The Elements of Counseling Children and Adolescents

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

SECOND EDITION
Catherine P. Cook-Cottone, PhD, is a licensed psychologist, registered yoga teacher, full professor at SUNY at Buffalo, and co-editor in chief of *Eating Disorders: The Journal of Treatment and Prevention*. She is also the founder of Yogis in Service, a not-for-profit organization that creates access to yoga. Her research specializes in embodied self-regulation (i.e., yoga, mindfulness, and self-care) and psychosocial disorders (e.g., eating disorders, trauma). She has written seven books and over 50 peer-reviewed articles and book chapters. Her most recent books are titled *Mindfulness Workbook for Anxious Kids: Emotion Regulation Activities to Help You Cope With Anxiety, Panic, Stress and Worry*, and *Mindfulness and Yoga in Schools: A Guide for Teachers and Practitioners*. Presenting nationally and internationally, Catherine uses her model of embodied self-regulation to structure discussions on empirical work and practical applications. She teaches courses on mindful therapy, yoga for health and healing, self-care and service, and counseling with children and adolescents. She also maintains a private practice specializing in the treatment of anxiety-based disorders, trauma, and eating disorders (including other disorders of self-care) and development of self-regulation skills.

Laura M. Anderson, PhD, is a licensed psychologist, assistant professor, and director of the PULSE Healthy Weight Research Team at the University at Buffalo School of Nursing. Her research team consists of graduate and undergraduate students, faculty collaborators, and community members. Her current projects focus on promoting normal weight and behavioral health through personalized, multicomponent, self-management interventions for severely obese and bariatric surgery patients. All projects are based in clinical/health or community settings. She has received foundation and federal funding for her work and has published and presented nationally and internationally. Laura also maintains a private practice specializing in the assessment and treatment of behavioral, mood, and anxiety disorders among child and adult populations struggling with eating and/or weight-related problems in living.

Linda S. Kane, MEd, LMHC, is a licensed mental health counselor in private practice, a certified school counselor in the Williamsville Central School District, and has been an adjunct professor at SUNY at Buffalo, teaching counseling, consultation, and collaboration. As a certified yoga instructor, she implements the mindfulness, wellness, and relaxation techniques of yoga philosophy with her clients and is a coauthor of a book on this topic: *Girls Growing in Wellness and Balance: Yoga and Life Skills to Empower*. Her areas of interest and expertise in working with children, adolescents, and adults include prevention, early intervention, and treatment of eating, anxiety, and mood disorders; expression, empowerment, and assertiveness training; media resistance and coping; communication and relationship skills; and emotional regulation.
Copyright © 2019 Springer Publishing Company, LLC

All rights reserved.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without the prior permission of Springer Publishing Company, LLC, or authorization through payment of the appropriate fees to the Copyright Clearance Center, Inc., 222 Rosewood Drive, Danvers, MA 01923, 978-750-8400, fax 978-646-8600, info@copyright.com or on the Web at www.copyright.com.

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

Acquisitions Editor: Rhonda Dearborn
Compositor: Amnet Systems

ebook ISBN: 978-0-8261-6214-4
DOI: 10.1891/9780826162144

Instructor’s Materials: Qualified instructors may request supplements by emailing textbook@springerpub.com:
Instructor’s Manual: 978-0-8261-6212-0

19 20 21 22 / 5 4 3 2 1

The author and the publisher of this Work have made every effort to use sources believed to be reliable to provide information that is accurate and compatible with the standards generally accepted at the time of publication. The author and publisher shall not be liable for any special, consequential, or exemplary damages resulting, in whole or in part, from the readers’ use of, or reliance on, the information contained in this book. The publisher has no responsibility for the persistence or accuracy of URLs for external or third-party Internet websites referred to in this publication and does not guarantee that any content on such websites is, or will remain, accurate or appropriate.

Library of Congress Cataloging-in-Publication Data

Names: Cook-Cottone, Catherine P., author. | Anderson, Laura (Laura M.), author. | Kane, Linda, author.
Title: The elements of counseling children and adolescents / Catherine Cook-Cottone, PhD, Laura M. Anderson, PhD, Linda Kane, MEd, LMHC.
Classification: LCC BF636.6 (ebook) | LCC BF636.6 .C663 2019 (print) | DDC 158.3083—dc23
LC record available at https://lccn.loc.gov/2018056816

Contact us to receive discount rates on bulk purchases.
We can also customize our books to meet your needs.
For more information please contact sales@springerpub.com

Catherine Cook-Cottone: https://orcid.org/0000-0001-7146-066X
Laura Anderson: https://orcid.org/0000-0002-2100-8752
Linda Kane: https://orcid.org/0000-0001-5022-8204

Publisher’s Note: New and used products purchased from third-party sellers are not guaranteed for quality, authenticity, or access to any included digital components.

