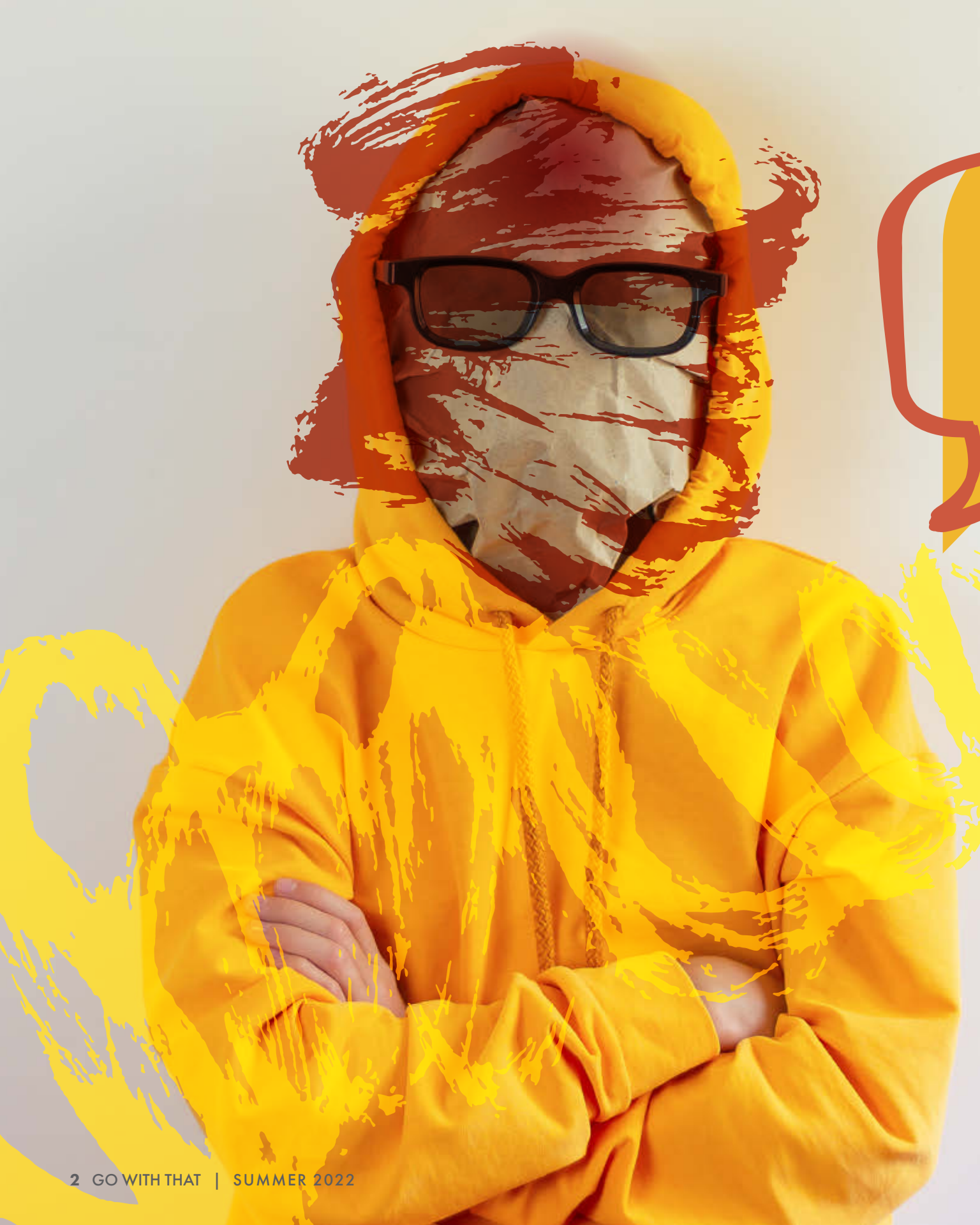


I don't want to be here.

