

Interviewing and “Vibing” with Adolescents: Tools from Psychology, Anthropology & Neuroscience



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THANK YOU!

Quick Check: Adolescents

- 01** What is an example of a time you had trouble communicating with an adolescent?
- 02** What is an example of a time you connected with an adolescent?
- 03** How does your own experience of adolescence - or of parenting adolescents - impact your view/work?

Wishes from our Adolescents

"Please tell them to **listen to us!**"

"Dude! **Just be YOU!** Stop trying to be "cool," or whatever you say.

"They might know some theories; **these are not me!**"

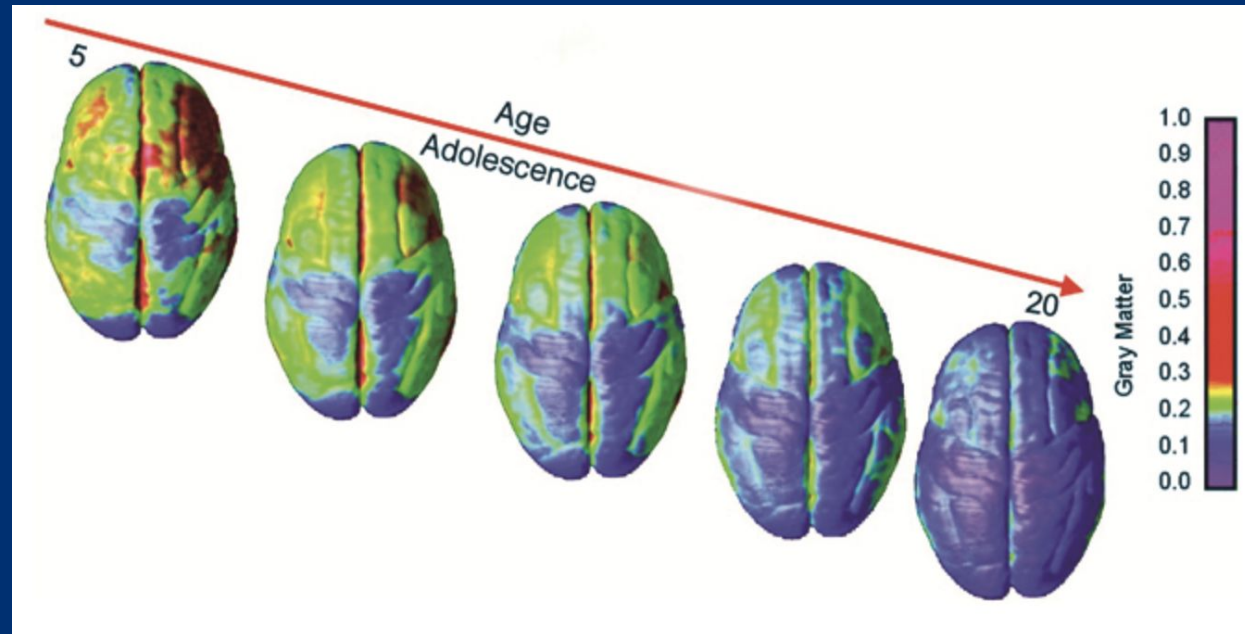
"These [court-related professionals], they have hypotheses, like 'alienation hypothesis' please tell them **this is not actual life**. We have to live this...if they believe the hypotheses I'd rather die."

"I might not like you, but I'll still **tell you stuff.**"

"Do NOT say one thing to my face and another behind my back. **Never ever again will I talk to you.**"

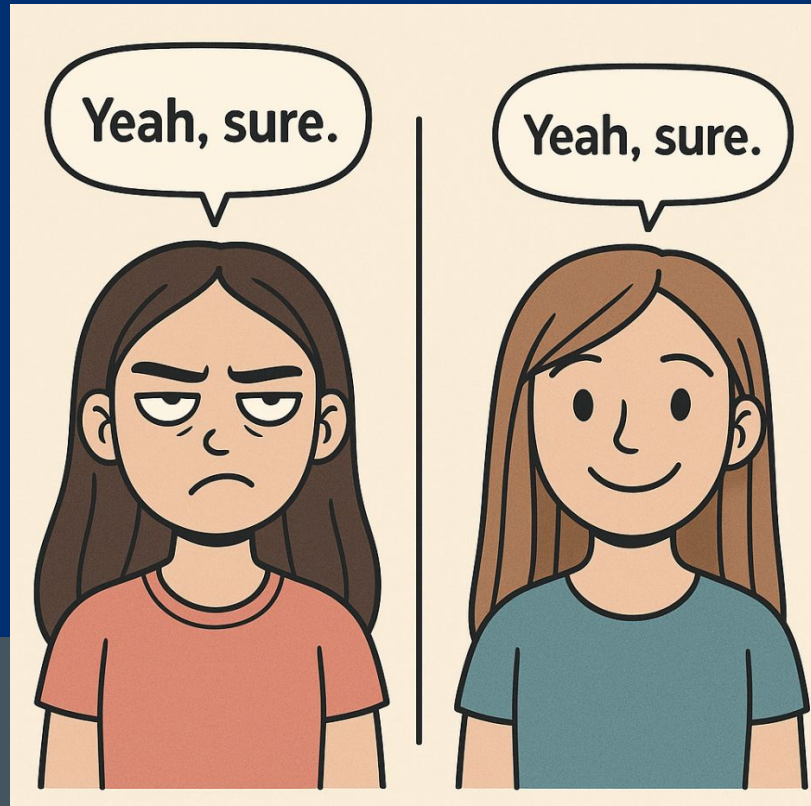
What does neuroscience teach us?

Brain structure and function matter



What does psychology teach us?

HOW someone says something matters



What does anthropology teach us?

Culture & perspective matter



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Our Goals for Today

01

Adolescent Brain Development

Focusing on brain development, communication challenges, and establishing clinical best practices.

02

Trauma-Informed Voice

Integrating psychology with voice-centered communication and adolescent linguistic listening skills.

03

Anthropological Tools

Utilizing cultural models and the adolescent communications hierarchy checklist for comprehensive analysis.



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What is Adolescence?



Neuroscience

Last significant period of neuroplasticity in the human life cycle, spanning ~12-25 years.



Psychology

Developmental time of remarkable growth in identity, peer relationships, cognitive, social, emotional, and moral development.



Anthropology

Period of transition between childhood and adulthood.

What else matters for our adolescents?

Key Challenges & Vulnerabilities

- **Trauma**
- **Broken trust and relationships**
- **Mental Health Crisis:**
Time where even under typical circumstances half struggle with mental health problem — virtually all of ours.
- **High-Risk Behaviors:**
Risk taking behavior skyrockets typically — ours exaggerated or foreclosure.

