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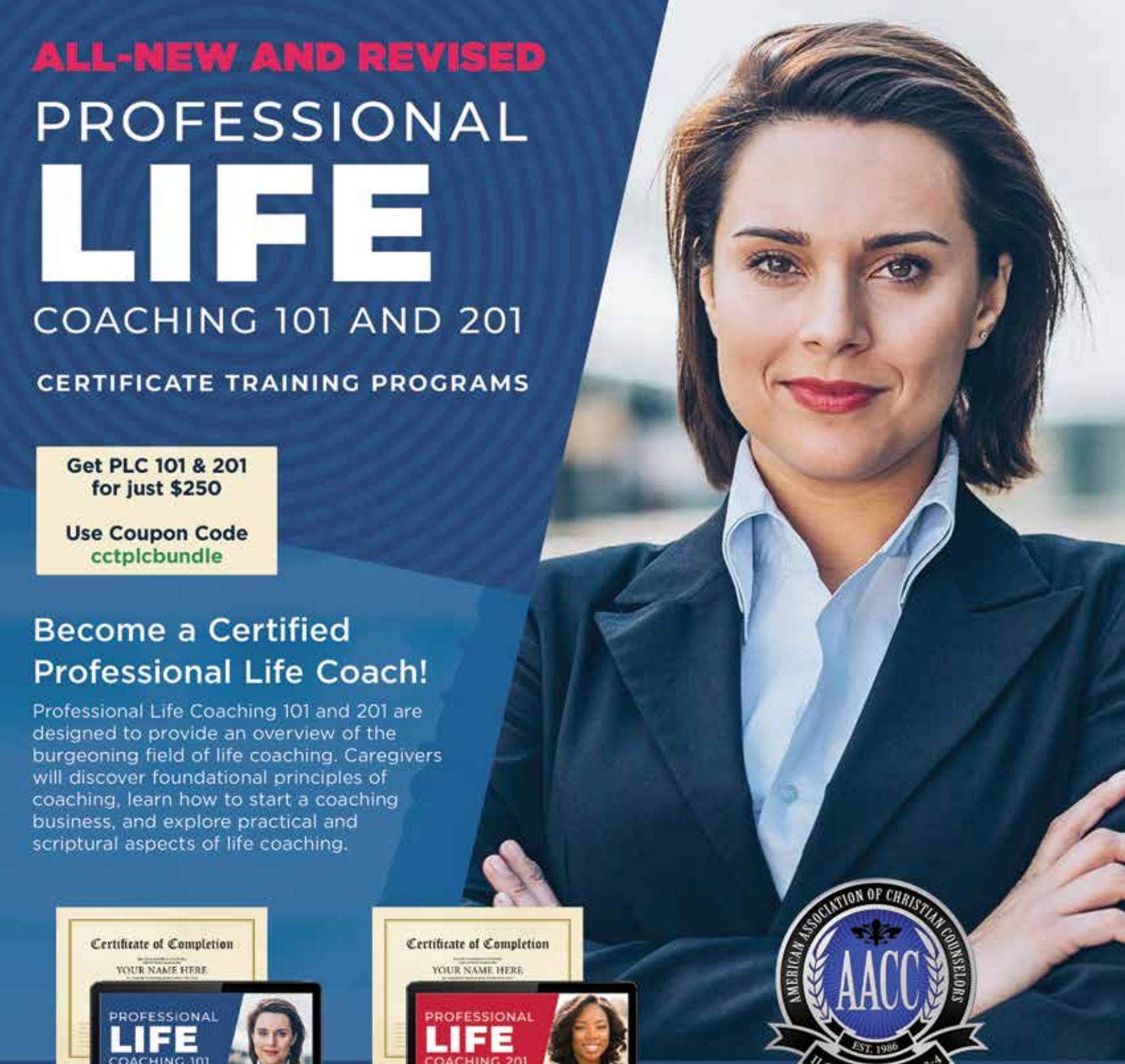

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Emma Benoit serves as an Ambassador for LivingWorks (livingworks.net), the world's leading organization in suicide prevention training. She is a suicide survivor who shares her personal story at conferences and events, including the California Department of Education Youth Summit, the National Federation of Families for Children's Mental Health Conference, the Hope Rising Suicide Prevention Summit, the Hope Squad National Conference, and more. The documentary film, My Ascension (myascension.us), tells her story.

Karl Benzio, M.D., is a board-certified psychiatrist who has held many clinical and administrative healthcare positions. His passion and expertise are integrating the Bible with psychiatric science to help people heal, lead abundant lives, and be a lighthouse to others. Dr. Benzio is a writer, frequent speaker, media guest expert, and expert witness in many legislatures throughout the U.S. and internationally. He has been a consultant to many ministries, co-founder of the unique Christian residential treatment center, Honey Lake Clinic, and serves as Medical Director for the American Association of Christian Counselors.

Anna Brose, M.A., is a second-year doctoral student at Wheaton College, where she works as a Teaching and Research Assistant in the Sexual and Gender Identity Institute.

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.

Chap Clark, Ph.D., is the co-founder of CulturePivot.com and President of Parenteen, Inc. He is a global speaker and consultant, the author of two dozen books, and a nationally recognized expert on adaptive leadership, cultural trends, Gen Z and Alpha Gen, and adolescent and young adult development. His years of academic leadership, research, and teaching offer a rare interdisciplinary perspective on societal trends and the impact of emerging generations. He is the author of *Hurt 2.0: Inside the World of Today's Teenagers.*

Tim Clinton, Ed.D., LPC, LMFT, BCPCC, is president of AACC, the largest and most diverse Christian counseling association in the world. Dr. Clinton also serves as the Executive Director of the Liberty University Global Center for Mental Health, Addiction, and Recovery. He 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, Dr. Clinton 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. He has authored or edited nearly 30 books. Dr. Clinton and his wife, Julie, have two children and two granddaughters.

Zach Clinton, M.A., is a doctoral student in the Counselor Education & Supervision program at Liberty University. He currently serves full-time in a leadership role at the American Association of Christian Counselors. Further pursuits include serving as a resident counselor at Light Counseling, where he primarily works with youth and the next generation. Zach also fulfills the role of President & Host of the Ignite Men's Impact Weekend and hosts The Built Different Podcast. A former Division I college baseball player and now chaplain of the Liberty University baseball team, Zach is a recognized growing authority and voice on performance and mental health for today's generations.

Ted Cunningham, MACE, is the founding pastor of Woodland Hills Family Church in Branson, Missouri. He is a graduate of Liberty University and Dallas Theological Seminary.

Jennifer Cisney Ellers, M.A., is a counselor, life coach, and author. She is an approved instructor with the Critical Incident Stress Foundation and a faculty member. Jennifer co-authored the course, Youth Suicide, with her husband, Dr. Kevin Ellers. She serves as Senior Director of Advancement, Special Projects, and Church Engagement with the American Association of Christian Counselors.

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 being in private practice as a clinical psychologist, serving as an associate pastor for a Latino church, and fulfilling a role in pastoral care ministry.

Sissy Goff, M.Ed., LPC-MHSP, is the Director of Child and Adolescent Counseling at Daystar Counseling Ministries in Nashville, Tennessee. She is also the best-selling author of 12 books, including *Raising Worry-Free Girls: Helping Your Daughter Feel Braver, Stronger, and Smarter in an Anxious World*, and is a part of the podcast, Raising Boys and Girls.

Stephen Grcevich, M.D., is a child and adolescent psychiatrist who serves as President and Founder of Key Ministry, a non-profit ministry that connects churches with families impacted by disabilities. He is an Associate Professor of Psychiatry at Northeast Ohio Medical University. Dr. Grcevich is a past recipient of the Exemplary Psychiatrist Award from the National Alliance on Mental Illness (NAMI) and a participant in the 2019 White House Summit on Mental Health. He is the author of *Mental Health and the Church*.

Gregory L. Jantz, Ph.D., is the founder of The Center • A Place of HOPE, a healthcare facility in Edmonds, Washington, which emphasizes whole-person care, addressing the emotional, relational, physical, and spiritual aspects of recovery. He is the best-selling author of multiple books and a sought-after speaker in person, on television, and on radio.

Diane M. Langberg, Ph.D., is globally recognized for her 47 years of clinical work with trauma victims, having trained caregivers on six continents. She directs a group practice in Jenkintown, Pennsylvania, and her most recent book is *Redeeming Power: Understanding Authority and Abuse in the Church*.

Michael R. Lyles, M.D., is a board-certified psychiatrist and has a private practice with Lyles & Crawford Clinical Consulting in Roswell, Georgia.

Jeanneane Maxon, J.D., Esq., has 11 years of executive level, non-profit leadership. She is an attorney and nationally-recognized speaker. Jeanneane formerly served as the Vice President of External Affairs and Corporate Counsel for Americans United for Life and as the General Counsel of Care Net.

Joe S. McIlhaney, Jr., M.D., is a board-certified obstetrician/gynecologist. In 2001, Dr. McIlhaney was appointed to the Presidential Advisory Council on HIV/AIDS. He also serves on the Advisory Committee to the Director of the Centers for Disease Control and Prevention. In 1995, he left his private practice of 28 years to devote his full-time attention to working with the Medical Institute for Sexual Health, a nonprofit medical/educational research organization he established in 1992. Dr. McIlhaney has co-authored more than six books, including *Hooked: The Brain Science on How Casual Sex Affects Human Development* and *1001 Health-Care Questions Women Ask*.

Meg Meeker, M.D., is a pediatrician, mother, and grandmother. She has practiced pediatrics for 32 years and has written seven books on parenting. Her best-selling book, *Strong Fathers, Strong Daughters*, has recently been made into a movie of the same name by Pureflix.

Gary W. Moon, M.Div., Ph.D., served as the founding Executive Director of the Martin Institute for Christianity and Culture and the Dallas Willard Center for Christian Spiritual Formation at Westmont College and continues to direct their resource development initiatives through serving as the director of *Conversatio Divina: A Center for Spiritual Formation*, www.conversatio.org.

Mark Yarhouse, Psy.D., is the Dr. Arthur P. Rech and Mrs. Jean May Rech Professor of Psychology at Wheaton College, where he directs the Sexual and Gender Identity Institute.

CHRISTIAN counseling TODAY

Christian Counseling Today *is published by the American Association of Christian Counselors, Inc.*

PRESIDENT AND PUBLISHER: Tim Clinton

VP OF PUBLICATIONS/EDITOR-IN-CHIEF: Mark Camper

GRAPHIC ARTIST: Amy Cole

ADVERTISING DIRECTOR: Keisha Queen

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Christian Counseling Today *is published quarterly (Winter, Spring, Summer, Fall). Individual, church, and institutional subscriptions to* Christian Counseling Today *are available at the annual rate of $35 (pre-paid with U.S. funds, add 25% outside the U.S.A.).*

Unsolicited manuscripts are not accepted and will not be returned.

Editorial Offices: AACC Editorial Office, P.O. Box 739, Forest, VA 24551, 1.800.526.8673. Postmaster: Send address changes to AACC Member Services, P.O. Box 739, Forest, VA 24551, 1.800.526.8673.

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

Kids, Life, and Mental Health

"But Jesus said, Suffer little children, and forbid them not, to come unto me: for of such is the kingdom of heaven."
– Matthew 19:14, KJV

Growing up should be all about belly laughs, bikes, best friends, sports, being loved, and maybe ice cream. It should not be about watching mom and dad fight/divorce, experiencing abuse, or battling depression and/or anxiety. The truth is, youth and mental health issues shouldn't be discussed in the same sentence, but that's not the reality. The bottom line is that our kids are hurting and in a real spin, and something needs to be done about it.

Mental health challenges have been the leading cause of disability, poor outcomes, and lifelong health challenges in our kids. Prior to the COVID-19 pandemic, one in five youth between the ages of three and 17 had a mental or behavioral disorder.[1] One in three students shared persistent thoughts and feelings of hopelessness or sadness, which was a 40% increase from the previous decade.[2] In addition, high school students reported a 36% increase in suicidal behaviors over the last decade, with almost 19% seriously considering an attempt.[3] Another alarming statistic revealed that 16% actually planned suicide, a 44% increase from the last decade.[4] From 2007 to 2018, we saw a 57% increase in suicide rates of youth aged 10-24, and early reports estimate that the same age group showed more than

6,600 suicide deaths in 2020 alone.[5, 6]

Then came COVID. The pandemic brought mental health issues into the light and thrust them into national headlines. Our kids' lives were thrown into a spiral as they lost loved ones, friends, and family members. They sorely needed and missed activities like sporting events, dances, proms, and other social outlets that were canceled without warning. Home life was also turned upside down, as moms and dads tried to keep up with the drastic changes to daily life, including working from home and encouraging kids to sit in front of a computer screen to keep up with school requirements.

Since COVID and all that we have been through, suicide is now the second leading cause of death in America among 10-to 24-year-olds.[7] Mental health emergency room visits in 2020 increased by 24% for children between five and 11 and more than 30% for those ages 12 through 17.[8] Over the past year, 16.39% of America's youth suffered a major depressive episode.[9] Additionally, more than 2.7 million youth in the U.S. encounter severe depression, and multiracial youth are at the greatest risk.[10] Also, in the past year, 6.34% of youth in the U.S. had a substance use disorder.[11]

Another glaring concern is equitable access to mental healthcare for our youth. Vulnerable kids living in rural areas, racial and ethnic minorities, and those with disabilities are proportionally disadvantaged when accessing mental healthcare. There is a massive shortfall of mental health providers to meet the burgeoning mental health demands, as well as faith-based providers for children and families with sincerely held religious beliefs. Estimates show more than 150 million people live in federally designated areas with a mental health professional shortage.[12] In rural areas, the gap increases, as more than 50% of U.S. counties are without even one psychiatrist.[13] Children with mental health needs have become one of the most underserved populations in today's culture.

Unfortunately, on top of it all, the care often offered is based on adult models of intervention and not tailored to childhood needs and issues. Yet, research shows that half of mental illnesses usually start before or by age 14, and we also know that early detection and treatment lead to better prognoses and outcomes.[14, 15]

What can we do to stop the oncoming tsunami that has already made landfall?

These are unprecedented times. Families are busier than ever and fight daily for time together. And when they are together, phones, TVs, and other distractions pull them away from each other. Hear me on this, the problems that my generation, and even our kids, faced are nothing like what we see today. Kids now have access to almost anything at their fingertips—pornography, gaming, movies, social media, and more. And while parents often work to curb the digital invasion, kids today are so tech-savvy that they can essentially get around most controls on any mobile device.

In the fall of 2021, numerous organizations declared a national emergency on children's mental health, and for good reason. In December of 2021, the U.S. Surgeon General, Vivek Murthy, issued an advisory on youth mental health, citing the crisis facing today's kids and highlighting the urgent need to address it.

That is what this issue is all about. And even more, I believe the Church needs to help lead the way. That is why our team is feverishly creating a Youth Mental Health Coach First Responder program planned to release in early 2023. Much like our Mental Health Coach First Responder program, this version is dedicated to helping parents, youth pastors, and peers to be trained to help recognize, respond, and provide immediate care to our youth. This issue is not something that we take lightly. We believe God has uniquely positioned us to provide quality training to equip the Church to answer His call to care. Please join us in prayer that He would go before us. We have much work to do for the sake of our kids. ✠

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52 DEVOTIONS

An Invitation To Hope

BARB HILL
is a licensed therapist and founder of Holding Space Counseling with a specialty in trauma. She holds an undergraduate degree in biblical studies, as well as a master of arts in biblical counseling, and a master of arts in clinical mental health counseling. As a therapist, Barb recognizes the importance that faith and mental health have in our lives, and she is passionate in the pursuit of bridging these two important worlds.

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BARB HILL, NCC, LPC-MHSP

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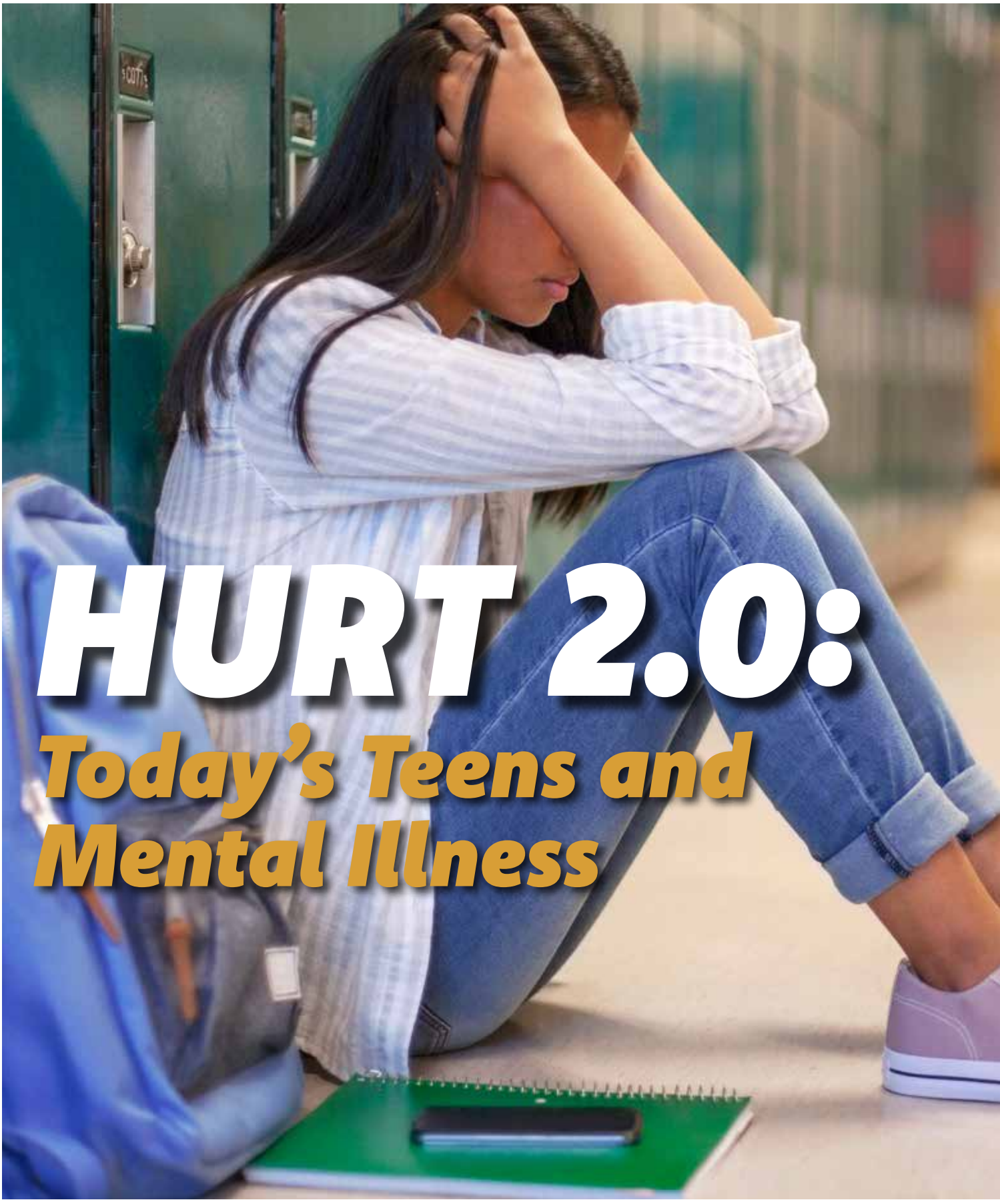

HURT 2.0:

Today's Teens and Mental Illness

PBS News Hour opened with the following headline: "Devastating mental health crisis among American teens today." The U.S. surgeon general had issued "a rare public advisory" regarding teenage depression and anxiety: "Every child's path to adulthood—reaching developmental and emotional milestones, learning healthy social skills, and dealing with problems—is different and difficult. Many face added challenges along the way, often beyond their control. There's no map, and the road is never straight. But the challenges today's generation of young people face are unprecedented and uniquely hard to navigate. And the effect these challenges have had on their mental health is devastating."[1]

The advisory identifies two different sources: *biological* and *environmental* factors (i.e., culture).[2] Biological factors are easier to diagnose and treat than the broad environmental factors that are "unprecedented and uniquely harder to navigate." To take on this "mental health crisis," we must give greater attention to understanding the environmental influences and the impact such factors have had on today's teens.