EMDR Therapy for Challenging Teenagers

By Annie Monaco, LCSW-R RPT and Nicole E. Wolasz, LCSW-R

Most therapists agree that teenagers can be among the most challenging clients we see in our therapy practice, and to have a positive treatment outcome, we need engagement and retention. Many teen clients are not interested in connecting to a strange adult, let alone doing something even stranger like EMDR. This population may refuse to attend sessions, give short answers when they do attend, swear at parents and therapists, and storm out of the room when they hear things they don't like.

"I don't want to be here. This counseling is stupid. I am bored. What time is this over? You can't make me talk. This is my life, and you can't tell me what to do," are typical statements heard in the therapy room. Even the most seasoned therapists may struggle with how to engage a client that does not want to be in therapy.

Developmentally, as teenagers begin to assert their independence and find their identity, they can be challenging to parents. A troubled teen who has experienced adversity may present even more challenges and might exhibit risky behaviors, such as the use of substances, violence, self-harm, and criminal acts. They may be skipping and failing school and could be the victims or aggressors of bullying and cyberbullying as well as having an intense and unhealthy connection to social media. In addition, they may exhibit symptoms of mental health problems, such as depression, anxiety, or eating disorders.

"He refuses to go to school. He walks out of the house, and we don't know where he is all night long. She stays in her room all day. What happened to my loving child who now claims to hate me?" These are common concerns that parents might express to therapists during counseling sessions.

Building effective therapeutic alliances with these youth can seem daunting to even the most experienced counselor. As directors of a teenager offender program in an

outpatient setting at a mental health agency for more than 10 years, we provided intensive family therapy treatment (under the Functional Family Therapy model), EMDR for all family members as needed, and restorative justice programs, such as victim offender meditation and restorative circles. We came to passionately enjoy the resistant teenagers, who put their feet on the coffee table, crossed their arms, pulled their hoods over their eyes, and pretended to go to sleep. We learned to engage them, and their caregivers, to deliver successful EMDR therapy that helped teens function at home, in school, and in the community.

If you can float back to when you were a teen.... it's a time of pushing limits, finding your way, and having a sense of power and control. Between dealing with the changes in the teen body and the social pressures put on adolescents by their classmates and society, the teen years can be a difficult and confusing time of life. Teenagers are in the developmental stage of constant transformation—whether it be physical (growth, sexual development), cognitive (formal operations), moral (values and spirituality), or identity (self-image and self-esteem) development (Eyrich-Garg, 2008). As a result, teens often require a balance between both structure and freedom and dependence and independence in counseling (Veach & Gladding, 2007). We know that brains are not fully developed until the age of 25 years old, and teens can change tremendously during these years in both positive and negative ways. The front part of the brain, called the prefrontal cortex, is one of the last brain regions to mature. This area is responsible for skills like planning, prioritizing, and controlling impulses. Because these skills are still developing, teens are more likely to engage in risky behaviors without considering the potential results of their decisions. This can be very challenging for parents to navigate.

Engaging teens towards change and healing often involves instilling hope and motivation, understanding what is important to the teen, exploring core issues, and involving parents and caregivers in the process. While all phases of EMDR are employed in working with teens, this article will focus on critical pieces needed for Phases 1, 2, and 4 of EMDR therapy, which are the foundation of effective trauma therapy for this age group. History taking, preparing, and engaging the family system will set the stage for good trauma processing.

Engaging the Resistant Teen

Resistance is the language of teens. You must decipher it. Here are common feelings among this population:

- We hate our lives, and we don't feel good enough.
- We may not have people in our lives who believe in us.
- We certainly hate school, and we may struggle to learn like others.
- We are not connecting with our parents, yet we are connecting with friends (that make us feel good in the moment), who don't always encourage us to do the right thing.
- We can't see a future. Doing drugs, drinking alcohol, stealing, vandalism, and violence become part of daily life as these activities are a good way to distract from the emotional pain.
- You (the therapist) look like a probation officer, caseworker, or the last therapist who told me to "be nice to my parents" and "cut this bad behavior out" or "I will end up in a juvenile residential center or worse, prison." It is just way too hard to trust you and give you a chance.
- We don't think we are good enough or have what it takes to have a good, happy, and prosperous life. You will figure it out soon enough too that family members or community supports to assist with stabilizing the family and working towards increasing strengths and communication.

