CHAPTER 61

Reaching Treatment: An Overview of Mental Health Treatment

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Why This Matters

Many people have preconceived notions about mental health and therapy. Symptoms of mental health can make some people afraid because they view psychological symptoms as threatening or dangerous. Other people may see it as a form of weakness or may diminish emotional pain as "just a phase" or a way to "get attention." Finally, there are those who just find it uncomfortable to talk about and avoid these discussions. Societal stigma is perpetuated not only by movies, TV, and social media but also by the people we know. Stigma directed at adolescents with mental health problems can also come from family members, peers, and teachers. This can lead to distrust, avoidance, social exclusion, and loss of relationships. Furthermore, the internalized shame that can result creates a barrier for someone getting the treatment that they need and overall poorer treatment outcomes. (For a more thorough discussion of stigma, refer to Chapter 49, Helping Youth Overcome Shame and Stigma [and Doing Our Best to Not Be a Part of the Problem].)

Let youth know that getting therapy is not a lifelong commitment. The goal of therapy is to overcome emotional distress and develop enough skills that one no longer needs it.

It is no small act of bravery for an adolescent (or anyone, really) to admit that they need help. The key step in getting someone help is engaging them into treatment. You are best positioned to help this youth ease into this new and important relationship. You have already done the work of building trust, communicating your positive regard of the youth, and forming a therapeutic alliance as described throughout *Reaching Teens.* Your approach in this process can make critical differences toward the youth's willingness to seek help. It can also assist with the youth's overall attitude about professional support, which in turn influences their investment in the process and the likelihood of its success.

Talking With Teens About Therapy

How you introduce your recommendation for therapy plays a key role into whether the youth will actually get to that first appointment. Because no therapy works without a patient, you play the most critical role in setting the stage for change. But it can be tough to guide an adolescent to agree to seek professional guidance. When you are recommending therapy, an unspoken message the adolescent can hear is

1. "You think I'm crazy."
2. "You think I'm weak."
3. "You don't care [or want] to help me, so you are just passing it off to someone else."
4. "You don't get me at all."

When done effectively, a conversation and referral for mental health conveys

1. "I have heard and understood you."
2. "I take what you say seriously."

3. "I see you as a whole person—not just a set of diagnoses, symptoms, or problems."
4. "Your feelings are valid; however, this level of emotional discomfort is treatable."
5. "I am concerned and invested in connecting you to proper treatment because you deserve to feel better."
6. "I have hope for your future, in reducing these symptoms and in what you can accomplish with your unique strengths."

Take the time to get to know the youth and their current mental health symptoms, but at their pace. Use empathetic listening, allow for pauses for reflection, and ask questions for clarification, keeping in mind that the youth is the expert of their own experiences. If they are showing signs of distress, you may help them pause and remind them that as honored as you are they are sharing their experiences with you, your concern for their comfort and well-being outweighs the need for specific details. The next step is validation.

> You: *You have been through so many challenging situations. You are far from weak; you are a survivor. But you don't go through a war without sustaining some wounds; we are all human, after all. Some of these wounds sound very painful. And like all wounds, if they are deep enough, they don't just get better on their own. If they were going to pass by sheer willpower alone, I think they would have by now—your determination and survivor instincts would have figured out a way. This kind of depression, however, is not just a passing feeling. What do you think of that?*
>
> Youth: *I feel like I'm losing control. Everyone is acting like I'm some psycho b***h. I snapped out last night at my mom, and I don't even know why. Maybe I am crazy….*
>
> You: *You are not crazy or a psycho, but you have a medical condition that needs treatment. There are treatments out there; what are your thoughts about them?*

It will be important that the client feels understood and not judged. Many well-meaning people may have dismissed clients in the past—"You don't need therapy; just quit moping about the past—you have to move on" or "You're just lazy; that's why your grades are failing." Asking youth about their thoughts on treatment at this point will give you a chance to correct certain messages and assumptions that youth are carrying with them about mental health treatment. More on referral without shame or stigma can be found in Chapter 49.