Printed in the United States of America.
This book was written in honor of the part in all of us that wants to learn, grow, and thrive; to all of the children and adolescents who have the courage to seize the opportunity of therapy and sort through their struggles, challenges, heartaches, and trauma; and to all of those brave enough to ground their feet, breathe, and feel it all. And, Jerry, Chloe, and Maya Cottone, as always, it is dedicated to you, the loves of my life.

—Catherine P. Cook-Cottone

With all I have learned from my clients, the least I can do is give back through this text. I hope those reading this can embrace the importance of the microskills addressed. As years of research have illuminated, the therapeutic alliance is key to our success as therapists, and these elements will help solidify that alliance. With that said, I dedicate this text to my current and former clients. Also, to my spouse and daughter (who literally hangs on me as I write this): I could not do this work without your constant love and support. Finally, Ellen, my forever angel friend, I keep you with me always and dedicate this to you and your boys. Don’t forget to play!

—Laura M. Anderson

My clients have been and certainly will continue to be a source of deep and profound inspiration, which I am moved to pay forward in as many ways as possible. This book is one of those ways. Our work in helping others heal and grow is such a work of synergy: the end result is exponentially more than the combination of all of the elements. This experience is difficult to express in words. My hope is that those who read this book will come to know this synergy with their clients, in their own unique way. I dedicate this book to the desire for connection, learning, and growth in all of us, spurred by eternal curiosity, which was fueled in me by my parents and is now constantly ignited by my amazing daughter, Makenzi Rasey. I am beyond grateful.

—Linda S. Kane
CONTENTS

Foreword Scott T. Meier, PhD
Preface
Share: The Elements of Counseling Children and Adolescents

1. Setting the Stage for Counseling Children and Adolescents
   1. Initial Contact
   2. Respect Caregivers and Family Members in the Process
   3. The First Appointment
   4. Share Your Background
   5. Explain Counseling
   6. Provide an Overview of Logistical Guidelines
   7. Address Confidentiality and Privacy
      A. Privacy Between Child and Caregiver
      B. Privacy Rule
   8. Detail Your Policy and Practices for Parent Involvement
   9. Explore the Client’s Story—Taking a Holistic Approach
  10. Cocreate Counseling Goals
  11. Create a Developmentally Accommodating Office Space
  12. Be On Time
  13. Individualize Counseling
  14. Work Within a Developmental Framework
  15. Address Resistance and Create a Working Alliance
  16. Be Informed and Sensitive to Diversity in All Forms
  17. Competently Support or Effectively Refer LGBTQIA Clientele
  18. Be Trauma Informed
19. Know Substance Use Warning Signs and How to Refer for Treatment
20. See the Big Picture

Summary and Discussion Questions
References

2. The Processes of Counseling With Children and Adolescents
   21. Reflect First (Content, Feeling, and Meaning)
   22. Focus on Feeling
   23. Summarize
   24. Reflect the Process
   25. Speak Briefly
   26. Allow and Use Silence
   27. Use Open-Ended Questions
   28. Confront Effectively and With Care
   29. Use Developmentally Appropriate Language
   30. Be Concrete
   31. Match the Strategy or Technique to Processing Level
   32. When Words Fail, Draw or Play
   33. Use Stories and Metaphors

Summary and Discussion Questions
References

3. Strategies for Assisting Self-Awareness and Growth in Counseling
   34. Reflect and Give Time for Processing (Do and Do Not Do)
   35. Avoid Giving Advice
   36. Avoid Relying on Questions
   37. Listen Carefully to the Words Used
   38. Focus on the Client
   39. Pay Attention to Nonverbals
   40. Identify and Ground Feelings in the Body
   41. Teach Tools for Distress Tolerance
   42. Pause and Reflect Themes/Enumerate Topics
   43. Address Social Media, Sexuality, and Harassment
   44. Cocreate Boundaries for Technology
   45. Teach and Practice Skills for Negotiating Social Conflict
46. Use a Problem-Solving Model
47. Set Clear, Measurable Goals and Monitor Progress Regularly

Summary and Discussion Questions
References

4. Misconceptions and Assumptions in Counseling
48. Do Not Assume That Change Is Simple
49. Academic Developmental Level Does Not Equal Emotional Developmental Level
50. Agreement Does Not Equal Empathy
51. Avoid Moral Judgments
52. Saying They Understand Does Not Mean That They Understand
53. You Can’t Assume That You Know (Feelings, Thoughts, and Behaviors)
54. Do Not Assume That You Know How Clients React to Their Feelings, Thoughts, and Behaviors
55. Do Not Assume That All Interventions Will Be Safe or Appropriate for All Clients
56. Positive and Rational Thinking Are Not the Same