CULTURAL PIVOTS

Over the past several decades, three significant cultural shifts (pivots) have converged to create a toxic developmental environment that has taken its toll on the young. To understand what it is to grow up today is to recognize and address the impact of these pivots.

PIVOT 1: The Virtual Self. In the early 2000s, the teenage social landscape was comprised of two distinct "worlds"—the visible, where adults hold power (e.g., school, family, etc.), and the world of peers, described as the "world beneath."[3] While during mid-adolescence, teens have not yet developed a well-formed identity (or "self"), they know they must present *someone* in the visible adult world. Each self is *authentically* them, but not *wholly* them (e.g., "I don't know who I am" is a common cry of this age group). Two decades ago, while juggling various "selves" around adults, they felt freer to be "themselves" alongside peers in the world beneath. Now, being relatively safe with peers has been shattered under the weight of the technologically mediated world. For most teenagers, the rapid cultural shifts that have taken place (e.g., the first iPhone was introduced on June 29, 2007) have made peer relationships increasingly just as perilous as the adult-controlled world. In every social setting, today's young have learned to protect themselves by living behind avatars.

CHAP CLARK

As a society, we have pivoted from providing safe environments to being almost entirely transactional. So long as someone can offer something of value, they are safe and secure.

An *avatar* is a virtual representation of oneself, usually through technology.[4] In the electronic world, an avatar is how one virtually connects to others. The development of the self requires a robust community where young people can explore and identify the uniqueness that makes them distinct; yet, in today's world, there are few safe places. In the constant shifting from one avatar to another, kids ask, "Where can I be me?"

PIVOT 2: Mosaic versus Linear Thinking. In the 1960s, Canadian philosopher, Marshall McLuhan, identified "world history in three phases:"

- Pre-Gutenbergian (communal, oral)
- Gutenbergian (individualism, linear thinking)
- Electronic (not linear, "mosaic" thinking)[5]

To McLuhan, the printing press era led to people being alienated from one another. As a media theorist, he celebrated the opportunity the age of electronic media brings to human relationships (i.e., the "global village").[6] He foresaw "mosaic thinking" as redeeming human interaction. He could not, however, envision how this would actually drive us even further apart. Teenagers now spend nearly nine hours a day in the virtual world (and for tweens, eight to 12-years-old, 5½ hours), more than half of their waking life,[7] yet there is more depression and loneliness than ever before.

In 2001, George Barna, the founder of the research firm, The Barna Group, used the label, "Mosaics," to describe the "first generation among whom a majority will exhibit a non-linear style of thinking—'a mosaic, connect-the-dots-however-you-choose approach'…. Mosaics' non-linear approach to thinking means that 'any route to any end point is equally valid'…. Mosaics are comfortable living with contradictions and with the tension of not driving an issue to resolution."[8]

Barna's predictive descriptions of "mosaic" non-linear thinking were remarkably accurate. He could not, however, imagine how this would impact the mental health of today's teens. Mosaic thinking—where "every endpoint is equally valued," and contradictions are "comfortable"—may sound attractive and even healthy; however, the cost of such thinking is high for the developing young mind. The inability to resolve conflict and work through and reconcile contradiction and pain is discouraging and fosters a sense of hopelessness. Among other outcomes, this is what mosaic thinking has done. As researcher, Margarita Dudina, summarizes: "The interiorization of contemporary cultural phenomena bears the signs of fragmentary, mosaic thinking that makes it difficult to nurture the ability to analyze and identify cause-and-effect relationships. A superficial approach to the ever-expanding volume of knowledge prevents one from comprehending concepts, which has a negative impact on the development of consciousness, cognitive and affective functions, activity, verbal and non-verbal communication, and of the conceptual structure of the world and self-reflection on one's place in the world."[9]

Mosaic thinking hinders the ability to reflect in a way that brings depth, nuance, and, ultimately, a resolution to life's challenges. Thus, media-saturated teenagers and young adults are easily non-reflectively swept from one issue to another. Conflicts go unresolved. Behavior patterns become reactionary, not thoughtful. All desire to relieve the anxiety of this treadmill, but they cannot conceptualize any other way to live. In the complex and dangerous world in which we have handed our young, being a "mosaic thinker" hinders healthy development and is exhausting. Today's young people have become developmentally "… infants, tossed back and forth by the waves, and blown here and there…" (Ephesians 4:14, NIV).

PIVOT 3: Transactional Relationships. In Henri J.M. Nouwen's 1980s classic, *In the Name of Jesus*, he asserts that in modern society, we develop our identity according to three criteria: I am what I do, I am what power or control I have, and I am what others say about me.[10] He rightly points out that by defining ourselves according to these external voices, we will ultimately find ourselves depressed and broken. Nouwen argues, in response, that our true identity is found in God's unconditional blessing declaring each of us in Christ the Beloved Child of God. God created, God loves, and God redeems.

Nouwen's description illustrates how modern life influences our sense of self so much that we have a hard time filtering out the voices that communicate we are not enough and never will be enough to please a hostile and condemning world. In the three decades since, contemporary life has become even less subtle in its condemnation of the self. In the 1980s, unspeakable violence was limited to schoolyard bullies—there were no unfiltered windows into the world and no social media. Growing up then may have been filled with comparison and competition but, for most, there were at least a few who cared for the sake of walking alongside us. However, today, the pressures of image, conformity, and performance have overtaken us all.

Not only do the questions of what someone does, what they control, and what others say continue to affect how

they see themselves in relation to others and the world, but it is also difficult to find places where they can expect to be loved and appreciated as they are for who they are. As a society, we have pivoted from providing safe environments to being almost entirely transactional. So long as someone can offer something of value, they are safe and secure. Consider a setting any teenager finds themselves in—family, church, school, sports, friends—and, increasingly, each young person knows that as long as they contribute to the well-being of someone else, they are welcome and celebrated. If not, or when they fail or disappoint, it is up to them to find a way to fix it. They are loved if they get an A, score a goal, or show up at youth group. If not, they have failed to deliver. Our kids have grown up knowing that life is transactional. Today's young people know they must perform their way to blessing.

Life is a Solitary Journey

The sum of the cultural pivots? A gnawing sense of isolation and all-pervasive loneliness. Each story is unique and often hidden from even those closest to them, but for every teenager and emerging adult, these are common feelings and experiences:

- Virtual living: "The person I show is me, but not the total or even 'real' me. If I'm honest, I don't even know who the real me is!"
- Mosaic thinking: "With all I have to deal with, I can't seem to make sense of it all. I'm so often anxious and insecure. I can't get a grip on what is true and good and what is false and destructive. I just keep moving from one thing to the next, hoping that eventually things will come together."
- Transactional relationships: "I know I am supposed to have a purpose and make a difference in the world. I also know that when I do what is expected of me, I will be liked, even loved. It is up to me to be loveable, and this scares me to death."

Once they have enough trust that they will honestly share, listening to teenagers is to hear firsthand the effects of growing up with virtual living, mosaic thinking, and transactional relationships. The cumulative nature of these pivots produces an environment where young people feel increasingly isolated and alone. As a result, studies overwhelmingly reveal that today's young generation may be history's loneliness. An article in *Business Insider* titled, "Lonely, burned out, and depressed: The state of millennials' mental health in 2020,"[11] examines the increased rate of depression in this generation. According to an article in *PLOS One* journal, there is little doubt that "loneliness has become a major contemporary public health concern."[12]

Responding to the World We Have Handed Our Young

Innumerable environmental factors affect teen mental health. However, these major cultural pivots encompass the macro aspects that every young person is forced to deal with today. The pressures and expectations to constantly relate through external avatars, to have the capacity to make sense of this world, and to know that every relationship is transactional have led to the overwhelming experience of isolation that has created the loneliest generation in history. Young people desperately long for a light and guide to help them rise above the chaos we have handed them. So what is the solution?

First, every encounter with a young person must be bathed in authentic vulnerability. This means to wade through the impact of the cultural pivots; our presence must come devoid of our own needs or expectations. If we approach teenagers with an agenda that ignores the relational reality they experience, we will force them into relating through an avatar. To ever get to a place where they can trust someone to explore what is inside of them, we must come to them from that place.

Second, adults (i.e., parents, teachers, bosses, etc.) often talk over and beyond young people, failing to recognize that they have been steeped in mosaic thinking. Appealing to linear logic will not only miss them but also push them away. The antidote? Build a bridge for them to share with you how they process the topic or issue at hand. Stay with the process. Ask questions. Be open, and see if the built connection may help you both realize the value of linear logic and free-wheeling exploration. Marshall McLuhan believed that mosaic thinking brings people together. Perhaps being willing to see the value of how our young have been taught to reflect and consider life will open up new ways of processing today's radically nuanced world together.

Third, be aware of how your interaction with young people is transactional. Where do you expect something from the person standing before you? What do you want from them? To genuinely care for a teenager/emerging adult, you must check yourself and your motive for them. Can we recapture the age-old biblical commitment to nurturing without judgment, listening without condemnation, and caring without controlling?

Last, the best thing we can do—before our tips, techniques, and strategies—is to exude welcome. Belonging is a powerful gift. In a world where so many feel alone, for young people to know they are loved *as* they are *because* they are should be the central calling of a caring adult. ✠

CHAP CLARK, PH.D., *is the co-founder of CulturePivot.com and President of Parenteen, Inc. He is a global speaker and consultant, the author of two dozen books, and a nationally recognized expert on adaptive leadership, cultural trends, Gen Z and Alpha Gen, and adolescent and young adult development. His years of academic leadership, research, and teaching offer a rare interdisciplinary perspective on societal trends and the impact of emerging generations. He is the author of* Hurt 2.0: Inside the World of Today's Teenagers.

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Transgenderism, science, and kids:

What Every Parent and Practitioner Need to Know

"Parents say to us, 'What do you really know about the long-term effects of puberty blockers? Who has really studied the children for 20 years?'" said Dr. Diane Ehrensaft, the University of California San Francisco clinic's Mental Health Director. "We say, 'That's what we plan to do.'"

The current practice of giving puberty blockers to children as young as 10 has ignited a firestorm of controversy and confusion. Most who oppose giving GnRH (gonadotropin-releasing hormone) to children do so because of ethical or religious convictions or simple common sense. However, others argue for transitioning kids from a medical or psychiatric perspective. They surmise that if children are so distressed by being gender dysphoric, then they deserve intervention. This rationale is valid—any child with deep distress deserves medical or psychological care. The issue is not so much the problem of gender dysphoria but rather the appropriate treatment for this issue. This matter is vital for parents, teachers, physicians, and psychologists to reconcile because, after all, those who administer puberty blockers may *genuinely believe they are helping kids*. While certain studies show that some kids can be better off in the short term, when it comes to their physical and psychological health, no one knows for sure because *good data doesn't exist yet*.

Many excellent research papers agree. According to the prestigious Institute of Research and Evaluation, "Scientific evidence has not shown that cross-sex medical treatments are beneficial to children or adolescents. The research making these claims is not scientifically reliable. In fact, there is evidence of harmful impact. Consequently, a growing number of scientific agencies do not recommend such treatments. Instead, they recommend counseling and watchful waiting for gender-confused youth."[1]

An article in *European Child & Adolescent Psychiatry* stated, "Empirical evidence concerning the psychosocial health outcomes after puberty suppression and gender-affirming (GA) medical interventions of adolescents with gender dysphoria (GD) is scarce."[2] The most reasonable justification for *not* giving puberty blockers should be the lack of evidence that the treatment consistently and reproducibly results in good outcomes. My research confirms that puberty blockers do not deliver favorable results.

The Problems with a Gender Dysphoria Diagnosis

For many clinicians, even the diagnosis of GD is troublesome. There are no objective parameters in the diagnosis because it is made based on a child's *strong desires* to: be rid of sex characteristics, gain the opposite gender's sex characteristics, be the other gender, or have a firm conviction that he/she has typical feelings of the other gender. Thus, drastic medical interventions are made based on a child's feelings.

Proponents of puberty blockers cite that they are reducing the prevalence of depression or suicidal tendencies in GD kids; however, this is not proven to be true. Depression is a complex disease; if the primary means to resolution is gender reassignment, other contributing factors to depression will be missed, and the depression will persist.

When suicide rates and depression are at epidemic proportions as they are currently, it is imperative to address all issues contributing to them thoroughly. Suppose depression in a GD child is treated with puberty blockers, and the treatment has not been proven to alleviate the depression or improve the quality of life. In that case, even good clinicians are depriving children of life-saving help.

Physical Dangers of Puberty Blockers

The gonadotropin-releasing hormone works by affecting the performance of the hypothalamus in the brain. When impacted by GnRH, the hypothalamus triggers a cascade of interruptions of hormone formation by the pituitary, ovaries, and testes. Multiple organs are thus affected. Are these effects reversible? Some say yes, but we do not actually know. It is incumbent upon anyone giving hormone treatment to children to know this—particularly when treatment threatens fertility, brain development, severe mood disorders, possible reduction in long-term spatial memory, and more.

Other serious concerns resulting from puberty blockers are their effects on brain matter and growth, bone thinning, and mood. The Food and Drug Administration has issued warnings about the use of GnRH because it has caused *pseudotumor cerebri* in some patients—an illness where the brain appears to swell, resulting in increased brain pressure. The brain acts as though it has a tumor.

MEG MEEKER

Many of us can argue against transitioning kids from a moral or theological perspective, which is important. However, if we can use science to back up our beliefs, this will strengthen our arguments.

The Immature Brain

Brain immaturity is the most glaring reason for withholding puberty blockers in children and teens. We know that higher cognitive function is not complete until a person is well into their 20s. As a result, one cannot adequately assess the long-term consequences of actions until that time. An article presented by Gender Healthy Query stated, "Even if the youth has intractable gender dysphoria and will want to seek SRS (sexual reassignment surgery), brain development is not complete until *age 25*. Children simply cannot absorb the *consequences* of sterility, impacted sex organs and sexual function, vaginal atrophy, cardiac risks and possible serious side effects from puberty blocker use that an adult would."[3]

Another article in *Nature Neuroscience* looks at teenagers' hasty and precarious decision-making process that supports their inability to make such crucial, life-changing decisions. It states, "*This suggests that decision-making in adolescence may be particularly modulated by emotion and social factors, for example, when adolescents are with peers or in other affective ('hot') contexts…. You don't need to be a neuroscientist to know that adolescence is also a time of greatly increased impulsivity, sensation-seeking and risk-taking. One aspect of risk behaviour in adolescents appears to be an apparent inability to match their behaviour to the likely rewards (or punishments) that might follow.*"[4]

The diagnosis of gender dysphoria is complex, and good arguments can be made that it results from confusion, depression, peer and media pressure, or it is a fad. If these possibilities are not enough to withhold or pause treatment with puberty blockers, then the possible side effects should be sufficient.

Where Do We Go From Here?

So what can we do as parents, teachers, counselors, and concerned adults? First, we need to know the scientific data supporting withholding puberty blockers to children. Many of us can argue against transitioning kids from a moral or theological perspective, which is important. However, if we can use science to back up our beliefs, this will strengthen our arguments.

Second, we must pressure the schools and those promoting current sex education programs to stop mandating that teachers talk to kids as young as five-years-old about transgenderism. If you go to https://advocatesforyouth.org, you will find the latest standards and curricula for sex ed programs for kids K-12. Please do it. It is appalling.

It is a travesty to teach children that changing their gender is an easy, acceptable process that will bring them joy and fulfillment. Children have no idea what they need to overcome regarding feelings of any kind—from anger, sadness, depression, anxiety, or gender dysphoria. To encourage children to transition or silently sit while others promote medical and surgical intervention to solve a problem is cruel.

Therefore, those concerned about our children must be well-versed and strong in our assertions that giving them puberty blockers is unacceptable on several fronts. I fear that religious and moral arguments will not be enough if we are not educated regarding scientific studies.

MEG MEEKER, M.D., *is a pediatrician, mother, and grandmother. She has practiced pediatrics for 32 years and has written seven books on parenting. Her best-selling book,* Strong Fathers, Strong Daughters*, has recently been made into a movie of the same name by Pureflix.*

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Sexual Activity and the Molding of the Adolescent Brain

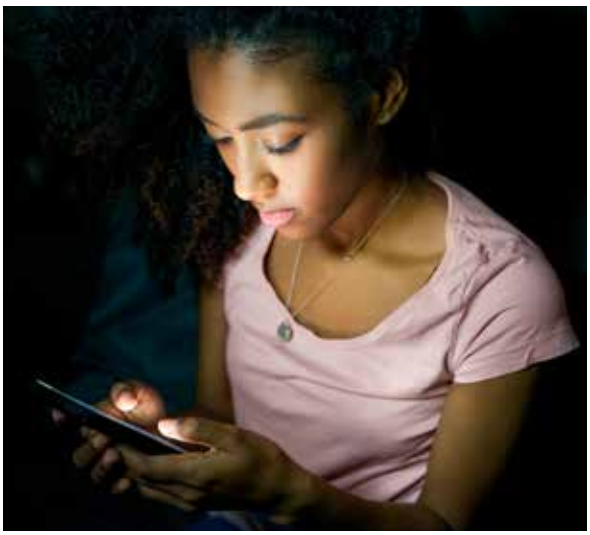
Brains are amazing organs. The human brain is, without question, the most complicated three-pound mass of matter in the known universe. It is always good to be reminded of this because it will help us not be so surprised at the dramatic discoveries about its function.

When an individual reaches adulthood, their brain is made up of about 90 billion neurons. In addition, the brain consists of another 100 billion support cells necessary for normal neuron function. Neurons communicate with one another through miniscule extensions of their cell bodies that reach out to other neurons. They do not physically touch each other but correspond across a tiny gap. The gap is called a synapse. There are more than 100 trillion synapses in an adult brain.

