action may be warranted, and even necessary, where the deceased was a student in the school. In cases of school-wide violence, specific courses of action might be useful. I will address this topic later in this book. Whatever you do or say to the grieving child, his family, or to the class, remember that you do not walk this path alone. Your school should have counselors or psychologists who can support you, and other adults who may have traveled this road previously. Unfortunately, even licensed mental health professionals may have limited coursework in this area and are unprepared to offer formal training. Personal experience can be an adequate prerequisite for coping

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with loss and grief, if individuals keep in mind that every bereavement period is unique and that individuals cope and react differently. Team up with other teachers or staff, if for no other reason than to bounce ideas off them and to serve as a support system for you.

That last point bears emphasizing. Helping a grieving person to navigate the waters of hurt and loss after a death is difficult and drains our own emotional reserves. Hearing details of another's experience may trigger memories and feeling we thought we had processed. Watching another suffer, especially a child, yanks at our heartstrings and can exhaust us psychologically, mentally, and physically. While expressing emotions is healthy, be careful not to react in extreme ways in front of students who are looking to you for support (Johnson, 1998). Be aware of your own sense of vulnerability and fulfill your own needs throughout this process. Whether that means exercising and eating right to maintain health and strength, distracting yourself via activities you enjoy, or reaching out for help from a friend or a professional, be sure to take the time to replenish your own coping skills. It may be clichéd, but the idea is correct: you cannot help anyone else if you are in falling apart yourself.

Remember that your students look up to you, for information and support, and as a model of acceptable behavior. They are discretely studying you, and they note your actions and reactions. It is often useful to join in class discussions and present your experiences, but this must be completed as a "controlled sharing" (Klingman, 1989). Showing emotion is fine and can help normalize expressions of grief, but intense reactions may scare young kids. Monitoring your own responses and serving as a role model may be heavy burdens when undertaken within the context of grief, but your job is to comfort, not scare. You have a unique opportunity to help not only the grieving child through their pain, but to teach other students how to be supportive and cope through loss. The experience may even be personally beneficial. We learn best by doing, and though sad but true, learning how to cope with loss is a lesson we must learn at least once in our lives. You can be the teacher who guides this subject—none of us want to tackle it. Unfortunately, we do not always pick our own curriculum; we just learn the best way to make the lessons stick.

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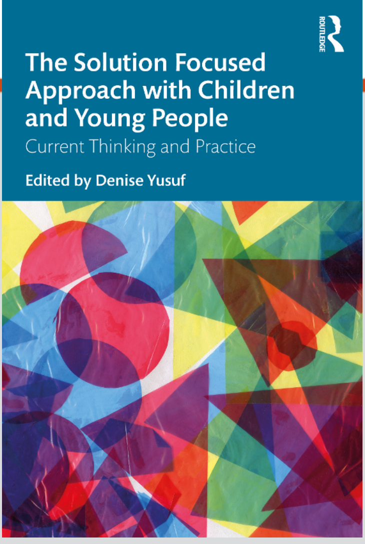

This chapter is excerpted from

The Solution Focused Approach with Children and Young People: Current Thinking and Practice

by Denise Yusuf.

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THERE'S MORE TO CHILDREN THAN MEETS THE EYE

Excerpted from *The Solution Focused Approach with Children and Young People*

Amir: joining a circle

I had seen Amir and his parents three times with little progress to show for it, so little progress that I was surprised that they wanted to continue. In my mind I had tried to blame the parents for my failure; after all, they had insisted at each of our meetings on cataloguing all of Amir's many failings. However, the failing was actually mine; all they were doing was trying to fill me in on the details of the problem, hoping that this would make the finding of a solution more likely. My failure was not finding a way to invite them into a different sort of conversation. Luckily (or so I thought), the parents were unable to make the fourth meeting but were so keen for it to happen they arranged with Amir's school for me to see him there. I thought that without the parents' helpfulness I might be able to do better with Amir. Not so! It was worse. Amir was clearly irritated at being brought out of class, irritated with my questions and seemingly irritated with everything else. Just more so than when he was with his parents.

Amir was six and was loved to distraction by his parents, but somehow things were not working out for him at school. He had few friends and those friendships he made did not usually last long, sometimes ending in fights. The school had become worried by increasing violence in Amir's behaviour, which would eventually lead to his exclusion. And there I was, totally failing to make a difference.

It is in these moments of failure and frustration, when we tell ourselves to change jobs because we are no good at the job we are doing, when we feel stretched beyond the limits of our knowledge and skills, when we want the ground to open and swallow us up, that we sometimes do our best work, and, sadly, more often than not, we don't even notice. All we remember is we got by – thank heavens!

Sitting in the corner of the school hall with this six-year-old bundle of irritation, I suddenly jumped up and demanded that he take me to his classroom. With this clear instruction backed up by my obvious belief in his ability to perform the allotted task, Amir transformed himself into a confident and sociable guide, pointing to his brother's class and one of his own pictures as he led me round the school. It was when we reached the classroom door that I lost my own confidence and seriously thought of pushing Amir in and running away. But his expectant look restored enough of my courage to knock on the door. Even before my last rap I began to shrink. The door became larger and larger and as I watched Amir's teacher through the glass she grew by several feet, towering above me as she opened the door. I was now six and terrified! I don't remember my primary school

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being that frightening, nor can I fathom why I should find myself reverting to a six-year-old when faced with a charming young woman half my age simply because she is a teacher. But the experience was real enough for me to be almost surprised that she spoke to me as a responsible adult colleague and asked how she could help me. Yet more panic surfaced since she would surely be outraged at the impertinence of my request. In almost a whimper I asked:

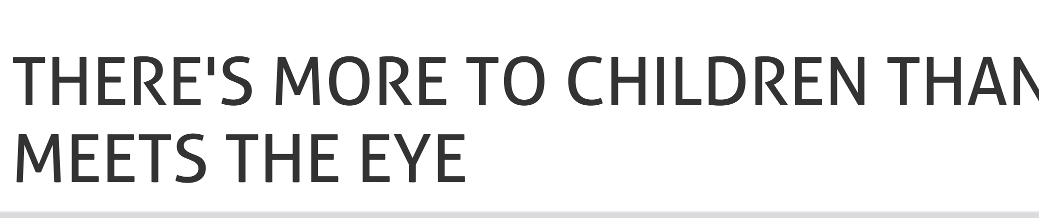
> "Please could I borrow six of your children?"

What hard-pressed teacher wouldn't jump at such an offer, and before I could apologise for the foolishness of my request, I had six more children to take back to the hall. I wasn't even sure of what we were all going to do together and what came to mind seemed ridiculously inconsequential. However, it was all I could think of, so we got on with it.

> "Could you all sit in a nice round circle and hold hands?" I asked the new six, which they did.
>
> "Amir, I'd like you to join the circle nicely. Can you do that?"
>
> "Yes," said Amir, launching himself at the group and nearly puncturing eardrums with his elbows as he forced his way in.
>
> "Is that joining the group nicely?" I asked my little band. "No!" they cried in unison.
>
> "Does anyone know how to join the group nicely?"
>
> "Me!" "Me!" "Me!" "Me!" "Me!" "Me!" was the cacophonous response. "And what's your name?" I asked the nearest. "Emma," she answered. "Emma, can you show us how to join the circle nicely?"
>
> "Yes," she said, and turning to the group she asked (with a little lisp) "Please may I join the circle?"

No one responded until I suggested they might let Emma join them, whereupon a chorus of yesses gave her permission. I then suggested that some room may need to be made, and two of the children immediately shuffled apart so Emma could take her place.

"Who else would like to show us how to join the circle nicely?" And five more pleading voices and waving hands. Warren was next with his "Please may I join the circle?" followed by the "Yes you may" chorus and the eager shuffling of bot- toms to make room for him.



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By the eighth turn, Amir's second go, they were unquestionable experts, Amir included, and they wanted to show me just how good they were so we had seven more "Please may I join the circle?"s and seven more "Yes you may"s with associated shufflings.

What next? Another act of courage on my part – back to the class. This time I managed to hang on to the remnants of my adulthood as Amir's teacher's face visibly brightened at my reappearance. "The children want to show you a little play we've been performing. Would that be possible?" Still doubtful about my licence to make such a request, once again I was surprised by the teach- er's enthusiasm for this interruption to her plans. Immediately she called all the children to sit on the floor in a big semicircle in order to watch the performance. And they did! Seven times each with a different principal. As we finished and took our bows amid tumultuous (albeit teacher-led) applause, a little voice broke through the noise to ask, "Please can I do it?" It was the start of an avalanche, the whole class waving their hands pleading for the chance to show off their own skills. As (my now friend) the teacher began to organise them into small groups, I quietly took my leave and hoped against hope that word of this foolish enterprise did not leak out into my 'high-flying' professional world. Two weeks later, I changed my mind. The parents phoned to say what a transformation they and the school had seen in Amir's behaviour. Suddenly I had turned from fool to hero. There is a large body of aids for promoting conversations with children, but these are only accessories to the main 'tool' which is yourself, the person inside the professional. A puppet on your hand won't engage with a four-year-old child; the puppet is just a conduit for you. So that needs to be the starting point – finding your way to relate to children. If you have children of your own or have regular social contact with the children of friends and family, notice how you are when you are most at ease with them or when they are most interested in you. This will give you the best insight into how to be with children professionally. My grand- children call me 'silly' and I find this 'silliness' helps me engage with small children. On the other hand, adolescents remind me of my own uncomfortableness as an adolescent, and I often feel inadequate in their presence. I have dealt with this by being the opposite of silly and assuming the mantle of an interested but 'out of touch' older person. This too seems to work, which is just as well since I often see teenagers in their schools. This is not to say that social and professional relation- ships are the same, but rather we, the professionals, are the same whether at work or not; we do best by being our best and this cannot be faked.

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Excerpted from *The Solution Focused Approach with Children and Young People*

Lucy: "the voice of a child"