Summary and Discussion Questions
References

5. A Brief Introduction to Evidence-Based Practice and Contemporary Interventions
57. Be Familiar With Limitations of ESTs With Children and Adolescents
58. Practicewise Clinical Decision-Making Support
59. Contemporary Psychotherapy Interventions With Children and Adolescents
   A. Brief, Solution-Focused Therapies
   B. Cognitive Behavior Therapy
   C. Trauma-Focused Cognitive Behavior Therapy
   D. Eye Movement Desensitization and Reprocessing
   E. Dialectical Behavior Skills Therapy
   F. Behavior Therapy
   G. Play Therapy
   H. Family Therapy
I. Mindfulness-Based Approaches
J. Mind-Body Approaches
K. Creative and Innovative Techniques to Enhance Evidence-Based Interventions
L. Multisystemic Therapy

60. Consider Integrative Approaches

Summary and Discussion Questions

References

6. Crisis Intervention, Mandated Reporting, and Related Issues in Counseling

61. Develop Crisis-Intervention Skills
   A. Assess for Suicide Risk: Specificity, Lethality, Access, Proximity, Prior Attempts
   B. Take Control of the Situation
   C. Focus on Competencies and Strengths
   D. Mobilize Social Resources and Engage Caregivers
   E. Know and Use Community and Technology Supports

62. Learn and Understand Grief, Loss, and Trauma

63. Become Literate in Mandated Reporting
   A. Know Your State Laws and Nomenclature
   B. Consider a Probability Threshold
   C. Use Framework Proposed by Levi and Portwood
   D. Be Prepared for Reactions and Seek Supervision Appropriately

64. Be Effective in Collaborating Regarding Psychoactive Medication

65. Refer Carefully and Responsibly (Substance Use, Eating Disorders, Attention Deficit Hyperactivity Disorder Evaluation, and More)

Summary and Discussion Questions

References

7. Knowing and Caring for Yourself as a Counselor

66. Begin With Self-Awareness
   A. Why Did You Choose Counseling as a Career?
   B. Be Aware of Emotions and Topics That Challenge You
C. Know When You Are Impaired
D. Know the Signs of Burnout and Compassion Fatigue

67. Get the Support and Supervision You Need
   A. Create a Support Group
   B. Supervision Leads to Competence
   C. Get Personal Counseling

68. Demonstrate Appropriate Boundaries
   A. Practice Disengagement
   B. Establish and Keep Physical Boundaries
   C. Create and Maintain a Manageable Schedule
   D. Practice Within Your Competency
   E. Accept That Clients Grow at a Pace That Makes Sense for Their Mental Health

69. Engage in Consistent Practice of Self-Care
70. Engage in Regular Self-Care Assessment

Summary and Discussion Questions
References

Appendix: How to Use This Book in Training
Counselor-in-Training Instructions
Index
This book describes the foundational elements of counseling and psychotherapy with children and adolescents. This is an Elements-style book in that the authors expertly identify key domains, describe them succinctly, and provide illustrative examples. Through these methods the book answers the question “What are the key concepts for conducting effective therapy?”

As experienced clinicians, researchers, and teachers, the authors provide 70 key elements related to effective therapy with children and adolescents. These elements can be grouped into the following categories:

1. Laying a strong foundation, such as explaining counseling procedures and addressing confidentiality and privacy
2. Attending to process, including reflecting, being concrete, and using developmentally appropriate language
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 all interventions are safe or appropriate for all clients
5. Providing brief descriptions of evidence-based and contemporary interventions, including play therapy and family therapy
6. Describing crisis intervention, mandated reports, and related issues
7. Emphasizing the importance of counselor self-care, including appropriate support and supervision

This second edition includes updates and expanded material about clients’ affect, trauma, substance abuse, progress monitoring, self-care, referral for medication, and mindfulness. Of particular interest is a series of new elements including elements addressing sexual and gender identity, social media, sexuality and harassment, and rules for use of technology. All of these topics have become increasingly important in counselors’ conceptualization of children and adolescent clients and therapy.

The authors’ previous and new choices of key elements have resulted 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, a way to think about counseling, and a primer to clarify the nature of the counseling process. Consequently, Elements should be useful for students in all helping professions, including psychiatry, psychology, social work, and counseling.

Scott T. Meier, PhD
University at Buffalo,
State University of New York
We, Catherine Cook-Cottone, Laura Anderson, and Linda Kane, present the second edition of 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 as well as in working in schools and private practice with children, adolescents, and their families. We offer a focused and practical guide to supplement coursework in counseling children and adolescents.

The Elements concept is not new. William Strunk 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). 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, in essence.

**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-profession 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 over 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 is 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 for use with transcript analysis in training programs.

Specifically, the second edition of this 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 new edition of this book takes a holistic approach to exploring the client’s story, details
goals setting as a cocreation, and highlights the importance of being informed about and sensitive to all forms of diversity. Further, this new edition includes content about competency or referral for lesbian, gay, bisexual, transgender, questioning/gender queer, intersex, and asexual (LGBTQIA) students, trauma, and substance.