Who Are Psychotherapists?

Psychotherapists can include psychiatrists (ie, MD, DO), psychologists (ie, PhD, PsyD), clinical social workers (ie, MSW, LCSW, LCISW), nurses (ie, APRN, MSN, CRNP), counselors (ie, LPC, MA, MS, MEd, LMFT, LCADAC), and pastoral counselors. No matter what the training or degree, it would be important to ensure that the professional you are referring to is licensed to do this type of clinical work. Many adult therapists are also equipped to work with adolescents, but certain therapists have completed specialized training to work with children and adolescents.

What may be important to convey to our youth is that professional therapists work with youth because they want to help. They go through years of training to provide the right kind of help. They honor privacy and strive to provide support without judgment. It is important to let youth know that getting therapy is not a lifelong commitment. The goal of therapy is to overcome emotional distress and develop enough skills such that one no longer needs it.

There is often an intake form that a potential therapy client will need to complete before the initial intake appointment. It may be helpful to offer to complete this together with the youth so that the paperwork itself does not become a barrier to moving forward in treatment.

Types of Therapy

In recommending therapy, you will often get asked to describe what to expect from therapy. An exhaustive list of the different forms of therapy is too numerous to discuss here. Even though you may not be the one performing the work, it would be useful to have a working knowledge of what treatment our youth will be getting into. In this section of the chapter are just some of the more widely recognized and used forms of therapy. If you are interested, I would encourage you to read more about them (see the Suggested Reading and Related

Websites and Resources section in the online version). For research purposes, the differences between these therapies are clear. In practice, however, it is important to note that a substantial proportion of therapists use a more eclectic approach that draws on the techniques and principles from a variety of therapies.

Cognitive Behavioral Therapy

The treatment approach of cognitive behavioral therapy (CBT) is based on the premise that unhelpful thoughts and assumptions we make can contribute to the maintenance of emotional and behavioral problems. Some of these unhelpful, or maladaptive, thought patterns can be so ingrained in us that we are unaware we hold them, despite how much they shape how we view the world. The cognitions often pop up automatically and without warning in particular situations, and they tend to be negative, self-defeating, irrational, and distorted.

Here is an example of a situation and common automatic thoughts of a youth who is struggling with anxiety and depression.

CASE EXAMPLE 1. During a piano recital, 16-year-old Timothy played remarkably and was met with applause from the audience. Afterward, it was clear that he was not as happy with his performance. When asked why he was upset, he said, "I got the tempo messed up in the beginning, and everyone noticed. Someone even walked out because they hated it. This was a disaster! I'm just a failure." Timothy then pushed past his family and isolated himself in his room. His friends and family were baffled. Despite all the praise they were giving him, Timothy was quick to dismiss it and focused only on what he perceived to be his huge mistake. He concluded that a person who had to leave the room was leaving because of his poor performance. He catastrophized the situation and then turned it back on himself as a reflection of his inadequacy.

If this is the pattern by which Timothy thinks daily, you can easily see how that would contribute to his mood, anxiety, and behaviors.

Cognitive behavioral therapy uses therapeutic strategies to challenge these maladaptive thought and behavioral patterns. The patient will actively participate in a collaborative problem-solving process to test and challenge the validity of maladaptive cognitions and to come up with alternative thoughts and behaviors.

