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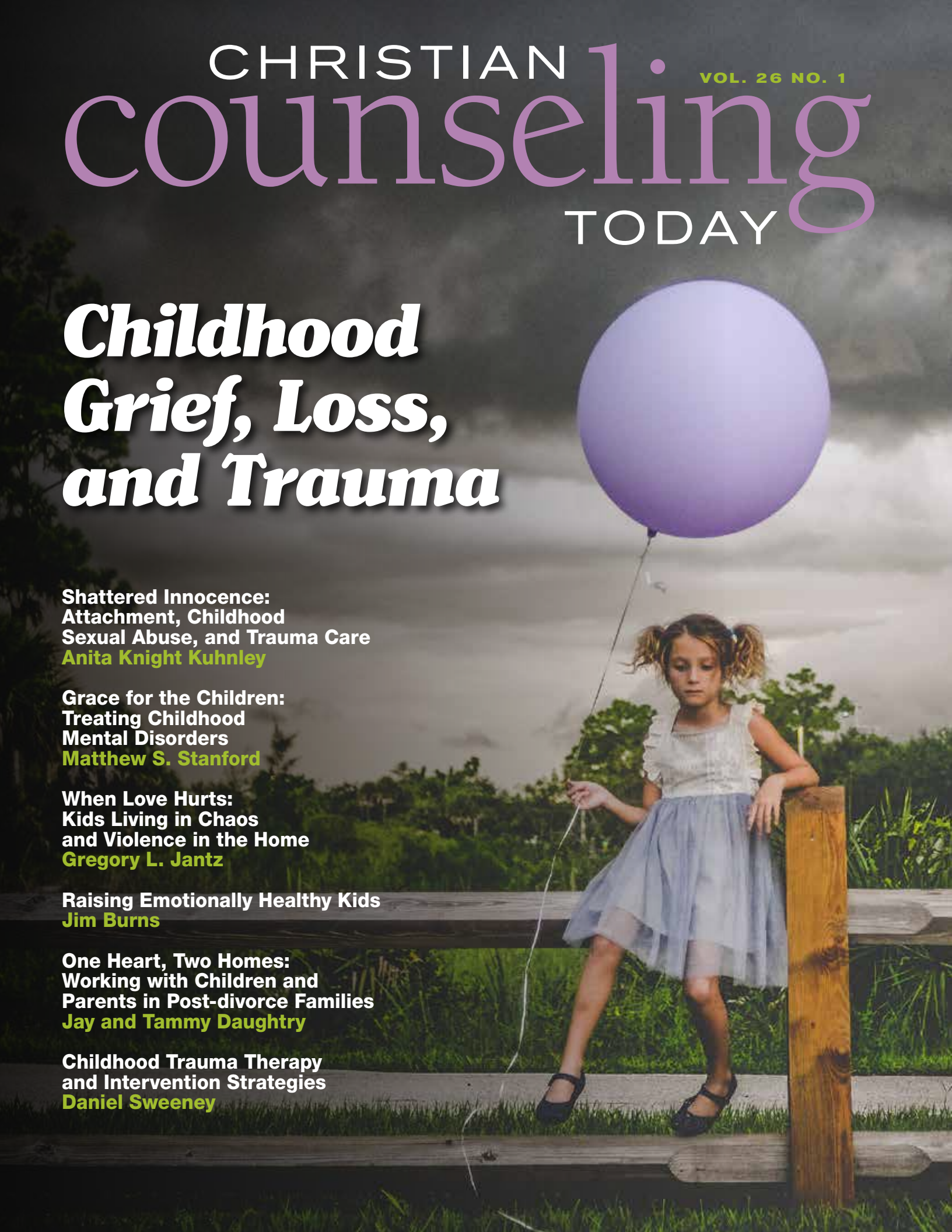
TODAY
VOL. 26 NO. 1

Childhood Grief, Loss, and Trauma

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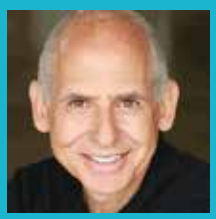
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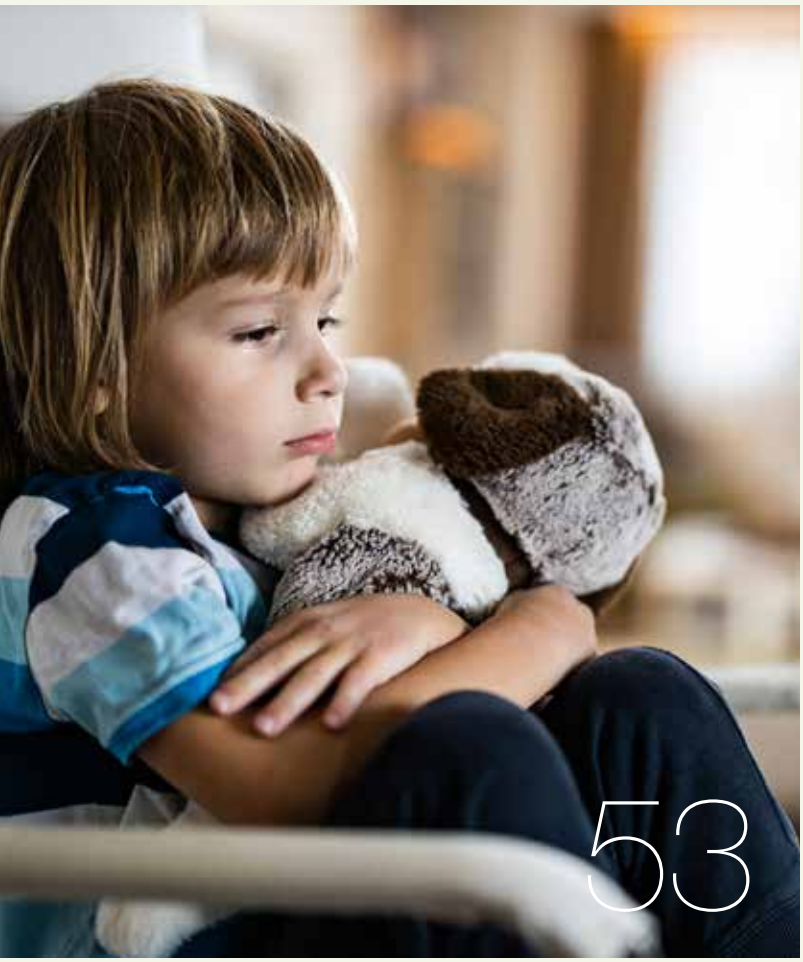

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« TIM CLINTON, ED.D., LPC, LMFT, BCPCC

Helping the "Least of These" Find Their Way

Grandparenting is *not* overrated. It is actually as delightful as I anticipated and maybe a little more. I came home the other day, opened the front door to our house, looked down to see a small pair of toddler sneakers, and had to smile. I gently echoed through the house, "Is there a Papa girl around here?" I grinned when I heard a squeal.

Since our granddaughter, Olivia, who is three going on eight, was born, and now with our second, Sophia, just a couple of months old, Julie and I have been amazed at the gift of life once again. The daily joy these kiddos have brought into our lives is absolutely remarkable! Julie helps take care of Olivia during the week, and sometimes I get to sneak home to play. I am also discovering how to play house again, name and taste plastic foods, complete the alphabet and numbers, use Play-Doh,© color, and take part in "dress-up princess." We have a blast playing chase, tag, soccer, and basketball, catching lightning bugs, telling stories, singing childhood songs, and praying together. My new Papa motto? Play, spoil, rinse, and repeat… then, o' yes, I can get them ready to go home to mom and dad (smile).

This new season of life has also renewed my heart's interest in childhood development and the significance of parenting and grandparenting. I marvel at how Olivia seems to change by the hour… how much "love and attention" matter to her… and how vulnerable, tender, and impressionable she is. Each day is like a new adventure in the odyssey of life. When her new baby sister, Sophia, was born this summer and Olivia came to the hospital to meet her, I stepped out of the room to greet Olivia. As soon as she saw me from down the hallway, she screamed and bolted on a full dead run, shouting, "Papa, Papa!" I thought… that girl already knows how to earn extra Christmas presents.

I have also found myself thinking about kids who grow up in broken homes, those in poverty, screamed at, abused, ignored, abandoned, bullied, hurried, and hurt by people who are supposed to love them. I think about those with extra challenges growing up in a world that is not the way it is supposed to be. I think about the millions of lives taken before they are ever given a chance to live beyond the womb. With the nightmare we witness today in a culture flooded with hatred and animosity toward families, the Church, and the things of God, have you ever wondered what the future holds for today's generations?

Our schools are not doing any better. Parental rights are being challenged, and it seems that a focus is shifting from educating to indoctrinating our kids in the classroom—that they are somehow the property of the state. All of this reminded me of a quote by Adolf Hitler, "He alone, who owns the youth, gains the future."[1] One thing is certain, it is a fast-changing world that appears bent on controlling and destroying childhood innocence.

When considering the impact on family, it is only natural that it would matter so much. Family is the first institution created by God and the place where little hearts and hands are fashioned. Ultimately, children have no real advocates except for the adults who love, care about, and fight for them—those who are invested, careful, and focused on bringing them up in the nurture and admonition of the Lord. And when it comes to mental healthcare, children are one of the most underserved populations in our culture. We can, and must, do better!

No wonder Jesus said, "Let the little children come to me and do not hinder them, for to such belongs the kingdom of heaven" (Matthew 19:14, ESV) and "Whosoever receives one such child in my name receives me, but whoever causes one of these little ones who believe in me to sin, it would be better for him to have a great millstone fastened around his neck and to be drowned in the depths of the sea" (Matthew 18:5-6, ESV). The admonishment of the Apostle Paul fits here, too, "But if anyone does not provide for his relatives, and especially for members of his household, he has denied the faith and is worse than an unbeliever" (1 Timothy 5:8, ESV).

Our Assignment

In a world flooded with stress, pain, confusion, and tension, including a horrific battle for the hearts and minds of our kids, we must anchor ourselves in what God wants and desires for our children. Proverbs 22:6 (ESV) is instructive, "Train up a child in the way he should go; even when he is old he will not depart from it." I have learned that there are two ways to interpret that verse. Train them in their natural bent—such as their unique personality, temperament, and learning style—and the other is to train them up spiritually in the ways of the Lord. I have concluded that a both/and model is best. Train them up in the ways of the Lord, sensitive to or attuned to their uniqueness. Ephesians 6:4 (ESV) also offers a strong word, "Fathers, do not provoke your children to anger, but bring them up in the discipline and instruction of the Lord." I have often wondered why this verse is in Scripture, and then I realized two possible reasons. First, dads can anger and hurt their children in how they handle them in everyday life, and second, following the ways of the Lord establishes a firm foundation to help kids launch into life. God's love flows through fathers into children's hearts and minds. What better gift of love and grace than to show them the Father?

Ultimately, children have no real advocates except for the adults who love, care about, and fight for them—those who are invested, careful, and focused on bringing them up in the nurture and admonition of the Lord.

I am reminded of Austrian medical doctor and psychotherapist, Alfred Adler, who espoused that children are excellent observers but terrible interpreters.[2] To me, those who parent and influence children's lives are responsible for helping them find their way. With the massive uptick in mental health issues since the COVID pandemic, especially among kids, we decided to dedicate this issue of *CCT* to children. Our prayer is that God will help provide wisdom and insight to each of us as we seek to be better attuned to the "least of these" and bring hope and healing.

A closing thought… they are only little for a while.

TIM CLINTON, ED.D., LPC, LMFT, BCPCC, is president of AACC, the world's largest and most diverse Christian counseling association. He also serves as the Executive Director of the Liberty University Global Center for Mental Health, Addiction, and Recovery. Tim is the co-host of "Dr. James Dobson's Family Talk," heard daily on nearly 1,400 radio outlets. Licensed as a Professional Counselor and Marriage and Family Therapist, he is recognized as a world leader in mental health and relationship issues and spends much of his time working with Christian leaders and professional athletes. Tim has authored or edited nearly 30 books. He and his wife, Julie, have two children and two granddaughters.

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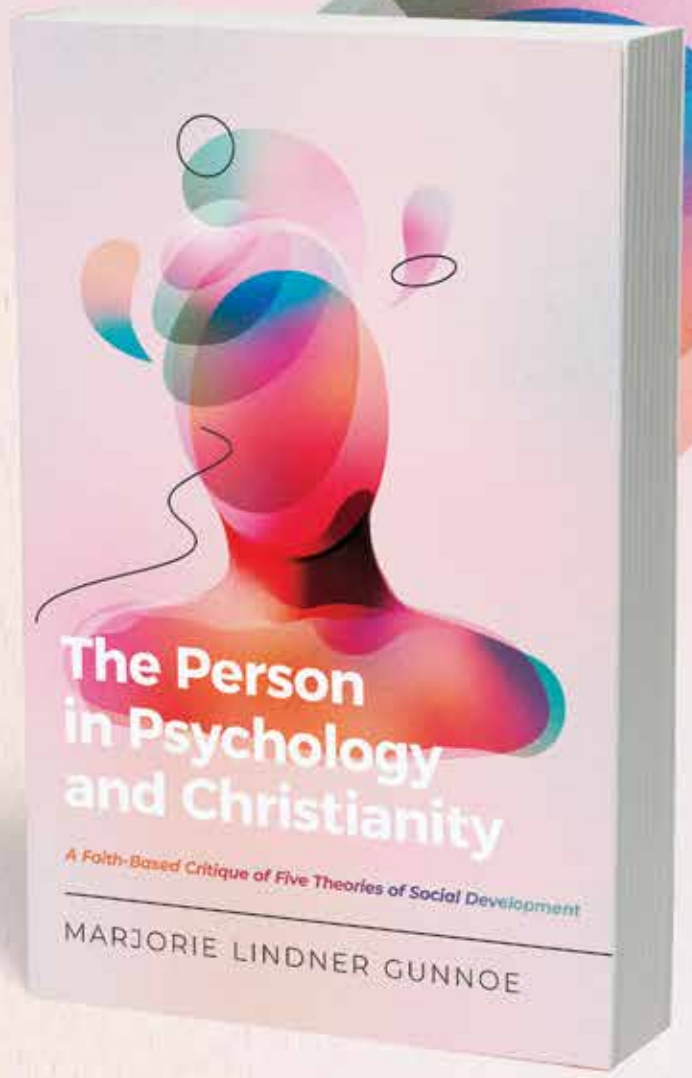
An Introduction to Social Development



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Shattered Innocence

ATTACHMENT, CHILDHOOD SEXUAL ABUSE, AND TRAUMA CARE

How the adults in our early lives treat us forms the blueprint of the attachment beliefs we develop and our sense of whether we are worthy of love and others can be counted on for love and support. Childhood trauma, such as childhood sexual abuse (CSA), is a disorganizing experience. When this abuse happens at the hands of a parent, step-parent, or other caregivers, the shattered innocence is far-reaching, represents an attachment failure, and is often associated with a disorganized or unresolved attachment style.

Shattered innocence refers to the concept that children are helpless to prevent sexual experiences and the confusing emotions accompanying them. They feel tiny and terrified in a fallen world sometimes filled with mean giants. These children face an irreconcilable problem—the people they need to go to for care and support are also the source of abuse. Children learn other people's needs supersede their own and, over time, as their needs are continually discounted, they may conclude that they are unimportant. This perception informs their relationship beliefs, and these children are likely to determine they are not worthy of love and cannot depend on others.[1, 2]

Before celebrating their 18th birthday, approximately 19% of girls and 8% of boys worldwide face CSA.[3] These numbers represent a fraction of the tragedy of stolen innocence due to problems with CSA underreporting. Despite rigorous analysis, the most accurate estimates are an underrepresentation of CSA because young women tend to avoid disclosing experiences for years, and males often avoid reporting altogether. If males do disclose, it is usually for specific practical purposes such as receiving services.[4]

Sexual traumatization encompasses children's experiences with sexuality that are premature and inappropriate.[5] CSA survivors' defense mechanisms represent an *appropriate* response to an *inappropriate* situation. There is not something wrong with them, but there is something wrong with what happened to them. These defense mechanisms aid in coping with being forced into a vulnerable situation for which they are not developmentally prepared. Their shattered innocence leaves them reaching for anything to stop the pain and overwhelms their capacity to cope, leading to unbearable states of loneliness that can be managed only one way, with defenses.[6] These defenses include, but are not limited to, ego-splitting, disassociation, avoidance, and self-destructive tendencies.

None of us escape this life without adopting self-protective strategies, and avoidance strategies help us survive difficult life circumstances. CSA survivors have developed expert levels of avoidance because their survival depended upon it.[7] Like avoidance, dissociation is often an adaptive coping mechanism (in the short term) for severe trauma. However, this surviving method helps children retain a positive sense of self while decreasing the intensity of the painful experiences, often leaving a gap between thoughts and feelings.[8]

Children are encouraged early on through programming like Mister Rogers' Neighborhood to travel to "The Land of Make Believe," *not to escape from reality*, but to deal with the crudeness of reality.[9] Through the indirect use of puppets, children can connect with and express their feelings. For example, each puppet tended to represent the expression of certain emotions (Daniel Stripped Tiger=vulnerability, King Friday=anger and powerful feelings, and the comfort of Lady Elaine, who often represented the empathic other/counselor in this metaphor). Children could confront challenging topics like divorce with puppets before being transported on the red trolley back home to the neighborhood to debrief with Mister Rogers. He helped us distinguish between the imaginary and "the neighborhood" with the highly visible trolley that traveled through a tunnel in the wall. His consistently clear cues and frequent trips facilitated the seamless transition from imagination to reality. He helped children bridge the disconnect between thoughts and feelings,[10] reminding us that feelings are "mentionable and manageable."

Good clinicians can do the same thing with young clients, using these and other tools to help increase children's comfort in indirect disclosure. For example, I was part of a treatment team that worked with a five-year-old named Nellie. During a session, she drew pictures of herself with makeup and jewelry. When we discussed these images with her, she began to discuss sex and disclosed that she "had sex" with her grandfather. Thankfully, Nellie was able to reveal this in counseling and receive treatment and CPS intervention, protecting her from further sexual abuse.

