

Welcome



Girls Matter!

*A webinar series addressing
adolescent girls' behavioral health*

Deborah Werner



Deborah Werner

Project Director

SAMHSA's TA and Training
on Women and Families
Impacted by Substance
Abuse and Mental Health
Problems

Technical Information



- Your lines will be muted for the duration of the call.
- Today's webinar is being recorded and will be posted online.

Logistics

- Questions may be submitted by typing them into the questions box. To open the question box – click the go-to menu (4 small boxes on right).
- If you experience technical difficulties during the webinar, put a question in the question-box or email Noah Shifman at nmshifman@ahpnet.com
- At the end of this webinar, is a quick feed-back survey. Please take a few minutes to give us feedback.

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- NAADAC and NBCC CEU are available for this webinar by the Addiction Technology Transfer Center Network (ATTC) Coordinating Office.
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- The contents of this presentation do not necessarily reflect the views or policies of SAMHSA or DHHS.
- The webinar should not be considered a substitute for individualized client care and treatment decisions.

About Girls Matter!



Purpose of Girls Matter!



- Increase the behavioral health workforce's understanding of the needs and concerns of adolescent girls (primarily ages 12-18)
- Bring visibility and attention to the specific behavioral health concerns of adolescent girls

Webinars

- **Growing Up Girl** — recording coming soon
- **Girl in the Mirror** — March 13
- **Girls and Substance Use** — April 22
- **Digital Girls** — May 20
- **Sanctuary and Support** — June 10
- **Youth Development and Recovery Supports** — July 24

The Girl in the Mirror: Behavioral Health of Adolescent Girls



*A girl's smile
can often hide
identity struggles,
anxiety, depression,
self-loathing and
pressure to
succeed bubbling
under the surface.*

Featured Speaker



**ANNE THOMPSON,
M.A., MFT**

UConn Department of Wellness
& Prevention Services

What you saw when you looked at me and what I saw when I looked in the mirror were very different people.

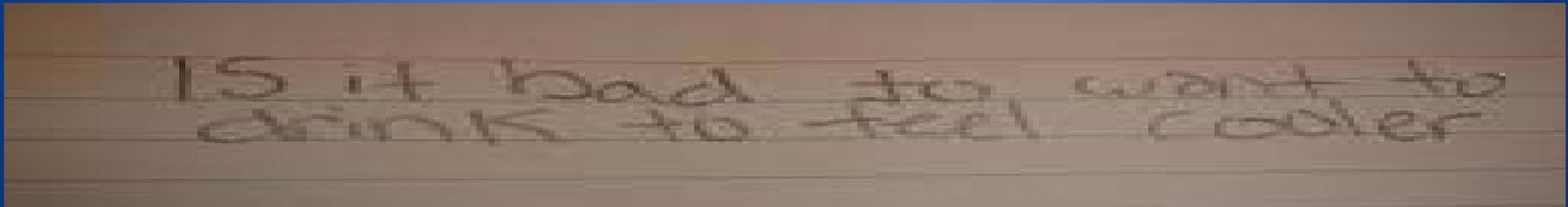
Difficult experiences as a child shaped my internal working model, the way in which I viewed myself and the world from a very young age.



Led to low self esteem and a negative self image

I was well liked, an athlete, and a good student....I was waiting to be “found out”

Partying for me was a coping skill...it silenced the negative voice in my head telling me I was not good enough



At 19 years old I entered recovery from alcohol and other drugs and have had to face that girl in the mirror, love her through the pain, and begin to heal

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Featured Speaker



STEPHEN HINSHAW, PH.D.