Engaging teens towards change and healing often involves instilling hope and motivation, understanding what is important to the teen, exploring core issues, and involving parents and caregivers in the process.

PHASE 1: HISTORY TAKING AND TREATMENT PLAN

Phase 1 focuses on engaging resistant teens, assessing their risky behaviors, and determining their level of dissociative strategies. Taking an attachment history of not only teenagers but of the caregivers as well provides you with an understanding of how and why certain parenting techniques are being utilized. It is crucial to connect to caregivers and reframe their anger towards their child, so they can be a support to the teen throughout all the phases of EMDR. We encourage therapists to also identify extended

Some Tips for Therapists

- Have fidgety gadgets for teens to become interested in playing with
- Have available drawing materials, painting supplies, clay, and mandalas
- Acknowledge that this is not ideal to be at counseling, and you, too think this sucks for them
- Acknowledge that you are a stranger and not here to force them to talk and tell you things
- Acknowledge their perspective. It's helpful to acknowledge how they see things and how strongly they are feeling about this. Talk about the pain of school, friends, and home life not being what they want. Do not start problem-solving too early in the treatment.
- Don't discuss future effects of risky behavior. Hearing about risky behavior can be very hard for therapists. In the early sessions, do not talk about the long-term effects of their behaviors, such as failing, residential, jail, prison.
- Engage caregivers. Involving caregivers (parents, extended family, school

we are not worth fighting for. We will do everything to push you away and then you will give up on us like everyone else.

Until you engage resistant teens, you cannot move forward with processing traumatic events. The therapist's role is to engage them and help them feel safe in the office to work on the past.

Nicole's Case Example

A 14-year-old teenage boy, who was violent at home, had engaged in sexual offending behavior towards his sibling, depicting violent images in his drawings, and had a strong preoccupation with guns and death. He was disrespectful to all his family members and came into therapy very guarded. "I'm not the problem. How much longer do we have?" were typical statements throughout the first four months of therapy. Having a good snack available at the start of each session helped relax this client. I found that he was masterful in distracting, and providing some options and structure to the session (snack, board game, and drawing) came to be the perfect fit for him. He started to look forward to our sessions, telling me that it was the only time he felt that he was heard. We began to explore dissociated parts of self, and he identified several hostile and agressive parts were coming out in violent drawings. It was evident that these self-states needed their deep wounds to be heard and understood. Resourcing helped to strengthen the idea that "I can do this" when he was hesitant in moving forward with EMDR processing. He identified a time that he felt strong and capable, and mom was able to tap that in for him in an attachment related resourcing experience. This teenager began to identify that his core negative beliefs of self, ("I am different. I am disgusting. There is something wrong with me.") were linked with his early childhood wounds. Moving into phase 4, allowed us to desensitize his early traumatic wounds and the rage that was part of his victimization. Desensiziting and reprocessing his early experiences freed him of his anger and negative beliefs.

This teen was stuck in feeling that he should have done something when it came to his own abuse. As the work continued, he was able to identify that it "wasn't my fault" and that he couldn't have changed things. Good interwearves around having no control as a young child were also helpful. Over time, this client became much more connected to his family, and he became a high achiever in school. An empathetic part of him also emerged following reprocessing, which then improved relationships with family members.

Key Lessons

Slow and steady with teens has to be a strong skill among therapists. Allowing teens to have a sense of control in session is also critical as well as understanding what is important to the client since this can help to move the teen towards doing the work. Identify parts of self to help the teen understand themselves and support the most wounded part receive trauma therapy.

ENGAGING THE RESISTANT PARENTS

Many parents are frightened and worried about their child's behavior and use repetitive ineffective communication techniques, such as yelling, nagging, and threatening. Here are some examples and some possible messages behind the parent's statement.

"If he doesn't get his act together, I am sending him away." (Caregivers' anger can imply fear that their children's choices will harm their future, and they may even end up dead. Caregivers feel helpless and inadequate, and possibly a residential center might keep their children alive.)

"Every day I ask him to do his homework." (Nagging equals the caregiver's feeling about the importance of the future and worrying that the teen will not graduate and end up struggling later in life.)