Art therapy and other expressive therapies have evidence to support their efficacy because they help bridge the gap between cognition and emotion, as in Nellie's case. However, not all stories have a positive trajectory like Nellie's. Many survivors keep their abuse secret, often fostering feelings of shame and isolation. Research reveals that those who share their traumatic experiences with a trusted other are more likely to encounter better adjustment and mental health. Dr. Sandra Graham-Bermann, professor of psychology and psychiatry at the University of Michigan, and her colleagues, studied 121 participants exposed to trauma and found that more than 50% disclosed it during treatment.[11]

Improving access to treatment and helping co-create

a safe space for clients are essential ingredients in the healing process. Why co-create a safe space? Psychiatrist, author, researcher, and trauma expert, Dr. Bessel van der Kolk, has emphasized the idea that we do not want to inflict our kindness on clients. The problem with imposing kindness in trauma cases is it does not always create safety. In some instances, children's perpetrators were extra kind before or after the abuse took place (a process known as "grooming"), which could serve as a trigger for some clients.

Trauma Care

A variety of research-based interventions are available.[12] Some effective practices include art therapy, family therapy, eye movement desensitization and reprocessing (EMDR), dialectical behavior therapy (DBT), mode deactivation therapy (MDT), and trauma-focused cognitive behavioral therapy (TF-CBT).

As a proponent of attachment theory, it is imperative to consider attachment when treating CSA survivors and preventing the intergenerational transmission of CSA risk. Attachment styles are often intergenerationally transmitted, and because they are birthed out of many experiences over time with early caregivers, they are unlikely to change without intentional intervention. Unfortunately, there is a correlation between a mother's insecure attachment and history of being a CSA survivor and her child's risk of experiencing CSA.[13] For example, research suggests that a mom's childhood attachment injuries and CSA experiences may set her up to struggle with depression in adulthood, which may interfere with her capacity to identify a supportive partner. She may experience heightened stress regarding parenting, leading to a diminished capacity to comfort and protect her own children.[14]

The good news is, as licensed clinical psychologist, Dr. Gary Sibcy, illustrates through multiple case studies in the text, *Redeeming Attachment*, you are not stuck with the attachment style you have; you can become more secure.[15] For example, a mother who has had similar CSA experiences but works through those traumatic encounters in counseling is more likely to have a secure relationship with her child, and her child is less likely to be at risk of experiencing CSA, which interrupts the generational cycle.

Attachment styles are often intergenerationally transmitted, and because they are birthed out of many experiences over time with early caregivers, they are unlikely to change without intentional intervention.

Two caveats to beware of are: 1) using misguided techniques, and 2) skirting past trauma. Preparing for trauma work and pursuing continuing education in this area is essential. My colleague and research partner, Dr. Lisa Compton, author of *Preparing for Trauma Work*, says: "Our most effective resource to improve attachment, foster resiliency, and heal trauma in the therapeutic setting lies *within ourselves* as clinicians."[16] Throughout treatment, clinicians walk alongside clients as they participate in the process of making sense of their traumatic interpersonal experiences. Therapists can assist clients in both resolving their trauma and developing a coherent attachment story.

As clients return to that traumatic time and engages the brain structures, such as the amygdala, and accesses the memories stored in the deep limbic system that may not have words, they develop a personal narrative. However, now as they go back through these memories, they are in the presence of a caring and safe counselor. They realize that they are not alone in those deepest times of despair. As clients share this with a counselor, they can experience on an emotional level and in a concrete way the realistic comfort that Christ is also with them, carrying them through. As they benefit from your presence as their counselor, there is a greater capacity to be aware of God's presence and appreciate him as Immanuel, God with us. This emotionally corrective practice is pivotal when one's interpersonal history has schooled them in doubt, mistrust, and abandonment.

When clients realize they are not alone, can put their memories to coherent words, and develop a personal narrative with the help of an empathic caregiver, it sets the stage for right-left brain hemisphere integration, neuroplasticity, and top-down (rather than bottom-up) processing. This new understanding makes it easier for clients to develop a coherent narrative and can lead to moving toward a more secure attachment style, resolving trauma, and healing on many levels. ✠

ANITA KNIGHT KUHNLEY, LPC, PH.D., *is the author of the only book to examine America's greatest television therapist through a psychological lens,* The Mister Rogers Effect: Seven Secrets to Bringing Out the Best in Yourself and Others from America's Beloved Neighbor*, and is the co-author, along with her colleague, Dr. Gary Sibcy, of* Redeeming Attachment. *She trains psychologists and counselors at the world's second-largest Christian university and mentors a research team uncovering the impact of research-based interventions for increasing attachment security and emotional intelligence. Baker Books will release her next book in the coming year.*

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Grace for the Children:

TREATING CHILDHOOD MENTAL DISORDERS

All children are *"fearfully and wonderfully made"* in the image of God (Psalm 139:14; Genesis 1:26). A creative act similar to the creation of Adam is repeated at the origin of each person. God wills that each individual life comes into existence and actively sustains them moment by moment (Colossians 1:16-17). God knits all children together in their mothers' wombs (Psalm 139:13-16), and they are all, even those who later develop a mental disorder, conceived for the purpose of displaying His glory (Isaiah 43:7). God is intentional in the creation of His children (Psalm 119:73), endowing each with a divine purpose and plan (Jeremiah 29:11) and bestowing them as a gift and reward upon their earthly parents (Psalm 127:3). Where better for a child struggling with a mental disorder to look for love and acceptance than the Church? Where better for desperate parents to go for support and comfort than the Body of Christ?

A mental disorder is a clinically significant disruption of a person's thoughts, moods, behavior, or ability to relate to others—severe enough to require treatment and/or intervention. While many children will have significant changes in their thoughts, emotions, and relationships during childhood and adolescence, those changes are usually not severe enough to require treatment or intervention. On the other hand, a mental disorder is a debilitating experience in which the child is unable to function normally over an extended period.

Approximately 20% of children (three to 17-years-old) living in the United States experience a mental disorder each year. One out of every five children in the U.S. fulfills the measures that characterize a mental illness.[1] Fifty percent of all chronic mental illnesses start by the age of 14, while 75% originate by 24.[2] Attention-deficit hyperactivity disorder (ADHD) is the most prevalent psychiatric condition in children, while anxiety disorders are the most common among teens. Suicide, of which mental illness is a major precipitating factor, is the second leading cause of death among children between 10 and 14-years-old.[3] While mental illness is a significant public health issue that negatively impacts the lives of more than 17 million children and youth, it is estimated that only 20% of these individuals ever receive the treatment they need.[4]

The SARS-CoV-2 pandemic has only made these troubling statistics more disturbing. A national survey conducted by the University of Michigan's C.S. Mott Children's Hospital found that 50% of parents with teens reported that their children had a new or worsened mental health problem since the beginning of the pandemic.[5] In addition, the proportion of mental health-related emergency department visits has increased by 24% among children between the ages of five and 11-years-old and 31% among adolescents aged 12-17-years-old compared to the year before the pandemic.[6]

Mental disorders result from a complex interaction of biological (nature) and environmental (nurture) factors. All children are born with differing degrees of biological vulnerabilities or predispositions for developing mental health-related difficulties and disorders. Some individuals have a greater set of biological vulnerabilities than others. However, having a natural propensity for developing a mental condition is, by itself, not enough to produce the illness. Instead, an individual's biological vulnerability must interact with environmental triggers (e.g., trauma) to prompt the onset of the condition. The stronger the underlying biological vulnerability a child is born with, the less environmental stress is needed to trigger the start of the illness. Conversely, more significant environmental influence is required to produce the disorder in children born with a weaker biological predisposition. Until they reach this critical level of life stress, children generally function normally, and their biological vulnerabilities remain hidden.

MATTHEW S. STANFORD

Mental illnesses are disorders of the brain that often require medication for recovery. The use of drugs, when necessary, is simply making wise use of the abundant resources provided to us by our loving Heavenly Father. Unfortunately, psychiatric medications only treat the symptoms of mental disorders; they do not cure the underlying neurobiological problems. However, minimizing the condition's symptoms allows the child or adolescent to function more normally. Every person responds differently to medication, and it is normal to try several different medicines before finding the one that works best. While researchers are trying to clarify how early treatment affects the developing brain, parents and physicians should always weigh the potential benefits against the risks before prescribing medication to children.

For a medication to be approved by the Food and Drug Administration (FDA), the drug's manufacturer must provide the agency with clinical data demonstrating that the drug is both safe and effective in treating a specific problem in a particular group of individuals. Based on this information, the drug's label lists the proper dosage, potential side effects, and approved ages for use. Unfortunately, most psychiatric medications have not been approved by the FDA for use in children. However, physicians may prescribe medications as appropriate, even if those uses are not included on the drug's label, called off-label use. Research shows that the off-label use of psychiatric medications can be helpful for many children.

Psychotherapy (i.e., talking therapy) is also an essential part of a treatment plan for childhood mental disorders. More than just a free-flowing discussion, therapy is guided by the theory and goals associated with the specific therapeutic approach used by the therapist (e.g., Cognitive Behavioral Therapy). In general, treatment focuses on managing symptoms related to the disorder and improving a child's overall quality of life. Research has consistently shown that mental illnesses are often best treated using a combination of medication and therapy.

The Scriptures tell us that we have been created as an embodied spirit, having both physical (material) and nonphysical (immaterial) aspects to our being (1 Thessalonians 5:23). Describing the developing Christ child, Luke outlines four elements of our being (Luke 2:52). He writes, *"Jesus kept increasing in wisdom* [mental] *and stature* [physical], *and in favor with God* [spiritual] *and men* [relational]*."* So, like the young incarnate Christ, a child is a unity of physical, mental, spiritual, and relational facets, with each aspect affecting and being affected by all the others. Because of this, when children struggle with a mental disorder, they require a holistic approach to care that considers all aspects of their being. A holistic approach to mental healthcare relieves physical and psychological suffering while revealing the unconditional love and limitless grace only available through a personal relationship with Jesus.

The physical needs associated with a mental disorder go far beyond simply taking medication, including sleep, nutrition, and regular physical activity. Keeping the body (and brain) healthy will help lessen the severity of symptoms related to the disorder and can enhance the action of psychiatric medication. Mental disorders are often a battle between reality and wrong or negative thoughts that overwhelm a child's mind. A structured approach to psychological needs is just as important as physical needs and includes regular therapy, healthy thinking, developing positive coping skills, and enjoyable mental activities.

The Church has a significant role to play in the lives of children (and their families) struggling with mental illness. Studies have shown that religious support offers benefits to psychologically distressed children that are unavailable from general social support. These benefits include a sense of belonging, value, purpose, and connec-

tion to a healing community. Religious support is vital to recovery and wholeness. More importantly, we serve a God who loves us deeply, hears our desperate cries, and responds with sustaining mercy and grace. A mental illness affects more than just the child with the disorder; it also touches their entire family. Stigma and shame often isolate families from the world around them when caring for a mentally ill child. In addition, high levels of stress and difficult symptoms can result in relational conflict requiring forgiveness and reconciliation.

The Body of Christ must not fear or withdraw from the problem of mental illness but instead choose to face it with God's grace and wisdom. Jesus said that the world would know we were His disciples because of our love for one another (John 13:35). As a community of believers, our approach to these problems should be one of love and grace. We must lead by example. So *"let us love one another, for love is from God…"* (1 John 4:7).

MATTHEW S. STANFORD, PH.D., *is CEO of the Hope and Healing Center & Institute and adjunct professor of psychiatry at Baylor College of Medicine and Houston Methodist Hospital's Institute for Academic Medicine. He is the author of* Grace for the Children: Finding Hope in the Midst of Child and Adolescent Mental Illness.

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Suicide is the second leading cause of death among youth aged 15-24. With mental health issues in youth on the rise, it is critical for anyone who interacts with children, teens, or young adults to be aware of the issues contributing to suicide risk. It is even more vital for parents, teachers, youth pastors, and leaders to know how to talk about suicide, take active steps to prevent suicide, and intervene effectively with young people who may be suicidal.

Jennifer Cisney Ellers, M.A., is a professional counselor, life coach, crisis response trainer, author and speaker. She speaks extensively and provides training, counseling, and coaching in the field of grief, crisis and trauma through the Institute for Compassionate Care. Jennifer is an approved instructor for the International Critical Incident Stress Foundation, teaching several CISM courses. In addition, she serves on the Executive Board and as Director of the Grief, Crisis and Disaster Network of the American Association of Christian Counselors and Clinical Director for the Crisis Response Team of the United States Concealed Carry Association. Jennifer is the co-author of *The First 48 Hours: Spiritual Caregivers as First Responders, Spiritual and Psychological First Aid,* and *Understanding Suicide: Effective Tools for Prevention, Intervention, and Survivor Support.*

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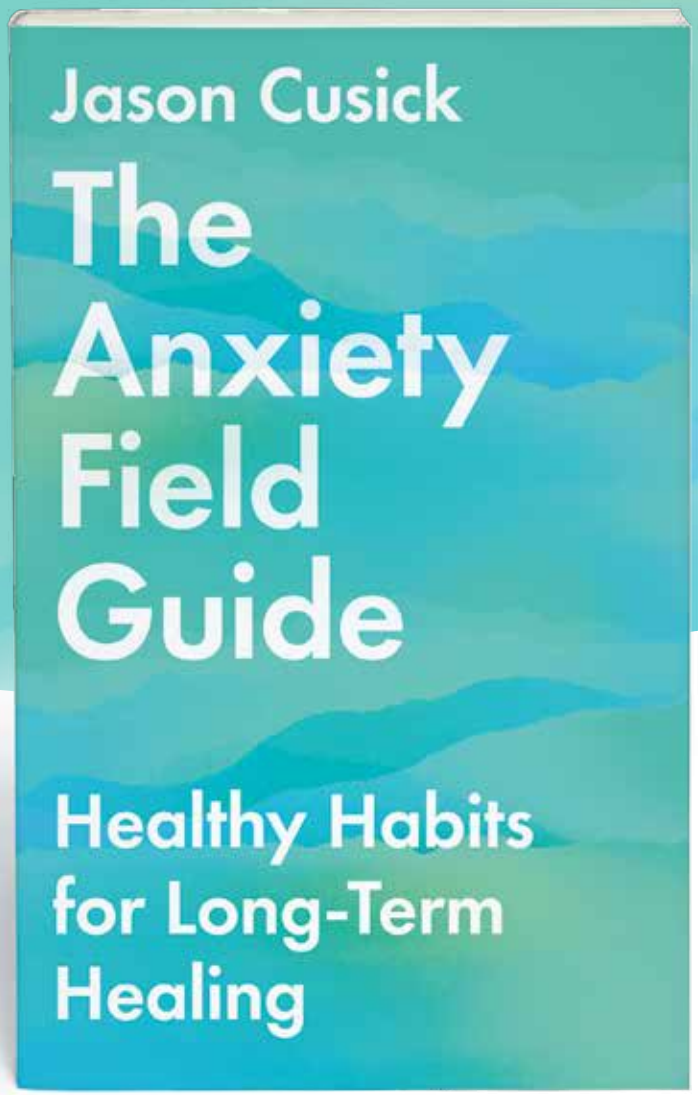

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Jason Cusick is lead pastor at Journey of Faith in Southern California. He was previously the pastor of care ministries, overseeing grief, recovery, crisis, and counseling ministries, and has also worked as a board-certified hospital chaplain.

Lonely Kids:

A MODERN-DAY EPIDEMIC

Gabriella and her parents entered my office and sat down on the couch. She folded her arms and stared out my window. Her parents took a deep sigh as they looked at each other. Feeling the tension in the room, I said, "Thank you for coming in today. You mentioned on our phone call that you were concerned about Gabriella and the recently discovered self-injury. How can I be of help?" Gabriella's mom quickly spoke up, "This is so out of character for her; we just want to make sure she's okay, but we have no idea what to do."

It took some time but, eventually, Gabriella was able to open up to me in session. She was 14 years old and the eldest of four siblings. Though her parents were present and engaged in their children's lives, they also worked full-time to adequately provide for their growing family. Gabriella became the "pseudo" parent and, as a result, had to make sure she was home after school to help her siblings with homework. Frequently she would find herself cooking dinner for her family. The responsibilities and felt needs of the family were overwhelming for Gabriella. She eventually disclosed that she was dealing with immense loneliness.

MARK MAYFIELD

Consequently, Gabriella began struggling with shame because, in her words, "I shouldn't feel lonely. I am surrounded by a bunch of people who love me." Over the next several weeks, I was able to walk alongside Gabriella and help her put words to how she was feeling. As we moved forward, she became capable of communicating her mental and emotional needs with her parents, and things at home started to change.

Unfortunately, this has become a prevalent conversation among myself and my staff. The pandemic has forced us into isolation, resulting in our teenagers facing new challenges. According to a recent Cigna study, children and young adults are twice as likely to wrestle with loneliness than older adults, with 79% reporting feeling lonely compared to 41% of older adults.[1] As a result, there has been an increase in suicidal ideation and self-injury, with an age-adjusted suicide rate of 14.24 deaths per 100,000 compared to the national average of 13.48 deaths per 100,000.[2] Our children are at greater risk, and those in the helping profession must talk about this in both a clinical and practical way.

Let's briefly examine how loneliness and isolation can contribute to suicidal ideation and self-injury. (PLEASE NOTE: Loneliness and isolation can be potential contributors to suicide and self-injury, but they are not direct causes. The desire to self-injure and the thoughts associated with suicide are much more complex. For further research on this, read my free e-book, *Help! My Teen is Self-injuring: A Crisis Manual for Parents* – www.drmayfield.com.)

Loneliness is defined as "the state of being unseen or unnoticed relationally, mentally, emotionally, physically, or spiritually. It can be driven by a lack of purpose or meaning, relationship, and/or identity and is marked by a deep sense of hopelessness."[3]

Here are five ways loneliness and isolation contribute to suicide and self-injury:

1. **Loneliness deteriorates your connection to others.** We are designed and created for connection. Being in relational reciprocity allows us to develop a healthy symbiotic relationship with others. When thoughts of loneliness enter in, the relational connection has the potential to sever, and we subsequently begin to feel isolated and alone. Isolation can then be a direct link to negative self-talk and thoughts.
2. **Loneliness can hijack our emotional regulation.** If/when our relational connection is severed, the failure of our emotional regulatory system is close behind. Why? We need each other to regulate. Our brains do not fully function (both emotionally and cognitively) unless they are in a safe, trusting relationship with someone else. Therefore, when our relationships/connections are compromised, so will the regulatory functions of our emotions.
3. **Loneliness calls into question our identity.** When connection is lost and our emotions are dysregulated, we begin to question consciously or unconsciously who or whose we are. Satan's whisper, "You are worthless," becomes a scream, "YOU ARE NOT LOVED!" We lose sight of the promises of God and get lost in the sea of isolation.
4. **Loneliness negates our purpose.** When our identity is compromised, our purpose gets lost. Purpose flows out of identity—it is what helps us get out of bed in the morning. Without it, a narrative of "who cares" develops.
5. **Loneliness misplaces hope.** Hope is essential for life. Without hope, all seems lost. Loneliness

is forgetful and does not remember what hope is or where it was placed, and everything feels lost in that moment. NOTE: When hope is lost, it is crucial to consult with a mental health professional, as this is where suicide can be most prevalent.