The Path to Healing & Resilience

1. Longing for Connection

And, they *long* for a caring adult relationship.

2. The Power of ONE

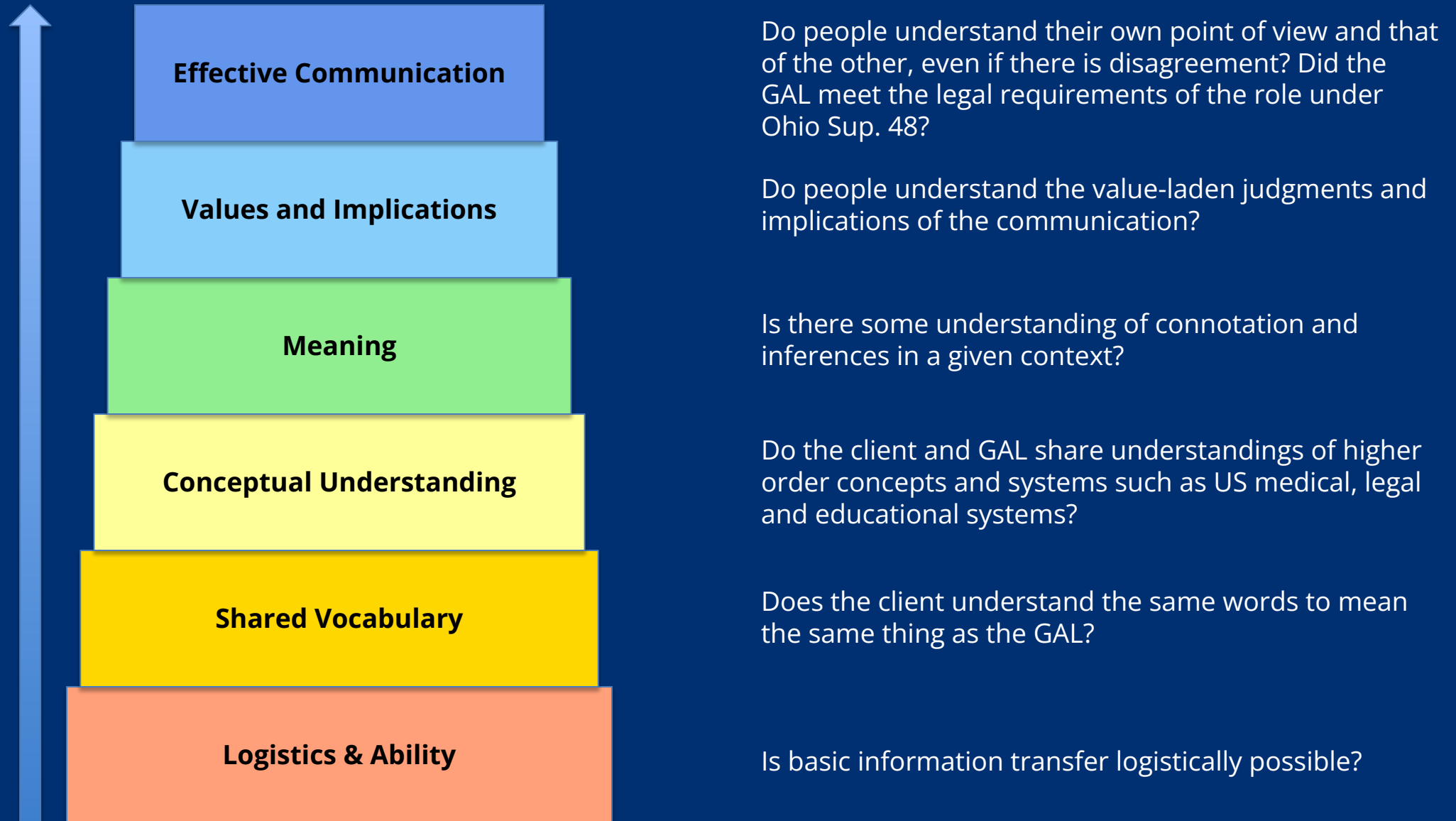
ONE caring adult relationship is enough for long term healing, resilience and thriving.

3. The Cornerstone

Listening well is a cornerstone to building such a relationship.

Communications Hierarchy of Needs for the GAL

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Short Checklist of Communications Hierarchy of Needs (Traywick & Anderson, 2025) Adapted for Adolescents

Logistics & Ability

Individual's Abilities

- ☐ Wants to (or understands they need to) communicate with CASA/GAL
- ☐ Is willing and able to schedule with the CASA/GAL
- ☐ Is physically able to hear and speak
- ☐ Speaks/understands English
- ☐ Is alert and oriented
- ☐ Is not under the influence of an inappropriate substance
- ☐ Has the cognitive capacity for a conversation
- ☐ Can use a cell phone
- ☐ Knows how to access the Internet

Electronic Communications

- ☐ Working phone & charger
- ☐ Phone service
- ☐ Access to Wi-Fi /Internet

Environment

- ☐ Quiet enough
- ☐ Privacy to discuss confidential issues
- ☐ Limited distractions (electronic devices turned off or on silent unless being used to enhance communications)
- ☐ Place individual feels safe
- ☐ Place CASA/GAL feels safe
- ☐ Online conference/Zoom capacity (if relevant)

Shared Vocabulary

- ☐ Does the individual speak and understand English fluently

- ☐ Understands their own educational issues
- ☐ Understands their own medical issues
- ☐ Understands safety for themselves

Meaning

- ☐ Understands the role of the CASA/GAL
- ☐ Understands the role of the child's attorney (if applicable)
- ☐ Understands the difference between privilege and confidentiality
- ☐ Understands the role of the case worker and any organizations involved
- ☐ Understands their responsibilities in the situation

Values and Implications

- ☐ Understands implications of words/actions within the system
- ☐ Understands CASA/GAL's position, even if different from their own
- ☐ CASA/GAL understands individual's position, even if different from theirs
- ☐ Understands CASA's/GAL's concerns in a situation
- ☐ Understands CASA's/GAL's safety concerns in a situation
- ☐ CASA/GAL understands individual's safety concerns or lack thereof/different values
- ☐ CASA/GAL has communicated their interpretation of observable facts (e.g. mess, safety concerns, medical/educational neglect, etc.)
- ☐ Adolescent shares their own valuation of experiences (even if CASA/GAL sees it differently)

- ☐ Is the individual developmentally able to converse about the topic
- ☐ Does the individual have adequate/typical cognitive functioning
- ☐ Does the individual have culturally different understanding of words
- ☐ Does the individual have generationally different understanding of words