Professor of Psychology at
University of California (UC) Berkeley

PART 1: “THE TRIPLE BIND”



Motivation for Topic

- NIH Research: Findings on girls with ADHD
 - BGALS, largest sample of girls with ADHD
 - Summer camps, 5- and 10-year follow-up
 - Young adulthood:
 - Risk of cutting and suicide attempts, even in “controls”

Hinshaw et al. (2012)

- Wider literature on girls and teen years
- Individual development during adolescence, paired with today’s cultural changes



Adolescence

- When 'discovered'?
 - 1904, officially; but most cultures recognize such a period
- When does it begin?
 - Puberty, but age of maturation is decreasing
 - When does adolescence end? Longer span
- What does it signal?
 - Most 'thriving' time of life, physically and cognitively
 - BUT, time of huge increase in risk: accidents and emotions

See Dahl (2004)

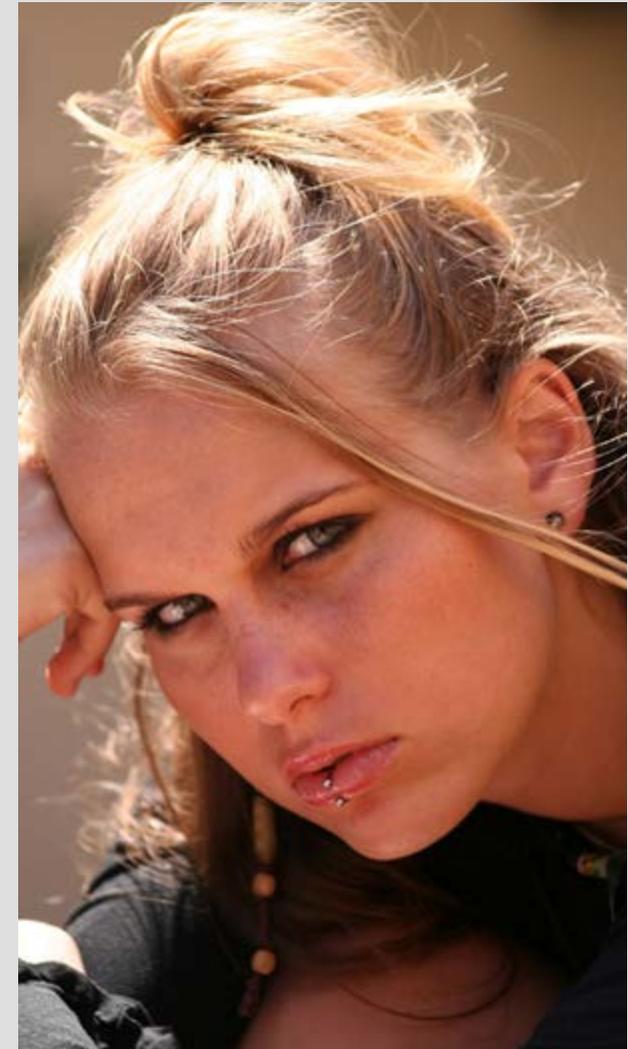


Adolescence 2

- Psychologically:
 - Surge in risk taking and cognitive ‘independence’
 - Yet frontal lobe maturation lags far behind (mid-20s)
- Physiologically:
 - Hormone release (hypothalamus to pituitary to glands)
 - But same hormones circulate back to brain, acting as ‘transmitters’: stress vulnerability
- Evolution: time to prepare for independence
 - Exploration ‘selected for’

Adolescence 3: Mechanisms?

- Maybe teens don't "get" risk?
 - Actually, they go 'get it,' cognitively
- But increased risk-taking and delay aversion
 - Salience of reward, NOW
- Importance of peers
 - Teens do risky things if they think peers are observing, far more than if they believe no one is there



