Look Both Ways Before You Cross the Intersection to a Therapist for Your Teen

When I came out of graduate school, I knew enough to be dangerous. I had studied hard, completed supervised training, conducted research, and earned my doctorate. What I did not yet possess was the understanding that comes from sitting with suffering people, discovering where your favorite theory falls short, and learning that human beings refuse to fit neatly into the boxes we construct for them. Graduate school prepared me to begin. After more than forty years in clinical psychology, I would be considerably more concerned about a therapist who could not make that admission.

Choosing a therapist for your teenager matters enormously. You are inviting someone to help your child interpret suffering, relationships, identity, and the future. A capable clinician can help restore stability, address painful experiences, and recover a sense of possibility. An ineffective therapist can miss serious risks, reinforce helplessness, encourage dependency, or steer a vulnerable young person toward conclusions shaped more by the therapist's assumptions than the teenager's needs. When serious depression, self-harm, or other dangerous conditions are involved, getting this right may also help protect your child's life.

Parents deserve to understand what they are entrusting to us. Teenagers deserve a voice in the care they receive. Neither should have to fight through professional arrogance to ask a reasonable question.

Look for Someone Whose Education Is Still in Progress

Years ago, my supervisor, Dr. Steve Parkison, offered a memorable way to evaluate a psychologist: examine the books and journals in the office, then return several years later. If nothing has changed, run. He was talking about intellectual growth. Today, that library may live on a laptop, but the question remains: Is this person still learning, questioning assumptions, and refining the work?

Research gives that question teeth. Goldberg and colleagues (2016) found that accumulating experience did not reliably make therapists more effective. There are excellent young clinicians whose training, supervision, and humility make them exceptionally capable. There are seasoned clinicians who keep deepening their craft, and others whose twenty years of experience look suspiciously like one year repeated twenty times. Certificates can accumulate while curiosity quietly dies.

A doctorate does not automatically make someone an excellent therapist, just as a master's degree does not automatically make someone a lesser one. Appropriate credentials, an active license, relevant experience, and sound supervision matter. So does the ability to say, "That is outside my expertise," or "I need to consult someone." Ask what the clinician has learned recently that changed how they practice. Your teenager needs thoughtful judgment from someone whose education is still very much in progress.

Connection Matters and Competence Matters Too

Adolescents often have a remarkably sensitive detector for adults who are performing concern. They recognize condescension, rehearsed reassurance, and the moment their experience is squeezed into a theory before they have finished describing it. A capable therapist offers the experience of being understood without being indulged, challenged without being humiliated, and taken seriously without becoming a diagnosis with sneakers.

McLeod's (2011) meta-analysis found a modest association between the therapeutic alliance and outcomes in youth psychotherapy. Connection deserves attention, but warmth alone cannot establish competence. A likable clinician may lack the expertise your teenager needs, while an impressive specialist may accomplish little if your child never feels safe enough to speak honestly. After an initial appointment, ask whether your teenager felt listened to and could imagine discussing something difficult with that person. I would also ask, "Could you disagree with this therapist and still feel respected?" That answer may tell you more than whether the appointment was pleasant.

Psychotherapy does not become harmless simply because its intentions are compassionate. A clinician can overlook a medical condition, misunderstand symptoms, mishandle risk, or reinforce the conviction that a teenager is fragile and permanently damaged. Abigail Shrier's Bad Therapy (2024) raises an uncomfortable challenge: Might some well-intentioned therapeutic attention

encourage young people to organize their identities around distress? Her investigative critique is a reason to examine our practices, rather than a verdict on every clinician or treatment.

Research on youth depression demonstrates both meaningful benefits and the need for accountability. Cuijpers and colleagues (2023) found benefits from psychotherapy, including a lower risk of deterioration compared with control conditions, yet many young people did not achieve a treatment response. Families need clinicians who monitor what is happening and reconsider the plan when necessary. Compassion should make us more willing to examine our results, not less.