A startling discovery about the brain from many years ago is that it is moldable from before birth until death. The molding occurs from the stimuli that enter the brain from outside itself. I will explain in a moment. However, this molding is different from molding a piece of clay. Molding clay is an "outside" process. The brain molds "inside" (though, due to what is happening inside, the brain's visible folds change).

Molding results primarily from two processes. It occurs because of changes in synapses. New synapses can develop because the brain is actively engaged in an activity or stimuli a person is experiencing. New neurons (brain cells) can and do develop, even into old age, but synapses can also die if unused. So, the old saying, "Use it or lose it," actually describes one of the very intricate activities of the brain. One way to explain this would be to say that the increased number of brain cells and synapses serve to support a behavior that is important to a person functioning, such as applying the brakes when needed while driving. Perhaps the brain thinks this is an activity essential to an individual and must do its part.

JOE S. MCILHANEY, JR.



Molding can also result from unhealthy behavior, as we shall see. The brain cells and synapses present at birth but not used die, and others that are used very little weaken. For example, in certain cultures, particular vowels are not a part of the language. The neurons and synapses present at birth that could be maintained to speak those vowels die. This makes it extremely difficult for people raised with those languages to ever learn to pronounce words with the vowels they never used while growing up. Therefore, this means that nearly anything we do or do not do affects the physical structure of our brains in one way or another. The result is that our brains often influence what we subsequently choose to do. As we then make behavior decisions, we are usually unaware that our choices can be motivated by our brains' now-changed physical nature.

All of us know there are aspects of being human that proclaim it is impossible to plumb the depths of love, hate, intuition, self-sacrifice, faith, worship, miracles, and on and on. This discussion of the brain is so physical, yet it is real and a major aspect of the way we are created. It is essential to take this science into account for the way humans behave.

Although there are many others we could examine, two issues seem important for exploring regarding human experience and human behavior. The first is the role of pornography in the lives of young people. Lessons learned here can certainly be applied to older people also. Our experiences can have a different intensity of stimulating the reward hormone, dopamine. Making an A on a test does produce a dopamine response for a high school student, but having intercourse creates a much stronger effect. Dopamine responses are one brain path to produce brain molding. Synapse strengthening and neuron development are much more abundant for the sex act. Not only does the strong synaptic response cause intense memory, but it also triggers the person to repeat that act again and again.

One could say that the experience of pornography, whether by hearing, reading, or viewing, is counterfeit sex. And, for many people, male or female, the dopamine response is extremely intense. And just like the synaptic response, it causes some to remember the experience intensely and want to repeat the occasion.

We all know that pornography is ubiquitous. Even young people can hardly avoid it because of its easy availability on the Internet. For example, 11 porn sites are among the world's top 300 most popular on the Internet. The most popular of these 11 outranks such commonly popular sites as eBay, MSN, and Netflix.[1] Millions of our young people are seeking out these sites. One nationally representative survey found that 64% of young people ages 13-24 actively seek out pornography weekly or more often.[2]

Some may ask, "Can porn be that bad? What are they seeing?" Typical porn shows crude shots of men's and women's genitals. Commonly pictured are active oral, anal, and vaginal sexual activity, with the man often withdrawing and then ejaculating on the woman's face. Then it gets much more vulgar, including rape and incest, even with children.

Our lesson here is that the brain is molded by input from the "senses." The more intense the input, the more the brain is impacted. Porn is designed by those who produce it to show powerful images that significantly impact the human brain. We now know that pornography viewing leaves such an imprint on young (and, yes, even older) minds that it can become addicting. Pornography is such a powerful initiator of the brain's dopamine reward system that the desire for it can override the frontal cortex's cognitive ability to make wise decisions about attention and behavior.

As a result of the severe conditions porn can have on the brain, a warning seems appropriate, especially for our young people. When pornography shows up while "surfing the Web," it can seem "electrifying" and quickly draw a

person in deeper and deeper. And as previously pointed out, they are unaware that brain "programming" is leading their desire to proceed—not realizing they are "playing with fire." Yet, overall, studies show that 67% of young men and 49% of young women 18-26 years of age consider viewing pornography as acceptable behavior.[3]

The impact of porn on the behavior of people who access it suggests changes have occurred in their brains. Otherwise, why would there be so much pathologic and unhealthy behavior? An article by Robert Jensen titled, "Pornographic Lives," in the *Violence Against Women* journal found that men who accessed pornography were more likely to be involved in a whole host of unhealthy behaviors: casual sex, anal intercourse, group sex, sexual experimentation, dominant male view of sexuality, and difficulty separating sexual fantasy from reality.[4]

Dr. Jill Manning, author of, *What's the Big Deal about Pornography?: A Guide for the Internet Generation*, testified before a U.S. Senate sub-committee regarding her report on the harms of pornography. The following are some of the effects she listed that have been reported when a child is subjected to pornography: "… lasting negative or traumatic emotional responses; earlier onset of first sexual intercourse, thereby increasing the risk of STD's over the lifespan; increased risk for developing sexual compulsions and addictive behavior; and increased risk of exposure to incorrect information about human sexuality…."[5]

I could go on, but most parents, physicians, and counselors see that pornography is unhealthy, progressively addictive, and dangerous to an individual's emotional, physical, and spiritual health. "The eye is the lamp of the body. If your eyes are healthy, your whole body will be full of light. But if your eyes are unhealthy, your whole body will be full of darkness. If then the light within you is darkness, how great is that darkness" (Matthew 6:22-23, NIV)! These words seem prophetic. When we ignore them, we put ourselves and our kids at great risk.

The second issue regarding brain molding that needs to be considered is "social contagion." The American Psychological Association *Dictionary of Psychology* defines social contagion as "the spread of behaviors, attitudes, and affect through crowds and other types of social aggregates from one member to another." Hearing those words, social contagion, brings chills from remembering the teen suicide epidemic in Plano, Texas, in 1983. An Associated Press article from March 22, 1987, recalls the tragedy, "Plano, a fast-growing, high-flying Dallas suburb, was devastated by six suicides from February to August 1983, including three in one week. Within nine months, the toll was eight."[6] This epidemic brought national attention to the issue of teen suicide.

The American Psychological Association *Dictionary of Psychology* defines social contagion as "the spread of behaviors, attitudes, and affect through crowds and other types of social aggregates from one member to another."

For our purpose here, let us remember that the brain is molded by experience. For example, a boy's brain can be molded by catching a pass and winning a football game. His brain then motivates him to want to repeat this thrilling experience. If something as simple as catching a football can change a boy's brain, just think what the shocking experience of a friend committing suicide can do in molding the brain of another teenager. Social contagion may be at work here.

It seems possible that social contagion may also be related to much of the "gender confusion" (or "gender dysphoria") we so commonly see today. There has been an exponential rise in the occurrence of these issues over the past 10 years. The distress of these young people is real, and the causes of this unprecedented trend are unclear. One of the most recent comprehensive and reliable scientific papers from The Institute for Research & Evaluation titled, "Transgender Research: Five Things Every Parent and Policy-Maker Should Know,"© states, "Scientific evidence indicates that the causes of gender dysphoria are complex. Social and cultural factors can have a significant influence on whether a young person will identify as transgender."[7] The paper further maintains, "Recent unprecedented increases in transgender identity worldwide suggest that non-biological influences are a major factor. Studies show gender identity development is a complex process with bio-psy-

cho-social components. This means children and young people are susceptible to social, educational, and cultural influences."[8] Additionally, we need to understand the issues behind the following startling fact, "In Great Britain, between 2010 and 2020, the number of teenage girls referred for gender dysphoria (GD) to the largest pediatric gender clinic in the world, increased by about 5000%...."[9]

It is fitting to remember that preteens' and teenagers' brains are rapidly molded due to their "experiences." Clearly, repeated messages on social media are changing adolescent brains. Young people constantly hear on social media that people are trapped in the wrong body. They are hearing from friends that if a girl is considered a "tomboy," she is actually a boy "trapped" in a girl's body. In the article, "The Simple Rules of Social Contagion," published in *Scientific Reports*, the authors contend, "Therefore, the probability that a healthy individual becomes infected increases monotonically with the number of exposures, potentially causing a global epidemic involving a substantial fraction of the population."[10] It is reasonable to conclude that the bombardment of messages to our young people that they are either a girl trapped in a boy's body or a boy trapped in a girl's body can "infect" or, by brain terminology, "mold" their brains to believe what they are hearing. Understanding how this can spread spontaneously and broadly via social media seems appropriate.

Conclusion

I close with a fitting piece from my book, *Hooked: The Brain Science on How Casual Sex Affects Human Development*, "Current neuroscience research shows us that the human mind is an astounding organ, one we will never totally comprehend. But beyond that, just as the brain is remarkably complex, it is even more difficult to fully grasp what it means to be fully human. There is far more to human experience than we can ever explain. Life is not just a collection of choices. Nor are we robots or mechanical beings who hopelessly get hooked on certain behaviors. And to think that we are nothing more than a group of 'brain cells' or neurochemicals moved about by our environment is ridiculous. We cannot be explained by quantity, matter, or motion. However, we do know and understand some things about ourselves. This information, properly interpreted and utilized, gives us direction toward the most beneficial behavior choices. It gives us so much new insight into how to live in harmony with our innate nature and, therefore, to be more fully human. Living in accordance with this information gives us the greatest possible chance to enjoy our lives to the fullest."[11]

JOE MCILHANEY, M.D., *is a board-certified obstetrician/gynecologist. In 2001, Dr. McIlhaney was appointed to the Presidential Advisory Council on HIV/AIDS. He also serves on the Advisory Committee to the Director of the Centers for Disease Control and Prevention. In 1995, he left his private practice of 28 years to devote his full-time attention to working with the Medical Institute for Sexual Health, a nonprofit medical/educational research organization he established in 1992. As an innovator in reproductive medicine, he introduced laparoscopy, gynecologic microsurgery, and laser surgery to the Central Texas area. Along with three other physicians, Dr. McIlhaney was instrumental in bringing in-vitro fertilization and embryo transfer to Austin, Texas. Dr. McIlhaney has co-authored more than six books, including* Hooked: The Brain Science on How Casual Sex Affects Human Development *and* 1001 Health-Care Questions Women Ask.

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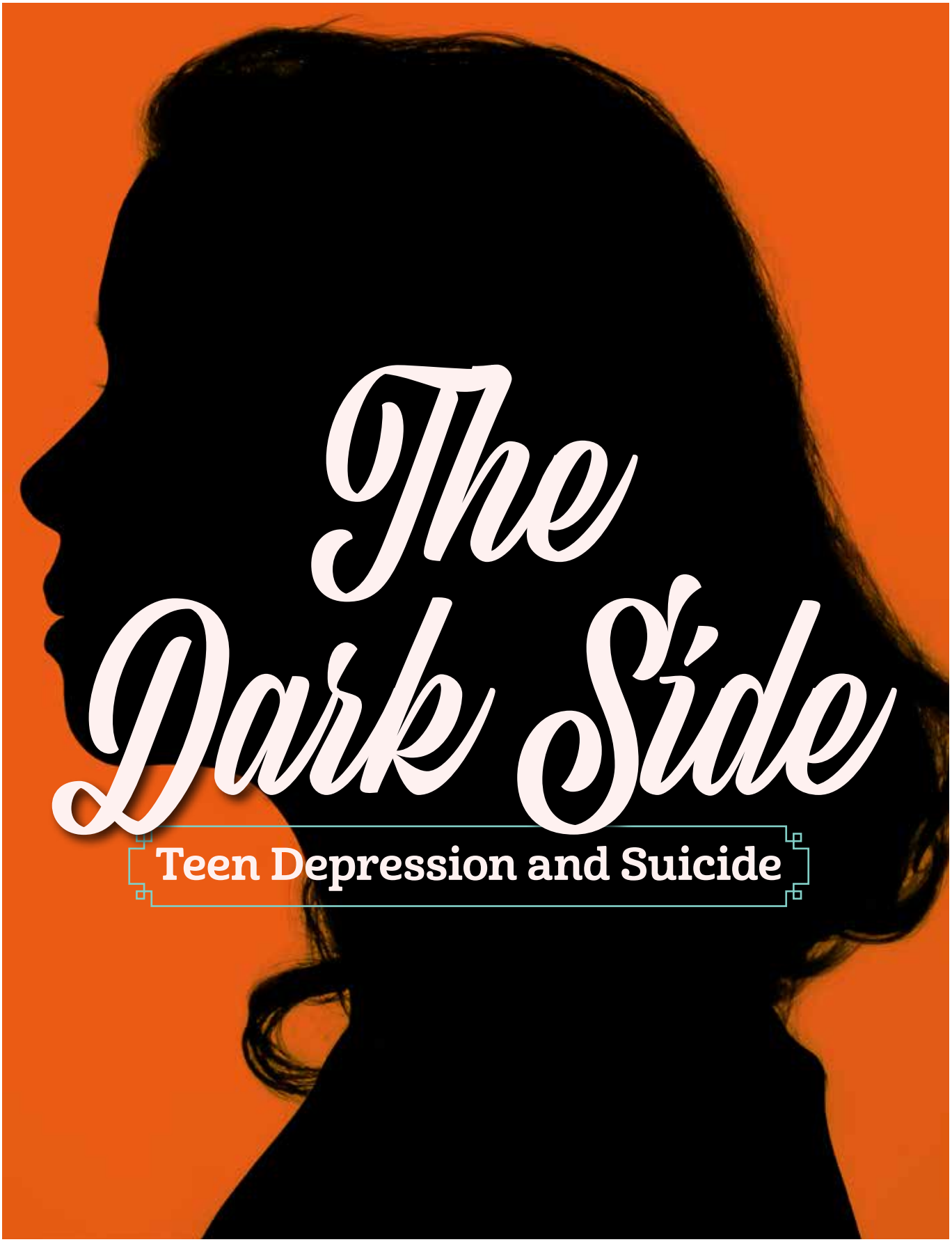

The Dark Side

Teen Depression and Suicide

Depression is an increasing problem among American teenagers. Although this was the case prior to the COVID pandemic, the Pew Research Center conducted a National Survey on Drug Use and Health in 2017 that showed 13% of American teenagers aged 12-17 (3.2 million) expressed "they had experienced at least one major depressive episode (MDE) in the past year"—that number was 8% (two million) in 2007.[1] The latest data show the rate has increased to 16.39% in the past year.[2]

Even more concerning than the number of youths struggling with depression is the figure (60%) of teenagers who received no mental health treatment for depression—not counseling or medication.[3] This issue is made even more frightening by the increasing suicide rates among youth. In the U.S., suicide is the third leading cause of death among those ages 15-24 and the second leading cause for that same age group worldwide.[4]

One of the biggest challenges with depression in our kids and teens is simply helping parents, teachers, and other adults recognize the disorder. Many adults expect teens to be moody or withdrawn and accept it as typical teenage behavior, making it difficult to identify the symptoms of depression. These include changes in eating or sleeping patterns, overreactions to criticism, restlessness and agitation, or problems with authority. It can be challenging, even for professionals, to determine what is normal adolescence versus indications of a more serious mental health issue.

That was true for Emma Benoit. Emma is now 22, but at 16, she shot herself in a suicide attempt. Miraculously, and thanks to God, she survived and has become an advocate for youth mental health and suicide awareness. "I never talked to my parents about my mental health, period," says Emma. She says she was terrified of not being heard and not having her feelings validated. Emma silently struggled with anxiety and depression for years. By all appearances, her life was that of a typical, even successful, teen. She had good grades, many friends, and was a cheerleader. However, that was a mask Emma put on for the world. In the privacy of her room and her heart, she was battling low self-worth and intense depression. Now, she works with many young people who have told their parents they are depressed, hurting, or hopeless but are still not being taken seriously.

The following are a few tips to help adults know the difference between what average teens experience and indications of depression.

- If you notice your teen being moody or sad, consider how long the shift in mood lasts and how different it is from their normal personality. If the mood change is significant and lasts more than two weeks, it may be a sign of depression.
- Is your teen experiencing a substantial change in school performance? One bad grade is not necessarily a reason for panic. However, a significant downward shift in overall academic performance over time may be caused by a concentration issue related to depression.
- Everyone can experience sadness from time to time, but ongoing sadness that includes persistent hopelessness and consistent feelings of low self-worth can indicate a mental health issue.
- Any teen substance abuse or self-harm, such as cutting, should be taken seriously and warrants support from a mental health professional.
- Any teen who talks about suicide, wishing they would die, or having never been born requires immediate attention from a mental health professional.

JENNIFER CISNEY ELLERS AND EMMA BENOIT

It is also critical to know there are life situations and experiences that research shows have a significant correlation to depression and suicide in youth.

Bullying. In 2014, the U.S. Centers for Disease Control and Prevention (CDC) issued the first uniform definition of bullying. A federal government Web site, www.stopbullying.gov, has been established to provide descriptions, statistics, and resources on this pervasive problem. According to the CDC, "Bullying is a form of youth violence and an adverse childhood experience (ACE)."[5] It is defined as "… any unwanted aggressive behavior(s) by another youth or group of youths, who are not siblings or current dating partners, that involves an observed or perceived power imbalance, and is repeated multiple times or is highly likely to be repeated. Bullying may inflict harm or distress on the targeted youth, including physical, psychological, social, or educational harm."[6]

The CDC describes universal forms of bullying as:

- **Physical** – hitting, kicking, and tripping
- **Verbal** – name-calling and teasing
- **Relational/Social** – spreading rumors and being left out of a group
- **Damage to property** – theft, alteration, or damage to the victim's property

Technology is another form of bullying, which is labeled "electronic bullying" or "cyberbullying." This dangerous practice of bullying can affect the offender, the recipient, or both (known as "bully/victim"). Current statistics suggest that one in five high school students has been bullied at school, and one in six high school students has been bullied electronically in the past year.[7] Bullying rates are even higher in middle school, and some of this aggressive behavior even occurs in elementary school. Both those who are bullied and those who bully others are at an increased risk for mental health issues like depression and suicide. Cyberbullying victims are at a higher risk of harming themselves and experiencing suicidal ideation.[8]

Sexual Violence. Sexual violence is a broad term that includes, but is not limited to, sexual abuse, rape, and sexual harassment. Statistics show that one in five girls and one in 20 boys are victims of sexual abuse.[9] Most of those who treat sexual abuse survivors as adults acknowledge that those statistics are probably lower than the actual numbers. Considering the number of sexual assaults by peers and authority figures, as well as the use of technology to engage in harassing and unsolicited and non-consensual sexual interactions, we know that many teens and young adults experience the trauma of sexual violence in one way or another. We also know there is a strong correlation between all types of sexual violence and depression. People who have been raped are three times more likely to experience a major depressive episode, and studies show those who have been raped are 4.1 times more likely than non-crime victims to contemplate suicide and 13 times more likely to attempt suicide.[10]

Substance Abuse. Substance use and abuse are linked to suicide across all age groups. Alcohol is a particular problem, and research has linked it to increased suicide risk. The disinhibition that occurs when a person is intoxicated contributes to suicide risk. In fact, the Substance Abuse and Mental Health Services Administration (SAMHSA) reports, "… a diagnosis of alcohol misuse or dependence is associated with a suicide risk that is 10 times greater than the suicide risk in the general population, and individuals who inject drugs are at about 14 times greater risk for suicide."[11]

Other significant issues, like the death of a parent, sibling or close friend or a serious illness, can also lead to depression. However, for many teens, no major event or trauma precipitates depression. An increasing number of young people with stable families, ordinary lives, and no substantial trauma are experiencing depression, and some become suicidal. Emma was one of those teens.