For example, in reviewing the situation described about Timothy, a therapist might say,

Therapist: *You think that the man left because of your performance.*

Timothy: *Yes, he looked angry. He left in the middle of me playing. I know that's what happened.*

Therapist: *OK, so it's possible. But how do you know for sure? Did you talk with him?*

Timothy: *No.*

Therapist: *Could you really see his face if you were playing the piano?*

Timothy: *I guess not. But I just can tell.*

Therapist: *Like I said, it's possible. But let's also explore whether there are any other explanations for him having to leave abruptly. We can create a chart with evidence for your conclusion and evidence against and compare.*

Another strategy in CBT is exposure therapy. In this type of therapeutic work, feared situations that the patient had previously avoided get gradually exposed back to the patient. The youth decides collaboratively with the therapist which exposures to do and in what order. During the exposures, the youth uses relaxation strategies to maintain a state of control. As the youth experiences firsthand their capacity to

face the feared situation without being overwhelmed, their anxiety decreases and their confidence grows. Exposure and response prevention for youth who have obsessive-compulsive disorder has the added goal of the youth not performing their undoing behavior despite being exposed to their feared stimulus (ie, not washing hands immediately after touching the floor).

Cognitive behavioral therapy is time limited and involves very structured sessions with homework in between the visits. It is not a "lie down on the couch and talk about your past" type therapy. Over the course of therapy, a youth learns to self-monitor for automatic thoughts and challenge and/or block them. The youth also gains a sense of mastery over situations that had been previously locked in negative thought, emotion, and/or behavioral patterns.

Dialectical Behavioral Therapy

Dialectical behavioral therapy is a specific form of CBT that primarily treats borderline personality disorder (BPD). Borderline personality disorder is diagnosed when there is a pervasive pattern of thinking, feeling, and behaving characterized by efforts to avoid being abandoned, overly intense anger outbursts, chronic feelings of emptiness, and negative self-image. People who have BPD often struggle with impulse control, emotional dysregulation, unstable mood, and self-harm behaviors. This pattern of repeated conflicts and dramatic behaviors is often quite frustrating and taxing for the caregivers and supports in the lives of these patients. It can be easy for all involved to fall into a dynamic in which we blame them or feel that they are simply acting out to get attention. It is not that simple. Dialectical behavioral therapy operates on the theory that both biological processes and environment contribute to why these features develop in a person with BPD. The dramatic and often contradictory behavioral patterns of people who have BPD develop because of a dilemma between the person's opposing needs and feelings that need to reach a state of synthesis. In fact, the word *dialectical* means a synthesis or integration of opposites. A guiding principle of this work is that people with BPD are usually doing the best they can to manage their emotional and physiological instability. We must remember that as hard as it can be to be subjected to the ups and downs of crisis after crisis as a caregiver, it must be even that more difficult for our client who is experiencing it firsthand.

CASE EXAMPLE 2. Corrie is a 19-year-old woman who lives at home with her parents. She stops in to see her career adviser one afternoon very distraught. She and her boyfriend have been getting into increasingly more intense fights. This most recent one happened at the grocery store and became so escalated that the police were involved. Corrie states that the fight began because she perceived that her boyfriend had been paying too much attention to the clerk at the store. She accused him of cheating on her and proceeded to verbally berate him. When he tried to walk away, she began to panic that he, indeed, was going to leave her and attempted to drag him back, begging him to forgive her. When he pushed her aside, she impulsively grabbed a nearby pair of scissors and placed small cuts along her arm. After the police came, she was evaluated at the emergency department and discharged with a recommendation for outpatient therapy.

Over the first few sessions of therapy, a pattern of intense but volatile relationships and breakups emerges in Corrie's life story. Corrie reports that she could never stay single for long because an overwhelming feeling of emptiness and intense loneliness consumes her whenever she is alone. In describing that past incident, she says, "I don't know what took over me—I just got so convinced that he betrayed me, just like all the other a******s I've dated. I don't even know if he was really flirting, but I couldn't stop myself from attacking him. Once I realize he may actually dump me, I remember what an amazing guy he is. It feels like I'd disappear, like I'd be nothing without him. I become desperate. In that moment, I would do anything to keep him. This kind of thing happens over and over and not just in this relationship. My friends are sick of me. They think I'm a psycho. Even my own mother doesn't want to hear about it anymore. My life and emotions feel like a roller coaster that I can't get off of."