Adolescence 4

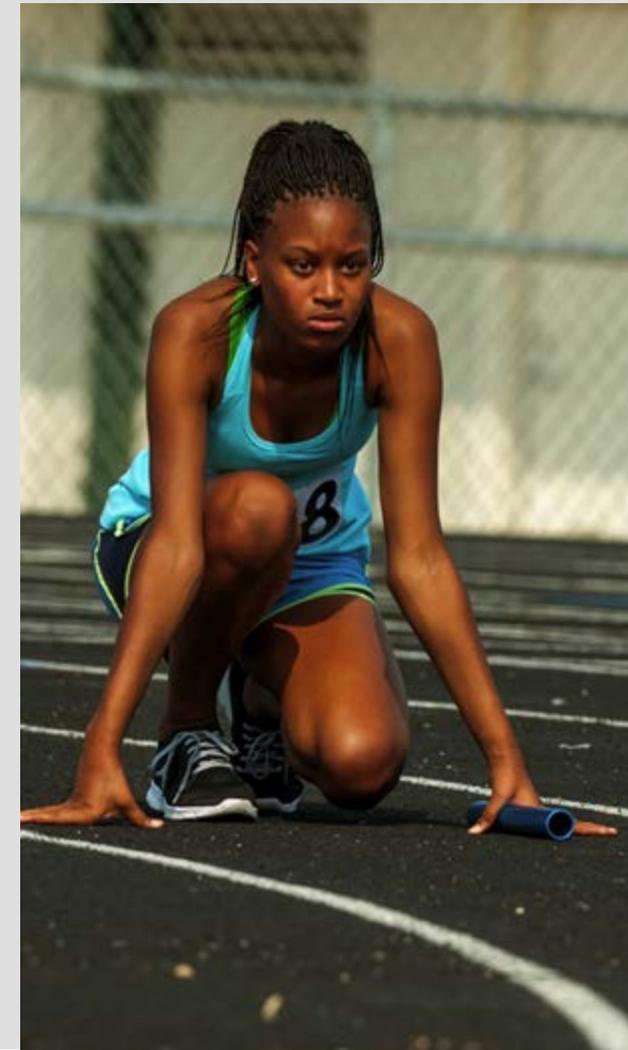
- Key 'goal'—formation of identity
- But how to do this?
 - Trying things out
 - Failing at some
 - Seeing what truly interests you
 - **WON'T HAPPEN WELL** under conditions of impossible perfection
- Why is risk for **GIRLS** so elevated during adolescence? The idea of 'the triple bind'



Hypothesis: The Triple Bind

Hinshaw (2009)

- **#1:** Girls must be nurturing, kind, caregiving
- **#2:** Girls must now compete, academically and athletically, and show assertiveness and ambition
- **#3:** Girls must conform to narrow, unrealistic standards, effortlessly, with appearance crucial
 - i.e., Girls must do #1 and #2, a double bind, while “looking hot” and “without sweat”



Probable Consequences

- Internalization
 - My fault if I can't do it all, effortlessly
- Learned helplessness
 - How long before giving up?
- Pseudo-individuation/"false self"
 - If it's always someone else's standards, who am I?



Also...

- Relentlessness of pressure
- Alternative role models?
 - But so many co-opted; rock singers, athletes
- How to develop identity and true self if you're relentlessly pleasing others the whole time?
- Cyberculture
 - Never-ending instant replay



