COUNSELING CHILDREN & ADOLESCENTS

DIAGNOSTIC AND TREATMENT CONSIDERATIONS FOR SPECIALIZED ISSUES

DEBRA M. PEREZ AND TRICIA M. MIKOLON | EDITORS

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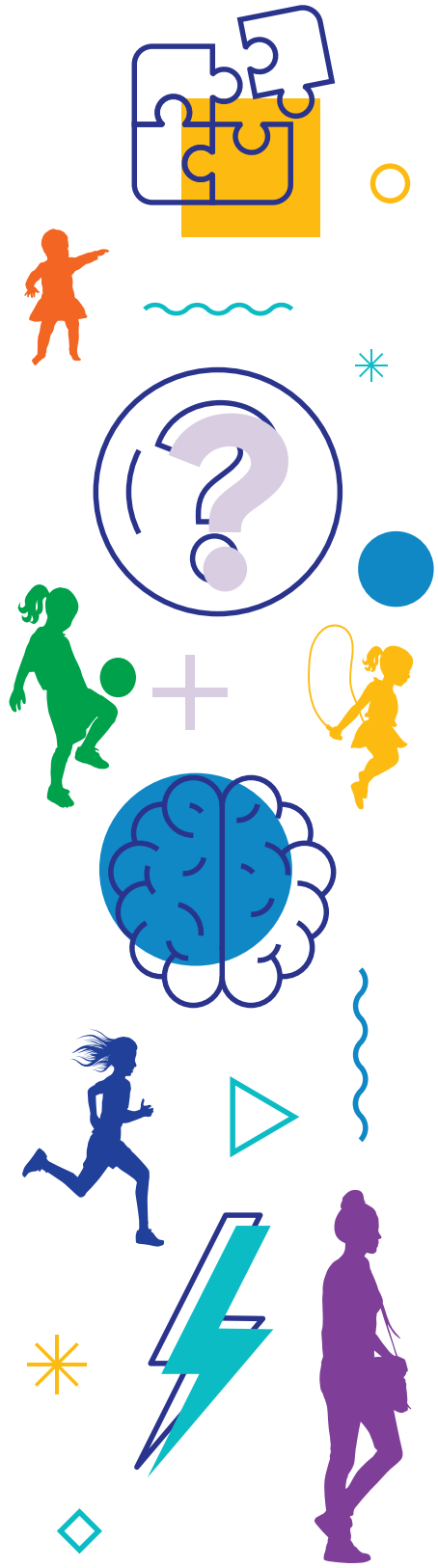
PART I

Fundamentals of Counseling Children and Adolescents



CHAPTER 1

Counseling Children and Adolescents

MEETING THE NEEDS OF THE POPULATION

Smyrna Khalaf, PhD, NCC

Childhood and adolescence are times of transition and exploration when character and personality are shaped. It is at this formidable time that the onset of mental health issues may first be present (Johnson et al., 2023). Counselors need to be aware of the unique needs of this population and the challenges present when developing and implementing appropriate interventions (Glenn, 1998; Johnson et al., 2023; Todd et al., 2022). Counselors working with children and adolescents, regardless of their platform of practice, need to provide effective treatment interventions aligned with the needs of the client (Cigrand et al., 2022; Todd et al., 2022). Working with this population involves working within the system of the individual, including their families, schools, and other providers (Perez et al., 2022). The complexity of this dynamic, coupled with the varying presentations of symptomology within this population, creates a challenging therapeutic setting for the counselor to navigate.

Our role as counselor educators has provided us with a unique vantage point to see how counselors in training are working to develop their skills within the field. We have found that the population of children and adolescents tends to be the focus of school counselors but is minimally addressed in counseling as a whole. When addressed, it is within the realm of school counseling, leaving counselors in other settings challenged to apply the concepts. Additionally, the lack of focus on specific diagnoses, their presentations across the developmental stages, and the appropriate assessment and intervention are concerning. Our hope is to provide a foundational knowledge of assessment and skills appropriate to children and adolescents to assist not only counselors in training, but counselor educators as well, to have a firm understanding of the unique needs, approaches, and interventions for this population.

Understanding the developmental milestones of children and youth is essential for the counselors who work with them (Johnson et al., 2023). Mental health

concerns may impact the developmental process but can also be misconstrued as part of the normal inconsistency typical of this time of significant transition (Johnson et al., 2023; Noble et al., 2021). Mastering this complexity, as well as other important factors that influence development, such as social support and family structure, is essential if a counselor is going to provide effective interventions. Consideration of the unique needs, presentation, and preferences of children and adolescents will be explored, rooted in empirically supported research is necessary for counselors.

This population goes through unique changes, and we will divide those phases into four distinct stages: Toddlers/Preschool-Aged Children (ages 1–5), Elementary-Aged Children (ages 6–9), Preadolescent-Aged Children (ages 9–11), and Adolescents (ages 12–18). During those four phases, children and adolescents go through significant physical, cognitive, social, and moral development. An overview of the history of mental health with children and adolescents, as well as of the main developmental theories, is provided. In addition, recommendations for considerations, competency, and skills for counseling children and adolescents are offered.