Your Family Has a Right to Understand the Treatment

Informed consent should mean more than signing intake paperwork. Families deserve an understandable explanation of the proposed treatment, its rationale, supporting evidence, meaningful risks, uncertainties, alternatives, costs, and how progress will be evaluated. If a diagnosis is offered, ask what supports it and how it will guide care. Naming a teenager's suffering does not establish that the clinician understands its origins or knows how to help.

With adolescents, clinicians must also explain applicable consent requirements, developmentally appropriate assent, confidentiality limits, and the respective roles of parents and teenagers. The APA's ethics code addresses these responsibilities, along with professional competence (American Psychological Association, 2017). A signature cannot substitute for a candid conversation. Your teenager should understand the work in language appropriate to their age, and you should understand how to support it.

Parents can ask direct questions before committing: What experience do you have treating teenagers with similar concerns? How will assessment guide your recommendations? How will my child participate in setting goals? What will we do if treatment is not helping? Ask about the limits of the clinician's expertise and arrangements for urgent concerns. You do not need a dissertation over the telephone, but you should hear clear thinking, reasonable humility, and willingness to consider alternatives. If ordinary questions produce irritation or a performance of professional superiority, take that information seriously.

Your Child Is Not a Recruitment Opportunity

Your teenager enters therapy at a vulnerable moment. The clinician's authority can influence how that young person understands identity, family, faith, suffering, and personal possibility. Your child's pain must never become an opportunity to recruit another believer into the

therapist's worldview. I have become increasingly concerned about ideological capture within my profession: allegiance to a favored explanation taking precedence over careful investigation. The conclusion arrives before the assessment, and disagreement becomes evidence that something is wrong with the person asking questions.

My concern comes partly from supervising doctoral students. Some struggled to examine questions outside a dominant ideological framework; some reported fear of faculty disapproval if they expressed different views. Those experiences do not characterize every training program, but they reinforced my conviction that professional education must cultivate independent judgment. Universities should teach students to test explanations, examine evidence, and tolerate respectful disagreement. Institutional endorsement does not relieve a clinician of those obligations in the therapy room.

The practical test is how the therapist handles a different perspective. Can your teenager reconsider an explanation the clinician favors? Can parents raise concerns and receive a thoughtful hearing? Can the therapist acknowledge uncertainty or revise an assumption? If exploration is permitted only when it reaches a predetermined destination, the young person's freedom has already been compromised. A clinician should be able to explain recommendations without placing your motives on trial.

This standard applies equally to my Christian convictions. My faith does not authorize me to impose conclusions, humiliate a struggling teenager, or confuse spiritual agreement with psychological healing. Political commitments confer no such authority either. Your child deserves competent care, compassion, and room to ask difficult questions. Agreement with the therapist should never become the price of receiving respect.

Parents Belong in the Picture

Your teenager needs room to speak honestly, and you need to understand how treatment works and how to support it. A skilled adolescent therapist explains what can remain private, what parents can expect to learn, how safety concerns will be managed, and when family participation will be helpful or necessary. "I will tell your parents everything" can undermine trust, while "Your parents have nothing to do with this" can dismiss people essential to recovery. Thoughtful care requires a more careful arrangement, consistent with applicable law and the teenager's developmental needs.

Parents may also need to examine their contributions to family difficulties, including conflict, expectations, communication patterns, or well-intentioned protection that maintains avoidance. We should be willing to hear that. Sometimes genuinely unsafe family behavior needs attention; sometimes relationships need repair; sometimes parents are already doing an extraordinary job under difficult circumstances. Beware of a therapist who assigns blame before understanding the family or automatically assumes the adults are right because they pay the bill. Your teenager needs someone capable of understanding complexity without immediately assigning villains.