Over the course of dialectical behavioral therapy, the client establishes a feeling of acceptance while learning more adaptive behavioral patterns and problem-solving skills. This is achieved through a combination of individual therapy, group skill training sessions, and ongoing telephone contact in between sessions. Throughout the course of therapy, behaviors are shaped by using contingency management, a systematic way of reinforcing the adaptive behaviors, while avoiding the reinforcement of maladaptive ones.

Skills of mindfulness, emotional regulation, distress tolerance, and interpersonal effectiveness are taught and integrated through practice and repetition. Mindfulness is a practice that focuses on acceptance and the ability to be present in the moment. Distress tolerance is the skill of increasing one's ability to tolerate negative emotions instead of trying to run from them. Emotional regulation skills manage the intense emotions that had been causing issues in areas of a person's life. Interpersonal effectiveness consists of communication techniques that convey one's needs in an assertive manner, as a way of respecting oneself and strengthening relationships with others.

Family Therapy

There are several forms of family therapy. Some operate using psychodynamic principles or cognitive behavioral principles, but here we discuss family therapies based on family systems theory. Family systems theory considers the family as a whole as the focus of the treatment instead of isolating any individual or subgroup as the problem. Each family is an ecosystem with its own culture, unspoken rules, strengths, and weaknesses.

When family dysfunction exists, it is common for a family to scapegoat a member as the one to blame instead of recognize and deal with the problems within the system itself. It is also common for stressors to create rifts between family members. In these scenarios, another family member is caught in the middle, between the 2 members in conflict who use that third family member to communicate or mediate. This is a form of what is called *triangulation,* and it is often a child or an adolescent who gets caught in this unhealthy dynamic. Because the maintenance of the family ecosystem depends on these maladaptive patterns and forced roles, the members that get affected need to take on the symptoms to maintain this tenuous level of stability.

CASE EXAMPLE 3. **Matthew is 16 years old and lives at home with his parents. Last year, his older sister left for college. Ever since then, Matthew has noticed that his parents are fighting more often, snapping at each other at the dinner table, and going through periods during which they refuse to speak with each other. Recently, a particularly bad night of arguments led to his mother moving out for a period of 2 weeks without warning. She eventually returned, but then his father began to work late and become increasingly distant. Because they never seemed to be in the house at the same time, Matthew found himself used as the messenger between the 2 of them—"Tell your father I'm going out tomorrow and won't be home be back until late" or "Tell your mother to not bother with dinner; I'm working late—not that she cares." Matthew took these as opportunities for him to intervene—he would try to tone down the harshness of his father's message, by changing it to "Dad says he's sorry to miss dinner." Meanwhile, his mother explained to Matthew that she and his father were in a rocky period but thanked him for being such a good kid—"You're the only thing keeping me sane." She told him not to worry because it had nothing to do with him, but Matthew began to feel increasingly anxious. Even though it wouldn't be for another year, he feared that if he went away for college, his parents would fight constantly and would surely get divorced. His grades began to drop and he opted to stay at home instead of pursue basketball camp that summer. He began to withdraw from friends, and, after a while, they stopped calling.**

The first phase of therapy allows the therapist to observe and ask questions to gain insight into the functioning of the family and its individual members. Often the dynamics described on the previous page will be demonstrated during a session in the form of arguing, interrupting, invalidating, or silencing. This gives the therapist an opportunity to intervene right away to change this pattern or reframe it (provide an alternative perspective to what may be occurring). Interventions are aimed at emphasizing relationships and enhancing communication patterns and flexibility within the family.

Trauma Therapies

There are several types of therapy for trauma. Many of the most recent studies focus on treatment modalities that contain components of CBT (cognitive restructuring and prolonged exposure therapy). In addition, eye movement desensitization and reprocessing has been shown to be an effective therapy for post-traumatic stress disorder (PTSD). Other forms of therapy include trauma-focused psychodynamic therapy and group therapy.