"He goes out with his friends until all hours of the night; we never see him." (The emotional pain of being disconnected from the child and fear of the teen's behaviors interfere with the caregiver's listening and understanding of the child.)

"Do you see the color of her hair? And the number of piercings? And now he wants to be called by a different name! How will she ever get a job?" (The caregiver is frightened by differences and worried about what this means and how the child might be treated in society.)

TREATING CHALLENGING PARENTS

Acknowledging caregivers' fears and worries (which is underneath their anger) and using relational interventions will improve the relational discord between teen and caregiver. Many therapists will only provide individual therapy to the teen and will not engage or provide collateral or family sessions with the challenging parents as they might feel overwhelmed in dealing with the parents' problem behaviors. The therapist might be upset by the caregiver's behavior toward the teen and feel hopeless that the caregiver can change. In addition, the therapist might feel worried that the teenager will not want to stay engaged if the caregiver is involved or has a relationship with the therapist. It is a difficult and delicate balance to work with the whole family.

Slow and steady with teens has to be a strong skill among the therapist. Allowing teens to have a sense of control in session is also critical as well as understanding what is important to the client since this can help to move the teen towards doing the work.

Annie's Case Example

A 15-year-old boy was encopretic daily and violent at home. He made suicidal statements, which prompted crisis services at the house weekly. In addition, he refused to go to school and was failing all subjects. For all therapy sessions, he didn't speak more than 10 words per session. He exhibited significant dissociative symptoms at any mention of his childhood. Prior to me, he had spent two years with a previous therapist and made no progress. In our therapy sessions, we used creative arts materials, including colored pencils, markers, and modeling clay as well as fidget toys, a yoga ball, and splat balls. He would nod yes or no if I asked about emotions, negative beliefs, and body sensations. Through drawings, he was able to do parts of self work and identify self-states (sabotage parts, wounded parts, etc.) that were interfering with his success. We used the yoga ball to bounce during desensitizing childhood memories (Phase 4), which helped him to stay grounded while we processed small bits of his past. He was able to tolerate about 10-15 minutes of processing traumatic material for each session.

In the beginning, I was meeting separately with mom and providing parenting therapy. After six months of treatment, I helped this teenage client to understand that his father needed to be part of the treatment, so they could repair his early attachment wounds. I began more intense work with both parents separately for four months to teach parenting, emotionally support their son, and preparation to partake in phase 4 sessions to repair past traumas and attachment wounds. His father's first words when he met me were, "I don't believe in therapy." I told him that "he was one of the most important people in his son's life, and he would need to heal his son." In separate trauma processing sessions, each parent sat with the son and engaged in family-style EMDR trauma processing during the toilet training years (verbal arguments, eventual separation and divorce) to gain success around his encopresis. After his trauma processing sessions with both parents, his encopresis and violence diminished. He has been successful in returning back to school and passing classes.

Key Lessons

It was challenging that he did not speak in sessions (he still doesn't!), but finding creative ways to communicate was key. Engaging his challenging parents in the therapeutic process was vital for him resolving the attachment wounds that his body was holding on to.