Watch for Progress and Know the Warning Signs

No therapist is perfect, and one awkward conversation does not automatically justify ending treatment. Patterns are more revealing. Be concerned when a clinician discourages second opinions, cannot explain the treatment plan, makes sweeping conclusions after minimal assessment, pressures your teenager to accept personal beliefs, dismisses deterioration, or encourages unnecessary dependency. Boundary violations and promises of a cure deserve particular scrutiny. Parents should be able to describe concerns without having them reflexively dismissed as resistance to treatment.

A quieter problem is pleasant stagnation. Everyone likes the therapist, appointments continue, and months pass. Yet nobody can explain what is improving or why the same approach remains appropriate. Some conditions require prolonged care, and progress is rarely linear, but duration should have a clinical rationale. Look outside the office: better sleep, more consistent school attendance, less avoidance, stronger relationships, fewer destructive arguments, and a growing ability to recover after disappointment. Review these changes with the clinician and your teenager rather than relying only on whether appointments feel good.

Therapeutic work can be uncomfortable. Your teenager may need to confront a fear, tolerate grief, accept responsibility, or abandon an escape behavior. Parents may need to make changes as well. The question is whether that discomfort serves an understandable purpose within competent, respectful care. Worsening symptoms deserve reassessment, not a professional shrug dressed up as “Trust the process.” Attendance is easy to count. Benefit requires closer attention.

Coping Better Is Important and Identity Matters Too

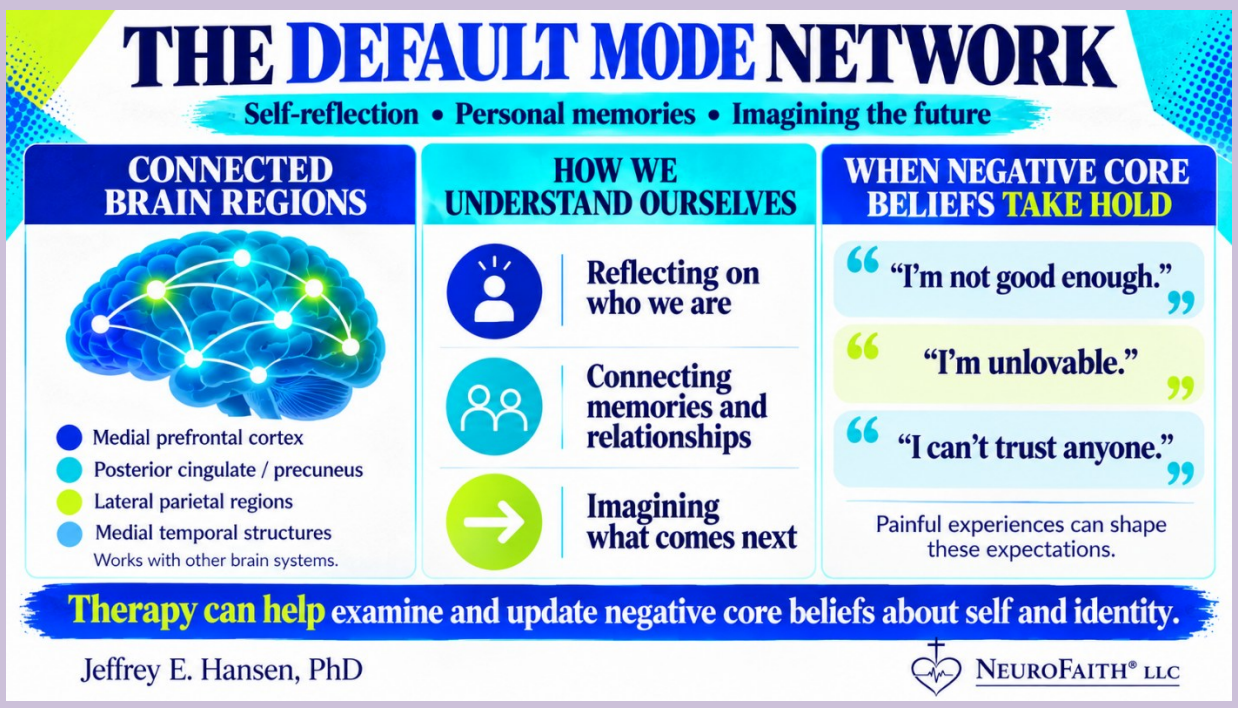
Dr. Tori Olds, one of my clinical psychology heroes, describes a useful distinction between incremental change, which develops through practice and new responses, and transformational change, which addresses underlying emotional expectations and core beliefs (Olds, 2026). CBT and DBT offer valuable tools for changing behavior, regulating emotions, tolerating distress, and developing healthier responses. Sometimes these changes provide exactly what a teenager needs. Sometimes they create the stability necessary to address deeper wounds. The important question is whether treatment reaches what is driving this particular young person’s suffering.