Analogy/Metaphor

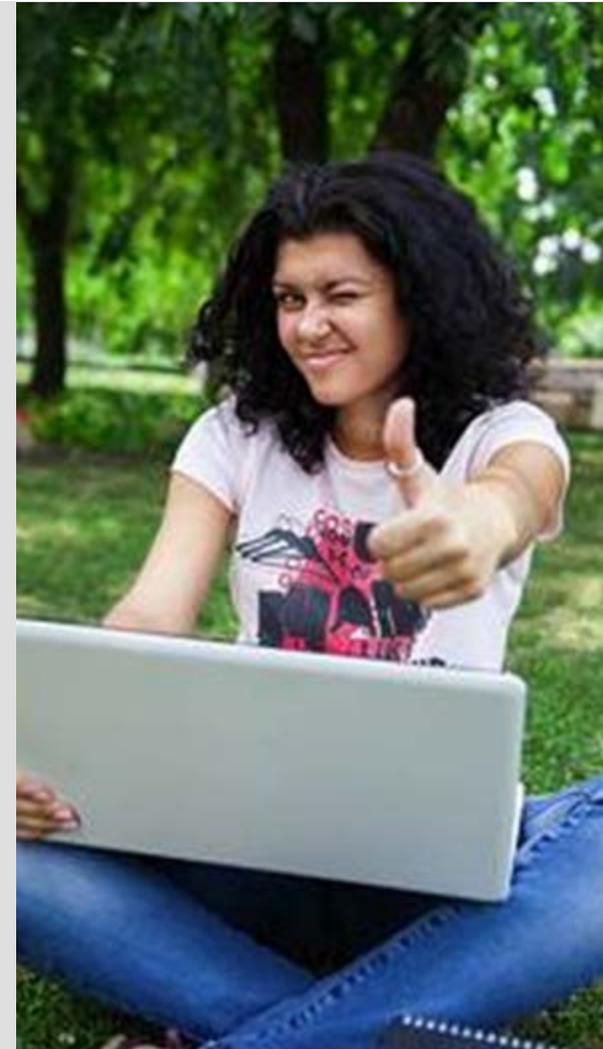
- Teen girls in room full of tobacco smoke
 - Harmful for all, but ones with vulnerability have worst outcomes
 - Triple Bind is toxic at a cultural level
- What is 'vulnerability'?
 - 'Risk' genes, mood-disordered parents, maltreatment
 - Everyone, including boys, lies in the wake
 - But only girls are subject to the triple bind
 - Developmental psychopathology background:

See Hinshaw (2013)



Mechanisms

- Is the core problem “overscheduling”?
 - Actually, data show the opposite
 - Mahoney et al. (2006): the amount of extracurricular activities is correlated with nearly every good outcome, esp. for low SES youth
- A better candidate: “pressure”
 - Homework, pad extracurric’s for resume, no quality time with parents, lack of privacy related to 24/7 media
 - ‘Problem with no name’



Sleep

- Associated factor: lack of sleep
Wolfson & Carskadon (1998)
- Consequence of sleep deprivation:
 - Inability to consolidate memory
 - Inability to suppress negative affect, mediated by inability of PFC to inhibit “emotional brain”
 - fMRI investigations, paralleling sleep deprivation studies
- Additional issue of ‘no alone time’/’no down time’— taking away from creativity/pondering/awe?



Self-focus, sexualization

- Fredrickson et al. (JPSP, 1998) swimsuit study
 - Randomly assign men and women to swimsuit vs. sweater
 - Men: pride...and better performance on complex math test
 - Women: shame...and worse performance on the test
 - Preoccupation with body, and sexualized images (“observer role”) reduces cognitive resources
- And, because girls are more socialized to please:
 - Failures taken more “to heart”
 - Empathy, here, may lead to belief that failure has let everyone down

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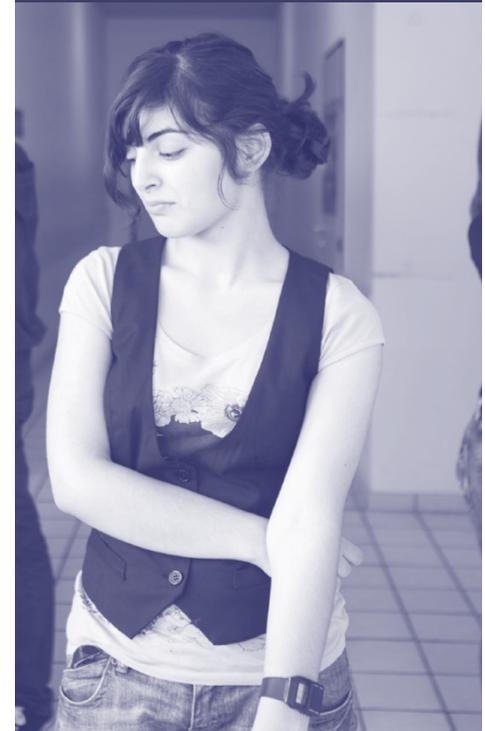


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PART 2: GIRLS AND MENTAL HEALTH RISK



Girls: Best of Times, Worst of Times

- Unprecedented success and opportunities for girls and women today
 - Academic, athletic, professional, lifestyle choices
- At another level, greatly increasing risks that teenage girls face re: serious disorders



The Best of Times...