A Historical Overview of Mental Health With Children and Adolescents

Mental health and psychological attending to children was first documented by Freud (1909/1955) when he studied "Little Hans" in 1909. His work was more of a psychoanalytical study and explanation of the problems rather than treating them. Most of the earliest works of psychotherapy for children and adolescents were based on the psychodynamic approach and on Freud's psychosexual stages (Delgado et al., 2015). Those who were contemporary to Freud, as well as his followers, made significant contributions to the field, such as William Stekel and Hermine von Hug-Hellmuth. Hermine von Hug-Hellmuth had a strong impact on Anna Freud and Melanie Klein, who came after her (Prout & Fedewa, 2015). Anna Freud presented lectures titled "Introduction to the Technique of Psycho-analysis of Children" at the Vienna Institute of Psychoanalysis in 1926 and became known as a child psychotherapist after those lectures (Prout & Fedewa, 2015). Afterward, Melanie Klein (1932) started to include free play in psychotherapy as a form of symbolic play, which led to the invention of play therapy.

During the early 20th century, various developments occurred concurrently that placed greater importance on working with children. One significant event took place in France in 1905 when Alfred Binet conducted initial research on an intelligence test (Prout & Fedewa, 2015). This test was later utilized to determine educational placement for students in Paris schools. Binet's work laid the foundation for studying individuals from a psychometric perspective and had a profound influence on the fields of child study and applied psychology.

Similarly, in the United States, the University of Pennsylvania established a clinic for children in 1896 under the direction of Witmer (Prout & Fedewa, 2015). This clinic focused on assisting children in adapting to school environments. In 1909, Healy founded the Institute for Juvenile Research in Chicago, which remains active today (Prout & Fedewa, 2015). These milestones provided the groundwork for the child guidance movement, which emphasized a collaborative approach

involving various disciplines in diagnosing and treating children's psychological and adjustment issues. The child guidance model progressed and later started encompassing treating both children and their parents.

In 1924, the American Orthopsychiatric Association was established because of the emerging and growing interest in clinical and research endeavors pertaining to children's difficulties. This organization included psychologists, social workers, and psychiatrists who shared a common concern for the mental health challenges that children were experiencing (Prout & Fedewa, 2015). Jean Piaget created a cognitive development theory that emphasized that children think differently than adults in the way they process and interact with their environment (Piaget, 1936). After a few decades, Erik Erickson developed a psychosocial model of development that explains common human experiences and crises across eight life stages (Erikson, 1963). Those developmental models have heavily influenced the framework of how counselors view and treat children and adolescents (Prout & Fedewa, 2015).

During the 1940s and continuing into the 1950s, psychoanalytic psychotherapies dominated the field of child treatment. However, a significant shift occurred when Virginia Axline (1947) published *Play Therapy*, introducing a nondirective approach to treatment that involved using play. This form of therapy, known as nondirective play therapy, can be seen as an adaptation of Carl Rogers's client-centered therapy, which was originally developed for adults. Both nondirective play therapy and client-centered therapy marked a departure from psychoanalytic theory, differing in their conceptualization of the therapeutic process and the role of the therapist. Axline's impact on child therapy mirrored Rogers's impact on adult psychotherapy. The emergence of behaviorally oriented methods marked a significant shift in psychotherapy in terms of treatment (Prout & Fedewa, 2015). While the concepts and possible uses of behavioral psychology had been recognized for some time, it was not until the 1960s that behavior modification and therapy gained popularity in clinical practice, particularly when working with children. In recent years, cognitive-behavioral approaches have become increasingly recognized and widely used as a treatment method.

Two significant policies and legislative mandates have had a profound influence on the mental health treatment of children and adolescents. The first mandate, initiated through a federal program in 1963, aimed to establish local and community-based mental health centers and shift away from large institutional treatments (Prout & Fedewa, 2015). This movement gained momentum as it emphasized the effectiveness of community-based mental health interventions and prioritized early intervention and prevention of mental disorders.

The second mandate, very similar to the first, focused on providing special education services to all children and adolescents with disabilities, including those who were emotionally disturbed or had behavioral disorders (Prout & Fedewa, 2015). The Individuals with Disabilities Education Improvement Act (2004) represented this movement, which supported children to receive support from their local communities and expanded the role of public education in delivering these services to children and adolescents. By law and policy, psychotherapy and mental health treatment have been recognized as educational services when necessary for a child's overall educational program.

In recent times, the focus in child and adolescent treatment has shifted toward the identification of evidence-based interventions (Weisz & Kazdin, 2010). These interventions have been referred to by various terms, such as empirically validated or supported treatments, evidence-based practice,

or simply treatments that have proven efficacy. Efforts have been made to assess and quantify the level of support for these treatments, including factors such as the number of studies demonstrating their effectiveness.