Conceptual Understanding

- ☐ Understands legal system roles (judge, magistrate, attorney, GAL, CASA)
- ☐ Understands custody/visit types
- ☐ Understands abuse, neglect, and dependency as defined by law

Effective Communication

- ☐ Individual knows what to expect from CASA/GAL generally and at hearing/trial
- ☐ Difficult issues discussed prior to court date
- ☐ Individual understands what actions are necessary to achieve outcomes & how to do so
- ☐ Adolescent feels adequately summarized/described, even if there is ultimate disagreement with CASA/GAL
- ☐ Adolescent can describe CASA/GAL position and logic
- ☐ Adolescent weighs in on CASA/GAL report as appropriate; dissent can be noted



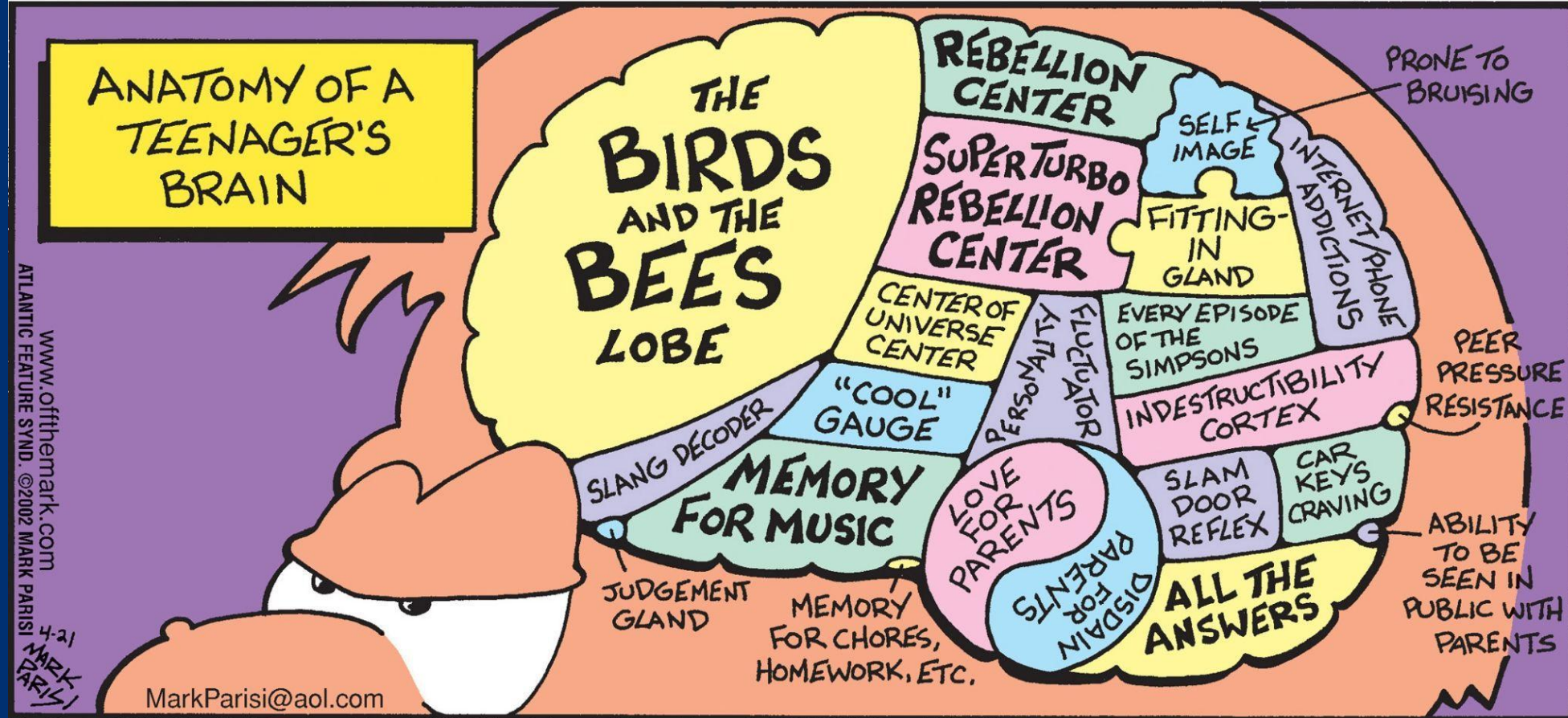
The child him/herself recognizes and approves of the “child’s wishes”

Adolescent Brains

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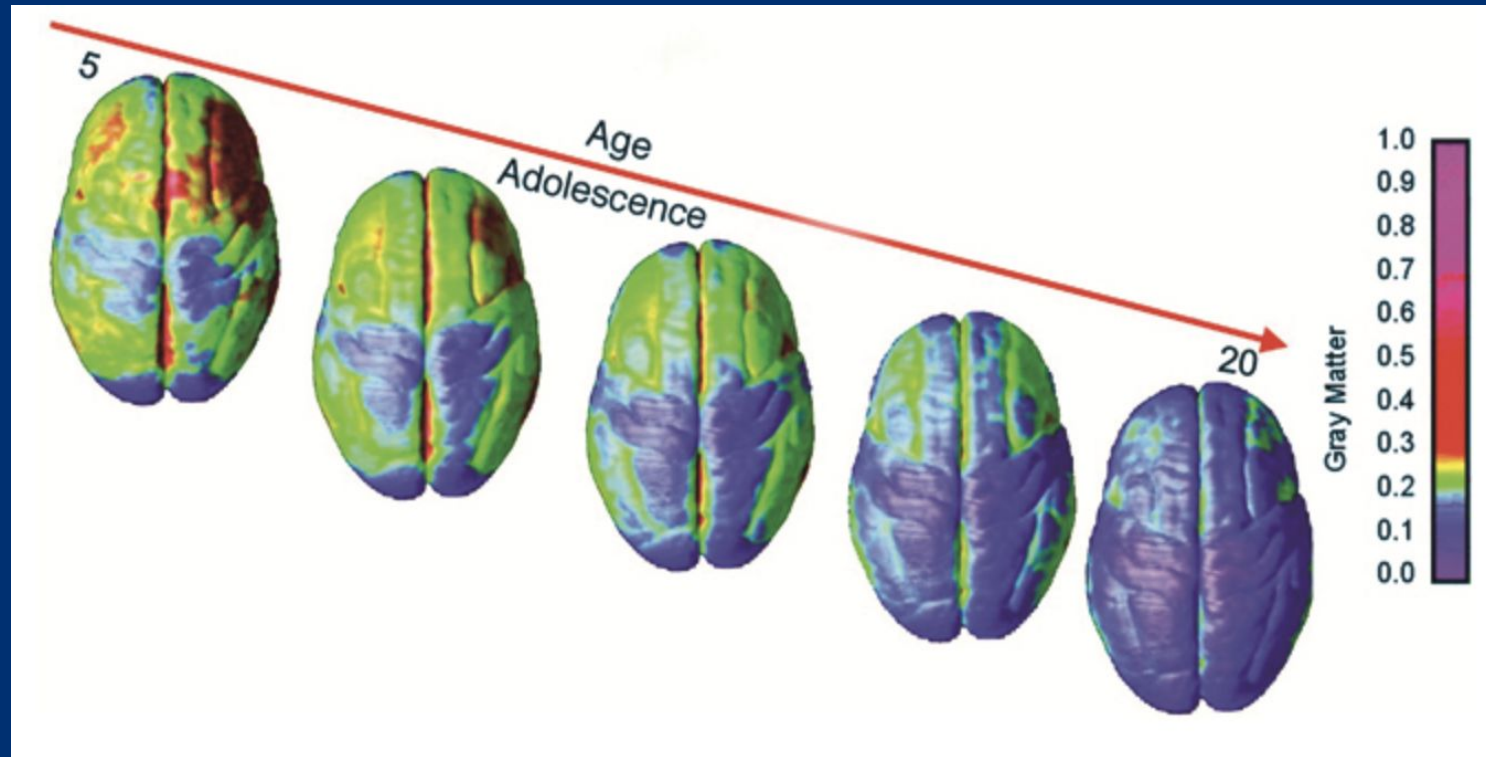
by Mark Parisi



