The ELEMENTS *of* Counseling *Children and Adolescents*

Catherine P. Cook-Cottone
Linda S. Kane
Laura M. Anderson

SPRINGER PUBLISHING COMPANY

The Elements of Counseling Children and Adolescents

Catherine P. Cook-Cottone, PhD, is associate professor in the Department of Counseling, School, and Educational Psychology, University at Buffalo. She is also a licensed psychologist, certified school psychologist, and certified/registered yoga instructor with a private practice. Dr. Cook-Cottone teaches classes in counseling with children and adolescents, mindfulness interventions, and yoga therapy for mental health. Working with adults, adolescents, and children, she specializes in the assessment and treatment of anxiety-based disorders, eating disorders, and development of emotional regulation skills. She is the author of the upcoming book *Mindfulness and Yoga for Embodied Self-Regulation: A Primer for Mental Health Professionals*, coauthor of *Healthy Eating in Schools: Evidence-Based Intervention to Help Kids Thrive,* and has authored more than 50 refereed journal articles and book chapters. Dr. Cook-Cottone has presented numerous workshops at both national and regional conferences.

Linda S. Kane, MEd, LMHC, is a licensed mental health counselor and a certified school counselor in the Williamsville Central School District and has also been an adjunct professor at University at Buffalo. As a trained yoga instructor, she implements the mindfulness, wellness, and relaxation techniques of yoga philosophy with her clients and is a co-author of a book on this topic. Her areas of interest and expertise in working with children and adolescents include prevention, early intervention, and treatment of eating, anxiety, and mood disorders; assertiveness training; media resistance; and emotional coping. She is a certified yoga instructor and implements mindfulness, wellness, and relaxation techniques of yoga philosophy with her clients. She is coauthor of *Girls Growing in Wellness and Balance: Yoga and Life Skills to Empower.*

Laura M. Anderson, PhD, is an assistant professor and director of the PULSE Healthy Weight Research Team at the School of Nursing, University at Buffalo. She is also a licensed psychologist. Her work with at-risk populations in urban and rural settings has inspired her interest in healthy weight and mental health in children and families. Dr. Anderson maintains a private practice specializing in the assessment and treatment of behavioral, mood, and anxiety-based disorders. She has authored more than 20 peer-reviewed journal articles and book chapters and has presented at numerous national and local professional and academic conferences.

The Elements of Counseling Children and Adolescents

Catherine P. Cook-Cottone, PhD
Linda S. Kane, MEd, LMHC
Laura M. Anderson, PhD

SPRINGER PUBLISHING COMPANY
NEW YORK

Springer Publishing Company, LLC
11 West 42nd Street
New York, NY 10036
www.springerpub.com

Acquisitions Editor: Nancy S. Hale
Production Editor: Shelby Peak
Composition: S4Carlisle Publishing Services

ISBN: 978-0-8261-2999-4
e-book ISBN: 978-0-8261-3004-4
Instructor's Manual ISBN: 978-0-8261-3019-8

Instructors may request the Instructor's Manual by emailing textbook@springerpub.com

14 15 16 17 / 5 4 3 2 1

Library of Congress Cataloging-in-Publication Data

Cook-Cottone, Catherine P.
The elements of counseling children and adolescents / Catherine Cook-Cottone, PhD, Linda Kane, MA, LMHC, Laura Anderson, PhD.
pages cm
Includes bibliographical references and index.
ISBN 978-0-8261-2999-4—ISBN 978-0-8261-3019-8 (instructor's manual)—ISBN 978-0-8261-3004-4 (ebook) 1. Children—Counseling of. 2. Teenagers—Counseling of. 3. Counseling. I. Kane, Linda. II. Anderson, Laura (Laura M.) III. Title.
BF636.6C663 2015
158.3083—dc23

2014028650

Printed in the United States of America by Edwards Brothers.

To Jerry, Chloe, and Maya Cottone. Thank you for all of your support. I love you always.—Catherine Cook-Cottone

With deep gratitude for the love and support of my family and friends who are encouraging, inspiring, and present . . . especially my daughter, Makenzi.—Linda Kane

To Kim, sweet Gloria Joan, and my parents. You keep me going. All my love and gratitude.—Laura Anderson

Contents

Foreword

This book is the product of a sincere and well-considered effort to describe the foundational elements of counseling and psychotherapy with children and adolescents. It answers the question, what are the key ideas to conducting effective therapy with young people?

The field of counseling and psychotherapy is notable for its hundreds of different approaches. All claim to be effective, many with empirical support. But equally important at this early stage of research is the judgment of experienced clinicians, teachers, and researchers who know the field. The authors are such people.

Their choices of over 50 key elements are sound. They include

1. Important preliminaries, such as explaining counseling procedures and addressing confidentiality and privacy
2. Attending to process, including reflecting, being concrete, and summarizing
3. Increasing self-awareness, such as teaching distress tolerance and paying attention to nonverbals
4. Avoiding mistaken assumptions on the part of the counselor, such as assuming that emotional development matches cognitive development
5. Descriptions of crisis intervention and mandated reporting
6. Brief descriptions of age-relevant interventions, including play therapy and family therapy

For therapists working with children and adolescents, these are the foundational categories. The authors' choice of key elements results in a book that provides knowledge essential for beginning counselors to learn and for experienced counselors to review. The book may be employed as an advanced organizer for subsequent instruction and practice, providing a way to think about counseling and clarifying the nature of the counseling process. Consequently, *The Elements of Counseling Children and Adolescents* should be useful for students in the helping professions, including psychiatry, psychology, social work, and counseling.

Scott T. Meier, PhD
University at Buffalo

Preface

With encouragement from Meier and Davis, we (i.e., Catherine Cook-Cottone, Linda Kane, and Laura Anderson) present a much-needed book bestowing the key elements that comprise the practice of counseling with children and adolescents. We are excited to share our extensive experience both in teaching the counseling process to graduate students and in working in schools and private practice with children, adolescents, and their families. We offer a focused and practical guide to supplement course work in counseling children and adolescents.

The *Elements* concept is not new. William Strunk Jr. first published *The Elements of Style* text in 1919. It was and has remained, across several editions and years, an introduction to clear, concise writing for college students. In 2005, Scott Meier and Susan Davis published *The Elements of Counseling*, inspired by the current edition of the famous text (e.g., *The Elements of Style;* Strunk & White, 2000). In essence, the objective of these texts is to distill essential elements of a process (e.g., writing or counseling)—the most potent and practical guidelines—in a user-friendly manual.

A TEXT BORN FROM NECESSITY

This book is designed to be an introductory or supplemental textbook for graduate courses in counseling with children and adolescents.

It would be appropriate across the helping professions fields: social work, counseling psychology, clinical psychology, school psychology, school counseling, mental health counseling, and rehabilitation counseling. I (Catherine Cook-Cottone) have been teaching a course titled Counseling With Children and Adolescents for nearly 20 years. In an effort to teach what my husband calls an art form, I have used a variety of course packets of empirical articles, textbooks, and case studies. Never satisfied with attempts at organizing volumes of writings into understandable elements of knowledge, I decided to do what William Strunk Jr. did in 1919 to help his students learn their art—writing. I began to "cut the vast tangle of . . . rhetoric down to size" into digestible rules and principles, a set of guidelines from which my students could effectively work with children and adolescents. Essentially, I have been working to identify and deliver a key set of elements that could guide them in their practice and refocus them when they struggle.

KNOWLEDGE AND PRACTICAL SKILLS PRESENTED IN AN ACCESSIBLE FORMAT

These elements, essential threads of instruction on the process of counseling children and adolescents, are organized in a logical sequence from setting the stage for the counseling process to the essentials of active counseling practices. Both empirical and theoretical papers published in respected, peer-reviewed journals are provided to support the practices presented. As in other *Elements* texts, each of the elements are numbered and followed with a brief description and examples as needed. The numbered elements provide a shorthand for meaningful discussions about the counseling process and ease of use with transcript analysis in training programs.

Specifically, the book begins with a section on how to set the stage for the counseling process. This includes keys to developmentally appropriate language, activities, and arrangement of office

space for work with children and adolescents. The text emphasizes the conditions and processes of creating growth within the child explicating the process of assisting growth and self-inquiry. This text also addresses frequent misconceptions and mistaken assumptions. There is a section on crisis intervention and effective referral skills and another on critical topics (e.g., mandated reporting).

As in the original *Elements of Counseling*, there is a section on knowing oneself as a counselor. In this section, issues such as coming to terms with one's own childhood and adolescence and the rescue fantasy (i.e., I can save me by saving you) are addressed. There is a succinct introduction to interventions (i.e., including a list of more comprehensive texts on counseling with children and adolescents) and a review of techniques often used in work with children and adolescents (e.g., play therapy; brief, solution-focused therapy). For ease of reading, throughout the text, the word *caregiver* will be used to indicate parent, legal guardian, foster parent, and the like. In addition, since there are three authors, each will indicate when she is referring to her own personal practice or experience by noting her initials (CCC, LK, and LA, respectively). Finally, the text closes with a brief overview of how to use the text for transcript analysis in training programs. **For course instructors, there is an Instructor's Manual available from the publisher upon request. To obtain an electronic copy of these materials, faculty should contact Springer Publishing Company at textbook@springerpub.com**.

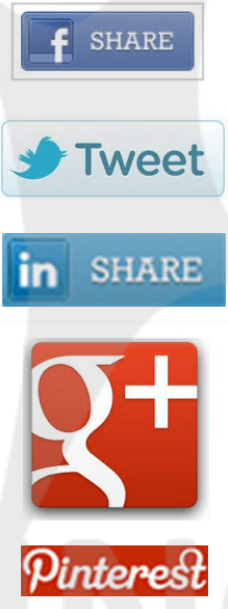
WELCOME

We welcome you to use this text to develop or further improve your counseling skills. Both the expert and the novice can benefit from a close look at essential skills. You will find that these distilled elements and the guiding questions at the end of each chapter provide a user-friendly format that spurs growth and enhances skills.

Acknowledgments

The authors would like to acknowledge Dr. Scott Meier and Dr. Susan Davis for their support for this project and for their groundbreaking distillation of the counseling process.

Share
The Elements of Counseling Children and Adolescents



One

Setting the Stage

This chapter details the elements of counseling children and adolescents that are essential to setting a solid stage for deeper work. Techniques addressing the initial contact and important contextual issues such as setting up a child- and adolescent-friendly office space are covered.

1. INITIAL CONTACT

The first interaction with the client's caregiver is typically on the phone as the result of a referral. The caregiver is seeking counseling for his or her child because of a concern the caregiver has or one that has been brought forward by a school, agency, or pediatrician. The relationship with your client begins here. Whether this first communication is directly with you or with an office staff member, the demeanor should be warm and professional. This conversation is intended to briefly explore the nature of the client's concern and to ascertain the fit between you and the client.

Once you have a basic understanding of the needs of the child, and you have determined that your qualifications are appropriately matched with these needs, provide a review of your practice location, hours, and rates. Again, this information may be provided by you or an office staff member. Keeping in mind that the caregiver may be apprehensive or nervous about counseling, another way to establish comfort in this first conversation is to describe what the first appointment will be like so the clients know what to expect:

- Describe the outer office or waiting area and what clients are to do while waiting for you.
- Provide an overview of what will occur during the first appointment.

Finally, schedule the first appointment and offer to schedule follow-up appointments ahead of time in order to ensure regular visits. Close the conversation with thanks and say that you are looking forward to meeting them.

2. RESPECT CAREGIVERS AND FAMILY MEMBERS IN THE PROCESS

Since children rarely self-refer, the counseling relationship with children includes caregivers. Beginning with the first contact, safety and trust must be established with family members. It can be difficult for caregivers to let go and allow another adult to develop a caring relationship with their child, especially if the relationship between caregiver and child is stressed. You must demonstrate that your intention and your counseling approach are always in the best interest of the child, and that your support is simultaneously present for both the child and caregiver (Hawley & Garland, 2008; Tsai & Ray, 2010).

COUNSELOR: All relationships can be difficult or stressed at times. My job is to understand and support you both [or all], with the ultimate goal of doing what is best for [name of child].

3. THE FIRST APPOINTMENT

The first appointment is unique in a variety of ways. You and your client are meeting for the first time. Furthermore, guidelines and paperwork must be formally reviewed. As with all appointments, you should be on time and greet your client warmly (i.e., with eye contact, a smile, and a handshake). After introductions, describe the office setting (waiting area, reception, others' offices, restrooms, and other facilities such as kitchen or vending machines) as you lead them to your office. You can also describe for them the office etiquette of keeping the waiting area a quiet and safe space for others so that the privacy of everyone is respected. Once in your office, allow the child and caregiver(s) to sit wherever they like. You can explain the variety of things in your office—toys, games, sand tray, books, white board, and so forth. Begin the first session by pointing out that this session is indeed unique because of the formality of it and that future sessions will be less formal. Next, provide an overview of the contents of this first session. As an example, you might go over your plans to

- Share your background and professional experience
- Explain what counseling is and isn't
- Review paperwork and guidelines
- Ask the clients background questions
- Give clients the opportunity to share their story and determine broad goals for counseling

4. SHARE YOUR BACKGROUND

When sharing your background, it is important to summarize your training and professional experience. What specialized or advanced training have you completed? How are your education, training, and professional experiences well suited, in your opinion, to addressing the presenting concerns of the child and family? You

may also include personal interests, if appropriate. This may help with early rapport establishment for some clients.

5. EXPLAIN COUNSELING

Research has shown that educating clients about counseling improves treatment progress, outcome, and attendance, and helps to prevent premature termination (Coleman & Kaplan, 1990; Orne & Wender, 1968; Reis & Brown, 2006; Walitzer, Derman, & Connors, 1999). Meier and Davis (2011) caution that "clients frequently approach counseling with misconceptions about the process. . . . If mistaken expectations are ignored, clients drop out or fail to make progress" (p. 3). Your explanation of counseling should be concise rather than a dissertation on the theories of counseling or an overview of the field of psychology. Therapeutic counseling is not easily summarized, as it has breadth and depth, and encompasses many perspectives, theories, and approaches to growth and problem solving. It also varies depending on the personality of both the therapist and the client, the particular chemistry of counselor and client, and the particular issues that the client brings. Regardless of theory, counseling is a relationship, with the client's personal growth as the goal. Counseling provides a safe, nonjudgmental space in which clients can self-reflect, identify strengths, experiment with new ideas of self and ways of being, and learn effective emotional regulation and relationship and life skills.

It is wise to establish realistic expectations about the fact that counseling is a process that takes considerable time and effort (Swift & Callahan, 2011). It is equally important to instill a sense of realistic hope that counseling will lead to improvement and positive change (Meier & Davis, 2011; Swift, Greenberg, Whipple, & Kominiak, 2012).

In this initial session, you should also emphasize the importance of clients expressing their feelings about the counseling process on an ongoing basis so that you can address any concerns as they arise.

Giving them the permission and the opportunity to provide feedback that you can respond to is not only helpful in terms of process, but also very empowering and validating to your clients (Knox et al., 2010; Swift et al., 2012). Since your clients may not have the skills to do this, you must check in with them occasionally to process this with them.

COUNSELOR: Please communicate with me about our counseling relationship. I will ask you from time to time how you think things are going with counseling. Kind of like bumpers in a bowling alley, we help keep each other on track by communicating what works. This is also good practice for how to express yourself with all people in your life.

Ultimately, your objective is to help your clients grow to a place of self-reliance in coping with their lives to the point where they no longer need your assistance. This is, therefore, also an opportunity to talk about closure—that when growth and goals have been achieved (progress will be discussed at various times throughout the counseling process), counseling will come to an end. Since saying goodbye can be a difficult experience for many, exploring this at the onset helps clients considerably when the time actually comes (Swift et al., 2012). Help your clients conceptualize what it might look and feel like when they have met their goals.

COUNSELOR: Great, so that would mean you have done everything you came here to accomplish. Imagining that now, how do you think you might like to end counseling when that time comes?

Often, clients like to do something special that symbolizes their work and growth when they say goodbye. For example, this author's (LK) client led her on a hike, which reversed roles, empowering the client not only to lead her counselor on a journey, but also to symbolize her growth. The process of closure or termination may take several sessions.

6. PROVIDE AN OVERVIEW OF GUIDELINES

There are logistical guidelines to discuss during the first session, which also help to set limits with your client, such as

- Not allowing interruptions during the counseling session (phone calls, other technology)
- How to schedule appointments
- Cancellation policy
- How to communicate concerns that arise in the time between appointments
- What to do in case of an emergency

However, one of the most significant guidelines in counseling is that of confidentiality.

7. ADDRESS CONFIDENTIALITY AND PRIVACY

The American Counseling Association (ACA, 2005), American Psychological Association (APA, 2002), National Association of School Psychologists (NASP, 2010), and the Code of Ethics of the National Association of Social Workers (NASW, 2008) all address confidentiality, privileged communication, and privacy.

A. Privacy Between Child and Caregiver

Mental health professionals must balance their clients' need for a safe space in which to share and experience their emotions with the caregivers' need to know about their child's well-being and safety. While privacy in therapy is very important, particularly with teenagers, caregiver involvement is also essential to successful treatment, particularly with younger children.

State laws vary regarding the age at which a child is entitled to full confidentiality, and it is incumbent upon the counselor to

know, adhere to, and discuss the laws with the child and caregiver. It is the caregiver's right to be informed of what progress takes place during a counseling session with a minor. It must be made clear that counseling with children who are minors involves providing necessary information to their caregivers. However, many children, especially adolescents, are more likely to more fully disclose given the privacy and space to do so (Huss, Bryant, & Mulet, 2008; MacCluskie, 2010). Full disclosure is therapeutic. The limits of full disclosure must be clearly discussed, processed, understood, and agreed upon.

To create an environment and relationship that is conducive to therapeutic growth, caregivers should be encouraged to respect the personal boundaries and privacy of the child or adolescent (Huss et al., 2008; Mitchell, Disque, & Robertson, 2002; Tan, Passerini, & Stewart, 2007). For example, the difference between safety and privacy should be emphasized. If issues of safety arise, the caregiver can rest assured that he or she will be informed. Otherwise, you as a therapist will generally respect and maintain confidentiality such that only progress and general information will be shared with the caregiver. Should the child be a danger to him- or herself or others, the caregiver will be informed, by law and for the well-being of the child. The basic guideline is that safety is the utmost priority and takes precedence over the child's desire for privacy.

COUNSELOR: We need to agree on a guideline that is both safe and comfortable when it comes to privacy. Can we agree that [name of child] can freely express and explore here without my sharing every detail with you? If there is a matter of safety, your child and I will figure out how [he/she] can share that with you. I will support [both/all] of you with that process.

When necessary, the approach to breaking confidentiality is critical. Confidentiality can be "breached in a respectful and caring manner" (Tan et al., 2007, p. 205). During the first session, it should be made clear to the child that you will always discuss with him

or her when caregiver involvement must occur, and before giving caregivers any information, you will try to resolve any objections the child may have about what will be discussed with the caregivers. You should give the child an idea of what this will look and/or sound like, process what fears the child has about the caregiver's reactions, explore what the possible outcomes will be in order to help the child think beyond his or her fears, and discuss the support that you will provide and the support you will encourage the caregiver to provide.

The child can be given options as to how this communication will occur. Given options and choices, the child can engage in this communication with his or her caregiver, thus eliciting a healthy connection with the caregiver. Generally, the options for communicating with the caregiver are that the child can share with his or her caregiver independently, in which case the counselor will verify and follow up via direct communication with the caregiver; that the child and counselor can share with the caregiver together; or that the child can choose for the counselor to share with the caregiver, either with or without the child being present. By giving choices, the child is more likely to feel empowered rather than violated, betrayed, or coerced, and the counseling relationship is strengthened (Sullivan, Ramirez, Rae, Razo, & George, 2002). Agreeing on this during the first session allows the needs of both child and caregiver to be met, for them to feel mutually safe, supported, united, and relaxed as opposed to anxious, separated, divided, or pitted against one another.

It should also be noted that many states give children of any age the right to independently consent to and receive mental health treatment without caregiver consent if they request it and if it is determined that such services are necessary and that requiring caregiver consent would have a detrimental effect on the course of the child's treatment (MacCluskie, 2010). In that situation, information about that treatment cannot be disclosed to anyone without the child's agreement.

B. Privacy Rule

Another aspect of confidentiality is the *Standards for Privacy of Individually Identifiable Health Information*, or the *Privacy Rule*, which is a federal law that established, for the first time, a set of national standards for the protection of certain health information. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) gives clients rights over their health information and sets rules and limits on who can look at and receive their health information. The Privacy Rule applies to all forms of individuals' protected health information (PHI), whether electronic, written, or oral. For complete information, refer to the U.S. Department of Health and Human Services website at www.hhs.gov (U.S. Department of Health and Human Services, n.d.).

A review and discussion of the HIPAA laws must be done during the first session. A paper copy must also be provided to the caregiver; he or she must then sign a form to verify receipt of this HIPAA document copy. You should also explain and provide separate authorizations to exchange information, as applicable, with other providers or agencies (e.g., school personnel, pediatricians, etc.). Be certain to be familiar with your state's and/or agency's requirements for this kind of document.

8. BEGIN TO EXPLORE THE CLIENT'S STORY AND CREATE COUNSELING GOALS

With the introductions, guidelines, and preliminary information established, it is now time to begin to explore with your clients what brings them to counseling and to develop initial goals for therapy. While a full discussion of this is presented in Chapter 3, the first session should offer time to generally explore the nature of your client's concern and to begin to conceptualize what the client is hoping to achieve. Although you will provide an intake questionnaire for the caregiver to fill out, during the first session you

can directly ask pertinent questions to collect information about the client's past and current history. Choose the questions you ask carefully, leaving less relevant details to the intake form. Use this time wisely so that the relationship can begin to be formed. These questions are the segue and invitation for the client to begin to tell his or her story.

9. CREATE A DEVELOPMENTALLY ACCOMMODATING OFFICE SPACE

In order to create a warm, peaceful space that is conducive to a child feeling comfortable, it is helpful to consider a wide variety of factors, including

- Warm, gender-neutral color
- Small furniture to accommodate younger clients
- Child-oriented furniture such as bean bags, floor pillows, butterfly chairs
- Furniture arrangement—chairs on angles or in a circle; if you have a desk, it should be obscure rather than central in the office space
- Blankets
- Microwaveable heating bags or heating pads
- Stuffed animals
- Easel and paints
- Paper, markers, crayons
- White board or chalkboard
- Clay, Play-Doh
- Stress balls
- Books geared to each developmental level
- Items that provide sensory stimulation (soft, fuzzy, silky, mushy, etc.)
- Toys
- Games
- Water, healthy snacks

Depending on the counselor's training, the following therapeutic tools may be available:

- Sand tray
- Puppets

Ideally, the space should be large enough to allow for movement so that kinesthetic learners can be accommodated and physical therapeutic approaches such as yoga could be included.

The outer office, waiting area, or reception area should provide a comfortable, quiet sitting area with soft music, a variety of reading materials, and perhaps some toys or drawing materials. Sound machines should be placed outside counselors' offices to provide privacy.

Dress appropriately—professionally and comfortably. Business suits can seem off-putting to a child and make you appear less approachable or relatable. If you will be using play therapies or yoga, of course you must dress accordingly.

10. BE ON TIME

Be on time for all appointments. It is important to stay on time with your appointments when they are scheduled back to back, in order to respect all of your clients and to maintain boundaries. If agreed upon with your client, an alarm can be used, preferably with a soft or soothing tone, music, or nature sounds, to indicate that a session will be coming to an end in a specified amount of time (5 or 10 minutes). This will allow the client to pace the conversation so that he or she does not have to end or feel cut off in the middle of sharing something. This provides for comfortable closure of each session.

11. INDIVIDUALIZE COUNSELING

Meeting your client's individual needs means understanding his or her age and developmental level, personality, and where he or

she falls on the continua of openness, extroversion, and comfort level. Meier and Davis (2011) also suggest considering psychological sophistication, level of motivation, social maturity, intelligence, prior experience in counseling, awareness of strategies that have worked and not worked in the past, and use of language that the child understands.

Swift et al. (2012) recommend accommodating client preferences regarding such aspects as type of treatment, therapist behaviors such as giving advice, and whether or not to give homework. Giving choices elicits engagement in treatment modalities that clients prefer and ultimately increases clients' willingness to participate. This research was with adult subjects, and the authors add that with clients who lack awareness regarding what treatment may be best for them, counselors should present various approaches and collaborate with clients to decide which approach to take. Walitzer et al. (1999) also support this, suggesting that the counselor "provides a menu of options for change, based on clinical research regarding effective treatments" (p. 146).

Working with children and adolescents means that you must be able to work with and relate to the very wide range of distinct needs of the toddler, preadolescent, and adolescent. You must understand the perspective of that person's current relevant cultural norms and cohort as well. Your client must feel that you "get" him or her while also feeling that you are the adult and a role model. You may be seen as a caring and capable adult, teacher, coach, mentor, and leader. Ultimately, you must be adaptable and responsive.