- Young girls outperform boys:
 - Verbal skills, empathy, compliance, close relationships
- Girls have lower rates of psychopathology before 10-11
 - ADHD, autism, aggression, some LD's
 - Even for depression, boys have slightly higher rates before adolescence
- Girls skyrocketing re: test scores/college admissions; unprecedented success re: professional education
 - 50% of medical students, 48% of law students
- 'New' opportunities athletically
 - Scholarships, professional leagues (though non-equal pay)

See notes in Hinshaw (2009)

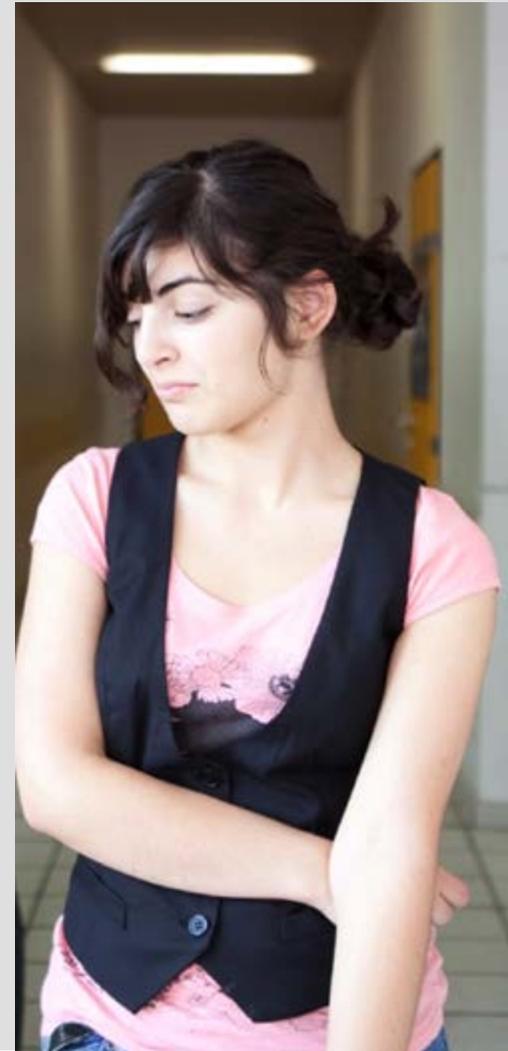
But...second decade of life...



**THIS
IS THE
MAJOR
RISK
PERIOD
FOR
GIRLS**

1. Depression

- World Health Organization:
 - 1st or 2nd most impairing disease on earth
- Boys have a slightly higher risk before puberty
- Girls' rates skyrocket between 11 and 18 years of age
- By that age, rates are twice-plus those of boys, which holds until late life
- Not a true epidemic, but AGE OF ONSET lowering
 - From 30's to 20's, and now to teen years



2. Suicide

- Absolute rates still low, but third leading cause of death for people 11-24 years of age
 - 2nd leading cause of death among college students
- 1950-1988, rates of adolescent suicide tripled
- Then, gradual decline from 1989-2004
- In last decade, rates went up 76% in girls 10-14 and 32% in girls 15-18
 - No comparable increases for boys



See notes in Hinshaw (2009)