After going over this list with Gabriella and her parents, her dad asked, "So, how do we help Gabriella regain some of these components in her life?" "Good question!" I answered. "You must be purposeful and intentional in your relationship with Gabriella."

The following are several action items that every parent can take:

1. **Create opportunities for your child to be seen.** Find opportunities to do things with your child on their level. This interaction will allow them to feel valued and seen for who they are and what interests them. Doing this for only 15 minutes a day can create a considerable change.
2. **Allow for conversations to happen.** Not feeling as though they have anyone to talk to is one of the biggest reasons children feel lonely. Change this. Make yourself available to "talk" with your child. I emphasized the word talk because you should not talk at all (or at least minimally). Instead, listen with curiosity. Ask good questions, but do not give advice or try to fix your child. If you try to offer guidance or resolve their problems, there is less chance they will come back for another talk.
3. **Find ways to speak truth over them.** Tell them who they are and whose they are. One simple way to do this is to pray or speak Scripture over your child. Do this when they are awake and also when they are asleep—words matter. What we say to our teens will profoundly impact their identities.
4. **Dream with them.** It can be scary to think about the future. Many teens feel lost when it comes to their purpose. Help them explore the intersection of who/whose they are and what they were put on this earth to do.

This list is not extensive, nor a prescription… but it is a start. Please slow down, pay attention, lean in, and engage your teenager at their level. You will not be disappointed. Remember, loneliness leads to isolation, and isolation leads to death (mentally, emotionally, and spiritually). It is our job to step in and speak truth and life. When our children are seen, they feel loved; when they feel loved, they have an identity; when they develop an identity, their purpose grows; and as their purpose grows, they find hope—and hope and loneliness cannot co-exist.

Please slow down, pay attention, lean in, and engage your teenager at their level. You will not be disappointed.

Note: Portions of this article were previously published in Christian Parenting *titled, "Five Ways Loneliness and Isolation Contribute to Teen Suicide and Self-injury," by Dr. Mark Mayfield and are being used with permission.*

MARK MAYFIELD, PH.D., *is an author, speaker, leadership coach, and professor. He has extensive experience in executive leadership as the former founder and CEO of Mayfield Counseling Centers, a 501c3 non-profit in Colorado Springs, which serves more than 25,000 appointments a year. Dr. Mayfield is an executive leadership coach, helping churches and organizations navigate the complexities of their mental and emotional health. He is an Assistant Professor of Clinical Mental Health Counseling at Colorado Christian University and also partners with the American Association of Christian Counselors as a mental health consultant.*

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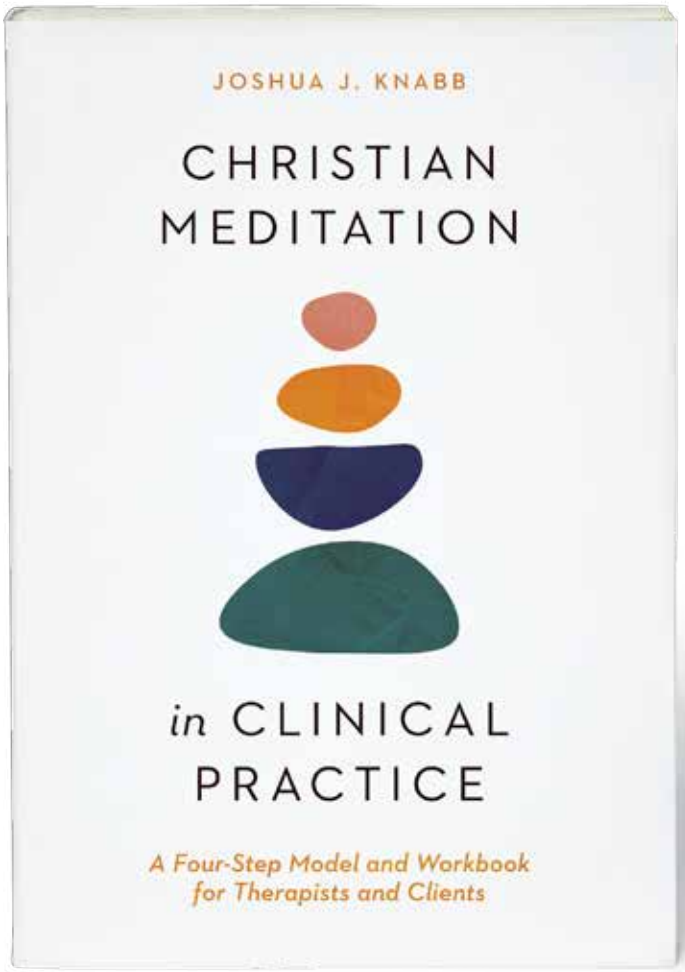

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One Heart, Two Homes:

Working with Children and Parents in Post-divorce Families

Growing up with divorced parents has a distinct impact on a child's experience of "family"—it can either be one of "brokenness" or of "neutrally parenting apart." One of the most emotionally influential factors to a child is how their mom and dad co-parent. Co-parenting takes on a variety of experiences, the most important being how two parents communicate, share parenting time, and make decisions together. Co-parenting also directly impacts what the child believes about being able to freely love their other parent or feeling guilty or "deeply divided" and pulled apart between their two favorite humans. We believe that children *can* come through a divorced family experience and still have every hope to thrive as young adults, and divorce does not have to ruin their childhood. The hope comes with walking alongside the children and parents to give everyone healthy tools to navigate how they communicate and interact with one another for the children's best interests.

Now, let's define a few helpful terms:

- **Parenting time** – This is the active time that mom and dad have the shared children. Some co-parents have a 50-50 arrangement, and some have 60-40 or even 80-20 (with mother's usually having most of the parenting time). Research vets out that children will thrive the most when they have shared parenting (equal time with mom and dad). When both parents are available, stable, and able to provide a nurturing home, it is always best that they have equal time. However, geographics may not allow for that in all cases. There is extensive information available on the National Shared Parenting Web site (https://sharedparenting.org), including an inspection of all 50 states and an assessment of which ones are, by default, shared parenting states versus which ones have a long way to go.
- **Parenting Plan** – This is a legal document each state has on the .gov Web sites that begins the template for the legal decisions made during separation and into divorce. The parenting plan addresses issues like parenting time, decision making, and all things financial. In the area of decision making, there are three core distinctives that divorced parents either have joint decision making or one has full decision-making power: medical, religious, and education. These three areas are the base of all future co-parent decisions. (Note: Counseling for children and professionals working with them falls under the medical area. It is critical for counselors to get a copy of the parenting plan to be 100% certain on whether both parents are needed to agree on their child getting counseling or if one can make the medical decision independent of the other. It is essential that therapists pay attention to this matter so they do not get into a complicated legal issue.)
- **Handoffs** – This is when the biological co-parents exchange their shared children. Sometimes this takes place on a Friday at 6:00 p.m. and other times on a Sunday evening. Each parenting plan outlines the specifics as to where and when this will happen and who is responsible for the transportation of the child(ren). Since most divorced co-parents will exchange their children hundreds of times before they turn 18, we want to do our best to help with this topic. Some families will make multiple transitions during the week and, thus, can do up to 156 "handoffs" in a given year! In 10 years, those children experience a handoff up to 1,516 times, which will impact them profoundly.

  Three core suggestions to give co-parents: be mindful of your facial expressions, tone of voice, and body language. Also, never use the handoff as a time to discuss co-parent business (e.g., money, schedule, doctor appointments, etc.) because children are waiting and watching. The exchange is stressful enough for kids without witnessing their parents talking for a long time and often getting into an argument. Another note about the handoff is to make it as positive and pleasant as possible for the kids—this may require a bit of "faking it," but putting on a smile and being respectful to each other will help ease the stress for children. The goal of a successful handoff is to prepare the child to go to the other parent's home and give "emotional permission" to go and enjoy their time there. In our work, this is one of the most important tasks in helping co-parents so those hundreds of handoffs can go smoothly without pain and frustration.
- **Co-parent Meeting** – This is a very strategic focus of our work in trying to equip co-parents with a compartmentalized time and space to discuss all the details of their shared children. It is the time to discuss school, discipline, financial matters, upcoming trips, and schedule changes. Also, this is the appropriate time for one parent to notify the other parent that the child will be meeting someone he or she is dating. When divorced co-parents begin to re-couple, it can be an emotional landmine for the children if they are the "accidental messengers" of this news. Instead, we suggest the protocol include informing the other co-parent about introducing the children to a new partner *before* it happens. This communication will prevent the children from finding themselves in a situation of, "Mom, I met daddy's new girlfriend, Tracey. She's really nice, and

JAY AND TAMMY DAUGHTRY

I like her!" Clearly, this has the potential to be a massive trigger for mom or dad, causing an immediate reaction like a harsh response, an emotional outburst, or even an inflammatory comment—none of which are ideal for children to hear because they may think they got their other parent in trouble and stop openly communicating. Meeting once a quarter by phone, Zoom, or even in a local coffee shop to discuss details related to shared children is a very proactive solution to arguing or having co-parent meetings during handoffs, ballet recitals, or baseball games.

- **Co-parent Apps** – Several useful apps can help divorced co-parents with communication, changing schedules, sharing financial responsibilities, reimbursements, handouts from school or the doctor, and so much more. A co-parent app is a practical tool divorced parents can use to minimize "misfires" and keep all the important information in one place. One of the co-parent apps even has a "tone monitor" to help parents adjust the wording when they message each other to keep their conversations neutral instead of conflictual and hostile. It even suggests word replacements and phrases that constructively keep the communication moving forward.
- **Co-parent Categories** – The late Dr. Constance Ahrons, a prominent psychotherapist, mediator, and author, presented research on the Five Categories of Co-parenting.[1] It is one of the most helpful tools we use in our practice with divorced co-parents. The categories were created by measuring the quality and consistency of divorced co-parents' communication and interactions. The categories are: Dissolved Duos, Fiery Foes, Angry Associates, Cooperative Colleagues, and Perfect Pals.

  The handouts we share also include the direct impact children experience with each of the unique categories. The children of Dissolved Duos experience abandonment; Fiery Foes experience parent alienation; Angry Associates experience emotional anxiety and stress; Cooperative Colleagues experience freedom (emotionally and developmentally); and Perfect Pals experience confusion about what it means to be a family or be divorced.

  Feel free to contact us for this free handout, the Indicators of Healthy Co-parenting Questionnaire, and other resources that can be used in your practice at CoParentingInternational.com. These educational tools can motivate and educate divorced co-parents to move from being angry to a more collaborative, productive approach. For all the things divorced parents disagree on, co-parents usually want the healthiest outcome for their shared children, and these tools can help equip them to get there.
- **Adverse Childhood Experiences (ACE) Study** – According to the Adverse Childhood Experiences (ACE) Study (cdc.gov/violenceprevention/aces/about.html), one of the "adverse childhood experiences" that can have an impact is the divorce of biological parents.

However, the good news is it is not the fact of the divorce that makes it adverse, but what happens *next* that matters most. This study speaks to the issues of "adjustable stress" and "toxic stress" after divorce, and the possibility that children and parents experience divorce with adjustable stress means they can recover and adjust. The children who live in post-divorce "toxic stress" are the ones who suffer the most. Educating and equipping co-parents to move toward Cooperative Colleagues can mitigate the negative impact of divorce on children and provide adults and children with tools to process their pain and loss while moving forward into a healthy future.

If working with stepfamilies, children, and parents impacted by divorce is your passion, please connect with us. We will be doing evidence-based research in 2023 and would enjoy collaboration with therapists worldwide who have a desire to support these children and parents.

There is hope. God's good plans continue for children and parents, especially when they find grace and support from the professional therapeutic community. Together, we can break the cycle, create healthier single-parent families, and empower those affected to raise well-adjusted children who believe in God's plan for marriage and family!

JAY DAUGHTRY, M.MFT., and TAMMY DAUGHTRY, M.MFT., *are authors, national trainers, and co-founders of The Center for Modern Family Dynamics in Nashville, Tennessee. Together, they oversee Co-parenting International and train therapists, pastors, military chaplains, pregnancy center directors, and school leaders on the critical topics of co-parenting, stepparenting, and understanding kids from complex families. Tammy's book,* Co-parenting Works! Helping Your Children Thrive after Divorce*, has been featured on FamilyLife Radio, Focus on the Family, Moody Radio, Life, Love, and Family with Dr. Tim Clinton, and more than 50 other radio and TV outlets. For more information, visit their Web site at www.CoParentingInternational.com.*

Endnote

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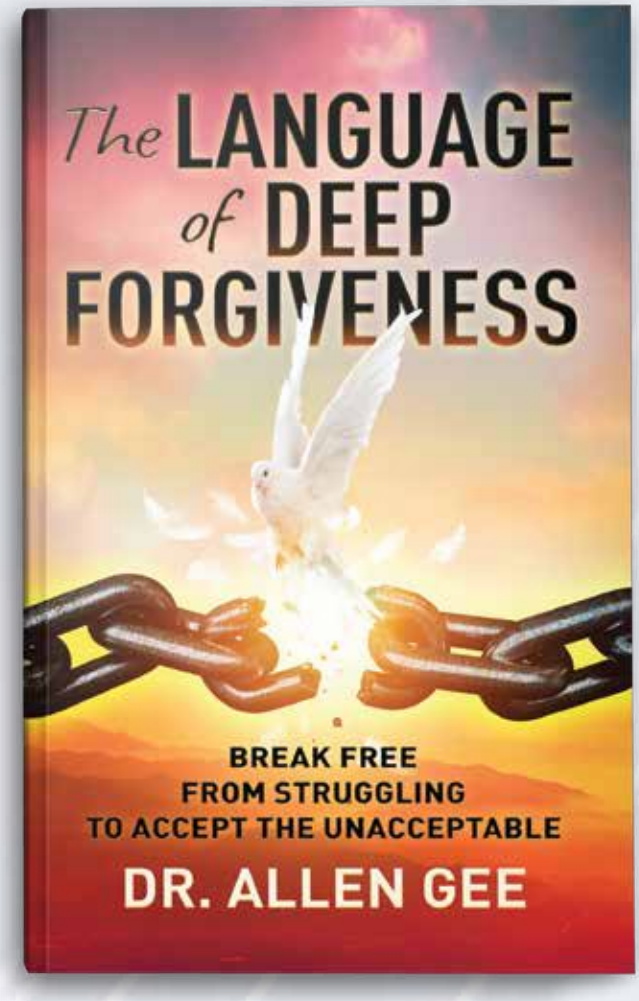

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RAISING EMOTIONALLY HEALTHY KIDS

Who can't relate in even a small way to the statement Stitch made about his family in the Disney movie, Lilo & Stitch, "This is my family… it's little and broken, but it's still good. Yeah, still good." Here is another statement you have never heard from any parent *ever*: "My kids are perfectly emotionally healthy!" Sure, our goal is to raise emotionally healthy kids, but we all fall short in one way or another. However, this does not mean parents cannot play a key role in raising emotionally healthy kids who will become responsible adults. In fact, the goal in parenting isn't that we would develop completely obedient children but rather that we would raise responsible adults. The most effective parents keep that end goal in mind.

Becoming Students of the Changing Culture

Raising emotionally healthy kids in today's culture is not an easy task. The culture is not exactly our friend when it comes to helping kids develop healthy emotions, morals, values, or strong faith. With this in mind, here is a prayer I often need to pray, *"Lord, teach me to parent the children I have, not the child I was or the kids I thought I would have."* If we are going to help our children navigate this ever-changing culture, the following are a few distinctives about this generation we must keep at the forefront of our minds.

They are shaped by technology. Today, almost every aspect of children's lives is influenced by technology and media. Parents need to be extremely intentional about creating media-safe homes and helping kids learn from an early age to discern the consequences media can have on their lives.

They view tolerance as one of the major traits of a loving person. This dominant view of culture has influenced our children's generation. It makes for complicated conversations regarding gender identity, politics, faith issues, and, of course, morals and values. Parents can take the lead and continue to have a "biblical worldview" while being loving to those who disagree.

Every child needs someone who can be irrationally positive toward them, but they also need parents who will express expectations, set high standards, and hold them accountable.

They experience what parents often call "the cringe factor." Research says that the average age a child will view pornography is 11 years old.[1] Sixty-nine percent of the people in the United States believe cohabitation is acceptable regardless of whether the couple plans to marry.[2] Gender identity issues have gone mainstream. In a recent Gallup poll, the percentage of LGBTQ adults in the U.S. has doubled over the past decade.[3] Another cultural cringe factor is that Gen Z reports twice as many atheists as the general population.[4] Parents must talk with their children about these critical issues while teaching them biblical values from a positive, God-honoring point of view.

What's a Parent to Do?

Unfortunately, too many parents become paralyzed with today's culture and give up. However, you can make a difference when you are proactive. Research shows there are several factors a parent can implement to help their children become emotionally healthy and responsible adults. The following are seven things parents can do to raise emotionally healthy kids:

1. Lead. I fear that too many parents have indulged and enabled their children to the extent that they have helped create irresponsible and even narcissistic kids. Parents must lead with love, purpose, and authority. Children are unwilling to grow up when they have weak, inconsistent discipline and poor boundaries. I do not mean that kids should not be nurtured and affirmed. Every child needs someone who can be irrationally positive toward them, but they also need parents who will express expectations, set high standards, and hold them accountable.

2. Shape Behavior Without Crushing Character. Developing character and responsibility is one of the key factors in raising emotionally healthy kids. Still, one of the ironies is that we *must* give our kids the freedom to fail for them to grow up. Keep in mind that kids are moving from dependence to independence—if we hold on too tightly, they will not learn to take full responsibility or build healthy character. In his excellent book, *Parenting Teens with Love & Logic*,[5] Foster Cline offers four steps toward teaching your kids to become responsible.

- **Step one:** Give your child responsibilities (that are appropriate with their age development).
- **Step two:** Trust that your child will carry them out.
- **Step three:** When they blow it, stand back and allow the consequence to occur while expressing empathy.
- **Step four:** Turn right back around and give them the same responsibilities all over again because it sends a powerful implied message: "You're so smart that you can learn from your mistakes."

The more parents can empathize with their kids' mistakes because they have already discussed the consequences, the better it is for raising emotionally healthy kids.

