1 SETTING THE STAGE FOR 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

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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, & Kominiak, 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, misunderstood, threatened, resentful, and/or a loss of control. Resistance may be a reflection of the need for autonomy and/or safety and therefore

must be honored (DiGiuseppe, Linscott, & Jilton, 1996; Fitzpatrick & Irannejad, 2008; Hawley & Garland, 2008). To this end, creating a comfortable space, exploring what counseling is, and establishing guidelines that allow for a child's privacy go a long way in establishing safety and alleviating apprehension.

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

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

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

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

individuals who are in their 20s and who have a college education have more positive attitudes toward seeking professional help" (p. 415).

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-solvingskills; 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?*

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