The text emphasizes the conditions and processes of creating growth within the child, explicating the process of assisting growth and self-inquiry. There are new sections on grounding feelings in the body, teaching tools for distress tolerance, and highlighting the importance of progress monitoring. Critically, we added content on teaching skills for negotiating social conflict—a substantial stressor for children and adolescents. Also, this edition of the text provides guidance on cocreating individual and family rules for use of technology.

This text also addresses frequent misconceptions and mistaken assumptions. There is an updated section on crisis intervention and effective referral skills and another on critical topics (e.g., cultural competency, mandated reporting).

As in the original The Elements of Counseling Children and Adolescents, 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 an updated review of techniques often used in work with children and adolescents (e.g., play therapy, solution-focused brief therapy). For ease of reading, throughout the text, the word caregiver will be used to indicate a parent, legal guardian, foster parent, and so on. 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, LA, and LK). The final chapter of the text focuses on counselor self-care and provides guidance for setting boundaries, knowing your edge, practicing within competency, and assessing and planning personal self-care. 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.
Share
The Elements of Counseling Children and Adolescents
INTRODUCTION

This chapter details the elements of counseling with 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

Initial contact sets the stage for the therapeutic alliance (Hofmann, Sperth, & Holm-Hadulla, 2015). 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 their child because of a concern they have or one that has been brought to their attention from 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 client and counselor.

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, you can establish comfort in this first conversation by describing what the first appointment will look like so they know what to expect:

- Describe the outer office or waiting area and what they 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 in order to ensure regular visits. Close the conversation with thanks and 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 (de Greef, Pijnenburg, van Hattum, McLeod, & Scholte, 2017). 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 is always in the best interest of the child. Your support is simultaneously present for both the child and caregiver (de Greef et al., 2017; Hawley & Garland, 2008; Tsai & Ray, 2011).

**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, other 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—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 on. Begin the first session by pointing out that it 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 is not (see section 5).
- Review paperwork and guidelines.
- Ask them background questions.
- Give them 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 address the concerns presented by 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 and outcome and attendance, and helps to prevent
premature termination (Coleman & Kaplan, 1990; Reis & Brown, 2006; Walitzer, Derman, & Connors, 1999). Meier and Davis (2011) caution, “Clients frequently approach counseling with misconceptions about the process…. If mistaken expectations are ignored, clients drop out or fail to make progress.” 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 is 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, 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, & Komeriak, 2012).

In this initial session you should also emphasize the importance for the client to express their feelings about the counseling process on an ongoing basis so that you can both 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 client (Knox et al., 2011; Swift et al., 2012). Since your client may not have the skills to do this, you will 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 client grow to a place of self-reliance in coping with their life 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 client 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 LOGISTICAL 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, technology)
- Policy on cellphone use during sessions
- 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
- Billing and payment procedures and guidelines
However, one of the most significant guidelines in counseling is that of confidentiality.

7. ADDRESS CONFIDENTIALITY AND PRIVACY

The American Counseling Association (ACA, 2014), American Psychiatric Association (2010), American Psychological Association (2017), National Association of School Psychologists (NASP, 2010), and the Code of Ethics of the National Association of Social Workers (NASW, 2017) 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 caregiver’s 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 clear that counseling with children who are minors involves providing necessary information to his or her 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.

In order to create an environment and relationship that is conducive to therapeutic growth, caregivers should be encouraged to respect personal boundaries and privacy of the child or adolescent (Huss et al., 2008; Mitchell, Disque, & Robertson, 2002; Tan, Passerini, & Stewart, 2007). The term conditional confidentiality has been used to describe this
process by some states (e.g., Butler & Middleman, 2018). In conditional confidentiality agreements, parents/guardians waive the rights to confidential portions of the medical record, be present for sessions or assessments, or be present for risk behavior conversions (e.g., Butler & Middleman, 2018). When presenting a conditional confidentiality agreement to a parent, emphasize the difference between safety and privacy. 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 or 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 he or she 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 their 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, which will be verified or followed up on by the counselor in direct communication with the caregiver; the child and counselor can share with the caregiver together; or 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 it is determined that such services are necessary, and 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 establishes, 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 (n.d.; www.hhs.gov).

A review and discussion of the HIPAA laws must be given during the first session. A paper copy must also be provided to the caregiver, and he or she then signs 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 (i.e., including school personnel, pediatricians, etc.). Be certain to be familiar with your state/agency’s requirements for this kind of document.