3. Encourage Positive Peer Relationships. Peer pressure does not always have to be negative. Positive peer influence is immensely powerful. The Bible says, *"… Bad company corrupts good character"* (1 Corinthians 15:33, NIV), but the opposite is also true—good company encourages good character. Healthy friendships will help your children deal with unhealthy cultural influences, sometimes even in ways you cannot help. Research reveals that young people who are engaged with positive friendships, school activities, and church youth groups tend to have more strength in overcoming negative cultural temptations.

4. Foster Spiritual Growth. Remember, you cannot live out your children's spiritual growth, but you can energize their faith in many positive ways. Nagging them into a deeper relationship with God has never worked, ever. Friendships play a vital role, so involvement with other kids at church is often very influential. Encouraging faith to be an adventure with mission and service experiences and providing other role models enhance spiritual growth. Recent studies show that "faith conversations at home with parents" are key to keeping your kids on track.

JIM BURNS

5. Teach Your Kids Healthy Biblical Sexuality From a Positive Viewpoint. All studies show that the more positive, value-centered sex education kids receive from their parents, the less promiscuous and confused they will be. Unfortunately, many parents with young children today never received healthy sex education from their parents, so they tend to refrain from discussing this topic with their kids. However, this must change—no one is safer than a parent in having those sometimes awkward and uncomfortable conversations. Today, there are excellent resources available to help parents with this subject.

6. Have Serious Fun. Yes, it is proven that fun and play with your family are incredible ways to open a closed spirit, build healthy lifestyle traditions, and develop family closeness, which brings everyone emotional health.

7. Get as Emotionally Healthy as You Possibly Can. Too many parents are emotional wrecks because they carry the weight of their children's behavior on their backs. No matter how good of a parent you are, your child is quite capable of making poor choices and horrible decisions. Remember, parenting is a marathon, not a sprint. So, do not put all of your energy into your children and neglect your own emotional health. An emotionally healthy parent is one of the best factors in having emotionally healthy children. Someone once told me, "Untended fires soon become nothing but a pile of ashes." Fuel the fire within your own life. Develop a parenting plan focusing on your children becoming responsible adults and nurturing healthy emotional and spiritual growth. And do not neglect your own life as you create that parenting plan for your kids.

The Bottom Line

The bottom line is that there is hope in building character, responsibility, and emotionally healthy kids. Even if you are in the pit of pre-adolescent or adolescent hormones, drama, and rebellion, know that most kids make it to adulthood and do just fine—although not perfect, but healthy. Our three strong-willed kids gave my wife and me a run for our money. Even in the emerging adulthood years, it was challenging. And then they got married and matured.

As I write this, I am just returning from a vacation with our entire family. One night on our recent escape with all the kids and grandchildren around us, I leaned over to my wife and said, "This is an awesome, mostly emotionally healthy family—and no, it's not perfect, but I'm not sure it gets any better than this." We smiled, held hands, and enjoyed a wonderful time together. ✠

JIM BURNS, PH.D., *is the President of HomeWord. He is the author of* Doing Life with Your Adult Children: Keep Your Mouth Shut and the Welcome Mat Out *and* Understanding Your Teen. *Jim primarily writes and speaks on HomeWord's values, which are: strong marriages, confident parents, empowered kids, and healthy leaders.*

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When Love Hurts:

Kids Living in Chaos and Violence in the Home

"Read me a story!" A refrain of small children everywhere to parents or caregivers. When my children were young, they often picked out the same book to be read over and over again. What was borderline boring and repetitious to me was comforting and predictable to them. Their world was stable and secure because they knew the ending; they knew what was going to happen next. However, there are no happy endings for children living with violence in the home, and what happens next is no fairy tale. There are no predictable endings for children living in chaotic households, and what happens next is anyone's guess.

How Children are Affected

Domestic violence brings its own brand of chaos, deceptively wrapped in recognized patterns of the abusive cycle (tension, incident, reconciliation, calm). When the family "story" includes domestic violence, children learn by experience *what* eventually will happen; the unanswered question is *when*. Knowing the what but not the when leads to a childhood filled with fear and anxiety.

Fear and anxiety are present even when domestic violence is kept "hidden." As one study put it: "Parents or caregivers involved in a violent relationship may think that the fighting does not affect their children. Even children who do not see domestic violence are affected by the conflict in the family. Children may develop serious emotional and behavioral problems."[1] Children recognize violence in the home, whether they see it or not. When children internalize that violence, the conclusions they come to about *why* and *who* can be misunderstood and misplaced.

We know domestic violence and the chaos shrouding it devastates children. What may be less recognizable is the damage a chaotic household, without the presence of domestic violence, can have on children. In this "story," the *when* is predictable, and the lack of order is constant. It is the *what* that is unknown—what will be the chaos, and what must the child do to cope?

Research, based on the review of 112 studies regarding the effects of chaotic homes, found: "Household chaos represents the level of disorganization or environmental confusion in the family home, and is characterized by high levels of background stimulation, lack of family routines, absence of predictability and structure in daily activities, and an overly fast pace of family life. Importantly, the construct of household chaos has been associated with a diverse range of adverse childhood outcomes, including poorer social-emotional function, cognitive development, academic achievement, and behavioral problems."[2]

Signs of Their Pain

The signs of a chaotic household on the functioning of children have been shown as:

- Lower test scores
- Lower cognitive ability
- Decreased self-regulation
- Poorer language skills
- Poorer social-emotional functions
- Greater behavior problems
- Learned helplessness[3, 4]

When this chaos is accompanied by domestic violence, the resulting fear and anxiety can manifest differently, depending upon the age of the child:

- Preschool children will revert to younger behaviors such as bedwetting, crying, whining, and thumb-sucking.
- School-age children become better able to internalize guilt and blame, thus reducing their sense of self-worth. This blow to their self-esteem can cause them to isolate from activities, such as:
  - school work, resulting in lower academic scores
  - friendships, as they doubt their ability to have and maintain friendships
  - increased difficulties at school, with adults and peers
  - physical effects, such as stomachaches and headaches
  - changes in appetite and sleep

GREGORY L. JANTZ

Such is the substance of our profession—helping people overcome the pain of their past and find healthy ways to move forward.

- Teens may act out negatively:
  - skipping school
  - engaging in fights
  - changing peer groups
  - rebellious or oppositional behavior
  - engaging in risky behaviors, such as alcohol, drugs, and unprotected sex
  - difficulty in making and maintaining friendships as a result of low self-esteem
  - fighting, bullying, and interacting with law enforcement (more common in boys)
  - isolating and experiencing depression (more common in girls)[5]

Higher health risks perpetuate into adulthood from childhood, including depression, anxiety, low self-esteem, diabetes, obesity, and heart disease.[6] "The results of this study also support and extend previous research suggesting that psychological maltreatment may be just as or more detrimental to health than physical abuse (Irving and Ferraro 2006; Teicher et al. 2006)."[7]

How to Help Them Process Their Pain

Not all affected children will end up in therapy as kids. Not all therapists are specially trained in working with children, especially younger ones. Most therapists will be called upon to help these children process their pain as adults. However, there are ways for adults, professional or not, to help children process their pain. The organization, Domestic Shelters (DomesticShelters.org), has created a manual outlining 18 ways adults can help. They include strategies such as spending time regularly, letting children talk about what they want, and not pushing disclosure. It is essential to answer their questions honestly and appropriately, while avoiding making promises you cannot keep. It is also crucial to allow them to express their emotions, encourage them to find peer friendships, and link them with things they love, such as clubs or activities.[8]

What Recovery Looks Like

As therapists, we recognize that recovery from chaos and domestic violence may occur years or decades after the fact. Such is the substance of our profession—helping people overcome the pain of their past and find healthy ways to move forward. Recovery means assisting people in recognizing they are not to blame for their childhood circumstances. Recovery means helping them shed damaging coping mechanisms, understanding they are no longer needed, and acknowledging they are no longer wanted. Recovery looks like someone in control of their own story, equipped to face the future, and confident in their ability to produce a healthy, if not always happy, ending. ✠

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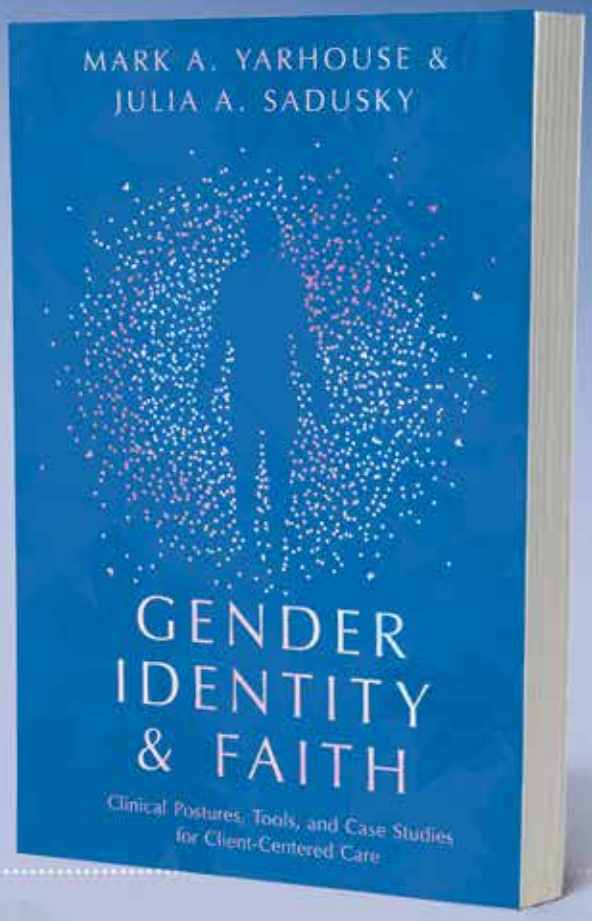

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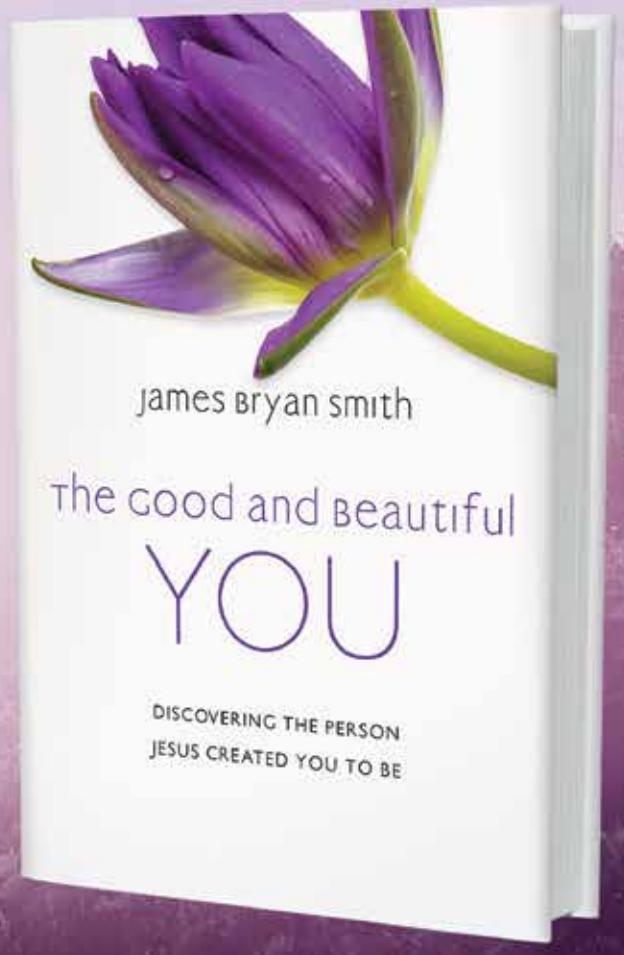

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Medication Intervention for Children Who Have Experienced Trauma

When parents, teachers, and other stakeholders become concerned about a child's behaviors, they may refer them to counselors. In working with children, it is essential to view them from the perspective of their world—both internal (brain-body) and external (all aspects of the environment in which they live and interact).

Child behavior includes actions toward need-fulfillment (acquisition of needs and wants), attention-seeking (social connection), non-verbal communication/expression of needs or emotions (ranging from pleasure to frustration and rage), escape or withdrawal from noxious circumstances, and aggression against perceived or real adversity. Children learn behaviors in the context of attachment to caregivers and experiences with people and environmental settings. A child with a responsive caregiver is likely to be more emotionally regulated as the parent is present and available to help soothe them when needed. In environments where the primary caregiver is preoccupied, unavailable due to depression or other illness, or otherwise inconsistent, the child develops defense mechanisms to cope with an overwhelming situation.[1] These mechanisms may be the impetus for seeking treatment, and parents may be unaware of their role in the manifestation of these behaviors.

An old proverb says, *"Train up a child in the way he should go: and when he is old, he will not depart from it"* (Proverbs 22:6, KJV). As this proverb suggests, children develop behaviors and guidelines for functioning during childhood and often continue walking these paths (neural pathways created in the brain directing behavior) through adulthood. Often, a child's behavior represents an attempt at coping based on their understanding and learned behaviors in the face of a situation. The developmental level of the youth requires consideration to differentiate normal from pathological. This awareness includes a review of behaviors regarding domains of frequency, intensity, duration, context, and functional impairment.

One-fourth of children and adolescents experience a

mental disorder in a given year.[2] Mental conditions involve disturbances in cognition, emotion regulation, behavior, reality testing, and physiologic parameters. They impact biological, psychological, social, and spiritual functions. In childhood, ongoing development is at risk based on the age and stage of the individual. Anxiety disorders are the most common, followed by attention-deficit/hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), mood or severe disruptive disorders, autism spectrum disorders, and substance abuse. Many children have more than one condition.

Traumatic experiences in children include witnessing or being victims of physical, sexual, and emotional abuse and/or neglect. Extreme stressors may occur in 25% of the general youth population.[3] Traumatic experiences may contribute to or amplify mental and physical illnesses. They may produce post-traumatic stress disorder (PTSD) with intrusive daytime and nighttime memories of the traumatic event in response to triggers, avoidance of the reminders, physiologic symptoms, hyperarousal, and emotional numbing.

Addressing trauma in children is challenging. Psychiatrist, author, and researcher, Bessel van der Kolk, noted, "Traumatized children tend to communicate what has happened to them not in words but by responding to the world as a dangerous place and by activating neurobiologic systems geared for survival, even when they objectively are safe."[4] Spirituality can provide a sense of coherence and meaning to life; however, early trauma may enhance, destroy, or impair the development of spiritual and religious beliefs.[5]

Early intervention is crucial for optimal response and long-term function. The bio-psycho-social-spiritual model is a comprehensive, humanistic, and holistic approach to understanding and treating human beings needing clinical care. A team, including parents/caregivers, counselors, physicians, teachers, ministers, and others, provides observations and assessments to seek the best understanding of the child and their world. Then, a multimodal approach to healthy intervention follows an algorithm based on the individual's response.

Medication is also a significant part of this model, but it is not the first line of treatment. The foundation of therapy for children with mental illness, especially those who have experienced trauma, starts with co-creating a safe, secure environment—one with nurturance, emotional support, predictability, creativity, acceptance, validation, reassurance, and receptivity to the expression of feelings. This atmosphere is also recommended for normal child development and education. Exemplified by Fred Rogers, host of the TV series, Mister Rogers' Neighborhood, and the book by Dr. Anita Knight Kuhnley, *The Mister Rogers Effect: 7 Secrets to Bringing Out the Best in Yourself and Others from America's Beloved Neighbor*,[6] this type of environment unpacks how clinicians can apply these principles to establish better therapeutic outcomes through a series of seven, key psychological strategies.

The second step is to address medical and psychological needs. Multiple emotional and behavioral problems are likely present. Based on severity, specialized group and individual therapies may be necessary. Play therapy invites children to an alternative mode of expression for their feelings and story. Anxiety management and stress-reduction skills include breathing, meditation, relaxation, and mindfulness. Cognitive-behavioral therapy (CBT) is a mainstay approach, particularly trauma-focused CBT (TF-CBT). Dialectical Behavior Therapy (DBT) may focus on emotion regulation, distress tolerance, acceptance of situations, change-oriented strategies, and interpersonal effectiveness. Family therapy engages the parents and others in the child's world to address healing. It is imperative to address the family's contributions as possible perpetrators of trauma. Collaboration with school counselors, teachers, pediatricians, pastors, and psychiatrists provides a comprehensive approach.

Often, physical and emotional symptoms are so intense that they interfere with the ability of the child to attend or respond to appropriate non-pharmacologic interventions. When other measures produce an insufficient response, medications may help. Medications alleviate symptoms and may promote neural synaptic growth and brain neuroplasticity. On a personal note, I inform the child, parents, and others involved in the child's circle of the following perspective: "Pills don't produce skills but may reduce ills enough to engage wills to develop skills." By reducing children's symptoms and suffering, medications may help them participate and respond to the non-pharmacologic measures. In

addition, medications may sometimes be indicated for the short term to stabilize behaviors while the treatment team is working with the child and family on other lifestyle changes and skill development that will help make the medication no longer essential.

Medications in general child psychiatry are also helpful in treating traumatized children (many of whom may meet the criteria for PTSD). Medication management requires assessment to achieve the best impression of diagnoses, specific indications, review of precautions and potential contraindications, monitoring for adverse effects, consideration of possible medication interactions with other treatments, and education to achieve understanding and consent. Medication selection targets the primary presenting symptoms more than a specific diagnosis. However, diagnoses may have symptoms that overlap and several conditions may occur together (comorbid). This situation may confuse definitive diagnosis, and treatments for one disorder may aggravate treatments for another.

Starting with one medication at a low dose while closely monitoring is followed by adjustment to optimal response. Sometimes, multiple drugs are necessary and require closer observation. As treatment progresses and the child improves, gradual medication withdrawal is a consideration. Counselors can collaborate with prescribers on medication management. The counselor may actively discuss medication compliance with the client and encourage self-monitoring or journaling to track symptom severity, rate mood, and record when medication is taken or missed. Counselors and psychiatrists can only work with the information they are given. If a client is missing doses and experiencing setbacks but is not aware of, or tracking, the frequency of missed dosages, it can impede the treatment.