Lucy was just four and had been raped by her fifteen-year-old brother six months earlier. The family was in a rehabilitation programme aiming to keep them together while safeguarding Lucy. Significant progress had been made, but one voice was missing – Lucy's. Lucy hadn't spoken since the abuse took place. Otherwise she seemed a well-adjusted happy child. The trouble with relationships in which one person doesn't speak is that they don't get spoken to – so don't speak. This is what had happened to Lucy. For several sessions, no attempt had been made to ask her questions. Eventually becoming wise to this, the therapist realised that Lucy had not been as 'quiet' as was thought. In the file were various drawings, but none that gave a clue about Lucy's feelings. However, there was another clue. One drawing was an outline of Lucy's two hands showing her ten fingers, while another was a jumbled collection of numbers from one to ten. The therapist had been using scales to 'assess' each person's idea of safety but had not thought to ask Lucy. Unfortunately, bringing out the drawings and asking Lucy about them seemed to irritate her, and she withdrew to the toybox corner. The therapist returned to Lucy's mother until he saw that Lucy had placed a number of farm animals in a row. Having, at last, got the message, the therapist sat on the floor with Lucy and counted out the animals; as expected, there were ten. The conversation with the mother had been based on a safety scale, so the therapist asked Lucy how safe she felt – which animal represented her felt level of safety. Lucy slowly pointed at the first, second, third, fourth and fifth before settling on the sixth, a pig. "What makes you this safe?" asked the therapist, whereupon Lucy rummaged through a box to produce a small female doll in 'adult' clothing. "Is this your mummy?" asked the therapist to which Lucy nodded. "And what's your mummy doing?" Another rummage from which came a little girl doll which Lucy placed very close to her mother. "Is that Lucy?" produced another nod, as did the question "Is your mummy keeping you safe?" Moving on, Lucy was asked "If you moved from the pig to the next animal, this cow, what would be different?" More rummaging brought out her 'daddy,' whom she placed a little farther away and her 'brother,' whom she put close to the 'daddy.' "What are your daddy and brother doing?" asked the therapist, forgetting that Lucy "did not speak." Lucy gave the therapist a disdainful look for asking such an obvious question and replied, "Going to foot-ball, of course!" Lucy, only having just turned four had, in her own way, articulated the textbook conditions of safety in such cases: her mother to watch out for her and her father to build a closer relationship with her brother.

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With experiences like this, it makes no sense to limit our expectations of children or hold strong views about how we might work with them. Each child is going to be different and each will challenge us to discover their 'language' and rise to their level. At the same time, we have to remember that Solution Focused Brief Therapy has a very specific focus: the client's hoped-for future and those aspects of the past and present which may support that future. Working with children does not exempt us from these simple guidelines. However, the guidelines are just that. They give us guidance about the sorts of question to ask, and they provide a coherent framework for our conversations, but they give us no clues about *how* to ask those questions or *how to operate* within the framework. That is the human side of our work, the 'self' that we put into our conversations, and I doubt that this can be taught. Instead, we each must find our own way of being sufficiently 'with' each client, so they remain in the conversation because it is the conversation that does the work, not the 'relationship.' Paradoxically, any reasonably competent Solution Focused conversation will generate a powerful relationship during the conversation because it requires of the therapist an absolute focus on the client's words and the linking of every question to those words. This is very intense listening, and being actively listened to is one of the main ingredients of a successful relationship. However, it is not the relationship that carries the therapeutic message; rather, it is the client's answers, the client's words that make the difference. All we are trying to do is ask questions which the client has never been asked before and which lead them to say things they've never said before in the hope that they hear something in their answers which opens up new possibilities for their future.

Aaron: "silence is golden"

Aaron was five and not doing well at school, and so the school had referred him to me. He seemed unable to follow even the simplest of instructions and had been deemed to be insufficiently emotionally and cognitively developed to manage mainstream school. The head teacher asked me to meet with school staff first and, with a little persuasion, agreed to Aaron and his mother, Doreen, also attending. At first the meeting focused on Aaron's problems, not in an unkind way but still a way likely to lead to his transfer to a 'special' school. When it was my turn to speak, I asked what everyone thought of Aaron's behaviour during the meeting, as he had been sitting quietly for more than ten minutes. Initially this was dismissed as situational – he wouldn't be like this in the classroom! However, I had been told

that Aaron was incapable of such self-control, and sitting quietly for that length of time was surely an act of self-control. Talking to Doreen about this, she cited many situations where Aaron was perfectly able to behave well, not that he always did so. In the Solution Focused world, any behaviour which occurs in one situation can be transferred to others. I asked Aaron whether he liked being a good boy at home and when he said yes, I asked if he would like to be a good boy at school. Again he said yes, so I embarked for the first time on a routine which has been hugely effective in helping four-, five- and six-year-olds to settle into school.

"When you are a good boy what's the first thing you do when you come into the classroom in the morning?" is a typical first question, and then perhaps it is adjusted to fit the child's understanding. So far, I have not met a child who doesn't know how to hang up their coat and put their lunch box, homework or whatever else they have in the appropriate places and then sit on the carpet with their arms folded. This knowledge might flow smoothly, or it may be teased out with "what next?" questions, and eventually it will lead to sitting on the carpet. Here the fun starts:

> "Do you know how to sit on the carpet?" "Yes."
>
> "Can you show me?" "Yes."
>
> "Let me see if I can do it, too."

The child and I are now sitting on the floor.

> "What do you have to do when you are sitting on the carpet?" "You have to fold your arms."
>
> "Like this?" "Yes."

We are now sitting on the floor with arms folded.

> "Wow! You really do know how to sit on the carpet, don't you?" "Yes."
>
> "Shall we see whether everyone else can do it as well as you?" "Yes."
>
> "Come on everyone, let Aaron teach us all how to sit on the carpet!"

Head teacher, class teacher, teaching assistant, educational psychologist and Doreen with varying degrees of enthusiasm joined us on the floor.

> "And what do you have to do while you are sitting on the carpet?" "Be quiet."
>
> "Do you know how to do that?" "Yes."

THERE'S MORE TO CHILDREN THAN MEETS THE EYE

Excerpted from *The Solution Focused Approach with Children and Young People*

> "Okay! Then show us how quiet you can be and see whether everyone else can be as quiet as you."