3. Self-Harm

Dr. Lader will elaborate soon

- Also known as self-mutilation, parasuicidal behavior, non-suicidal self-injury (NSSI), cutting, etc.
- Continuum: picking skin to severe cutting, burning, etc.
- From all accounts, skyrocketing in teens, with girls at highest risk
- Intent to make real inner pain and get help, without actual suicidal intent
 - BUT risk for actual suicidal behavior is quite high in those with NSSI

4. Binge Eating

- Rates of anorexia nervosa and bulimia nervosa remain relatively low (ca. 1% each), but precursor behaviors (dieting, preoccupation with weight) are endemic
- OVER HALF OF GIRLS IN 3RD GRADE ARE WORRIED ABOUT WEIGHT
 - A third percentage dieting
- For binge eating disorder, NCS-R:
 - Revealed that there was over a 3% prevalence in young women; far higher than expected

See notes in Hinshaw (2009)



5. Aggression

- Boys' rates have declined since mid-90's, after having increased for decades
- But girls' rates have, at the same time, increased
 - Artifact of reporting procedures, zero-tolerance?
- Yet self-report reveals that girls are indeed “catching up” by adolescence
- 16-32% of teen girls have committed at least one act sufficiently violent to have seriously hurt another, compared to 30-40% of boys

See notes in Hinshaw (2009)

Overall:

30% of Girls 11 Through 19

- Depression
 - 15-20%
- Suicide
 - Completion rate low, but attempts rising
- Self-Harm
 - At least 15%
- Binge Eating
 - 3-4% by young adulthood
- Aggression/Delinquency
 - Self-report: 25% of girls report serious violent act
- This is true even when overlap is subtracted out
- Even higher if 'moderate' levels considered

But what about biology?

- Genetic vulnerability does exist
- But environment (triple bind) may raise risk for everyone, especially most vulnerable



TRIPLE BIND: SOLUTIONS?

#1: TALK ABOUT IT

- My own family history: professionally prescribed silence
- Silence can be contagious

2: GET PROFESSIONAL HELP IF INDICATED

- Low rates of help-seeking
- 10-year delay
- Stigma, insurance coverage

Hinshaw (2007)



SOLUTIONS...

#3: CRITICAL THINKING/SELF-DISCOVERY

- What's an ad? What's a news story?
- Do ALL girls/women actually look like this?
- Try new avenues and pursuits, not 'having right answer'

#4: WIDER COMMUNITY AND PURPOSE

- Efforts in families/schools/communities to foster group action
- NOT the same as resume padding with multiple clubs...



Key References

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Featured Speaker



WENDY LADER, PH.D., M.ED

President and Clinical Director of the S.A.F.E.
ALTERNATIVES Program



Teen Girls and Self-Injury

Wendy Lader, Ph.D., M.Ed.

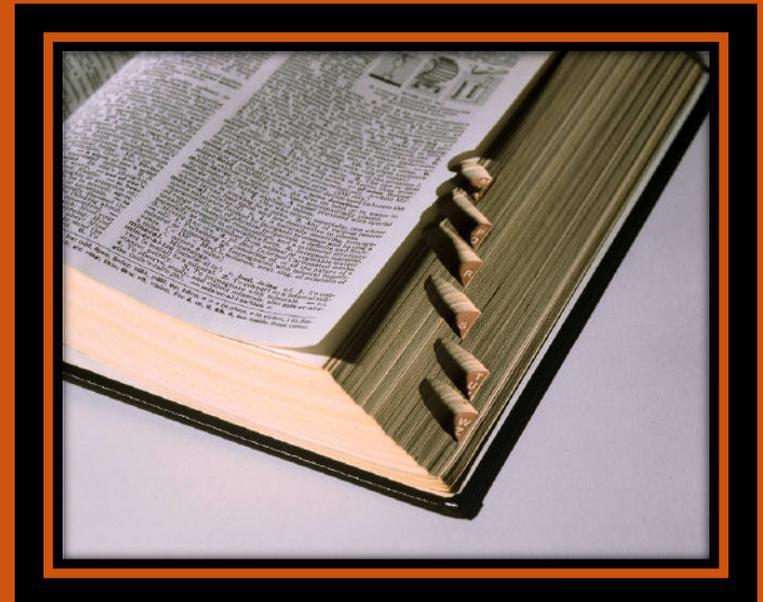
Self-Injury Foundation

www.selfinjuryfoundation.org



DEFINITION

Non-suicidal self-injury (NSSI) has been defined by the International Society for the Study of Self-Injury as the deliberate, self-inflicted destruction of body tissue without suicidal intent and for purposes not socially sanctioned (ISSS, 2007)