Social Media. Emma believes social media played a huge role in her depression and anxiety and also has the same impact on other young people. The connection between social media use, depression, and suicide is apparent but complex. Studies show a correlation between time spent on social media and isolation and depression. Several studies show that teens and young adults who spend the most time on Facebook, Instagram, and other social media platforms report 13-66% higher rates of depression.[12]

While research cannot entirely point causality at social media and screen time, we can all see that rates of depression and suicide have been rising in the same period that smartphone usage has soared among our youth. There are undoubtedly many reasons to contend that social media negatively impacts mental health. Emma believes that the false reality portrayed in social media leads to unrealistic expectations and standards and contributes to feelings of low self-worth and discouragement.

So, how do counselors help, and what guidance do they give parents? Ultimately, one of the most critical aspects of addressing depression and suicide in our youth is having more open and honest conversations with them. Genuine relationships are the key, but that requires a significant investment of time and energy. It necessitates spending time with young people and truly making an effort to enter their world and reality. It means having conversations about what interests them instead of only what concerns you as their parents. It requires having honest discussions about their feelings, their friends, their faith, and, of course, their mental health. Emma believes that if her parents had introduced the conversation about mental health, it would have made a difference for her. "I know if they had initiated that conversation, I would have opened up," she said.

While research cannot entirely point causality at social media and screen time, we can all see that rates of depression and suicide have been rising in the same period that smartphone usage has soared among our youth. There are undoubtedly many reasons to contend that social media negatively impacts mental health.

It is also critical to understand brain development and how it impacts thinking and mental health. Often, adults fail to consider that the pre-frontal cortex is not fully developed until the mid-20s.[13] This affects many executive functions for youth, including impulse control and the ability to have a long-term perspective on challenging life events. Adults must try to understand teens' viewpoints and realize that their pain is real and significant.

Emma believes education and dialog about mental health in schools are also critical to turning the tide on youth mental health. "One of the best ways to initiate change is to put programs in schools that promote mental health awareness," she said. That would have made all the difference for Emma and others whose pain leads to thoughts of suicide. "I didn't want to die," says Emma, "I just wanted to get rid of the pain I was stuck in." Emma learned that there is so much help for that emotional pain. God is now a vital part of her daily life, and she feels His guidance and direction. She knows many people, including her parents, friends, mental health professionals, and advocates, who she can turn to for support. And spreading this vital message of hope to other hurting teens is now part of her life calling.

JENNIFER CISNEY ELLERS, M.A., *is a counselor, life coach, and author. She is an approved instructor with the Critical Incident Stress Foundation and a faculty member. Jennifer co-authored the course, Youth Suicide, with her husband, Dr. Kevin Ellers. She serves as Senior Director of Advancement, Special Projects, and Church Engagement with the American Association of Christian Counselors.*

EMMA BENOIT *serves as an Ambassador for LivingWorks (livingworks.net), the world's leading organization in suicide prevention training. She is a suicide survivor who shares her personal story at conferences and events, including the California Department of Education Youth Summit, the National Federation of Families for Children's Mental Health Conference, the Hope Rising Suicide Prevention Summit, the Hope Squad National Conference, and more. The documentary film, My Ascension (myascension.us), tells her story.*

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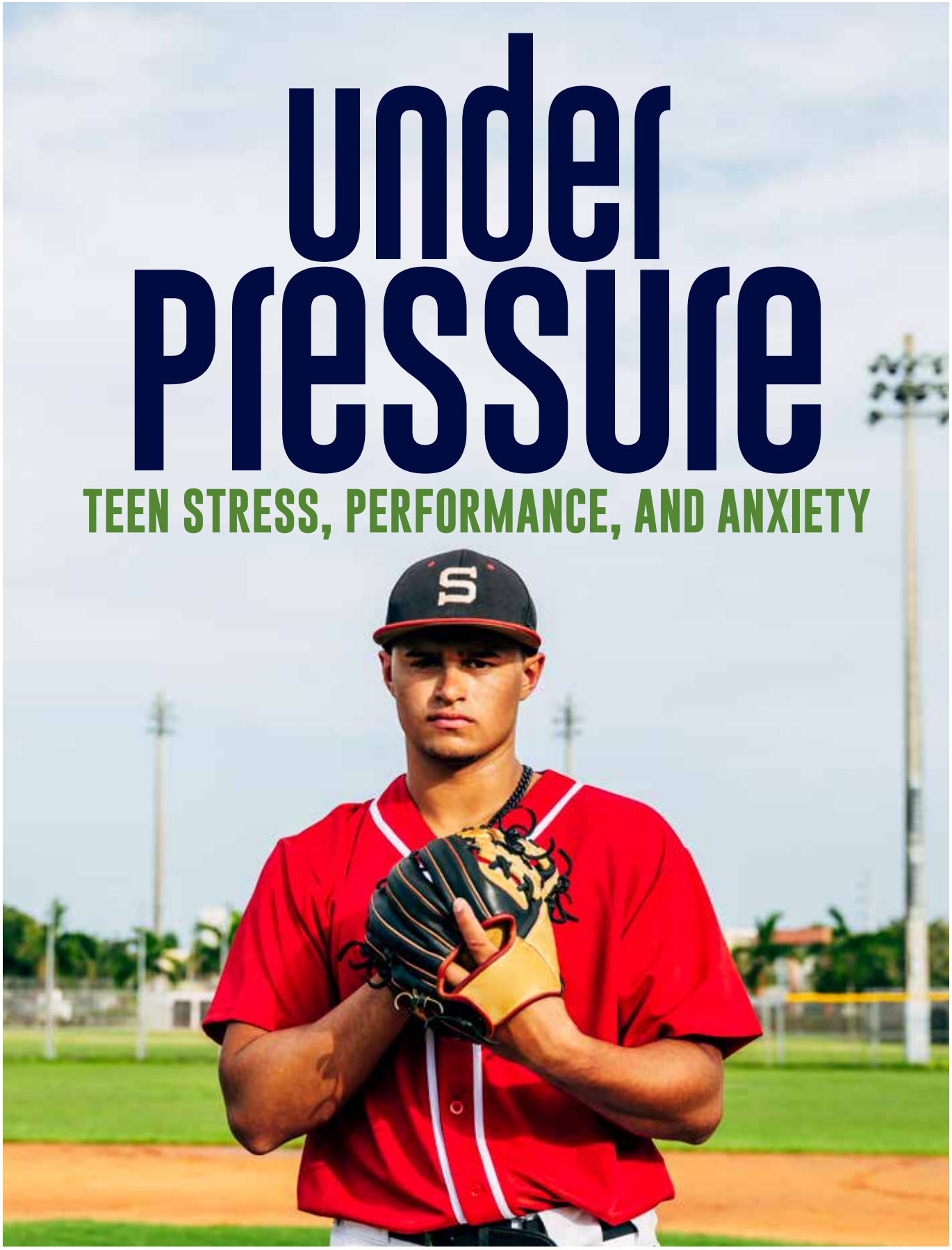
TEEN STRESS, PERFORMANCE, AND ANXIETY



It is no secret that we have a major challenge on our hands in helping today's generations manage and overcome issues related to stress and anxiety. According to Johns Hopkins All Children's Hospital (2021), statistics reveal that nearly 8% of children and adolescents suffer from an anxiety-related disorder (Johns Hopkins All Children's Hospital, 2021). That number only increased due to the COVID-19 pandemic and its resulting effects. Unfortunately, we live in a day and age of stress and anxiety unlike any we have ever seen. Many are indicating that it will take years to fully realize the impact of the potential mental health tsunami on our kids.

Although there are several contributing factors relating to this stress and anxiety, one of the most prominent that I often see in my work with high school and collegiate athletes, as well as youth in my clinical practice, revolves around pressure to perform. *HELLO!* magazine (2020) identified some of the most common stressors our youth and next generation face today, including the pressure to perform in school, specifically on exams; the pressure to perform within athletic competition; peer pressure and the desire to fit in; and the pressure to meet the demands and expectations within the home. Many kids are getting lost and desperately "white knuckling" their way through life with little or no help. However, one of my greatest joys is devoting my time and effort to helping our youth, adolescents, and young adults thrive under pressure.

If you recall, in psychologist Erik Erikson's eight stages of psychosocial development, he reminds us of a very pivotal fifth stage known to be experienced during adolescence, approximately between the ages of 13-19 years old when children begin seeking independence, increasing peer interaction/influence, and structuring a sense of identity by asking questions such as, "Who am I?" or "How do I fit in?" (Maree, 2020; Wong et al., 2015). Unfortunately, many of those answers in our culture and society have to deal with whether or not a person makes the team, wins the big game, or gets a good grade. Therefore, when the stakes are at their highest, many kids, especially those growing up with lots of brokenness and lack a sense of stability to keep them anchored, become incredibly stressed, afraid, and/or anxious. This mentality is typically a result of believing that if they do not perform to the level expected or demanded of them, they will no longer be accepted or feel as if they belong. However, I believe these high-pressure moments can be viewed as windows of opportunity. With intentional preparation, I think the next generation can embrace the pressure and confidently run into the storms of life.

Three Principles to Performing at Your Best Under Pressure

The following three principles are positive outlooks that can help young people overcome their anxiety and shape the future of the next generation.

1. Perspective Steers Potential. We have all heard the old saying, "Pressure can burst a pipe, or it can make a diamond." In simpler terms, pressure either brings out the best or the worst in people. To make sure it brings out the best, I love introducing people to a quote one of my favorite motivational speakers, Inky Johnson, always says: "How you VIEW what you do will always affect how you DO what you do" (Undefeated Motivation, 2021). In other words, we often get out of life precisely what we look for in life. When facing a high-pressure situation where someone needs to perform to the very best of their ability, rather than viewing it as a stressful obligation, I always try to help them reframe their perspective and view it as businessman, motivational speaker, and personal trainer, Tim Grover, would call a "privilege" or an "opportunity" (Grover & Wenk, 2014).

ZACH CLINTON

Research has continually shown that developing a positive expectancy, no matter the situation, can have life-changing results such as increasing self-esteem, lessening fear and anxiety, developing resilience and mental toughness, and even improving physical health (Make Me Better, 2019). I believe pressure, like adversity, is what we must work through to produce the growth and development we ultimately desire in life. Although pressure may sometimes induce stress and anxiety, when viewed with the proper perspective, it may just be an individual's opportunity to separate themselves and rise to the top.

2. Preparation Determines Separation. I have never met a kid who did not want to succeed, but I have met several who lack the discipline and commitment that success requires. Another favorite Inky Johnson quote reminds us of this: "In the midst of challenge or adversity, you never rise to the occasion; you simply revert back to your training" (Undefeated Motivation, 2021). However, as previously stated, many kids grow up in broken homes and families without someone to look up to and serve as a positive example. Therefore, the question I desire to help many find a productive answer to is: How do we train for our trials? Former great professional basketball player, Michael Jordan, once said, "It's what happens in empty gymnasiums that fill arenas."

One of the most well-known theories in mental healthcare that I often practice and teach involves Cognitive Behavioral Therapy (CBT). When struggling with stress and anxiety, CBT works to help individuals identify their negative or intrusive thoughts, stop/challenge them in the moment, and then replace them with something positive and true. Spiritually speaking, Philippians 4:6 (NKJV) is a perfect reminder for those struggling with stress and anxiety as it says, *"Be anxious for nothing, but in everything by prayer and supplication, with thanksgiving, let your requests be made known to God."* I have heard Pastor Craig Groeschel state that stress and anxiety are signals alerting us that it is time to pray. Philippians 4:8 (NIV) says that we are called to meditate on the truth of God's Word, noting, "… *if anything is excellent or praiseworthy—think about such things."* The mind is clearly a battlefield; therefore, we must prepare ourselves daily to take our thoughts captive and make them obedient to Christ (2 Corinthians 10:5).

3. Power in Relationships. The truth is every kid needs someone who will undoubtedly be there for them—to believe in them—some-

WE ARE THE ONES WHO HAVE BEEN ENTRUSTED WITH THE RESPONSIBILITY AND OPPORTUNITY TO REMIND THEM OF THEIR POTENTIAL EVEN WHEN THEY MAY NOT QUITE SEE IT FOR THEMSELVES.

one who will remind them of their worth no matter the situation, circumstance, or result. Kids crave the words, "I'm proud of you," in both moments of victory and defeat. This encouragement is precisely why I love counseling and emphasize pouring into those who have the opportunity to regularly impact and influence our youth, adolescents, and young adults. We are the ones who have been entrusted with the responsibility and opportunity to remind them of their potential even when they may not quite see it for themselves.

In sports, I often say there are two major types of coaches: recruiter coaches and relational coaches. Recruiter coaches have a relentless drive and can recognize talent, but they are highly result-driven and oriented. They typically have a "set in stone" structured way of doing things reverting to the "my way or the highway" mentality. Unfortunately, these coaches often leave kids believing their worth, value, and identities are attached to their performance. I have seen a lot of talent and gifts get wasted due to a coach, teacher, and even a mom or dad who possessed this mindset. Unfortunately, they are unwilling to take the time to be ATTUNED to their players, students, or children.

However, on the contrary, relational coaches take a much different approach. They have the same drive and desire to win but emphasize developing the individual, doing everything possible to get every last drop of effort and ability out of their players. Relational coaches care about the process more than the result. Through the power of encouragement, they consistently SHOW UP and pour into the lives of their players. As Daniel Siegel, a neuropsychiatrist and author, and Tina Payne Bryson, a child and adolescent psychotherapist and parenting expert (2020), note, when a child feels confident that they can count on an attachment figure to consistently SHOW UP for them through reliably providing safety, focusing on seeing their emotional needs, and soothing them amid difficulty, they can then begin to develop and trust the secure attachment.

Having someone who is crazy about you reminds you of your worth, value, identity, and place in this world. There is POWER in RELATIONSHIPS, and I believe if we attune ourselves to the next generation and better understand when to support and when to challenge, it will significantly impact the trajectory of their lives and those with whom they interact.

ZACH CLINTON, M.A., *is a doctoral student in the Counselor Education & Supervision program at Liberty University. He currently serves full-time in a leadership role at the American Association of Christian Counselors. Further pursuits include serving as a resident counselor at Light Counseling, where he primarily works with youth and the next generation. Zach also fulfills the role of President & Host of the Ignite Men's Impact Weekend and hosts The Built Different Podcast. A former Division I college baseball player and now chaplain of the Liberty University baseball team, Zach is a recognized growing authority and voice on performance and mental health for today's generations.*

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THE IMPACT OF SOCIAL MEDIA ON TEENAGERS

When you have been counseling for almost 30 years, you will inevitably see some things change. But what technology has introduced into kids' lives is like nothing I have ever seen. Not just technology—social media. And, even more specifically, as of late, TikTok.©

Let me go ahead and give a disclaimer at the outset. I am not one to ban social media in the lives of kids. I certainly understand the reasoning behind wanting to; however, I am more of an advocate for helping parents teach kids to use technology responsibly. I believe that involves trying and, most likely, failing in the arena of technology. Kids are failing—not the grownups, although we certainly do, too. We want to teach kids while under our roofs how to handle the things they will learn and encounter using technology. Therefore, I advocate for a more training wheels approach. We start small, with their first little e-mail address, and then, as they prove themselves (mostly) responsible, we give them more freedom. I have held that perspective as long as technology and social media have been a force in kids' lives. But, in recent years, TikTok has been the one app that has made me question my approach.

Like most of you, I first heard of TikTok back in the days when it was called Musical.ly. It seemed to bring with it a few concerns, such as children could perform a duet with someone they might not know in an environment parents could not necessarily control. However, for the most part, I was not considerably concerned. Until about five years ago, that is, when I learned that some of the shifts I was seeing in my counseling office were a direct result of TikTok.

I first started noticing around that time that more and more teenagers seemed to understand a great deal about a variety of mental health issues—depression, anxiety, post-traumatic stress disorder, and many others. One day it dawned on me that it was a little like they had memorized the *Diagnostic and Statistical Manual* before coming to see me. They would rattle off the list of diagnostic criteria as though they were discussing their classes in school. Then, the conversations around diagnosis shifted. In addition to enumerating the list for anxiety and depression, they included diagnoses with which I was unfamiliar. All with initials, of course—but ones that sounded more like someone was reading off an eye chart at the optometrist's office than truly discussing a diagnosis.

In the past year, I have seen a few more shifts. One I see more is kids showing signs of a tic disorder. After doing some research, I discovered that there are actually influencers with tic disorders and Tourette syndrome on TikTok. While it might be helpful for people who are genuinely and organically struggling with tic disorders and/or Tourette's to see role models with similar issues, another phenomenon has occurred as a result—tic disorders are considered a psychogenic illness, so they spread by watching others display the same behavior. A study from Harvard showed that kids with tic disorders were grouped in certain areas where they were spending more time watching these media influencers on TikTok.[1] And then, as we all know, once you watch one video, the algorithms just keep suggesting more of the same.

We are also seeing evidence of adolescents learning tricks to self-harm, hiding their eating disorders, and even ways to commit suicide on TikTok. Girls in my office will tell me that TikTok is their source to learn about all things mental health related. I even had a 13-year-old who told me she created an account solely to help others learn about mental health—I am not sure what sage advice a 13-year-old will have on the subject.

SISSY GOFF

Kids need help regulating their social media and technology use, and parents need help regulating technology use for their kids and, sometimes, themselves.

Social media is undoubtedly here to stay. It is still up in the air about TikTok, but kids of all ages are not just going to Google anymore. Rather than talking with their parents to learn about important life topics, they are taking to social media. And they are not only tapping into social media; they are addicted to it. A study from Common Sense Media in 2021 found that the percentage of tweens using social media had risen from 31% in 2019 to 38% in 2021. One in five tweens said they use social media daily. Regarding teenagers, 84% use social media and average an hour and a half per day.[2] The conversations in my office suggest those numbers are lower than what many kids are averaging.

Research has linked social media use with depression and anxiety, as we are all well aware. We are also seeing kids who need help recovering from social media addiction. The brains of teens who watch TikTok have the same areas light up on a scan as those who have an addiction.[3]

Dr. Julia Tartaglia, a digital and behavioral health researcher, has outlined the following criteria as signs a child may be suffering from a social media addiction:

- "Spending increasing amounts of time on social media."
- "Losing friendships, slipping grades, or conflicts with teachers or parents over social media use."
- "Choosing to spend time online over real-life activities, such as seeing friends, attending school, and personal interests."
- "Unsuccessful attempts to cut down or stop using social media."
- "Neglecting personal hygiene, sleep, nutrition, and exercise."[4]

I sit with girls daily who check off every item on this list. Kids need help regulating their social media and technology use, and parents need help regulating technology use for their kids and, sometimes, themselves.