Given the wide range of needs and treatment methods of the broad age group of childhood and adolescence, it is important that you do not accept referrals from clients if you are not comfortable with a particular age group. You must always practice within your training and competencies.

12. MEET YOUR CLIENT'S AGE AND DEVELOPMENTAL LEVEL

Interactions with your client must be aligned with his or her levels of comprehension and maturity. It is important to communicate in terms and modalities that the client understands, frequently checking for understanding. Responses and explanations should be provided in a variety of ways while asking the client to explain back to you in his or her own words. Not only will you be listening reflectively, but you will also ask your client to reflect back to you how he or she understands what you have communicated. ("Does that make sense? What does that mean to you? Tell me how you interpret what I just expressed. What are your thoughts about what I might mean by that?") This reciprocal process minimizes incorrect assumptions and miscommunications and allows you to scaffold your client's learning upon prior foundations of his or her understanding.

13. DEVELOPMENTAL FRAMEWORK

Human development occurs in broad, overlapping stages of early childhood (ages 3–5), childhood (ages 5–13), and adolescence (ages 13–21). These are not mutually exclusive stages or categories. Instead, they are transitionary periods, overlapping circles, or Venn diagrams; age ranges are only averages. Some development is continuous and gradual: achievement at one level builds on achievement at previous levels. Some development is discontinuous and occurs in distinct steps or stages. That is, changes achieved are qualitatively different than at earlier or later stages. Development occurs through change and growth as well as through stability, consistency, and continuity. Development is also multidimensional, including physical, cognitive, personality, and social dimensions.

There are universal principles that exist regardless of culture, ethnicity, or gender. There are also cultural, racial, ethnic, and environmental differences that play a role in determining when developmental events occur. There are individual differences of traits and characteristics. Individuals mature at different rates and reach developmental milestones at different points.

Development is also influenced by the following, which should be explored in counseling:

- Cohort influences
- Environmental influences of a particular historical movement
- Normative influences, such as puberty, that are similar for individuals in a specific age group, regardless of when or where they were raised
- Normative influences of social and cultural factors that are present at a specific time for a specific individual depending on unique variables, such as ethnicity or social class
- Non-normative life events—specific, atypical events such as a chronic illness

For an overview of child and adolescent development, refer to such textbooks as

- *Essentials of Life-Span Development*, Santrock (2013)
- *Human Development: A Life-Span View* (6th ed.), Kail and Cavanaugh (2013)
- *Development Through the Lifespan* (5th ed.), Berk (2009)

It is also important to be mindful of and to explore with your client the various multidimensional environmental levels that simultaneously affect him or her (Bronfenbrenner, 1986, 2005):

- Microsystem—the immediate environment of family, friends, teachers

- Exosystem—the broad influences of local community, schools, places of worship
- Macrosystem—the larger cultural influences of society, religious systems, political thought

14. ADDRESS RESISTANCE, CREATE A WORKING ALLIANCE

Although some children welcome the opportunity to talk and share their feelings, many are brought to counseling against their will. It is your job to overcome a child's resistance to counseling. "The challenge is to involve the child in treatment and to work toward a change that the child may not view as necessary or even potentially useful" (Kazdin, 2003, p. 256). Resistance can manifest itself differently at each developmental level. Younger children may exhibit apprehension more in the form of a fear of the unknown adult, while young adolescents are seeking autonomy and therefore may feel that participation in counseling threatens this. Adolescents may feel invalidated, coerced, blamed, misunderstood, threatened, resentful, and/or a loss of control. Resistance may be a reflection of the need for autonomy and/or safety, and therefore must be honored (DiGiuseppe, Linscott, & Jilton, 1996; Fitzpatrick & Irannejad, 2008; Hawley & Garland, 2008). To this end, creating a comfortable space, exploring what counseling is, and establishing guidelines that allow for a child's privacy go a long way in establishing safety and alleviating apprehension.

Fitzpatrick and Irannejad (2008) explore how readiness for change and the working alliance interact. They found that with adolescents who have not made a commitment to change, bonding with the client is most effective, whereas with clients who are ready for change, finding agreement on goals and approaches is effective in creating a working alliance.

To create connection between client and counselor, conveying empathy and reflective listening are imperative (Walitzer et al., 1999). A child needs to feel truly heard and understood. It is not necessary to agree or even express agreement or disagreement. When a child experiences the feelings of being understood and validated, an emergence of trust and the freedom to open and explore begins, releasing the potential to problem solve and to reshape coping skills and emotional regulation.

In a review of alliance literature, Zack, Castonguay, and Boswell (2007) highlight that the therapeutic relationship is critical for effective therapy. A weak alliance predicts premature termination whereas a strong alliance predicts symptom reduction. Hawley and Garland (2008), in their research with adolescents, found that "youth alliance is significantly associated with several domains of therapy outcomes, including decreased symptoms, improved family relationships, increased self-esteem, and higher levels of perceived social support and satisfaction with therapy" (p. 70).

In a review of the literature on psychological factors that inhibit seeking help, Vogel, Wester, and Larson (2007) outline the avoidance factors of social stigma, treatment fears, fear of emotion, anticipated risk, discomfort with self-disclosure, social norms, and protection of self-esteem. They also outline the moderating factors of gender, cultural values, treatment setting, and age. As adolescents age and mature, the stigma of counseling often decreases (Boldero & Fallon, 1995), and as adulthood emerges, openness toward counseling often increases. This may depend, in part, however, on level of education. According to Vogel et al. (2007), "Most of the literature on help-seeking . . . has consistently shown that individuals who are in their 20s and who have a college education have more positive attitudes toward seeking professional help" (p. 415).

15. SEE THE BIG PICTURE

Ultimately, children and adolescents are a work in progress. They are discovering who they are and are trying out various aspects

of their personality. Many behaviors that elicit a reaction from the adults in a child's environment are actually part of normal development. In his review of the research in child and adolescent therapy, Kazdin (2003) summed it up nicely: "Deciding whether and when to intervene presents special challenges because many of the seemingly problematic behaviors may represent short-lived problems or perturbations in development rather than signs of lasting clinical impairment" (p. 256). Adolescent problem behavior is often resolved by early adulthood. In their review of the research on adolescent development, which explores the void of any widely accepted new theories of normative development since the decline of the theories of Erikson, Piaget, and Kohlberg, Steinberg and Morris (2001) point out that a recent focus of research is in discerning the difference between problems that are displayed during adolescence versus those that have earlier onset and are persistent across the life span.

You may see only artifacts of adult onset disorders. Do not jump to adult diagnoses. The very nature of adolescence includes features that are used in the diagnosis of disorders. For example, the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013) outlines the following diagnostic features for borderline disorder, which are relatively descriptive of adolescence:

- "Very sensitive to environmental circumstances"
- "Sudden and dramatic shifts in their view of others"
- "Sudden and dramatic shifts in self-image, characterized by shifting goals, values, and vocational aspirations"
- "Affective instability that is due to a marked reactivity of mood"
- "Easily bored, they may constantly seek something to do." (pp. 663–664)

Many teens exhibit these features, which are actually within the range of normal childhood development. The *DSM-5* clarifies that "it should be recognized that the traits of a personality disorder that appear in childhood will often not persist unchanged into adult life" (p. 647).

On the other hand, do not ignore or dismiss the indicators of disorders either. The work is in understanding and discerning the source. Is this normal, albeit tumultuous, development, or is it the actual onset of disorder? Monitoring over time is critical. Trends must be noted rather than immediate conclusions drawn from limited information or from a narrow perspective. Normal development is not always systematic, steady, or with consistent growth or progression. The pace of development varies widely, and milestones are met within a range of time. The backdrop of normal adolescence must be incorporated and be the lens through which you view your client.

SUMMARY AND DISCUSSION QUESTIONS

Setting the stage for counseling is quite involved and demands the use of a wide variety of counseling skills. A counselor must be organized in his or her preparation for and thoughts about what he or she will need to accomplish in the first session. Consider the following:

- *What are the most essential aspects that I must cover during the first session?*

Some counselors feel that the first interactions and session are particularly challenging. Beginning counseling can be quite stressful for some children and their caregivers, and breaking down barriers is essential. Once relationships are established and counseling is flowing naturally, both the counselor and the client feel more relaxed. It is helpful to reflect on the following questions:

- *How are communication skills different in counseling than in other settings?*
- *What are the skills that are involved in establishing a safe environment?*
- *What skills do I possess (and what skills do I need to enhance) that elicit a client's trust?*

Confidentiality is a critical element in counseling and is governed by codes of ethics as well as by federal and state laws. A counselor

must have a clear conceptualization of confidentiality and privacy in the therapeutic setting. To help you apply this information, summarize how you would communicate confidentiality and privacy with your client and your client's caregiver.

Individualizing counseling to meet your client's needs at his or her developmental level is also quite a complex undertaking. To begin to clarify this for yourself, reflect on the following:

- *What are some of the key developmental factors to keep in mind when working with children at each developmental level?*
- *How might I adjust counseling in response to each of these developmental levels?*
- *Which developmental level would I be most effective working with and why?*

REFERENCES

American Counseling Association. (2005). *ACA code of ethics*. Alexandria, VA: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

American Psychological Association. (2002). *American Psychological Association ethical principles of psychologists and code of conduct*. Washington, DC: Author.

Berk, L. E. (2009). *Development through the lifespan* (5th ed.). New York, NY: Pearson.

Boldero, J., & Fallon, B. (1995). Adolescent help-seeking: What do they get help for and from whom? *Journal of Adolescence, 23*, 35–45.

Bronfenbrenner, U. (1986). Ecology of the family as a context for human development: Research perspectives. *Developmental Psychology, 22*(6), 723–742.

Bronfenbrenner, U. (2005). Ecological systems theory (1992). In U. Bronfenbrenner (Ed.), *Making human beings human: Bioecological perspectives on human development* (pp. 106–173). Thousand Oaks, CA: SAGE.

Coleman, D. J., & Kaplan, M. S. (1990). Effects of pretherapy videotape preparation on child therapy outcome. *Professional Psychology: Research and Practice, 21*, 199–203.

DiGiuseppe, R., Linscott, J., & Jilton, R. (1996). Developing the therapeutic alliance in child adolescent psychotherapy. *Applied and Preventive Psychology, 5*, 85–100.

Fitzpatrick, M. R., & Irannejad, S. (2008). Adolescent readiness for change and the working alliance in counseling. *Journal of Counseling and Development, 86*, 438–445.

Hawley, K. M., & Garland, A. F. (2008). Working alliance in adolescent outpatient therapy: Youth, parent and therapist reports and associations with therapy outcomes. *Child and Youth Care Forum, 37*, 59–74.

Huss, S. N., Bryant, A., & Mulet, S. (2008). Managing the quagmire of counseling in a school: Bringing the parents onboard. *Professional School Counseling, 11*, 362–367.

Kail, R. V., & Cavanaugh, J. C. (2013). *Human development: A life-span view* (6th ed.). Belmont, CA: Wadsworth.

Kazdin, A. E. (2003). Psychotherapy for children and adolescents. *Annual Review of Psychology, 54*, 253–276.

Knox, S., Adrians, N., Everson, E., Hess, S., Hill, C., & Crook-Lyon, R. (2011). Clients' perspectives on therapy termination. *Psychotherapy Research, 21*(2), 154–167.

MacCluskie, K. (2010). *Acquiring counseling skills: Integrating theory, multiculturalism, and self-awareness*. Upper Saddle River, NJ: Merrill.

Meier, S. T., & Davis, S. R. (2011). *The elements of counseling* (7th ed.). Belmont, CA: Brookes/Cole.

Mitchell, C. W., Disque, J. G., & Robertson, P. (2002). When parents want to know: Responding to parental demands for confidential information. *Professional School Counseling, 6*, 156–161.

National Association of School Psychologists. (2010). *Principles for professional ethics*. Bethesda, MD: Author.

National Association of Social Workers. (2008). *Code of ethics of the National Association of Social Workers*. Washington, DC: Author.

Orne, M. T., & Wender, P. H. (1968). Anticipatory socialization for psychotherapy: Method and rationale. *American Journal of Psychiatry, 124*, 1202–1212.

Reis, B. F., & Brown, L. G. (2006). Preventing therapy dropout in the real world: The clinical utility of videotape preparation and client estimate of treatment duration. *Professional Psychology: Research and Practice, 37*, 311–316.

Santrock, J. W. (2013). *Essentials of life-span development*. New York, NY: McGraw-Hill.

Steinberg, L., & Morris, A. S. (2001). Adolescent development. *Annual Review of Psychology, 52*, 83–110.

Sullivan, J. R., Ramirez, E., Rae, W. A., Razo, N. R., & George, C. A. (2002). Factors contributing to breaking confidentiality with adolescent clients: A survey of pediatric psychologists. *Professional Psychology: Research and Practice, 33*, 396–401.

Swift, J. K., & Callahan, J. L. (2011). Decreasing treatment dropout by addressing expectations for treatment length. *Psychotherapy Research, 21*, 193–200.

Swift, J. K., Greenberg, R. P., Whipple, J. L., & Kominiak, N. (2012). Practice recommendations for reducing premature termination in therapy. *Professional Psychology: Research and Practice, 43*, 379–387.

Tan, J. O. A., Passerini, G. E., & Stewart, A. (2007). Consent and confidentiality in clinical work with young people. *Clinical Child Psychology and Psychiatry, 12*, 191–210.

Tsai, M. H., & Ray, D. C. (2011). Children in therapy: Learning from evaluation of university based community counseling clinical services. *Children and Youth Services Review, 33*, 901–909.

U.S. Department of Health and Human Services. (n.d.). *Summary of the HIPAA privacy rule.* Retrieved from http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/

Vogel, D. L., Wester, S. R., & Larson, L. M. (2007). Avoidance of counseling: Psychological factors that inhibit seeking help. *Journal of Counseling and Development, 85*, 415.

Walitzer, K. S., Derman, K. H., & Connors, G. J. (1999). Strategies for preparing clients for treatment: A review. *Behavior Modification, 23*, 129–151.

Zack, S. E., Castonguay, L. G., & Boswell, J. F. (2007). Youth working alliance: A core clinical construct in need of empirical maturity. *Harvard Review of Psychiatry, 5*, 278–288.

Two

The Processes of Counseling With Children and Adolescents

Microskills are the basic foundational skills involved in effective counseling that facilitate the process of counseling and alliance formation. The success of counseling interventions depends largely on these skills, which help to create the necessary conditions from which positive change can take place.

16. REFLECT FIRST (CONTENT, FEELING, AND MEANING)

Reflecting, one of the essential microskills of counseling, serves a multitude of purposes (Harms, 2007; Ivey, Packard, & Bradford Ivey, 2007; MacCluskie, 2010; Meier & Davis, 2010; Sharpley, Fairnie, Tabary-Collins, Bates, & Lee, 2000):

- Expresses the counselor's interest, empathy, understanding, and acceptance of the client
- Helps the client feel that the counselor is listening and that the client is heard
- Helps the client to feel recognized, cared about, respected, validated, and understood

- Enhances the therapeutic relationship
- Encourages further expression, creates momentum
- Elicits engagement in the counseling process
- Mirrors for the client—gives the client the opportunity to "see and hear" back his or her thoughts, feelings, behaviors, values, interpretations, and conclusions
- Reduces or eliminates avoidance, minimizing, or repression of emotions
- Provides the client the opportunity to clarify, understand, and process
- Allows the client to further explore thinking, feeling, behaving as the impetus for growth
- Assists the client in gaining insight
- Gently challenges the client's position
- Clarifies for the counselor exactly what the client means

Effective reflection requires continuous alert tracking of the client's verbal and nonverbal responses and their possible meanings. Again, the counselor must formulate reflections at the appropriate level of complexity for the client. Optimal reflective listening suspends advice, agreement, disagreement, suggestions, teaching, warning, and questioning in favor of continued exploration of the client's own processes.

Reflection is done at the levels of content, feeling, and meaning:

- Reflection at the level of content is also called paraphrasing. Here, the counselor is simply restating, in a nonjudgmental way, the essential information from the client's verbal message or behavior in play.
- Reflecting feeling emphasizes the emotional dimension through feeling statements and makes the client's feelings explicit. Clients may or may not be aware of their feelings. Reflection deepens the client's awareness, experience, and understanding of his or her feelings. Furthermore, feelings may be complex, and/or difficult to deal with. Teasing out and untangling the variety of

feelings that a client can be having all at once can be very enlightening and relieving for him or her. As feelings are understood and unraveled, further expression and release of emotions can occur. Through attention and observation, the counselor can also include reflection of what the client is expressing in body language, facial expression, and tone of voice.

- Reflecting the meaning in the client's expressions is to communicate back to the client his or her values, beliefs, interpretations, and conclusions. This facilitates the client's growth and insight.
- Reflections should start with leading phrases such as "It sounds like . . .," "I hear you saying . . .," or "You're wondering. . . ."

After you reflect, it is important that you check in with your client to ascertain that your reflection is accurate and aligned with your client's experience. Do not assume you are correct—you may be wrong and your client is likely to feel misunderstood and invalidated, and the relationship is damaged. Verifying not only prevents this, but also further assists your client in expressing him- or herself fully, and allows the client to be empowered as well as take ownership of his or her experiences.

17. FOCUS ON FEELING

The emotional aspect of experience is often the most difficult to negotiate. Many people feel easily overwhelmed by emotions and have few tools to deal with them effectively. As a result, feelings are often ignored, minimized, and not processed effectively. Children and adolescents are in the process of developing emotional competency (MacCluskie, 2010). Often, due to their own challenges, parents and other adults in their lives have modeled avoidance of uncomfortable feelings. Furthermore, it is common that when a child or adolescent approaches someone else with a problem or struggle, most adults and peers respond by helping or moving directly toward problem solving. The feelings are often missed. There can be a disconnect

between the cognitive understanding that they are experiencing and the emotional content. Focusing on feelings helps integrate the emotional and the cognitive content of an experience, allowing the client to work through, within the context of a safe and supportive relationship, challenges and seemingly overwhelming feelings.

In the following example, you will see that the counselor could have easily moved into problem-solving mode or reflected content as there was a lot said. Instead, she effectively moved into feelings, noticing the nonverbal signs and reflecting the feelings she observed. The client was able to clarify and process the emotions she was feeling. Getting to and processing the feelings effectively is the essence of good counseling.

CLIENT:	I failed my chemistry exam. I am not going to be able to play in the lacrosse game today. My grandparents drove 3 hours to see me and my dad says there might be a recruiting coach to watch me in the game. I can't tell my dad I won't be playing. I just can't (wringing hands, brows furrowed, voice high, speech fast).
COUNSELOR:	You look and sound really anxious.
CLIENT:	I can't breath I am so scared. My dad is going to kill me.
COUNSELOR:	You are afraid.
CLIENT (crying):	My dad played lacrosse in college. He wants me to play too. He will never understand (sobbing now). I am not good enough.

18. SUMMARIZE

Summarizing involves integrating content and feeling, boiling down the child's or adolescent's expressions into the essentials (Smaby & Maddux, 2011). Summarizing content can help the client see the connections, have a sense of a cohesive bigger picture, notice gaps or incomplete thoughts, and recognize incongruence (Smaby & Maddux, 2011). When a summary is presented, the child or adolescent is given an opportunity to expand on his or her own observations, insights, and narrative. Smaby and Maddux (2011)

observe that students of the counseling process often wait too long to summarize, missing opportunities to validate, encourage, and refine understanding of and for the client.

For example, a female adolescent explains a situation to you that has deeply affected her. She might explain the context (e.g., the people involved, where she was when the event occurred, the time of day). She may also have explained all of her thoughts about the event and the situation. Furthermore, as she was speaking she may have described, or shown you, the feelings associated with the event and the feelings that presented upon recollection of the experience. When summarizing, you draw the context, feeling, and cognition together. This provides her with the experience of being heard and seen while providing a sense of connection and integration of experience, thoughts, and feelings. In the following, you see the counselor summarize a young athlete's struggle with a teammate, integrating the feeling the client demonstrated with the verbal content she shared. This allows the client to move forward with the essential aspect of the interaction that was especially triggering for her. The summary helped the client to move toward insight (Smaby & Maddux, 2011).

CLIENT: The coach told Sarah and I that we needed to meet at the field to go over a few key plays before practice. We told the coach we could meet. We made a commitment. (The client drops her head into her hands. She looks anxious and distressed.) Well, Sarah showed up 25 minutes late and acted like I was making her do the drill. She said she didn't feel like doing it. She said the coach was a jerk for making us do extra practice. She didn't do it right and she put it all on me (As she spoke, she lifted her head, made eye contact, and then dropped her head in her hands again). Why do I need to be the one who makes Sarah try? Why? I did not know what to do. I know the coach would be mad at Sarah if he knew what she was saying and doing.

COUNSELOR: You and Sarah agreed to extra practice. Sarah was late, uncooperative, and spoke negatively about the coach. This was stressful and anxiety provoking. It feels like Sarah is putting you in a difficult position. You are not sure what to do or say.

CLIENT: Yes. I freeze when I am in these situations. Like when someone is doing something wrong or not taking responsibility. It is like I know in my heart that maybe I should say something and I am too afraid to, or I think the person might get mad, and then I don't say anything. I just feel stressed.

19. REFLECT THE PROCESS

Reflection also involves a reflection of the immediate processes within the counseling situation (Smaby & Maddux, 2011). That is, the in-the-moment interaction that is taking place within the counseling session is a very important learning context. It is akin to the powerful difference between (a) someone describing the steps of doing a tree pose in yoga and then asking you to try it later and (b) someone asking you to stand up and try tree pose while he or she coaches you through it. Real-time processing of interactions creates a wonderful opportunity for a client to learn about him- or herself, and engage in the processing of feelings as they are happening. For example, a counselor working with a fourth-grade girl notices that each time he begins to transition her to discuss her parents' divorce (the reason for referral), she says she's too tired to talk anymore and asks if she can leave. The effective response lies in the reflection of the process as opposed to the content. You see in the following that he is able to connect the client to her feelings by reflecting the process.

CLIENT: I am really tired. I don't want to talk anymore. Can I go now?

COUNSELOR: Megan, I noticed that when I bring up your mom and dad's divorce, you say you're tired and want to go.

CLIENT: (With tears in her eyes, Megan nods her head yes.)

COUNSELOR: It is very sad for you. It is really hard to talk about things that are this sad.

Once Megan has accessed her feelings about the divorce, the counselor can move to processing them with her. For example, he might have her draw her feelings, ask her what she usually does when she feels sad, and so forth. If he answered her question or

engaged in a conversation about the length of the session or her fatigue, he would have likely missed an opportunity to help Megan process her feelings.

20. SPEAK BRIEFLY

The less you speak, the more your client has the time and room to speak or play in order to do the work of therapy. Counselors should stay out of the way so their clients can be present and engaged. The work of the counselor is to facilitate the client's expression, not to intrude on it (Harms, 2007; Ivey et al., 2007; Meier & Davis, 2011). The use of minimal encouragers such as head nods and verbalizations (e.g., "uh-huh"), demonstrate to the client that you are attentive and listening, without interrupting or dominating (Harms, 2007; Ivey et al., 2007; MacCluskie, 2010; Meier & Davis, 2011; Sharpley et al., 2000). Minimal encouragers also indicate to clients that they should continue to share their experiences, thoughts, and feelings.

21. ALLOW AND USE SILENCE

It's common in social communication to feel the urge to rush in and say something when there is a lull in conversation. In a therapeutic setting, silence can be extremely valuable. Much like speaking briefly, it is important to give your client the room to express. Rushing in during a lull in a therapeutic conversation can prevent your client from contemplating his or her thoughts and feelings and expressing them further. Silence allows time for reflection and processing that leads to self-awareness and growth. Therefore, although it may feel awkward at first, you are likely to circumvent the goals of counseling if you don't learn how to effectively use silence. In addition, you may actually misunderstand or misinterpret your client's message if your client does not

have the opportunity to finish his or her thought (Harms, 2007; MacCluskie, 2010; Sharpley, Munro, & Elly, 2005).

In their research on silence and rapport, Sharpley et al. (2005) found significantly higher amounts of silence in minutes of counseling sessions that were rated by clients as very high in rapport. "Attempts by the counselor to fill these silences with questions probably do not contribute towards the vital emergence of rapport which sets up the Therapeutic Alliance. Silence should be seen as part of the interaction, rather than the absence of the interaction" (p. 158). They also found that silences that were initiated by the counselor and terminated by the client, and silences that were initiated and terminated by the client contributed to rapport.