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Typical Adolescent Brain Development



The adolescent brain with trauma

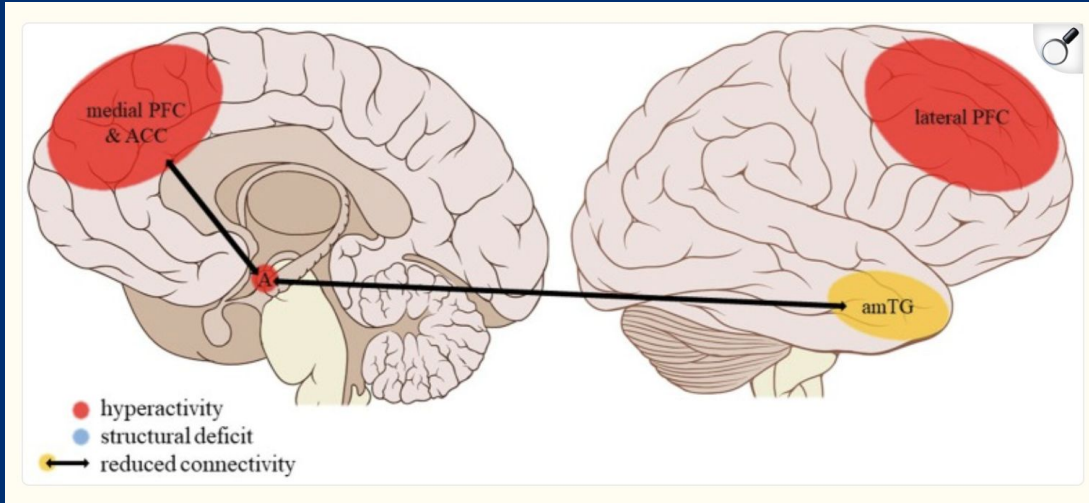
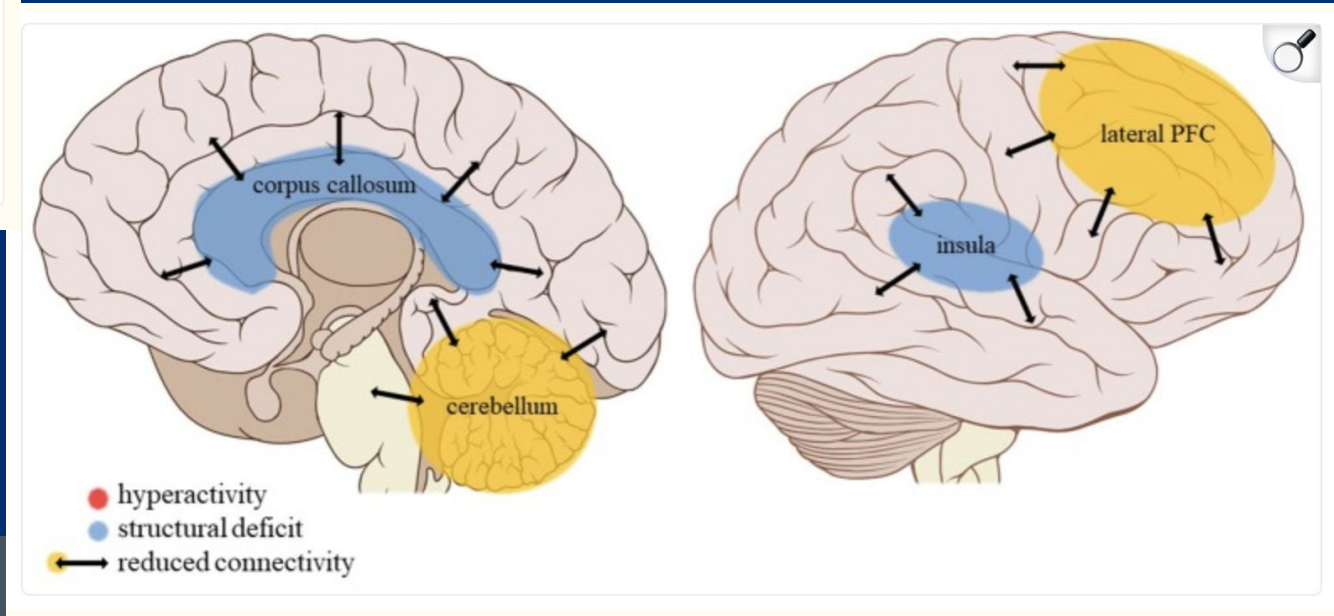


Figure: Neuroimaging findings associated with childhood abuse showing structural deficits in the reward circuit, genitosensory cortex, and amygdalar hyperreactivity during sad autobiographical memory recall. From *Cassiers, L. L. M., Sabbe, B. G. C., Schmaal, L., Veltman, D. J., Penninx, B. W. J. H., & Van Den Eede, F. (2018). Structural and Functional Brain Abnormalities Associated With Exposure to Different Childhood Trauma Subtypes: A Systematic Review of Neuroimaging Findings. *Frontiers in Psychiatry*, 9, Article 329.