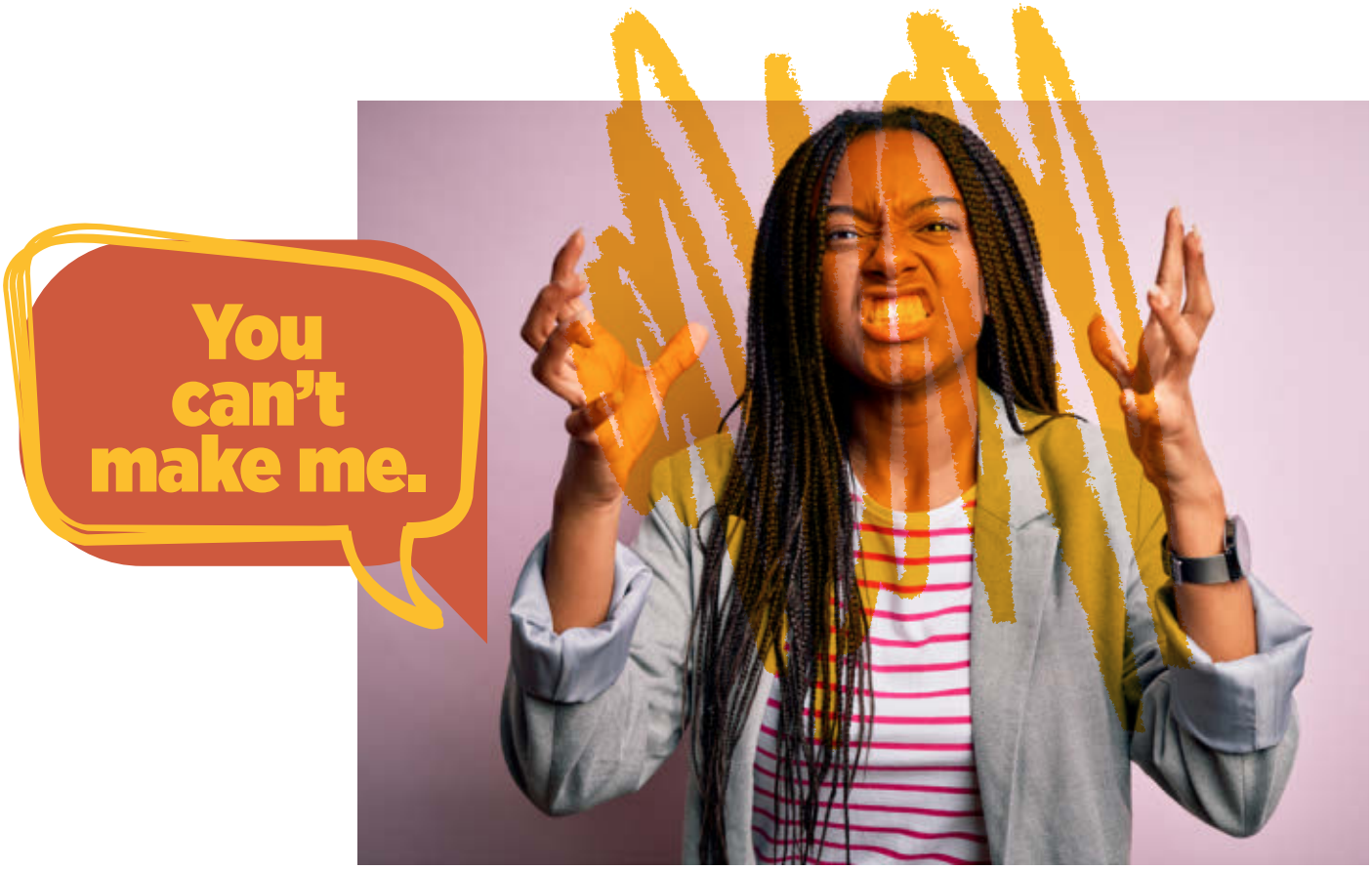
THE NECESSARY USE OF PARENTAL REFRAMES

The child's problems and symptomatic behaviors may be the initial causes of concern; nevertheless, these are only one manifestation of discord and tension in a dysfunctional family system. The chronic blaming behaviors have significantly affected communication and cohesiveness within the family.

The goal is to use reframes to help change the family's view of the problem, and shift how the family communicates by working with all family members to search for alternative behavioral, cognitive, and affective responses.

"Mom, when you nag, you just are trying to make sure your son is successful with school and his future. However, the way that you are communicating this to him, unfortunately, is only pushing him away."

"You are so worried about him and his future. When he does risky behavior and you use punitive punishment, it causes more problems between you two."



Annie's Case Example

An adopted mom of three children had a 13-year-old son, who was engaging in risky behavior of stealing, and not coming home after school. The mom's strategies were to shave his hair, make him sleep on the couch, and give physical punishment. These parenting strategies only further strained their relationship.

There were many conversations of acknowledging her fears and worries about his future and that he would end up arrested and in jail like his birth father. She was using these parenting tactics as a fear response.