Trauma-Focused Cognitive Behavioral Therapy

The goal of trauma-focused CBT (TF-CBT) is to help adolescents learn the skills that they need to master their reactions (eg, stress, hyperarousal, flashbacks) to reminders of their trauma. Like CBT, TF-CBT is time limited, with sessions that build on each other and therapeutic assignments to practice at home. The average length of treatment is approximately 8 to 20 sessions, with the options for booster sessions following the initial course of therapy. During treatment, the youth who has experienced trauma is provided with psychoeducation and taught skills in relaxation, affective modulation (changing how feelings are experienced), and coping skills for negative thoughts.

Cognitive restructuring, as it pertains to TF-CBT, addresses maladaptive cognitions and beliefs. After experiencing trauma, one is often left with more than just the physical and emotional hurt that took place. Trauma at an early developmental age may cause the experience of trauma to be incorporated into a person's core beliefs about oneself, other people, and the outside world. For example, it is not uncommon for youth who have experienced sexual abuse as children to believe that they were somehow at fault for what happened to them. They then may go on to believe that they are doomed or worthless and that "bad things just happen to bad people." Relationships, school engagement, community involvement, and any future aspirations can be greatly affected by this mentality. The negative beliefs about the trauma and trauma-related cues are part of the fuel by which their symptoms feed and grow. Therapists trained in TF-CBT work toward bringing awareness to these thoughts to process and correct them. By doing this, one can turn "I am worthless" into "I have value and I am good enough." Alternatively, "I am defective" can be adapted to "I am a survivor." "I am powerless" can become "I can protect myself; I control what I can."

As discussed in Chapter 36, The Impact of Trauma on Development and Well-being, any combination of certain people, places, noises, and smells can trigger flashbacks, anxiety, or full-blown panic attacks in one who has experienced trauma. Often the triggers can overgeneralize or expand to include other objectively safe and indirect reminders to trigger the same reaction. For example, a survivor of a mass shooting has to avoid all news stories because even the local stories about robberies are reminders that the world is not safe. This recurrent thought, when triggered, leads to a panic attack. Once triggers are identified, youth will be encouraged to do the emotional and cognitive processing work to uncover the maladaptive association that underlies them. They will learn to use the relaxation skills that they have gained to remain in control when facing these situations.

The exposure therapy component of TF-CBT has the patient face feared stimuli that they usually avoid or endure with significant distress. With support, the patient overcomes a series of gradually more intensive exposures. Each successful trial becomes a mini triumph that reinforces the notion that they are capable of tolerating these stressful situations and that they do not need to be avoided. The exposures can start off as imaginal instead of in person. The process of telling or writing a detailed account of trauma can itself be a triggering exposure. Once this trauma narrative is given, it is either recorded or typed out and the patient is encouraged to listen and/or read it over and over to allow it to gradually lose its intensity. Later, in-person exposures can further efforts to master trauma reminders. Some of these may be conducted conjointly with a parent.

CASE EXAMPLE 4. Leila, a 19-year-old survivor of sexual assault, has been experiencing post-traumatic stress disorder (PTSD) symptoms for many years. She has nightmares of being chased, experiences hypervigilance in crowded spaces, and avoids all men in general. The thoughts and images of the assault intrusively return every evening as she tries to settle down for bed. She would come up with a list of chores to do in the middle of the night to avoid sleep and distract herself from these thoughts. She began to find, however, that the harder she worked to avoid these thoughts, the more intense and frequent they would become.