EXAMPLES OF SELF-INJURY

- Scratching/ Excoriation
- Cutting
- Burning
- Head banging
- Biting
- Interfering with wound healing
- Trichotillomania
- Facial picking/skinning
- Ingesting/ Injecting sharp objects or toxic substances
- Breaking bones
- Amputation/ Blinding



SELF-INJURY AKA

- ❖ DELIBERATE SELF HARM
- ❖ PARASUICIDE (“like suicide”)
- ❖ SELF ABUSE
- ❖ SELF MUTILATION
- ❖ “CUTTERS”
- ❖ NSSI (Non Suicidal Self-Injury)



PREVALENCE IN YOUNG TEENS

A study of 665 students (ages 7-16) found:

- ❖ that overall 9% of young girls have engaged in NSSI
- ❖ the percentage increased with age (19% of girls by ninth grade)
- ❖ differences in gender:
 - ❖ Ninth-grade girls engaged in NSSI in greater numbers than boys : 19% of girls and 5% of boys
 - ❖ Girls most often cut and carved their skin while boys most often hit themselves.
- (Barrocas, A., Hankin, B., Young, J, and Abela, J.. Pediatrics Vol.130, Number 1, July 2012)



PREVALENCE IN COLLEGE POPULATION



- ❖ Research of 14,372 college students showed an overall lifetime prevalence of 15.3%.
 - ❖ 18.9% for females and 10.9% for males. (Whitlock, 2011).
- ❖ Almost a quarter of the NSSI above sample had told no one. And only 16.9% of self-injurers who had attended therapy reported disclosing their NSSI to a health professional. (Whitlock, 2011)

MAIN PURPOSE OF SELF-INJURY: Emotional Regulation



*Palliative Aims:

Calm fears and anxiety

* Analgesic:

Numbing (car accident)

* To Feel Something:

Counteract numbing / dissociation

* Survival

(to survive annihilative fear) Rockies Hiker

TREATMENT GOALS 1

- ❖ To get through defenses to core affect.
- ❖ To help youth identify and communicate experiences to others verbally, in an age appropriate manner.
- ❖ To challenge irrational thoughts



TREATMENT GOALS 2



❖ To learn to differentiate

❖ *thoughts*

❖ *feelings*

❖ *behaviors*

❖ Increase the “Window of opportunity” between an impulse (thought) and an action (behavior).

TREATMENT GOALS 3



- ❖ To experience a feeling (anger) without an action (violence)
- ❖ To face fears directly, and to challenge irrational thoughts, rather than running from/ medicating with self-injury.
- ❖ To mourn the loss of the idealized childhood