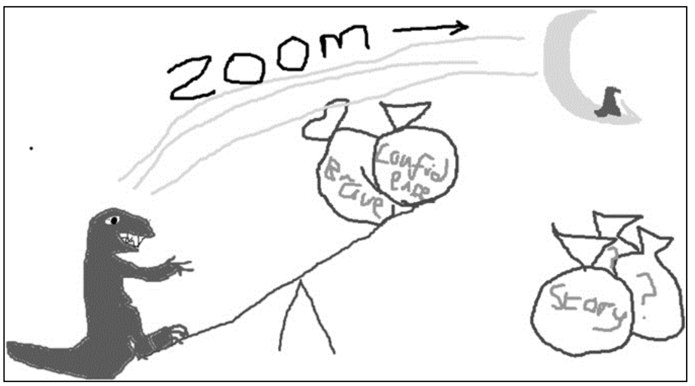
Sitting quietly on the carpet might be a challenge for some, but not for Aaron or his mother. The head teacher and psychologist were the first to break, with the class teacher and assistant soon following.

> "Wow! Aaron! You really do know how to sit quietly! You are one of the quiet-est children I've ever met! Didn't he sit quietly, Doreen?"

Carrying on with the morning routine, we learn that standing in line quietly comes next, followed shortly by walking quietly. Aaron is invited to lead both these activities, which he does with confidence and pleasure. He and his mother are repeatedly complimented on his knowledge and performance before he is sent off to his class.

The head teacher was both pleased and doubtful: pleased that Aaron performed so well in an activity only the school could have taught him and doubtful that such exemplary performance would transfer to the less protected reality of the start of the school day. Arrangements were made for Aaron and Doreen to attend the clinic the following week, where they were able to report a major improvement in Aaron's behaviour at school. No further meeting was necessary.

There is a continual debate in the Solution Focused field (and beyond) about whether techniques constrain or free the practitioner. If they do constrain, then it might be because it is an approach which does not fit that practitioner, something to be welcomed if we want a diversity of therapeutic approaches. On the other hand, if the techniques are seen as the 'model,' then they are likely to lead to



Simon's Solution

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ineffective therapy. The model itself is a set of principles rather than techniques; the techniques are simply ways to implement the principles and we should expect them to evolve over time.

Simon and his "bags of confidence"

Simon was seven and afraid of the monster under his bed. He thought that being more brave would help him, so we talked about all the ways he could remember being brave. He came back for a second session with a plan. He had felt braver and this had made him feel stronger. His plan was to get the monster to sit on a seesaw so that when he (Simon) became strong enough, he could catapult the monster up to the moon. We then thought about what would make him stronger, and he came up with "confidence," so we began filling a bag with past examples of confidence. Good stories also helped him feel calmer and more confident, so we began filling that bag. By the third session, Simon had done the job himself. He had calculated that five bags of confidence and stuff would be enough to send the monster on its way, and this had proven to be the case. This is a copy of the picture he brought to illustrate his victory. He was also pleased not to have to spend so much time lining up his toys exactly: "What's the point?" he said, "I'll only mess them all up tomorrow!"

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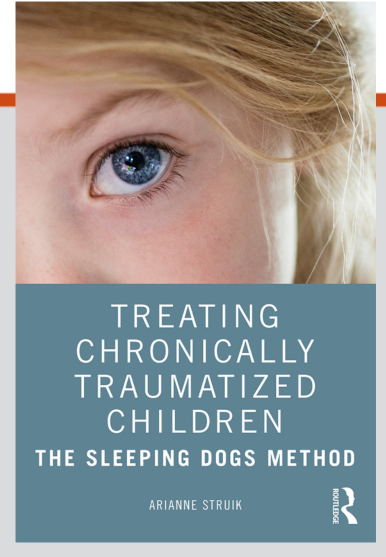

This chapter is excerpted from

Treating Chronically Traumatized Children: The Sleeping Dogs Method

by Arianne Struik.

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WHAT IS NEEDED TO OVERCOME RESISTANCE?

Excerpted from *Treating Chronically Traumatized Children*

Once children have started to use psychological defences, motivating them to process their trauma becomes more difficult. Very young children do not have these defences yet, which makes their trauma more easily accessible. The older children get, the more difficult it can be to access their memories, as their strategies to avoid become better and better. This chapter describes what processing of memories entails and how problems in the child's life can form barriers to engage in trauma treatment. Then the key principles of the Sleeping Dogs method are described.

What is processing of traumatic memories?

It is important to have an understanding of the way the memory works, how traumatic memories cause problems and what is needed to process them into integrated memories. This information makes it easier to understand why some problems form barriers, and what can be done to overcome them.

Processing and integration of experiences

Human beings are able to survive because they are 'programmed' to learn from their experiences, so we can avoid dangerous situations and do more things we like or enjoy. From our experiences, we learn important lessons such as 'I like chocolate ice-cream, I don't like vanilla, and the fireplace really is hot.' After learning these lessons, the experience becomes vaguer and loses its details, colours, smells, images and feelings and changes into a memory, stored away in a memory bank. The experience is then integrated in our self-image, our memories and our life. When a child talks about an integrated memory, he can tell the story coherently without becoming overwhelmed. Proper integration of experiences offers the best chances of survival, because it teaches us what to avoid and which situations to seek out.

The brain does not want to remember the past as accurately as possible, but the brain stores memories so it can predict the future.