A Historical Overview of the *DSM*

The American Psychiatric Association (APA) first started publishing the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* in 1952. The manual went through many changes and several editions until March 2022, when the *DSM-5-TR* was published. In this book, we will be using the latest version: *DSM-5-TR*. The *DSM* serves as an essential guide that aids in making symptom-based diagnoses of mental health disorders. There was a major shift in terms of diagnosis across the editions of the *DSM*. The authors of the *DSM-I* agreed that psychopathology resulted from the inability to resolve these conflicts, it was assumed, if not outright stated, that anxiety was the root cause of all psychiatric illnesses (Shatkin, 2015). The second edition of the *DSM (DSM-II)* was published 16 years after *DSM-I* and included for the first time the signs and symptoms of the diseases themselves, albeit no official diagnostic criteria were given (APA, 1968).

In the *DSM-III*, the authors initially provided descriptions of the symptoms and diagnostic criteria for these disorders. The *DSM-III* marked a significant milestone in the field of child and adolescent mental health by incorporating a category of disorders referred to as "usually first present in infancy, childhood, or adolescence" (Substance Abuse and Mental Health Services Administration [SAMHSA], 2016, June, p. 6). This category encompassed disorders such as reactive attachment disorder, autistic disorder, separation anxiety disorder, overanxious disorder, and avoidant disorder. Furthermore, the *DSM-III* allowed for the application of anxiety diagnoses that were originally designed for adults to be used with children and adolescents (APA, 2013; Shatkin, 2015; Williams, 1985). A new perspective was also introduced by the *DSM-III*: a multiaxial approach to coding disorders (APA, 1980). Axis I listed the clinical psychiatric disturbances; Axis II listed personality disorders and mental retardation, which are considered to affect the individuals' functioning across their lives; Axis III contained mainly diagnoses related to medical issues, such as asthma, hypertension, and diabetes; Axis IV gave evidence to psychosocial and environmental issues; and, finally, Axis V evaluated individuals' Global Assessment of Functioning (GAF), which is a scale that assesses social, occupational, and psychological functioning. *DSM-IIIR, DSM-IV,* and *DSM-IV-TR* mainly refined the diagnoses and introduced clinical significance to most disorders (APA, 1994, 1987, 2000). The *DSM-5* adopted a novel method for defining the criteria of mental disorders, incorporating a developmental lifespan perspective. This perspective holds particular relevance in diagnosing mental disorders in children. It acknowledges the significance of age and developmental factors in relation to the onset, presentation, and treatment of mental disorders (APA, 2013; Center for Behavioral Health Statistics and Quality, 2016).

The *DSM-5* had a major change in that it removed the multiaxial system and adopted a lifespan approach where the age, onset, manifestation, and treatment of mental disorders were taken into consideration (APA, 2013). There were also some changes in specific items related to childhood and adolescence such as eliminating a class of disorders "disorders usually first diagnosed in infancy,

childhood, or adolescence" and giving them other classes, such as "neurodevelopmental disorders, feeding and eating disorders," as well as other classes (SAMHSA, 2016, June, p. 6). This version of the *DSM* also added two new childhood mental disorders which were social communication disorder and disruptive mood dysregulation disorder (DMDD). Moreover, *DSM-5* replaced the GAF in Axis V with an objective scale, which is the World Health Organization's Disability Assessment Schedule (WHODAS). This scale measures six areas, which include cognition (understanding and communicating), mobility (moving and getting around), self-care (hygiene, dressing, eating, and staying alone), getting along (interacting with other people), life activities (domestic responsibilities, leisure, work, and school), and participation (joining in community activities). The WHODAS is a longer scale, making it longer to complete or score (World Health Organization, 2012). Another major change in the *DSM-5* was the deliberate attempt to enhance the consistency of data-gathering techniques using "cross-cutting symptom measures." These measures are designed to assist clinicians in conducting thorough assessments by providing standardized approaches for collecting data (APA, 2013).

There were not any drastic changes in the *DSM-5-TR*, only some clarifications to certain criteria and the addition of one new diagnosis—prolonged grief disorder (APA, 2022a). In terms of childhood and adolescence, some childhood diagnostic criteria were updated to try "to capture the experiences and symptoms of children more precisely" (APA, 2022b, p. 1). Those disorders include autism spectrum disorder, DMDD, post-traumatic stress disorder, and prolonged grief disorder. A significant focus of the *DSM-5-TR* includes the importance that every child needs to be diagnosed with a careful and comprehensive evaluation. Since parents and caregivers are an essential part of the process of treatment, several of the *DSM-5-TR* criteria necessitate that either the parent or another individual who interacts with the child on a regular basis have observed the symptoms and confirm them (APA, 2022b).

Considerations for Counselors

Counselors working with children and adolescents need to take into consideration numerous aspects of the client population. Those considerations include counselors' attitudes, competence in working with children, as well as the different stages of development of the client. Modification to the techniques used with adults will be necessary for the successful treatment of this population.