Adolescent Brain With Trauma - Summary

BRAIN DEVELOPMENT & PLASTICITY

Neural pruning continues, meaning trauma can get **“wired in”** for adulthood. (Note: significant plastic healing time remains, alongside emerging therapeutic modalities.)

RELATIONAL THREAT

Hypervigilance

Adolescents are **hypervigilant** about relational threat in their interactions and environment.

COGNITIVE LOAD

Communication Challenges

Communication is more difficult due to **cognitive and working memory deficits**.

EMOTIONAL REGULATION

Affective Control

Emotional regulation is significantly more difficult under trauma-impacted states.

NARRATIVE PROCESSING

Narrative Derailment

Narrative creation can get derailed at multiple points due to **attentional and contextual challenges**.

Working with Adolescents with Trauma: Neuroscience-Informed Strategies

RELATIONAL THREAT

Hypervigilance

- Be authentic!
- Ensure predictability in contact; give limited-choice control
- Transparent discussion of roles

Adolescents are highly sensitive to perceived relational threats.

COGNITIVE LOAD

Communication

- Keep sessions shorter
- Multi-modal contact (Talk, Text, Video, Memos, Multi-media, Parallel, etc.)
- Check-ins/feedback

Working memory deficits make narrative creation difficult.

EMOTIONAL CONTROL

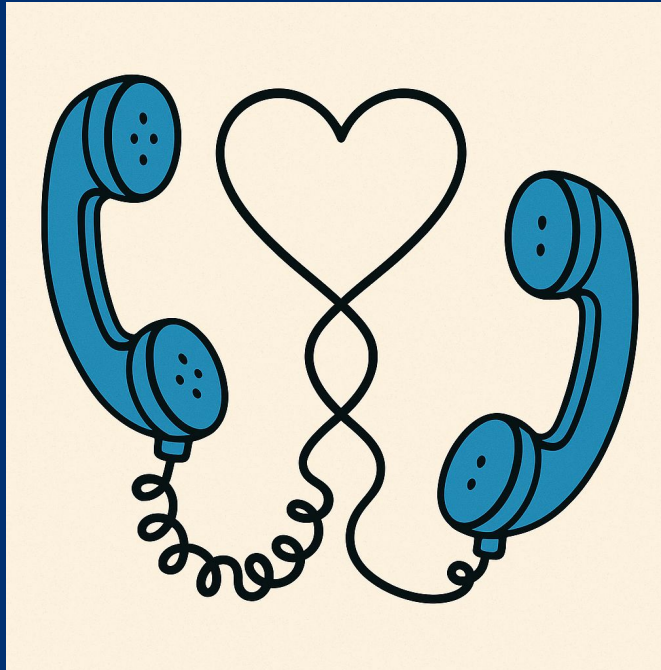
Self-Regulation

- Explicit discussion of coping skills
- Bookend with neutral, adult-led topics
- If overwhelmed, change course immediately

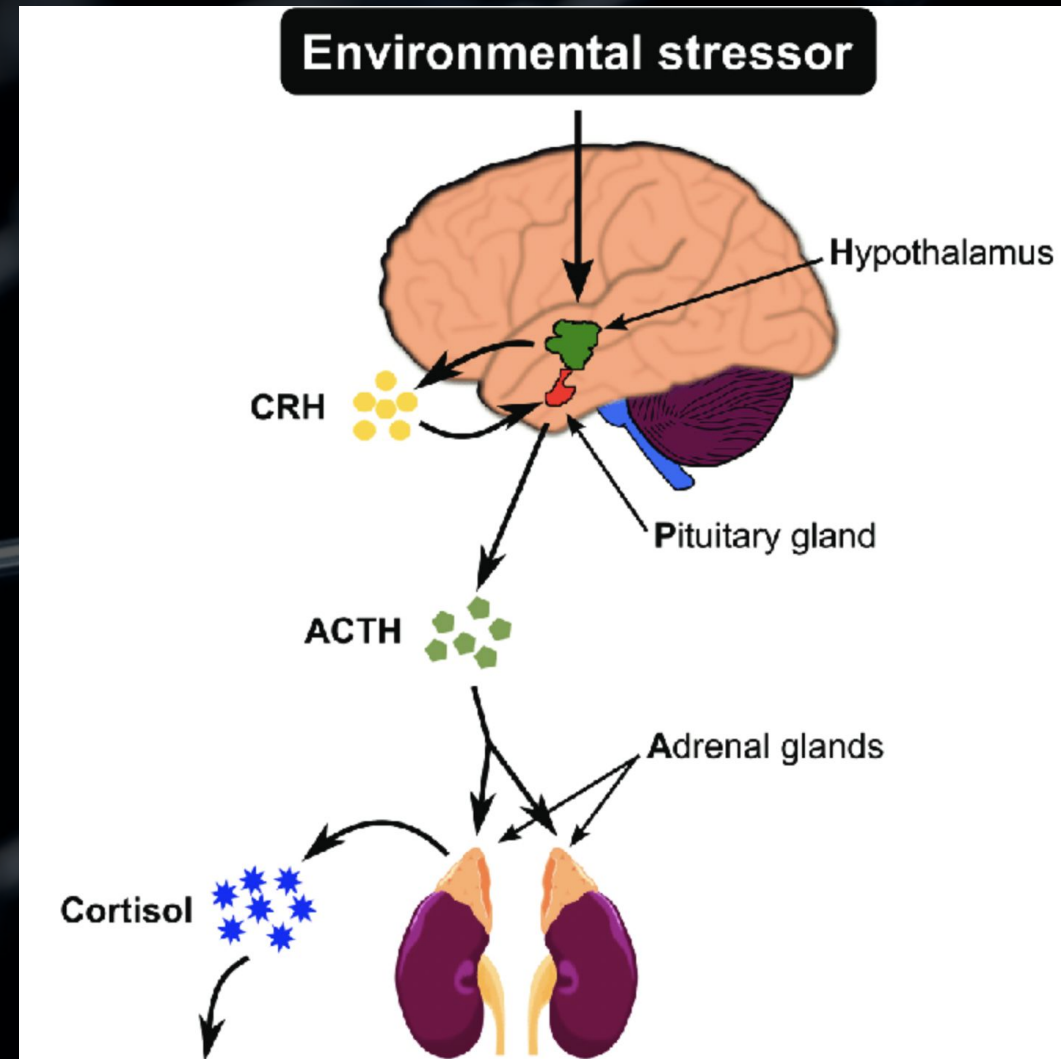
Amygdalar hyperreactivity complicates emotional control.