Anxiety and depression are the most common conditions in general, as well as in traumatized children. Selective serotonin reuptake inhibitors (SSRIs), such as fluoxetine, escitalopram, and sertraline, are antidepressants that may reduce these symptoms and decrease intrusive thoughts and avoidance behavior. Propranolol is a beta-blocker that may reduce anxiety, stress reactions, and performance issues. However, propranolol may increase depression. Guanfacine and clonidine are alpha-adrenergic agonists that may reduce anxiety, aggression, and symptoms of ADHD and improve sleep. Mood stabilizers, such as carbamazepine and valproic acid, may reduce aggression, mood lability, and impulsivity; however, they have significant side effect profiles requiring laboratory monitoring. Atypical antipsychotics, particularly risperidone, aripiprazole, and quetiapine, have anti-psychotic and mood-stabilizing effects. Although they may reduce aggression, mood lability, and impulsivity, these drugs have metabolic (blood sugar and lipids) and muscle movement effects that require close monitoring. Stimulants, such as amphetamine, methylphenidate, and atomoxetine (an antidepressant with an indication for ADHD treatment), target symptoms of ADHD, a condition with frequent comorbidity that can contribute to, and complicate, the treatment of other disorders. Trazodone is an antidepressant that produces sleepiness, but it may aggravate the nightmares associated with PTSD. Benzodiazepines (such as clonazepam) are rarely used in children and are recommended only for short-term treatment of severe anxiety, panic, or insomnia. However, they are not recommended for PTSD.

With a comprehensive evaluation and treatment approach, counselors, in collaboration with other healthcare professionals, can reduce the suffering of children with mental illness, including victims of trauma, and promote physical, mental, and spiritual health and well-being. *"The Spirit of the Lord God is upon me; because the Lord hath an-ointed me to preach good tidings unto the meek; he hath sent me to bind up the brokenhearted, to proclaim liberty to the captives, and the opening of the prison to them that are bound…"* (Isaiah 61:1, KJV). ✠

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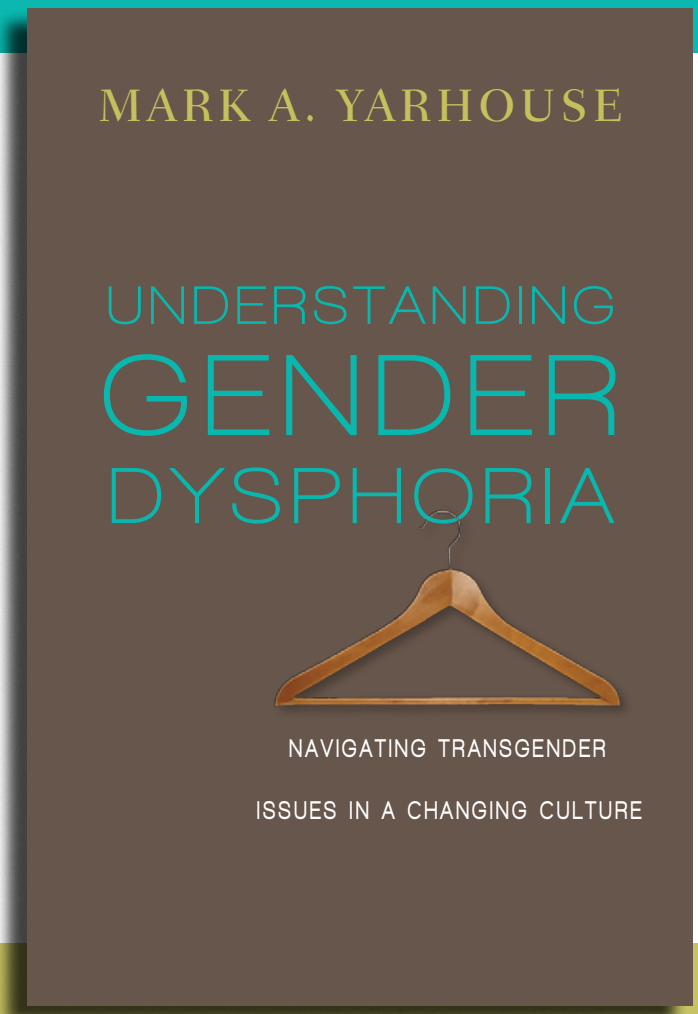

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professor of anthropology,
Messiah College

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CHILDHOOD TRAUMA THERAPY and INTERVENTION STRATEGIES

Childhood trauma is extraordinarily impactful on victims and quite challenging to deal with therapeutically. While most therapists assert that the trauma narrative must be expressed and processed, I would argue that this does not need to focus on verbalization. As an expressive/play therapist, I will use nonverbally based interventions with most traumatized clients, and always with children!

There are central basic developmental, psychological, and neurological reasons for taking this approach. Whereas adults primarily process verbally with words, children do not have this ability. Through expressive and play therapy, children indeed "talk." In their case, however, play is the language, and toys are the words (Landreth, 2012).

Trauma should be further defined. Psychiatrist, author, and researcher, Bessel van der Kolk, (2002) states: "Trauma by definition involves speechless terror: patients often are simply unable to put what they feel into words and are left with intense emotions simply without being able to articulate what is going on" (p. 150). As we consider trauma in the context of using expressive therapies, Cathy Malchiodi (2020), psychologist and art therapist, recognizes the benefits of expressive therapy when dealing with trauma-based issues: "Trauma's impact often requires approaches that address the sensory-based experiences many survivors report. Expressive arts therapy—the purposeful application of art, music, dance/movement, dramatic enactment, creative writing, and imaginative play—are largely nonverbal ways of self-expression of feelings and perceptions. More importantly, they are action-oriented and tap implicit, embodied experiences of trauma that can defy expression through verbal therapy or logic" (p. 1).

More About Trauma

Before I move on to further comments about treatment, I would like to comment on some basic thoughts I have in my work with traumatized clients:

- Trauma is inherently intrusive. Therefore, the therapist's interventions should be facilitative and not a recapitulation of this intrusion. Questions can themselves be intrusive.
- Trauma always occurs within the framework of a system of some kind. The trauma may have occurred within the family system. Therefore, a systemic/family therapy approach must be a crucial element of the therapeutic process.
- Treatment must attend to a continuum of issues—including physiological, cognitive, psychological, and spiritual concerns. Trauma involves various levels of impact to all these areas.
- Clinical work with trauma cases involves direct encounters with horrifying circumstances. The impact of this on helpers should never be underestimated.
- The focus of treatment should never be the trauma itself, the diagnosis, or the child's symptomatic response to the trauma. The focus of treatment should always be on the child. If we focus on the previously mentioned elements, we lose sight of the child.
- Trauma treatment takes time. It is entirely inappropriate to expect two, five, or 10 years of trauma, neglect, terror, and pain to be resolved by an hour once a week, limited to six or eight sessions by managed care. We should fight for what our children need.

It is essential that we are all aware of the neurobiological effects of trauma. Neuroimaging studies with posttraumatic stress disorder (PTSD) clients demonstrate: 1) deactivation of the prefrontal cortex (executive functioning), which interferes with the ability to formulate a measured response to threat; 2) increased activation of the limbic system; and 3) decreased activation in the Broca's area in the brain, which relates to verbalization (van der Kolk, 2014). To ask the "classic" counseling question—"How does that make you feel?"—makes little sense considering these neurological realities alone.

Traumatized clients need a safe and soothing intervention. Polyvagal therapy expert, Stephen Porges (2018), stresses a short but poignant therapeutic truth: "Safety is treatment" (p. ix). Trauma leaves clients' brains in an alarm state, where alarm reactions trump cortical processing (Perry, 2006; van der Kolk, 2014). The cortex can be overwhelmed by lower regions of the brain; thus, expressive interventions, which do not rely on verbal processing and executive functioning, help soothe clients who may have alarm reactions in the therapy process.

Why Use Expressive Therapies?

It is also important to consider my basic rationale for play and expressive therapies. In Homeyer and Sweeney (2023), and Sweeney and Lowen (2018), several are offered:

- As noted, play is fundamentally the child's natural medium of communication, as opposed to verbal communication. I posit that it is unfair and dishonoring to expect children to leave their world of expressive play and enter the adult world of verbal communication. Doesn't empathy involve entering the client's world?
- Play and expressive therapies inherently have a unique kinesthetic quality. They provide an unparalleled sensory experience, which meets a basic need that I believe all people have for kinesthetic experiences.
- Play and expressive therapies create the therapeutic distance often needed for traumatized clients of all ages. While they may be unable to express their pain in words, they can find expression through projective media.
- This therapeutic distance then creates a safe environment for catharsis to occur. Traumatized clients need a therapeutic setting in which to experience this—a place of safety where painful issues can emerge and be relived.
- Expressive and play therapies provide a unique and natural setting for the emergence of therapeutic metaphors. The most powerful metaphors in treatment are those generated by clients themselves (as opposed to those orchestrated by therapists).

Give hope to children and parents.

Provide children with a safe, reparative, and relational experience.

Provide a developmentally appropriate and honoring therapy experience.

Concluding Thoughts

I teach my graduate students that I have three primary goals when working with traumatized children: 1) Be a "hopemonger" – give *hope* to children and parents, 2) Promote *safety* – provide children with a safe, reparative, and relational experience so development and potential may be realized, and 3) Recognize developmental realities – provide a *developmentally appropriate* and honoring therapy experience. I believe this comes through play and expressive therapies.

I obviously cannot go into practical intervention material in this short article. However, consider exploring some of the resources on the reference list at the conclusion of this article. I will leave you with a favorite quote. My friend, Eliana Gil (2010), a clinician, author, and lecturer, summarizes a challenge for using expressive therapy with traumatized children, which we should all keep in mind: "At the very core of the problem is that child victims of interpersonal complex trauma often long for and fear the very same thing: an intimate and safe relationship with a trusted and caring individual. Clinicians are thus advised to be patient, hopeful, and above all, prepared to engage fully with children who may push them away, or worse, children who find or create obstacles at every turn" (p. 7). ✠

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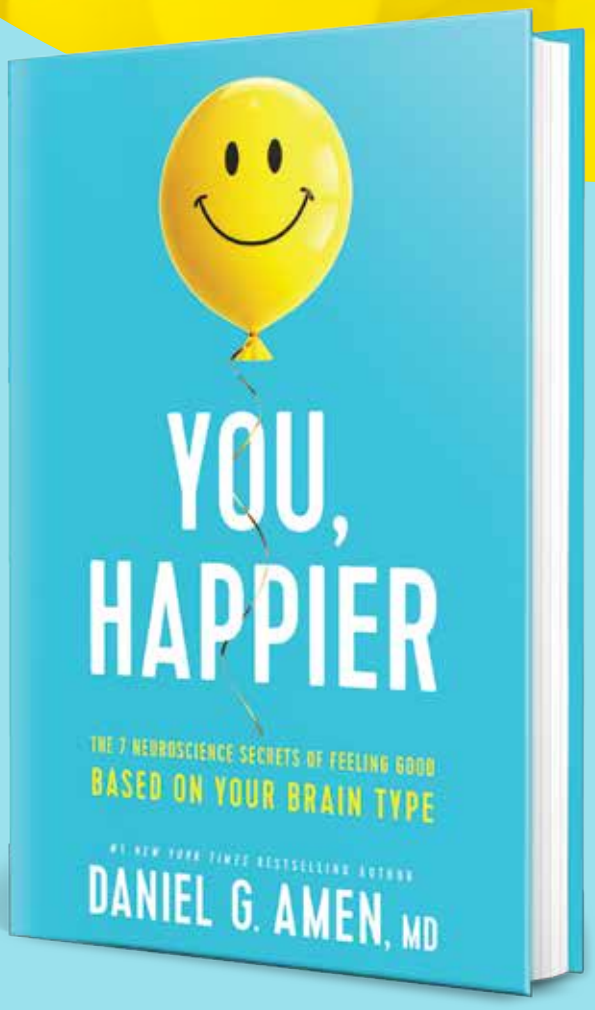
THE HIDDEN LIES ABOUT WHAT YOU THINK WILL MAKE YOU HAPPY—AND THE SEVEN LITTLE-KNOWN SECRETS TO GENERATING GREATER HAPPINESS.



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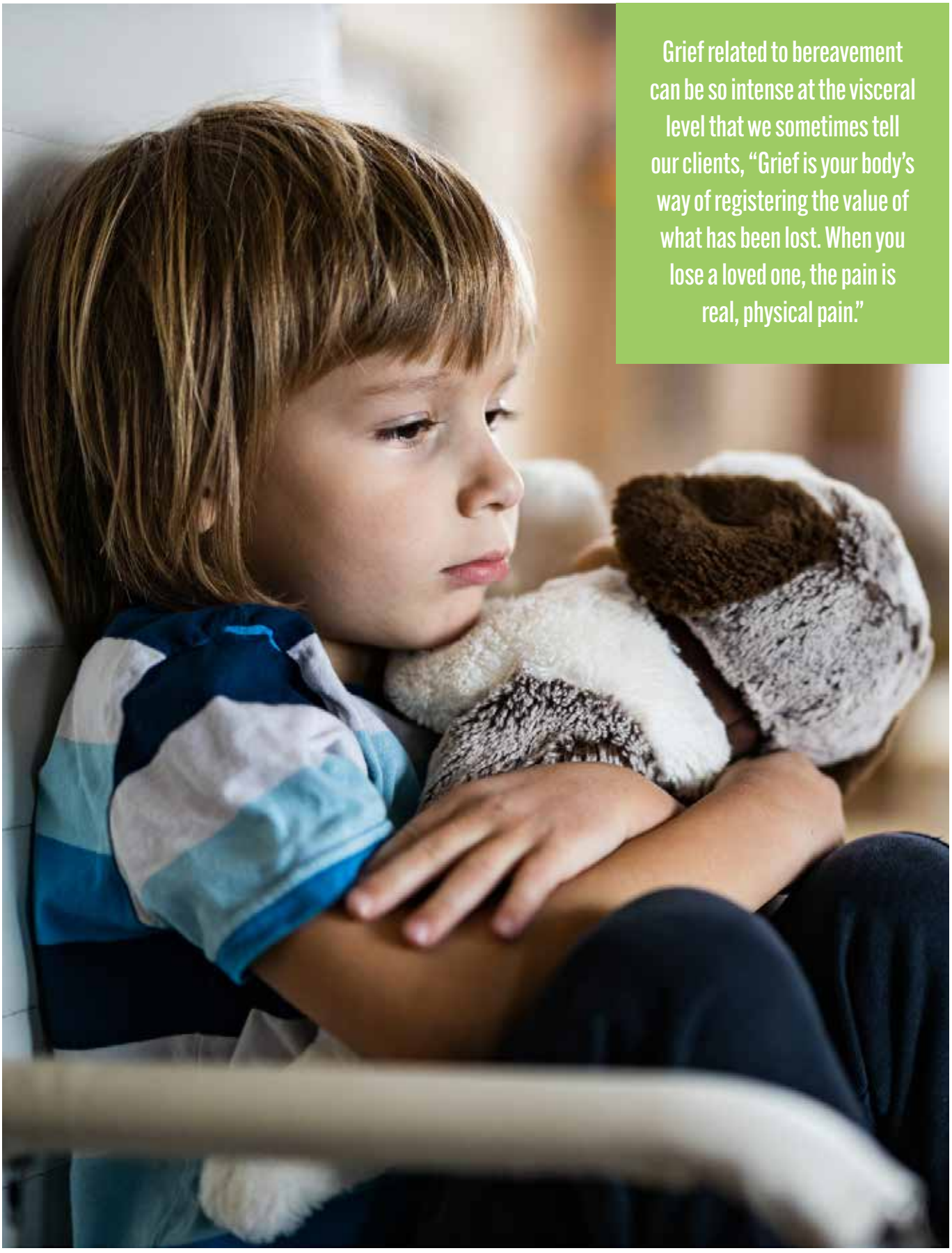
DANIEL G. AMEN, MD, has helped millions of people change their brains and lives. He is the founder of Amen Clinics, with 10 locations across the United States; a 12-time *New York Times* bestselling author; and the cohost of *The Brain Warrior's Way Podcast*, which he created with his wife, Tana. He has produced 16 national public television specials about the brain that have aired more than 130,000 times across North America. Dr. Amen believes we can end mental illness by creating a revolution in brain health, and he regularly speaks to businesses, organizations, and churches about how to have a better brain and a better life.

Tyndale



Grief related to bereavement can be so intense at the visceral level that we sometimes tell our clients, "Grief is your body's way of registering the value of what has been lost. When you lose a loved one, the pain is real, physical pain."

Assessment Strategy for Childhood Grief and Trauma

Bereavement, Grief, and Mourning

Loss occurs when we are deprived of something important we once had, whether it be some physical object, like a favorite toy, or something more symbolic, like the hope of becoming a star baseball player. Loss triggers feelings of grief. Bereavement refers to the grief process initiated by losing a loved one to death. Grief is a subjective experience involving every aspect of our being—thoughts, feelings, physical sensations, and behaviors. Grief related to bereavement can be so intense at the visceral level that we sometimes tell our clients, "Grief is your body's way of registering the value of what has been lost. When you lose a loved one, the pain is real, physical pain." Mourning is how different cultures characterize the process of bereavement and loss (e.g., funerals, eulogies, celebration of life services).[1]

Recent research[2] estimates roughly five million children (anyone younger than 18) in the United States will experience the death of a parent or sibling. Children may also encounter many other types of traumatic losses, including the loss of grandparents, other relatives, and friends. Of course, we will all go through this normal, but painful, process. Most will endure this process without developing emotional, psychological, and spiritual complications. However, roughly 10-15% of grievers will experience a more prolonged grief reaction[3] that can lead to more severe and disabling psychological, emotional, and spiritual outcomes. It is common for therapists who treat children and families to encounter problems related to grief and trauma. This article provides therapists with some guidelines and strategies for assessing referred children who have had such experiences. We will also discuss several useful psychological instruments you can utilize to help with assessment and treatment planning.

The Effects of Trauma and Loss

Trauma and loss can affect each child differently. Some may develop *internalizing problems* like depression, anxiety, or somatization (i.e., complaining about mild physical symptoms that have no medical cause). In contrast, others may exhibit *externalizing problems* like oppositional behavior, irritability and aggression, and even hyperactivity and impulsiveness. The overwhelmed and grieving child can also develop difficulties with school performance as attention, organization, and planning skills can deteriorate due to intense negative emotions. Trauma and loss can also disrupt a child's adaptive skills, such as social communication, decision making, assertiveness, and problem-solving abilities.

GARY A. SIBCY, II AND JOSHUA LOVE

Assessment Strategy

For valuation purposes, we recommend using a broadband assessment instrument, like the Behavior Assessment System for Children (BASC-3),[4] to better understand these effects. This assessment package has multiple advantages. First, it gathers information from various perspectives—self-report, parent-report, and teacher-report. This information is crucial because many children have poor insight into their behaviors and consequences, leading them to underreport and sometimes over-report symptoms. Also, a multi-rater system allows different teachers to rate children, so you can get a more robust perspective on how their behavior may change based on the type of class (e.g., English, math, music) and the influence different teachers have on their behavior.