"Mom, I know how much you are worried about him, worried he will do something stupid and ruin the rest of his life. I too am worried. You are using punishments that make him mad and unfortunately do not result in any better behavior. I know I can help you (instill hope). Let's try some different approaches that will make you two closer." I said this statement about five different ways in the session, and she wouldn't back down. I started laughing and said, "I am not backing down either!" She laughed and agreed to try a different approach. My request was to playfully hug him multiple times a day! I had her do it in the waiting room before she left, and the teen smiled and laughed and said, *"Were you two smoking weed in the office?"* The next week, she described playfully chasing him around the house and kissing and hugging him. She recognized that he loved it, and instantly there was a significant reduction in behavioral problems in school and at home. This allowed him to start to work on his attachment wounds of his biological parents.

We acknowledge that not all caregivers are capable of being involved and repairing attachment wounds. We encourage therapists to find other adults and support to be part of the treatment. It is not unusual for us to have extended family, neighbors, teachers, and/or caseworkers be part of our sessions.

ATTACHMENT HISTORY OF TEENS AND CAREGIVERS

Through history taking and questioning, the clinician begins to understand the connection between the parent and the child. The attachment relationship is considered critical in establishing a foundation children will use to interact with others and dictate how they feel about themselves. This can impact three key areas:

1. A child's sense of self,
2. A child's sense of others, and
3. the caregiver and the child. (Bowlby, 1958)

Assessment tools, such as the Parental Bonding Instrument, Family Experiences Scale, and creating a family diagram or genogram that tracks at least three generations, are

an excellent method for gathering this information (Bowen, 1980; McGoldrick, Gerson, & Shellenberger, 1999). Therapists need to inform parents that understanding their attachment history is important to knowing how they came to use certain parenting strategies. Taking an attachment history of parents is often overlooked as many therapists do not know how to broach this topic with parents. In the beginning, we meet with all parents separately to understand their backgrounds and how they were parented. This history and knowledge helps the therapist empathize with the problematic strategies and work to change how they communicate and parent within the home.

ATTACHMENT AND SOCIAL MEDIA

"With heads down and screens lit up, watching our teens plug in can feel confusing, disappointing and even like rejection to us." (D. Siegel, 2013). We find that securely and insecurely attached teenage clients seek connection and attachment using social media. To get ready to leave the home nest, adolescents seek out membership in groups of other adolescents not only to feel good, but to *survive*. And feeling connected to others doesn't just *seem* crucial to contemporary teenagers. In fact, our brains' very engrained genetic programming gives us a feeling that connection is a matter of life and death. Parents often feel confused, hurt, and rejected as the pull to peers strengthens. It is important to encourage understanding of this connection and the need for teens to find a balance between connection with peers and maintaining a connection with family.

PHASE 2: PREPARATION

This phase is about expanding the Window of Tolerance and finding soothing and grounding techniques that manage hyper and hypo aroused dissociation. In Phase 2, we are also establishing a safe place that works for teens. We are helping teens invest in their future by mapping out their true dreams and desires so that they are open to reprocessing their past, which is the obstacle to moving forward.

WOT

Staying in the optimal Window of Tolerance and understanding Soothing and Grounding tools/skills to manage hypo and hyperarousal may look different with teens. Options could include utilizing creative arts material such as painting and clay, or a yoga ball to bounce to stay present, playing upbeat music, eating snacks, watching Tik Tok, or throwing splat balls at the wall... all this to get teens in the optimal window of tolerance to move towards Phase 4.

Future Self

"A teen who feels hopeless about their future is unlikely to invest their time in therapy let alone do trauma therapy." (Greenwald, 2013). Asking teens to see into the future and envision how they see themselves in five to 10 years can be done using Future Self (Monaco, 2022) intervention. Dreaming about their future and identifying details on how to get to their goals gives hope to teens that they will not always be living in this situation, and they can live different lives. A teen who has future possibilities is more likely willing to improve or get better and to do trauma therapy.