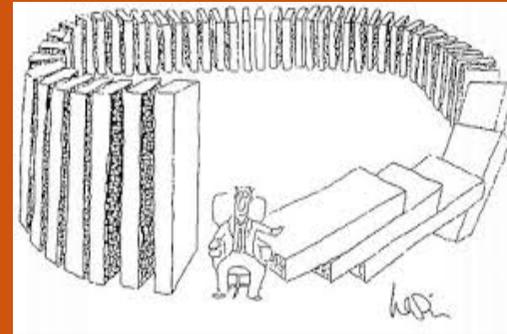
DON'T

- ENGAGE IN POWER STRUGGLES



DO

- HELP CLIENT ASSESS THE CONSEQUENCES OF HER CHOICES



DON'T

- TRY TO RESCUE OR INFANTILIZE CLIENT

DO

- HELP CLIENT IDENTIFY HER OWN STRENGTHS AND ABILITIES



DON'T

- MINIMIZE SELF-INJURIOUS BEHAVIOR

DO

- TAKE THE BEHAVIOR SERIOUSLY. IT IS ALWAYS A “CLUE” THAT THE PERSON IS STRUGGLING EMOTIONALLY
- TRY TO HELP IDENTIFY THE MEANING OF THE BEHAVIOR AND HELP THE CLIENT COMMUNICATE HER NEEDS MORE DIRECTLY.



Resources

- www.selfinjuryfoundation.org
(Information and support for self-injurers, their loved ones and the professionals who work with them)
- www.crpsib.com (Cornell NSSI Website headed by Dr. Janis Whitlock)
- www.itriples.org (International Society for the Study of Self-Injury)
- www.selfinjury.com (Offers a free webinar for parents of teens who self-injure along with a variety resources including a therapist referral list.)



Where there is life there is hope. Self-injury is treatable and no one need suffer in silence.

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Featured Speaker



**ANNE THOMPSON,
M.A., MFT**

UConn Department of Wellness
& Prevention Services

Community and Peer Support

Providing an opportunity for belonging and the development of one's sense of self

Involvement in a positive, healthy community can foster the growth and development of the adolescent socially and emotionally.



Leadership

Servant Leadership: conceptualization, foresight, listening, empathy, awareness, persuasion, committed to personal growth and development, building community, stewardship, and healing

Social supports and positive social influences provide scaffolding to people working to achieve a behavior change by providing social norms that help behavior

(Bandura, 1998).

Self-Efficacy

Perceived self-efficacy is the belief one has about their personal ability to organize and carry out intended actions to achieve various goals.

If someone does not believe they are capable of something they are unlikely to do it (Bandura, 1998).

Provide opportunities for involvement, responsibility, ownership over a task

“Empowering individuals to take a share of control over their immediate environment within the community helps them to reshape their perception of themselves and their ability to influence their own lives and the lives of others” (Bosivert, Martin, Grosek, & Claire, 2008, p. 217).

Rise to the occasion, not want to disappoint

Scaffolding

To build self-efficacy, a sense of mastery must be established. This will not happen if the student's efforts to achieve their goal are perceived as a failure.

Stress Management: developing an understanding of healthy stress and learning skills to reduce stress which is not healthy

“I believe in me because you believe in me...and then I believed in myself”



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Closing Comments



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Resources

- SAMHSA's Girls Matter! <http://www.tinyurl.com/girlsmatter2014>
- Other SAMHSA resources <http://www.samhsa.gov>
- HHS, Office of Women's Health, girls health website www.girlshealth.gov
- HRSA Office of Women's Health, health & wellness <http://www.hrsa.gov/womenshealth/wellness/>
- Futures without Violence <http://www.futureswithoutviolence.org/>

Resources *continued*

- Interagency Working Group on Youth Programs, collaborative website <http://findyouthinfo.gov/>
- National Institute on Drug Abuse, teen website <http://teens.drugabuse.gov/>
- National Online Resource Center on Violence Against Women, Teen Dating Violence Special Collection <http://www.vawnet.org/special-collections/TDV.php>
- Federal collaborative website on bullying <http://www.stopbullying.gov/>

Announcements

- Following the webinar you will see a brief satisfaction survey. It takes a minute to open on your screen so don't close your browser. Email us at GBH@ahpnet.com if it does not open. Must complete the survey and enter name and email addresses for CEUs.
- All qualified attendees for today's training will receive an email from ceu@attcnetworkoffice.org within 72 hours of today's event with instructions for obtaining your certificate of attendance.

THANK YOU

We hope you enjoyed the presentation
and that you will join us for the
Girls and Substance Abuse on April 22nd.