8. DETAIL YOUR POLICY AND PRACTICES FOR PARENT INVOLVEMENT

With these guidelines established at the onset of the counseling relationship meeting the aim of supporting both the child and the parent(s), explore with them the manner in which they would feel comfortable proceeding with parental involvement and clarify your policy regarding this. Include:

- Frequency of parental participation with and without the client present, for the purposes of updating the parent regarding general progress
- Your approach for inviting parental participation in the event that the client requests it
- The manner in which you will respond to a parent’s request for information
  - Remind the parent of the confidentiality and privacy agreement made during initial counseling sessions
  - Discuss with the client to determine willingness to disclose progress at various levels of detail (broad overview to specific concerns and challenges)
  - Meet with the client and parent to discuss progress together
  - If you determine that it is not essential to disclose, yet the parent presses, ally with the parent and elicit support for confidentiality as a means of furthering work toward the counseling goals
  - Provide a general assessment of counseling progress

Ultimately, again referring to state laws, if parents persist in requesting information regardless of the fact that the client does not want to
disclose and you do not feel that it is necessary, and if you are legally obligated to share, inform the parent of the potentially negative impact on the client and on the counseling relationship (Glosoff & Pate, 2002). As stated in section 7, support your client by making them aware that this is about to unfold and give them options of how this will occur.

9. EXPLORE THE CLIENT’S STORY—TAKING A HOLISTIC APPROACH

With the introductions, guidelines, and preliminary information established, it is now time to begin to explore with your client what brings them to counseling and begin to develop initial goals for therapy. While a full discussion of this is introduced in Chapter 3, the first session should offer time to generally explore the nature of your client’s concern and 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 be left 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 their story.

Our clients’ lives are a complex web of interrelated interpersonal and intrapersonal, multisystemic components. These include the self (thoughts, feelings, physical self, gender, sexuality, race, ethnicity), family, friends, peers, school (relationship and interaction with teachers, being a student), community (neighborhood, school, religion), culture, and society. As such, it is essential to use a holistic approach to tease out the multiple determinants of a client’s psychosocial, emotional, and physical wellness. Although the parent and/or client may present with a focus on one or two concerns, all of the domains of the child’s world should be explored in order to reveal sources of struggle and strength, patterns, relationships among domains, and avenues for growth.
10. COCREATE COUNSELING GOALS

Ryan, Lynch, Vansteenkiste, and Deci (2011) review many theories and therapies that highlight the need for autonomy in the counseling process in order to elicit motivation for lasting growth and change. At the onset of counseling, creating goals is one of the first stages of the process. Engaging your client’s autonomy from the start involves creating goals with your client rather than for your client. “Autonomy support includes methods that foster or encourage voice, initiative, and choice and that minimize the use of controls, contingencies, or authority as motivators” (Ryan et al., 2011, p. 230). Thus, motivation to grow and change is increased when clients have participated in creating goals, eliciting a sense of ownership by incorporating their ideas and voice as opposed to feeling told what to do, which can elicit the adverse reaction of resistance.

The interviewing dialogue can begin with the concerns brought up by the client and parent, follow with the exploration into the holistic domains listed in the section above, and move to a reflection of the desired outcomes the client and parent have expressed. Together, these can be listed in priority, or ranked using a 5- or 10-point scale in terms of importance or intensity. A global summary can then be given, for example:

COUNSELOR: Reflecting on everything you have shared: You began by saying that you wanted help with feeling stressed and depressed. It seems as though things like your relationship with your parents, your ability to manage school demands, and your interest in sports are areas of your life that are strengths you enjoy and you do not seem to need much help with. The things that seem to concern you most, that you gave high numbers to, are stress in your relationships with your friends, especially when you are in conflict; the demands of social media; and managing your emotions related to both your friends and social media. Is that right? (Using this summary, you can now ask the client to consider more specifically what he or she would like things to look like and what goals he or she would like to accomplish, while incorporating your therapeutic goals.)
CLIENT: Yeah, I get really overwhelmed when me and my friends are not getting along and by the stress from my phone.

COUNSELOR: So, let’s create some goals around handling conflict with friends, managing social media, and working on some skills for feeling, listening to, and managing your emotions. Sound good?

It is helpful to list or have your client list the goals you cocreated. You can use a white board to draw, write, and diagram with the client, and then both counselor and client take pictures of the board to reflect on in future sessions as well as for the client to easily access between sessions. Be creative!

11. CREATE A DEVELOPMENTALLY ACCOMMODATING OFFICE SPACE

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

- Warm, gender-neutral colors
- Small furniture to accommodate younger clients
- Child-oriented furniture, such as bean bags, floor pillows, or 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 sitting area with quiet music, a variety of reading materials, and perhaps some toys or drawing materials. Sound machines should be placed outside the counselor’s office 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, sitting on the floor, or doing yoga, of course you must dress accordingly.

12. 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.

13. 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 with regard to 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 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 role model. You may be seen as a caring, capable adult, teacher, coach, mentor, and leader. Ultimately, you must be adaptable and responsive.

Given this 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.

14. WORK WITHIN A 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 at 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 trait 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
- Nonnormative life events—specific atypical events such as a chronic illness

For an overview of child and adolescent development, refer to Berk (2017).

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

On a very pragmatic 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? Can you give me an example? 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.

15. ADDRESS RESISTANCE AND 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, mis-understood, 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).