PHASE 4

At this point in treatment, client, caregivers, and supports are engaged and informed of EMDR and clear expectations on how to support the teen during this time have been discussed. If the teens are hesitant, we recommend having a conversation about their future selves and how working through the past can help them get to their dreams. The therapist has tools to manage the teen's dissociation and small targets have been indentified to start. These are called "bee stings" or recent events or discreet memories. Both types of memories are non-family, low SUDS memories. This can help the client see how the process works and have success with a small memory.

Dreaming about their future and identifying details on how to get to their goals gives hope to teens that they will not always be living in this situation, and they can live a different life.

Safe Place

Nicole developed "the GOAT" (Greatest of All Time), which is a safe place for teens. It is a magical place where all of the best options are available to help relax and soothe the client. This can also be a place of fun and excitement that will house the resources that may have been installed. Drawing out the GOAT on paper, or a pillowcase or making this out of clay will help the client use it more consistently, especially during stressful times.

Annie's Case Example

A mom of a 17-year-old adopted boy asked for counseling services for her son, who was drinking, snorting substances, vandalizing property, and failing school. Mom and her son could not be in the office together without extensive yelling between the two. In separate sessions with mom, and through the use of reframes, I helped her understand that her nagging and yelling was indicative of her profound fear that her son would die (her husband had passed away right before the adoption) and how she so much wanted to give him a better life because of his orphanage experience. She didn't understand why her love for him was not enough, and I did extensive psychoeducation about trauma, dissociation, and the need for trauma therapy. After a few sessions, she started to communicate her concerns and fears to him, and their relationship improved so that we could have effective family therapy sessions.

The client was extremely resistant to therapy and was often not genuine in his responses. He would come in pretending to have different psychotic symptoms, and it became apparent that he was reading diagnostic manuals online. I also found out that he had created an online forum and posed as a therapist and provided diagnosis and treatment recommendations. I used this to my benefit to talk about how smart he was and how he was providing excellent advice, and we talked about how he could use these strategies with himself.

He had no interest in sharing experiences about the orphanage that he lived in until he was age nine. We did the "Future Self intervention." He was able to imagine 10 years into the future, and he was able to identify that he saw his final vision was him being with his girlfriend and getting their son onto a school bus on his first day of kindergarten. He burst into tears (I almost did, too!). By sharing his desire to have a typical and loving family, he understood that the past was the reason for his deep emotional pain and acting out behaviors. He agreed to do trauma work, and we worked through his early attachment wounds memories. After treatment with me, he went into a substance abuse residential center. A year later I received a long letter talking to me about how doing the future self-vision was the reason that he kept on living and working so hard to get better. His last statement in the letter, "My dream will come through."

In working with teens, it's important to be flexible and open. Not every session will go smoothly, but keeping things structured, consistent, and connected with core issues is the most helpful.

Nicole's Case Example

A 16-year-old boy was in therapy due to a referral from school. His behaviors included skipping/missing school, struggling to get along with teachers, being arrested once, and being suspected of drug use use. The client and father came into therapy for first session, and the dad immediately began to cry saying, "I'm not sure where things went wrong." Dad's tearfulness often led to the client to begin screaming. The client would yell, saying, "I just can't handle him, he makes it all about himself." Dad's anxiety and fear led to client being nagged constantly. When the client went out of the house, dad would follow him, call his friends, etc. This pushed client farther away from dad. Dad was encouraged to meet for education on trauma and attachment (biological mother was not involved due to her substance use). As a female therapist, I also considered my role in working with a young man who did not trust women. This was something that was discussed openly in session.

Reframing helped dad understand that his yelling was centered around the fear of losing his son (the only thing he truly cared about). Dad was able to acknowledge that he needed strategies to do things differently. Dad was open to a referral to work through his issues during his son's treatment.

Through reframing with dad, the client began to engage/connect with the therapist, understanding that he was not solely the issue. There was family work that also needed to be done for things to change/shift. While looking at the client's perspective and keeping trauma glasses on, the client slowly began to relax in the therapy space. His hyperarousal began to minimize. He was often grounded using scents and physical movement. He did not like to deep breathe but instead loved to stretch and do progressive muscle relaxation.