The same is valid with caregivers. In some instances, children exhibit more problem behaviors and emotional symptoms when in the presence of one caregiver versus another. Of course, the BASC-3 has a robust, developmentally-sensitive self-report component for youth (ages six to 25) that covers several problem areas, including attitudes toward school and teachers, depression, anxiety, relationships with parents and peers, self-esteem, sense of inadequacy, and more.

Developmental Background

Additionally, the BASC-3 has a Structured Developmental History that gathers a great deal of information about the child's development, as well as their social, psychological, educational, and medical information. This part of the assessment is crucial because it is essential to know if the problems the child is currently experiencing are an exacerbation of previous difficulties or the onset of brand-new issues. Prognostically, children exhibiting these problems for the first time in the wake of a traumatic loss are likely to fare much better than those who have already been exposed to various adverse experiences and exhibited behavioral and emotional problems before the most recent adversity.

Parent-Child Relationship

Finally, the BASC-3 has a relationship assessment questionnaire that allows you to assess the quality of the parent-child relationship, including both the parent and child's perspectives on the warmth and quality of attachment experiences. Again, we recommend obtaining a historical perspective on how well the child functioned before the most recent traumatic loss.

Parenting Stress and Depression

As we noted, assessing the quality of the parent-child relationship is especially important from a treatment perspective. Keep in mind that when children suffer the loss of a parent or sibling, the surviving parent is also suffering profoundly and may not have the psychological and emotional resources available to help support their children as much as needed. Thus, it is crucial to measure parental stress.

We recommend using the Parenting Stress Index™ (PSI-4).[5] This measure also gauges the quality of the parent-child relationship, attachment, the amount of stress the child's behavior has on the parent, the degree of support parents receive from both within the family and external

sources, and it also taps into paternal depression. In instances where the parent produces elevated scores on this measure, we suggest following up with more specific actions such as the Beck Depression Inventory-2® (BDI-2)[6] and the Beck Anxiety Inventory® (BAI).[7] Parents who score in a high range on these measures may also be referred for individual treatment, which might include medication.

Grief, Depression, and Post-traumatic Stress

Based on BASC-3 findings, therapists may want to assess more carefully for major depression, post-traumatic stress, and specifically a prolonged grief reaction. It is important to distinguish between these three outcomes, as increasing evidence shows each condition responds to different treatment components.[8] For a more detailed assessment of depression, we recommend the Child Depression Inventory-2™ (CDI-2),[9] which can be used with children ages seven to 17. For adolescents 18 years of age, use the Beck Depression Inventory-2® (BDI-2). For post-traumatic stress, we recommend the Trauma Symptom Checklist for Children™ (TSCC)[10] for ages eight to 16. A screener version of this checklist is also available, which takes approximately five minutes to administer.

Some children may not develop major depression or post-traumatic stress disorder but still suffer from persistent, complicated grief extending beyond the normal recovery pathway. The Inventory of Complicated Grief (ICG) – Revised[11] is a particularly beneficial instrument. This 28-item scale has a cut-off score of 68 that identifies youth who continue to suffer well beyond the normal range. They will respond most effectively to grief-focused therapy approaches.[12]

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« TED CUNNINGHAM, MACE

When the Church Helps Those with Childhood Trauma

"Then they cried to the Lord in their trouble, and he saved them from their distress. He brought them out of darkness, the utter darkness, and broke away their chains. Let them give thanks to the Lord for his unfailing love and his wonderful deeds for mankind..."
– Psalm 107:13-15, NIV

The Lord is present, and He will never leave you. He protects and guides His children through life's darkest valleys and tempest seas: *"He stilled the storm to a whisper; the waves of the sea were hushed. They were glad when it grew calm, and he guided them to their desired haven"* (Psalm 107:29-30, NIV). God gives salvation and freedom to those who cry out to Him.

We tend to carry our scars from childhood hurts into adulthood and our relationships. Parents, church leaders, teachers, and family members who were distant, angry, harsh, neglectful, or selfish wrote messages on our hearts of a God who treats us likewise. However, this is not true. We do not want those mistreated in their childhood to walk in darkness and pain for one second. We declare the truth of God's Word over them so they may walk in His ever-present, unfailing, and eternal love.

The Church carries a sacred trust. We help people heal from childhood grief, loss, and trauma. This is our prayer: "Lord, please let your church be the safest place on earth for children, victims, and survivors. Where we need to do better, convict us. Where we need training, send those to equip us."

I first heard the term, "trauma-informed," a few years ago. Simply stated, it is the approach pastors, teachers, leaders, counselors, and coaches must take to prevent re-traumatizing victims. My desire is to make sure nothing I say or do, even in jest, brings more harm to a victim of abuse or trauma. For this reason, I have been listening to and learning from survivors and advocates through books, articles, podcasts, and workshops.

I am grateful for leaders like leading Christian psychologist, Dr. Diane Langberg, who has dedicated her life and ministry to helping the Church do better by preventing abuse and calling out abusers. She mixes no words on the subject, "Whenever God's people fail to speak truth, expose the deeds of darkness to light, and function as a refuge for the abused, afflicted and needy… they have not only failed you but have failed our God as well, for they look nothing like Him."[1] How we help people heal speaks directly to the heart and character of God. Dr. Langberg reminds us of this special calling, "If you want the survivor to grasp the faithfulness of God, then be faithful to them. If you want the survivor to understand the truthfulness of God, then never lie to them. If you want the survivor to understand the infinite patience of God, then be patient with them."[2]

Honestly, I feel way over my head as a pastor on this subject. When I address it in messages, my lower lip quivers from a mix of empathy and lack of understanding of what many in the congregation have endured at the hands of an abuser. I always ask for grace before I try to help. I have pastored and counseled many victims and their families, which have helped me learn much, but I am still learning. The following are a few considerations that may help you in your ministry and practice.

First, there's a great deal I don't know. When I find myself unqualified to help, there is still plenty I can do. I can refer to counselors and clinicians. Our church keeps an updated list of qualified clinicians and their specialties. It is also encouraging that therapists live by this "know what you don't know" mantra. When your therapist refers you to someone else, that signifies professionalism and humility. In these cases, they are acknowledging, "I know someone better trained to help you."

A counselor recently encouraged me to "soothe before you solve." The ministry of presence says, "I am here to help, not judge." When I am present and listening, I find that it opens the other person up to recommendations I make for further care. And again, it reminds them that God is present.

Second, encourage victims to share their stories with safe people in safe environments. Psalm 107:2 reminds us, *"Let the redeemed of the*

"… Truly I tell you, whatever you did for one of the least of these brothers and sisters of mine, you did for me" (Matthew 25:40, NIV).

Lord tell their story—those he redeemed from the hand of the foe.…" It is best to share your story with someone, but not everyone.

The longer I pastor, the more I am convinced that the Internet is a terrible place to heal. You have probably heard it said, "Facebook is a terrible therapist." When you post your deepest hurts on Facebook or Twitter for the world to witness and share, there are four types of potential viewers: 1) those who never see your posts because the algorithm kept them from their feed, 2) those who do not care, 3) those who care but do not know what to say, and 4) those who care and speak life over you.

Proverbs 2:11 (NIV) says, *"Discretion will protect you, and understanding will guard you."* Fight the urge to share with strangers. Safety is found in trusted friends, family, and church leaders.

Finally, protect children and adults from abuse. I have asked the question repeatedly in counseling, "Do you feel safe?" When the answer is "no," our church goes to work immediately to help with housing, food, and clothing. Our church goes to great lengths to keep kids safe on Sunday. When guests, victims, and survivors step into our church and see all that is done to protect children, it lets them know it is a safe place. Every church needs a rigid plan to protect children, prevent mistreatment, and report abuse immediately. When the physical or emotional marks are seen or heard, report. As mandatory reporters, we contact the authorities and let them investigate and arrest and prosecute if warranted.

I know many church leaders are uncomfortable with this conversation, and I understand. We avoid discussing this subject, but not because we do not care. We do care and want to do better. I pray you lean in when it is awkward and fight for those who cannot fight for themselves. Let's provide for those who have nowhere else to turn.

In the parable of the sheep and goats, Jesus tells the story of the ones who feed the hungry, care for the sick, and welcome the stranger: *"… Truly I tell you, whatever you did for one of the least of these brothers and sisters of mine, you did for me"* (Matthew 25:40, NIV).

Jesus, we do all of this for You.

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« DIANE LANGBERG, PH.D.

Who is the Greatest in the Kingdom of Heaven?

You may have experienced abuse, but you are precious to Him. You may be ignored, but God sees you. These truths cannot be undone; they are eternal.

We have recently witnessed a great deal of destruction in the Christian world—accounts of sexual abuse covered up and allowed to continue in the house of our God. Apparently, we have been more concerned about protecting famous people, large organizations, income, and reputations than the vulnerable in our midst.

The disciples asked Jesus, *"Who is the greatest in the kingdom of heaven"* (Mathew 18:1)? The King of Kings then instructs His disciples about greatness. Jesus gives them a picture utterly unlike what they imagined. They were looking for a kingdom with a king and officers of state all the way down to the ordinary people. The disciples expected Jesus to exert His power, break Rome's authority, and re-establish David's throne. He told them their King was headed to Jerusalem to suffer, be humiliated, be murdered, and rise again. After crushing their hopes of Him reigning, they asked, *"Who, then, is the greatest…?"* Jesus calls a little child forward and essentially says,

if you cannot be like this child, you cannot be great. That is so backward from our perspective. We, the grown-ups, are the teachers of children. However, we often seem to lose sight of the fact that the little ones are also our teachers. Jesus made it very clear: *"… unless you turn and become like children, you will never enter the kingdom of heaven. Whoever humbles himself like this child is the greatest in the kingdom of heaven"* (Matthew 18:3-4, ESV).

In the next chapter of Matthew (19:14), Jesus says to let the little children come to Him and not hinder them. Has our reach for fame, money, and power hindered little ones? Do you think abusing a child might get in the way of their coming to our Lord? Would lying, hiding, denying, and covering up such abuse be a hindrance? We have so often failed to be great by our Savior's standards by crushing precious children created in the image of God and loved by Him. As a result, we have caused both God and these treasured children immense grief.

We are all human and were once children. I suspect that means many things to each of us—some good, some precious, and some painful. Some of us have a childhood full of grief. Let me also tell you what it means in the eyes of our God. One, you were deliberately created by Him bearing His image. You were knit together by the hands of our Father in your mother's womb. He who knit you loves you. You are precious in God's sight. Nothing on earth can take that away—no wrongdoing, no suffering, and no mistreatment can erase these truths. You may be treated as worthless, but you are not. You may have experienced abuse, but you are precious to Him. You may be ignored, but God sees you. These truths cannot be undone; they are eternal.

Also, it is true that God created us for Himself. St. Augustine said, speaking to God: "You have made us for yourself, O Lord, and our hearts are restless until they rest in you."[1] God not only created us; He wants us. We are a treasure to Him. Nothing can remove or destroy that truth. This fact is accurate for each of us, regardless of age or gender. Some of us were damaged as children, while others have wounded God's children, exploited them, and used them to feed or elevate themselves. Still, others have hidden the harm that has been done—as if God did not see.

In the presence of the King of Kings, it is the little children, the vulnerable, who stand out. There is no crouching, no timidity, or hiding because of fear. There is no dismissal, no diminishing or silencing, and no crushing. The children came freely to the Lord of glory. There was no fear, no trepidation—the King rules by the power of His love. We are God's children and are to go freely to Him and open the way for others—to honor Him by serving others in the power of His love.

As people who stand before others and care for them in the name of Jesus, we are His disciples. We work for Him, which means we are never to be a hindrance to the little ones. And we will only be great in His kingdom if we serve with humility. Children are to see Jesus' character in us as we operate in the power of His love. We are not here to acquire bigness, control, or gain fame. Many little ones have been destroyed by those who name the name of Jesus yet look nothing like Him. Whether we are an adult caring for a child or a leader caring for one who is vulnerable, we say we serve in the name of Jesus. Our lives are to match the name under which we serve. We are a people into whose keeping God has put His honor. Whenever we minister in the name of someone, we carry their honor in our person. Jesus carried the honor of the Father in His life, and so do we. This means we are not to hinder the little ones but instead honor and protect those in our sphere.

Our God has made Himself vulnerable *yet again* by putting His name in our keeping. We are to care for others in a way that honors God's reputation. We are present in the lives of others for His name's sake—not our own. The little ones, the vulnerable, the wounded, the grieving, and the fearful are to get a taste of their loving Father through our lives. We quickly focus on the external kingdom, forgetting that the highest need is the rule of the heart. In Matthew 25:34-36, Jesus says that those He calls blessed are those who bend for the hungry, the thirsty, the strange, the naked, the sick, and the captive—so often the ones we set aside. Jesus says that when we go back and open our lives to the least of these, we go back for Him. When we welcome the little and turn for them, we embrace Jesus, but when we hinder the little, we hinder Him. We have been given the honor of God for our keeping. May we represent Him well. ✠

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« GARY W. MOON, M.DIV., PH.D.

Theological Malpractice: Overcoming the Trauma of a False View of God

Author's Note: This will be a difficult article to write. However, given the theme of this CCT *edition, I feel I must reflect on the issue of potential childhood trauma, which may result from well-meaning adults passing on false and disturbing images of God.*[1]

Have you ever been "saved?" Do you remember when it happened? I sure do. I can even tell you about the sermon and preacher who screamed it. I got saved in a little church so far out in the country that you would have to drive back toward town if you wanted to hunt. Rev. Thurman was preaching a revival, and it was a big one. I think there was someone sitting on each of the 12 pews.

Rev. Thurman had been brought into our little church as a salvation specialist. He was the type of preacher who told many scary stories about hell and some of the tortured souls who lived there. And he knew some who had recently been set ablaze. According to him, they had heard him preach in the past but did not listen to his warnings and then went out and got themselves killed in car crashes or by lightning bolts.

The imagery was gruesome. But to make a long story short, he scared the hell out of me. When he gave the invitation, I darted down front and asked Jesus to forgive all my sins—even though I couldn't recall very many as a five-year-old, and I begged God not to make me a rotisserie item in the afterlife. Somehow by walking to the front, I had made God feel a lot better about the huge pile of wrath my sins had caused Him to store up. I also remember feeling very guilty that I had caused Jesus so much pain and suffering.

Not long afterward, I got a booster shot. I was sitting on the front pew listening to a picture story. Our Vacation Bible School teacher was showing a series of images from one side of the pages in her book. She read from the other side while making

180-degree turns with her torso. More images of the Trinity flooded my impressionable mind.

The little boy in the story, who was obviously playing the part of me, had done something bad. His punishment was to stay alone in a single room on the top floor of the orphanage where he lived. And, if that were not enough trauma, the building caught fire during the night. Everyone had been evacuated from the building but the little boy on the top floor. And that is when a fireman appeared and made a dramatic rescue by climbing up several floors of the burning building using his bare hands and a scorching iron drainpipe.

I (that is, the little boy) was rescued, but at a great cost to the fireman, whose hands were now permanently scarred. Even so, he adopted the little boy, who then spent the rest of his life staring at the hands of the fireman. The teacher said it was a wonderful reminder of how much the fireman loved the little boy. For me, it was a constant reminder of the pain and disfiguration I had caused someone I hardly knew and in whose presence I now felt shame.

Who was this God who would allow kids to be tortured in ways that Adolf Hitler would not have invented? At least Hitler's horrific systems allowed for the relief of death. Who was this "good guy" member of the Trinity who would take my punishment but remain mutilated forever? I was not a psychologist yet, but it seemed as if the first two of the three members of the Trinity had very different personalities—and the third, the faceless member, was almost as ambiguous as a Rorschach card, even in our Pentecostal churches.

For the next two decades, if anyone asked about the day I got saved, I would faithfully point them to the night that Rev. Thurman painted a vivid picture of hell and offered me a magic phrase and an escape plan. Now, looking back through the decades, I realize that the ghastly images from that evening and a host of other God views provided by well-meaning teachers did not mark the beginning of my salvation journey, but actually put off my salvation (aka, *sozo* or "healing") for more than two decades.

In my late 20s and early 30s, I started collecting friends who knew a great deal about ancient Christianity. Some even dressed in black robes on Sundays and walked through their small congregations chanting and swinging incense. Over coffee and baklava, hummus and pita bread, they told me how the Western Church had been strongly influenced by Roman law and imperial rule. Because of this, themes such as "God's sovereign rule" and the believer's "legal standing" before Him as a pardoned sinner began to predominate salvation thinking across the centuries.

They also shared that, on the other hand, the Eastern Church—you know, the ones that stayed away from the Crusades, the Inquisition, and televangelism—has always tended to ponder things with their right brains while allowing for mystery and creeds to coexist. For them, grace was not so much about a legal release from guilt but the real possibility of spiritual wholeness and the process of becoming more fully human.

This more mystical, experiential tributary of Christian spirituality did not look to a courtroom to find images of salvation but to a hospital and the healing words of Jesus' commencement address to His disciples. Especially the part just after the Last Supper when Jesus said, *"And the glory which thou hast given me I have given them, that they may be one, as we are one; I in them and thou in me, that they may be perfected into one…"* (John 17:22-23, DARBY).

From these conversations and my reading from the theology of the early

For them [the Eastern Church], grace was not so much about a legal release from guilt but the real possibility of spiritual wholeness and the process of becoming more fully human.

Church, I began to wonder if "being saved" was about entering into an intimate and progressive friendship with a very good and very beautiful God as part of a journey toward union. More about the marriage journey than the occasion of the wedding vows.

Even so, the chasm between my own culture and the ways and customs of these modern ancients I was encountering was so wide that I am not sure I would ever have been willing to make the leap. That is, except for the discovery and re-discovery of writings by some amateur theologians—such as C.S. Lewis, George McDonald, and Dallas Willard. They seemed to be saying some strikingly similar things without causing too many evangelicals to raise their eyebrows.

Against this backdrop, let me now offer a quick 10-item test for separating false from true visions of God, ourselves, and salvation. Take a moment and ask yourself the following questions. And here is a hint: the correct answer for each question is "yes."

My View of God

- Am I growing in the realization that God is an incomprehensible mystery, "always bigger" than my biggest ideas about the Trinity, and certainly can never be contained by caricature images such as "grandfather," "cosmic sheriff," or "concierge?"
- When I think of God, is my first reaction a profound experience of awe? [After all, God did create, and lives in, a 12-dimensional universe, while I often find four dimensions of awareness baffling.]
- Do I truly believe that God is Christlike and, in God, there is no "un-Christlikeness" at all?[2]
- As a sure and certain heresy check, am I committed to never ever letting anyone tell me anything bad about God?