16. BE INFORMED AND SENSITIVE TO DIVERSITY IN ALL FORMS

Diversity exists in many forms:

- Age, generation
- Race, ethnicity, culture
- Gender, gender identity
- Sexual orientation
- Religion, spiritual beliefs
- Socioeconomic status
- Education, occupation
- Marital/relationship status
- Physical ability
- Intellectual ability
- Family composition
- Political beliefs

Individuals with diverse lives, backgrounds, or experiences may encounter life obstacles, bias, prejudice, marginalization, aggression, hostility, violence, or victimization that may be chronic. Although a thorough exploration of diversity is beyond the scope of this text, the essential element is to maintain ongoing awareness of diversity in all its forms. Diversity and cultural sensitivity competencies in counseling can be accomplished by staying informed through continuing education, diversity and social justice training, ongoing participation in professional associations, and continuously reading current literature.

Hendricks (2005, pp. 3–4) highlights that counseling should be a dynamic learning process between counselor and client, and he provides the following guidelines for beginning clinicians:

1. Always question your assumptions.
2. Be real.
3. Know the signs of respect in different cultures, especially your client’s.
4. Let go of being the authority, and be inquisitive about the client’s uniqueness.
5. When possible, have the family assess its own differences and strengths.

6. As you proceed, educate the client as to your model, intentions, and techniques.

It is imperative to reflect on your diversity and cultural sensitivity competencies in counseling and congruence with clients and whether or not a lack thereof creates a poor fit and results in harm to the client. Ultimately, know when to refer the client to a more appropriate therapist if your skills are not developed enough for that particular client.

17. COMPETENTLY SUPPORT OR EFFECTIVELY REFER LGBTQIA CLIENTELE

The acronym LGBTQIA refers to lesbian, gay, bisexual, transgender, questioning/gender queer, intersex, and asexuality.

- Lesbian and gay refer females who are sexually attracted to other females and males who are sexually attracted to other males.
- Bisexual refers to those who are sexually attracted to both male and females.
- Transgender refers to a person who was born as the opposite gender with which they identify.
- Questioning refers to a person who is in the process of inquiry about their sexual orientation.
- Gender queer refers to a person who does not identify as either a male or female.
- Intersex refers to a person who does not fit the role of either gender and/or someone between genders.
- Asexuality refers to someone who lacks sexual attraction.

To date, there is limited research with LGBTQIA adult populations, and even less research in this area among children and adolescents. The Association for Lesbian, Gay, Bisexual, and Transgender Issues in
Counseling Competencies (ALGBTIC) states that “the aim of these competencies is to provide a framework for creating safe, supportive, and caring relationships with LGBTQIA individuals, groups, and communities that foster self-acceptance and personal, social, emotional, and relational development” (ALGBTIC LGBTQIA Competencies Taskforce et al., 2013, p. 2). Overarching tenets include being vigilant about not interpreting differences as psychopathology as well as maintaining ongoing awareness of the many current issues that affect LGBTQIA people. The task force outlines 120 competencies in the areas of human growth and development, social and cultural foundations, helping relationships, group work, professional orientation and ethical practice, career and lifestyle development, assessment, and research and program evaluation. Some salient examples are paraphrased here (ALGBTIC Competencies Taskforce et al., 2013, pp. 9–13):

- Affirm that LGBTQIA individuals have the potential to integrate their affectional orientations and gender identity into fully functioning and emotionally healthy lives and relationships.
- Consider that developmental periods throughout the life span (e.g., youth, adolescence, and young, middle, and older adulthood) may affect the concerns that LGBTQIA individuals present in counseling and how stigma, prejudice, discrimination, and pressures to be heterosexual may affect developmental decisions and milestones in the lives of LGBTQIA individuals regardless of their resiliency.
- Understand that affectional orientation is not necessarily solid—it is or can be fluid—and may change over the course of a life span.
- Understand that the LGBTQIA individual, throughout the life span, may or may not be out about their affectional orientation in any or all aspects of their life and that reasons for disclosing or not disclosing an affectional orientation may vary.
- Acknowledge that affectional orientations are unique to individuals and they can vary greatly among and across different populations.
• Acknowledge and affirm identities as determined by the individual, including preferred labels, reference terms for partners, and level of outness.

• Be aware of misconceptions and/or myths regarding affectional orientations and/or gender identity/expression (e.g., that bisexuality is a “phase” or “stage,” that the majority of pedophiles are gay men, lesbians were molested or have had bad experiences with men).

• Acknowledge societal prejudice and discrimination (e.g., homophobia, biphobia, sexism) and collaborate with individuals in overcoming internalized negative attitudes toward their affectional orientations and/or gender identities/expressions.

• Acknowledge the physical (e.g., access to healthcare, other health issues), social (e.g., family/partner relationships), emotional (e.g., anxiety, depression, substance abuse), cultural (e.g., lack of support from others in their racial/ethnic group), spiritual (e.g., possible conflict between their spiritual values and those of their family’s), and/or other stressors (e.g., financial problems as a result of employment discrimination) that may interfere with the ability to achieve their goals.