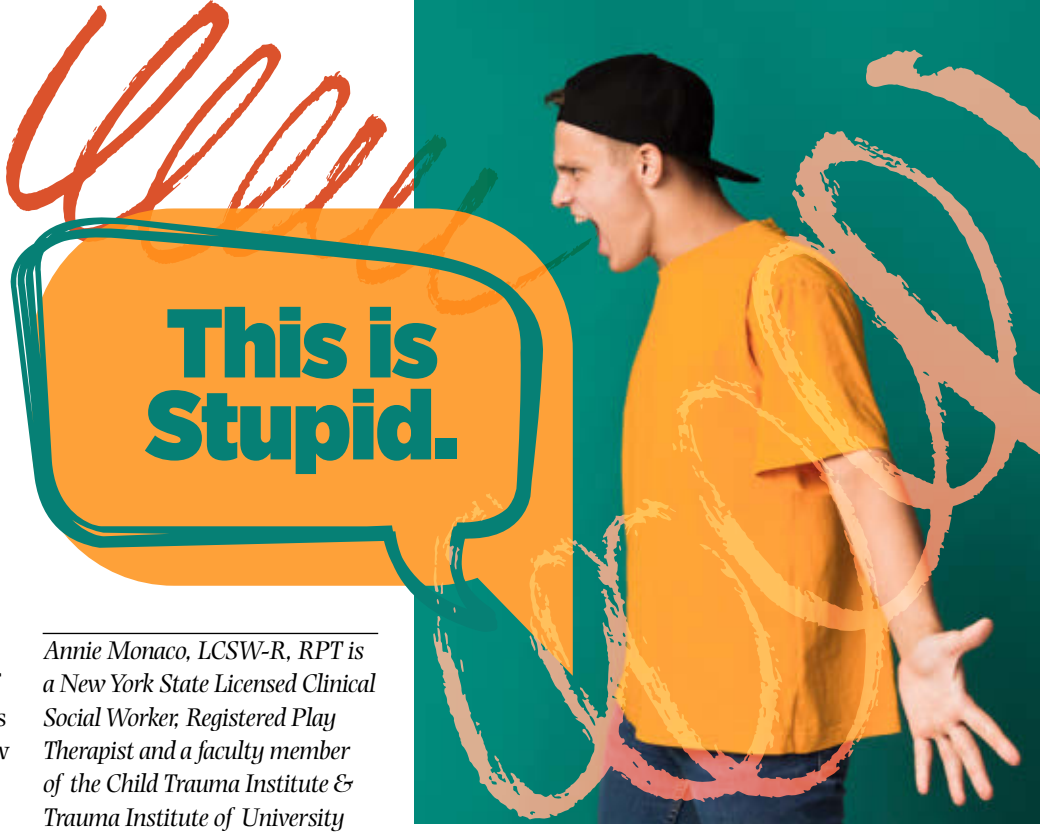
The client was able to identify the negative cognition of "I am not good enough" as a theme. This connected to mom not getting her life together,

the client not doing well in school, and getting into trouble with friends. He began to understand that his early childhood wounds of his mom leaving caused him to feel "less than." Work was done with dad in talking through examples of why his son *was* "good enough." These examples were used in EMDR processing as cognitive interweaves and resourcing experiences when the client was "stuck."

The GOAT for this client was a car repair shop. The client was in charge at this shop, surrounded by beautiful cars, rap music blasting, the sun shining, and a kitchen full of his favorite food. When installing this place, client's face relaxed, and a slow smile spread. The GOAT was talked about often throughout treatment.

In working with teens, it's important to be flexible and open. Not every session will go smoothly, but keeping things structured, consistent, and connected with core issues is the most helpful. This specific client went through highs and lows but never gave up. The therapeutic attachment relationship was helpful for this client to be able to do EMDR. Dad leaning into a place of support for his son during the process was also critical.

It can be overwhelming to work with challenging parents, and risky teens and do family therapy. High risk teens need to be seen weekly, and often we are providing separate collateral sessions with parents. Therapists need to have energy and have creative arts options to engage this population. A good sense of humor and thick skin is a must! The reward is facilating the attachment repair with their caregivers and watching them work hard towards their dreams. This is the population that seeks us out years later to say "thank you" when they enter their adult years.



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