Child and Adolescent Counselor Attitudes

Children and adolescents go through different developmental changes until they reach adulthood. Those developmental differences should influence the way counselors attend to this population in their sessions which is different than when working with adults (Johnson et al., 1997). Children face limitations in their ability to effectively express, understand, and create meaning from their experiences as well as limitations in processing these experiences verbally and emotionally in contrast to adults who have the capacity to actively understand and communicate with a counselor (Landreth, 2012; Springer et al., 2019, Vernon, 2002). Therefore, counselors working with children

and adolescents need to become aware of certain attitudes and develop them to be more effective in their practice. Those attitudes can be considered as prerequisites needed for a better understanding of the child or adolescent and for building and maintaining good rapport with them.

Counseling children requires the counselor to love working with children and having a child-like attitude. This means being comfortable acting silly, sitting on the floor, playing games, and getting dirty with paint, sand, or any other creative element that might be used as part of a counseling intervention. Children's language is play, and to effectively reach children and tap into their world, counselors need to be able to speak their language (Clark et al., 2022; Landreth, 2012).

Counselors should be aware of their own values and beliefs as they relate to children and adolescents, specifically in terms of stages of development and parenting styles, since it directly impacts their perspective toward children and their caregivers. Another attitude entails understanding that a child is more than one person (Clark et al., 2022). Children are embedded in a community, and to better understand them, counselors need to understand their relationships and the role of those relationships in the children's lives. This will give counselors a wider viewpoint, and it helps in assessment and treatment.

A counselor should be aware that children are not going to act or behave like adults, and counseling children is a distinct and different process from counseling adults. Also, awareness and knowledge that children are more than the product of their behavior is needed since their behavior can be a symptom of the dysfunctions of their family (Clark et al., 2022). Counselors need to understand that children, like adults, can have resilience, can overcome their mental health issues, and can get better. Also, since children have high imaginations and fantasies, it is important to recognize that gaining insight into children's perspectives necessitates immersing oneself in their world and establishing a connection with their lived experiences rather than dismissing their words as mere fantasy or lack of understanding.

Creating a Comfortable and Therapeutic Experience

Child and adolescent counselors should think about the therapeutic space where they will deliver their counseling sessions, where it needs to be age-appropriate in its setting and furnishings, as well as taking into consideration the height of the seating arrangements. For example, the counselor should be sitting at eye level with the client, so chairs need to be lower than an adult chair, and couches should not sink too much when a child sits in them (Broderick & Blewitt, 2015; Dowell & Berman, 2013; Kress et al., 2019). Moreover, since young individuals might feel that the counseling session resembles a teacher-student dynamic, which counselors may want to steer clear of, involving them in an activity will help them respond well. Hence, having a table available for playing games, engaging in art, and providing a space to place toys or other materials used by the counselor can be beneficial (Kress et al., 2019). It is important to note that the counseling room should not be too distracting with toys, yet at the same time, it should encourage curiosity and exploration. Some good choices for toys can include sand trays, doll houses, puppets, art materials, Play-Doh, stress balls, stuffed animals, fidget toys, etc. (Landreth, 2012). One important note to consider is that when you have children 6 or below, you should make sure safe toys are available and smaller items, such as those that can cause choking or are not age-appropriate, are put away and kept out of reach.

Snacks and Gifts

Some counselors prefer to have small snacks and water ready for their clients in case they come either hungry or thirsty. Not attending to those basic needs can affect the counseling session in terms of interaction or focus. If counselors choose to have snacks and water in the room, it is important to communicate with the parents first and get their consent prior to working with the child or adolescent. Additionally, counselors may opt to give small gifts or tokens at the end of a counseling session. This practice is debatable, as some argue that giving small gifts has the potential to blur professional boundaries, encourage manipulative behaviors from both the counselor and the client, and compromise the overall purpose of counseling (Kress et al., 2019), while others consider presenting a small item as a token at the conclusion of sessions as developmentally suitable and culturally accepted. These small items can serve as motivators for young clients and effectively engage them in the counseling process (Kress et al., 2019).

Competence

Counselor competencies are essential to provide good treatment to any population. When working with children and adolescents, additional knowledge and skills are required to facilitate the treatment process. These include specific understanding and skills tailored to the child's or adolescent's comprehension and skill levels. Thus, making appropriate modifications to interventions to meet the client's needs and understanding. Such amendments allow the counselor to focus their interventions and meet the child appropriately to increase successful treatment outcomes.

Child and Adolescent Counselor Knowledge

Child and adolescent counselors should be knowledgeable in specific areas to be able to provide the best therapeutic work in their sessions. Understanding the distinct developmental milestones that children and adolescents go through is extremely important in treatment. These life stages are marked by critical periods of growth and development, making children's needs and progress unique. Counselors must possess an acute awareness of these distinctive aspects to effectively support and address the needs of children and adolescents (Ray, 2019). Some of those developmental areas include psychosocial, cognitive, moral, emotional, physical, social, faith, etc. Below, some of the main developmental theories will be listed as tables with a brief description (see Tables 1.1, 1.2, and 1.3).

TABLE 1.1 Erikson's Stages of Psychosocial Development

Erikson's psychosocial development theory emphasizes the presence of crises or developmental tasks that individuals need to successfully navigate throughout their lifespan (Erikson, 1963). Each stage in the theory involves a specific crisis that must be effectively resolved. While it is possible to progress to later stages without fully mastering earlier ones, unresolved earlier crises are likely to resurface until they are adequately addressed and resolved.