As always, counselors should seek appropriate supervision to foster ethical practices and should refer to other qualified agencies or counselors if not adequately prepared to counsel a particular client.

18. BE TRAUMA INFORMED

The impact of trauma on child and adolescent development can be pervasive, affecting social, emotional, cognitive, and psychological development. Frydman and Mayor (2017) provide a table outlining the wide range of outcomes and symptoms, including impaired family and peer relationships, isolation, emotional dysregulation, lowered frustration tolerance, increased behavioral problems, inhibited executive functioning, impaired working memory, and detriments in inhibition.
To be trauma informed means to be aware of and sensitive to the impact of trauma, being alert to triggers and symptoms, having the ability to differentiate between symptoms and behavior and put adverse behavior into perspective, and understand how to approach youth who have been traumatized to prevent further traumatization.

Trauma-focused cognitive behavioral therapy (Cohen, Mannarino, & Deblinger, 2012a; Cohen, Mannarino, Kliethermes, & Murray, 2012b) and dialectical behavior therapy (Mazza, Dexter-Mazza, Miller, Rathus, & Murphy, 2016) are the primary evidence-based treatment models. Treatment includes assisting the client to increase a sense of safety; to identify and understand the trauma and resulting triggers; to differentiate past experience from the present; to learn, synthesize, and apply adaptive skills such as stress reduction, anxiety management, distress tolerance, emotional regulation, and social problem-solving skills; and to make new meaning of their trauma (Conners-Burrowet al., 2013). Comprehensive resources can be found at nationally established trauma organizations such as the National Child Traumatic Stress Network (NCTSN) and the Child Welfare Information Gateway (2012) and Child Welfare Collaborative Group, National Child Traumatic Stress Network (2008).

19. KNOW SUBSTANCE USE WARNING SIGNS AND HOW TO REFER FOR TREATMENT

According to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2017), adolescent substance abuse is prevalent and there exists a wide range of impacts and a high cost to children, adolescents, and their families; schools; and health systems. Substances include alcohol, tobacco, and illicit drugs: marijuana, cocaine, heroin, hallucinogens, inhalants, methamphetamine, opioids, or prescription psychotherapeutic drugs that are misused (i.e., pain relievers, tranquilizers, stimulants, and sedatives). Furthermore, in 2016, among adolescents aged 12 to 17, use of illicit drugs was higher among those with co-occurring major depressive episodes (MDE):

Youths with a past year MDE in 2016 were more likely than those without an MDE [(31.7 vs. 13.4 percent)] to be users of
marijuana, misusers of prescription psychotherapeutic drugs (i.e., pain relievers, tranquilizers, stimulants, and sedatives), users of inhalants, and users of hallucinogens in the past year. An estimated 333,000 adolescents (1.4 percent of all adolescents) had [a substance use disorder] and an MDE in the past year.

Thus, it is possible that clients may present with MDE and not be forthcoming about their drug use. In order to effectively diagnose, treat, or refer a client for treatment of substance abuse, one must know the warning signs. In addition, knowing the current common vernacular of the slang or “street” names of drugs is important in order to be alert to and recognize possible drug use.

Here are some warning signs for substance use problems (adapted from the National Council on Alcoholism and Drug Dependence, Inc.; NCADD, 2018):

**Physical and health signs of alcohol or drug abuse:**
- Bloodshot eyes, pupils that are smaller or larger than normal
- Nosebleeds when not present previously
- Changes in appetite and/or sleep patterns
- Sudden weight loss or weight gain
- Seizures without a history of epilepsy
- Deterioration in personal grooming, physical appearance, and self-care
- Impaired/poor coordination, shakes, tremors
- Speech that is incoherent or slurred
- Unexplained or poorly explained injuries, accidents, and bruises
- Atypical odors on breath, body, or clothing
- Recognizable scent of drugs or alcohol on breath and body

**Behavioral signs of alcohol or drug abuse:**
- School problems
- Not going to class, failing or declining grades, disciplinary referrals
- Poor work attendance and poor performance at work
• Loss of interest in extracurricular activities, sports, hobbies, time with nonusing friends
• Concerns and feedback from peers, coaches, coworkers, supervisors, teachers, or school administration
• Missing money and/or valuables
• Asking to borrow money, borrowing money from friends, getting into debt
• Missing prescriptions or prescription drugs
• Drug seeking such as wanting to go to an urgent care for pain complaints
• Isolating, presenting as quiet and withdrawn
• Engaging in secretive or suspicious behaviors, hiding/locking phone and computer
• Wanting increased levels of privacy, locking bedroom door
• Recent conflicts with family values, beliefs, and accepted rules
• A focus on alcohol- and drug-related lifestyle as indicated by choice of clothing, music lyrics and artists, and stickers and posters
• Changes in relationships, friends, favorite hangouts, and hobbies
• Frequently getting into trouble (arguments, fights, accidents, illegal activities)
• Using incense, perfume, or air freshener to hide smell of smoke or drugs
• Using eye drops, dark glasses, or hats to mask bloodshot eyes and dilated pupils
• Changes in relationships with family members, fighting more, or avoiding eye contact and withdrawing