Core Themes: Authenticity, Transparency, Multi-modal contact, and Regulation

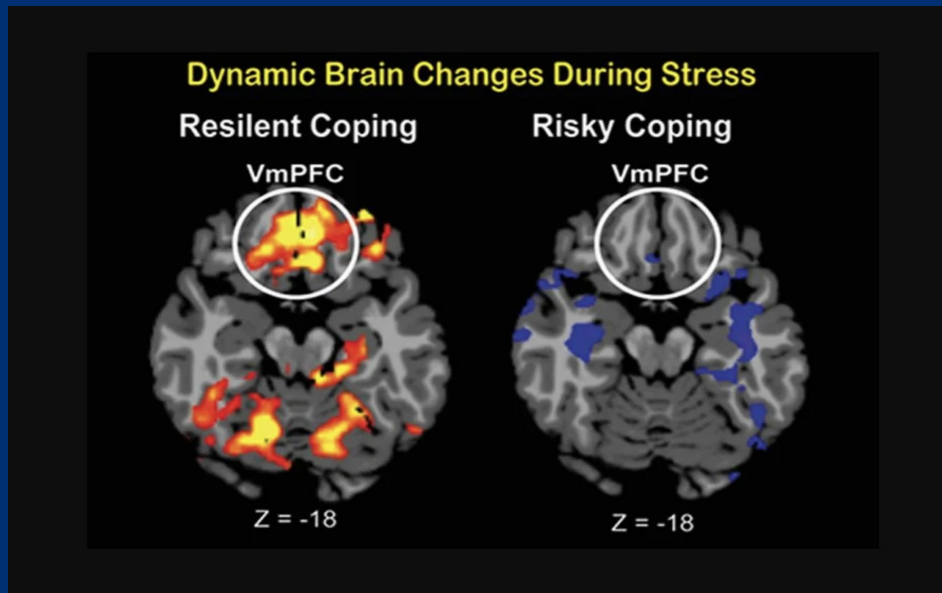
Trauma-Informed Communication Best Practices: How WE speak/listen matters...



The brain on stress:

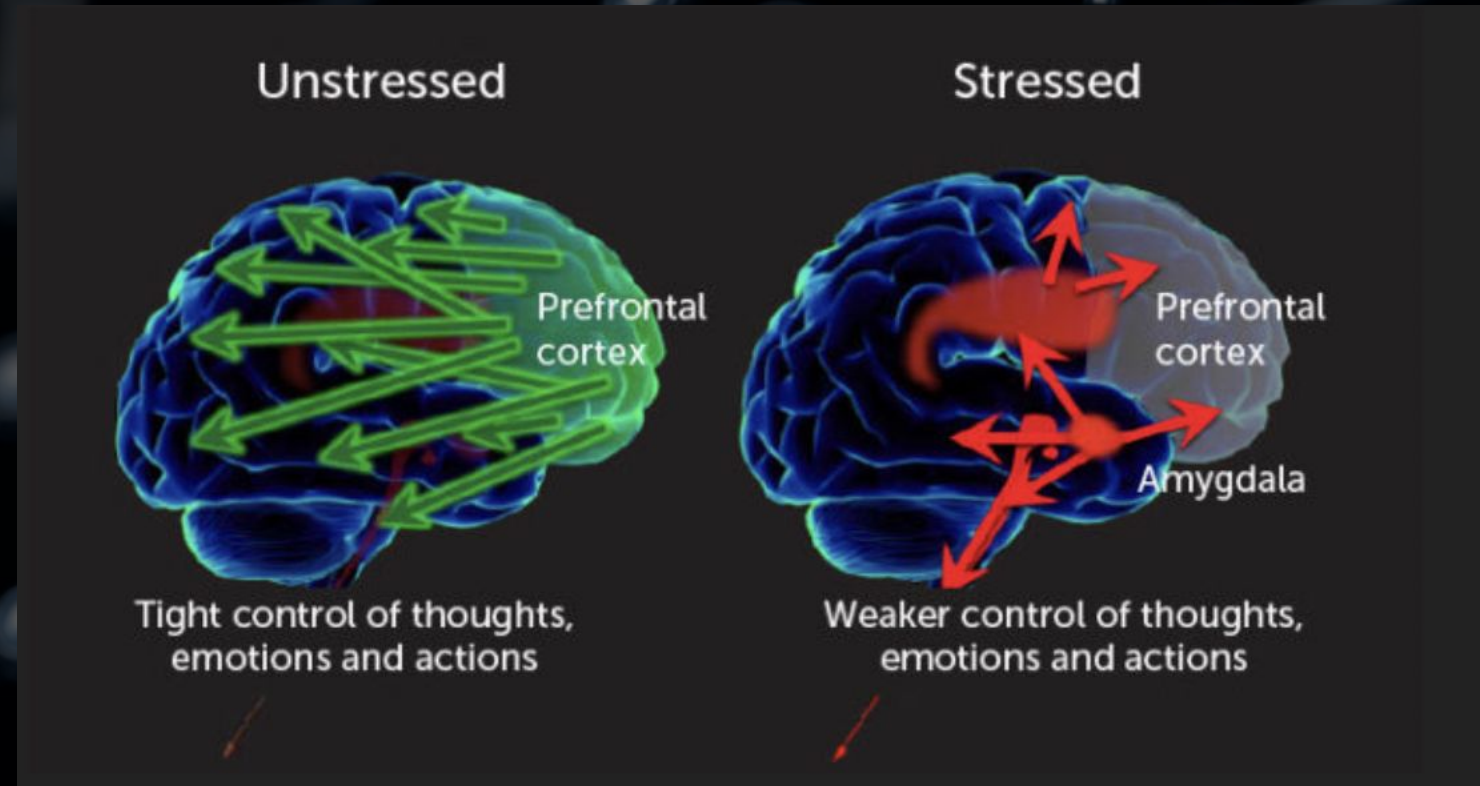


Working with the brain on stress



- Trauma affects how people **process and respond to information**. When traumatized people of all ages may:
 - Dissociate or “zone out” during questions.
 - Respond with aggression, silence, or contradictory statements.
 - Misinterpret tone or intentions as threatening.
 - Can be heightened during adol
- The midbrain survival drive may override the prefrontal cortex ability to suppress impulse and reason or speak clearly.

The brain on stress:



Trauma-Informed Communication (SAMHSA; NCTSN; ACEs)

Core Principles of Trauma-Informed Communication

1. Safety

To the best of your ability, create a physical and emotional environment where the child or adult feels secure.

Unrushed.