22. USE OPEN-ENDED QUESTIONS

Open-ended questions are difficult to answer with "yes," "no," or only a few words (Smaby & Maddux, 2011). Open-ended questions serve to encourage elaboration, elicit specific examples, and to facilitate client communication. They can be explicit questions, such as, "How did you respond to Sarah when she told you the coach was a jerk?" They can also be statements, which implicitly request a response, such as "Tell me about your relationship with Sarah." When used effectively, questions can move a child or adolescent into further insight or thoughts, feelings, and processes. Specifically, "How" questions often lead to discussion about feelings. "What" questions tend to lead to discussions about the facts and circumstances associated with the topic at hand (Smaby & Maddux, 2011). Open-ended questions can also effectively evoke change (Arkowitz, Westra, Miller, & Rollnick, 2008). These questions, often used in motivational interviewing, are worded to move a client into envisioning and taking action. For example, a counselor might ask, "Why do you think others are worried about your drinking?" or "Suppose you don't change, what is the worse thing that could happen?" These

questions are intended to be somewhat confrontational. The counselor uses them to bring explicit attention to the situation at hand and create motivation for change (Arkowitz et al., 2008).

Examples of open-ended questions:

- Tell me more about your relationship with Sarah.
- What would you do if you weren't afraid how she'd react?
- How were you feeling when Sarah showed up late?
- What would you like to be different about the current situation?
- What makes you want to change the current situation?
- What would be different if you told Sarah how you were feeling?
- What would things look like 6 months from now if you started telling your friends how you feel?
- If you were to decide to change things, what would you do?
- What is the best thing you could imagine that could result from you changing?

23. CONFRONT EFFECTIVELY AND WITH CARE

A rule of thumb for practitioners is that for every one piece of critical feedback or confrontation, you must have already provided three supportive, validating, and encouraging reflections. Supportive, validating, and encouraging statements help build a sense of trust and acceptance within the therapeutic relationship. For example, validating statements such as "It is so stressful when friends don't take reasonability for their own actions" can help the client feel seen and understood. Supportive statements such as "You have made so much progress learning how to handle challenging emotions" reflect the client's success reinforcing a sense of self-efficacy. Furthermore, encouraging statements such as "I have a sense that if you work really hard at this you are going to nail it. You've got this" can also help the client feel a sense of hope and possibility. These types of statements create a strong foundation for successful confrontation as they lower defenses and bring the client to an open

and curious state within the relationship. To illustrate, confrontation without support can look like this:

COUNSELOR: This is the third week you have arrived 15 minutes late.

CLIENT: I know. I am sorry. We keep getting stuck in traffic. I think there has been an accident each time (lying).

Here is the same confrontation with support:

COUNSELOR: Joe, I want to acknowledge how hard you have been working to understand your anger and your dad's drinking (support). It is not easy to talk about all of the hurt you have been through (validation). Also, I know that you have been working hard to understand your own relationship with alcohol. I see such wonderful possibilities for you when you make healthy choices (encouragement). Perhaps it is a bit difficult to come in every week and talk about such challenging things (validation). This is the third week you have arrived 15 minutes late. I am wondering about this.

CLIENT: I know. I am sorry. When I start to get ready to come to counseling, I find a million other things to do. I like talking to you, but it is really hard and I get sad, sometimes for days afterwards. To be honest, sometimes I don't even want to come.

COUNSELOR: It took a lot of courage to be that honest (validation). I would like to set a goal for being on time and then figure out, together, how to make these sessions more manageable for you. How does that sound?

When confrontation was provided with supporting statements and validation, the client was able to be less defensive in his response. Furthermore, his response provided an opportunity for the counselor to explore distress tolerance and emotional regulation skills with the client, both helpful tools in substance use reduction.

24. USE DEVELOPMENTALLY APPROPRIATE LANGUAGE

Meet your clients where they are. Developmentally appropriate practice is based on knowledge of the typical development of children within an age span as well as the unique abilities of the child.

With regard to your client's language acquisition and development, you must speak in terms that your client can understand, according to his or her developmental level and individual abilities. The process of effective communication results in understanding. Always consider the cognitive sophistication of your client and communicate in terms and at cognitive levels that he or she can understand. If you are not aligned with your client's level of cognitive complexity and ability to think abstractly, your client will not understand you and may even become confused.

Developmental theorists and researchers Erikson (1964), Piaget (1962), and Vygotsky (1962) identified a lack of language development and abstract thinking in young children. Children do not have meaningful awareness or understanding of complex feelings, thoughts, and issues. Due to the lack of ability to think and reason abstractly, concrete communication is required (Erdman & Lampe, 1996). Concrete and specific expressions will be better understood than abstract ones. It is helpful to keep in mind some of the key features of cognitive development:

- Early childhood:
  - Preoperational stage (2–7 years): Children at this stage begin to represent the world with words, images, and drawings. While their language and thinking is becoming more sophisticated, they still tend to think about things in very concrete terms. They tend to be egocentric and struggle to see things from the perspective of others. At 4 to 7 years, children begin to use primitive reasoning (Piaget, 1962).
  - Children's use of private speech while approaching a problem shifts from externally talking to oneself during preschool years, to privately talking to oneself during elementary school years. Children begin to internalize and self-regulate using their private speech (Vygotsky, 1962).
  - At this age, there is increased use of emotion language, understanding of emotion and the causes and consequences of feelings, and ability to reflect on emotions. There is also

growing awareness that others may have different feelings and that more than one emotion can be experienced at a time (Kuebli, 1994).

- Childhood:
  - Concrete operational stage (7–11 years): thinking becomes much more cognitively complex. Although thinking is still primarily concrete, it becomes more logical and organized. Children at this stage can consider interrelationships and begin using inductive logic or reasoning from specific information to a general principle (Piaget, 1962).
  - In terms of language development, vocabulary, mastery of grammar, syntax, and pragmatics are increasing. Language helps children control their behavior (Santrock, 2013).
- Adolescence:
  - Formal operational stage (11 years and up): Abstract thought emerges. Cognitively, adolescents are beginning to use formal operations, to think abstractly, increasingly use deductive logic and reasoning, and think in idealistic ways. By late adolescence, this is firmly established, as is the ability to think ahead and make predictions about probable outcomes and consequences (Piaget, 1962).
  - Teens also begin to think more about moral, philosophical, ethical, social, and political issues that require theoretical and abstract reasoning (Santrock, 2013).

For more comprehensive and detailed information regarding child and adolescent development, refer to human development textbooks and reference materials such as *Essentials of Life-Span Development* by Santrock (2013).

In addition, Meier and Davis (2010) suggest that counselors should also parallel a client's language form and sentence structure. It is also helpful to be aware of your client's relevant cultural and social norms, experiences, and topics of concern (e.g., an adolescent's use of social media).

25. BE CONCRETE

Beyond the process of communicating at your client's developmental level, an essential counseling skill is helping your client to understand and manage the complex and intangible world of feelings and thoughts. This can be difficult for people of all ages. Feelings are nonverbal by nature. Making feelings and thoughts concrete is an important starting point when working with children and adolescents.

Helping children and adolescents identify their physical feelings can help them understand their emotional feelings.

COUNSELOR:	Where do you feel that anger in your body? What does it feel like?
CLIENT:	I feel my hands squeeze tight. My arms too. And it kinda even feels that way in my stomach. And I'm hot all over!
COUNSELOR:	So your body feels anger in your hands, your arms, your stomach, and even in your body's temperature.
CLIENT:	Yes! I wonder if my face gets all red like my friend Joe.

The use of emotion charts is also valuable in assisting children to identify their feelings and make them more explicit and concrete. Using images provides a more direct means of expression and communication of intangible emotions. Stone, Markham, and Wilhelm (2013) developed a nonverbal instrument to enable clients to communicate and show recognition of a broad range of emotions. The Pictured Feelings Instrument (PFI) proved to be valid and reliable with children and adults and was created with ambiguity of age, gender, and ethnicity in order to be used across cultures and ages.

With older children and adolescents, journaling can assist them in releasing, exploring, reflecting on, and regulating their emotional responses. This can also become a tool for communication between the client and the counselor (Pennebaker, 1997; Stone, 1998). It has been suggested to voice journal or record narrations of clients who cannot or are uncomfortable with writing. With those who can read, it is even more powerful to present them

with a written transcription of their narration (Stone, 1998). It is important to note that Ullrich and Lutgendorf (2002) found in their study that participants who journaled with a focus solely on expressions of negative emotions actually reported more physical illness, whereas those who included cognitive processing as well as the emotional component reported less. The latter group made efforts to understand and make sense of their stressful events and experienced greater awareness of the positive benefits of these events.

26. MATCH THE STRATEGY OR TECHNIQUE TO PROCESSING LEVEL

It can be tempting to simply match the intervention to the child's age or grade level. However, when dealing with emotionally laden and challenging personal information, an individual's processing capacity can regress or be below age-expected levels (see Cook-Cottone, 2004). That is, it can be difficult for a child or adolescent to apply his or her highest level of intellectual capacity or skills to difficulties that are emotionally challenging and anxiety provoking. It is common for a child or adolescent to have a more highly developed vocabulary for everyday concepts and experiences and have a comparatively smaller emotional vocabulary (MacCluskie, 2010). As children and adolescents work through the counseling experience, they learn how to map words onto their emotional experience in order to express themselves more effectively. This is a process. Matching the counselor's strategy to the child's or adolescent's current emotional processing and verbalizing level is critical.

CLIENT: My mom acts strange at night sometimes. She says "I love you" too much. It's weird and she doesn't speak clearly. Sometimes she falls asleep while she is talking to me. My dad said she has a problem with alcohol and I don't know what that means [adolescent is 14 years old, in advanced placement classes].

COUNSELOR: I have this book that tells the story of a kid growing up with an addictive parent (Black, 1997). I was thinking we could read through it together. I think you are going to see a lot of your experience in this story. Things might make a bit more sense after.

In everyday experience, a 14-year-old might not be reading a story written primarily for younger kids (Black, 1997). However, in this case the story captures the essence of growing up in an addictive home and illustrates scenarios with which the client will identify (Black, 1997). This strategic use of a tool more typically used for younger children will carefully match this student's level of processing around his mother's alcoholism. Overall, in order to increase self-awareness and growth, when a child seems to have a less-developed sense of an issue or associated emotions, stay with the basics; use art, stories, and metaphors; be concrete; and match the approach to the developmental, and not the chronological, age.

27. WHEN WORDS FAIL, DRAW OR PLAY

Play is a natural, enjoyable, and satisfying activity that provides children the benefits of expression, experimentation, exploration, social interaction, and the opportunity to release excess energy. In therapy, children and adolescents may not be able to express their thoughts and feelings verbally. Developmentally, young children do not have the cognitive ability to do so. Erikson (1964), Piaget (1962), and Vygotsky (1962) believed that play is the natural mode of expression for children and serves to advance young children's cognitive development. Older children and adolescents who have greater language skills may still struggle to find the words to express their inner experiences or may not feel safe enough to do so. When traditional talk therapies are not effective, play and art can open the door to the inner self and can help children and adolescents to safely explore, communicate, and resolve their struggles or conflicts.

Play therapy has a rich history with a plethora of research that supports its efficacy and use as a valid and developmentally appropriate approach to treatment and intervention with children. A meta-analysis conducted in 2005 reviewed 93 studies in which play therapy had proven to be an effective intervention with children who presented a wide range of behavioral and emotional concerns. Play therapy has been found to help children and adolescents practice competencies and skills, exercise cognitive structures, advance creative thought, safely explore and seek out new information, and master anxieties and conflicts. Through play therapy, counselors can analyze the child's conflicts and ways of coping with them (Bratton, Ray, Rhine, & Jones, 2005).

Formal training can be obtained in the areas of nondirective, psychoanalytic, Jungian, Gestalt, sandtray, and the widely used Child-Centered Play Therapy (CCPT), which was designed for children age 3 to 10 years. CCPT is based on Carl Rogers's (1942) person-centered theory, with the foundational belief that children have an inherent tendency toward growth and ability to heal that is self-directed. Having emerged from person-centered theory, empathy, acceptance, and unconditional positive regard are the hallmarks of CCPT. The focus is on the experience of the child and the child's ability to make substantial internal and external changes. Thus, the CCPT counselor allows children to freely play and thus express their inner worlds. This affords children the opportunity to move toward self-enhancing ways of being and increases the child's sense of self-responsibility for behavior (Axline, 1947; Landreth, 2012; Landreth, Baggerly, & Tyndall-Lind, 1999). A recent study by Bratton et al. (2013) found significant effects of CCPT with preschool children who exhibited aggressive and disruptive behavior in the classroom. These researchers emphasized that early mental health intervention with CCPT can prevent the development of more severe impairment across the child's life span.

One of the tenets of Jungian Play Therapy (JPT) is that through the emotionally safe and nonthreatening experience of play, disowned parts of the self are integrated in order to become psychologically

whole (Jung, 1973). Jung believed that drawing and coloring mandalas creates a relaxed meditative state that allows for and elicits discovery of personal meaning. This enables the client to safely recover the dissociated self. In their research, Green, Drewes, and Kominski (2013) explored the efficacy of drawing and coloring mandalas to reduce stress and anxiety in adolescent males with attention deficit hyperactivity disorder (ADHD). Green et al. state that this meditative approach is "characterized by self-regulation and attention to the present moment with an open and accepting orientation toward one's experiences" (p. 160). Meditative approaches such as drawing can be used to enhance self-awareness, self-expression, conflict resolution, and healing.

While JPT utilizes meditative drawing, giving clients the opportunity to simply draw as they please can elicit their voices. In her meta-analysis on the facilitative effects of offering young children the opportunity to draw as part of the interview process in pediatric health care, Driessnack (2005) reported that numerous studies have found that drawing appears to facilitate children's abilities to express themselves verbally. This seems to be especially important when they are working to express themselves about those events or concepts they find difficult to describe. Driessnack (2005) states that "[T]heir drawings might be . . . inviting an entry rather than a momentary glimpse into children's worlds" (p. 416).

Eaton, Doherty, and Widrick (2007), in their meta-analysis of the use and efficacy of art therapy with traumatized children, found that it has been successfully used internationally across a variety of contexts. They found that many art therapists feel that art therapy is more effective with children than with adults, perhaps because children will more readily partake in imaginative articulation. The process of art therapy is a conduit to express experiences, memories, and emotions that the child may not otherwise be able to verbalize. The child and counselor can connect and communicate on the child's terms, which creates a sense of empowerment and safety as well as a therapeutic bond.

These authors outline that pencil drawing, coloring, painting, and clay are the most common media used with children in

counseling. They suggest that as the therapeutic relationship develops, having the child tell a story about his or her artwork gives the counselor the opportunity to facilitate the interpretation of that story by the child. "As the story unfolds, fantasy and reality are teased apart, leading to self-discovery and cathartic release, and the child is assisted in coping with the reality of the trauma and the accompanying emotions" (p. 256).

Other expressive therapies include music, drama, dance/movement, and bibliotherapy. Malchiodi (2005) points out that people have different expressive and learning styles; therefore, utilizing a medium that is comfortable for a client enhances that client's communication so that it is authentic and effective.

Discussion continues regarding the importance of formal training in expressive therapies, as well as the level of training in each art form that is necessary in order to be effectively implemented. As cited by Malchiodi (2005), Carson and Becker (2004) see expressive therapies as part of a larger realm of creativity in counseling. They propose that creativity in counseling involves being able to flexibly respond to clients with a variety of techniques and to encourage creativity within therapy. Gladding and Newsome (2003, as cited by Malchiodi, 2005) emphasize that a quick client drawing or collage can move a client forward when talk therapy is resisted or ineffective. Many expressive techniques have been used to complement a wide range of psychotherapy and counseling theories, including psychoanalytic, object relations, cognitive–behavioral, humanistic, transpersonal, and others (Malchiodi, 2005). Without formal training in play or art therapy, counselors can simply utilize play and drawing to help children relax, to be creative, to be active in their treatment, to use their imagination in corrective ways, and to develop the therapeutic environment and relationship.

With regard to deciding whether or not to utilize play and art therapy with any particular client, Kool and Lawver (2010) suggest that

> *very small children and perhaps those with profound developmental delays would be excluded from play therapy. At the other end of the spectrum, there is a point when the adolescent no longer wishes to engage in play, desiring instead to be treated as an adult.* (p. 19)

Counselors must explore their clients' ability and desire to engage in symbolic play, as well their ability and desire to talk in order to determine the utility of play therapy.

28. USE STORIES AND METAPHORS

Use of stories and metaphors is a way of helping children or adolescents make sense of their emotional experiences and problem solve. Often, the feelings and experiences that they are having are difficult for them to conceptualize or think about. Children or adolescents will know they are feeling a lot and understand that what they are going through is important for them to process, yet not be able to problem solve about it because they lack an understanding of what is happening. Stories and metaphors create a bridge of understanding. They do two things: (1) provide an emotional distance that allows for a more effective emotional processing of a situation, and (2) provide a conceptual bridge for circumstances that are difficult to understand (Sunderland, 2000). Sunderland (2000) suggests that everyday language is not language of feeling for children. She submits that image and metaphor are the natural language of feelings for children, giving them easier access to their feelings.

To illustrate, this author (CCC) created a story that teaches children how to manage worries while in school. Words like "let go," "allow your feelings," and "accept your emotional experience" can be difficult for even adults to negotiate. For most children, these phrases simply don't make any sense. In order to provide a metaphor for letting go or accepting anxieties, she tells children about *The Worry Tree* (see theyogabag.blogspot.com). The worry tree is a strong tree that exists to hold children's worries until they are ready to be with them

again. A child need simply to take his or her worry to the tree, hold it up, and the tree's branches reach out and wrap fine branches and leaves all around the child's worry. Then, the tree draws the worries in close to hold for as long as the child needs it to. The tree gains strength from the honor of holding the child's worries, so the child need not fret over the tree. In session, the counselor and client can draw this tree together and the worries listed in the branches. The child can practice placing his or her worries in the tree's branches and choosing which ones he or she wants to take back when the time seems right.

There are many story- and metaphor-based tools available for counselors. For example, for obsessive compulsive disorder *Up and Down the Worry Hill: A Children's Book about Obsessive-Compulsive Disorder and Its Treatment* by Wagner (2004) and *Will and the Wobbly House* by Sunderland and Armstrong (2000) are great choices. There are several presses dedicated solely to the publishing of therapeutic books for children. For example, Magination Press (www.apa.org/pubs/magination/), a division of the American Psychological Association, publishes books that are written by mental health professionals or those who work closely with them and with children. Magination Press books help children understand their feelings, provide information about the topic or situation, and offer extensive practical coping strategies. For more information about using storytelling as a therapeutic tool with children, see Sunderland (2000).

SUMMARY AND DISCUSSION QUESTIONS

The process of counseling comprises several essential microskills that must be practiced and mastered. Reflecting on each of these microskills helps to deepen and internalize them. Consider the following:

- *Discuss what is missed when you don't take the time to reflect.*
- *Share an experience in which you summarized effectively.*

- *Create a list of effective open-ended questions specific to the children and/or adolescents with whom you work or wish to work.*
- *How important is it to support and validate before you confront? Share examples.*
- *Recall a time in counseling in which your client did not understand you. How did you realize this? What was this the result of?*
- *Can you think of other ways to be concrete when counseling?*
- *If you don't have formal training in play therapy, how could you effectively utilize play in your practice?*
- *Research places where you might be able to obtain play or art therapy training, and consider whether this would be a priority for you for enhancing your skills.*
- *Role play the differences between reflecting content/paraphrasing, reflecting feeling, and reflecting meaning.*
- *When would you utilize the different types of reflection and why?*
- *Speak briefly. What is your perspective on how much you should speak versus how much your client should speak? What would this depend on? What are the conditions under which this should shift?*
- *What are your responses to silence? What feelings does silence in conversation elicit from you?*
- *How do you feel in times of silence when working with a client as opposed to when speaking with a friend? Parent? Teacher? Your counselor?*

REFERENCES

Arkowitz, H., Westra, H. A., Miller, W. R., & Rollnick, S. (2008). *Motivational interviewing in the treatment of psychological problems.* New York, NY: The Guilford Press.

Axline, V. (1947). *Play therapy.* New York, NY: Ballantine Books.

Black, C. (1997). *"My dad loves me, my dad has a disease"—A child's view: Living with addiction*. San Francisco, CA: Mac Publishing.

Bratton, S. C., Ceballos, P. L., Sheely-Moore, A. I., Meany-Whalen, K., Pronchenko, Y., & Jones, L. D. (2013). Head start early mental health

intervention: Effects of child-centered play therapy on disruptive behaviors. *International Journal of Play Therapy, 22*(1), 28–42.

Bratton, S. C., Ray, D., Rhine, T., & Jones, L. (2005). The efficacy of play therapy with children: A meta-analytic review of treatment outcomes. *Professional Psychology: Research and Practice, 36*, 376–390. doi:10.1037/0735-7028.36.4.376

Cook-Cottone, C. P. (2004). Using Piaget's theory of cognitive development to understand the construction of healing narratives. *Journal of College Counseling, 7*, 177–186.

Driessnack, M. (2005). Children's drawings as facilitators of communication: A meta analysis. *Journal of Pediatric Nursing, 20*, 415–423.

Eaton, L. G., Doherty, K. L., & Widrick, R. M. (2007). A review of research and methods used to establish art therapy as an effective treatment method for traumatized children. *The Arts in Psychotherapy, 34*, 256–262.

Erdman, P., & Lampe, R. (1996). Adapting basic skills to counsel children. *Journal of Counseling & Development, 74*, 374–377.

Erikson, E. (1964). *Childhood and society*. New York, NY: Norton.

Green, E. J., Drewes, A. A., & Kominski, J. M. (2013). Use of mandalas in Jungian play therapy with adolescents diagnosed with ADHD. *International Journal of Play Therapy, 22*(3), 159–172.

Harms, L. (2007). *Working with people: Communication skills for professional practice*. New York, NY: Oxford University Press.

Ivey, A. E., Packard, N. G., & Bradford Ivey, M. (2007). *Basic attending skills* (4th ed.). Alexandria, VA: Alexander Street Press.

Jung, C. G. (1973). *Mandala symbolism* (2nd printing, R. F. C. Hull, Trans.; Bollingen Series). Princeton, NJ: Princeton University Press.

Kool, R., & Lawver, T. (2010). Play therapy: Considerations and applications for the practitioner. *Psychiatry, 7*, 19–24.

Kuebli, J. (1994). Young children's understanding of everyday emotions. *Young Children, 49*, 36–48.

Landreth, G. L. (2012). *Play therapy: The art of the relationship* (3rd ed.). New York, NY: Routledge.

Landreth, G. L., Baggerly, J., & Tyndall-Lind, A. (1999). Beyond adapting adult counseling skills for use with children: The paradigm shift to child-centered play therapy. *The Journal of Individual Psychology, 55*, 272–287.

MacCluskie, K. (2010). *Acquiring counseling skills: Integrating theory, multiculturalism, and self-awareness*. Upper Saddle River, NJ: Merrill.

Malchiodi, C. A. (2005). *Expressive therapies*. New York, NY: Guilford.

Meier, S. T., & Davis, S. R. (2010). *The elements of counseling* (7th ed.). Belmont, CA: Brookes/Cole.

Pennebaker, J. W. (1997). Writing about emotional experiences as a therapeutic process. *Psychological Science, 8*(3), 162–166.

Piaget, J. (1962). *Play, dreams, and imitation in childhood.* New York, NY: Norton.

Rogers, C. R. (1942). *Counseling and psychotherapy*. Boston, MA: Houghton Mifflin.

Santrock, J. W. (2013). *Essentials of life-span development*. New York, NY: McGraw-Hill.

Sharpley, C. F., Fairnie, E., Tabary-Collins, E., Bates, R., & Lee, P. (2000). The use of counselor verbal response modes and client-perceived rapport. *Counseling Psychology Quarterly, 13*(1), 99–116.

Sharpley, C. F., Munro, D. M., & Elly, M. J. (2005). Silence and rapport during initial interviews. *Counseling Psychology Quarterly, 18*, 149–159.

Smaby, M. H., & Maddux, C. D. (2011). *Basic and advanced counseling skills: The skilled counselor training model*. Belmont, CA: Brooks/Cole, Cengage Learning.

Stone, B. A., Markham, R., & Wilhelm, K. (2013). When words are not enough: A validated nonverbal vocabulary of feelings (Pictured Feelings Instrument). *Australian Psychologist, 48*, 311–320.

Stone, M. (1998). Journaling with clients. *The Journal of Individual Psychology, 54*(4), 535–545.

Sunderland, M. (2000). *Using story telling as a therapeutic tool with children*. Oxon, England: Winslow.

Sunderland, M., & Armstrong, N. (2000). *Willy and the wobbly house.* Bicester, England: Winslow.

Ullrich, P. M., & Lutgendorf, S. K. (2002). Journaling about stressful events: Effects of cognitive processing and emotional expression. *Annals of Behavioral Medicine, 24*(3), 244–250.

Vygotsky, L. S. (1962). *Thought and language.* Cambridge, MA: MIT Press.

Wagner, A. P. (2004). *Up and down the worry hill: A children's book about obsessive compulsive disorder and its treatment*. Mobile, AB: Lighthouse Press.