Because of sleep deprivation and growing anxiety, Leila spoke to a counselor at school who referred her to a therapist. After conducting a thorough assessment of her PTSD and comorbid symptoms, her therapist explained the nature of PTSD and a rationale for why exposure therapy could help with her symptoms. She learned various relaxation techniques, which she practiced in the sessions and at home. When she was ready, she narrated an initial account of what had happened to her years ago. With guidance, she described in detail where she was at the time, who she was with, what she saw, any of the sensations she had, and what was going on in her mind. The first time telling this narrative was very taxing on Leila, but she was able to get through it by using her relaxation skills and with guidance from her therapist. Over the next several sessions, this process repeated each time with more prompts from her therapist, expanding the amount of sensory and emotional details about the experience. The narratives were recorded so that Leila could listen outside of her session as homework. Over time, the story itself became less distressing and required less effort on her part to maintain her sense of calm.

Eye Movement Desensitization and Reprocessing

Recall that traumatic memories often contain a mixture of images, sounds, and physical sensations, in addition to the narrative context. Eye movement desensitization and reprocessing is a form of multisensory therapy that addresses a patient's past, present, and future by using dual attention to facilitate information processing. The procedural part of this therapy is as follows: the patient focuses their mind on the traumatic experiences while they experience a new series of visual, auditory, or tactile stimuli in the office. The patient is asked to recall the traumatic memory with vivid detail, including associated bodily sensations, emotions, and negative cognitions about themselves as they relate to that memory. Simultaneously, the patient is asked to use their eyes to track lights or the therapist's finger as it moves across their field of vision. Auditory beeps and light touches on the patient's hand can also be used, all while maintaining this dual attention of internal and external.

Each 30-second presentation of stimuli is followed by a period during which the patient is asked to allow their mind to go blank and freely associate (ie, say whatever comes to mind). The same memory is targeted until the patient is able to recall the memory without much stress or anxiety. At that point, the therapist guides the patient toward a positive belief about themselves, which they now focus on as they are once again presented with the same visual, auditory, and tactile stimuli. This therapy aims to decrease the negative associations and increase positive ones. To perform eye movement desensitization and reprocessing, a therapist needs extra training and possible certification.

Interpersonal Therapy

Interpersonal therapy is a brief psychotherapy focused on the aspects of a patient's social functioning as a contributor to psychological distress. Interpersonal conflicts, relationships, role transitions, and grief are focuses of the treatment. Interventions can include skills training, problem-solving, role-playing, communication analysis, processing of emotional affect, and supportive listening. Interpersonal therapy tends to run for 16 to 20 sessions, with the aim that the patient's gains continue to consolidate even after therapy ends.

A Quick Word on Psychotropic Medication

The question of whether the prescribing of psychotropic medication is necessary is best decided by professionals. However, questions about medication often come in the beginning stages of therapy. For severe depression, mood swings, and other severely impairing conditions, medication may be recommended to be started concurrently alongside therapy to produce the most benefit.

Adolescents often have the following worries:

1. "Will I be a zombie [too sedated]?"
2. "Will the medication change who I am?"
3. "Will I be addicted to this medication? I don't want to become dependent on a pill."
4. "Will I have to be on this medication for the rest of my life?"

It would be important to encourage the youth to have these discussions with the prescriber, who will explain the particular indication, adverse effect profile, and treatment plan regarding that specific medication. But because medications are another area that is stigmatized within mental health, it may be important to address some of these questions now, as they come up, so that these fears do not become barriers later on. At the same time, it is important for us to examine our own attitudes about this area and ensure that our own unconscious biases do not get placed onto the youth that we are serving.

You may say,

> *If a doctor or prescriber feels that a medication would be helpful in treating the mental health condition, you may be prescribed a medication. The decision of whether you may benefit from medication depends on what symptoms you are having and how much it interferes with your life. Depression can cause changes in both your mind (thoughts and feelings) and your body (such as changes in sleep, changes in appetite, drop in concentration, and drop in energy), so it makes sense that if it is severe enough, it may really benefit from medication to recover from it. These medications shouldn't change who you are; they just treat that condition, and ultimately, you have a choice on what you feel comfortable doing. The goal of treatment is to get you feeling better, back to your normal life, and, once you get there, to keep this depression away, and, sometimes, medication can play an important role in making sure you get there quicker.*