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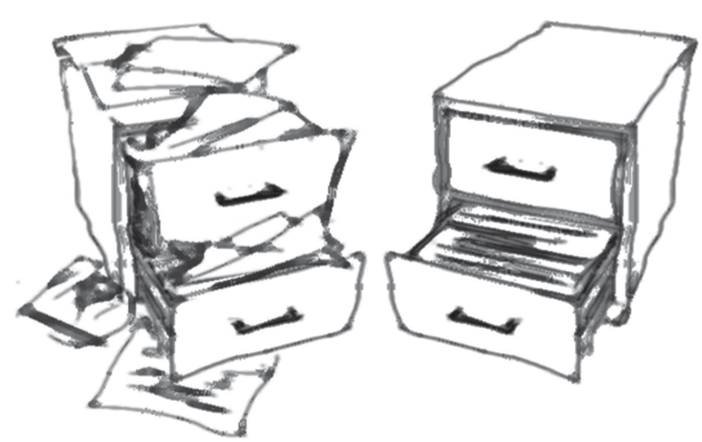

Temporary memory bank

However, when an experience is very overwhelming, such as experiencing violence or sexual abuse, the body automatically enters a state of hyper- or hypo-arousal, before we have had a chance to learn the lesson or we avoid thinking about it and try to push it away. From the brain's point of view this is a dangerous situation, because our survival depends on learning from experience. Therefore the experience is stored away in a temporary memory bank and brought back into consciousness later to evaluate and learn the wise lesson.

Re-experiencing traumatic memories

The memory is stored and presented back to re-experience the event. Because the chances we learn the wise lesson are the greatest if the recalled experience is exactly the same as the real experience. This re-experiencing is done with as much detail as possible, including behaviour, emotions, physical sensations and cognitions. So the purpose of having flashbacks, intrusions or nightmares about traumatic experiences is to enable the child to evaluate these experiences, learn wise lessons such as 'It was not my fault, I am lovable', and to integrate the experience.

Unfortunately that usually does not happen. The child becomes overwhelmed again and pushes the memory away instead of learning from it. This becomes a repeating cycle. Every time the child has a nightmare or flashback, the stress levels exceed the child's Window of Tolerance and the child goes into a hyper- or hypo-arousal state. Because we feel exactly the same physical sensations and terror, the stress caused by a flashback is re-traumatizing.

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If a child dissociated during a traumatic situation, he often dissociates again during a flash- back, which reinforces the need to continue to dissociate, and a vicious circle is established. When the child eventually processes the memory during trauma processing, this circle is broken.

What is needed to be able to process a traumatic memory?

In order to process a traumatic memory, the child needs to stop avoiding and re-experience the traumatic memory while tolerating the strong emotions and learn a wise lesson. Then the memory can be stored in the long-term memory bank. The memory become vague and loses its emotional content. We need our human brain, our ability to think and evaluate to be able to learn this wise lesson. This means that while processing the traumatic memories, the child's stress level needs to stay within his (often very small) Window of Tolerance while re- experiencing the memory. This is the work that needs to be done in the preparation phase.

Unprocessed memories block safety on the inside and attachment

Unprocessed traumatic memories can prevent a child from benefiting from a safe placement. Some children have been in a safe and stable foster placement for years, but continue to be afraid of being hit or do not attach to foster care- givers. Their foster parents don't understand why the child still doesn't trust them enough to relax, as the traumatization has stopped, they should know better. Even though the child is safe on the outside, the traumatic memories continue to make them feel unsafe on the inside, until he processes and integrates these memories. This demonstrates the importance of waking up sleeping dogs.

> Fifteen-year-old Paul was placed in a foster family when he was five after experiencing severe physical abuse. For ten years Paul suffered from nightmares and flashbacks but refused to talk about his memories. When the foster parents got angry at Paul, he would always say: 'please don't hit me'. The foster parents said Paul did not seem to have formed a relationship with them and they were very angry, as Paul should know by now that they would not hit him. They were his parents already for ten years. Paul's example demonstrates how traumatic memories can block learning from new experiences and continue to make a child feel unsafe on the inside, even though the child is perfectly safe.

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First-line treatment for traumatic memories

For children with PTSD, psychotherapy focusing on processing traumatic memories is considered first-line treatment. The Practice Parameters for the Assessment and Treatment of Children and Adolescents with PTSD state:

> Trauma-focused psychotherapies should be considered first-line treatments for children and adolescents with PTSD. Among psychotherapies there is convincing evidence that trauma-focused therapies, that is, those that specifically address the child's traumatic experiences, are superior to nonspecific or nondirective therapies in resolving PTSD symptoms.
>
> (Cohen et al., 2010, p. 421)

For children, TF-CBT or EMDR therapy are both evidence-based treatments recommended by international guidelines (Cohen et al., 2010; de Roos et al., 2011; de Roos et al., 2017; Diehle, Opmeer, Boer, Mannarino, & Lindauer, 2015; Rodenburg, Benjamin, de Roos, Meijer, & Stams, 2009; World Health Organization, 2013). In order to participate in these therapies, the child needs to come to therapy and talk about his memories. Both are problematic for these children. They deny having traumatic memories or become dysregulated when thinking or talking about them. It all happened a long time ago and they have found ways to live with it. Some children refuse to even come to sessions or to engage in any form of therapy: 'Going to a psychologist? No way, I am not a psycho!'

Barriers to engage in therapy

Caregivers and family can be reluctant to address the trauma out of fear making things worse, which was the case for Cynthia who engaged in therapy but after each session tried to strangle herself. Her therapist decided Cynthia was not ready to work on her trauma and ended therapy, leaving her alone with her guilt and self-blame without anyone to help her overcome those feelings. Therapists can get stuck and say 'it is better to let sleeping dogs lie' meaning, the traumatic memories should not be addressed. But these children continue to have severe symptoms damaging their development, feeling lonely and bad about themselves. Some, as a consequence, grow up going from one foster or adoptive family to another because of their problematic behaviour.