Three

Strategies for Assisting Self-Awareness and Growth

This chapter presents the elements of counseling that can influence self-awareness and growth among children and adolescents. This chapter builds on the basics and offers guidance to enhance effectiveness. As children develop into adolescents and later into adults, their capacity to reflect on their own thoughts and behaviors develops (Sebastian, Burnett, & Blakemore, 2008; Weil et al., 2013). Accordingly, it is expected that younger children will require additional support and guidance as they reflect on their experience in order to develop an understanding themselves. Self-regulated growth is dependent on this awareness. A good counselor balances the child's or adolescent's need for support and the necessity of independence in self-reflection. Facilitating self-awareness and growth is contingent on both what you, as the counselor, do and what you *don't do* (Meier & Davis, 2011). The fields of motivational interviewing, self-determination theory, and counseling with children and adolescents are filled with specific techniques to encourage growth and change (e.g., Erickson, Gerstle, & Feldstein, 2005). Accordingly, this chapter highlights key elements of counselor action. Of equal importance, there will be instances in which being present, in absence of action, will create space for the child or adolescent to experience and consequently increase

awareness of his or her own self—a critical foundation for growth and change.

29. REFLECT AND GIVE TIME FOR PROCESSING (DO AND DO NOT DO)

Most counselor training programs review reflective listening and motivational interviewing (MI) techniques. The MI framework conceptualizes an empathic relationship and the client's awareness and acceptance of *what is* as the foundation for the motivation to change (Erickson et al., 2005). Reflective listening is a tool used to create the empathic relationship and to provide a context for awareness and acceptance. Reflecting what a child or adolescent is telling or showing you conveys acceptance, understanding, and validation (Erickson et al., 2005). A sense of self (i.e., self-concept) and self-awareness arise through the reflective function as the child or adolescent experiences how he or she is seen by others (Sebastian et al., 2008). When we move too quickly to and through problem solving or an intervention technique, we may miss an opportunity to provide the condition that enhances self-awareness and self-understanding, experiences critical for self-determined growth. Here, the counselor quickly dives into teaching an effective technique, perhaps missing an opportunity to reflect and allow for awareness and growth.

CLIENT: I can't handle another anxiety attack. I just can't.

COUNSELOR: Let me teach you some effective breathing techniques that can really help you when you feel an anxiety attack coming on.

Yes, breathing techniques can be very effective for helping mitigate the symptoms of anxiety (see Velting, Setzer, & Albano, 2004). However, a counselor who is mindful of the power of building an empathic relationship and of enhancing self-awareness and self-understanding might approach this client in a different way.

CLIENT: I can't handle another anxiety attack. I just can't.

COUNSELOR: You sound like you have reached your limit. This is really getting to you.

CLIENT: Yes.I don't know when the anxiety is going to hit. Seems like whenever I am about to do anything it sets in. I can't do anything with my friends, start my homework. I can't even make phone calls sometimes.

COUNSELOR: Your anxiety shows up when you are going to take action.

CLIENT: Yeah. I have so many things I think of and want to do. It is when I go to do them . . .

You can see here that by reflecting, the counselor has been able to get closer to pinpointing the adolescent's onset of symptoms. First, this subtle understanding of when anxiety is setting in can allow for a targeting of breathing techniques at the point of action. Furthermore, the client himself has discovered this, thereby enhancing self-efficacy and better serving an intrinsic motivation to change (Vansteenkiste, Williams, & Resnicow, 2012).

Keys to a solid reflection of the client's statement (see MacCluskie, 2010):

- Repeat key words (words that the client has "verbally underlined"; MacCluskie, 2010, p. 87).
- Restate the client's statement using a longer phrase.
- Exactly restate the client's statement.
- Paraphrase what the client has said, highlighting key points.
- Use words such as, "It sounds like," "I hear you staying that," and "It seems that. . . ."
- Capture and reflect back the feeling manifest in the client's statement.
- Give space for processing and self-initiated awareness.

30. AVOID GIVING ADVICE

Although advice can be useful in later stages of addressing a particular issue, there are some downsides to advice giving. Opportunities for growth can be missed as nontherapeutic dependency is fostered (Anderson & Handelsman, 2010; Meier & Davis, 2011).

CLIENT: I can't handle another anxiety attack. I just can't.

COUNSELOR: Have you tried deep breathing?

Here, asking the client if he has tried deep breathing suggests that deep breathing is a good thing to try (Meier & Davis, 2011). In fact, deep breathing is an effective tool for anxiety mitigation (see Velting et al., 2004). However, there are opportunities to increase the client's self-awareness and independent growth by using other techniques such as reflection (as illustrated in the previous example). Such exploration allows time and creates space for self-discovery. As in our example, with this opportunity to reflect, the client becomes aware that his anxiety manifests when he is about to take action. This critical movement toward self-awareness may have been missed had the counselor moved right into advice.

Not all information giving is considered advice (Meier & Davis, 2011). Anderson and Handelsman (2010) make a distinction between process advice and substantive advice. Substantive advice involves the imposition of specific suggestions or solutions for problems. The example illustrates substantive advice (telling the client he should be deep breathing when he feels anxiety). Process advice involves teaching your clients strategies for how to solve problems. This can be done by teaching the problem-solving model as addressed in this chapter or by providing empirically supported options for the issue at hand. In this way, you are providing knowledge regarding what is known to be effective in the area in which the client is struggling, expanding response options, and offering facts known about the area so that the client can make an informed decision as he chooses his next steps (Meier & Davis, 2011).

Overall, advice giving can be helpful. Specifically, it is helpful when implemented strategically and as process advice. Before giving advice, ask yourself these questions:

- *What are my motivations for giving advice?*
- *How frequently am I giving advice?*
- *Is my advice good? Is it based on research and state-of-the-art knowledge?*
- *Does giving advice short circuit self-exploration?*

- *Is this process advice or substantive advice?*
- *Can I lead the client to find his or her own answers? (Anderson & Handelsman, 2010)*

31. AVOID RELYING ON QUESTIONS

Beginning counselors often rely on questions because they do not have, or feel confident in, a variety of other counseling skills. It is critical for counselor training programs to provide practice counseling experiences in which asking questions is not permitted. It is much like practicing a passing drill for soccer in which the soccer players must pass back and forth to each other moving the ball up and down the field, not permitted to score. Yes, the primary purpose of playing soccer is to score goals and win. However, a team that only practices shooting will have less of a chance of winning. Good passing skills can separate a mediocre player from an effective competitor. This metaphor works for counseling. A good counselor does ask questions; however, it is one of many skills the counselor has in his or her repertoire. A counselor with many skills is much more effective in helping a client increase self-awareness and growth.

CLIENT:	Sarah is mad at me. Karla won't return my texts. Worst of all, my mom does not understand.
COUNSELOR:	What is your mom confused about?
CLIENT:	I don't know. I am not sure.

As you see in this example, often clients of all ages do not necessarily know the what's and why's regarding the events in their lives. Questions like this can shut down the counseling process rather than move a client into increased self-awareness and growth. Also, asking questions shifts the session from a client-centered exploration to a counselor-controlled interview (Meier & Davis, 2011). Children and adolescents may misperceive the interview-like condition and think that answers to questions are evaluated as right or wrong. Once this happens, the session has stopped feeling therapeutic and looks more like a lot of the other adult–child relationships. To allow

for self-exploration, shift to reflection of the content or feeling that the child or adolescent has expressed (Meier & Davis, 2011).

CLIENT:	Sarah is mad at me. Karla won't return my texts. Worst of all, my mom does not understand.
COUNSELOR:	There is a lot going on with your friends and you don't feel like your mom has a sense of what this means to you.
CLIENT:	Yeah, she doesn't get it and I need her. I feel alone with this. I don't have my friends to turn to and my mom thinks it is all just stupid. I don't have anyone (crying).

Questions can influence the session in other ways. Know that if you ask a question, you can shift the sense of control within the session. Asking questions, like providing advice, keeps the counselor on the side of control (Meier & Davis, 2011). When the counselor is leading, or in control, the probability of missing a client's authentic experience and empowering the client in self-exploration are decreased.

CLIENT:	My mom is very sick.
COUNSELOR:	What is going on with her?
CLIENT:	She has pulmonary fibrosis. It is a rare disorder. . . . [client continues with a detailed explanation].

Although the counselor now has more specific information, this may not be the most effective use of the client's session. In this example, the client is moving through information rather than processing emotions. There may be a missed opportunity to help the client become more aware of her feelings surrounding her mother's illness. Reflection with emphasis can be effective here.

CLIENT:	My mom is very sick.
COUNSELOR:	Your mom is *very* sick.
CLIENT:	Yes. I haven't told anyone. It's too hard to talk about.
COUNSELOR:	You've been on your own with this. It feels overwhelming.

If you are asking questions, pay attention to the kinds of question you are asking. Some questions can be less helpful than other questions. For example, be wary of the "why" question. For those of us who are psychologically minded, "why" is always on our minds

(MacCluskie, 2010). However, for the most part, it is not the most effective way to promote self-awareness and growth. In some cases, "why" questions can put a child or adolescent on the defensive. In defensiveness, a client is less likely to openly process sensitive emotional content.

CLIENT: My mom is very sick.
COUNSELOR: Have you talked to your friends about this?
CLIENT: No.
COUNSELOR: Why?
CLIENT: I don't know. I didn't want to.
COUNSELOR: Why haven't you reached out? Friends can be very supportive.
CLIENT: I don't want to.

It is important to differentiate between closed-ended questions and more effective open-ended questions (MacCluskie, 2010; Meier & Davis, 2011). A closed-ended question often begins with words like "is, are, do, did, could, would, have, etc." (MacCluskie, 2010, p. 102). Only use close-ended questions if you need specific information (Meier & Davis, 2011). Otherwise, use other techniques and when you must question, use open-ended questions or encouraging requests. MacCluskie (2010) uses a fishing analogy when considering the use of questions. She considers specific closed-ended question like dropping a line in the water to catch a fish. With these questions you end up with a discrete piece of information. You get your fish. Still, you run the risk of the session taking on a counselor-directed conversational pattern with the client waiting for the next cue from the counselor. When this happens, self-exploration and emotional growth are stunted as the session becomes information driven and counselor directed.

CLIENT: My mom is very sick.
COUNSELOR:
1. *Is* this new?
2. *Are* you going to appointments with her?
3. *Do* you have a support group to go to?
4. *Did* you tell your friends?
5. *Could* a support group help?
6. *Would* a support group be helpful?
7. *Have* you talked to your friends about this?

An open-ended question more frequently results in a longer response, increasing the opportunity for self-exploration and growth. Open-ended questions often beginning with words like: "how, what, when, where, who, why, etc. . . ." (MacCluskie, 2010, p. 102). Open-ended questions are like casting a wide net in which it is possible to catch many different fish (MacCluskie, 2010). Of note, to increase the effectiveness of an open-ended question, provide a reflection of emotion and then present the question, as illustrated in the following.

CLIENT: My mom is very sick.
COUNSELOR: You look worried. What is happening with her health?
CLIENT: I am worried. We just found out that she has a rare lung disease. Everybody is stressed. I haven't been able to talk to anyone about it. My dad is trying to be strong and handle it all himself. I haven't told anyone.

As another option, the counselor can also make a request for the child or adolescent to tell him or her more about the situation.

CLIENT: My mom is very sick.
COUNSELOR: You look worried. Tell me more about this.

32. LISTEN CAREFULLY TO THE WORDS USED

Listening is fundamental to counselor effectiveness, enhancing empathy and enhancing the therapeutic alliance (Baylis, Collins, & Coleman, 2011; Meier & Davis, 2011). As counselors, we listen carefully to the words clients use, for meaning and context. It can also be helpful to listen for words that can reflect how a child or adolescent may view the problem at hand, the world, and his or her own life story (Cook-Cottone & Beck, 2007; Meier & Davis, 2011; Pennebaker, 2011).

Pennebaker (2011), a researcher who studies words and psychology, suggests that our emotions can be found in our word choices. For example, anger and sadness show up quite differently in word choices. Pennebaker (2011) reports that when individuals are angry their language tends to focus on others rather than themselves. They

use high rates of second-person (e.g., you) and third-person (e.g., he, she, they) pronouns. Also, angry people tend to talk in the past tense. Sadness is associated with I-words and the past tense. Also, both anger and sadness are associated with the use of cognitive words that reflect causal thinking and self-reflection. Positive emotions (e.g., love and pride) tend to be expressed with little introspection. For more about language and emotions, see Pennebaker (2011). Look at this example as an illustration of a counselor addressing words used.

CLIENT: My mom never listens to me.
COUNSELOR: Never?
CLIENT: Well. . . . she does sometimes. She didn't today.
COUNSELOR: There are times your mom listens and today, it really *felt like* she wasn't.

Global words like "always" and "never" may suggest that your client is feeling a lot about what is going on and underutilizing effective cognitive appraisal of the situation. In the case illustrated above, the fifth-grade boy was expressing his frustration with his mother. His emotional response to this is reflected in a more global and negative use of language. As the counselor questioned the term "never," the child was able to shift to a more accurate cognitive appraisal of his mother's behavior as well as a more coherent awareness of what was happening. Furthermore, the counselor validated the child's feelings reflecting that it "felt like" she never listens. For most of us, when we are frustrated things "feel like" they are "always" this way or "never" going to happen. Although, the probability of something always or never happening is low, it still feels that way. It can be helpful for the counselor to validate this feeling while providing a context for a more effective cognitive appraisal.

Words like "should," "have to," and "must" reflect a potential distortion of reality. It is important to investigate the child or adolescent's perceptions and the possibility of perceptual distortion. For some children, there are real pressures from parents, coaches, and teachers to perform to unrealistically high standards. In these cases, the use of these terms may be a reflection of the child or

adolescent's environment. If this is the case, family or systems work should be done to address the issues. In many cases, however, children and adolescents using these terms have what the field of cognitive behavioral therapy (CBT; see Chapter 5) describes cognitive distortions.

Finally, listen to the child or adolescent's self-story (Cook-Cottone & Beck, 2007). The stories that we tell ourselves can have a powerful influence on our perception and behaviors (Chernin, 1998; White & Epston, 1990). Individuals can experience dissonance when the stories of their lives, as they or others have constructed them, do not sufficiently or accurately reflect their lived experience (see White & Epston, 1990). Counseling creates an opportunity to story or re-story your clients' lives in a manner that authentically maps onto their lived experience and a positive developmental trajectory (White & Epston, 1990). Listen to the role your clients play in their stories and the words. Are they the victim, disempowered, frustrated in their striving, judged, evaluated, recognized, or seen? Reflect their words back, underscoring and challenging discrepancies and self-imposed trajectories. Compare their story with their counseling goals and help them find congruence. The words a client uses, from the single word to the entirety of his or her self-story, is a very effective target of the counseling process. Working with words and story can help enhance self-awareness and growth. For more on the basics of narrative therapies, see White and Epston (1990).

33. FOCUS ON THE CLIENT

In general, children and adolescents who come for counseling often focus on other people as a source of their challenges and difficulties (Meier & Davis, 2011).

CLIENT: My mom is very sick. My dad and brother are super stressed.

COUNSELOR: Your mom is sick and your family is stressed. That is a lot for you to handle.

CLIENT: It is too much for me. I am trying to help them all and I can't (crying).

In this example, the counselor reflected the content of the child's statement while bringing the session back to the child's experience. Although the child's or adolescent's context matters, the client remains the object of change in a one-on-one counseling session. Notably, there are times when the child or adolescent is experiencing real concerns with his or her family. Whenever possible, arrange for a series of family sessions to address the issues at hand (see Chapter 5). These sessions should be aligned with the goals, plans, and work being done within the individual sessions.

34. PAY ATTENTION TO NONVERBALS

Counselors should consider the nonverbal behavior of a client as an access point to his or her emotional experience. Nonverbal behavior involves the physical aspects of our communication. Nonverbal behavior manifests in facial expressions, body movements and motion, and the way in which individuals say what they say (e.g., word emphasis, pitch, tone of voice, congruence with words stated; MacCluskie, 2010; Meier & Davis, 2011). Often, feeling states are not explicitly reported by our patients (e.g., "I feel so angry at my dad"; MacCluskie, 2010). Rather, the child or adolescent will report the content and the feeling is presented in the nonverbal behaviors. Here the counselor observes the nonverbal and reflects the feeling expressed to the child.

CLIENT: My dad never listens (child is agitated, frowning, voice is gruff).

COUNSELOR: You are angry with your father.

It can be particularly important to reflect incongruence between verbal content and nonverbal presentation. Helping a child or adolescent

increase awareness of his or her own nonverbal presentation as well as to any potential incongruences in experience can be very helpful in moving him or her toward growth (MacCluskie, 2010; Meier & Davis, 2011).

CLIENT:	I am so angry with my father (crying, eyes downcast)
COUNSELOR:	You are saying how angry you are and you seem so sad.
CLIENT:	I am hurt. I thought if I made all-county orchestra he would show up. I thought I would be good enough for him to care (crying).

Notice that the child has used an I-statement, which is more consistent with sadness than anger (Pennebaker, 2011; see the element. Listen carefully to the words used). Furthermore, the nonverbals (e.g., eye downcast) suggest sadness. By reflecting the emotion that presented, the counselor was able to work though the child's self-perceived anger, an emotion some feel more comfortable experiencing or expressing. The opportunity for growth was beyond self-perceived anger. Here the child can explore issues related to her father, her father's lack of presence in her life, and her achievement as a form of coping. These are powerful areas for growth.

35. GROUND FEELINGS IN THE BODY AND TEACH DISTRESS TOLERANCE

Even though children and adolescents are often consciously aware of their emotional states, they have not yet developed an emotion-specific awareness of the physiological presence of emotions in their bodies. By developing an awareness of where the emotions are experienced in the body, children and adolescents can refine their conscious, emotional self-awareness. Nummenmaa, Glerean, Hari, and Hietanen (2014) used a topographical self-report tool to reveal that different emotional states are associated with topographically distinct bodily sensations. Participants were shown two silhouettes of bodies alongside emotional words, stories, movies, or

facial expressions. They colored the body regions where they felt activity increasing or decreasing while viewing each stimulus. Researchers found that different emotions were consistently associated with statistically separable bodily sensation maps across experiments. These findings suggest that emotions are represented in the somatosensory system as culturally universal categorical somatotopic maps. Helping clients become aware of sensations in their bodies can provide clients with one more tool for emotional awareness and emotional problem solving.

CLIENT: I am so worried about tomorrow. It's really bothering me.
COUNSELOR: You are feeling a lot. Show me or tell me where you feel that in your body.
CLIENT: I feel it in my chest, it's tight like I can't breathe and down my arms a tingling feeling. I don't like it.

The identification of uncomfortable or challenging emotions provides the opportunity to teach the child or adolescent distress tolerance and emotional-regulation skills (Callahan, 2008). Once a feeling is identified and mapped on the body, engage in instruction of self-management skills. These skills include self-soothing, distraction, and improving the current moment (Callahan, 2008). The child or adolescent learns to first identify the emotion, then experience it without avoidance, and ultimately use the emotion to make decisions.

CLIENT: I am so worried about tomorrow. It's really bothering me.
COUNSELOR: You are feeling a lot. Show me or tell me where that shows up in your body.
CLIENT: I feel it in my chest, it's tight like I can't breathe and down my arms a tingling feeling. I don't like it.
COUNSELOR: I'd like you to stay aware of the feeling in your chest and begin to slow your breathing and soften and relax your muscles from the center of your chest to your shoulders. With each exhalation soften a bit more while staying aware of the feeling you are experiencing.

For more on developing emotional regulation and distress-tolerance skills with children, see Callahan (2008).

36. PAUSE AND REFLECT THEMES/ENUMERATE TOPICS

A counseling skill related to summarizing (see Chapter 2 for more on basic reflection) is reflecting themes or enumerating topics (MacCluskie, 2010). Some children and adolescents enter the counseling process ready to talk about many things all at once. For some children and adolescents, all of the things they are worried about are in one conceptual pile with little discernment between issues. As such, when one issue is triggered or addressed, their thoughts and feelings about all their other worries arise, making it difficult for them to focus on addressing the issue at hand. These children and adolescents are easy to detect. They will look something like this:

CLIENT: I am so worried about my mom. She is really sick, still and she won't take her medicine. My dad keeps telling her to and she says she does, but I know she isn't. I can tell because her bottles are full and she doesn't feel good enough to keep track. My brother is not doing his homework either. I am sure of that. His half-quarter grades came in and my dad was so mad and he said that my brother had to try harder cause mom is sick and everyone is stressed, even our dog was crying. He needs grooming but dad is so busy with mom he hasn't gone. I know I should do it, but I put it off and put it off and just don't do it. etc. . . .

In cases like this, if a counselor waits until the child takes a break, the whole session can pass without therapeutic response. The counselor must gently and kindly interrupt and provide an overview of all of the topics at hand, creating and modeling a conceptual boundary around each one. Next, the counselor can bring the client back to the prioritized problem or focus of the session.

CLIENT: I am so worried about my mom. She is really sick, still and she won't take her medicine. My dad keeps telling her to and she says she does, but I know she isn't. . . [as written above] And then . . .

COUNSELOR: Sara, (interrupting) hold on for a minute here while I get a handle on all that you are telling me. First, we have your mom and her illness, medication, and all of the concerns related to her. That is really important and is affecting your

> whole family. Second, we have your dad, how he is coping and all he needs to do. You sound worried about him. Third, your brother doesn't sound like he is coping well either. Fourth, you are even worried about your dog. Last, I hear you taking responsibility for many things going on here and it seems pretty overwhelming to think about all of these things at once. So, [using a piece of blank paper to make it very concrete; see Chapter 2, Element 25], we have your mom, your dad, your brother, your dog, and you taking on responsibility and worries for all of it, all at once. Let's start with your mom and you feeling worried about her.

Discerning the separate concerns allows the child or adolescent to refine cognitive schema associated with each of the issues with which she is grappling. The process of delineating creates a cortical, or thoughtful, connection to her initial limbic, or emotional, reaction to all of the worries experienced collectively. Neurological integration of the thinking and feeling parts of the self moves the child or adolescent into a more open, accepting, and reflective state (for more on integration, see Siegel, 2012).

37. USE A PROBLEM-SOLVING MODEL

Problem-solving models create a structure for the current referral problem and counseling goals as well as a structure for the future difficulties the child or adolescent will surely face. Problem solving is also a key component of self-determination interventions designed to increase self-regulated growth (Karvonen, Test, Wood, Browder, & Algozzine, 2004). Meta-analytical data suggest that increasing a student's problem-solving skills enhances positive outcomes including adjustment and academic performance (e.g., Durlak et al., 2011; Whiston, Tai, Rahardja, & Eder, 2011). Using the core problem-solving structure, help the child or adolescent structure their thinking using these steps (Macklem, 2008):

- Understand the priority problem
- Generate and evaluate strategies

- Choose one strategy and set a goal (see following section for goal setting element)
- Determine whether or not the strategy worked
- Repeat for the next strategy or next problem

38. SET CLEAR, MEASUREABLE GOALS

As mentioned in the chapter on setting the stage for counseling, the process should be orientated toward goals. Your goals should be anchored on what is known to be effective for the referral question and/or diagnosis for which the child or adolescent was referred, match the setting in which he or she is functioning (school, home, inpatient setting), match the team that is working with the child or adolescent (e.g., psychologist, pediatrician, nutritionist, social worker), and be a good fit developmentally. Critically, the goals should be concrete and measurable. The following guiding questions can help you structure and evaluate your goals.

1. Are your goals empirically supported or a component of an empirically supported treatment for the disorder you have diagnosed?
2. Do your goals match, or are appropriate for, the treatment setting and is the treatment setting specified?
3. Do your goals match the treatment provider? If there are multiple treatment providers (e.g., in school and out of school), have you specified who is doing what?
4. Are your goals developmentally appropriate?
5. Do your goals include all of the critical goal elements?
    1. Student will _____ (state a measureable behavior—frequency, intensity, duration) [for example, Maya will increase her daily study time to at least 15 minutes a day for each of her core areas of study];
    2. by/via/through/etc. _____ (state how this will happen, where, with whom) [for example,

during the afterschool program with supervision of the volunteer tutoring staff];

3. so that/in order to/etc . . . _____ (report more abstract reason for doing this) [for example, in order to improve her homework completion rate and academic grades];
4. Examples of goals:
   i. Jordan will practice taking four deep breaths (i.e., inhaling for a count of four, holding for a count of two, and exhaling for a count of five), four times a day (at Jordan's locker in the morning, before lunch, after lunch, and before last period), for the next 2 weeks to reduce overall feelings of anxiety in school.
   ii. Erica will attend the social skills group, twice per week during afterschool, in order to increase her experience of positive social interactions with her peers.
   iii. Erica will select one social skill technique introduced at her social skills group and practice this skill three times a day, Monday through Friday, with her peers for the next 15 weeks in order to gain competence in peer-related social skills.