Group Learning and Discussion/Personal Reflection

1. Break off into pairs. One of you plays the role of a youth who is reluctant to go into treatment because "I'm not crazy; why do you think I need to see a therapist?" while the other guides a discussion regarding therapy and how it could be helpful. Help the teen understand the following key points:
    a. Mental health symptoms are not a sign of weakness or something to be ashamed of.
    b. Seeking help is an act of strength.
    c. What is therapy like.
    d. What is the goal of therapy and possible medication treatment.
2. Practice preparing parents to support their children in help seeking. Use the following resource:
    - Center for Parent and Teen Communication "Preparing Your Teens to Seek Professional Help": https://parentandteen.com/seek-professional-help

Self-reflection Exercises

3. Take a minute to think about your experiences with mental health—whether it be a personal history or a family member or friend.
    a. a. In what ways have these experiences affected how you feel about the mental health system, therapy, and psychotropic medication?
    b. b. In what ways may these ideas affect the way you refer to mental health?

Suggested Reading and Related Websites and Resources

General

American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Washington, DC: American Psychiatric Association Publishing; 2013

Mental Health and Seeking Treatment of Patients and Families

American Psychiatric Association "What Is Psychotherapy?"
www.psychiatry.org/patients-families/psychotherapy

American Psychological Association "Understanding Psychotherapy and How It Works"
www.apa.org/helpcenter/understanding-psychotherapy?item=1

Center for Parent and Teen Communication "Preparing Teens to Seek Professional Help"
https://parentandteen.com/seek-professional-help

National Alliance on Mental Illness

"Types of Mental Health Professionals"
www.nami.org/Learn-More/Treatment/Types-of-Mental-Health-Professionals

"Psychotherapy"
www.nami.org/Learn-More/Treatment/Psychotherapy

Stigma

Psychology Today "Mental Health & Stigma: Mental Health Symptoms Are Still Viewed as Threatening and Uncomfortable"
www.psychologytoday.com/us/blog/why-we-worry/201308/mental-health-stigma

Moses T. Being treated differently: stigma experiences with family, peers, and school staff among adolescents with mental health disorders. *Soc Sci Med*. 2010;70(7):985–993

Cognitive Behavioral Therapy

Academy of Cognitive Therapy

www.academyofct.org
Website to find a certified cognitive therapist

Dialectical Behavioral Therapy

National Alliance on Mental Illness "Borderline Personality Disorder"
www.nami.org/Learn-More/Mental-Health-Conditions/Borderline-Personality-Disorder

Miller AL, Rathus J, Linehan MM. Dialectical Behavioral Therapy With Suicidal Adolescents. New York, NY: Guilford Press; 2007

DBT-Linehan Board of Certification
http://www.dbt-lbc.org
Website to find a certified dialectical behavioral therapy clinician

Trauma-Focused Cognitive Behavioral Therapy

Canadian Psychology "A Review of Trauma-Informed Treatment for Adolescents"
www.researchgate.net/publication/254734638_A_Review_of_Trauma-Informed_Treatment_for_Adolescents

American Psychological Association "Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder (PTSD)"
www.apa.org/ptsd-guideline

Choen JA, Mannarino AP, Deblinger E, Berliner L. Cognitive-Behavioral Therapy for Children and Adolescents. In: Foa EB, Keane TM, Friedman MJ, Cohen JA, eds. Effective Treatments for PTSD: Practice Guidelines From the International Society for Traumatic Stress Studies. 2nd ed. New York, NY: Guilford Press; 2010:223–244

Eye Movement Desensitization and Reprocessing

Shapiro F. Eye Movement Desensitization and Reprocessing (EMDR) Therapy: Basic Principles, Protocols, and Procedures. 3rd ed. New York, NY: Guilford Press; 2017