One of the tools I often recommend is a parental control app called Bark, which helps monitor technology use. A variety of helpful resources exist in today's world, and we need to point parents toward them as their kids are learning to navigate both technology and social media. A few other recommendations I regularly make to parents include:

- Do not allow your child to be the first or the last to have any kind of technology, including social media. The first kids will often be perceived as fast, while the last will often be the ones who sneak their way into it.
- Start small with very limited time and access and increase that access as they prove to be more responsible.
- Take breaks from technology together as a family.
- Be aware of your own technology use and what you are modeling for your kids.
- Wherever your kids are on social media, you also need to be there.

Children do not just learn to ride a bike one day. They start with training wheels, with a parent running alongside them, cheering them on. The wheels eventually come off as they gradually learn the skill of riding. The same is true of technology; kids need to be surrounded by support, and with that support, they will progressively fall away as they develop the skills necessary to function in this digital age. They need our help. Parents need our help. They both need the voices of supportive and wise people, just like you, to help them navigate the turbulent waters of technology.

SISSY GOFF, M.ED., LPC-MHSP, *is the Director of Child and Adolescent Counseling at Daystar Counseling Ministries in Nashville, Tennessee. She is also the best-selling author of 12 books, including* Raising Worry-Free Girls: Helping Your Daughter Feel Braver, Stronger, and Smarter in an Anxious World*, and is a part of the podcast, Raising Boys and Girls. You can find more about her at raisingboysandgirls.com.*

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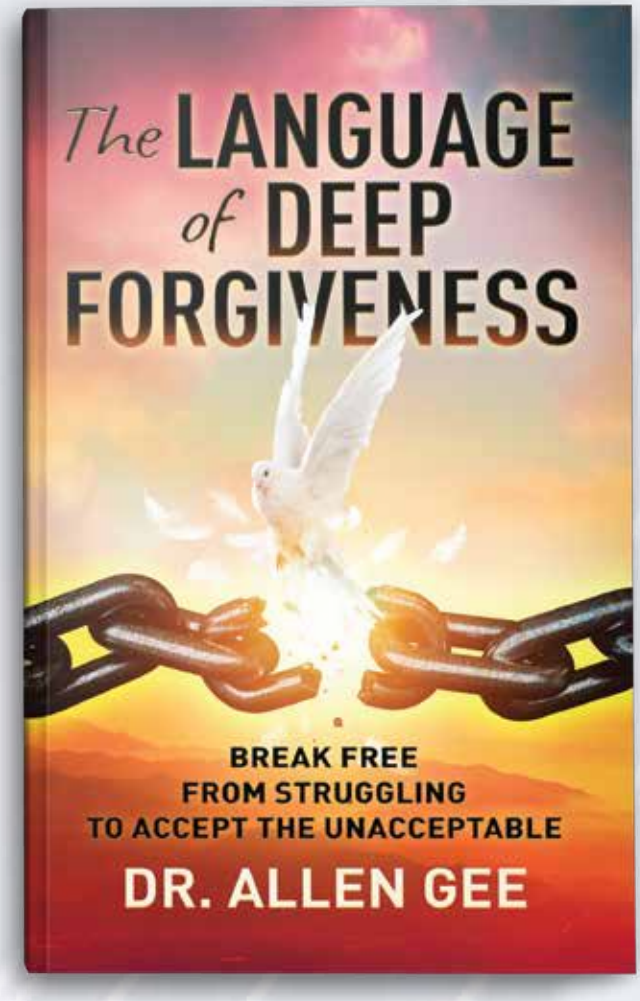

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Why Families of Kids with Common Mental Health Conditions Don't Come to Church

"People in the Church think they can tell when a disability ends and bad parenting begins." This statement began the testimony of a couple at my church's inaugural Disability Ministry Sunday, describing their experience of looking for a church in suburban Cleveland with two young boys with moderate to severe attention-deficit/hyperactivity disorder (ADHD).

From the early days of my now 30-year-old child and adolescent psychiatry practice, I have observed that the kids and families I serve are far less likely to be regularly engaged in a church or place of worship than is typical for our community. Research supports that observation.

Noted sociologist, Andrew Whitehead, published a study examining the impact of physical and mental health and developmental disabilities on church attendance using data from nearly 100,000 phone interviews conducted in each of three waves of the National Survey of Children's Health (NSCH). His findings on the effect of mental health on family church attendance were eye-opening.[1]

- Families raising a child with depression were 73% less likely to have attended church in the past year.
- Families of children with disruptive behavior disorders (Oppositional Defiant Disorder, Conduct Disorder) were 55% less likely to attend.

- Families of children with anxiety disorders were 45% less likely to attend.
- Families of children with ADHD were 19% less likely to attend.

The church attendance problem is not confined to families with children. According to the 2011 Baylor Study of Religion, adults who reported significant anxiety or depression were more than 50% less likely to attend weekend worship services.[2]

Why might the presence of common mental health conditions have such a dramatic impact on church attendance? One hypothesis suggests the attributes of common conditions make entry into "church culture" more difficult. Seven potential barriers to church attendance include:

1. Stigma. In 2013, LifeWay Research conducted a telephone survey of 1,001 U.S. adults in which 55% of non-churchgoers *disagreed* with the statement: "If I had a mental health issue, I believe most churches would welcome me."[3] Outsiders may fear mental illness will be interpreted by churchgoers as evidence of a lack of faith or diligence in religious practice.

2. Anxiety. People with anxiety disorders are prone to misinterpret the risks associated with entering new or unfamiliar situations. Opportunities for intense anxiety are plentiful at church. First-time visitors may fear being singled out for attention. Children may fear they will not know anyone in Sunday school. A parent with social anxiety may be wary of scrutiny from everyone they interact with during an initial visit. Expectations for self-disclosure in small groups may cause extreme discomfort for teens or adults.

3. Capacity for Self-control. Executive function deficits are characteristic of ADHD and are common in children and adults with mood disorders, anxiety disorders, and fetal exposure to alcohol, drugs, and other toxins. Executive functioning is adversely affected by stress hormones and neural pathways activated in response to trauma. The process of getting a child ready for church who struggles to self-regulate can leave parents exhausted. Children's or student ministry programming may be too stimulating for kids with executive functioning deficits. Children may experience more difficulty sitting, standing, or kneeling during worship services designed for adults, especially when they become bored.

4. Sensory Processing. Abnormal sensory processing impacts more than 5% of U.S. children and adults and commonly occurs along with autism, ADHD, and anxiety disorders.[4] Families of children with sensory processing differences face multiple potential pitfalls when attending a worship service. Ambient noise levels and numerous conversations taking place at once near entrances and exits can produce distress. Physical proximity often results in lots of bumping and touching. Bright lights and loud music, common at contemporary services, may be experienced as aversive.

5. Social Communication. Social communication is often a significant source of functional impairment among children and adults with psychotic disorders, ADHD, anxiety disorders, and pragmatic language disorders. Many kids and adults with social communication challenges desire authentic friendships. They desperately want to belong to a church where they can be recognized for their gifts and talents, but casual conversation and participation in small groups may be difficult.

6. Social Isolation. Families impacted by mental illness are less likely to meet people who might invite them to church. Their options for childcare are often limited. It is also less likely that children with mental health conditions will attend Christian schools where they might connect with other families actively engaged at church or have friends who invite them to church activities.

7. Family Experiences of Church. The multigenerational expression of mental illness suggests that many children and teens with no church experience are more likely to have parents whose church experience was disrupted by their own mental health issues. Serious mental illness (SMI) is highly heritable. A truly effective mental health inclusion strategy for kids and teens also needs to address the challenges parents experience at church resulting from their own mental health conditions.

Christian counselors and mental health professionals have the expertise and influence to meaningfully impact these statistics. Six steps they might take to support church attendance and engagement for families affected by mental illness include:

1. Meet with your pastor or church leadership to increase awareness of the problems children and adults with mental illness experience in attending church. Church leaders cannot respond to issues they do not know exist.

2. Offer to come alongside your church leadership in designing and implementing a strategy for welcoming and including individuals and families impacted by mental illness. Key Ministry offers free consultation to church teams interested in mental health outreach and inclusion and authored *Mental Health and the Church*, which presents a model for churchwide mental health inclusion sufficiently flexible for congregations of all sizes and denominations.

3. Offer training to church leaders, staff, key volunteers, or small group leaders. A 2021 LifeWay study of 1,000 Protestant pastors reported only one church in five offers any formal training for pastors, staff, or key leaders on recognizing symptoms of mental illness, and fewer than one in five has a counselor on staff skilled in mental illness.[5]

4. Encourage your pastors to talk about mental health concerns during worship services. The 2013 LifeWay study previously mentioned reported the most common request of churches from families of adults with serious mental illness was for pastors to talk about it from the pulpit because doing so enabled them to share their struggles with others openly.[6] Pastors might address mental health-related topics in sermons or offer prayer for people impacted by mental illness.

Families raising children with common mental health conditions represent one of the largest underserved groups by the Church in North America.

5. Offer to start or promote church-based mental health support groups. Mental Health Grace Alliance and Fresh Hope are two Christian non-profits offering biblically-based mental health support models that have been successfully implemented in hundreds of churches in North America and beyond.

6. Work with church staff to help accommodate clients with specific support needs. Consider asking clients about their church attendance and involvement during the intake process or initial assessment. Offer to speak with church staff if the problems they seek counseling for impact church participation or engagement.

Families raising children with common mental health conditions represent one of the largest underserved groups by the Church in North America. Christian counselors are uniquely positioned to help local churches with outreach to a population desperately in need of the love of Christ and care and support from a loving church family. ✠

STEPHEN GRCEVICH, M.D., *is a child and adolescent psychiatrist who serves as President and Founder of Key Ministry, a non-profit ministry that connects churches with families impacted by disabilities. He is an Associate Professor of Psychiatry at Northeast Ohio Medical University. Dr. Grcevich is a past recipient of the Exemplary Psychiatrist Award from the National Alliance on Mental Illness (NAMI) and a participant in the 2019 White House Summit on Mental Health. His book,* Mental Health and the Church*, was published in 2018 by Zondervan.*

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Understanding and Responding to Emerging Sexual and Gender Identities

This article will introduce readers to diverse sexual and gender identities emerging among youth today. We define key terms and offer a sense of how common these emerging identities are, as well as our thoughts on why they appear more familiar in recent years. Additionally, counseling models that may help navigate conflicts between a person's sexual or gender identity and their religious identity as a Christian are discussed.

Sexual Identity

Sexual identity, or sexual orientation identity, refers to the label people use to account for their sexual attractions. Frequently used sexual identities include straight, gay, lesbian, bisexual, and queer. Additional sexual identities, referred to as emerging, include pansexual, asexual, bicurious, graysexual, and so on. Sexual identity labels can be made public (how individuals are known to others) or kept private (how the individual thinks of him or herself).

The prevalence of diverse, non-straight sexual identities has typically hovered between one and four percent of the population. However, a recent Gallup Poll survey reflected an increase in the prevalence of those personally identifying as lesbian, gay, or bisexual (LGB), particularly among Gen Z (19.5%) and Millenials (9.5%), as compared to Gen X (3.6%) and Boomers (2.4%) (Gallup, 2022). Among the largest cohort of diverse sexual identities, Gen Z, the most commonly reported diverse sexual identity by far was bisexual (15.0%).

Gender Identity

Gender identity refers to the use of common gender labels, such as boy or girl, man or woman, etc., also including transgender (adopting a cross-gender identity) or gender non-binary (a gender identity in-between or outside of the binary of man/woman). Emerging gender identities include pangender, agender, bigender, genderfluid, gender expansive, and so on (Yarhouse & Sadusky, 2020). As with sexual identity, gender identity labels can be public, meaning how they are known to others, or private, referring to how one thinks of the self.

Although most people report a gender identity corresponding to their biological markers (i.e., chromosomes, gonads, genitalia), a smaller percentage of people claim a discordant gender identity (ranging from 0.6-0.7% of the population) (The Williams Institute, 2022). Similar to sexual identity, a recent Gallup Poll revealed differences in the prevalence of diverse gender identities across generations, with as many as 2.1% of Gen Z identifying as transgender, followed by 1.0% of Millennials, 0.5% of Gen X, and 0.1% of Boomers (Gallup, 2022).

When a discordant gender identity becomes distressing to a person, it is referred to as gender dysphoria. The prevalence of gender dysphoria is estimated to be lower among those identifying as transgender.

Common Concerns

Now that we have a better understanding of diverse sexual and gender identities, including emerging sexual and gender identities, it can be helpful to understand some of the common concerns youth may present in counseling. Difficulties can range from lesbian, gay, bisexual, transgender, queer, or another identity (LGBTQ+) of youth reporting higher levels of traumatic experiences, unstable housing, and financial stress (Salerno, 2020) to difficulties in their family relationships and even family rejection. For many sexual and gender minority youth, familial tension increased during COVID-19 as they were predominantly restricted to the home and were not attending schools, which are often vital sources and spaces for social support (Salerno, 2020). Negative experiences such as these are correlated with increased symptoms of depression, post-traumatic stress disorder, and suicidal ideations and attempts (Fulginiti, 2020; Marshal et al., 2011; Toomey, 2018). Elevated rates of suicidality and attempts are highly concerning, as past attempts are one of the best predictors for suicide completion (Fulgini, 2020).

How Should Christian Counselors Respond?

We encourage Christian counselors in their work with youth and their families who are navigating questions of sexual or gender identity to help improve family relationships, increase social support, and create an environment for them to explore what their experiences of sexual or gender identity mean in light of their Christian faith.

For many sexual and gender minority youth, familial tension increased during COVID-19 as they were predominantly restricted to the home and were not attending schools, which are often vital sources and spaces for social support (Salerno, 2020).

One approach to working with youth navigating sexual and religious identity is Sexual Identity Therapy (SIT; Yarhouse, 2019). Sexual and religious identities can be explored using a number of techniques. We currently favor narrative approaches that allow clients to identify the problem through stories that have been written about them, either from their faith community growing up or the mainstream LGBTQ+ community, entertainment, or the media. Once these problem stories have been identified and explored sufficiently, counselors can help clients develop a counternarrative in which they can thrive. The counternarrative aims to help clients find a life of congruence so that their lives and identities fit well with personal beliefs and values.

One method of working with youth who report a conflict between their gender identity and Christian faith is the Gender and Religious Identity Therapy (GRIT) approach (Yarhouse & Sadusky, 2022). A unique aspect of GRIT is its intentional work with the client's parents. For example, GRIT emphasizes parental scaffolding, which aims to reduce fear-based parenting as well as help parents identify and work through fears they may have when their child expresses having atypical gender experiences. Through GRIT, children are also invited to explore their genders in an open-ended manner. Play therapy can be a beneficial modality for exploration. Additionally, when working with younger children, the GRIT approach introduces the idea of gender patience, which refers to allowing gender to develop and reveal itself over time (rather than attempting to manipulate a resolution), recognizing that many experiences of gender dysphoria appear to diminish gradually.

However, suppose the dysphoria was to continue or worsen as the child goes through puberty and enters late adolescence or early adulthood. In that case, it is widely assumed that the dysphoria is unlikely to dissipate. At this point, therapy with older adolescents and young adults moves toward strategies to manage dysphoria. The GRIT posture recommends doing so in the "least invasive" way possible. Such strategies may include basic coping skills like deep breathing and mindfulness, religiously-congruent coping (e.g., prayer, reading Scripture), and altering the clothing clients wear or how they style or cut their hair. More invasive strategies include medical interventions, such as hormone therapy and gender confirmation surgeries. Interestingly, less invasive coping strategies are not only more common among adults who report gender dysphoria but also entail fewer risks and side effects. Additionally, less invasive strategies may be more value-concordant with Christian clients for whom medical transitioning may be morally problematic.

Both of the previously mentioned approaches can be used with broader considerations for improving parental and peer group support, as well as family communication in general. Navigating tensions between sexual or gender identity and faith can be difficult, but it is essential for Christian counselors to be well equipped to walk with youth through these significant challenges.

MARK YARHOUSE, PSY.D., *is the Dr. Arthur P. Rech and Mrs. Jean May Rech Professor of Psychology at Wheaton College, where he directs the Sexual and Gender Identity Institute.*

ANNA BROSE, M.A., *is a second-year doctoral student at Wheaton College, where she works as a Teaching and Research Assistant in the Sexual and Gender Identity Institute.*

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TEEN BRAINS AND SUBSTANCE ABUSE

In 2021, the Centers for Disease Control and Prevention (CDC) listed the following causes of death in the United States as the top three: cardiovascular (693,021), cancer (604,553), and COVID (415,399).[1] However, when taking a deeper look into the numbers, if cigarette smoking (480,000),[2] obesity (300,000),[3] excessive alcohol use (140,000),[4] and drug overdoses (107,000)[5] are considered, substance abuse is actually the #1 killer in the U.S. at more than *one million* preventable deaths each year.

Since 1999, drug overdoses have taken the lives of nearly *one million* Americans[6] and are rising as much as 30% each year.[7] What is even more frightening is the age at which people begin abusing drugs. The National Survey on Drug Use and Health study found that children as young as 12-13 years old are already using drugs.[8] As our society becomes more chaotic, less structured, and highly stressed with the media pushing kids to engage in mature themes much earlier, our naïve children are faced with added temptations regarding sex, pornography, illegal activity, and substance abuse at younger ages than ever before.

Sobering Reality

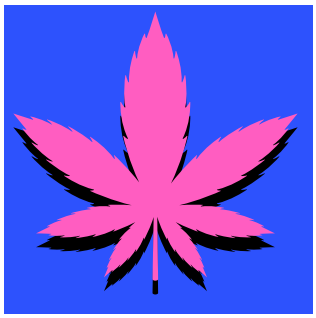
According to a study by the National Center for Drug Abuse Statistics (NCDAS), the following data regarding drug and alcohol use among teens and young adults are incredibly alarming:[9]

- Between 2016 and 2020, drug use increased by 61% for 8th graders
- 50% of teenagers have abused a drug at least once
- In the last month, 8.7% of 8th graders used illicit substances
- Among 8th graders, 21.3% have taken illegal drugs at least once
- By 12th grade, 61.5% have abused alcohol, 2.7% drink daily, 16.8% consume more than five beverages in a row when drinking, and 46.6% have tested illicit drugs
- 43.7% have tried marijuana
- 7.0% have misused tranquilizers
- 7.5% have abused hallucinogens
- 5.9% have consumed LSD
- Opioid abuse among 12th graders occurred at least once in 5.3% (most using pills)
- Among 12th graders, 4.4% have used Adderall, 4.3% amphetamine, 1.7% Ritalin, and 1.4% methamphetamine
- 11.2% of deaths in 15-24-year-olds occur from overdose

Marijuana Facts

Several studies track marijuana use and related issues in the U.S. In 2019, 48.2 million Americans (18%) used marijuana at least once, making it the most frequently used illegal substance.[10]

- Because medicinal marijuana is legal in 37 states and recreational marijuana is legal in 19 states, many believe it is safe.[11]
- One in six who use marijuana before 18 years old will develop a dependence.[12]
- Most dangerously, the Δ9-tetrahydrocannabinol (THC) concentration in marijuana has significantly increased over the past 50 years.[13] THC, the most toxic component of marijuana, has become more potent over the last several years as the liquid version of marijuana (commonly used by dabbing) is now legally accessible in various edibles.[14] Sadly, concentrations are not regulated or labeled.