1. Trust vs. Mistrust (Birth to 1 year) Infants learn to trust based on the consistency of their relationship with their primary caregivers. If trust grows successfully, they gain security and confidence (trust). Failure to successfully complete this stage may lead to a lack of trust (mistrust).
2. Autonomy vs. Shame and Doubt (1–3 years) Children start to become more confident in their surrounding environment if encouraged (autonomy). Children who are too controlled develop doubt in their own abilities (shame and doubt).
3. Initiative vs. Guilt (3–5 years) Children start to initiate actions rather than imitate (initiate). If others criticize them, they develop feelings of guilt (guilt).
4. Industry vs. Inferiority (6–11 years) Children start to develop their abilities such as sports, artistic, academic, etc. If encouraged, they will develop a sense of self-worth and become proud of their accomplishments (industry). If confined, they start to question their own abilities and have less self-worth (inferiority).
5. Identity vs. Role Diffusion (11 years–end of adolescence) Adolescents gain greater autonomy, start to develop their own personalities, and become more independent (identity). Failure to find one's identity and feeling confused in society (role diffusion).
6. Intimacy vs. Isolation (21–40 years) Young adults venture into establishing lasting connections with individuals beyond their immediate families (intimacy). Choosing to avoid intimacy can result in feelings of isolation and loneliness (isolation).
7. Generativity vs. Stagnation (40–65 years) Adults in their middle years have established careers and committed relationships (generativity). They can stagnate if they don't succeed in achieving these goals (stagnation).
8. Integrity vs. Despair (over 65 years) Elderly adults engage in introspection, assessing their achievements and finding a sense of integrity in a life well-lived (integrity). However, if they perceive their lives as lacking productivity, it can lead to feelings of despair (despair).

TABLE 1.2 Piaget's Stages of Cognitive Development

Piaget (1977) presented a cognitive developmental theory that describes how individuals acquire, comprehend, and apply knowledge. He observed that learning takes place through two processes: *assimilation*, where new information is integrated into existing cognitive frameworks, and *accommodation*, where existing cognitive frameworks are modified to incorporate new knowledge (Berger, 2008; Ziomek-Daigle, 2017, p. 9).

Sensorimotor stage (0–2 years) Where children learn by physically interacting with their surroundings
Preoperational stage (2–7 years) Where children begin to use symbolic thought. Children can only see from their own perspectives
Concrete operational stage (7–12 years) Where children start thinking logically and can sort things by similarities and differences
Formal operational stage (12 years–adulthood) Where adolescents can understand abstract ideas, analyze, and critically think and solve problems

TABLE 1.3 Kolberg's Stages of Moral Development

Kohlberg (1973, 1981) developed a moral development theory by presenting individuals with hypothetical moral dilemmas and analyzing the reasoning behind their responses. Based on his findings, he categorized his theory into three levels and six stages, with higher levels indicating more sophisticated and personalized moral reasoning.

Level	Motivation	Stages
Preconventional *(infancy and preschool)*	Individuals are motivated by external rewards and events	**Stage 1:** What should I do to avoid being punished?
		Stage 2: What should I do to get a reward I want?
Conventional *(school-aged children)*	Individuals are motivated by performing "right" roles and duties within society	**Stage 3:** What should I do to gain approval from others around me?
		Stage 4: What should I do to follow the rules?
Postconventional *(adolescents to adulthood)*	Individuals are motivated by internalized standards and duties	**Stage 5:** Are there exceptions to some rules in certain situations?
		Stage 6: What action is consistent with my values while respecting others at the same time?

Source: Kohlberg's Moral Stages (Ziomek-Daigle, 2017, p. 11, Table 1.3)

In addition to developmental knowledge, child and adolescent counselors need to be highly knowledgeable about child-related disorders and diagnostic categories outlined in the *DSM-5-TR*.

Clinician and Supervisors' Competencies and Skills

Competencies and skills are required to be effective counselors. Even though the literature does not specify specific competencies for working with children outside a school setting, there are instances where professionals are calling for action toward embracing certain competencies since children and adolescents are a unique population (Byrd et al., 2022). One of the most important competencies is the need to be aware of ethical and legal considerations specific to these populations. Several recommendations for competencies and skills for counseling children and adolescents will be covered in this section.

Counseling Session Skills

The counselor-client relationship in the context of children and adolescents is very important, especially since, most times, they come to therapy being defensive, guarded, uninformed, and not trusting adults (Land et al., 2017). Therefore, counselors need to honor and acknowledge those behaviors, including tendencies of being shy, reluctant, or resistant to engage in therapy, which are commonly observed and considered normal, especially in the early stages of counseling. Creative and nonverbal techniques such as art and play can effectively reduce anxiety and foster a solid foundation of connection and rapport. Therefore, certification in additional treatment modalities (play, art, sand, etc.) is highly recommended. It is a good strategy to give them ample time and silence to think through, process, understand, and make sense of what has been said (Broderick & Blewitt, 2015; Headley et al., 2015). Young clients can use this silence to reflect on their reaction to a prompt or feel more comfortable in a therapeutic environment. Giving them time to process conveys respect for their autonomy and independence (Clark et al., 2022; Roaten, 2011; Vernon & Schimmel, 2019).