My View of Myself

- Do I view myself as being deeply loved by each member of the Trinity?
- Do I see myself as an unceasing spiritual being with an eternal destiny in God's great universe?
- Am I comfortable being an image-bearer and a friend of God, in whom the Trinity indwells and delights?
- Am I able to see those who are not actively following the way of Jesus as simultaneously being lost and of immense value to God?

My View of Salvation

- Is my view of "salvation" even more at home in a hospital than in a courtroom?
- Do I see salvation as a healing journey "back home" to living in union with God? ✠

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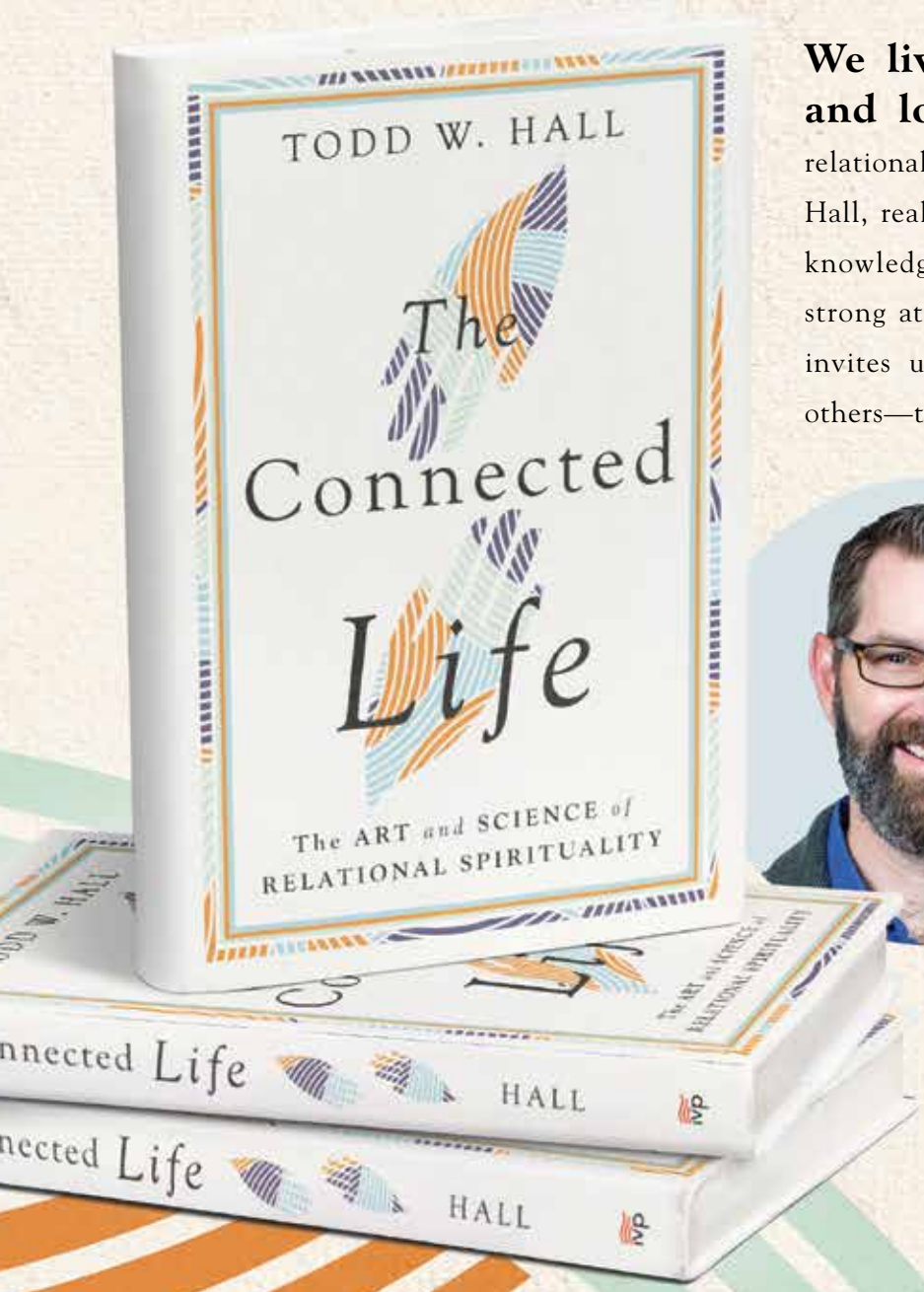
Endnotes

1 Some of the ideas presented here originally appeared in my book, *Apprenticeship with Jesus*, Baker Publishing, 2009. However, this current article expands and adds to that discussion.

2 See John 14:9, Colossians 1:15, and also, *The Christlike God,* by John V. Taylor, 2004.

Forming Healthy Attachments *in* God's Family



We live in an increasingly isolated and lonely world. How do we find genuine relational connection? According to psychologist Todd Hall, real human growth doesn't come through head knowledge alone but through relational knowledge and strong attachment bonds. This accessible introduction invites us into lasting relationships—with God and others—that lead to authentic transformation.

ivp

« MICHAEL R. LYLES, M.D.

Understanding New Medication Strategies for Psychiatric Disorders

Four variables can differentiate all pharmacological treatments in medicine: 1) safety (can it cause significant damage to an organ?), 2) side effects (will it make you sick?), 3) efficacy, and 4) cost. Newly approved medications seldom have cost advantages but seek to improve the other three variables. They may do this by having different action mechanisms, sites of action, delivery systems, and/or disease indications. The following is a sampling of medications that have been approved since 2019 for psychiatric symptoms, listed by brand names and their FDA approval dates. This author has no financial interest in any of the following products.

Schizophrenia and Bipolar Disorder

Second-generation antipsychotics (i.e., atypical neuroleptics) interact with serotonin and dopamine systems in varying ratios in treating schizophrenia and/or bipolar disorder. Invega (2006), Saphris (2009), Fanapt (2010), Latuda (2013), Vraylar (2015), and Rexulti (2015) have all sought to increase efficacy while decreasing side effects such as weight gain and metabolic problems. Caplyta was approved for schizophrenia (2019) and bipolar disorder (2021) with a higher ratio of serotonin activity relative to dopamine than its previously mentioned predecessors. The goal is efficacy with fewer side effects. Secuado (2020) is a delivery system advance that is the first transdermal antipsychotic patch for schizophrenia.

Zyprexa (olanzapine) is a highly effective older atypical neuroleptic but can cause weight gain that significantly limits compliance. Lybalvi (2021) is a combination of olanzapine and an opioid receptor antagonist (samidorphan) that reduces the weight gain issue. Since the samidorphan component is an opioid receptor antagonist, it can trigger withdrawal in patients who are using opioids or undergoing opioid withdrawal.

Compliance is a major problem in the treatment of schizophrenia. Long-acting injectable antipsychotics seek to provide longer-term symptom control with less frequent dosing. Invega Hafyera (2021) is an antipsychotic that can be given by injection once every six months. It is designed for patients who have been stable on monthly Invega Sustenna injections for four months or one cycle of Invega Trinza, which is given by injection once every three months.

Depression

Newer treatments for depression focus on different mechanisms of action

than serotonin, norepinephrine, or dopamine transporters. Zulresso (2019) is a neuroactive steroid that interacts with GABA-A receptors that control the majority of inhibitory signaling in the central nervous system (CNS). It is Food and Drug Administration (FDA) approved for postpartum depression and given by 60-hour intravenous infusion in special inpatient settings. It can work rapidly to relieve severe levels of depression. Zuranolone is an oral drug that is chemically like Zulresso without the requirement of intravenous infusion. It is in phase 3 clinical trials for depression and postpartum depression.

Ketamine and esketamine modulate glutamate systems by blocking N-methyl-D-aspartate (NMDA) glutamate receptors that participate in excitatory neurotransmission in the CNS. They have both been associated with rapid neurogenesis, which can rapidly improve depressive symptoms. Ketamine consists of two isomers (R, S), whereas esketamine is just the S isomer. Ketamine is used off-label by intravenous infusion in patients with depression, suicidal ideation, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), and social anxiety disorder. Esketamine is FDA approved as Spravato (2019) and used in conjunction with an antidepressant for mitigating treatment-resistant depression (TRD) and major depressive disorder (MDD) with suicidal ideation. Spravato is delivered by intranasal spray at Risk Evaluation and Mitigation Strategy (REMS) outpatient centers. These glutamate-mediated neurogenesis strategies have spawned research interest in other agents with similar mechanisms, such as the hallucinogen, psilocybin.

Attention-deficit/Hyperactivity Disorder (ADHD)

Medications for ADHD have differentiated themselves by the duration of action, delivery systems, and whether or not they are a stimulant/amphetamine. Jornay PM (2019) is an extended-release methylphenidate (stimulant) given at bedtime with the onset of action at night. Thus, the patient awakens to the medication already working. Qelbree (2021) is a selective norepinephrine reuptake inhibitor that adds a non-stimulant FDA-approved option to their other authorized non-stimulants: Strattera, Kapvay, and Intuniv. It can be used when stimulants are not medically safe or desired, contraindicated because of addiction risks, or in combination therapy with stimulants in treatment-resistant ADHD patients.

Azstarys (2021) is a combination of an active stimulant (dexmethylphenidate) and an inactive stimulant prodrug (serdexmethylphenidate). Prodrugs are inactive when given and are converted by enzymes in the body into the active drug over the course of the day. This approach can decrease stimulant abuse risks and increase the duration of action. Prodrugs can take time to activate, as Azstarys releases an active stimulant as a bridge until the prodrug initiates.

Sleep

Medications for insomnia usually work by promoting sleepiness. The two new agents in this class block wakefulness rather than promote sleepiness. They do this by inhibiting orexin, a promoter of wakefulness in the sleep/wake switch in the brain (i.e., suprachiasmatic nucleus, SCN). Dayvigo (2020) and Quviviq (2022) are both dual orexin receptor antagonists (DORA) that seek to minimize problems seen with other insomnia medications, especially memory impairment in the elderly. Potential DORA side effects include daytime impairment, worsening depression/suicidal ideation, sleep paralysis, sleep-related hallucinations, cataplexy (sudden loss of muscle tone while awake), and complex sleep behaviors.

Closing

The FDA mandates complete prescribing information about medications with their initial approval, including dosing, drug interactions, safety/warnings, side effects, contraindications, and usage in special populations. This prescribing information can usually be found by searching the name of a drug along with .com. Many resources can be invaluable as reference tools.[1, 2, 3] A great deal of information about newer medications is based on clinical trials, which may not reflect real-world results. Also, these drugs are seldom compared to their peers in clinical trials, so inter-drug comparisons are limited. Finally, many "older" medications are repurposed for "new" off-label indications based on community usage.[4] As a result, old and new medications can be part of evolving strategies to relieve human suffering safely and efficiently. ✠

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Endnotes

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« JEANNEANE MAXON, J.D., ESQ.

Understanding the Legal System When a Child May Have Been Abused

Sadly, in 2019 Child Protective Services (CPS) received 4.4 million referrals for investigation involving the alleged maltreatment of approximately 7.9 million children.[1]

As a counselor, your role in child abuse situations should be: 1) abiding by your legal obligations, 2) helping any client working with the judicial process to be calm and cooperative with the courts, CPS, guardian ad litem (GAL), and others, and 3) encouraging your client to seek independent legal assistance.

Legal Obligations for Child Abuse/Neglect Reporting

Suppose you are a mental health professional, including a licensed professional counselor (LPC); more often than not, you will be legally required to report any "reasonable suspicion" of a child being abused or neglected. Your first step should be to determine your legal obligations to report to CPS, which vary from state to state.[2] Next, you should establish whether the conduct you are concerned about meets your state's definition of child abuse and/or neglect.[3] Childwelfare.gov is an excellent source of information. The specific definitions and nuances of the law often call for a review by someone trained in "legalize." Your best resource, therefore, will always be an attorney familiar with the laws and processes of your state.

Should you ultimately determine that you are legally required to address the abuse or neglect of a child, you *must* do so even if it means reporting your client or the parent(s) of a minor client. Otherwise, you will violate the law and the AACC Code

of Ethics (1-430-c: Special Guidelines When Violence is Threatened against Others).[4] Reporting child abuse and neglect is an exception to your confidentiality obligations to your client(s). For your protection, all states provide some form of immunity from criminal and/or civil liability for reporting child abuse in good faith.[5]

Working with Parent(s)/ Guardian(s)

Of course, these situations can become very uncomfortable when you may be required to report your client, a parent, or a close relative of a minor client. Should you find yourself in this situation, *do not panic* and inform your client to do the same. Most investigations (84%) are closed without further involvement for being either unsubstantiated, having no allegation of maltreatment or alternative response,[6] or closed with no finding.[7] Only 16% of all reports are substantiated and require further action. Of these 16%, 74.9% involved neglect, 17.5% physical abuse, 9.3% sexual abuse, 6.1% psychological maltreatment, 2.3% medical neglect, and 6.8% other maltreatment.[8]

If you believe it would not endanger the child in question, you may consider informing their parent(s) of your legal obligation to report the suspected conduct. All parties—you, the child, and the parent(s)—should fully and honestly cooperate with any CPS investigation.

The utmost goal of all parties—you, the courts, attorneys, and parent(s)—should be the welfare and continued protection of the child in question. However, this goal does not necessarily need to result in the removal of the child from the care of their parent(s), especially in cases where the maltreatment is minor and can be rectified. Throughout our nation, the courts, CPS agencies, attorneys, and others are working to find more cooperative solutions that benefit and help the whole family. The Child Welfare Information Gateway (childwelfare.gov) has many resources promoting this approach.[9] They offer this explanation: "The child welfare system is much larger than the child welfare agency alone, and federal statute mandates judicial involvement and oversight. Moreover, attorneys for children, parents, and the child welfare agency all share a common interest in ensuring that reasonable efforts are made to prevent unnecessary removals of children from their families. For children who must enter care, attorneys for all parties help ensure parent, child, and youth engagement and empowerment, engage in joint problem-solving, and work together to ensure no child or youth stays in care a day longer than absolutely necessary. In this light, reasonable efforts are a common goal. *It is in no one's interest to remove children unnecessarily or keep children and youth in care longer than absolutely necessary.*"[10]

Encourage the Parent to Seek Legal Assistance

If you choose to involve the child's parent(s), it may be helpful to generally inform them of what to expect and what you can and cannot do to help. *Do not seek to provide legal advice.* After explaining your obligations to report, remind the parent(s) that you are not an attorney and recommend they seek legal counsel if they need specific advice on how they should handle the situation. If the parent(s) is not the alleged abuser(s), they will have an interest in protecting their child from further harm and obtaining justice. To this end, they may wish to hire an attorney to represent the child's best interest. Suppose the parent(s) is accused of maltreatment. In that case, they still have rights and may be able to seek resolution and reunification with their child (when the child has been removed) without direct court intervention through negotiation and conflict resolution. An attorney can be a significant asset to these goals.[11]

One common practice of the courts when the parents are the suspected abusers is to appoint a guardian ad litem (GAL) to represent the child's interests. A GAL is often an attorney or a court-appointed special advocate (CASA) who has been appropriately trained.[12] Family Matters Law Group provides some good suggestions for working with GALs, including: making a good first impression, being honest, and maintaining good communication.[13]

Your role as a counselor does not end when CPS or the courts become involved. You can still counsel without giving legal advice and assist your client(s) with the stress and trauma they will inevitably face in such a heart-wrenching process.

The information contained in this column is provided for educational purposes only. Nothing in this column should be construed as legal advice, and readers should seek advice from a qualified attorney within their jurisdiction for concerns/questions on specific matters. Law varies from jurisdiction to jurisdiction.

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1 "Child maltreatment 2019: Summary of key findings." Child Information Gateway, U.S. Department of Health and Human Services, Office of the Administration for Children and Families. (2021). Available at: https://www.childwelfare.gov/pubpdfs/canstats.pdf (accessed 25 June 2022).

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[13] See "5 tips for working with a guardian ad litem" Family Matters Law Group. (2022). Available at: https://thefamilymatterslaw.com/5-tips-for-working-with-a-guardian-ad-litem/ (accessed 25 June 2022).

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« GREGORY L. JANTZ, PH.D.

Physician Heal Thyself

The old adage, "Physician, heal thyself," is well known, even in ancient times. Jesus, Himself, referenced it in Luke 4:23. This saying has rung true for centuries, if not millennia, because people are people, willing or able to address a condition in others while being unwilling or unable to address the same condition in themselves. It rings true because it is true. As people, regardless of age, we need the reminder to first deal with our own sickness or pain to be better able to deal with the sickness or pain of others.

Jesus talked about this tendency to see something clearly in others but not in yourself when He told the speck and plank parable in Matthew 7:3, 5: *"Why do you look for the speck of sawdust in your brother's eye and pay no attention to the plank in your own eye? … first take the plank out of your own eye, and then you will see clearly to remove the speck from your brother's eye."* Sickness or pain, specks or planks, we need to be reminded that cobblers can wear the worst shoes.

When I saw the topic of this issue, "Childhood Grief, Loss, and Trauma," I thought about how embedded these types of hurt can be. They burrow deeply into hearts and minds during a time of intense vulnerability. Shame and guilt crust over the wounds, creating rigid, inflexible scars covering the pain underneath. Inadequate coping skills, forged in childhood, attempt to smooth over these rough patches, desperately grasping for an elusive state of "normal" and seeking the illusion that everything is "fine." Of course, everything isn't fine and, eventually, people figure that out and come to us for help.

I have found therapists to be highly empathetic people. As a group, we resonate with the pain of others and seek ways to alleviate that pain. In the process, we agree to share the pain of others, to lighten their load for just a moment, so they can gather the strength to move forward. I know empathic therapists who entered the profession after overcoming their own painful issues. And I know therapists who entered the profession with painful problems unresolved.

Because we live in a broken world, I also have a few of those scars and count myself fortunate that I do not have more. I spent time working through them when I was newer to the profession. Even after years, I was surprised to discover one I had hidden away so successfully that I'd forgotten it. The temptation was always there to look away from my pain and focus on the pain in others instead.

Cobblers help people by fixing shoes, often at their own expense. Therapists help people by fixing hurts, but that should never come at the cost of neglecting their own pain. So, my first responsibility is to "heal thyself." According to Jesus' parable, my next duty is to help others so they can see more clearly. Counselors know who these "others" are—their clients, patients, or whatever the designation. As a leader, I would like to add another category under the "other" column. I believe leaders have a responsibility to help those we lead to heal.