E.g.: Choose private, quiet spaces; avoid abrupt tone changes or body language; put phones away.

2. Trustworthiness & Transparency

Be clear about your role, the purpose of conversations, and what will happen with the information shared. Acknowledge that some topics may be difficult to talk about.

3. Empowerment & Choice

Offer appropriate choices and respect personal boundaries.

E.g.: Let the child choose where to sit or if they'd prefer to draw or use fidgets while talking.

Trauma-Informed Communication (SAMHSA; NCTSN; ACEs)

Core Principles of Trauma-Informed Communication (con't)

4. Empathy & Validation

Reflect the person's feelings without judgment or interrogation.

E.g.: "That sounds really hard. It's okay to feel that way."

5. Cultural Humility

Acknowledge and respect different backgrounds. Avoid assumptions based on identity.

E.g.: Ask open-ended questions like "What's important to you and your family?"

6. Avoiding Re-traumatization

Minimize unnecessary retelling of traumatic events, use neutral (i.e. not accusatory) language when possible, steer clear of "why" questions that sound blaming.

Say: "What happened next?"

Avoid: "Why didn't you tell someone sooner?"

Active Listening



Principles of Active Listening (APA, ABA, AMA, NCA, ICA)

1. Framing (& Introduction)

This is what we are doing, what it might be like and why

2. Observation v. Interpretation

3. Listen with All Senses (Be Fully Present)

Active, trauma-informed listening involves attention to **verbal and non-verbal cues**:

- Observe body language, eye contact, tone, and pacing.
- Look for signs of discomfort, fear, or shutdown (e.g., fidgeting, silence, looking away). Use repair bridges if needed (e.g. “it looks like that made you uncomfortable; would you like to come back to that?”)
- Don’t interrupt. Let the person take their time.

Principles of Active Listening

4. Reflect and Rephrase Carefully

Reflecting back what the interlocuter said can show understanding, but it must be done gently:

- Paraphrase and repeat back what the person said and ask if it reflects their meaning. Modify if necessary until there is shared understanding.
- Avoid repeating traumatic words or details when possible

5. Ask Open-Ended Questions

Encourage more than yes/no answers.

- Start with “What,” “How,” or “Tell me about...”
- “Can you give me an example of x?”
- “Can you tell me about a time when y happened?”

Principles of Active Listening (con't)

6. Use Minimal Encouragers

Small verbal and non-verbal cues that say “I’m listening.”

E.g.: “Mm-hmm,” “I see,” nodding

Body language e.g. leaning slightly forward, arms not crossed.

Avoid interrupting or shifting the topic too soon.

7. Respond Empathetically

Acknowledge and validate feelings when possible

Don’t try to minimize or overpromise

Instead, say: “That sounds really hard,” or “A lot of people would feel that way.”

Principles of Active Listening

8. Clarify When Needed

Don't guess – ask (watch tone).

- **Use clarifying questions to ensure you understand.**
- **“Can you help me understand what you meant by that?”**

9. Summarize and Close Thoughtfully

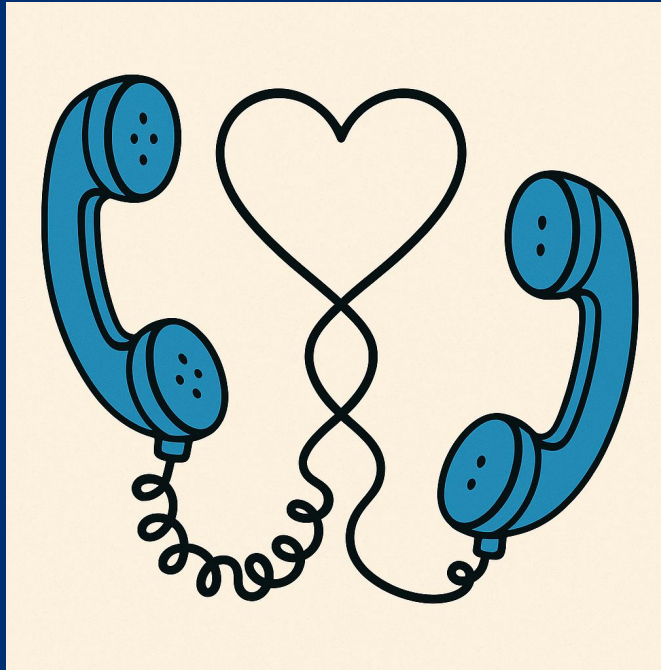
Wrap up by summarizing what you've heard.

Helps confirm key points and lets the speaker correct or expand.

For children, use simple, reassuring language to close the conversation gently.

Why it matters: Summarizing shows the speaker their words were valued and prepares them for what happens next.

Trauma-Informed Communication Best Practices: How the ADOLESCENT speaks matters...



Adaptation of a Voice-Centered Relational Framework to Explore the Perspective of Parents Who Have Transitioned to Home with a Child With Complex Care Needs

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Table 2. Framework used for analysis.

Reading	Questions considered
Reading for the plot and evaluating the narrative	What is the story being told by this parent? What are the key elements of that story? What images come to your mind when listening to the story? Are there contradictions in the story? Are there aspects of this story that are “unbelievable”? What impact does this story have on you as a person? What impact does this story have on you as a professional?
Reading for the voice of “I”	How many times is the personal pronoun used? What is the context of that pronoun’s use? Does the use of the “I” reflect an emotion or an opinion? Does the voice rise and fall to instill emotion? Is there evidence of distress? Anger? Frustration? Confusion? Resignation? Is “they” or “them” mentioned? What is the context of that? Are aspects of “I” as a parent noted?
Reading for relationships	How are people spoken about? How did relationship help or hinder the experience of the parent? Is there anything about the parent relationship to others and their feelings about that (for example, hopelessness, frustration, acceptance)?
Placing people within cultural contexts and social cultures	How do parents refer to the experience of caring for their child in the Irish system? How important is geography and environment (both at home and in hospital)? Are there any issues of race, gender, ability/disability to contend with? What is unspoken (that is, what might they be choosing not to say for fear of reviving old memories or being seen as critical of the system)? Were parents able to “negotiate” the system to their child’s advantage?

Cultural Models

- We all are born into multiple layers of culture
- What is **culture**?
 - A system of beliefs and behaviors shared by a meaningful social group



Cultural Models

- We have culturally derived ways we think about what is “good,” “desirable,” and “healthy.”
- However, there is significant variation
- E.g. “All fathers want to be good fathers”
 - But on the ground, this can look diametrically opposed

Cultural Models

- Who has them?
 - Supervisor
 - CASA/GAL
 - Each parent/custodian
 - Each child, especially by adolescence
 - Judges
 - Magistrates
 - DCFS/CPS
 - Health professionals
 - ...everyone involved!