KARL BENZIO

COVID Turned Epidemic into Disaster

Many of the previously listed teen and young adult substance abuse statistics are from 2020. When COVID hit that year, there were business shutdowns, the economy practically screeched to a halt, some schools closed, and the locked-in-at-home isolated society hindered manufacturing, transportation, and the distribution of substances. As a result, teens had difficulty getting out of the house to access alcohol and drugs, which momentarily decreased usage. However, now that we are past the acute dangers of the pandemic, substance use, abuse, and other addictive and harmful teen and young adult behaviors have undertaken a dramatic upsurge since 2021.

Why Teens Use Substances

With so much research and science revealing the toxic and dangerous effects on the brain, decision-making, functioning, and well-being in so many life domains, why is substance abuse in teens increasing?

With so much research and science revealing the toxic and dangerous effects on the brain, decision-making, functioning, and well-being in so many life domains, why is substance abuse in teens increasing? Based on what I am told from the ministries of which I am blessed to be part, let me share several key contributing factors:

• **Let's remember that we all struggle.** Jesus is the only one with perfect brain chemistry. Therefore, EVERYONE else has brain circuit glitches, which lead to breakdowns in perspective, emotion management, relationship skills, and decision-making.

• **The human brain does not fully develop until around the age of 25.**[15] This has two significant implications. First, the best hardware allowing us to take in, process, and output data in the form of sound, long-term, healthy decisions is not in place until close to the age of 25, and that is only if all other life experiences and situations are optimal. More adverse circumstances lengthen that timeline. The second implication pertains to the conditions affecting development. If toxins are added to the developing brain's ecosystem, healthy growth gets stunted and hijacked. This point lends partial truth to the old saying that an addict's level of emotional maturity is equal to the age they first started using substances.

• **Addiction is never primary.** Substance abuse and subsequent addiction are always secondary to some underlying psychospiritual struggle. Some struggles are common, like trying to fit in, having less anxiety when speaking to the opposite sex, decreasing loneliness or boredom, or escaping reality. Other more severe struggles include sexual trauma, parental divorce, losing a sibling, important academic or relationship rejection, or a significant life-interfering medical issue. Life is filled with challenges, adversities, trials, and tribulations. Some teens and young adults are resilient and deal with adversity using healthy coping skills. Others, unfortunately, self-medicate by using alcohol or substances to get them through these struggles.

• **Addiction's Six Stages.** I have developed a framework for addiction based on my research and experience over the years. The following stages usually progress in this order, and certain ones can last for some time.

1. Experimental – trying a substance once or twice out of curiosity
2. Social – social use, because others are using, and it is available
3. Situational – using to ease or soothe a particularly uncomfortable situation (e.g., taking stimulants to stay up to study, drinking alcohol to reduce social anxiety around others, or using marijuana or other hallucinogens to relieve stress or escape reality)
4. Regular – expanding the number and criteria of situations so use is more frequent
5. Intensified – using despite the consequences or problems it causes
6. Compulsive – substance controls you and is very difficult, or almost impossible, to stop on your own

During the situational stage, when a person gets tricked into thinking substances actually help them cope with life's problems, this rationale can start a dangerous slippery slope that quickly leads to increased use. The other downside of using substances to cope with struggles is users are not practicing healthy, godly coping skills to deal with their troubles.

• **Everyone's addicted to comfort.** We all struggle with pain, hurt, and discomfort. Even though the saying, "No pain, no gain," is constantly encouraged, none of us really want to deal with pain. So, we all turn to outlets to soothe, ease, escape, avoid, distract, or lessen our discomfort. Some outlets are acceptable, like getting a job to prevent the distress of poverty. However, work, money, or any coping skill can also become an addiction if we worship or allow them to push God's soothing and healing presence out of our everyday activities.

• **Constant screen use and dependence.** Social media streams traumatic events from around the world 24/7 into a still-developing teen brain. The comparison game, where teens unfairly evaluate themselves based on the "success" of others they see on social media, gradually erodes confidence. Social media actually makes many teens less socially skilled and more isolated as relationships become more electronic and less face-to-face. To deal with the discomfort of the trauma, isolation, or unrealistic expectations for themselves, they start self-medicating through various processes (also known as behavioral addictions such as shopping, pornography, more screen time, and anything to get approval) or chemicals that can quickly move them from the situational use stage through to compulsive addiction.

• **Feeling invincible.** Even though teens and young adults experience psychological stress, many believe they are physically indestructible. Playing into this lie is the phenomenon that after the immediate high, buzz, hallucination, or acute effect, they feel normal, believing no damage has occurred. However, sadly substance use accumulates and eventually causes microscopic brain damage (visibly impacting functioning) that flies below the radar and is not detected. It is similar to looking in the mirror after a week of only doing one pushup daily, revealing no apparent change. However, that one pushup per day caused many microscopic changes to the muscles, bones, ligaments, and tendons, making it easier to eventually do two pushups and more. Before we know it, we are doing 25 pushups each day. Once that happens, we can finally see that those microscopic changes produced a macroscopic impact.

• **They think they know everything.** The key realization in the course of God turning around my life and healing my addiction struggle occurred when I understood that I was not the most qualified person to write "Karl's Best Life Instruction Manual." Although I tried many times to write and then live out that manual, I would fail, rip out a chapter, and write a new one. My "aha moment" happened when I recognized that I did not know myself, love myself, care for myself, understand myself, or see my inner being or future better than everyone else. God is better than me in all those areas—and not just in general, but literally as they pertain to me! So, He, and only He, has the qualifications to write "Karl's Best Life Instruction Manual." Humility to accept His ways and plan is vital.

The Solution

Even though the odds seem against our teens and young adults winning this spiritual war on the battlefield of the mind, God provides answers. The previously listed contributing factors reveal what we need to do to address this dangerous epidemic. God's instruction manual, the Bible, uncovers many psychological principles and practices: to take every thought captive to the obedience of Christ, offer our bodies (decisions) as a living sacrifice, abide in His perfect peace, have no other gods before Him, accept His forgiveness and forgive others, be good stewards of our bodies/time/talents/decisions, know our identity/value/purpose, and recognize His plan and purpose. All of these are essential for painful times.

You play a crucial role in helping parents coach their children or directly equipping children and teens as early as possible with psychological skills to see life clearly, manage their feelings, and make healthy decisions. Teach and be a role model for them to have the ability to accept being bored, frustrated, lonely, sad, afraid, anxious, and stressed, while helping them understand how to bring God and healthy coping skills into that space. These abilities will divert them from Satan's quick fixes that might provide momentary relief but also lead to harm and interfere with appropriate coping skills. Decisions determine your life, so choose well!

KARL BENZIO, M.D., *is a board-certified psychiatrist who has held many clinical and administrative healthcare positions. His passion and expertise are integrating the Bible with psychiatric science to help people heal, lead abundant lives, and be a lighthouse to others. Dr. Benzio is a writer, frequent speaker, media guest expert, and expert witness in many legislatures throughout the U.S. and internationally. He has been a consultant to many ministries, co-founder of the unique Christian residential treatment center, Honey Lake Clinic, and serves as Medical Director for the American Association of Christian Counselors.*

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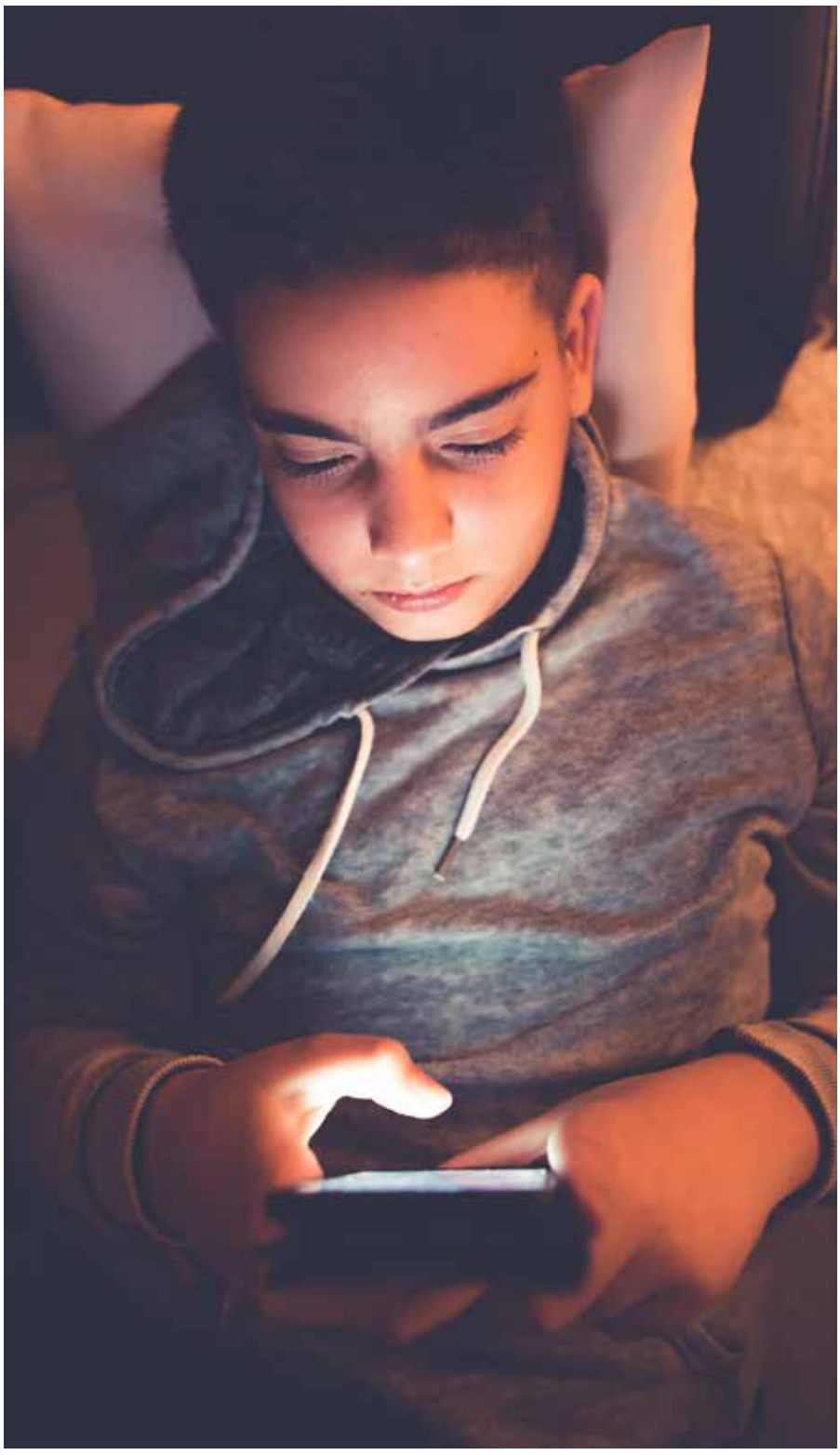
For I know the plans I have for you," declares the LORD, "plans to prosper you and not to harm you, plans to give you hope and a future. Jeremiah 29:11

« TED CUNNINGHAM, MACE

Helping Our Children (and Ourselves) with Online Discretion



My mom is a stickler for good manners. She taught my brother and me to say "Please" and "Thank you," never allowed us to use foul language, and corrected us for name-calling. My friends' parents followed similar guidelines in their homes.

The dawning of the Internet added a new challenge to parenting: new technology but the same guidelines. Proverbs 18:21 (NIV) says, *"The tongue has the power of life and death…."* I like to remind my family that our thumbs also have the power of life and death.

I do not post much online these days. The opinions and outrage of others lead me to preach and minister with frustration. My mental health does much better when I use words with restraint. These days, I mostly post pictures of family, friends, and fish. Proverbs 17:27-28 (NIV) reminds us, *"The one who has knowledge uses words with restraint, and whoever has understanding is even-tempered. Even fools are thought wise if they keep silent, and discerning if they hold their tongues."*

I recently asked a pastor friend why he deleted his social media accounts, and he answered, "I found myself preaching mad. I need to walk away from it for my well-being." Holding our tongues and thumbs is wise. You have heard it said, "You don't need to say everything you think." You also don't need to post everything you think and feel.

The pandemic and political unrest accelerated the outrage online. We wake every morning, grab our

"Live wisely among those who are not believers, and make the most of every opportunity. Let your conversation be gracious and attractive so that you will have the right response for everyone."

(Colossians 4:5-6, NLT)

phones, and find something new to infuriate us. What if there is a path forward that does not require surrendering our phones and WiFi? Proverbs 2:11 (NIV) says, *"Discretion will protect you, and understanding will guard you."* The Internet changed everything in the 90s. Social media outlets like Facebook, Twitter, Pinterest, and Instagram connect us to family and friends, but they also can hurt your family, reputation, and mental health. It only takes a minute or two online to see that many lack discretion and good manners.

When our kids were young, Dr. Gary Smalley encouraged my wife and me to write a family constitution. On it, we listed all of our family's values, which served as a guide for our daily interactions. It included honoring one another with our words, offering grace for mistakes made, praying together each day, and reading the Bible. The last line of our constitution reads, "We will live in the moment and not online." As a family, we have many special moments where we smile at each other to say, "That moment is just for us. We do not need to reenact it for a picture to post online."

The last line of our constitution led us to create a separate set of guidelines for online discretion. We wrote this as our children became teenagers. These are simple reminders we use to guard our hearts, home, and reputations:

- I will not seek validation for my feelings through likes, comments, replies, or retweets. The Internet is not always a safe place to heal from hurt.
- I will only post things that are encouraging and edifying. We want to esteem others with our words.
- I refuse to vent or speak negatively about anyone.
- I will take personal responsibility for my posts and remove posts that incite cruel and harsh criticism toward my friends, spouse, parents, or coworkers. The delete key is my friend.
- I will avoid passive-aggressive posting.
- I will not post seductive pictures or "selfies" in an effort to "put myself out there."
- If a relationship is struggling, as we pray and work toward reconciliation, we will suspend all use of social media for the sake of our children, family, and friends.
- If I question a post, I will ask my spouse, parent, or a mature friend to review it before posting.
- I will not stalk the behavior of another via social media.
- I will not create false accounts to manipulate, deceive, or act falsely toward someone else.
- I will share all of my passwords with members of my family.
- Above all else, I will strive to use social media in a way that honors God, others, and my family, regardless of my feelings.
- If I cannot use social media in an honoring way, I commit to deleting my account.

You may feel safe and protected in a room with just a computer, but the Internet is a powerful tool used for good and evil. Protect yourself, your ministry, and those you love with every keystroke. Everything you say and do online is repeatable, shareable, and retweetable.

The Apostle Paul's words to the Colossians serve as an excellent reminder for us online: *"Live wisely among those who are not believers, and make the most of every opportunity. Let your conversation be gracious and attractive so that you will have the right response for everyone"* (Colossians 4:5-6, NLT). Let your online presence build people up, and never add to their anxiety. *"Anxiety weighs down the heart, but a **kind** word cheers it up"* (Proverbs 12:25, NIV). People surfing the highlight reels of others have enough to deal with at the end of the day. I want my words to build up and bring life.

My mom did not raise her boys in the Internet age, but not much has changed. It is still "Please" and "Thank you," and no foul language or name-calling—in-person and online.

TED CUNNINGHAM, MACE, is the founding pastor of Woodland Hills Family Church in Branson, Missouri. He is a graduate of Liberty University and Dallas Theological Seminary.

« DIANE LANGBERG, PH.D.

Do Not Hinder the Little Ones

So often, when we write about children, we express how to teach them, train them, and shape them. That is both good and necessary; however, it is also critical that we do not lose sight of the fact that children have much to teach us. Our Lord said so.

We are all familiar with the story in the Gospels where the parents brought the children with them and pointed them to go to Jesus, and Jesus' disciples got in their way and forbade them from going. The Lord of the universe invited the vulnerable, small, humble, and weak to come to Him for blessing. His closest followers stepped in to prevent that from happening. He said, *"… do not hinder them…"* (Matthew 19:14, Luke 18:16, Mark 10:14).

Jesus told His disciples not to get in their way, not to hinder them, debar them, or forbid them. And then He says something staggering, *"… for **of such** is the kingdom of heaven"* (Mark 19:14, NKJV). Mark tells us Jesus was *"greatly displeased"* (Mark 10:14) with His disciples. The kingdom of heaven is not populated with power, thrones, riches, and fame. Though to look across Christendom today might lead us to make such a conclusion. Christendom, as Christ defines it, will be populated by the little, the needy, the vulnerable, and the humble. We are not only to welcome them into the kingdom of our God… we are to *be like* them.

Stand with me and look out at the Christendom of today. We have convinced ourselves that fame, size, and wealth are seen in the best of Christendom. However, if that is so, Jesus was at or near the bottom of the heap. We have fooled ourselves into thinking Christendom is safe. It is not. We protect our systems rather than the sheep, the little ones. And much of Christendom has turned its head—even lauding and protecting systems as the sheep are being used as food. We are crushing the little ones, the precious image bearers. We are forbidding their safety and a path to Jesus. It is like the temple in Jerusalem, which Jesus called a den (a safe place) for robbers (those who steal and exploit). He did not praise them but cracked whips and turned over tables.

Consider Ravi Zacharias International Ministries. The late Ravi Zacharias was a world-renowned apologist. He was honored and praised, and all the while, he was devouring precious little ones. It was covered up, and the "little ones" were forbidden and hindered from access to Jesus, and it was all done in His name. We have also covered the severe misconduct of many others: Hybels, Driscoll, Gothard, and the Southern Baptist church. All were large enterprises conducted in the name of Jesus… and all the time they were being praised, they were also hindering the little ones.

I have worked with countless victims over the last 50 years. Most of them were from Christendom and had been hindered, crushed, abused, and tossed aside by so-called "disciples" who prohibited them from coming in and *being safe*. Oh, they could go in, but safety was not provided—though it may have been promised.

Think about our ideas and images about what a kingdom represents. It signifies wealth, power, fame, and military prowess. Note the absence of the measure of character. Character is how our Lord measures greatness. In His life and teaching, our Lord (the Lord) ignored popular conceptions (of both then and now) of power and rule. Think about His statement: *"Let the little children come to me, and do not hinder them…."* Then, sit down with the Beatitudes (Matthew 5). Essentially, they teach us that a Christlike character brings joy and blessedness to the poor, the meek, and the little. You do not have to read too many news articles today about Christendom to realize the little, the poor, the hungry, and the weeping have not always been safe in the so-called House of God.