SUMMARY AND DISCUSSION QUESTIONS

Improving a child's or adolescent's self-awareness and growth is accomplished through a deep connection and experience of his or her emotional experience as lived in the moment. The pathway toward awareness and growth involves developing skills to tolerate and regulate that emotional experience and increasing vocabulary for describing feelings. A counselor should allow the child to be the center of the counseling experience, keeping the focus on the child and his or her experience and growth. Furthermore, stories and metaphors can be helpful tools, bridging the gap between difficult-to-experience emotions and concepts that are too conceptual

or close to home. Of note, stories provide a related tool through which children can see alternatives and problem solve without feeling emotionally defensive or overwhelmed (see Chapter 2 for use of stories). Listening carefully to a child's or adolescent's words and self-story provide another avenue for exploration, awareness, and growth. Finally, working with a problem-solving model will keep your session moving toward your stated goals and give your client a framework for handling future struggles. Using these elements, you will be able to effectively move the children and adolescents with whom you work toward increased self-awareness and growth.

Ask yourself these questions:

1. *Am I leading the session or providing the context for the child or adolescent to discover his or her own experience?*
2. *Are there ample opportunities to identify and learn to negotiate emotional experiences in real time?*
3. *Am I using the right questions strategically to service the client's growth?*
4. *Do I have a sense of my client's self-story? The role he or she plays? The trajectory of the story?*
5. *Have I maintained a problem-solving approach?*

REFERENCES

Anderson, S. K., & Handelsman, M. M. (2010). *Ethics for psychotherapists and counselors: A proactive approach*. Malden, MA: Wiley-Blackwell.

Baylis, P. J., Collins, D., & Coleman, H. (2011). Child alliance process theory: A qualitative study of a child centred therapeutic alliance. *Child and Adolescent Social Work Journal*, *28*(2), 79–95.

Callahan, C. (2008). *Dialectic behavioral therapy: Children and adolescents*. Eau Claire, WI: PESI.

Chernin, K. (1998). *The woman who gave birth to her mother: Tales of transformation in women's lives.* New York, NY: Penguin Putnam.

Cook-Cottone, C. P., & Beck, M. (2007). A model for life-story work: Facilitating the construction of personal narrative for foster children. *Child and Adolescent Mental Health, 12*, 193–195.

Durlak, J. A., Weissberg, R. P., Dymnicki, A. B., Taylor, R. D., & Schellinger, K. B. (2011). The impact of enhancing students' social and emotional learning: A meta-analysis of school-based universal interventions. *Child Development, 82*, 405–432.

Erickson, S. J., Gerstle, M., & Feldstein, S. W. (2005). Brief interventions and motivational interviewing with children, adolescents, and their parents in pediatric health care settings: A review. *Archives of Pediatric Adolescent Medicine, 159*, 1173–1180.

Karvonen, M., Test, D. W., Wood, W. M., Browder, D., & Algozzine, B. (2004). Putting self-determination into practice. *Exceptional Children, 71*, 23–41.

MacCluskie, K. (2010). *Acquiring counseling skills: Integrating theory, multiculturalism, and self-awareness*. Upper Saddle River, NJ: Pearson.

Macklem, G. (2008). *Practitioner's guide to emotional regulation in school-aged children*. New York, NY: Springer Science and Business Media, LLC.

Meier, S. T., & Davis, S. R. (2011). *Elements of counseling* (7th ed.). Belmont, CA: Brookes/Cole.

Nummenmaa, L., Glerean, E., Hari, R., & Hietanen, J. K. (2014). Bodily maps of emotions. *Proceedings of the National Academy of Science of the United States of America, 111*, 646–651.

Pennebaker, J. W. (2011). *The secret life of pronouns: What our words say about us*. New York, NY: Bloomsbury.

Sebastian, C., Burnett, S., & Blakemore, S. (2008). Development of the self-concept during adolescence. *Trends in Cognitive Science, 12*, 441–446.

Siegel, D. (2012). *The developing mind: How relationships and the brain interact to shape who we are* (2nd ed.). New York, NY: Guilford.

Vansteenkiste, M., Williams, G. C., & Resnicow, K. (2012). Toward systematic integration between self-determination theory and motivational interviewing as examples of top-down and bottom-up intervention development: Autonomy or volition as a fundamental theoretical principle. *International Journal of Behavioral Nutrition, and Physical Activity, 9*, 23. doi:10.1186/1479-5868-9-23

Velting, O. N., Setzer, N. J., & Albano, A. M. (2004). Update on and advances in assessment and cognitive behavioral treatment of anxiety disorders in children and adolescents. *Professional Psychology Research and Practice, 35*, 42–54.

Weil, L. G., Fleming, S. M., Dumontheil, I., Kilford, E., Weil, R. S., Rees, G., . . . Blakemore, S. (2013). The development of metacognitive ability in adolescence. *Consciousness & Conscience, 22*, 264–271.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York, NY: W. W. Norton.

Four

Misconceptions and Assumptions

There are several misconceptions and assumptions that can reduce the effectiveness of counseling with children and adolescents. New therapists and counselors-in-training may need to ultimately *unlearn* assumptions that they carried with them—knowingly or not—before entering professional training programs (Meier & Davis, 2011). This chapter aims to review some common misconceptions and assumptions made by counselors at all levels.

39. DO NOT ASSUME THAT CHANGE IS SIMPLE

In and of itself, change is neither easy nor simple (Prochaska, 1999; Prochaska & DiClemente, 1986). In addition to the hard *work* required to change, there are a multitude of variables that affect an individual's ability to change, making it a complicated and challenging endeavor (Arkowitz & Miller, 2008; Krause, Howard, & Lutz, 1998; Prochaska, 1999). Variables affecting change include but are not limited to:

- Environment
- Culture
- Family

- Readiness for change
- Cognitive ability
- Insight
- Supports
- Demands

It is wise to recognize client efforts, feel and express empathy with clients for the challenge of change, as well as encourage them for the sustained effort that is inherent in change and growth.

Readiness to change is especially important to keep in mind. Some clients simply may not be ready or willing to change. In Prochaska and DiClemente's (1992) stages of change model addressing problem behaviors, for example, clients may lack readiness because (a) they are unaware that a problem exists, (b) they have only recently become aware of the problem and are not yet considering specific solutions, or (c) they are in the earliest stages of being proactive about change. The field of motivational interviewing has emerged to address the resistance to change and the challenges associated with preparing clients for change (Arkowitz & Miller, 2008). For more on motivational interviewing, see Arkowitz, Westra, Miller, and Rollnick's (2008) book, *Motivational Interviewing in the Treatment of Psychological Problems* (Arkowitz & Miller, 2008).

40. ACADEMIC DEVELOPMENTAL LEVEL DOES NOT EQUAL EMOTIONAL DEVELOPMENTAL LEVEL

We are familiar with the adage "don't judge a book by its cover." Likewise, we must be careful not to make snap decisions based on child or client demographics. Age, academic success, intelligence, and physical maturity are not reliable indicators of emotional development. Be sure to explore and determine your clients' emotional developmental levels as well as their capacity for:

- Emotional vocabulary
- Emotional expression
- Emotional regulation and coping

Also keep in mind that these abilities are affected by many variables, such as stress level, and severity, frequency, intensity, and duration of presenting issues. A child or adolescent that typically functions at one level of development will likely need extra supports and interventions when faced with acute stressors or changes (Frankel, Gallerani, & Garber, 2012).

41. AGREEMENT DOES NOT EQUAL EMPATHY

Some beginning counselors may interpret *empathy* to mean agreement or sympathy (Meier & Davis, 2011). *Empathy* refers to a profound understanding of the subjective world of clients (see Egan, 2014). *Agreement* implies that the counselor is in approval of client behavior, and *sympathy* suggests that the counselor feels sorry for the client. While supporting our clients is critical, it is not in their best interests to merely agree with them or tell them what they want to hear (Meier & Davis, 2011).

As Meier and Davis (2011) indicated,

> Friends and family provide agreement and sympathy. Counselors provide empathy to help clients explore their problems and become aware of their feelings and thoughts. In that way, clients begin to understand what they need to *do to change.* (p. 29)

42. AVOID MORAL JUDGMENTS

For many beginning counselors, a very difficult tendency to alter is judging people (Meier & Davis, 2011; Smaby & Maddux, 2011). Judging people typically involves moral or personally subjective assessments.

CLIENT: So I started smoking pot again after failing my finals.
COUNSELOR: You really let yourself and your parent down, didn't you?

Instead of value-judging behaviors and decisions, counselors must assess clients in terms of psychological theory and practice. Related assessments may include questions regarding the origins

of behaviors and decision making, family historical background, educational experiences, psychopathology, intellectual abilities, physical health status, and situational influences (Meier & Davis, 2011; Smaby & Maddux, 2011).

CLIENT: So I began smoking pot again after failing finals. I sat at home a lot, and I just kept getting more depressed and angry.

COUNSELOR: It sounds as if you felt very disappointed and then started to smoke again.

In this example, the counselor suggests a psychological origin for the client behavior, a cause that the client can influence and for which the client bears responsibility. No condemnation of the person was involved (Meier & Davis, 2011; Smaby & Maddux, 2011).

Telling a client that he or she is right or wrong is not counseling; it may harm rather than help. Keep your own personal values in check and do not impose them on your clients. Again, the goal is to look for psychological sources of your clients' thoughts, feelings, and behaviors rather than criticizing or judging. Ultimately, helping your clients to understand and acknowledge the psychological causes will lead to growth.

43. SAYING THEY UNDERSTAND DOES NOT MEAN THAT THEY UNDERSTAND

As mentioned elsewhere in this text, counselors must check for understanding. When your clients state that they understand, it is imperative to ask them to expand, elaborate, and explain so that you can ascertain that understanding has taken place.

Children and adolescents, in particular, may be reluctant to admit that they are unsure about a concept or topic during the course of a session. During the early months of this author's practice (LA), it was not uncommon for a parent to paraphrase what the therapist had said to the child during joint sessions. This was a great

indicator that—even when you think you are using child-and adolescent-friendly language—it is always a good idea to use synonyms, check regularly for understanding, and empower children and teens to speak up if they are unclear about anything discussed during counseling sessions.

44. YOU CAN'T ASSUME THAT YOU KNOW (FEELINGS, THOUGHTS, AND BEHAVIORS)

Just as you must check for your clients' understanding, you must also check with your clients to be sure *your understanding of them* is accurate. Basic communication skills can help prevent misinterpretation. When you reflect back to your clients what you think you have heard, give them an opportunity to confirm or deny, and verify the conclusions you have drawn. Clients will often let you know when you are incorrect (MacCluskie, 2010; Meier & Davis, 2011; Smaby & Maddux, 2011). In addition, asking "Do I have that right?" (and even an occasional "Are you sure?" with children and adolescents) lets your clients know that it is safe to give you corrective feedback.

45. DO NOT ASSUME THAT YOU KNOW HOW CLIENTS REACT TO THEIR FEELINGS, THOUGHTS, AND BEHAVIORS

Clients vary in the way they perceive and react to events in their lives and even to their own feelings (MacCluskie, 2010; Meier & Davis, 2011; Smaby & Maddux, 2011). For example, one young adolescent may begin to panic when she notices anxiety, believing this to be the first sign of mental illness; another may accept stress and anxiety as a sign of increasing demands on her time and advanced courses. Be wary of assuming that your own responses to an event or feeling are the same as your client's reaction (Meier & Davis, 2011;

Smaby & Maddux, 2011). Observe how clients react to their psychological states, and gently seek clarification whenever you are unsure.

46. DO NOT ASSUME THAT ALL INTERVENTIONS WILL BE SAFE OR APPROPRIATE FOR ALL CLIENTS

It is important to individualize interventions, as one size does not fit all. Individual preferences exist, and each client may value a different approach. Implementing an intervention that is ill-matched to a client is likely to be ineffective and could even be counterproductive. Chapter 5 provides a brief introduction to evidence-based treatments and contemporary interventions; there is also a web-based resource that can assist with matching interventions to clients (www.practicewise.com/Home.aspx).

Of course, it is also essential to ascertain the contextual safety of suggested interventions. For example, suggesting that your teenage client express herself to her parents may be very empowering and healthy for one client, while it may actually be dangerous for another if her parents are volatile or potentially aggressive. Be sure to collaboratively think through potential outcomes with your clients.

Overall, children and adolescents are still developing in terms of cognitive style, self-concept, and overall worldview (Erk, 2008; Krueger & Glass, 2013; Vernon, 2009). It is key that interventions are tailored to match emerging abilities and relevant contexts (Krueger & Glass, 2013; Weisz, 2014).

47. POSITIVE AND RATIONAL THINKING ARE NOT THE SAME

"Some beginning counselors mistakenly equate Ellis's concepts of rational and irrational thinking with positive and negative thinking" (Meier & Davis, 2011, p. 30). Positive and negative thinking generally references thinking about either good or bad fortune or positively or negatively assessing ability or likely success (Noble,

Heath, & Toste, 2011). Irrational thinking, on the other hand, is a belief, unsupported by objective data, that can lead to a painful emotional state (Ellis, 1962, 1973). For example, a child may say, "I will never pass that math test." The counselor may know that this child has average or better academic skills in math. In this case, the child's irrational and negative thinking creates distress and may even affect his math performance. Most certainly, it is affecting or reflecting his current emotional state.

It is important to note that although irrational thinking may lead to a negative feeling state, irrational does not imply "negative" thinking. In fact, one can think negatively and still be rational, and vice versa. For example, a different boy might report that he too will never pass this upcoming math test. As a counselor, you are aware of his substantial, and historic, academic problems in math. You may have consulted with his teacher who reported his lack of assignment completion and difficulty making progress in the classroom. In this case, the child may be completely rational, likely making an accurate prediction about his upcoming math test.

Interestingly, Noble et al. (2011) found that positive illusions, or a systemically inflated self-perception of competence, may be associated with less depression among adolescents. In a study of 71 school-based adolescents, researchers found that positive illusions in math (a tendency to overestimate math performance) were negatively related to depressive symptoms. Authors suggested that positive illusion may not necessarily be a sign of poor mental health. Rather, they may serve to enhance well-being among those who struggle in particular areas.

It seems that rational, irrational, positive, and negative thinking are important to untangle when working with children and adolescents. The goal is to help clients to challenge erroneous thinking, distortions, or faulty interpretations that lead them to negative outcomes (Ellis, 1973; Meier & Davis, 2011) as well as help them to anchor their academic, interpersonal, and other efforts in an effective understanding of their current abilities, skills, and context (Noble et al., 2011).

SUMMARY AND DISCUSSION QUESTIONS

As a beginning counselor, or a counselor looking to improve your skills, it is important to stay mindful of these common misconceptions. As you assess the client's progress, or are struggling to support progress, review these misconceptions before moving to a new strategy or approach. Consider these questions and reflection points:

- *What are your feelings about change? Do you sometimes fall into the misconception that change is simple? Can you use something with which you struggled to change to help you develop empathy (e.g., trying to quit smoking, a change in eating behaviors, increasing studying hours, working out)?*
- *Look back though your experience and consider times when you observed a bright, cognitively capable friend, colleague, or patient grappling with an emotional challenge. Perhaps you have been challenged with an emotional struggle that, from the outside, might seem like an easy fix. Reflect on or share on these discrepancies.*
- *How can you be sure that a child or adolescent does not see your efforts at empathy as agreement? For example, if a child says, "My mom is so mean." How can you respond in a way that shows you hear and empathize, yet do not necessarily agree?*
- *Share a time when you felt moral judgments arising when working with a child or adolescent. How did you handle this?*
- *How do assumptions get in the way of the counseling process?*
- *Discuss the mismatches you have observed between child or adolescent and treatment plan. Have you observed a counselor so tied to one approach that he or she is not effective? Discuss this issue and how a counselor might navigate it.*
- *Discuss rational, irrational, positive, and negative thinking. Provide examples of each. Consider effective counselor responses for (a) irrational and positive thinking, (b) irrational and negative thinking, (c) rational and positive thinking, and (d) rational and negative thinking. Be sure to approach this in terms of positive emotional outcomes for the child or adolescent.*

REFERENCES

Arkowitz, H., & Miller, W. R. (2008). Learning, applying, and extending motivational interviewing. In H. Arkowitz, H. A. Westra, W. R. Miller, & S. Rollnick (Eds.), *Motivational interviewing in the treatment of psychological problems* (pp. 1–25). New York, NY: Guilford.

Egan, G. (2014). *The skilled helper: A problem-management and opportunity-development approach to helping* (10th ed.). Belmont, CA: Brooks/Cole.

Ellis, A. (1962). *Reason and emotion in psychotherapy*. New York, NY: Lyle Stewart.

Ellis, A. (1973). *Humanistic psychotherapy: The rational emotive approach*. New York, NY: Julian Press.

Erk, R. R. (2008). *Counseling treatment for children and adolescents with DSM-IV-TR disorders* (2nd ed.). Columbus, OH: Pearson, Merrill, Prentice Hall.

Frankel, S. A., Gallerani, C. M., & Garber, J. (2012). Developmental considerations across childhood. In E. Szighтey, J. Weisz, & R. Findling (Eds.), *Cognitive-behavior therapy for children and adolescents* (pp. 29–74). Arlington, TX: American Psychiatric Publishing.

Krause, M. S., Howard, K. I., & Lutz, W. (1998). Exploring individual change. *Journal of Consulting & Clinical Psychology, 66*, 838–845.

Krueger, S. J., & Glass, C. R. (2013). Integrative psychotherapy for children and adolescents: A practice-oriented literature review. *Journal of Psychotherapy Integration, 23*, 331–344.

MacCluskie, K. (2010). *Acquiring counseling skills: Integrating theory, multiculturalism, and self-awareness*. Upper Saddle River, NJ: Merrill.

Meier, S. T., & Davis, S. R. (2011). *The elements of counseling* (7th ed.). Boston, MA: Cengage Learning.

Noble, R. N., Heath, N. L., & Toste, J. R. (2011). Positive illusions in adolescents: The relationship between academic self-enhancement and depressive symptomatology. *Child Psychiatry and Human Development, 42*, 650–665.

Prochaska, J. O. (1999). How do people change, and how can we change to help many more people? In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 227–255). Washington, DC: American Psychological Association.

Prochaska, J. O., & Diclemente, C. C. (1986). Toward a comprehensive model of change. In W. Miller & N. Heather (Eds.), *Treating addictive behaviors: Processes of change* (pp. 3–27). New York, NY: Plenum.

Prochaska, J. O., & DiClemente, C. C. (1992). Stages of change in the modification of problem behavior. In M. Hersen, R. Eisler, & P. M. Miller (Eds.), *Progress in behavior modification* (Vol. 28). Sycamore, IL: Sycamore.

Smaby, M. H., & Maddux, C. D. (2011). *Basic and advanced counseling skills: The skilled counselor training model.* Belmont, CA: Brooks/Cole, Cengage Learning.

Vernon, A. (2009). *Counseling children & adolescents* (4th ed.). Denver, CO: Love.

Weisz, J. R. (2014). Building robust psychotherapies for children and adolescents. *Perspectives on Psychological Science, 9*, 81–84.

Five

A Brief Introduction to Evidence-Based Practice and Contemporary Interventions

Now that you have established a relationship with a child and caregiver, how do you proceed? The American Psychological Association (APA) has defined evidence-based practice (EBP) as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA, 2006, p. 273). Your *clinical expertise* has been covered throughout this text as well as in your graduate training, practical experiences, supervision, and so on. This chapter highlights a number of contemporary approaches to counseling with children and adolescents. First, though, it is important to consider some issues specific to empirically supported treatments (ESTs) with children and adolescents.

48. BE FAMILIAR WITH LIMITATIONS OF ESTs WITH CHILDREN AND ADOLESCENTS

There are insufficient resources to guide you as you navigate the complexities of applying empirical research in your own clinical

work with children (Lyon, Lau, McCauley, Vander Stoep, & Chorpita, 2014). It is important, though, to be familiar with inherent limitations that accompany ESTs with children and adolescents. For example, very few manuals tested in empirical studies were actually developed for children specifically (Schmidt & Schimmelmann, 2013). That is, many evidence-based treatments are actually downward extensions of interventions originally designed for adults (Frankel, Gallerani, & Garber, 2012). Furthermore, most ESTs have been tested with youths with subclinical psychopathology in highly controlled treatment settings and are not representative of real-world clinical practice (Weisz, 2014; Weisz et al., 2013; Weisz, Jensen-Doss, & Hawley, 2005). Finally, ESTs have been criticized as being too rigidly manualized to permit individualization and personalization that professionals can attempt in usual care (Weisz et al., 2013).

Although it has been mentioned elsewhere in this text, another inherent issue to consider is the developmental and contextual appropriateness for any treatment when working with children and adolescents. Children and adolescents are still developing in terms of cognitive style, self-concept, and overall worldview (Krueger & Glass, 2013). It is key that interventions are tailored to match emerging abilities and relevant contexts (Krueger & Glass, 2013; Weisz, 2014).

49. PRACTICEWISE CLINICAL DECISION-MAKING SUPPORT

For those who truly wish to approximate EBP as promoted by the APA (2006), there is a public database that compiles youth psychotherapy outcome research (www.practicewise.com/Home.aspx). The PracticeWise Evidence-Based Services (PWEBS) database allows users to enter demographic and clinical data for a client of interest (e.g., diagnosis, age, sex, ethnicity) and the desired strength of evidence (e.g., from 1 to 5, with 1 indicating the highest or strongest empirical support). The database will then produce a report of aggregate findings (i.e., regarding successful treatment studies) matching

the child's characteristics, including a rank-ordered frequency count of practice elements within the treatments (Lyon et al., 2014; PracticeWise, 2013). Clinicians receive support in implementing and tracking the effectiveness of evidence-based treatments in real-world settings.

50. CONTEMPORARY PSYCHOTHERAPY INTERVENTIONS WITH CHILDREN AND ADOLESCENTS

Although this section will not highlight *exclusively* evidence-based approaches, all approaches reviewed in the following are at least preliminary to substantial evidence (Thompson & Henderson, 2011; Vernon, 2009) and commonly appear in graduate-level child-counseling texts.

A. Brief, Solution-Focused Therapies

Brief counseling might be labeled *counseling for the millennium* (Thompson & Henderson, 2007, p. 133). Although insurance company reimbursement has definitely influenced this trend, it is not the only factor. Since the 1950s, deviations from longer term, analytic therapies have been developed, beginning with Carl Rogers's person-centered counseling, followed by a number of new therapies designed to help people meet goals in more efficient ways (Thompson & Henderson, 2007). (For those interested in reading specific to person-centered counseling, traditionally implemented with adults, please see the original *Elements of Counseling* book by Meier and Davis.)

Littrell (1998) defined eight characteristics of brief counseling: (a) time limited, (b) solution focused, (c) action based, (d) socially interactive, (e) detail oriented, (f) humor eliciting, (g) developmentally attentive, and (h) relationship based (Littrell, 1998; Littrell & Zinck, 2004). These features characterize brief counseling as a unique approach (Littrell, 1998) and must be integrated holistically in order to help child, adolescent, and family clients realize their goals (Littrell & Zinck, 2004).

The *time-limited* nature of brief counseling is self-explanatory and particularly well suited to child-serving practitioners in school settings who may have as little as 10 minutes at a time to work with children (Littrell & Zinck, 2004). *Solutions* are a central tenet and early yet ongoing focus within brief counseling. Client competencies, exceptions to their problem states (i.e., When is this NOT a problem for you?), and very specific, concrete goals are emphasized in the pursuit of solutions. Furthermore, goals are linked to very specific *actions*, as most brief counselors believe that talk *does not equal* action (Littrell & Zinck, 2004).

Brief counseling is highly socially interactive. Brief counselors focus on the interpersonal aspects of psychotherapy and the reciprocally powerful, reinforcing aspects of socially supportive relationships (Littrell & Zinck, 2004; Thompson & Henderson, 2007). Brief counselors may also assist clients in using other supportive people to support the change process. In working with adolescents in particular, this can be an especially powerful tool. Adolescents may need to be empowered, for example, to reach out to supportive or nurturing adults within their environment. Brief counselors also explore *in detail* what already works within the client's life, what has worked in the past, and specific methods to adjust current behaviors and situations in order to reach goals.

The final three aspects of brief counseling asserted by Littrell and Zinck (2004) include the humor-eliciting, developmentally attentive, and relationship-based nature of the work. All of these aspects are well aligned with the needs of older children and adolescents, especially if goals, activities, and outcomes are matched with the child's developmental, cognitive, and social–emotional needs.

B. Cognitive Behavioral Therapy

This chapter concludes with a discussion of integrative treatments that cut across and synthesize ESTs. Integrative approaches often involve the combination of two or more standard approaches into

one treatment modality. Cognitive behavioral therapy (CBT) is one such integrative approach and, in general, the available empirical evidence demonstrates that, for most emotional and behavioral youth disorders, cognitive–behaviorally oriented therapies produce the best outcomes (March, 2009).