The brain’s **Default Mode Network (DMN)** helps explain why identity deserves attention. Its interconnected regions include the medial prefrontal cortex, posterior cingulate and adjacent precuneus, inferior parietal regions, and portions of the medial temporal lobes. This network participates in self-reflection, autobiographical memory, and imagining the future (Buckner et al., 2008). Think of it as part of the brain’s machinery for weaving experience into a continuing story of who we are. During adolescence, that story is still taking shape. Rejection, chronic criticism, neglect, abuse, or overwhelming events may contribute to painful expectations about worth and safety. These beliefs involve multiple brain systems, rather than residing in one network.

Imagine a teenager who experiences every correction as proof of worthlessness. Therapy may help that adolescent challenge catastrophic interpretations and manage the emotional reaction. Those gains matter enormously. But suppose the conviction underneath remains: "If I make a mistake, I am unworthy of love." The young person may behave better while continuing to experience life through shame. When such beliefs are central, therapy should explicitly address the schema, the organizing framework through which experiences become evidence of being defective, unsafe, or unlovable.

Over forty years, I have encountered too many people who became better at managing symptoms without substantially changing how they experienced themselves. That clinical observation is a reason to ask more ambitious questions about treatment. CBT can address core beliefs, and cognitive, behavioral, relational, and experiential work can all support deeper change. Memory reconsolidation offers a scientific framework for understanding how established emotional learning may be updated, although its precise role in psychotherapy remains under investigation (Lane et al., 2015). The goal is for a teenager to begin experiencing, with growing conviction, "What happened to me was painful, but it does not establish my worth."

Symptom improvement matters. So do relationships, belonging, purpose, and the ability to imagine a future worth participating in. We should ask whether treatment is helping the teenager become freer to live, love, accept responsibility, and contribute. We should also remain humble about what short-term symptom measures can tell us about a person's unfolding life. Brief treatment can be excellent when it fits the need, and longer work can be appropriate when the assessment supports it. An insurance authorization cannot do our clinical thinking, and an open-ended schedule cannot substitute for a clear purpose.



NeuroFaith® as One Approach to Transformational Work

One approach I have developed to pursue this kind of transformational work is **NeuroFaith®**, an integrative therapeutic model built around four pillars. I brought these approaches together because I kept encountering people who could explain their pain intellectually while their bodies, protective reactions, and deepest beliefs continued responding as though the old danger were present. You may know that a conversation is safe while your chest tightens, your breathing changes, and every impulse tells you to fight, withdraw, or disappear. An explanation alone may do little to alter that experience.

I want to emphasize **that NeuroFaith®** is one integrative approach to transformational therapy, **not the only one.** There are other excellent therapeutic models, and different approaches resonate with different people, clinicians, and clinical needs. I have no interest in suggesting that everyone should practice or pursue NeuroFaith®. Should you wish to explore another integrative, transformational approach, please do so with my wholehearted blessing and encouragement. Find the approach, and more importantly, the clinician, who is right for you. My interest is not in promoting a particular therapeutic brand, but in helping people experience meaningful and lasting change. What matters is not allegiance to a model, but whether therapy can reach beyond symptom management to address the deeper emotional patterns, protective responses, negative core beliefs, and questions of identity that may be organizing a person's suffering. The goal is healing and transformation, not loyalty to a particular method.