Our call is not to systems, even those like the temple God designed. Our call is to *Christ Himself* and to live out His character in the flesh. He came in the flesh to show us the Father, repeatedly stating, *"I always do what pleases the Father"* (e.g., John 8:29). Now, you and I are His, and He has put His honor into our keeping. We are to bear Christ's character in the flesh, and He has made it clear that any hindrance of a little one is a misrepresentation of Him. Our work is not determined by human measures or external trappings but by likeness to Jesus Christ. May we bring Him joy through our responses to the little ones. Like Jesus, may we always seek to please the Father. ✠

DIANE LANGBERG, PH.D., is globally recognized for her 47 years of clinical work with trauma victims, having trained caregivers on six continents. She directs a group practice in Jenkintown, Pennsylvania, and her most recent book is *Redeeming Power: Understanding Authority and Abuse in the Church*.

You do not have to read too many news articles today about Christendom to realize the little, the poor, the hungry, and the weeping have not always been safe in the so-called House of God.

« GARY W. MOON, M.DIV., PH.D.

For the Sake of Mental and Spiritual Health… it's Time for a Teenage Rebellion

I have procrastinated writing this particular Reflections column for a variety of reasons. I am willing to share the top three.

1. While I have very fond memories of my *late* teen and young adult years, getting through the early teen ramp-up was repressively bad for me. So, from what I remember, let's just say that starting school a year early and getting my growth spurt a year late did not help me win any popularity or athletic awards during those years.

Plus, having the capital letters "I" and "J" as the Alpine peaks of my Myers-Briggs profile, I was keenly concerned about the fact that I would soon be facing a collection of life's most critical questions: With which career, person, and view of God would I spend the rest of my life?

And if those factors were not scary enough, I found myself holding inside most of the teenage rebellion I wanted to be spewing out. Noncompliance was not something my fundamentalist faith group would tolerate, nor could it be survived by my fragile parents.

Then things got worse. A few zits started popping out, and my much-anticipated new voice still could not sing any better than its higher-pitched predecessor. It is no coincidence that I developed a stutter for the first three months of my 10th-grade year, and even now, I want to avoid Reflections columns that cause me to step back into that early teenage time.

2. The second reason for my procrastination is that even though I became a psychologist (you may have seen that coming) and received significant training for working with

adolescents, I always found that particular age group to be more difficult for me than most other populations. I often reflected that one of my primary textbooks for working with that age group was aptly named, *The Fragile Alliance*. I thought chapter four was particularly descriptive of what I was experiencing with adolescent clients—"Malignant Defenses, Malignant Resistances, and Atypical Alliances."

And I had to work through all the issues that came with the awkwardness surrounding the situation where the client and the person paying for the session were most often two different people with poles-apart opinions of what would constitute therapeutic success.

Plus, there was the uneasy silence that so often followed my adolescent clients into each session. I remember once making an inner vow that I would not be the first to break the silence—no humor, no questions, no small talk, just non-verbal attending and empathetic eyes. Fifty slow-ticking minutes later, I had to admit I had met my match; and later wondered if the eerily-silent young man ever found work as a lethargic mime. Immediately after that session, I concluded there was nothing more important to success in psychotherapy than the client's motivation level.

3. The third reason I put off writing this Reflections column is the abrupt shift I experienced in parenting requirements when our daughters each entered their own vail of fragile alliances, mean girls, and finding their own path through a world that suddenly seemed confusing and overwhelming. We all survived those years of silence, tears, questions, confusion, and pain; however, not before I gained a lot of empathy for God, whom I could then imagine thinking something like, "Now, let's see how you like it when your precious image bearers start rejecting your help and deny your existence."

But here I am, pecking away at a keyboard. Why? Well, for starters, things did improve across all three of those areas of pain. It seems I did find a way to marry the right person and choose the right career and church; I almost grew into my nose; and I learned a few more creative ways to spend a therapeutic hour with an adolescent. And, happily, I found a way to mature and have a loving relationship with my adult daughters. Along the way, I developed a lot of empathy for those on the road that takes them through adolescence to young and older adulthood. Because as difficult as things were when I was on that path, the journey is so much more challenging today.

To be completely honest, I am not sure how I would navigate teenage life today. It was challenging enough five decades ago when the majority of that world was still seen as being supported by the transcendental pillars of beauty, truth, and goodness. The university system itself was built around them, anchored by the Colleges of Arts (beauty) and Science (truth). Sure, goodness (theology) had already been escorted off campus by modernism, but it was still upheld by most of the key authority figures in my life.

And, I do not want to think about how I might have handled, or more likely mishandled, a world with thousands of devices chirping for my attention and offering a universe of vices only a click away. Nor do I want to imagine a world where bullies can both torment you at school and follow you home through cyberspace to continue their cruelty right into the former sanctuaries of one's living room and bedroom.

So, with deep empathy and the realization of the minimum value of words, I pray. I pray for a groundswell of rebellious teenagers who will have a growing discontent with the advice-giving "authority figures." That is,

Along the way, I developed a lot of empathy for those on the road that takes them through adolescence to young and older adulthood. Because as difficult as things were when I was on that path, the journey is so much more challenging today.

their current culture of: controlling search engine algorithms tuned to surface-level desires; universities that deny the reality of the truth they previously championed; angry daily diatribes masquerading as nightly news; music that elevates God's wonderful gift of bios (bodily) life over the even more amazing gift of zoe (spiritual) life; and the very idea of "canceling" another human being—sometimes for very understandable reasons, but often only because their words do not echo and amplify your own.

I pray for the uprising of a rebellious generation who will say, own, and declare similar words of those from a remarkable rebel who, decades ago, was being assaulted by problems eerily resembling those of today and proclaimed: "The line separating good and evil passes not through states, nor between classes, nor between political parties either—but right through every human heart…. Alas, all the evil of the twentieth [and twenty-first] century is possible everywhere on earth. Yet, I have not given up all hope that human beings and nations may be able, in spite of all, to learn from the experience of other people without having to go through it personally" (Aleksandr Solzhenitsyn, *The Gulag Archipelago*).

Solzhenitsyn's prophetic words echo those of my favorite subversive leader of all time. He said and demonstrated radical ideas, such as listening to and loving enemies, resisting the norms of the prevailing culture, and doing good even to those who harm you. And then, to use the words of my friend, Trevor Hudson, he showed how it is possible to practice resurrection love, even in a crucifying world of polarizing anger.

Our dream for a better world, maybe even our hope for a future world at all, may hang on the possibility of a teenage rebellion against most of the prevailing authority figures on the planet. ✠

GARY W. MOON, M.DIV., PH.D., served as the founding Executive Director of the Martin Institute for Christianity and Culture and the Dallas Willard Center for Christian Spiritual Formation at Westmont College. He continues to direct their resource development initiatives by serving as the director of *Conversatio Divina: A Center for Spiritual Formation*, www.conversatio.org.

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« MICHAEL R. LYLES, M.D.

Successfully Managing Pharmaceutical Costs

Four factors must be considered when prescribing any medication: safety, side effects, efficacy, and costs. It does not matter if the drug is well-tolerated and effective if it is not safe… and none of this matters if the patient cannot afford the medication. It is very frustrating for doctors and patients to deliberate over a treatment plan only to find that we will need to "fight the insurance company" to get it covered. The following are practical strategies to maximize a patient's opportunity to manage the cost of prescription medications.

Prior Authorization

All insurance companies employ a formulary that lists the drugs the plan covers. Generic medications are usually covered. More expensive branded products are covered at various levels or tiers of coverage—if covered at all. These branded medications will require a "Prior Authorization" (PA) from the insurance company to allow for any level of coverage. This PA process amounts to the provider of care filling out forms explaining why a cheaper alternative is inappropriate. It is time-consuming, with some practices understaffed and charging for this assistance.

Informed patients can proactively help the process by finding out what drugs are covered in your formulary, which is available on the insurance companies' Web sites. Bring that list to your doctor's appointment and keep a list of medications you have tried and failed and whether side effects were prohibitive. Prior authorization forms will require this information. Services such as "Cover My Meds" can assist the provider's office in the PA process. If a denial letter is issued for a medication, read

the letter carefully to see if there are others you must try before your desired medication is covered. This process is called a "step edit." Some pharmaceutical representatives may have helpful resources to assist with the PA process for their products.

Discounted/Free Medications

If starting an expensive medication, always ask to try samples first, which will eliminate spending money on drugs that are not tolerated, do not work, or cause an allergic reaction. Most branded products have company-sponsored discount cards that can significantly reduce monthly co-pay costs or provide the first month of medication for free. Some discount cards will decrease the out-of-pocket medication costs during the first few months of the calendar year to provide support until deductibles are met. These programs can be accessed on Needymeds.com or by typing the drug name.com and looking for savings tabs on the Web site.

Mail Order

Many insurance companies have an option whereby a three-month supply of medication can be purchased for two months of co-pay (i.e., one month free). This service may be available through contracted suppliers such as CVS Caremark, Optum RX, or Express Scripts. It may also be available through local pharmacies with contracts with insurance companies. Information about these options can be obtained by calling the customer support number on the insurance card. Ninety-day supplies may also be available through newer services such as PillPack by Amazon or the Mark Cuban CostPlus Drug Company.

Local Pharmacies

Online sites, such as GoodRx.com, catalog potentially significant price variations between pharmacies for the same medication. Pricing information can be used to determine if different medication dosages are priced the same. For example, a 20 mg dosage may be the same price as a 10 mg dosage. In this situation, the 20 mg dose can be cut in half to get the 10 mg dose at a 50% cost savings. Local pharmacies may also offer price matching if you find a lower price elsewhere or offer discount incentives if you switch your prescription from a different pharmacy.

International Online Pharmacies

Many patients will find online advertisements for generic versions of branded products in other countries for drastically lower prices. Obtaining medications in this manner carries a risk of fake drugs or quality issues with the products. In addition, there is a financial risk of embedded viruses that can steal your financial identity. Never do business with any international pharmacy that sells controlled substances to minimize these risks. Offers like this are a red flag for fraud and criminal intent. Instead, look for quality certifications from organizations that set strict safety protocols for online pharmacies—the Canadian International Pharmacy Association (CIPA) is one example. Also, search for identity theft guarantee protection from services such as Norton Shopping Guarantee. Finally, use prepaid credit gift cards for payment and never give anyone your personal banking information.

Drug Specific

Many branded medications are generic molecules embedded in more exotic delivery systems, such as transdermal skin patches, extended-release oral systems, or injections. These delivery systems usually allow for less frequent dosings or lower side effect risks. One has to weigh whether the more expensive delivery system is worth the additional cost compared to a generic version. Some branded products may represent a combination of two generic products that can be prescribed separately to save costs.

Patient Variables

Patients must ask questions and advocate for themselves. Ask why each prescription is necessary to limit the number of different medications in use and reduce drug interactions, which will also save on cost. Also, question the plan and rationale for how long the prescription will be required. What are the criteria for termination of the medication? Taking medication a year longer than needed is a cost and safety issue. Keep a record of past drug trials to eliminate repeat treatment with failed medications. Ask family members if they had a successful response to a particular medicine. It is vital to exercise wise decision-making by not buying or using medication from others. Also, never use expired drugs and do not skip, reduce, or stop taking medications on your own. Even cost-effective medications are unsafe if misused.

There are many aspects of drug pricing that we cannot control. However, these strategies will help us manage the variables we can regulate. ✠

MICHAEL R. LYLES, M.D., is a board-certified psychiatrist and has a private practice with Lyles & Crawford Clinical Consulting in Roswell, Georgia.

« JEANNEANE MAXON, J.D., ESQ.

Suicide and Depression in Teens: A Therapist's Duty to Report

With nearly 20% of all high school students reporting serious thoughts of suicide, and 9% carrying out a suicide attempt,[1] any therapist who works with teens and young adults will inevitably confront this issue. In 2020, suicide was the second leading cause of death for people ages 10-14 and 25-34.[2] "Duty to warn" laws, which are in place in all but four (4) of the fifty (50) states, typically apply both to patients who pose a danger to others and *themselves*.[3] These laws vary state by state. Such laws are either "mandatory," meaning the therapist *must* warn or face legal/professional consequences, or "permissive," meaning the therapist is permitted to exercise their discretion without fear of legal or professional consequences imposed by the state. However, therapists could still be subject to civil lawsuits unless the state specifically provides immunity from civil actions. These laws are created by statute, case law, and/or state codes of ethics under state licensing boards.[4] To locate the specific duty-to-warn law imposed by your state, visit https://www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx.

Both the code of ethics for the American Counseling Association (ACA) and the American Association of Christian Counselors (AACC) have provisions that either mandate or allow counselors to disclose information to protect a client/patient from self-harm.

The ACA's code states:

B.2.a. Serious and Foreseeable Harm and Legal Requirements. "The general requirement that counselors keep information confidential *does not apply* when disclosure is required to *protect clients or identified others from serious and foreseeable harm* or when legal requirements demand that confidential information must be revealed. Counselors

While mental health professionals may adopt any multitude of criteria available, a standard evaluation tool focuses on four main areas: 1) Ideation, 2) Plan, 3) Behavior, and 4) Intent.

consult with other professionals when in doubt as to the validity of an exception. Additional considerations apply when addressing end-of-life issues."[5]

The AACC's code states:
1-430-a: The Duty to Protect Others. "The duty to take protective action is triggered when the counselor: (1) has reasonable suspicion, as specified in state and/or federal statute, that a minor child (under 18 years), elder person (65 years and older), or dependent adult (regardless of age) has been harmed by the client or has been perpetrated upon the client; or (2) *has direct client admissions of serious and imminent suicidal threats [or serious bodily harm]*; or (3) has direct client admissions of harmful acts or threatened action that is serious, imminent, and attainable against a clearly identified third person or group of persons."[6]

Tragically, it can be assumed that most people who commit suicide would make a different decision if given a second chance. An article published by the American Psychological Association (APA) reported that "… more than 3,000 people have leapt to their death from San Francisco's Golden Gate Bridge, but out of the 26 people who survived the jump, *all 26* reported that *the moment they leapt* from the bridge, *they regretted their action and wanted to LIVE*."[7]

The criteria by which a therapist makes a determination of danger of serious/deadly self-harm was first recognized by a 1976 case arising out of California, *Tarasoff v. Regents of the University of California*. In *Tarasoff*, a psychologist was treating a patient suffering from severe and acute paranoid schizophrenia. The patient confessed to the psychologist that he intended to kill his former girlfriend, Tatiana Tarasoff. The patient was civilly committed only for a short time and then subsequently carried out his plans and murdered Ms. Tarasoff. The court noted that the psychologist may have taken several actions to satisfy his duty to warn, including: notifying the police and informing the intended victim or the victim's parents. In the case of suicidal ideation, similar steps may include notifying law enforcement, notifying a minor patient's parents, or employing a longer civil commitment with longer-term plans for additional therapy and monitoring. When the patient is a minor, the therapist should almost always notify the parents unless it would harm the patient to do so.

While mental health professionals may adopt any multitude of criteria available, a standard evaluation tool focuses on four main areas: 1) Ideation, 2) Plan, 3) Behavior, and 4) Intent.

"Ideation" focuses on the frequency, intensity, and duration of suicidal thoughts. A sample question may be: *How often have you had these thoughts over the last 48 hours?*

"Plan" focuses on the timing, location, lethality, and availability/means. A sample question may be: *How would you kill yourself, when, and where?*

"Behavior" focuses on past attempts, aborted attempts, and rehearsals. A sample question may be: *Have you rehearsed a suicide attempt or done anything to hurt yourself, such as cutting?*

"Intent" focuses on the likelihood that the plan will be lethal if carried out. A sample question may be: *What do you think will happen if you carry out your plan?*

Once responses to these four areas are complete, a therapist should combine their analysis along with: 1) factors that make the patient more at risk for suicide (e.g., trauma, history of mental illness) and 2) "protective factors" that help buffer patients from suicidal behaviors (e.g., supportive family or friends, religious beliefs discouraging suicide) to create an overall risk assessment (High, Medium, Low).[8]

Many state departments of health offer risk assessment guides and tools. One good example is Minnesota's Suicidal Ideation Risk Assessment, which is available at https://www.health.state.mn.us/people/syringe/suicide.pdf.

Regardless of the tool or method used, it is critical that the therapist thoroughly document their assessment and recommendations. While the most common lawsuits against psychiatrists involve failure to prevent suicide, a psychiatrist's risk of being sued for malpractice is very low. Even when sued, clinicians win up to 80% of cases.[9] Courts will often defer to the expertise of the professional rather than attempting to become experts themselves. However, this only happens if the therapist can prove that they engaged in a proper suicide assessment and took appropriate action corresponding to that assessment.

Taking the duty to warn seriously in cases of teens or young adults may help save thousands of lives—lives created in the image of our God (Genesis 1:27). ✠

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.

JEANNEANE MAXON, J.D., ESQ., has 11 years of executive level, non-profit leadership. She is an attorney and nationally-recognized speaker. Jeanneane formerly served as the Vice President of External Affairs and Corporate Counsel for Americans United for Life and as the General Counsel of Care Net. She has a Bachelor of Science in Political Science and History from Westminster College, graduating summa cum laude, and a law degree from Boston University School of Law, graduating cum laude.

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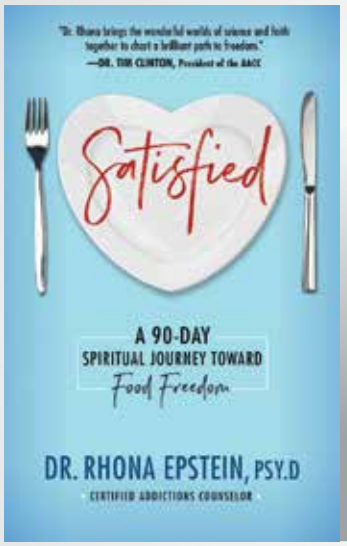

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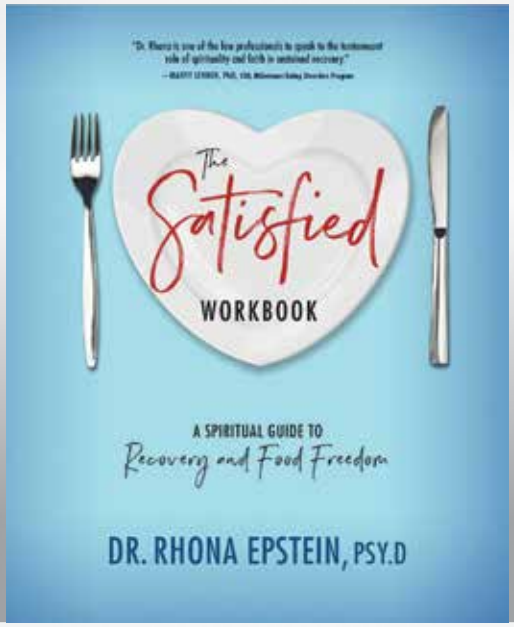

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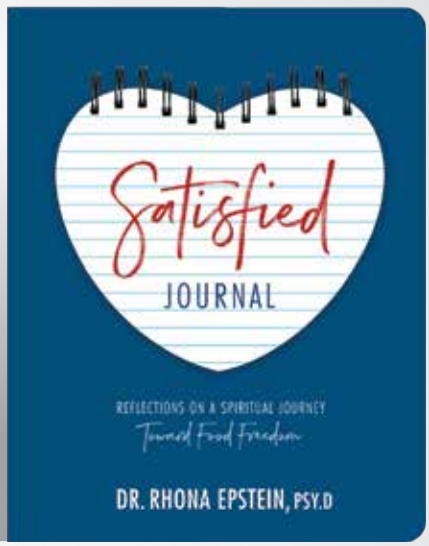

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« GREGORY L. JANTZ, PH.D.