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Children refusing to participate in therapy are often perceived as being not motivated or resistant. The word resistant or not motivated implies wrongly that there is fault in the child. The barriers to engage in therapy are created by the child's current social environment and by what has happened to him in the past.

Lack of safety

Chronically traumatized children have experienced many unsafe situations in their lives. Many are removed by child protection services, or have returned to their (unsafe) families. When they are referred for trauma treatment, it is not uncommon to find that abuse or neglect and therefore traumatization is still ongoing (Potter, Chevy, Amaya-Jackson, O'Donnell, & Murphy, 2009; Zeanah, Chesher, & Boris, 2016). Even when they are physically safe, they might still feel threatened or afraid of being abused again.

Being or feeling unsafe can be one of the reasons for chronically traumatized children to be unable to talk about their traumatic memories. They are trying to survive and cannot afford to become more vulnerable by talking about their traumatic memories. They can be afraid their parents will get angry or punish them for talking about what happened. For Joy this was a barrier and she refused to come back after talking about a few of her memories. She said, 'I feel bad now. I am afraid my mom and dad will hit me when they find out that I told you.' Children can also no feel emotional permission from their parents. Simona who was very loyal towards her parents who abused her before she was removed said: 'I don't want to talk about my memories, because you are not supposed to talk bad about your parents behind their back.'

Children need to feel loved by adults they are attached to and safe with in order to grow and develop. Many children in foster care have had several different foster parents caring for them and they might not be sure whether they can stay in their current placement.

Some children end up in residential facilities with little or no contact with their parents and family, and caregivers rotating on a roster. Child protection services are their legal guardian, and their parents passed away, are in prison or have abandoned them. They do not have a consistent attachment figure to support them during therapy.

A child without love is like a plant without water, it will not grow. Growing up without someone loving you, holding you in mind and making sure you are taken

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care of, is very unsafe. From a survival perspective you can die without protection and these children need to be in a survival state permanently. They become cactuses and build a strong wall around their heart so they cannot get hurt. They push everyone away and seem to only care about themselves, without empathy or compassion. Or children without love will start looking for water (love) by attaching themselves to residential staff, therapists or by developing unhealthy relationships with friends or partners.

Not feeling loved, supported and being noticed can be a barrier for these children to discuss their traumatic memories and relive their fear, anger and abandonment. They do not have anyone to do it for them and no one to rely on to support them while doing so. These children need an attachment figure to love them, water them. Fertilizer such as expensive treatment programs or medication will not provide a solution.

For children in out of home care, child protection workers decide on the arrangements for contact between the child and their parents. Decisions on these contact arrangements can either support or undermine treatment by forming another barrier for these children. Children in out of home care can be reluctant to talk about their memories of traumatic events, because they may be afraid that their disclosures will reduce contact with their parents or minimize chances to be reunified. Children can also have unsupervised contact visits with their parents during which traumatization is ongoing or the parent pressures or threatens the child not to talk.

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Unstable daily life

Chronically traumatized children can experience many problems in daily life, at home, in school and with their friends. Their posttraumatic stress symptoms, behaviour and/or learning difficulties can create problems in school as well. Being placed in foster families or a residential care facility, they go from one foster placement to the next especially when their behavioural or attachment problems are too difficult for caregivers to manage. Foster children in the United States have on average three different foster care placements (Childrens Rights, 2015) and in a study profiling children in out-of-home care in South Australia, Delfabbro, Barber, and Cooper (2002) reported that almost a quarter of all children had experienced ten or more placements during their time in care.

They worry that talking about their traumatic memories will increase their nightmares, anger, depression or anxiety and create even more problems than they already have. They can be afraid that when they become even more difficult, their caregivers cannot handle that and they will have to move or they will be expelled from school. Surrounded by threat and chaos, these children need all their energy to protect themselves and survive their daily lives and they cannot afford to become more vulnerable by talking about 'forgotten' and suppressed memories.

Unsafe attachment relationships

As discussed previously, children need to have an adult that loves them and supports them when they process their traumatic memories. When a parent is traumatized as well, or has mental health issues, it can be difficult for the parent to support their child processing their traumatic memories. When a parent is traumatized by the same events as the child, as in domestic violence, the child for example can trigger the parent's own traumatic memories. Parents or care-givers can become angry or so overwhelmed, they cannot comfort the child, but need comfort themselves. The child may then choose not to talk about his memories and take care of their parent as a defence strategy. Some children are so disappointed and hurt by their caregivers that they do not to attach themselves anymore. They have a safe and calm attachment figure, but their internal attachment system is not activated enough. Because of their traumatic memories, they are too afraid to go to that person when they are distressed and they try to regulate themselves by dissociating or avoiding contact.

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Lack of emotion regulation skills

Chronically traumatized children can have difficulty tolerating, expressing and regulating their emotions. They can be afraid to talk about their traumatic memories because of the strong feelings they might feel. Some say they do not want to talk about their traumatic memories because they will become too scared or angry and start to feel 'really bad'. The shame can make them feel so bad and passive, that they almost feel paralysed in those feelings. Caregivers or professionals can be afraid the child may dissociate or become dysregulated. Caregivers can be afraid the child ends up injured or dead, when children use maladaptive ways to cope with strong feelings such as drugs or alcohol, self-harming or attempting suicide, dangerous behaviour or violence.