The first pillar, Polyvagal-Informed Therapy, provides a lens for exploring bodily states, perceived safety, and protective responses. In teen-friendly language, we might ask, "What happens in your body when you think you're in trouble?" Learning to notice a racing heart,

clenched jaw, or urge to shut down can help a young person recognize what is happening before the reaction takes over. **The second pillar, HeartMath® and neurocardiology,** brings attention to heart–brain communication and practices involving breathing, attention, and heart rate variability biofeedback. I use these practices to support regulation so that difficult feelings become more manageable and the teenager can participate more fully in the work (HeartMath Institute, n.d.).

The third pillar, Internal Family Systems, offers a compassionate way to understand wounded and protective parts of our inner experience (IFS Institute, n.d.). One part of a teenager may demand perfect grades, another may lash out when embarrassed, and another may want to hide from everyone. We can explore what those responses are trying to protect against and what the young person has come to believe about themselves. "A part of me is terrified of failing" opens a different conversation from "I am a failure." The work includes helping protective responses become less extreme while addressing the shame, fear, and negative core beliefs beneath them. Compassion and responsibility belong together; understanding an angry reaction does not excuse hurting someone.

The fourth pillar is Spirituality and Faith, explored in accordance with the teenager's convictions, willingness, and applicable consent arrangements. Questions such as "Do I matter?" "Where do I belong?" and "What could make my life meaningful?" deserve a thoughtful hearing. For teenagers who want Christian faith integrated into care, those beliefs can be engaged explicitly. Spiritual agreement is never a condition of receiving respect or competent treatment, and a parent's enthusiasm for faith integration should not replace listening to the teenager's own questions and experience.

In my clinical experience, this integration has been valuable in helping people work toward deeper change. **NeuroFaith®** is one approach to that goal. Its purpose is to help a young person develop greater regulation, approach painful inner experiences with compassion, and update beliefs about worth and identity. The hope is that "Something is wrong with me" gradually gives way to a more secure understanding: "I have been hurt, I have things to learn, and I am still worthy of love." That change should begin reaching daily life, through healthier relationships, greater willingness to face challenges, and a future that feels more possible.

Your Child Is Worth Getting This Right

After more than forty years sitting with children, teenagers, and families, I still feel the weight of being trusted with someone's child. Parents bring sleepless nights and the hope that we might know how to help. Teenagers sometimes bring very little hope at all. They may arrive guarded, angry, embarrassed, or exhausted from trying to explain something they barely understand themselves. Being invited into that struggle is a privilege. I hope I never become so professionally comfortable that I forget it.

I have made mistakes, reconsidered assumptions, and needed help from colleagues. I am still learning. Families deserve our honest thinking, careful attention, and willingness to recognize when our approach is falling short. My colleagues and I cannot ask patients to face uncomfortable truths while protecting ourselves from every uncomfortable question. When institutional demands interfere with appropriate care, we have a responsibility to make the clinical case for what the young person needs.

There are wonderful therapists who bring both skill and heart to this work. If your family has been disappointed, I hope you will keep looking. Ask the questions and expect thoughtful answers. Look for someone who notices the courage it took your teenager to walk through the door, someone tender with pain and steady enough to help your child face the difficult work ahead. Your questions and your teenager's voice belong in the room.

There is so much worth working toward: hearing your teenager laugh freely again, watching a friendship take root, seeing the courage to return to school, accept responsibility, or try again after disappointment. There is the possibility of a young person beginning to feel worthy of love and imagining a future with room for them in it. You do not need every answer to help hold that possibility open. Your child's story is still unfolding, and the care you seek should help them discover that life can become larger than this difficult chapter.

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