Cognitive behavioral approaches focus on the triarchic and reciprocal relationships among cognition, affect, and behavior (Thompson & Henderson, 2011). Cognitive behavioral models often consist of four levels of treatment: (a) behavioral procedures including contingent reinforcement, shaping, prompting, and modeling toward the achievement of a clinical goal; (b) CBT interventions, which include pairing successful task completion with positive self-statements and reinforcement for those self-statements; (c) cognitive interventions, often used with social skills training, role playing, and self-management; and (d) self-control procedures such as self-evaluation and self-reinforcement (Thompson & Henderson, 2011). Cognitive behavioral approaches have been successfully applied to aggression, anxiety, depression, attention-deficit/hyperactivity disorder (ADHD), obesity, children of alcoholics, and specialized play therapy (Thompson & Henderson, 2011).

C. Trauma-Focused Cognitive Behavioral Therapy

Trauma-focused cognitive behavioral therapy (TF-CBT) is a specialized version of CBT that may be of particular interest to readers of this text. TF-CBT is an evidence-based treatment for traumatized children. TF-CBT has been evaluated in several randomized controlled trials for use with children with reported histories of sexual abuse, domestic violence, traumatic grief, terrorism, disasters, and multiple traumas (Cohen & Mannarino, 2008). The model of TF-CBT described by Cohen and Mannarino (2008) is a flexible, components-based model that provides children and parents with the skills necessary to cope with and manage symptoms associated with trauma. See Chapter 6 for a brief summary of TF-CBT.

D. Behavior Therapy

Contemporary behavioral counseling is an action-oriented therapy. Clients and parents do something about their behavior rather than attempting to fully understand and process it via talk therapy (Thompson & Henderson, 2007, 2011). Clients learn to monitor behaviors, practice new skills, and complete homework assignments to help them realize goals (Thompson & Henderson, 2007).

Behavioral counseling is ultimately relearning. Counselors help clients establish plans to reinforce positive behaviors and eliminate or extinguish maladaptive or harmful behaviors. The counselor seeks to—through principles of reinforcement and learning theory—help clients achieve specific goals. Operant conditioning and the use of reinforcement and punishment are critical aspects of many behavioral therapies. Though beyond the scope of this book, it is essential that readers understand concepts such as positive reinforcement, negative reinforcement, punishment, and extinction.

It should be noted that behavior therapy often accompanies another type of therapy and is not necessarily mutually exclusive relative to person-centered or brief therapies, for example. In my own practice (LA), I have found the most successful children and families to be those with whom I initially engaged in a highly person-centered fashion—establishing trust, sincere respect, rapport, and so on. Then, once trust has been firmly established and clients engage with you as a therapist, it is much easier to bring in behavior plans and/or "personal action plans" to help clients change their problematic behaviors through systematic reinforcement of successive approximations of behaviors we are seeking to change.

E. Play Therapy

Play therapy, as noted in Chapter 2 of this text, is an approach to counseling young children in which the counselor uses play, toys, and games as the primary communication vehicle, thereby also permitting the child to express his or her thoughts and feelings

nonverbally (Kottman, 2004; Landreth, 2002). The rationale for using play as the primary communication modality stems from the belief that young children—unlike many older adolescents and adults—lack the abstract reasoning, self-awareness, and communication skills that would assist them in recognizing, communicating, and processing their feelings. Instead, dolls, toys, art, creative activities, and games can be used to help the child label, communicate, and ultimately recognize and process feelings that may be upsetting or confusing to them (Kottman, 2004; Landreth, 2002).

Most children below 12 years can benefit from some form of play therapy. Of course, it must be tailored to the child's specific developmental and cognitive levels as well as his or her interests. Although play therapy has a history of some controversy and criticism in the literature, multiple syntheses of play therapy research have provided support for the effectiveness of play therapy as a treatment for many different presenting problems (Bratton & Ray, 2000; LeBlanc & Ritchie, 1999; Ray, Bratton, Rhine, & Jones, 2001).

Furthermore, similar to behavior therapy, it is important that we *not* conceptualize play therapy as mutually exclusive to other therapies. Theorists have suggested that, through play therapy and the relationship with the therapist, children are better able to grow and change. In addition, youth can become more self-accepting and reliant through internalizing the unconditional positive regard of the play therapist. Thus, incorporating play therapy into an EST such as CBT may facilitate meeting a child's developmental needs and creatively engaging them in mental health treatment (Myrick & Green, 2012). Myrick and Green (2012), for example, propose a model for integrating play therapy within evidence-based treatment for obsessive compulsive disorder. Interested readers should refer to the article for specific ideas (Myrick & Green, 2012).

In sum, play therapy for young children, in particular, makes sense as a vehicle to engage, complement, and enhance treatment effectiveness. Like any other treatment, it must be tailored to specific child needs, interests, and abilities.

F. Family Therapy

The primary difference between individual and family counseling is that family counseling focuses on the family and its members' interactions. It almost always involves interventions to affect the operation of the entire family system. The family counseling and therapy label "covers a wide variety of arrangements: It may be individual, husband and wife, parent and child, or the entire family, including all who live in the home" (Thompson & Henderson, 2007, p. 335). It is important to be culturally sensitive in one's definition of family.

Though a full overview of the different types of family therapy is beyond the scope of this book (see Thompson & Henderson, 2011), we wish to convey that professionals who seek to truly help children *must* work with families (Golden, 2004). "The family is in a position to support or sabotage therapeutic goals. Building a healthy counselor–child relationship is not enough. To best understand the child's problems, the counselor must see the child in the family context" (Golden, 2004, p. 451). A number of brief strategies with families exist, including brief family consultation, solution-focused family therapy, and strategic family therapy (Golden, 2004). As with many other therapies, integrative and eclectic themes are common within the family therapy literature. It is important to understand the constellation of the child's family of origin, and—as appropriate—seek supervision and training in order to conduct sensitive and effective family therapy in order to serve the best interests of the child (Golden, 2004; Thompson & Henderson, 2007, 2011).

G. Creative and Innovative Techniques to Enhance Evidence-Based Interventions

Bradley, Gould, and Hendricks (2004) review a number of techniques that can creatively enhance therapy with children and adolescents. A selection of creative therapies are reviewed here.

Art therapy techniques are especially helpful for working with diverse populations and can transcend cultural boundaries. Similar to play therapies, creative expression through art allows children a safe vehicle for expressing difficult, sometimes unspeakable, feelings (Bradley et al., 2004; Gladding, 1995). Art is relaxing and soothing and can facilitate the manipulation of various media. In using art, counselors should permit clients to select the medium they want to use—not limiting the child to drawings. Other effective media include clay, soap, or multimedia approaches (Bradley et al., 2004). It is important that counselors view child artwork similar to other confidential communication, thereby protecting any/all artwork at the highest level of privacy and confidentiality.

Bibliotherapy is another approach that has been integrated into counseling for many years. It has been used to establish rapport, explore client viewpoints, promote insight, and educate/reorient clients (Bradley et al., 2004; Jackson, 2000). Bibliotherapy is a process designed to help individuals solve problems and better understand themselves through reading (Pardeck, 1995). Books can be read, extended, related to, created, or acted out. There are also a number of books designed for therapeutic use—published by the APA's Magination Press, for example (www.apa.org/pubs/magination/).

Music therapy has been an especially popular approach in my own (LA) practice. Children and adolescents come alive when they are permitted to share their music interests and preferences. Music helps to alleviate feelings of depression, anxiety, loneliness, and grief, and it can help clarify developmental issues and identity (Bradley et al., 2004). Music can facilitate healing and is considered an effective adjunct to counseling children and adolescents (Bradley et al., 2004; Newcomb, 1994). It is an ideal approach for clients who have difficulty expressing themselves verbally (Newcomb, 1994).

Please see Bradley et al. (2004) for an overview and specific suggestions for the use of music within child psychotherapy. A number of other creative and innovative approaches are also reviewed,

including guided imagery, puppets, role-play, storytelling, metaphors, therapeutic writing, and multicultural techniques (Bradley et al., 2004). Children and adolescents are especially responsive to these creative processes and should be active, decisive agents in selecting them.

H. Multisystemic Therapy

Multisystemic therapy (MST) has been considered a revolutionary treatment for the child externalizing mental health problems (Borduin, Schaeffer, & Heiblum, 2009; Henggeler, 1999; Pane, White, Nadorff, Grills-Taquechel, & Stanley, 2013). It is based on an ecological model of treatment that views every child as part of a network of multiple systems interacting to influence behavior (Bronfenbrenner, 1979; Pane et al., 2013). The systems within the multisytemic approach include the child, family, peer group, school, neighborhood, community, and larger society (Bronfenbrenner, 1979).

Initially targeted toward youth with antisocial behavior (Painter, 2010), MST has the goals of decreasing problem and delinquent behaviors and reducing rates of out-of-home placement and incarceration (Curtis, Ronan, & Borduin, 2004; Pane et al., 2013). To meet these goals, MST therapists must promote familial and supportive relationships, parenting skills, positive youth development, and school success (Curtis et al., 2004; Pane et al., 2013). A combination of empirically supported, problem-focused treatment components tailored to the needs of the child and family and the surrounding system, is ultimately implemented (Pane et al., 2013). Goals are determined collaboratively, and the family is actively involved in all phases of treatment. Traditionally, intervention services within MST include an intake evaluation, individual therapy with the youth and family, peer interventions, crisis stabilization, and case management (Pane et al., 2013). MST also actively addresses barriers by providing treatment in the home, school, and community settings, and scheduling meetings at times that are convenient for families (Curtis et al., 2004; Painter, 2010; Pane et al., 2013).

Given the treatment intensity, each MST therapist has a small caseload of only four to six families (Pane et al., 2013). Treatment usually lasts 3 to 5 months, with therapists providing 24/7 support, as necessary, and an average of up to 60 hours of direct contact with each family (Pane et al., 2013).

Despite the intensity and clear expense of this work, studies of MST have generally found positive effects (Borduin et al., 2009; Curtis et al., 2004; Henggeler, 1999; Painter, 2010; Pane et al., 2013). As such, interest in MST for other diagnoses and problem areas has grown (Pane et al., 2013). Researchers and clinicians are likely very interested due to MST's roots in Bronfenbrenner's ecological systems theory and multicomponent approach. Most child mental health problems are the result of a number of factors of influence, and multicomponent interventions that demonstrate promise empirically, are likely going to have the most generalizability and potential effectiveness in the real world. Overall, if community resources are available, it is worthwhile for therapists to consider exploring how they might adopt a multisystemic approach in their practice/agency.

51. CONSIDER INTEGRATIVE APPROACHES

It is rare that contemporary, effective psychotherapies for children and adolescents are single-component in nature. Even the "gold standard" cognitive behavioral treatment is originally an integrative approach. Krueger and Glass (2013) recently published a practice-oriented literature review that would benefit all readers. The focus is on integrative paradigms of psychotherapy practice. Given the complexity of human behavior and the definition of EBP as asserted by the APA, integrative approaches, indeed, will be the wave of the future. Though more research is necessary regarding implementation details, adherence promotion, dosing, and so on, it is an exciting time for child and adolescent psychotherapists. Elements such as mindfulness, attachment theory, play therapy, and CBT can come together to form truly effective therapies that can help children and families who are hurting (see Krueger & Glass, 2013). It is important

that we continue to be fastidious in our consumption of empirical literature, clinical supervision, and community resources that will help develop and refine our approach to EBP.

SUMMARY AND DISCUSSION QUESTIONS

This chapter dealt with EBP, issues with ESTs, and contemporary interventions for child and adolescent psychotherapy. To help you understand and apply the information in this chapter, consider these questions:

- *How did you define EBP before reading this chapter? Comment on the three elements in your own practice: clinical expertise, research evidence, and client/contextual factors. In which of the three areas could you use the most professional development?*
- *Can you think of other limitations or drawbacks to ESTs that were not mentioned?*
- *What do you think of the PWEBS or PracticeWise database (www.practicewise.com/Home.aspx)? Do you think it should be a free database?*
- *Which contemporary treatment do you use most?*
- *Which creative or innovative treatments would you like to integrate within your practice?*
- *On the basis of your review of this chapter, make at least 1 or 2 professional development goals for yourself in terms of new skills/therapies/treatments you would like to learn.*
- *Does your community have a working MST agency or agencies? Make it your goal to learn about the available MST services that may exist in your region.*

REFERENCES

American Psychological Association. (2006). Evidence-based practice in psychology. *American Psychologist, 61*, 271–285. doi:10.1037/0003-066X.61.4.271

Bradley, L. J., Gould, L. J., & Hendricks, C. B. (2004). Using innovative techniques for counseling children and adolescents. In A. Vernon (Ed.), *Counseling children and adolescents* (3rd ed., pp. 75–110). Denver, CO: Love.

Bratton, S., & Ray, D. (2000). What the research shows about play therapy. *International Journal of Play Therapy, 9*, 47–88.

Borduin, C. M., Schaeffer, C. M., & Heiblum, N. (2009). A randomized clinical trial of multisystemic therapy with juvenile sexual offenders: Effects on youth social ecology and criminal activity. *Journal of Consulting & Clinical Psychology, 77*, 26–37.

Bronfenbrenner, U. (1979). *The ecology of human development*. Cambridge, MA: Harvard University Press.

Cohen, J. A., & Mannarino, A. P. (2008). Trauma-focused cognitive behavioral therapy for children and parents. *Child and Adolescent Mental Health, 13*, 158–162.

Curtis, N. M., Ronan, K. R., & Borduin, C. M. (2004). Multisystemic treatment: A meta-analysis of outcome studies. *Journal of Family Psychology, 18*, 411–419.

Frankel, S. A., Gallerani, C. M., & Garber, J. (2012). Developmental considerations across childhood. In E. Szighey, J. Weisz, & R. Findling (Eds.), *Cognitive-behavior therapy for children and adolescents* (pp. 29–74). Arlington, TX: American Psychiatric Publishing.

Gladding, S. (1995). Creativity in counseling. *Counseling and Human Development, 28*, 1–12.

Golden, L. (2004). Working with families. In A. Vernon (Ed.), *Counseling children and adolescents* (3rd ed., pp. 451–468). Denver, CO: Love.

Henggeler, S. W. (1999). Multisystemic therapy: An overview of clinical procedures, outcomes, and policy implication. *Child Psychology & Psychiatry Review, 4*, 4–9.

Jackson, T. (2000). *Still more activities that teach*. Salt Lake City, UT: Red Rock.

Kottman, T. (2004). Play therapy. In A. Vernon (Ed.), *Counseling children and adolescents* (3rd ed., pp. 111–136). Denver, CO: Love.

Krueger, S. J., & Glass, C. R. (2013). Integrative psychotherapy for children and adolescents: A practice-oriented literature review. *Journal of Psychotherapy Integration, 23*, 331–344.

Landreth, G. L. (2002). *Play therapy: The art of the relationship* (2nd ed.). New York, NY: Brunner-Routledge.

LeBlanc, M., & Ritchie, M. (1999). Predictors of play therapy outcomes. *International Journal of Play Therapy, 8*, 19–34.

Littrell, J. M. (1998). *Brief counseling in action*. New York, NY: W. W. Norton.

Littrell, J. M., & Zinck, K. (2004). Brief counseling with children and adolescents: Interactive, culturally responsive, and action-based. In A. Vernon (Ed.), *Counseling children and adolescents* (3rd ed., pp. 137–162). Denver, CO: Love.

Lyon, A. R., Lau, A. S., McCauley, E., Vander Stoep, A., & Chorpita, B. F. (2014). A case for modular design: Implications for implementing evidence-based interventions with culturally diverse youth. *Professional Psychology: Research and Practice, 45*, 57–66.

March, J. S. (2009). The future of psychotherapy for mentally ill children and adolescents. *Journal of Child Psychology and Psychiatry, 50*, 170–179.

Myrick, A. C., & Green, E. J. (2012). Incorporating play therapy into evidence-based treatment with children affected by obsessive compulsive disorder. *International Journal of Play Therapy, 21*, 74–86.

Newcomb, N. S. (1994). Music: A powerful resource for the elementary school counselor. *Elementary School Guidance and Counseling, 29*, 150–155.

Painter, K. (2010). Multisystemic therapy as an alternative community-based treatment for youth with severe emotional disturbance: Empirical literature review. *Social Work in Mental Health, 8*, 190–208.

Pane, H. T., White, R. S., Nadorff, M. R., Grills-Taquechel, A., & Stanley, M. A. (2013). Multisystemic therapy for child non-externalizing psychological and health problems: A preliminary review. *Clinical Child and Family Psychology Review, 16*, 81–99.

Pardeck, J. (1995). Bibliotherapy: Using books to help children deal with problems. *Early Child Development and Care, 106*, 75–90.

PracticeWise. (2013). *Evidence-based services database*. Satellite Beach, FL: Author.

Ray, D., Bratton, S., Rhine, T., & Jones, L. (2001). The effectiveness of play therapy: Responding to the critics. *International Journal of Play Therapy, 10*, 85–108.

Schmidt, S. S., & Schimmelmann, B. G. (2013). Evidence-based psychotherapy in children and adolescents: Advances, methodological and conceptual limitations, and perspectives. *European Child & Adolescent Psychiatry, 22*, 265–268.

Thompson, C. L., & Henderson, D. A. (2007). *Counseling children* (7th ed.). Belmont, CA: Thomson Higher Education Brooks/Cole.

Thompson, C. L., & Henderson, D. A. (2011). *Counseling children* (8th ed.). Belmont, CA: Thomson Higher Education Brooks/Cole.

Vernon, A. (2009). *Counseling children & adolescents* (4th ed.). Denver, CO: Love.

Weisz, J. R. (2014). Building robust psychotherapies for children and adolescents. *Perspectives on Psychological Science, 9*, 81–84.

Weisz, J. R., Jensen-Doss, A. J., & Hawley, K. M. (2005). Youth psychotherapy outcome research: A review and critique of the evidence base. *Annual Review of Psychology, 56*, 337–363.

Weisz, J. R., Kuppens, S., Eckshtain, D., Ugueto, A. M., Hawley, K. M., & Jensen-Doss, A. (2013). Performance of evidence-based youth psychotherapies compared with usual clinical care: A multilevel meta-analysis. *JAMA Psychiatry, 70*, 750–761.

Six

Crisis Intervention, Mandated Reporting, and Related Issues

It is not uncommon for children, adolescents, and families to seek our services when they are in crisis. Despite a growing literature base in school crisis prevention, intervention, and preparedness, there is relatively little literature addressing mental health crisis intervention for professional counselors. One recent study of professional counselors revealed that the majority of newly credentialed counselors report minimal crisis-intervention training within graduate curricula (Morris & Minton, 2012). This chapter addresses elements pertinent to crisis intervention, including mandated reporting, and associated trauma or grief.

52. DEVELOP CRISIS-INTERVENTION SKILLS

Kanel (2003) offered a palatable definition of crisis for those working with children, adolescents, and families. A crisis is defined by three features: (a) an individual or family's lowered psychological, emotional, or behavioral functioning due to a precipitating event; (b) associated subjective distress based on the overwhelming nature of the precipitating event; and (c) the inability or failure to implement

usual problem-solving or coping strategies (Kanel, 2003). Thus, in crisis situations, we are confronted with individuals who are functioning below their usual capacity (Sullivan, Harris, Collado, & Chen, 2006). Crises usually require intervention that is fairly immediate in order to assist people in returning to usual or homeostatic psychosocial or behavioral functioning (Gentry & Westover Consultants, 1994). See Kanel (2003) for a more comprehensive view of crisis intervention, in general.

Despite not always receiving formal training (Morris & Minton, 2012), most counselors agree about the basic steps for working with crisis clients (Meier & Davis, 2011). When faced with a new child or adolescent in crisis, counselor actions will differ from that of a more typical intake with a new client.

One of the first and most critical elements of crisis intervention with children and adolescents is *suicide risk* or *lethality assessment*. Lethality assessment ascertains the degree of risk or the likelihood of an actual suicide attempt.

Before proceeding, it is important to note that this is a brief overview. For a more thorough discussion of suicide assessment, one may consult the seminal document released by the American Psychiatric Association (APA) Work Group on Suicidal Behaviors' (2003) *Practice Guidelines*. Furthermore, the basic elements here do not address culture-specific differences in crisis intervention and suicide risk assessment (for a more complete discussion, see Chu et al., 2013 or Sullivan et al., 2006). Moreover, beginning counselors should familiarize themselves with local procedures to be employed with suicidal clients and should always consult with supervisors if suicide is a possibility (Meier & Davis, 2011).

A. Assess for Suicide Risk: Specificity-Lethality-Access-Proximity-Prior Attempts (SLAP-P)

You cannot *implant* suicidal ideation by addressing suicidal thoughts and feelings directly. Any indication that clients have considered

harming themselves needs direct and explicit attention (Meier & Davis, 2011). The components of a suicide risk assessment, as recommended by the APA (2003), include an evaluation of (a) personal psychiatric illness, (b) family history of suicide or personal history of attempted suicide, (c) individual competencies and vulnerabilities, and (d) current psychosocial circumstances. Furthermore, the acronym SLAP is often used to help professionals remember the critical elements of a lethality or imminent suicide risk assessment (e.g., see the following). Because *the best predictor for adolescent suicide completions* has been cited as *previous suicide attempts* (Harrison, 2013; Thompson, Kuruwita, & Foster, 2009), we are recommending that child and adolescent practitioners use a modified SLAP-P acronym (Specificity, Lethality, Access, Proximity, Previous attempts) for use with children and adolescents:

- *Specificity (S).* Specific, detailed suicide plans are relatively more lethal than vague ideas.

COUNSELOR:	Have you thought about how you would go about killing yourself?
CLIENT A:	My father's gun is loaded and is in his cabinet at our house. I will get his key when he is at work on Saturday and take the gun out to the woods . . . I don't want to make a mess in the house.
CLIENT B:	I would go to the Grand Island Bridge and ride my bike to the top; then I would leap.
CLIENT C:	. . . Not really. Probably pills.

In the above example, Clients A and B both have specific plans that would place them at least at moderate risk. Client A is at the greatest risk, based on the above information, as Client A indicates not only a specific method but also a time and place. His or her plan is quite detailed and well thought out. Client C would be (relatively) less lethal on the "S" continuum.

- *Lethality of means (L).* How lethal are the means or intended method? Once started, can it be reversed? In the above example, both Clients A and B are presenting highly lethal ideas. Ideas including firearms, jumping from very high locations,

and/or jumping in front of moving vehicles are very lethal. Intended means such as cutting, overdosing, or even driving recklessly (i.e., with intentions to crash) are *relatively* less lethal because there is a greater likelihood that clients could change their minds and/or reach out for help after having begun.

- *Access (A).* How accessible or available are intended means? Are means within "reach" to the client or in his or her possession? Would means have to be purchased, borrowed, or stolen, and—if so—how easily would it be for a client to do so? These issues should be explored and specifically queried. Needless to say, an adolescent with access to a loaded firearm is highly lethal.

  There are other highly lethal methods that may be more accessible to adolescents, however—especially with the rise in Internet "how-to" sites on suicide methods. Thus, it is critically important to obtain as much specific information as possible. For example, if an adolescent has learned about "suicide bags" via the Internet and has already purchased a helium tank and supplies (Schön & Ketterer, 2007), this would be considered at least as lethal as the adolescent with a loaded gun in his or her home.
- *Proximity to people (P).* To what extent is the child or adolescent alone? The degree of isolation of the child influences lethality risk. If the child/adolescent has plenty of friends and family who are frequently physically present, it is more likely that one of them could monitor the child, intervene, foil the plan, and/or confiscate means. Of course, this requires open and explicit communication with those individuals.
- *Previous attempts (P).* Predicting suicide, like predicting many other events in counseling, is highly problematic (Meier & Davis, 2011). Information about a previous, serious attempt, however—especially when combined with significant concerns along SLAP dimensions—would increase a child's or adolescent's lethality to serious and significantly elevated.

In summary, then, if a SLAP-P assessment leads you to conclude that your client is at serious risk for a lethal suicide attempt and/or

serious self-harm, you have an ethical and legal responsibility to take action and preserve that child's or adolescent's life (Meier & Davis, 2011). Of course, confidentiality may be broken if the client's life is in jeopardy. Furthermore, immediate counseling, emergency crisis services, and/or hospitalization (voluntary or involuntary, if necessary) may be required (APA, 2003; Meier & Davis, 2011).

As noted by Meier and Davis (2011), even when there is relatively low suicide risk, those working with clients in crisis need to be especially directive and proactive. The remaining crisis-intervention strategies are recommended.

B. Take Control of the Situation

Particularly when clients are suicidal, counselors must be especially directive and take action. Many times, clients feel a significant loss of control or have given up. The counselor can assist by creating structure that facilitates predictability and routine (Meier & Davis, 2011). That is, it is entirely appropriate for the counselor to take the lead.

It may be necessary to see the client more often if he or she is in crisis. This is acceptable, and the client should feel validated by and connected to you as a therapist. Helping the client to establish healthful routines and (re)discover pleasant activities is important.