When a child is distressed and hesitant, establishing a strong therapeutic alliance through the process of "joining" is advised. It might require several sessions to build a trusting and therapeutic relationship, especially for a child who may have experienced adults as reactive, conditional, unpredictable, critical, or even abusive in their world. Assisting children in realizing that trusting relationships are attainable, beneficial, and fulfilling becomes an important objective. It can serve as a valuable goal and potentially provide a reparative emotional experience, fostering trust and a sense of worthiness that extends to various environments (Oliver & Able, 2017).

It is important to note that young children, considering their cognitive level and expressive ability, struggle to engage in "talk therapy" for 45 to 50 minutes. Thus, the counselor needs to explain in concrete language and use short sentences, as well as be skillful in using a range of expressive art activities (see Chapter 10) (Clark et al., 2022; Landreth, 2012; Leggett et al., 2016; Vernon & Schimmel, 2019). It is important for counselors to note that the older the clients become, the more engaged in talk they can be since children cannot process emotions and experiences verbally (Prout & Fedewa, 2015).

Children and adolescents cooperate better in counseling when they feel that their counselor understands their world, their games, and their language. Therefore, counselors are encouraged to be curious and learn about their client's world (Vernon, 2009; Vernon & Schimmel, 2019). Critical thinking skills are needed by child and adolescent counselors to help them understand their clients' viewpoints and mental processes. It will also aid them in examining how a child's perspective affects his or her actual reality (Clark et al., 2022).

Child and adolescent counselors need to be flexible and adaptable in their practice, as well as open to learning. When using interventions with children and adolescents, counselors need to consider the psychosocial, cognitive, and emotional developmental stage of the child or adolescent to modify the interventions to best fit the client (Kress et al., 2019; Vernon & Schimmel, 2019). Moreover, being attentive to children and adolescents with advanced, delayed, or limited cognitive abilities is crucial, and counselors need to adapt the interventions and counseling approach to best fit them (Auger, 2013; Colangelo & Wood, 2015). Since every child has a different attention span in their ability to focus during a session, counselors need to adjust the session time frame accordingly (Kress et al., 2019; Vernon & Schimmel, 2019).

The intake and assessment of children and adolescents should start the moment the client comes into the room. It is also noteworthy to understand that sometimes with children and adolescents, rapport and trust need to be built before any intake or assessment takes place. This process might take more than one session, and collaboration with parents or main caregivers is essential at this point. It is very important to think about children and adolescents from a holistic point of view during assessment and take into consideration their age, developmental stage, abilities (physical, psychosocial, emotional, cognitive, moral, etc.), culture, spirituality, and context (Tuttle et al., 2017). In addition to the intake, it would be a good idea to collect a biopsychosocial history, which includes demographic information, presenting problem, family history, medical and health history, mental health history, and any other relevant information (Lenz et al., 2017).

Effective child and adolescent counselors are always looking to get better, and they understand that acquiring new counseling skills and therapeutic techniques necessitates extensive instruction, practice, consultation, and supervision. With the intention of continuously growing and improving, they look for ongoing education as well as peer guidance and counsel (Kress et al., 2019).

Special Considerations for Adolescents

Adolescents navigate through a period of uncertainty, particularly as they strive to establish their individuality and identity separate from their parents and siblings (Peterson, 2007; Vernon & Schimmel, 2019). It is crucial for counselors to recognize and validate the discomfort that adolescents may experience during this process. Building trust with adolescents can be more challenging compared to children. While some adolescents may be wary of casual conversations, engaging in such discussions can lead to unexpected personal connections and productive outcomes. Sometimes, adolescents may have developed coping mechanisms such as being cautious or emotionally shutting down around adults. Consequently, trying to "dig in" for personal information, especially in the early stages of counseling, can negatively impact building rapport. It is recommended to show respect and maintain a low reactivity, which can be more effective.

CONSIDERATIONS IN COMMUNICATION

Early Childhood

Interaction is recommended to begin with the parent, then the child, and remain on eye level with the child when working with them. Design your counseling session to be free from distractions and have transition objects such as toys to help initiate and enhance discussions with the child. When discussing topics, speak on the child's level, using their language, brief sentences, and simple language. Applying basic counseling skills to the session is helpful, such as avoiding interrupting the client, praising positive behaviors and attempts at change, and rephrasing and explaining concepts as needed to achieve understanding within their concrete and literal thinking patterns. Attention to body language, using open-ended questions, and focusing on strengths and abilities over limitations is essential. Assisting the child in identifying their strengths, supporting their interests, and understanding the connection between their

thoughts and behaviors is also helpful. Finally, keeping the focus on the identified client, the child, and their needs sets the stage for healthy communication and treatment planning.