When children grow up in a world of grief, loss, and trauma, it means the adults or authority figures over

them either could not or would not protect them from experiencing these losses. Those children grow up and find new authority figures. They may find themselves working for us. We can become the recipient if they are suspicious or distrust authority figures because of their past or if there is an intense desire for affirmation or validation from authority figures. We may also become the recipient if there is disdain or distance from authority figures. As leaders, our working relationships may be influenced by the unresolved childhood grief, loss, or trauma of those we lead.

Some of those we lead may have entered the therapeutic profession to work through their unresolved issues. Now, they may encounter submerged grief, loss, and trauma they can no longer keep hidden or even realize existed. What, at first, appears as secondary trauma from experiencing the pain of others may, instead, be the release of a very early, personal experience.

We know how to handle these situations in a counseling relationship, but how do we treat them in a leadership relationship? Are we as empathetic to those we work with as we are with those we counsel? Are we as patient and understanding? Do we see their issues or only see them in the light of "work product?" These are not new questions for me. I have had therapists in my organization for more than 30 years. There have been times when those who counseled *for me* needed to be counseled *by me* or one of the other senior therapists at my facility. I have also encouraged staff members to pursue counseling outside of my business. The last thing I want or need to do is disregard the pain of the people who work for me. I also realize their healing will strengthen not only themselves but the overall profession.

As a leader and cobbler, I need to be aware of the condition of my own shoes. I also need to keep an eye on the shoes of my fellow cobblers. ✠

GREGG JANTZ, PH.D., is the founder of The Center • A Place of HOPE (www.aplaceofhope.com), a healthcare facility in Edmonds, Washington, which emphasizes whole-person care, addressing the emotional, relational, physical, and spiritual aspects of recovery. He is the author of multiple books, including his latest, *The Anxiety Reset* and *So Much to Live For*. Dr. Jantz is a sought-after speaker in person, on television, and on radio (www.drgregoryjantz.com).

« FERNANDO GARZON, PSY.D.

Treatment for Prolonged Grief in Children, Trauma's Role in Teenage Psychopathy, and Understanding Adolescent Post-traumatic Growth

This Research Digest looks at a recent study on treating prolonged grief in children. We also consider the types of traumas associated with the development of psychopathy in youth. Finally, we examine the effect of numerous stressful life events on Post-traumatic Growth in teenagers.

Prolonged Grief in Children

Boelen, P.A., Lenferink, L.I.M., & Spuij, M. (2021). CBT for prolonged grief in children and adolescents: A randomized clinical trial. *The American Journal of Psychiatry, 178*(4), 294-304.

Currently, treatments are needed for children and adolescents suffering long-term grief reactions (persistent complex bereavement disorder in the *Diagnostic and Statistical Manual of Mental Disorders, DSM-5*, and prolonged grief disorder in the *International Classification of Diseases, ICD-11*). Boelen and associates developed cognitive-behavioral therapy (CBT) Grief-Help and compared it to nondirective supportive counseling with 134 children and adolescents suffering from prolonged grief. According to the authors, this was the first study on youth to compare two active treatments for prolonged grief. CBT Grief-Help involves nine individual sessions concurrent with five sessions with parents or caregivers. Nondirective supportive listening followed a similar therapy structure.

Children in the study had been grieving on average for just over three years, and their average age was 13 (+/- 3 years). Fifty-two percent were female. Seventy-four were randomized into the CBT Grief-Help group and 60 into the supportive counseling group. The study took outcomes data periodically for one year. It found that Grief-Help produced "… significantly greater reductions in prolonged grief disorder symptoms at all posttreatment assessments, and it was more successful in alleviating depression, PTSD symptoms, and internalizing problems six and 12 months after treatment" (p. 294). Overall, CBT treatment in the form of Grief-Help for children's prolonged grief appears very promising. While limitations exist, these findings in a well-designed comparative trial appear consistent with CBT results for adults with prolonged grief. For the Christian therapist working with children suffering from this condition, an evidence-base is now developing for CBT.

Trauma's Role in Teenage Psychopathy

Moreira, D., Sá Moreira, D., Oliveira, S., Ribeiro, F.N., Barbosa, F., Fávero, M., & Gomes, V. (2020). Relationship between adverse childhood experiences and psychopathy: A systematic review. *Aggression and Violent Behavior, 53*.

Moreira and colleagues reviewed the research literature to understand what types of childhood trauma were linked with the development of psychopathy. People with psychopathy display self-centeredness, deception, and manipulation in their interpersonal relationships. Though superficially charming, they display a lack of empathy for others and no remorse for their actions. Behaviorally, they tend to be irresponsible, sensation-seeking, and impulsive. Common childhood disorders that sometimes may involve psychopathy as a component include oppositional defiant disorder (ODD), attention-deficit/hyperactivity disorder (ADHD), and conduct disorder (CD). Psychopathy correlates with a poor response to treatment and has significant national costs. It predicts delinquency and antisocial behavior in teenagers and is associated with substance abuse, recidivism, and violent behaviors. Though only one to five percent of the adult population, 20% of individuals in prison display psychopathy as a feature.

The researchers note that these factors highlight the importance of understanding the role of trauma in psychopathy development. Primary and secondary subtypes of psychopathy exist, with the primary type having a stronger biological genetic loading and the secondary type having a more substantial environmental contribution. According to their literature review, environmental influences, such as neglect, physical abuse, and sexual abuse, may directly or indirectly predict psychopathy. Of course, many disorders may arise from such maltreatment.

More studies are needed on personality, temperament, and biological factors, as well as resilience elements, to ascertain what predicts that children will be more vulnerable to developing psychopathy than other trauma-related mental health conditions. For Christian therapists, these findings demonstrate the multitude of factors involved in children displaying psychopathic features as they age. The results also point to the importance of intervening early in childhood trauma. We are still at the initial stages of understanding the development of this condition.

Understanding Adolescent Post-traumatic Growth

Fraus, K., Dominick, W., Walenski, A., & Taku, K. (2021). The impact of multiple stressful life events on post-traumatic growth in adolescence. *Psychological Trauma: Theory, Research, Practice, and Policy.* Advance online publication.

While post-traumatic growth (PTG) is conceptualized commonly from a person's experience of a singular crisis in life, Fraus and colleagues wanted to know the factors influencing PTG when high school teenagers have experienced "… a multitude of highly stressful life events" (p. 1). They also wanted to explore the association between PTG and post-traumatic stress symptoms (PTSS). A convenience sample of 139 adolescents completed a survey that included six major types of childhood trauma (death of a family member or friend, parental divorce/separation, traumatic sexual experiences, physical abuse/assault, physical injuries/illnesses, and any other events the teenager experienced as traumatic). The adolescent convenience sample was 66% female, 50% white, 16% African-American, 16% Asian, 9% Middle Eastern, and 9% other.

Predictably, the researchers noted that the level of PTSS increased as the reported number of highly stressful events escalated. When multiple stressful life events occurred, however, the form of PTG that sometimes happened seemed more specific. Growth areas included developing a new life direction, changing one's priorities, and self-reliance growth. Consistent with present observations in PTG literature, when multiple life stressors were reported, most adolescents attributed their growth (PTG) as deriving from one main event. Both PTG and PTSS could be experienced together.

The findings are informative for Christian therapists as it is possible that PTG cultivation may take a similar form as evidence-based treatments to address PTSD. Many PTSD approaches focus on processing an index trauma even when many traumas have been experienced (e.g., prolonged exposure therapy and cognitive processing therapy). The cultivation of PTG may take a similar index trauma path. Outcomes-based research in this area is needed. ✠

FERNANDO GARZON, PSY.D., is a professor at Regent University in the School of Psychology and Counseling. His research interests focus on investigating spiritual interventions in therapy, multicultural issues, and evaluating psychologist/counselor education practices in spirituality. Dr. Garzon's professional experiences include private practice as a clinical psychologist, serving as an associate pastor for a Latino church, and fulfilling a role in pastoral care ministry.

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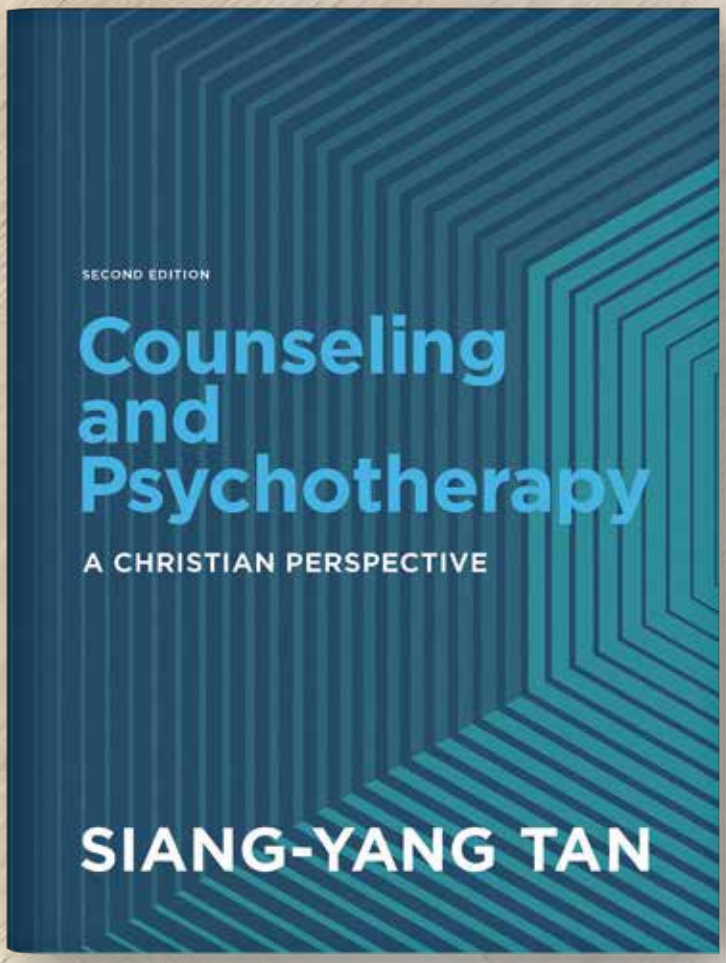

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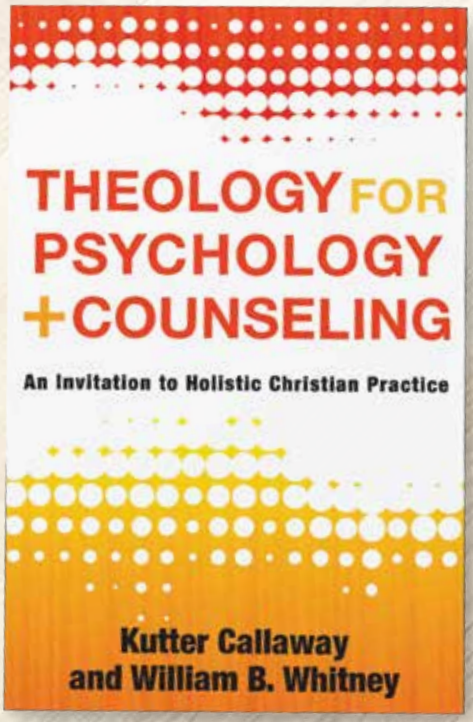

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Answer the following questions from this issue of Christian Counseling Today by marking the appropriate circle. Once completed, you may send in this entire page or a photocopy with your payment to the address below. Please do not send cash. The quiz is open-book and you will need a minimum score of 70% to receive a letter of completion.

Assessment Strategy for Childhood Grief…
– Gary A. Sibcy, II and Joshua Love

1. The prognosis of children exhibiting trauma for the first time
   - O a. is worse than those who have had previous trauma
   - O b. is not predictable due to unknown history
   - O c. likely will fare better than those exposed to previous trauma
   - O d. will vary depending on a host of family dynamics

Childhood Trauma Therapy and Intervention…
– Daniel Sweeney

2. Which of the following is **NOT** true of play and expressive therapies?
   - O a. they have a unique kinesthetic quality
   - O b. they are the natural medium of communication for a child
   - O c. they use words as the primary avenue of expression
   - O d. they create needed therapeutic distance

Lonely Kids: A Modern-day Epidemic – Mark Mayfield

3. The author says "Our brains do not fully function… unless…"
   - O a. we are in a state of good physical health
   - O b. they are in a safe trusting relationship with someone
   - O c. we have meaningful work that uses our abilities
   - O d. we have purpose and direction in life

Medication Intervention for Children… – E. John Kuhnley

4. Traumatized children tend to respond to the world
   - O a. as a dangerous place
   - O b. by activating neurobiologic systems geared for survival
   - O c. by using words and word pictures
   - O d. a and b

One Heart, Two Homes: Working with Children…
– Tammy and Jay Daughtry

5. Which is **NOT** true of "Handoffs" in co-parenting?
   - O a. they can impact children profoundly
   - O b. they are good times to discuss co-parent business
   - O c. they should be as positive and pleasant as possible
   - O d. they should clearly specify times, places, and responsibilities

Raising Emotionally Healthy Kids – Jim Burns

6. What "dominant view of culture" does the author say has influenced the current generation?
   - O a. computers and IT
   - O b. the atheistic theory of evolution
   - O c. the views of the political left
   - O d. viewing tolerance as a trait of a loving person

Shattered Innocence: Attachment, Childhood Sexual Abuse…
– Anita Kuhnley

7. It is important to consider attachment when treating childhood sexual abuse (CSA) survivors because
   - O a. attachment styles are intergenerational
   - O b. a CSA survivor puts her child at risk of CSA
   - O c. attachment styles are unlikely to change without intervention
   - O d. all of the above

When Love Hurts: Kids Living in Chaos and Violence…
– Gregory L. Jantz

8. Regarding recovery, the author says all of the following **EXCEPT**
   - O a. it may occur years or decades after the fact
   - O b. it means assisting people to recognize they are not to blame
   - O c. it means shedding damaging coping mechanisms
   - O d. it means always having a happy ending

Who is the Greatest in the Kingdom of Heaven?
– Diane Langberg

9. Langberg says "we will only be great in His kingdom if…"
   - O a. we serve with humility
   - O b. we pray for the hurting children
   - O c. we advocate against child abuse
   - O d. we embrace the wounded children

Grace for the Children: Treating Childhood Mental…
– Matthew Stanford

10. C.S. Mott Children's Hospital found that since the pandemic began
    - O a. mental health ER visits among children increased by 42%
    - O b. 50% of teens had new or worsened mental health problems
    - O c. 45% of 5-11-year-olds had increased mental health ER visits
    - O d. all of the above

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2. Be able to articulate a more comprehensive understanding of this issue's core theme.
3. Be able to integrate spirituality and faith-based constructs into the delivery of care.

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Please rate the following on a scale of 1–5 (1 meaning **Poor** and 5 meaning **Excellent**):
1. _____ This issue of CCT is relevant to my practice as a mental health professional.
2. _____ The articles in this issue are comprehensive and well written.
3. _____ I would recommend this home-study program to other professionals.

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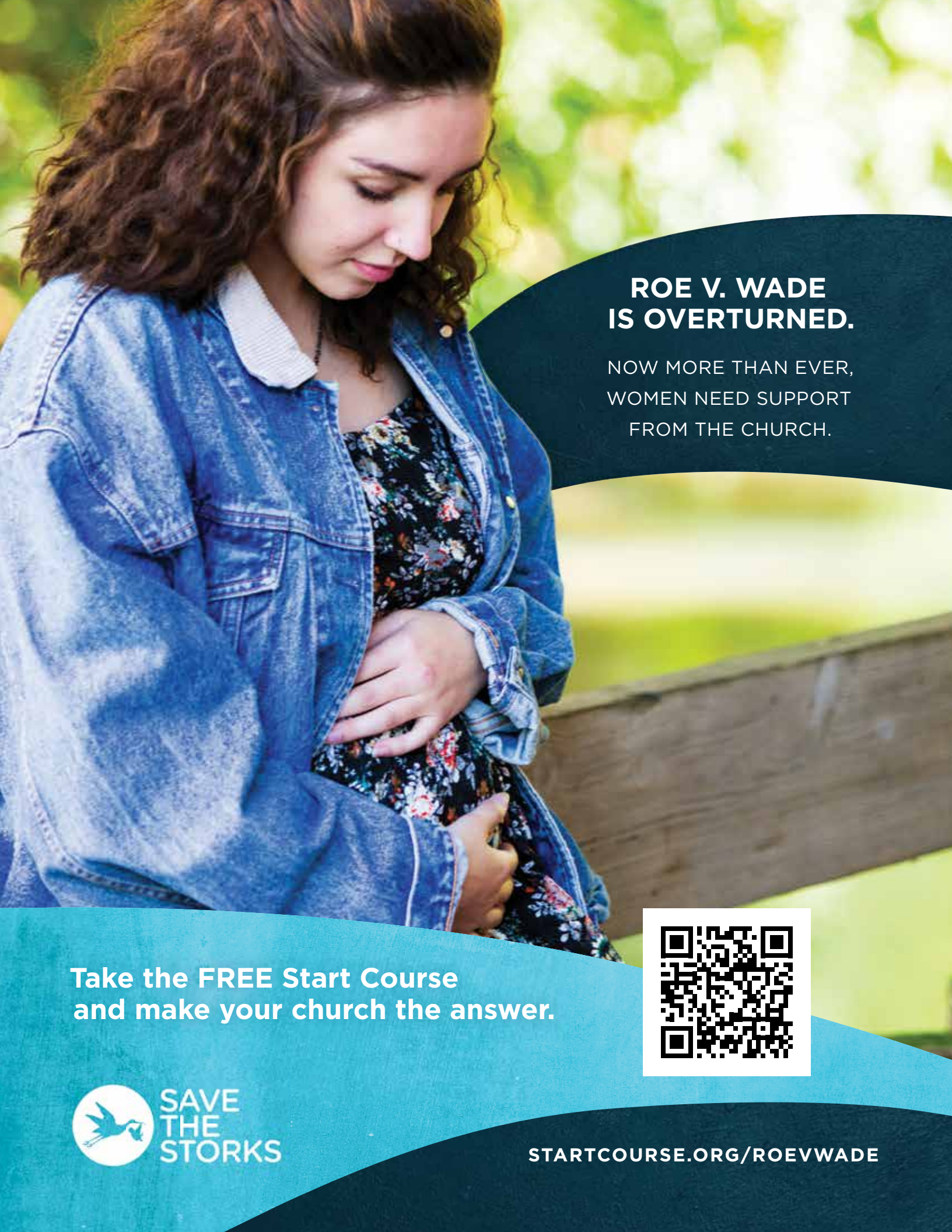

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