Developing a specific, clear, and detailed safety plan in collaboration with the client is also critical. Specific behaviors that help calm the client down can be incorporated within the safety plan, as can support people. Clients should be encouraged to reach out to support people in order to inform them that they are components of the safety plan. Oftentimes, adolescents need to be empowered and instructed to reach out to caring and safe adults. Preferred teachers, counselors, coaches, or others from the school or faith setting are often ideal individuals to include. The client may need support in reaching out to these individuals: Help him or her, if so, but be certain to obtain documented consent to communicate with those individuals. Furthermore, ensure that the client is aware of your

availability between appointments and has a back-up plan (e.g., a local crisis services number, an on-call therapist, or a hotline number) should he or she need you between visits. All of the aforementioned information—including the safety plan, support people, and "safety net" of 24/7 communication—should be written down by the client in your presence. You can then make a copy for your records should it need to be referenced or reproduced in the future.

C. Focus on Competencies and Strengths

Positive psychology and strengths-based practices are not new; however, they are especially important during times of crisis (Greene, Lee, Trask, & Rheinscheld, 2005; Meier & Davis, 2011). As Meier and Davis (2011) note, even relatively minor or seemingly small strengths can be highlighted. It is also important to note the degree to which clients accept your positive attributions. The more empowered your client, the more likely he or she will begin to accept his or her positive qualities, increase optimistic outlook, and ultimately regain control.

D. Mobilize Social Resources and Engage Caregivers

Clients may not have readily apparent social supports and networks; however, clinicians can empower children and adolescents to reach out—as noted previously—and lean on friends and family members. Given the level of stigma often associated with mental-health difficulties and treatment, adolescents may not have even considered reaching out to anyone in "real life." If a family tends to deny negative feelings or emotions, a child may be left feeling isolated and/or alone in these experiences. Assess the degree to which extended family members and close friends may be accessible and available to your child and adolescent clients. As noted previously, preferred school personnel are often willing and available to assist if they are aware of the situation.

CLIENT: My mom never notices anything good about me! I end up feeling like I will never do anything right in her eyes. *(Note: This is an instance wherein the child is quite intuitive and fairly accurate. Despite repeated attempts by the counselor to engage her mother and encourage praise and positive interactions, the mother has been resistant and refuses to obtain her own mental health treatment.)*

COUNSELOR: It is especially frustrating when those closest to you cannot "see" you (i.e., *followed by supportive validation*). . . . You have talked about how good you feel about yourself during art class and when spending time with your grandma. I am so glad that you have these experiences. Have you thought about approaching your art teacher and asking her if you can have lunch with her or stay after in her room sometimes?

CLIENT: No way! She will think I am crazy!

COUNSELOR: You only share what you want to share. Starting by expressing how much you enjoy her class and sharing that you would like to spend a little more time with her is a good first step. Then we can discuss if and how you want to share more with her.

CLIENT: Hmmm. . . . Yeah, I have noticed that other kids hang out in her room. Maybe I will think about it.

COUNSELOR: Wonderful! What about grandma? Let's talk about how you can spend more time with her during the school week. . . .

In this example, the adolescent female had not even *considered* reaching out to these adults in her life. She assumed that the therapist intended for her to self-disclose "everything." Sometimes children need explicit guidance about how to approach supportive adults, self-disclose in a cautious but open manner, and develop more meaningful relationships. Adolescents, in particular, are quite receptive to being empowered socially.

In 100% of the applicable cases in this author's practice (LA), adolescents have followed through with making supportive, additional social–emotional connections with safe adults. Of course, it is important to keep in mind that—sadly—not all adults will be receptive to an adolescent reaching out. As a counselor, you can prepare the child for this possibility ahead of time and be prepared to implement Plan B. Extended family members are also quite receptive to adolescent efforts to develop deeper relationships.

The preceding example is also poignant because it reinforced and encouraged one of the child's talents (artwork). Incidentally, this particular adolescent now stays after school with her art teacher three times weekly and has "coffee" (aka hot chocolate) with her grandmother on the other two days.

E. Know and Use Community and Technology Supports

Modern technology generally makes it much easier for counselors to generate resource lists of community supports, agencies, paraprofessionals, and other child/adolescent health care providers. Local psychiatric emergency services will be much more likely to follow up and collaborate with you if you have reached out and made an effort. Social workers at local psychiatric hospitals, for example, have been repeatedly "refreshingly relieved" (L. Anderson, personal communication, October 8 and 20, 2013) when a provider makes a proactive contact *before* any clients or patients have been referred or treated.

Make an effort to talk with other professionals in your community in order to determine the most helpful/effective crisis and emergency service agencies. Once you have learned this information, memorize the contact information so it is readily available should you need to share it with clients and families.

Finally, communication with primary care practitioners is invaluable. If your community has relatively limited psychiatric medical services for children and adolescents, your clients' pediatricians may be the primary prescribers of psychoactive medications. Advanced practice nurses and nurse practitioners also provide psychiatric prescription services for children and adolescents. Make an effort to learn about the primary care providers who refer to your practice. It is important to note that families may be more likely to follow up with primary care providers with regard to future mental health concerns due to the reduced stigma (Harrison, 2013).

Harrison (2013) noted a number of websites with useful information for providers who work with children and adolescents struggling with mental health crises and/or suicidality. The following websites were referenced:

- American Academy of Child and Adolescent Psychiatry (www.aacap.org)
- American Foundation for Suicide Prevention (AFSP; www.afsp.org)
- National Center for the Prevention of Youth Suicide (www.suicidology.org/ncpys)
- Substance Abuse and Mental Health Services Administration (SAMHSA) Suicide Assessment Five-Step Evaluation and Triage (SAFE-T; samhsa.gov)
- Suicide Prevention Resource Center (www.sprc.org)

53. LEARN AND UNDERSTAND GRIEF, LOSS, AND TRAUMA

Human suffering associated with crises is often tied to grief, loss, and/or trauma. Though it is beyond the scope of this book, it is critical for counselors to understand child and adolescent reactions within this domain. Children understand and process grief and trauma differently on the basis of developmental and cognitive ability levels (Cohen & Mannarino, 2004). Unfortunately, it is not uncommon for children to experience traumatic events before reaching adulthood. As an example, international studies document that child sexual abuse, physical abuse, or domestic violence affect approximately 25% of children (Cohen & Mannarino, 2008). War, natural disasters, motor vehicle accidents, violence, terrorist acts, and refugee experiences can all contribute to trauma reactions (Cook et al., 2005). Regrettably, if left untreated, complications

associated with *unresolved* trauma or grief can last well into adulthood (Cohen & Mannarino, 2008; Cook et al., 2005).

As Meier and Davis (2011) note, it is critical to assess how specific clients cope with grief, loss, or trauma. With children, however, it may be even more important to attend to contextual features and look beyond the stereotypical individual trauma reaction (Cook-Cottone, 2004; Jones, 2008). In fact, there is a growing consensus in the research literature that the majority of children exposed to trauma do *not* develop posttraumatic symptomatology unless they have experienced repeated traumas and/or other risk factors apply (Jones, 2008). It is important, therefore, to be attuned to child and family needs, strengths, and resources. Recent research in child trauma reactions has emphasized systemic, contextual, and ecological models of trauma processing and treatment (Cook-Cottone, 2004; Ellis et al., 2012; Jones, 2008).

Complex trauma survivors are more likely to exhibit dysregulated and/or problematic symptoms (Cohen & Mannarino, 2008; Cook et al., 2005; Gillies, Taylor, Gray, O'Brien, & D'Abrew, 2012). Symptoms of affect, behavior, and cognition dysregulation are not uncommon. The most well-known and validated treatment for complex trauma reactions in the pediatric population has been trauma-focused cognitive behavioral therapy (TF-CBT) with caregiver involvement (Cohen & Mannarino, 2008; Cook et al., 2005; Gillies et al., 2012). Cohen and Mannarino (2008) and Cook and colleagues (2005) provide concise yet expansive summaries in this area.

Cohen and Mannarino (2008) use the acronym PRACTICE in presenting the components of TF-CBT. Aptly noted, the acronym fits well given that children and caregivers should be practicing skills between therapy sessions. A central tenet of the TF-CBT model is gradual exposure (Cohen & Mannarino, 2008; Gillies et al., 2012). All TF-CBT components integrate graded exposure to the traumatic experience; intensity increases as the child and caregiver hierarchically progress. "PRACTICE stands for Psychoeducation and Parenting skills; Relaxation skills; Affective regulation skills; Cognitive

coping skills; Trauma narrative and cognitive processing of the traumatic event(s); In vivo mastery of trauma reminders; Conjoint child–caregiver sessions; and Enhancing safety and future developmental trajectory" (Cohen & Mannarino, 2008, p. 159). See Cohen and Mannarino (2008) or Cook et al. (2005) for more in-depth reviews of treatments for complex trauma reactions.

It is worth noting that supplemental creative and art therapies have been used with trauma survivors to help with the processing and regulation of affect within TF-CBT (Cohen & Mannarino, 2008; Jones, 2008). One of the most powerful sessions ever experienced in my own practice (LA) was a session wherein an established 13-year-old client started writing, spontaneously, in response to some basic questions about her traumatic experiences. The session inspired a series of three sessions that were completed without verbal language. I suggested that we play music. Thus, a particularly moving classical soundtrack was played in the background, and the child and I wrote back and forth to one another in pencil, including her intermittent drawings. The sound of the pencil on the paper and the music, together with the affect, produced a powerful reaction in both the child and me. She felt safer sharing her experiences in writing, and she preferred to write to me "live" versus producing something at home. The artful or creative construction of a personal narrative, provided the child feels safe enough to do so, can be especially therapeutic.

54. BECOME LITERATE IN MANDATED REPORTING

Just as trauma and grief reactions tend to accompany crisis intervention, it is not uncommon—sadly—for those of us working with children and adolescents to interact with state agencies as mandated reporters of child abuse and neglect. In the United States, any individual working with children in a professional capacity is legally obligated to contact child protective services if they have *reasonable*

suspicion that a child has been abused or neglected (Crowell & Levi, 2012; Gateway, 2012). This has been part of the professional life for child practitioners since the United States Congressional Child Abuse Prevention and Treatment Act of 1974. Though the system was designed to protect the best interests of children, many professionals have reported (a) difficulties with navigating the system, (b) a lack of confidence in agency response to reports, and (c) concerns about how mandated reporting ultimately influences the therapeutic alliance (Strozier et al., 2005).

A. Know Your State Laws and Nomenclature

State legal statutes outline what events must be reported and by whom, standards for report-making, what communications remain privileged, the degree to which the reporter's name must be included, and whether or not reporter identity may be disclosed (Bean, Softas-Nall, & Mahoney, 2011; Gateway, 2012). Gray areas may exist in the laws about what, exactly, defines abuse (Bean et al., 2011). Therefore, it is critical to seek supervision or counsel if you do not fully comprehend the mandated reporting laws within your state. The Child Welfare Information Gateway (2012; accessible via www.childwelfare.gov) offers a number of free and informative documents, including specific statutes for every state.

Relatedly, key statutory wording defining the threshold for mandated reporting of suspected child abuse varies by state. For example, 22 state statutes contain some variation of the word *belief*; however, the remaining 28 states utilize some variant of *suspicion* (Gateway, 2012; Levi & Portwood, 2011). As Levi and Portwood (2011) highlight, there are practical and conceptual differences between what it means to *believe* versus what it means to *suspect* child abuse or neglect. *Belief* implies a certain degree of certainty; however, the threshold for mandatory reporting does not and should not require clear evidence (Crowell & Levi, 2012; Levi & Loeben, 2004; Levi & Portwood, 2011).

B. Consider a Probability Threshold

Given that statutory wording can influence the interpretation of mandated reporting thresholds, it is also worthwhile to consider the addition of a "probability threshold." As Levi and Portwood (2011) noted, when reasonable suspicion is defined as ">25% chance that abuse occurred"—as compared with the more vague *suspicion* nomenclature—child-serving practitioners were 2 to 3 times more likely to report suspected physical and sexual abuse. This is not intended to suggest that 25% is the magic threshold percentage; however, specification of a numeric threshold may improve the validity of reports (Levi & Portwood, 2011). More research is needed in this area; however, if your state offers vague wording and could be enhanced by the conceptual integration of the 25% threshold, do consider advocating for these changes in your state and/or conducting preliminary research. Of course, any of these future changes would need to be accompanied by specific educational interventions (Levi & Portwood, 2011).

C. Use Framework Proposed by Levi and Portwood (2011)

Levi and Portwood (2011) put forth a framework to help child-serving practitioners determine whether to report possible abuse. With their explicit permission, we are sharing that framework with you. This framework offers a decision-making tree to help you answer "Do you have reasonable suspicion?" Feelings, conditions, and assessments of probability are included (see Figure 6.1).

D. Be Prepared for Reactions and Seek Supervision Appropriately

Counselors, especially those who are new, may feel intense doubt, anxiety, and or uncertainty when faced with the prospect of breaking confidentiality to make a report to authorities (Bean et al., 2011).

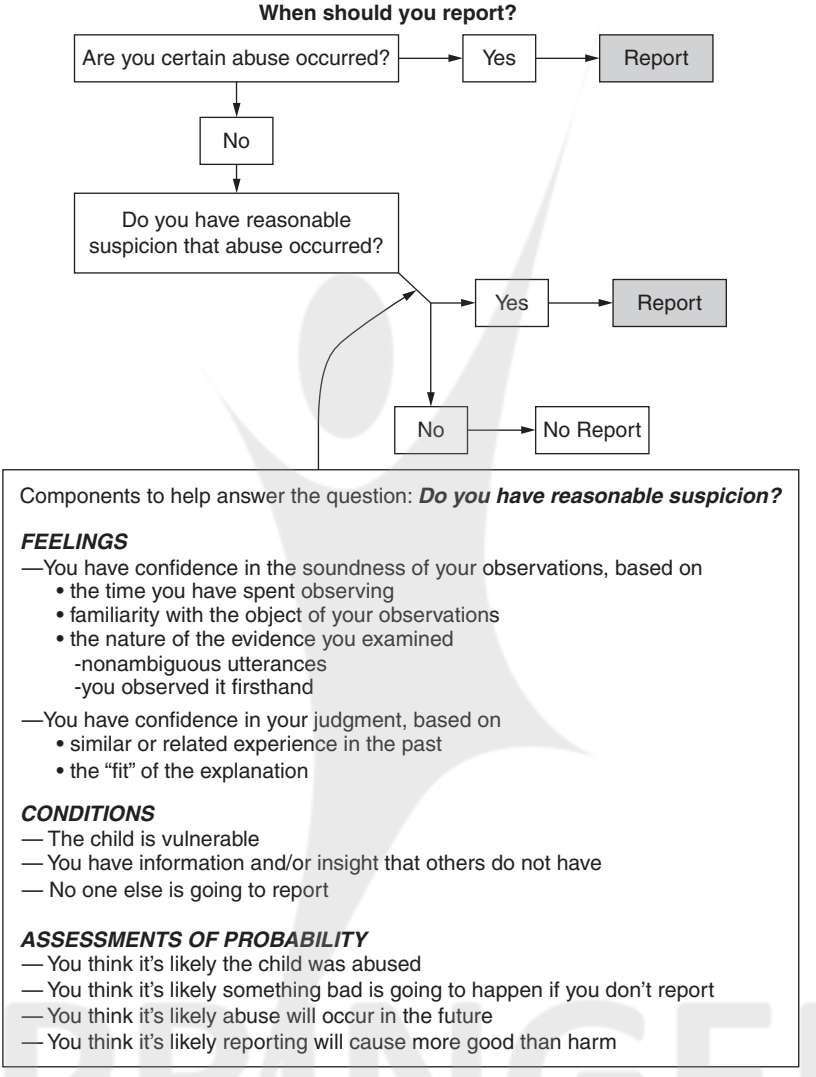


FIGURE 6.1 Proposed framework for whether to report possible abuse.
Reproduced with author permission (Levi & Portwood, 2011).

Clients—especially adolescent minors in romantic relationships with someone older—may feel betrayed by the therapist who reports the inappropriate relationship. Feelings of hurt, confusion, anger, and abandonment may ensue, and counselors must be prepared (Bean et al., 2011). Furthermore, family members and/or caregivers may

not embrace mandated reporting of abuse (i.e., either denied or perceived by them to be appropriate) or inappropriate sexual relationships of their minor child with an older individual. They may feel angry or perceive the counselor to have overstepped boundaries, infringing on the caregiver role (Bean et al., 2011). Finally, previous research has demonstrated that—when an adolescent becomes angry or feels abandoned about a mandated report made by a therapist—the adolescent and family may drop out of therapy 27% of the time (Steinberg, Levine, & Doueck, 1997).

55. REFER CAREFULLY

Of course, this discussion brings up the issue of referring clients to other providers. If you have a client or family who has discontinued treatment with you, you must be ready to refer to someone else who can continue the therapeutic work with the child and family (Bean et al., 2011; Meier & Davis, 2011).

As Meier and Davis (2011) note, "You cannot help every client" (p. 45). You may face an issue that exceeds your current competencies or comfort level, perhaps your client moves to a new location, or you may simply lack "fit" with certain individuals and families (Meier & Davis, 2011). You must be aware of other resources in the community and/or be willing to assist clients in locating providers in new locations. The Internet, modern technology, and even managed care databases make this process relatively easy. Of course, it is critical to address fears and misconceptions with your outgoing client. Furthermore, explicit written consent should be obtained for your communication with future providers, and—ideally—your client will approve your communication of basic and essential information to the new provider. Information transmitted may include the original referral reason, specific needs of the client, and relevant data from assessments. Finally, follow-up to ensure that the client connected with a new provider is a helpful, ethical, and professional way to conclude your relationship with your former client (Meier & Davis, 2011).

SUMMARY AND DISCUSSION QUESTIONS

This chapter dealt with some of the more difficult issues in our work—including crisis intervention, trauma/grief reactions, mandated reporting of suspected child abuse, and referrals. To help you understand and apply the information in this chapter, consider these questions:

- *What crisis intervention situations make you anxious? How can you develop and/or refine your current skill set?*
- *What is your experience with lethality assessment? Review the SLAP-P acronym until you have it memorized. You will be glad you did when you unexpectedly encounter a child in crisis (i.e., if you are a school-based practitioner and a student is sent to you mid-day).*
- *Practice role-playing with a fellow student or trainee. Intentionally create a difficult client in order to challenge your peer or fellow trainee to "work" to find competencies and strengths. Can you think of a recent, challenging individual and identify some important strengths/competencies?*
- *How familiar are you with current crisis-intervention supports in your community?*
- *Go to the literature and do some reading about pediatric trauma reactions. What risk and protective factors contribute to outcomes of traumatized children?*
- *What is your current training as a mandated reporter? Check your state laws and comment on the nomenclature.*

REFERENCES

American Psychiatric Association Work Group on Suicidal Behaviors. (2003). *Practice guideline for the assessment and treatment of patients with suicidal behaviors*. Washington, DC: American Psychiatric Publishing. doi:10.1176/appi.books.9780890423363.56008

Bean, H., Softas-Nall, L., & Mahoney, M. (2011). Reflections on mandated reporting and challenges in the therapeutic relationship: A case study with systemic implications. *The Family Journal, 19*(3), 286–290. doi:10.1177/1066480711407444

Child Welfare Information Gateway. (2012). *Mandatory reporters of child abuse and neglect.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. Retrieved from https://www.childwelfare.gov/systemwide/laws_policies/statutes/manda.cfm

Chu, J., Floyd, R., Diep, H., Pardo, S., Goldblum, P., & Bongar, B. (2013). A tool for the culturally competent assessment of suicide: The Cultural Assessment of Risk for Suicide (CARS) Measure. *Psychological Assessment, 25*(2), 424–434. doi:10.1037/a0031264

Cohen, J. A., & Mannarino, A. P. (2004). Treatment of childhood traumatic grief. *Journal of Clinical Child and Adolescent Psychology, 33*(4), 819–831. doi:10.1207/s15374424jccp3304_17

Cohen, J. A., & Mannarino, A. P. (2008). Trauma-focused cognitive behavioural therapy for children and parents. *Child and Adolescent Mental Health, 13*(4), 158–162. doi:10.1111/j.1475-3588.2008.00502.x

Cook-Cottone, C. (2004). Childhood posttraumatic stress disorder: Diagnosis, treatment, and school reintegration. *School Psychology Review, 33*(1), 127–139.

Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Sprague, C., . . . van der Kolk, B. (2005). Complex trauma in children and adolescents. *Psychiatric Annals, 35*(5), 390–398.

Crowell, K., & Levi, B. H. (2012). Mandated reporting thresholds for community professionals. *Child Welfare, 91*(1), 35–53.

Ellis, B. H., Fogler, J., Hansen, S., Forbes, P., Navalta, C. P., & Saxe, G. (2012). Trauma systems therapy: 15-month outcomes and the importance of effecting environmental change. *Psychological Trauma: Theory, Research, Practice, and Policy, 4*(6), 624–630. doi:10.1037/a0025192

Gateway, C. W. I. (2012). *Mandatory reporters of child abuse and neglect*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

Gentry, C. E., & Westover Consultants, I. W. D. C. (1994). *Crisis intervention in child abuse and neglect* (The user manual series). Washington, DC: U.S. Department of Health and Human Services.

Gillies, D., Taylor, F., Gray, C., O'Brien, L., & D'Abrew, N. (2012). Psychological therapies for the treatment of post-traumatic stress disorder in children and adolescents. *Cochrane Database of Systematic Reviews, 12*, CD006726. doi: http://dx.doi.org/10.1002/14651858.CD006726.pub2

Greene, G. J., Lee, M., Trask, R., & Rheinscheld, J. (2005). How to work with clients' strengths in crisis intervention: A solution-focused approach. In A. R. Roberts (Ed.), *Crisis intervention handbook: Assessment, treatment, and research* (3rd ed., pp. 64–89). New York, NY: Oxford University Press.

Harrison, R. (2013). Managing suicidal crises in primary care: A case illustration. *Clinical Practice in Pediatric Psychology, 1*(3), 291–294. doi:10.1037/cpp0000030

Jones, L. (2008). Responding to the needs of children in crisis. *International Review of Psychiatry, 20*(3), 291–303. doi:10.1080/09540260801996081

Kanel, K. (2003). *A guide to crisis intervention*. Belmont, CA: Brooks/Cole.

Levi, B. H., & Loeben, G. (2004). Index of suspicion: Feeling not believing. *Theoretical Medicine and Bioethics, 25*(4), 277–310.

Levi, B. H., & Portwood, S. G. (2011). Reasonable suspicion of child abuse: Finding a common language. *Journal of Law, Medicine & Ethics, 39*(1), 62–69. doi:10.1111/j.1748-720X.2011.00550.x

Meier, S. T., & Davis, S. R. (2011). *The elements of counseling* (7th ed.). Belmont, CA: Cengage Learning.

Morris, C. A. W., & Minton, C. A. B. (2012). Crisis in the curriculum? New counselors' crisis preparation, experiences, and self-efficacy. *Counselor Education and Supervision, 51*(4), 256–269. doi:10.1002/j.1556-6978.2012.00019.x

Schön, C. A., & Ketterer, T. (2007). Asphyxial suicide by inhalation of helium inside a plastic bag. *American Journal of Forensic Medicine and Pathology, 28*(4), 364–367.

Steinberg, K. L., Levine, M., & Doueck, H. J. (1997). Effects of legally mandated child-abuse reports on the therapeutic relationship: A survey of psychotherapists. *American Journal of Orthopsychiatry, 67*(1), 112–122. doi:10.1037/h0080216

Strozier, M., Brown, R., Fennell, M., Hardee, J., Vogel, R., & Bizzell, E. (2005). Experiences of mandated reporting among family therapists: A qualitative analysis. *Contemporary Family Therapy: An International Journal, 27*(2), 193–212. doi:10.1007/s10591-005-4039-1

Sullivan, M. A., Harris, E., Collado, C., & Chen, T. (2006). Noways tired: Perspectives of clinicians of color on culturally competent crisis intervention. *Journal of Clinical Psychology, 62*(8), 987–999. doi:10.1002/jclp.20284

Thompson, M., Kuruwita, C., & Foster, E. M. (2009). Transitions in suicide risk in a nationally representative sample of adolescents. *Journal of Adolescent Health, 44*(5), 458–463. doi:10.1016/j.jadohealth.2008.10.138

Seven

Knowing and Caring for Yourself as a Counselor

World-renowned therapist Irvin D. Yalom (2002) asked, "What is the therapist's most valuable instrument?" The answer: "the therapist's own self" (p. 40).

As your most valuable asset, this instrument must be cared for and tuned. How you show up matters to your clients. In fact, it can affect their outcomes (Norcross, 2000). By cultivating growth and well-being in yourself, you will increase your ability to cultivate growth and well-being in another. To do this, you must understand your own struggles and challenges. You need not be perfect. However, you must be able to cultivate well-being daily and know when you are vulnerable. You must be able to identify supports and know when you need to take time off. Ultimately, the process of knowing and caring for yourself involves self-awareness, getting the support and supervision you need, being prepared for and open to client/counselor feelings and reactions, having good boundaries, and engaging in a consistent practice of self-care.