Middle Childhood

When working with children in this developmental phase, it's important to use each skill applied to younger children with some additional adjustments. Be clear and concise, and avoid compound questions or thoughts. Focus on one change or topic at a time and support open communication by matching the client's pace of discussion, using encouragers, asking for clarification as needed, and checking for understanding/comprehension. Role model positive communication and emotional regulation, validate emotions, perceptions, and experiences, and agree to disagree. These skills will assist the child in increasing interpersonal coping skills and effective communication with others.

Adolescents

The foundations of healthy communication with younger children apply to adolescents with some slight modifications and additions. Support the adolescent's autonomy through sharing appropriate information and allowing for decision-making within their abilities and rights. Avoid lecturing and focus on sharing information, and openly accept their experiences, perceptions, and reactions with attention to the healthy expression of these rather than right verses wrong designations. Although the child is maturing, keep in mind that they are in a time of transition, still sorting out their personality and boundaries, so support their exploration and possible indecision until they gain additional information or skills. Keep in mind their peers play a significant role, as do their interests and hobbies, and school is their current focus, just as a job is often for an adult. Allow the adolescent to ease into conversations of more serious matters slowly, as they may not have the words or experience to share it openly from the start. As always, keep the focus of treatment on the client and their needs, not others, and validate their emotions, thoughts, and experiences.

Source: Adapted from Kress et al. (2017, p. 74, Figure 3.3)

Legal and Ethical Competence

Counselors working with the child and adolescent population need to take into consideration both specific legal and ethical codes that may apply to this population. These may vary by state in terms of the age of consent for treatment, meaning when parental/caregiver consent is required, as well as issues regarding confidentiality. The following sections explore these concepts in more detail.

Informed Consent

Child and adolescent counselors need to be competent in legal and ethical issues since at times those two areas can be in conflict (Hussey, 2008; Kress et al., 2019; Remley & Herlihy, 2016; Wheeler & Bertram, 2015). One of the primary considerations is the age of consent where a parent or guardian is needed to approve counseling. This can differ across states, as in some, the age of consent is 12 while it is 18 in others. It is important that counselors know the laws and regulations in their state

as to what it means if a minor is over the age of consent. If children are over the age of consent, it means they have the right to seek counseling on their own and have confidentiality rights.

Informed consent should be part of the intake session during which the client and parent/guardian are both informed and engaged in the conversation about the counseling process and its advantages and limitations (Remley & Herlihy, 2016). An important thing to discuss during this time is defining who is "the client" as mentioned in section B.4.b in the American Counseling Association (ACA, 2014) code of ethics.

The ACA (2014) code of ethics also emphasizes the significance of young clients participating in assent—or generally accepting—counseling, even though they might not be able to give consent legally. A client's assent can be given in addition to a guardian's legal approval. It is recommended that a simplified version of the informed consent, worded or illustrated according to the developmental age of the client, be given to the child or adolescent and can be signed by them as well in an effort of client assent (Kress et al., 2019). Counselors should revisit informed consent sessions as children and adolescents develop psychologically since consent is a fluid process rather than a fixed occurrence. This population may become more autonomous and independent as they get older, which may necessitate renegotiation as youth transition past the age of consent, which gives them the autonomy to make their own decisions in therapy (Kress et al., 2019).

Counselors must therefore review past discussions about informed consent and renegotiate boundaries as necessary to follow an ethical practice (Kress et al., 2019). Child and adolescent counselors need to have knowledge of the marital status of the parents. If they are divorced, counselors need to be aware of the legal issues that might impact counseling, such as who has the medical rights to the child based on court order and to check if consent should be provided by one or both parents (Welfel, 2010).

Confidentiality

Counselors need to manage the privacy and confidentiality rights of young clients in professional mental health settings in the same manner as they would with adult clients (Springer et al., 2019). When working with parents, counselors should choose one of the four positions recommended by Hendrix (1991) and let parents know at the onset of therapy (Sori & Hecker, 2015). The first is *complete confidentiality,* where nothing is disclosed to parents. The second position is *limited confidentiality,* in which minors waive their right to consent beforehand to what will be shared with parents. Third, *informed forced consent,* where children are provided ahead of time with what will be shared with parents. Finally, *no guarantee of confidentiality,* where counselors don't guarantee what they share or not with parents (Isaacs & Stone, 2001). Sori and Hecker (2015) have proposed two additional positions to Hendrix's (1991) positions: *mutual agreement* and *best interest agreement. Mutual agreement* is verbalized on what is and is not going to be shared with parents. *Best interest agreement* refers to both the client and the parents trusting the counselor to make the appropriate decision on what to share or not. Both call for honest communication and mutual trust between the counselor and the parents (Lloyd-Hazlett et al., 2017).

While parents possess a legal entitlement to access information about their children's lives, it is important to highlight a few points during the process of obtaining informed consent. Those points

suggest that effective counseling requires a trusting relationship, and sharing information could damage the relationship and the treatment process (Besler, 2017; Ziomek-Daigle, 2017). Except in cases where the counselor feels it is important to safeguard the kid or others, sharing information is not in the client's best interest. School-age clients frequently prefer their parents to hear what they say in sessions, but the client should have the choice as to what is communicated unless it is important to share in order to protect them or others from an obvious and impending threat. The goal of the counseling process is to empower clients through choice, and one of the ways to empower children and adolescents is to help them communicate to their parents what needs to be shared.