Negative core beliefs

As described, children can develop negative cognitions about themselves as psychological survival mechanism. They can blame themselves for abuse or neglect, or feel they do not deserve to be treated well, or are unlovable. They can feel ashamed and as a reaction to their shame avoid, withdraw, attack others or themselves with self-hatred (Nathanson, 1994). These strong negative cognitions about themselves (for example 'It's my fault') related to the traumatic memory ('I see dad beating up mum and I do nothing') can be based on what their parents have told them ('It's your fault, because if you had called the police, I would not have broken my nose'). Parents can reinforce these negative ideas, for example, by denying the abuse took place, minimizing the impact or even blaming the child for it. The child's defensive, aggressive behaviour can then lead to more rejection by their parents, caregivers, friends or teachers, which reinforces their negative ideas. The negative cognitions around events in the past add up and can eventually generalize and lead to the child forming a negative core belief, such as 'I am a bad person'.

When the child's parent does not acknowledge the child was innocent and continues to holds him responsible, the child risks the parent getting angry for believing these wise lessons. Making this shift seems dangerous and they would rather not talk about their memories and feel guilty or bad, than talk about them and risk being rejected. Jeremy got stuck on this barrier when he refused to continue during a trauma-processing session. He said: 'I am getting such awful thoughts about my mother. If she has left my dad earlier, my life would not have

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been so ruined. That makes me feel so bad, I don't want this anymore.'

Children who have experienced trauma often do not realize that their symptoms are trauma related and are actually normal reactions to an abnormal, frightening situation. They can feel hopeless that their behaviour or feelings will ever change. They don't understand why it would be beneficial to them to talk about their traumatic memories. They can be distrustful of the therapist's intentions in the therapy process. When these children would try and process their traumatic memories, they would have to learn wise lessons, such as 'It was not my fault and I am lovable'. They would have to make a cognitive shift from the negative ideas to positive ideas.

Key principles of the Sleeping Dogs method

The Sleeping Dogs method is originally developed as an adaptation for children of the Three Tests method for chronically traumatized adults by Joany Spierings (2009) The Three tests are used to assess the level of stability in chronically traumatized adults and to develop a customized treatment plan to increase the adult's stability in order to proceed with trauma processing. These principles are adapted for children into the Sleeping Dogs method.

The phased model

To be able to process traumatic experiences, a child must stay within his Window of Tolerance while exposed to the traumatic memory. Children who have had a single traumatic experience are usually able to do this. They are treated with EMDR therapy or TF-CBT and process their memories. Children who have been chronically traumatized in early childhood have such high chronic stress levels, that they have only a very small Window of Tolerance. Talking about their traumatic memories quickly takes these children outside their Window of Tolerance and, as a result, they are re-traumatized without processing their trauma. The fact that these children have such high chronic stress levels and are so easily upset is why it is essential for them to process their trauma to improve their functioning, but they are unable to do so, due to their poor functioning. This is a difficult dilemma.

For chronically traumatized children it is recommended to use a phased model (Child and Adolescent Committee of the European Society for Trauma and Dissociation, 2017; International Society for the Study of Trauma and Dissociation, 2004). In the first phase, the stabilization phase, the child needs to get enough

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Excerpted from *Treating Chronically Traumatized Children*

control over his symptoms to remain within his Window of Tolerance. This can be accomplished by working with the child or by stabilizing his environment. In the next phase, trauma processing, the traumatic memories are processed. During this phase, children need to seek out situations that they avoided before practising new behaviour. In the final phase, integration, the child works on better ways of handling stress to prevent traumatization in future. This is not a linear process and after trauma processing or integration takes place children can go back to the stabilization phase or go through several cycles.

What is meant by stabilization

In literature, the word stabilization is used to describe different things, which is confusing. The word 'stabilization' in the Sleeping Dogs method means the preparation phase with all interventions focused on overcoming the barriers for the child to start processing traumatic memories. Stabilization interventions can focus on improving the child's internal stability such as skills for self-regulation and emotion regulation, but more often on improving his environment such as family relationships, living environment, school or the child protection context.

Meeting the child's basic needs - autonomy, competence and connectedness

The Sleeping Dogs method uses the principles of the Self-determination Theory (Deci & Ryan, 2002). This theory describes autonomy, competence and connect-edness as the three basic needs determining human motivation. When these basic needs are not met, we become less internally motivated and as a result less per-sistent to reach goals. This view is also used in the treatment of drugs and alcohol abuse or overweight with a technique called Motivational Interviewing (Miller & Rollnick, 1991).

Most chronically traumatized children feel helpless, incompetent and disconnected from their families. They do not have these needs met at all. It is no wonder they present as unwilling or unmotivated to engage in trauma-focused therapy. The Sleeping Dogs interventions focus on increasing the child's feelings of competence, autonomy and connectedness. Professionals using the Sleeping Dogs method interact with children in a respectful and equal manner. Children are in charge of their own treatment and by providing them knowledge about themselves and treatment, through psychoeducation, they become competent to make their own decisions. A large part of the Sleeping Dogs interventions is focused on improving the child's relationships with family and caregivers to make them feel more

connected as the relational environment is the major mediator for therapeutic change (Perry & Dobson, 2013).

Structured assessment

The Sleeping Dogs method uses a structured assessment of the child's barriers to determine a customized treatment plan.

Collaboration with child protection services

The lives of children in care can be complicated by decisions made by child protection workers. These decisions can either support or undermine treatment and strengthening ongoing partnerships across disciplines can ensure children have the best chances to have their needs met (Greeson et al., 2011). The Sleeping Dogs method uses active involvement and collaboration with child protection services to engage children. Child protection workers can make or review decisions that form barriers to the child. They can inform the child of the possible consequences of what they tell the therapist about their memories.