56. BEGIN WITH SELF-AWARENESS

Everyone has needs and struggles. It is part of being human. Awareness is a key step in ensuring that your needs and struggles do not negatively affect the children and adolescents with whom you work. A counselor should begin by knowing and acknowledging his or her own personal issues, strengths, and vulnerabilities and how these issues might be presenting in work as a professional counselor (MacCluskie, 2010). Self-exploration is a lifelong process (Yalom, 2002). A thoughtful exploration of the following issues is recommended (Norcross, 2007).

A. Why Did You Choose Counseling as a Career?

Effectiveness as a counselor depends on self-awareness. First, as you enter the field of counseling it is critical to ask yourself why you chose counseling as your career path. There are many reasons that individuals go into the field of counseling (Cummins, Massey, & Jones, 2007; MacCluskie, 2010). Review this list and assess reasons for your interest:

- *Do you have a desire to be of service?*
- *Does your spirituality or religion play a role in your service (e.g., I [CCC] was inspired by Mother Theresa to help others)?*
- *Do you intend to help people move through personal pain as you have moved through personal pain?*
- *Do you hope no one ever feels like you did when you were little and you intend to rescue all the children with whom you work?*
- *Do you enjoy working and being with people and experience a tremendous sense of satisfaction helping others?*
- *Do you love the process of change and are excited about being part of the change process in others?*
- *Do you base your sense of success on whether or not you can help people?*
- *Do you love to be the hero, the reason people are okay?*

Consider how you answered these questions. Your motivation to be a counselor does not need to be entirely altruistic. In fact, you may

experience less burnout if helping and being with others through the process is part of what serves you. However, if your sense of self is solely, or largely, based on being a rescuer or hero (Meier & Davis, 2011), consider that your role (i.e., hero/rescuer) is not possible without someone else needing to be rescued or the victim. In an empowering supportive relationship, the counselor is the catalyst for change rather than the entity responsible for it. Counseling really works when it is the client who is the hero and the one who rescues him- or herself.

CLIENT: I can't handle another anxiety attack. I just can't.

COUNSELOR: You have my number. I will coach you through it. Call me anytime and I will help. Don't worry.

Consider what might be said by a counselor working to empower his or her client:

CLIENT: I can't handle another anxiety attack. I just can't.

COUNSELOR: I hear you. It *feels like* you can't handle another anxiety attack. Breathe deeply. Let's talk about some of the tools you have that can make this manageable.

Meier and Davis (2011) emphasize our choice as counselors. A counselor can solve the problems for clients or he or she can help clients learn how to problem solve for themselves.

B. Be Aware of the Emotions and Topics That Challenge You

Children and adolescents can experience intense emotions such as rage, extreme anxiety, and despair. Beginning counselors may not have the life experience or exposure to feel comfortable with particular emotions or the intensity at which they are expressed (Meier & Davis, 2011). Meier and Davis (2011) encourage counselors to ask themselves:

- *Are there emotions that you feel that you avoid?*
- *Could you remain present and engaged if one of your clients expressed an uncomfortable emotion with intensity?*
- *Could your discomfort with an emotion result in your leading a client away from processing the emotion?*

CLIENT: I miss my mom so much I feel like I can't breathe.
COUNSELOR: How is your dad taking it?

Here, the counselor is uncomfortable with the adolescent's grief. To avoid the emotion, the counselor leads the discussion away from the client's feelings about his mother's death by asking the adolescent how his father is handling the death. The result is that the client is not given the opportunity to process these emotions. To be an effective counselor, you will need to work to become comfortable with a wide range of emotions across a span of intensities. With the support of a supervisor or within a counselor support group, work to lean into emotions you find challenging.

The children and adolescents with whom you work are going to have mixed feelings about you, and you, despite your intentions, may have mixed feelings about some of them (Meier & Davis, 2011). Many children and adolescents are referred by someone else. Many times school personnel or a parent is concerned with the child's or adolescent's behavior. Your client may see counseling as punishment or the result of being in trouble. Similarly, you may struggle with the feelings triggered in you by a client's issues (e.g., attraction, abuse, bullying, resistance, antisocial behavior) and/or characteristics of the client (e.g., sexual orientation, religion, gender, appearance; Meier & Davis, 2011). It is important to accept and have tools (e.g., support, supervision, counseling) to handle the resistance and challenges inherent in this process (see Chapter 1 on resistance).

Clients will also bring in a variety of topics. These include death, love, sex, sexual play, sexual orientation, and masturbation. Counselors who work with children and adolescents are often asked about the issue of sexual play or how to distinguish sexual play from sexual abuse. They are asked how to handle topics like sex and masturbation. Bring these topics to your supervisor or your support network. Practice your explanations and know empirically supported suggestions for parents. Use bibliotherapy (i.e., the use of books to teach or illustrate a point).

CLIENT'S PARENT: My son's teacher told me that he masturbates in class. He has been diagnosed with autism, how do I know if he is self-stimulating or masturbating?

COUNSELOR: Oh, I am sure he is not masturbating. I know your son, he wouldn't do that.

In this case, the counselor has not explored the issue with the parent enough to make a distinction between self-stimulation and masturbation. The counselor's discomfort with the topic is apparent and interfering with intervention. Furthermore, the counselor is presenting masturbation as something that is not acceptable (e.g., "he wouldn't do that"). The counselor would better serve the parent and the client by educating herself on the topic and securing supervision.

C. Know When You Are Impaired

The American Counseling Association (ACA, 2005), the American Psychological Association (APA, 2002), and the Code of Ethics of the National Association of Social Workers (NASW, 2008) all address counselor impairment. Impairment can be described as a consistent pattern of incompetent performance that interferes with practice effectiveness (APA, 2002; NASW, 2008). It can be the result of personal problems, psychosocial distress, substance abuse, or mental health difficulties (NASW, 2008). Do you show signs of impairment such as the following:

- *Inability to make it to counseling sessions on time?*
- *Difficulty staying awake, paying attention, or feeling distracted during sessions?*
- *Not remembering what patients said or were processing session to session?*
- *Frequent cancelation of appointments, resulting in inconsistent treatment of the patient?*
- *Showing up to counseling sessions impaired, medicated, or physically disregulated due to a recent intoxication?* (Richards, Compenni, & Muse-Burke, 2010)

Across the board, guidelines recommend that counselors be alert to impairment from their own physical, mental, and emotional problems and to refrain from offering or providing services when their impairment is likely to harm the client or others. Furthermore, guidelines recommend that the counselor seek support and assistance or limit, suspend, or terminate their professional practice in accordance to level of impairment.

D. Know the Signs of Burnout and Compassion Fatigue

Burnout and compassion fatigue are distinct experiences for which counselors are at risk. Burnout typically relates to the working condition within which a counselor works (MacCluskie, 2008). Compassion fatigue is a risk for those who work frequently with individuals in crisis (Figley, 2002; MacCluskie, 2010).

Two factors are typically present when a counselor experiences burnout: (a) chronic job stress and (b) no hope for improvement (MacCluskie, 2010). A counselor can experience burnout related to external workplace demands as well as his or her own personal expectations and demands. If you are showing signs of burnout, assess the sources (external or internal demands), address the sources, and engage in self-care and/or respite. Assess yourself for signs of burnout (MacCluskie, 2010):

- *Do you feel consistent feelings of powerless, frustration, and hopelessness?*
- *Are you feeling drained of physical and emotional energy?*
- *Do you have a sense of detachment, isolation, and reluctance to socialize?*
- *Have you experienced a "trapped" feeling associated with your work?*
- *Do you perceive your work as a personal failure?*
- *Have you presented as irritable with coworkers and clients?*
- *Do you experience persistent sadness and cynicism about your work?*

Compassion fatigue occurs in a series of stages (Figley, 2002). The initial risk results from empathic engagement with a client during which the counselor directly experiences the pain and suffering of

the client (Figley, 2002; MacCluskie, 2010). Next, following the client engagement, the counselor experiences compassion stress or residual emotional energy. Finally, compassion fatigue results from the interaction of compassion stress and the therapist's self-evaluation of his or her ability to alleviate the client's suffering or solve the client's problems (MacCluskie, 2010). Compassion fatigue is decreased when a counselor is satisfied with his or her efforts to help the client and increases when he or she is not satisfied (Filgey, 2002). The ability to disengage, the duration of exposure, number of traumatic recollections (i.e., the counselor's recollections), and other life disruptions also play a role in the onset of compassion fatigue (Figley, 2002). Figley (2002) recommends psychoeducation on compassion fatigue, individual therapy (e.g., desensitization to traumatic stressors), and enhanced social support.

57. GET THE SUPPORT AND SUPERVISION YOU NEED

You need support. It is a given. Providing counseling services for others can be isolating, fatiguing, and difficult. Support is about sustainability. A counselor should not wait until he or she feels in need of support. Support should be built into the weekly schedule as part of the professional practice.

A. Create a Support Group

Yalom (2002) recommends a therapists' support group. This is a group of peers that meets regularly to process the experience and stressors of providing counseling services for others. Peer support functions in the personal, clinical/academic, and social domains (Gilroy, Carroll, & Murra, 2002; Norcross, 2007). As peers, you can help assess and address risks and challenges as they present. Self-awareness is enhanced as each of the peer-support group members commits to supporting the well-being and professional performance of the other members.

B. Supervision Leads to Competence

Individual supervision is a wonderful way for the new and the challenged counselor to assess and enhance effectiveness. This is especially critical for client issues that challenge your expertise and/or present with ethical dilemmas (Meier & Davis, 2011). Furthermore, dialogue between supervisor and supervisee can be part of an effective counselor self-care plan (Cummins et al., 2007).

COUNSELOR: A little boy I am seeing for behavioral issues is in foster care. He asked me if I could be his counselor forever. I froze. I did not know what to say.
SUPERVISOR: What comes to your mind when you recall this? What are your feelings as you tell me about this?
COUNSELOR: I think about my dad leaving mom when I was seven. I feel how rejected and abandoned I felt then. I can't imagine letting this little boy down the way my dad let us down.
SUPERVISOR: Let's figure out a way for you to be able to work on these issues and feel less triggered.

Supervision is an appropriate setting for you to explore feelings about your clients and the associated feelings and reactions that come up in your work (Meier & Davis, 2011). The process leads to more effective interactions and presence with your clients.

C. Get Personal Counseling

All human beings face challenges and issues as they negotiate life. This includes counselors (Norcross, 2007). Acknowledge that you will have issues and challenges. Continually assess your need for help. Then, engage in personal therapy (Richards et al., 2010; Yalom, 2002). The benefits are multifold. First, you will increase your personal insight (benefits listed previously). Second, you will gain empathy for your clients. You will know what it feels like to be the one who is helped and supported. You will understand the vulnerability as you experience it. Third, you will learn effective and ineffective techniques firsthand. You will get a firsthand sense of what empowers and inspires and what gets in the way of

growth. Fourth, seeking and engaging in your own personal psychotherapy is considered constructive self-care (Gilroy et al., 2002; Norcross, 2007; Richards et al., 2010).

58. HAVE GOOD BOUNDARIES

Creating and maintaining clear, identifiable boundaries between you and the children, adolescents, and families with whom you work can be a critical aspect of self-awareness and self-care. Boundaries refer to the degree and quality of differentiation between individuals (MacCluskie, 2010). Counseling can be a demanding process that requires you to be present, accepting, and open to the challenges, stressors, and even traumas of the children and adolescents with whom you work (MacCluskie, 2010). There are a few ways this can be done.

A. Practice Disengagement

A counselor can protect him- or herself from depletion by practicing a shift from empathy and connectedness during the session to disengagement between sessions (Cummins et al., 2007; MacCluskie, 2010). Such disengagement may be a necessity for long-term effectiveness. In fact, ineffective disengagement between sessions can lead to decreased empathy during sessions (Cummins et al., 2007). To functionally disengage, you can use thought-stopping techniques with a set of boundary supporting affirmations. As thinking about a counseling sessions arises, the therapist conducts self-talk, instructing him- or herself to "stop" and then refocus by stating a boundary-setting affirmation. For example,

- "My work with the patients is contained in my office and documented in their files."
- "Therapeutic work is done in present time and in person."
- "We have set up a good plan of action toward goals. It is the client's responsibility to do that work."

- "I can address this concern during our next session."
- "It will not serve me or the children or adolescents with whom I work to ruminate on their sessions."

B. Establish and Keep Physical Boundaries

Boundaries are also maintained on a concrete level (MacCluskie, 2010). First, keep your personal home address and phone number private. Some counselors require that their phone number not be published in phonebooks and the electronic equivalent. Magazines that are used in the waiting room do not detail home addresses. Second, have a 24-hour crisis phone call policy written into your office policy document. Detail when it would be appropriate for a child, adolescent, and/or family to contact you and how. Many counselors prefer to utilize an answering service or employ an office manager to receive and manage phone calls and scheduling. Third, consider your electronic footprint and the boundaries of it. If you have a Facebook, Twitter, or Instagram (or equivalent) account, establish a policy for how you will be interacting with clients. If you interact with them (e.g., accepting friend requests or followers), be mindful of the level of disclosure you practice in your posts and electronic behaviors. Detail this in your counseling policy document.

C. Create and Maintain a Manageable Schedule

Whether you work individually or in a private practice, in an agency, or in a school, establish a daily schedule that allows for work–life balance and breaks between sessions. Financial realities and limited funding for agencies often create pressure for counselors to schedule many clients in succession and to complete notes at home or late into the evening. This is a recipe for burnout and counselor impairment (Cummins et al., 2007).

D. Practice Within Your Competency

Ethical guidelines (see ACA, 2005; NASW, 2008) also address boundaries of competence. Acknowledge and practice within the boundaries of your training and competence. This should be based on education, training, supervised experience, and your credentials (ACA, 2005). If you are interested in branching out into new areas, secure appropriate education, training, and supervision (ACA, 2005; NASW, 2008). Continuing education can be a critical factor in maintaining professional competence. The children and adolescents with whom you work will benefit from your commitment to staying current in scientific literature and professional practice skills.

E. Accept That Clients Grow at a Pace That Makes Sense for Their Mental Health

The goal of therapy is positive growth. However, the pace of this growth should be based on the needs and challenges of the children or adolescents with whom you work. The pace of growth in therapy is a complex process that includes a client's readiness for change, the therapeutic environment you are creating, and the skills that the client learns and practices. Especially in work with children and adolescents, family members can be very anxious to see change in your clients. Counselors often feel pressure to show positive effects and evidence of change to prove that their interventions are working and to feel like they are doing a good job. This is good. Be sure to set goals, work on skills, and provide interventions appropriate to your style of counseling and the best practices for the needs of your client. Reporting on the progress and describing interventions is effective practice. Be current with research and educate families on the process of change. Be okay with gradual progress. Know when to refer or get supervision. Counseling is not a process of building your ego or status; it is a process of creating a therapeutic relationship and an environment

that supports positive change within your clients (Meier & Davis, 2011). When you have a sense that you are pushing your clients too hard or are frustrated with their progress, ask yourself:

- *Have I educated the family about the stages of change and pace of growth?*
- *Am I using empirically supported methods for my client's difficulties?*
- *Do I need supervision?*
- *Should I refer my client to, or consult with, a specialist?*
- *Do I need to remind myself that change takes time and that an engaged client who is doing his or her work is, in fact, progressing?*

59. ENGAGE IN A CONSISTENT PRACTICE OF SELF-CARE

Individuals have a finite amount of coping ability and energy available at any one given time, and it must be replenished (MacCluskie, 2010; Norcross, 2007; Richards et al., 2010). It is critical for a counselor to acknowledge the hazards of psychological practice (Gilroy et al., 2001; Norcross, 2000). As Freud himself said, no one can expect to come through the process unscathed (Freud, 1905/1933; Norcross, 2000). A practice of self-care allows the counselor to regenerate and restore and provides a model of mental health hygiene for the children and adolescents with whom he or she works.

Every counselor interested in a sustainable career of helping others must have a self-care plan that includes a repertoire of healthy activities (Cummins et al., 2007; Gilroy et al., 2002; MacCluskie, 2010). Cook-Cottone, Tylka, and Tribole (2013) conceptualized self-care as the foundation of emotional regulation. Self-care includes nutrition, hydration, exercise, self-soothing/relaxation, mindfulness practice, rest, social support, and spirituality (Cook-Cottone et al., 2013; MacCluskie, 2010; Norcross, 2000; Richards et al., 2010). Rate yourself from 1 (*deficient*) to 10 (*right where I need to be*) in each of the areas below:

- *Is my nutrition where it needs to be?*
- *Do I drink enough water each day?*

- *Do I exercise daily (more than 30 minutes)?*
- *Do I have several strategies to soothe/relax myself when I am upset or need to be nurtured (e.g., massage, yoga, meditation)?*
- *Do I schedule pleasant events?*
- *Do I get enough rest (e.g., sleep enough at night and take breaks during the day)?*
- *Are my relationships reciprocal, supportive, and nurturing?*
- *Do I have a spiritual practice and/or belief system that provides a sense of purpose and meaning of life?*

SUMMARY AND DISCUSSION QUESTIONS

Self-awareness, support, supervision, boundaries, and self-care are the foundations of a sustainable counseling practice. It is not a sign of strength or quality of character to be able to individually suffer through or manage the stressors inherent in counseling work. In fact, independent or isolated management of stress is a liability. The counselors who experience both effectiveness and well-being acknowledge stress and the compassion fatigue that is inherent to this work. They show willingness to look at themselves and get the help they need.

Ask yourself the following questions. Review your answers and reread the sections of this chapter that connect with you. Consider how you might increase your support or change your self-care practices.

- *Do you have a sense of your own challenges? Do you know what emotions, situations, client characteristics, or counseling situations may create stress or challenges for you?*
- *Do you have adequate supports in your life? Do you have a peer-support group, a supervisor, or have you attended personal counseling?*
- *Do you have good boundaries? Do these include a good work-and-life balance, a manageable schedule, effective and clear boundaries for client communications, and a solid sense of how to measure success in your practice?*
- *Do you have a plan for self-care?*

REFERENCES

American Counseling Association. (2005). *ACA code of ethics*. Alexandria, VA: Author.

American Psychological Association. (2002). *American Psychological Association ethical principles of psychologists and code of conduct*. Washington, DC: Author.

Cook-Cottone, C. P., Tylka, T. L., & Tribole, E. (2013). *Healthy eating in schools: Evidenced-based interventions to help kids thrive*. Washington, DC: American Psychological Association.

Cummins, P. N., Massey, L., & Jones, A. (2007). Keeping ourselves well: Strategies for promoting and maintain counselor wellness. *Journal of Humanistic Counseling, 46*, 35–49.

Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self-care. *Journal of Clinical Psychology, 58*, 1433–1441.

Freud, S. (1933). Fragment of an analysis of a case of hysteria. In *Collected papers of Sigmund Freud* (Vol. 3; pp. 13–134). London, England: Hogarth. (Original work published 1905)

Gilroy, P. J., Carroll, L., & Murra, J. (2002). A preliminary survey of counseling psychologists' personal experiences with depression and treatment. *Professional Psychology: Research and Practice, 33*, 402–407.

MacCluskie, K. (2010). *Acquiring counseling skills: Integrating theory, multiculturalism, and self-awareness*. Upper Saddle River, NJ: Pearson.

Meier, S. T., & Davis, S. R. (2011). *Elements of counseling* (7th ed.). Belmont, CA: Brookes/Cole.

Norcross, J. C. (2000). Psychotherapist self-care: Practitioner-tested, research informed strategies. *Professional Psychology: Research and Practice, 31*, 710–713.

National Association of Social Workers. (2008). *Code of ethics of the National Association of Social Workers*. Washington, DC: Author.

Richards, K. C., Campenni, C. E., & Muse-Burke, J. L. (2010). Self-care and well-being in mental health professionals: The mediating effects of self-awareness and mindfulness. *Journal of Mental Health Counseling, 3*, 247–264.

Yalom, I. D. (2002). *The gift of therapy: An open letter to a new generation of therapists and their patients*. New York, NY: HarperCollins.

Appendix
How to Use This Book in Training

Each of the authors of this book has extensive experience teaching counseling skills to professionals in training. This book was created to facilitate training in counseling with children and adolescents by providing an explication of the essential elements of this process. In counseling coursework, it is critical to video-record sessions and analyze session transcripts. Transcript analysis is extremely helpful in increasing the counselor's awareness of subtle nuances, missed opportunities, and areas of growth. This appendix provides a simple detailing of how to use this text and the elements in a transcript analysis.

These transcripts can be used for self-analysis as well as peer analysis. Require that the counselor-in-training complete the tables with client and counselor responses as they were stated in the session. Leave the analysis cells empty (i.e., Self-Analysis and Alternative Statement). This is the *pre-analysis copy.* The counselor-in-training retains a pre-analysis copy for his or her own review and emails a pre-analysis copy to a peer for peer review. At our university, we post the digital video of the session on a secure server that is password protected. Note that appropriate permissions must be obtained for video recording, storage, and review of videos. The counselors-in-training work from the pre-analysis copy as they view their classmates' and their own videos. The instructions for analysis are provided in the following section (see Counselor-in-Training Instructions).

Once the peer and self-analyses are complete, the self-analysis and the peer analysis are submitted to the instructor for review. For beginning students, course grades are based not on the perfection of the counseling skills, but on the quality of the analysis for both self and peer. Furthermore, once the instructor has reviewed and graded the analyses, the counselors-in-training have the benefit of comparing their self-analysis against the peer analysis done for the session. This type of reflection can be very helpful for developing insight and pointing out blind spots.

COUNSELOR-IN-TRAINING INSTRUCTIONS

Prepare a transcript of one of your counseling sessions with a child or adolescent. You will be typing out each word said by you, the counselor, and by your client. When there is a remarkable nonverbal behavior (e.g., crying, frowning, eyes cast down, arms folded) or a change in verbal expression (e.g., shouting, whispering, questioning [i.e., up-talking at the end of a statement]), write a short description in parentheses following the sentence.

Create a table for each child and therapist interaction, and complete the following process. Note what the child or adolescent has verbalized (Client) and your responses as the counselor (Counselor). The number (e.g., 1) indicates the number of the transaction that you are analyzing. These will simply follow a sequence (i.e., 1, 2, 3, 4, 5 . . .) for the entire transcript. Your pre-analysis copy will look like Table A.1. You will do this for each statement and response for the entirety of the session. Remember to retain a copy of the pre-analysis copy and email a copy to a peer for peer analysis if required by your instructor.

You will use the elements listed in this text to assess counselor responses as well as make recommendations for an alternative counselor statement (see Table A.2). Each of the "elements" of the counseling process in this book has been numbered (i.e., 1–59). In order to allow for a brief form of citation, you will simply list the

element number to which you are referring in parentheses. Please note, you must explain your answer/analysis. Citing the element number does not take the place of a detailed explanation. See Table A.3 for an illustration of the process.

TABLE A.1
Pre-Analysis Copy

Client 1	**Write here what the child or adolescent said** (in bold).
Counselor 1	**Write here what you said in response to the child or adolescent's verbalization** (in bold).
Self- (or peer) analysis	Leave blank.
Alternative statement	Leave blank.

TABLE A.2
Outline of Analysis

Client 1	**Write here what the child or adolescent said** (in bold).
Counselor 1	**Write here what you said in response to the child or adolescent's verbalization** (in bold).
Self-analysis	Write here what type of statement you or your classmate made and why. Use this text to do this. Cite the element number.
Alternative statement	Write here what you think would have been a better statement and why. Bold the response. Write all other text, your explanation and rationale, in nonbold, regular text. Cite the element number.

TABLE A.3
Sample Analysis

Client 2	**She caught me throwing up. My mom yelled at me so much last night. I want to run away. I hate my house. I hate them**.
Counselor 2	**You really hate your parents. You want to get away.**
Self- or peer analysis (this example is a self-critique)	I was trying to be sure she knew I was listening, so I reflected first (16). I was trying to speak briefly (20). I think I was also trying to reflect the theme of what she was saying (36), but I don't think I did that effectively. I was also torn regarding whether or not to confront or support (23). I know an alternative could have been to say nothing (21). I think I also could have processed what was happening (19). That is, I could have processed my understanding of the various components of what she was saying (the eating disorder symptoms, her anger at her mother, and wanting to run away). I think focusing on feeling might have also been a good choice. I could have helped her ground her feelings in her body (35).
Alternative statement and support of statement	**You were having symptoms and your mom saw you and yelled. You are angry and want to get away from this. Tell me, how are you experiencing the feeling of anger right now? Where do you feel it in your body?** Here I was nonjudgmental (42) and acknowledged the symptoms (confronted; 23) while still being relatively supportive (23). I also wanted to summarize (18) and reflect feeling (16). I helped her locate the feeling in her body (35). A lot was said here, and I wanted to capture how it all was working together so that she could process that (36).

Index