Multicultural Competence

While children can exhibit substantial variations among themselves, they also display considerable differences in their development and societal power in comparison to adults within their respective cultural groups (Axline, 1969). Children and adolescents possess distinctive cognitive processes, modes of expressing ideas, and behavioral patterns that set them apart from adults. Recognizing children and adolescents as a specific subset or culture within a population aids clinicians in perceiving their young clients as distinct from themselves in significant ways (Sommers-Flanagan & Sommers-Flanagan, 2007). This perspective prompts clinicians to conceptualize the counseling relationship as one that occurs between individuals belonging to different groups, even if the counselor and client share racial, ethnic, gender, and social class identities. Adopting this viewpoint will assist counselors in effectively conceptualizing their clients' cases (Smith-Adcock & Tucker, 2017).

Developing multicultural competence for counseling children and adolescents happens when counselors are actively aware of their own culture and context, as well as their characteristics and how those elements relate to the presenting issues in counseling (Byrd et al., 2022). The Multicultural and Social Justice Counseling Competencies have depicted four areas of competency—attitudes and beliefs, knowledge, skills, and action—which can contribute to the development of skills and expertise in working effectively with children and adolescents (Ratts et al., 2015). These areas are expressed in four domains of practice: counselor self-awareness, client worldview, the counseling relationship, and advocacy and interventions (Ratts et al., 2015).

Social justice is an important consideration for counselors as well and permeates all aspects of working with a client, taking into consideration human rights, access to resources, opportunities to participate in our society, and equity (Human Rights Careers, n.d.). This is evident in fairness in health care, employment, housing, and more (Human Rights Careers, n.d.). Counselors can achieve this with clients by approaching everyone as individuals, such as regarding their communication style, providing direction and support on how to use techniques, and providing information in various forms, such as languages, use of interpreters, and the like. Counselors also need to use a variety of ways to introduce and explain interventions to match the child or adolescent's age and abilities, as well as their interests, as well as when providing feedback to assist the personal growth of coping skills.

Candid discussions with the client explore the societal values, structures, policies, and practices that impact them and their family. It is important to appreciate the client's perceptions and

experiences with these elements and be able to support the client in processing their emotions, as well as exploring appropriate means to advocate for themselves. Counselors can enhance this understanding and appreciation of social justice by supporting student autonomy, valuing the perceptions and experiences of clients regardless of their age, and supporting each to share their views free from the judgment of others. Finally, counselors need to explore their theoretic approach to working with their clients with consideration of how each theory supports or hinders social justice issues with clients or social justice considerations when working with their families as well.

Collectivism is a multicultural consideration counselors may overlook. Collectivism incorporates consideration of interdependence, problem-solving style, and choice of coping skills (Kuo, 2004). It is important for counselors to understand that "collectivistic cultures center the family first, while therapy helps the client realize it's okay to center their emotional needs. Because of the common use of denial in multicultural communities, acknowledgement and validation provide your clients the security they need to excel" (Monfared, n.d., para. 1). Counselors need to maintain a constant consideration of collectivism and its impact on the available coping skills, boundaries, and treatment modalities that best suit the client in this arena.

SUMMARY

This chapter was an overview of the main history of mental health with children and adolescents starting with Freud and Anna Freud and ending with how policies and laws have influenced its approaches and perspectives. Developmental theories play a major role in how children and adolescents in the assessment, conceptualization, interventions, and treatment. Moreover, recommendations for considerations in the counseling room, competencies such as communication and multicultural, social justice, and collectivist aspects, and skills for working with counseling children and adolescents are highlighted.

Future chapters focusing on specific childhood diagnoses will clarify symptomology presentation within the population, aiding in diagnosis while enhancing treatment options. Other chapters will reinforce or perhaps introduce evidence-based practices useful to assist children and adolescents with a variety of mental health concerns. There are books on the market addressing interventions with children or specific diagnoses, but not one that combines both and includes multiple diagnoses afflicting children and adolescents.

Each diagnostic chapter will introduce the diagnosis, an overview of the diagnostic features, and a discussion of how each would present throughout childhood and adolescence. Additionally, these chapters will explore assessment procedures, evidence-based interventions, and treatment protocols for each of the following age groups: toddlers/preschool-aged children, elementary-aged children, preadolescents, tweens, and early teens (10–13 years old), and older teens (14–18 years old). Topics will include gender identity disorder, learning disabilities, attention deficit hyperactivity disorder, behavioral diagnoses, and autism spectrum disorders. Each treatment chapter will provide an introduction and history of the treatment approach and an overview of the techniques and interventions, again focusing on the age groups noted above. Treatment modalities will include general counseling

practices, expressive therapies, school counseling, eye movement desensitization and reprocessing, alcohol and other drug considerations, trauma, and cognitive development and assessment.

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PART II

Diagnostic and Treatment Interventions