Psychological warning signs of alcohol or drug abuse:
• Change in personality and attitude that are aligned with past behaviors (something seems off)
• Unexplained mood changes (e.g., irritability, anger outbursts, or inappropriate silliness and laughing)
• Periods of seeming driven or agitated in a way you have not seen before
• Recent reductions in motivation and increased lethargy
• Reduced ability to focus
• Seeming dissociated, flaky, or spaced out
• Acts fearful, withdrawn, anxious, or even paranoid, with no apparent or logical reason

Counseling can include individual, group, and/or family counseling and clients can be referred to outpatient treatment or inpatient rehabilitation or hospitalization. The reader should refer to Chapter 6 of this text for further information regarding referral for treatment.

20. 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 diagnosis. The very nature of adolescence includes features that are used in the diagnosis of disorders. For example, the American Psychiatric Association (2013, pp. 663–664) 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”

Many teens exhibit these features, which are actually within the range of normal childhood development. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (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. 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 their preparation for and thoughts about what they will need to accomplish in the first session. Consider:

• 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 their 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 in working with, and why?

REFERENCES


INTRODUCTION

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.

21. 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 he or she 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, conclusions
• Reduces or eliminates avoidance, minimizing, or repression of emotions
• Provides the client the opportunity to clarify, understand, and process
• Allows the child to further explore thinking, feeling, and behaving as the impetus for growth
• Assists the client in gaining insight
• Gently challenges clients’ positions
• 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 of 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 clients’ expressions is to communicate back to the client his or her values, beliefs, interpretations, and conclusions. This facilitates clients’ 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, it further assists your clients in expressing themselves fully and allows them to be empowered as well as take ownership of their experiences.

22. 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. Further, 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 what they are experiencing and the emotional content. Focusing of feelings helps integrate the emotional and the cognitive content of an experience, allowing them 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 three 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 breathe. 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.

23. SUMMARIZE

Summarizing involves integrating content and feeling, boiling down the child 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. Further, 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 example, you will 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 twenty-five 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.
24. 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 they coach 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. In the following example, you’ll see 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 shakes her head yes.)
COUNSELOR: Your parents’ divorce is very sad. 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 or ask her what she usually does when she feels sad. 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.

25. 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, 2010). The use of minimal encouragers such as head nods and verbalizations (e.g., “uh-huh”), demonstrates 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.

26. 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 he or she does not have the opportunity to finish their thoughts (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.
27. 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 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 discussions 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 worst thing that could happen?” These questions are intended to be somewhat confrontational. The counselor uses them to bring the client 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?
28. CONFRONT EFFECTIVELY AND WITH CARE

A rule of thumb for practitioners is that for everyone 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 responsibility 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. Further, 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 fifteen 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 fifteen 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 afterward. 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. Further, his response provided an opportunity for the counselor to explore distress tolerance and emotional regulation skills with Joe, both helpful tools in substance use reduction.

29. USE DEVELOPMENTALLY APPROPRIATE LANGUAGE

Meet your clients where they are. Developmentally appropriate practice is based on the 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, 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. In addition, Meier and Davis (2010) suggest that counselors should also parallel client’s language form and sentence structure. It is also helpful to be aware of your clients’ relevant cultural and social norms, experiences, and topics of concern (e.g., adolescents’ use of social media).

30. 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. For example, 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.

Journaling with older children and adolescents 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 counselor (Pennebaker, 1997; Stone, 1998). It has been suggested to voice journal or record narrations of clients who cannot write 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.

31. 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 to their emotional experience in order to express themselves more effectively. This is a process. Matching the counselor’s strategy to the child 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, or metaphors; be concrete; and match the approach to the development and not the chronological age.
32. 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 (Bratton, Ray, Rhine, & Jones, 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.

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 aged 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, Baggerly, & Tyndall-Lind, 1999; Landreth, 2012). 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 hyperactive 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 healthcare, 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 working with 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 compliment 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, p. 19) suggest as follows:

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.

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.

### 33. USE STORIES AND METAPHORS

Use of stories and metaphors is a way of helping a child or adolescent make sense of their emotional experiences and guide the development of problem-solving skills. Often, the feelings and experiences that they are having are difficult for them to conceptualize or think about. A child or adolescent will know they are feeling a lot and understand that what they are going through is important for them to process, yet they are 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 suggests that everyday language is not the language of feelings for children. She submits that images and metaphors 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 simply needs 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, this tree can be drawn 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 is comprised of 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