Collaboration between therapist and child protection services can be time consuming and sometimes difficult and frustrating. However, in many cases it is not fantastic therapeutic work, but these decisions that make the child participate in trauma treatment. The Sleeping Dogs method invests in this collaboration, in sharing information, using psychoeducation to speak the same language, analysing the child's barriers together, so that everyone becomes partners instead of opponents.

Collaboration with the child's network

As the child is not willing or able to participate in treatment at the start, collaboration with the child's current and past network of family, caregivers, previous foster families or caregivers, other professionals such as therapists, teachers and child protection workers, is necessary. Key figures from the child's network who have already established a relationship with the child, are identified and encouraged to participate either by attending sessions, or by phone or video conversations, by making stories or messages for the child. Child protection workers, teachers and foster parents are taught Sleeping Dogs interventions which they can use to explain things to the child in daily life. In this way, the child does not have to attend therapy sessions and treatment starts indirectly. When the child is ready to start with therapy, the number of sessions can be kept to a minimum.

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Involving the child's biological family including the abuser-parent

Many of the barriers concern the child's biological family, including the abuser. To overcome these barriers and motivate the child, they need to be included in treatment, provided this is safe. Biological parents are not judged or criticized, but they are invited to assist their children to heal from the trauma they have (unintentionally) caused. This often forms a powerful tool to overcome the child's barriers. Even for children in out of home care who are not returning to their families, involvement of the child's family is important. In some cases, a lot of motivating and psychoeducation for child protection workers, caregivers or other professionals is required to make this possible. However the Sleeping Dogs method is only for children with severe symptoms, who are stuck and desperately need treatment but refuse to do so. When all else fails, this approach provides an opening for the child.

When interventions focus on the biological parent's responsibility for the abuse, the terms abuser-parent and non-protecting parent are used for clarity purposes. Obviously every parent is more than just an abuser-parent or non- protecting parent. The pronoun 'he' can also be read as 'she'.

Minimal sessions with the child and not office-based

To engage resistant children it is important to keep treatment short and focused. The number of therapy sessions with the child is kept to a minimum. That is possible because of the collaboration with the child's network. They can do intervention with the child, without coming to therapy. The Sleeping Dogs treatment is not only office based but also outreaching. Interventions are not only done by professionals, but also by the child's network.

Structured treatment interventions

The sequence of the chapters follows the order of the interventions. When the child is resistant to become vulnerable, there need to be some prerequisites first. The child needs to be safe and calm, before relying on an attachment figure. After that, the child can start to feel and recognize and discuss his thoughts.

Then the child can become vulnerable by talking about traumatic memories, anger, fear, sadness and negative feelings about himself. The neurosequential model of therapeutics (NMT) (Perry & Dobson, 2013), an approach to clinical work informed by neuroscience, is based on the same principle. NMT provides a framework to

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sequence the application of interventions in a way that is sensitive to the principles of neurodevelopment: start with the lowest undeveloped/abnormally functioning set of problems and move sequentially up the brain.

Sleeping Dogs method combined with other methods

The Sleeping Dogs method is always combined with a treatment to process traumatic memories, preferrably an evidence-based treatment for children with PTSD such as EMDR therapy or TF-CBT. These structured methods have a clear-cut phase to process traumatic memories.

As discussed, many chronically traumatized children do not report having flashbacks or nightmares and they display fewer PTSD symptoms but more general problems. They can engage in psycho-therapy or family therapy focused on attachment or relational difficulties, improving emotion regulation and mentalization, reducing depression, suicidality or anxiety or behavioural problems. These methods have a less structured and more indirect approach, where traumatic memories are processed when they come up when for example discussing daily life situations, emotion regulation difficulties or relational problems.

The separation between the stabilization, trauma processing and integration phase and the Motivation and Nutshell Check are not applicable for those methods. The interventions in these chapters can be adapted to fit those approaches if needed. The analysis with the Barriers Form can be used in addition to these treatments for example to analyse situations where treatment is stuck or not effective, children do not engage or drop out, or when the child's situation is too unstable to start treatment.

Other similar methods

The Sleeping Dogs method describes interventions for the stabilization and integration phase of treatment and some to support the child during the trauma processing phase. The Sleeping Dogs method describes mainly interventions that are new or different from other methods, since there are many other great methods with comprehensive descriptions of interventions for these children which can easily be incorporated into the Sleeping Dogs method's plan. There are methods for the treatment of chronically traumatized children (Adler-Tapia & Settle, 2017; Blaustein & Kinniburgh, 2010; Gomez, 2013; Greenwald, 2002, 2005; Lanktree &

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Briere, 2013; Saxe, Ellis, & Kaplow, 2012; Wesselmann, Schweitzer, & Armstrong, 2014) and some are specifically focused on dissociative children (Silberg, 2013; Waters, 2016; Wieland, 2015). Most of these treatment methods describe an extensive stabilization phase in which some of the barriers mentioned earlier, such as safety, self-regulation, attachment, psychoeducation, motivation, emotion regulation and core beliefs, are addressed. The comprehensive description of interventions and tools in these methods are very useful for clinicians working with these children.

The brain does not want to remember the past as accurately as possible, but the brain stores memories so it can predict the future.

Children need to be safe on the outside by stopping the abuse, and safe on the inside by stopping the flashbacks and nightmares.

Trauma processing can be seen as integration of traumatic experiences in our self-image, our memories and our life. Trauma processing can only take place if levels of stress are within the Window of Tolerance.