Type E Leadership

"Rejoice with those who rejoice, and weep with those who weep."

– Romans 12:15, NKJV

According to the World Health Organization (WHO):[1]

- "Globally, one in seven 10-19-year-olds experiences a mental disorder, accounting for 13% of the global burden of disease in this age group."
- "Depression, anxiety, and behavioral disorders are among the leading causes of illness and disability among adolescents."
- "Suicide is the fourth leading cause of death among 15-19 year-olds."
- "The consequences of failing to address adolescent mental health conditions extend to adulthood, impairing both physical and mental health and limiting opportunities to lead fulfilling lives as adults."

According to the Substance Abuse and Mental Health Services Administration (SAMHSA):[2]

- "One in three (30.6%) young adults between the ages of 18 and 25 experienced a mental, behavioral, or emotional health issue in the past year."

The past two years have been difficult for teens and young adults. But, then again, can't it be said the past two years have been difficult for *everyone*?

What about other adults? Or other school-aged children? What about the difficulties for companies? Or workers? How hard has it been for medical professionals? For mental health professionals? Hasn't it been tough for *everyone*? Hasn't it been tough for *me*?

When suffering becomes competitive, such insidious comparisons can erode the capacity for empathy. I have found there is a human tendency, myself included, to view the struggles of others from the lens of our own experiences. Even with suffering, we can sometimes engage in a bizarre ritual of "adversity one-upmanship." When we play the "when I was your age" game, we rarely compare the hardship of others, especially those younger, as severe as our own—as if the intensity of difficulty another person faces somehow diminishes what we have experienced.

I encourage you, therefore, to examine your feelings when you read stories or see statistics about the deterioration of mental health among today's teenagers and young adults. Does the empathy you feel center around the "global" problem? How does your compassion engage when a key staff member is absent because of family issues with a troubled teen? Or your hiring manager has brought on three young adults, none of whom have worked out, resulting in lost time and productivity?

Competitively comparing what this generation is going through is one way to convey the impression that what they are experiencing "isn't as bad as it seems," and they need to "get over it and move on." After all, you have faced difficulty in your own life, and you got over it—and, frankly, you need them to do so, too. You have an organization to staff and run—right? I recognize no one wants to think this way; who would? The question isn't if you *want* to think this way but, instead, if you *have* or *do*. Empathy does not need to be your "default" setting to be utilized. For some leaders, empathy must be learned.

If you look over a list of leadership traits, they can be quite impressive: empowered, focused, self-controlled, strategic, pro-active, innovative, decisive, etc. Leaders tend to be Type A personalities, who are said to be driven, ambitious, organized, and competitive. I ask you to recognize the possibility that the very traits that make you such an effective leader may also hinder your capacity to be empathetic—toward teens and young adults today or someone else tomorrow.

Where do you learn to be empathetic if empathy is not a large part of your innate personality? The answer is the same place you go to learn about true leadership—the Scriptures. Romans 12:15 says, *"Rejoice with those who rejoice, and weep with those who weep."* This verse says to feel what the other person feels. Empathy is the ability to understand and share the feelings of others. This verse talks about rejoicing and weeping. I appreciate the opposite nature of the examples given. How difficult is it for you to truly rejoice with others… does that competitive streak interfere with feeling good about another person's positive outcome? Or, how hard is it for you to open yourself up to experience the depth of another person's grief?

As the workforce of today and tomorrow, when this needed demographic of teens and young adults is struggling, there will be an impact on your organization, no matter the size, and on you as a leader. This mental health crisis has a multitude of causes and is not going to dissipate overnight. Leaders are needed to contribute informed solutions. However, to contribute informed solutions, leaders must seek to include empathy in their organizational toolboxes to understand not just the financial or business impacts but also the emotional ones. Professional and personal impacts are foundationally interconnected.

Leaders set the tone for their entire organizations—organizations made up of a myriad of individuals who, in turn, interact with countless others in their professional and personal lives. Even if you do not directly interact with teenagers or many young adults, your organization does, and so do the people in your organization. The well-being of the next generation needs to be the concern of *everyone*. You may identify more with a Type A personality. If so, I urge you to develop your empathy skills and become a Type E leader.

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).

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« FERNANDO GARZON, PSY.D.

Exploring Teen Suicide, ADHD, and Young Adult Sexual Coercion

In this edition of Research Digest, we examine research focused on two challenges of adolescence—suicide risk and ADHD. We also consider the relationship between Internet pornography, gendered attitudes, and sexual coercion in young adults.

Teen Suicide

Runkle, J.R., Harden, S., Hart, L., Moreno, C., Michael, K., & Sugg, M.M. (2022, April 14). Socioenvironmental drivers of adolescent suicide in the United States: A scoping review. *Journal of Rural Mental Health.*

What social and environmental factors increase the risk of suicide in adolescents? Runkle and colleagues explored this question and considered geographic differences (urban vs. rural) through a careful examination of the current literature (a scoping review). They identified 143 studies from 2010 to 2019 meeting their review criteria and found numerous essential factors related to suicide rates.

Urban and rural areas demonstrated similar rates of suicide, and several factors had a prominent influence on both. Hopelessness was a key factor but particularly impacted ethnic and sexual minority populations. Low family support, decreased peer support, bullying, high-crime neighborhoods, and low socioeconomic status also increased suicide risk. Also, untreated traumatic experiences, along with undiagnosed mood disorders, substance abuse conditions, sleep disorders, and eating disorders, appear to be influential contributing factors to rates of suicide.

Based on these findings, the authors advocated for increased school-based screening for psychological disorders, especially around times of transition to new schools (e.g., elementary to middle school). They recommended longitudinal studies to synthesize the influence of the multiple identified factors in a more causal fashion. Buffering factors, such as religious involvement, merit a careful separate literature review. The findings highlight the various influences that can increase suicide risk and the vital role mental health professionals and school counselors can have in identifying students most at risk for this tragic outcome.

Adolescent ADHD

Sibley, M.H., Coxe, S.J., Zulauf-McCurdy, C., & Zhao, X. (2022). Mediators of psychosocial treatment for adolescent ADHD. *Journal of Consulting and Clinical Psychology, 90*(7), 545-558.

Therapists have access to various research-supported behavioral therapies for adolescent attention-deficit/hyperactivity disorder (ADHD) that usually involve a combination of individual work with the teenager and some sessions with the parent. However, little research has considered the mediators of positive outcomes engaged in these approaches. This is largely due to the low sample sizes involved in randomized control group studies (RCTs) utilized to assess treatment for its effectiveness. Sibley and

Based on their findings, the authors surmised that therapy approaches incorporating individual sessions with teenagers and separate sessions with parents produce better general outcomes than other models.

colleagues applied Integrative Data Analysis to combine data from four RCTs (N = 854) that evaluated client outcomes at pre-treatment, post-treatment, and several months follow-up (averaging about six months). The total sample had a diverse cultural population (13.5% African-American, 77.2% Latino(a), and 9.3% other ethnicities).

Based on their findings, the authors surmised that therapy approaches incorporating individual sessions with teenagers and separate sessions with parents produce better general outcomes than other models. This is not surprising given the increased level of client and parent attention involved in such approaches. However, the researchers note that group therapy may reduce the diminishing of social skills that sometimes occurs in ADHD.

Their other findings were more intriguing. Time management skills training demonstrated the most robust mediating influence on the outcome of ADHD treatment. Training involving both the parent(s) and adolescent focused on parent-teen communication skills to resolve their conflicts and proved to be another pivotal mediator impacting therapy outcome. The investigators encouraged the replication of their method with a broader range of adolescent therapy models. For Christian therapists, it is useful to recognize the components of behavioral treatment that appear to produce the most optimal results: training teenagers in time management skills, working to resolve parent-teen conflicts through communication skills training involving both parties individually, and considering group therapy for social challenges.

Young Adult Sexual Coercion

Bernstein, S., Warburton, W., Bussey, K., & Sweller, N. (2022, February 24). Pressure, preoccupation, and porn: The relationship between Internet pornography, gendered attitudes, and sexual coercion in young adults. *Psychology of Popular Media.*

Internet pornography usage is becoming the norm among young adults. It frequently portrays coercive, degrading, and violent acts by men against women and promotes women's objectification. Bernstein and associates wanted to examine the relationship between problematic viewing of this material in young men and women (17-25-years-of-age) and the presence of sexually aggressive attitudes and degrading beliefs toward women. To examine this issue, the researchers surveyed 385 young adults (70% women and 30% men) at an Australian public university.

Watching pornography started early in the sample for both sexes. Twenty-eight percent of men and 24% of women were exposed to pornography between the ages of 9-11, with one-third of the remaining women and over half the remaining men viewing pornography by age 14.

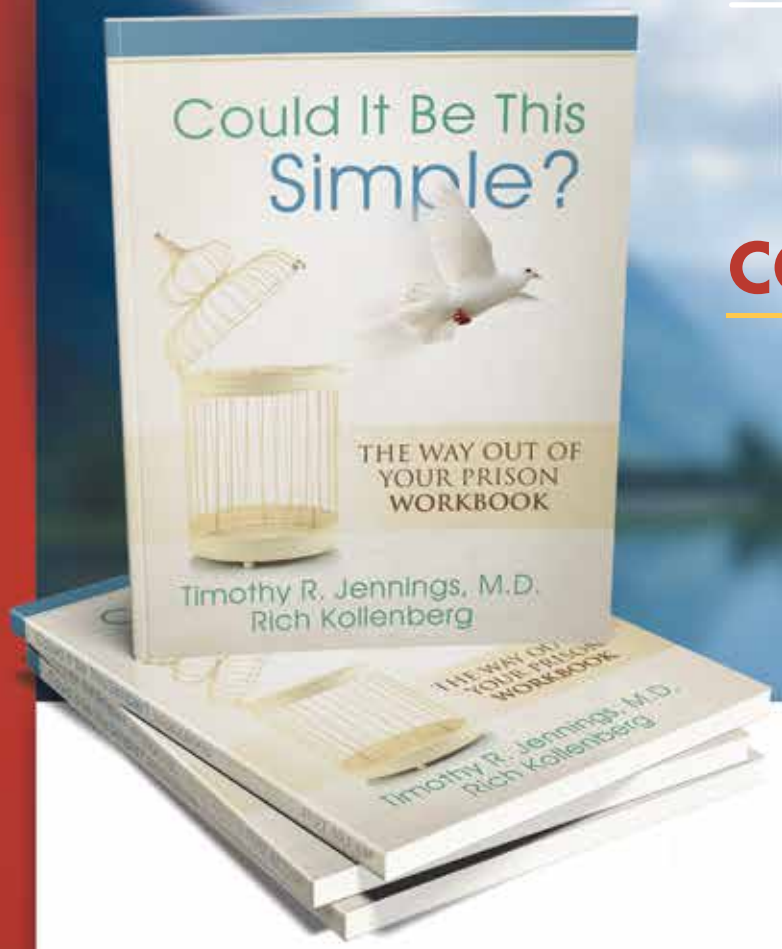
Early age exposure for both sexes has been linked to high-risk sexual practices. While males viewed pornography more frequently than women, surprisingly, no significant difference in the prevalence of harmful beliefs toward women existed between the men and women in this study. Besides potential sampling issues, the investigators noted the nature of today's pornography itself could be influencing young women even with less exposure than men. In addition, the authors suggested that regular Internet pornography viewing may be becoming normal behavior rather than the exception among young adults.

The seriousness of the results, in combination with findings from other recent studies, lead the authors to advocate for preventive programs to educate youth on the differences between sensationalistic pornographic content and healthy interpersonal and dating interactions between the sexes. "Community education around sexual consent, female sexual agency and respectful sexual interactions" (p. 9) are essential. Christian therapists would add a pornography abstinence component to the investigators' recommendations. Assessing a client's pornography usage level and its impact on their perceptions toward women, sexual behavior, and male-female relationships appear crucial.

Conclusion

The challenges of suicide, ADHD treatment, and Internet pornography facing adolescents and young adults are evident in the previously mentioned studies. Yet, our God is a big God! As we seek His face and excellent training, He can lead us in the best ways to treat these clients. ✠

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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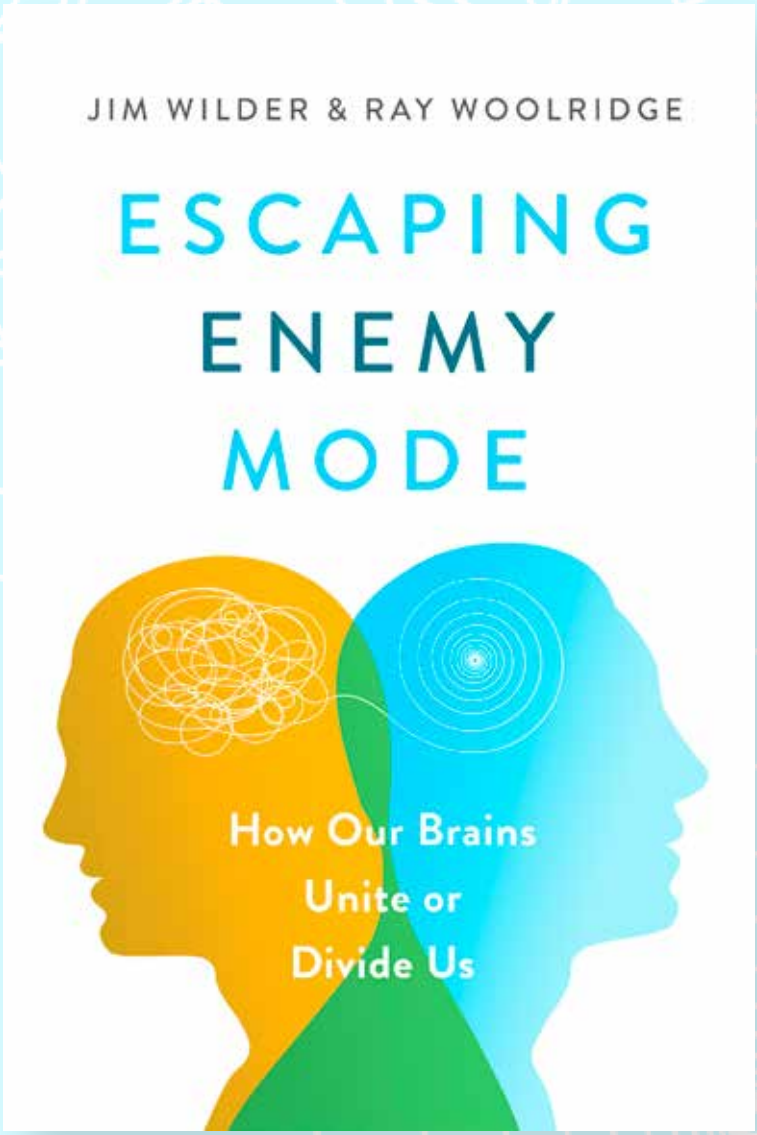

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Hurt 2.0: Today's Teens and Mental Illness – Chap Clark

1. "Mosaics" as described by George Barna
O a. exhibit a non-linear style of thinking
O b. are comfortable living with contradictions
O c. are comfortable with not driving an issue to resolution
O d. all of the above

Do Not Hinder the Little Ones – Diane Langberg

2. Langberg notes that _____ is absent in our ideas of what kingdom represents
O a. character
O b. history
O c. truth
O d. humility

Exploring Teen Suicide, ADHD, and Young Adult… – Fernando Garzon

3. Which of the following is true regarding sexual behaviors in young adults?
O a. harmful beliefs toward women were significantly higher in men
O b. early exposure to porn for both sexes is linked to high-risk sexual practices
O c. Internet porn use is not the norm among most young adults
O d. it takes more exposure to porn for it to influence young women

Sexual Activity and the Molding of the Adolescent Brain – Joe McIlhaney, Jr.

4. Research suggests that the unprecedented increases in gender dysphoria
O a. are due to hormones that end up in our food
O b. are caused by non-biological influences and social media
O c. are not significantly impacted by social media
O d. are the result of inborn biological traits

Teen Brains and Substance Abuse – Karl Benzio

5. Which of the following is NOT a finding of the NCDAS
O a. 50% of teenagers have abused a drug at least once
O b. 11.2% of deaths in 15-24-year-olds occur from overdose
O c. 21.3% of 8th graders have taken illegal drugs at least once
O d. By 12th grade, 79% of teens have abused alcohol

The Dark Side: Teen Depression and Suicide – Jennifer Cisney Ellers and Emma Benoit

6. A diagnosis of alcohol misuse or dependence is associated with
O a. a suicide risk that is 10 times greater than in the general population
O b. more social isolation and time spent on smartphone use
O c. rejection of family values and rebellious attitudes toward parents
O d. bullying behavior and antisocial attitudes toward others

The Impact of Social Media on Teenagers – Sissy Goff

7. The brains of teens who watch TikTok
O a. develop a tendency toward anxiety and depression
O b. are more prone to OCD and compulsive behaviors
O c. are twice as likely to move them toward self-harm
O d. have scans that light up the same as those with addictions

Transgenderism, Science, and Kids: What Every Parent… – Meg Meeker

8. Besides the moral and theological teaching against transitioning kids
O a. parents can pressure schools to stop mandating teachers to talk to children about transgenderism
O b. Christians can use science to back up beliefs and strengthen arguments
O c. many clinicians argue that there are no objective parameters in the transgender diagnosis
O d. all of the above

Type E Leadership – Gregory L. Jantz

9. The very traits that make an effective leader may also hinder
O a. the capacity to be empathetic
O b. the discipline to set boundaries
O c. the desire to help those in need
O d. the ability to prioritize family

Why Families of Kids with Common Mental Health… – Stephen Grcevich

10. Children with abnormal sensory processing become distressed by
O a. ambient noise levels and numerous simultaneous conversations
O b. physical proximity that causes bumping and touching
O c. bright lights and loud music
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LEARNING OBJECTIVES

Participants will:
1. Increase awareness and content expertise on current trends in mental health practice.
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.

PARTICIPANT EVALUATION

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.

The American Association of Christian Counselors (AACC) offers some therapists and counselors Continuing Education (CE) credit due to good standing with a limited number of professional organizations.

- *The training offered through AACC sponsored conferences and training programs meets the ongoing CE requirements for counselors, life coaches, mental health coaches, and crisis responders who are credentialed through the International Board of Christian Care (IBCC) or one of its affiliate boards: the Board of Christian Professional and Pastoral Counseling (BCPPC); the Board of Christian Life Coaching (BCLC); the Board of Mental Coaching (BMHC); and the Board of Christian Crisis and Trauma Response (BCCTR).*

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