Table 1 Anderson Healthy Child Development Cultural Models Questionnaire ©

AHCD-Q: Describe what a healthy, thriving child at age(s) [focal child/ren's ages] look(s) like.
Sample script: <i>I am trying to understand your perspective on what a healthy and thriving child x-years old looks like. I am going to ask you 10 questions that you may answer any way you wish. You may also add additional information I did not ask if you think it is important.</i>
1. What does a healthy, thriving x-year old look like?
2. What kinds of activities should this child be engaged in?
3. How should they behave at school? At home?
4. What makes them a “good” baby/child/adolescent?
5. What is “bad” or undesirable behavior from a child this age?
6. What are the most important factors in this child’s physical well-being?
7. What are the most important factors in this child’s emotional well-being?
8. What are the most important factors in this child’s social well-being?
9. Who are important people for this child to have in their life?
10. What do you hope for most for this child’s future?

Table 2. Anderson Healthy Parenting/Caregiving Cultural Models Questionnaire ©

AHPC-Q: Describe what a “good parent” or “good caregiver” looks like.
<i>Sample script: I am trying to understand your perspective on what good parenting/caregiving looks like. No parent/caregiver is perfect, but we all have goals and ideals we try to uphold. I am going to ask you ten questions that you may answer any way you wish. You may also add additional information I did not ask if you think it is important.</i>
1. What makes a parent a “good parent” or “good caregiver”? Why?
2. What is most important to do as a parent/caregiver?
3. What should a parent/caregiver never do?
4. What makes for a “bad parent” or “bad caregiver”? Why?
5. What challenges do you have right now with meeting your parenting/caregiving ideals?
6. How do you discipline/correct a child this child’s age?
7. What should be the relationship between home and school with respect to this child?
8. What should be the relationship between home and health care professionals with respect to this child?
9. Who else is important in this child’s life? Why?
10. How do you understand the role of the CASA/guardian ad litem, and what are your expectations for me?





Table 3. Anderson Adolescent Cultural Models Tool ©

AACM-Q: Describe your current goals for yourself	
Sample script: <i>I'm going to ask you some questions about your goals for yourself and your experiences of achieving your goals. These questions are designed for me to help you. I would like to hear answers to all the questions. You may answer how you like, ask more questions, not answer, or add other information.</i>	
1.	What do you hope for in the next stage of your life when you are 18?
2.	How will you know you are a successful young adult?
3.	What is an unsuccessful young adult?
4.	What does your ideal relationship with your parent(s) or guardian(s) look like?
5.	How will you know when you are achieving your current goals?
6.	How can your parent(s) or guardian(s) best support you through this next phase of your life?
7.	What in their relationship hurts or limits you in achieving this next phase of life?
8.	How will you use what you have learned during adolescence to help others?
9.	What else should I know to help you do well and be well?
10.	What do you understand about my role and how I can help you?



Listening: some tools from psychology & anthropology

Noting/positionality

Listening x 3:

1. Narrative/plot/story

2. Language (keywords, “I” language)

3. Relationship(s); what’s at stake

Discrepant Data

Description v. interpretation

Data check

Vignette 1: “I’m Fine”

Marcus is a 13-year-old boy living in Cuyahoga County. Juvenile court became involved after a neighbor called a well check and police found him and his eight-year-old brother alone overnight. Their mother was hospitalized following an opioid overdose. No other adult resided in the home. Marcus and his brother were temporarily placed with their maternal aunt, and the court appointed a CASA.

Marcus attends school regularly and earns mostly Bs. Teachers describe him as funny, polite, and protective of his younger brother. Since the placement, however, he has become tired, irritable, and frequently asks to leave class. He says that nothing is wrong.

During the CASA’s first visit, Marcus keeps his hood up, looks at his phone, and answers most questions with “I don’t know,” “whatever,” or “I’m fine.” When asked about his mother, he says, “She made one mistake. Everybody needs to stop judging her.” When asked whether he feels safe returning home, he shrugs and says, “It doesn’t matter what I say. You’re all going to do what you want.”

His aunt later tells the CASA that Marcus becomes anxious when his mother does not answer his calls. Marcus has also been checking whether his brother has eaten, completed his homework, and taken his asthma medication. The aunt believes Marcus has been functioning as his brother’s parent for several years. Marcus insists that he wants to return home immediately and asks the CASA not to tell anyone what his aunt said.

Vignette: “I’m Old Enough to Decide”

Clermont County abuse, neglect, and dependency case with a CASA

Kayla is a 15-year-old girl living in rural Clermont County. The juvenile court became involved after repeated reports that her father was drinking heavily, leaving her alone overnight, and becoming verbally aggressive during arguments. The family has unreliable transportation and limited access to behavioral-health services. Kayla is temporarily staying with her paternal grandmother.

Kayla wants to return to her father. She believes that at 15 she is old enough to decide where she lives. She views the CASA as another adult who intends to ignore her wishes.

At their first meeting, Kayla keeps her arms crossed, looks at her phone, and rolls her eyes when the CASA explains their role.

“I already told everyone what I want. I’m fifteen, not five. You don’t know me, and you’re not going to decide my life after talking to me for twenty minutes.”

When the CASA asks about her father’s drinking, Kayla responds, “He drinks. So do lots of adults.” When asked whether she feels safe, she says, “That is such a stupid question.” She accuses the CASA of twisting her words and refuses to answer further questions.

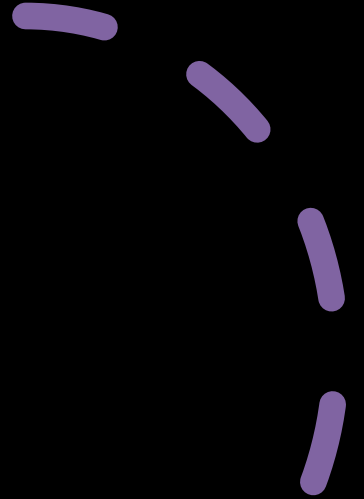
Kayla’s grandmother reports that Kayla becomes anxious when her father does not respond to texts. She also says Kayla regularly made dinner, managed household bills online, and covered for her father when he missed work. Kayla denies that these responsibilities were a problem:

“That’s what families do. At least I’m useful there. Here, everyone treats me like a little kid.”

Before ending the meeting, Kayla tells the CASA: “You can write whatever you want. Nobody listens to kids anyway.”



**Questions?
Comments?**



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KIDS' HEALTH
— AND THE COURTS —

THANK YOU again!

