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Special Issue: Counseling Children With Special Needs and Circumstances

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journal promoting
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within the profession of
counseling



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Children With Special Needs and Circumstances: Conceptualization Through a Complex Trauma Lens



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Edward Franc Hudspeth

When conceptualizing this special issue, we had a basic idea of what might be included; however, as submissions arrived, it was evident that our basic definition of special needs was limited and could include much more when broadened. Therefore, the issue was reconceptualized as “Children with Special Needs and Circumstances.” It is my hope that when practitioners, researchers and faculty read this issue, each begins to see that the term *special needs* encompasses more than we think, because anything that hinders the optimal growth and development of a child constitutes a special need. In this issue, readers will find articles concerning fears, trauma, sensory processing disorder, foreign adoption, cystic fibrosis, spina bifida, homelessness, special education and parent–child interaction therapy.

Keywords: counseling, children, special needs, complex trauma

To set the stage for this special issue, to provide a foundation for understanding and to link the various articles, I encourage readers to conceptualize the impact of a special need through a complex trauma or developmental lens. Over the past 15 years, countless articles have reported and described the impact of chronic stress and adverse childhood experiences (Anda et al., 2006; Edwards et al., 2005) and the subsequent development of complex trauma.

Complex and Developmental Trauma

The National Child Traumatic Stress Network (n.d.-a) has defined complex trauma as a series of traumatic experiences that are usually interpersonal in nature and lead to numerous long-term adverse effects on health and well-being. Similarly, van der Kolk, Roth, Pelcovitz, Sunday and Spinazzola (2005) described experiencing repeated traumatic events during childhood as developmental trauma. The duration and intensity of the traumatic experiences, as well as the age of onset of these experiences, can determine the outcome of both complex trauma and developmental trauma. Neuroscience research provides ample evidence of neurochemical and brain structural changes caused by complex trauma that result in affective and behavioral dysregulation (Lanius, Bluhm, & Frewen, 2011).

Though the terms developmental trauma and complex trauma were originally used to represent repeated abuse or an accumulation of traumatic experiences, recent neuroscience research has extended these terms to other conditions and experiences. Copeland, Keeler, Angold, and Costello (2007) noted that a long-term physical illness may lead to complex trauma, while D’Andrea, Ford, Stolbach, Spinazzola, and van der Kolk (2012) and Finkelhor, Ormrod, and Turner (2007) reported that bullying also may lead to similar outcomes.

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Courtois (n.d.), as well as Ford and Courtois (2009), Vogt, King, and King (2007), and the National Child Traumatic Stress Network (n.d.-b), offered a more descriptive explanation and extensive list when they stated the following:

Cumulative adversities faced by many persons, communities, ethno-cultural, religious, political, and sexual minority groups, and societies around the globe can also constitute forms of complex trauma. Some occur over the life course beginning in childhood and have some of the same developmental impacts described above. Others, occurring later in life, are often traumatic or potentially traumatic and can worsen the impact of early life complex trauma and cause the development of complex traumatic stress reactions. These adversities can include but are not limited to:

- Poverty and ongoing economic challenge and lack of essentials or other resources
- Community violence and the inability to escape/relocate
- Homelessness
- Disenfranchised ethno-racial, religious, and/or sexual minority status and repercussions
- Incarceration and residential placement and ongoing threat and assault
- Ongoing sexual and physical re-victimization and re-traumatization in the family or other contexts, including prostitution and sexual slavery
- Human rights violations including political repression, genocide/“ethnic cleansing,” and torture
- Displacement, refugee status, and relocation
- War and combat involvement or exposure
- Developmental, intellectual, physical health, mental health/psychiatric, and age-related limitations, impairments, and challenges
- Exposure to death, dying, and the grotesque in emergency response work (para. 7)

Cook et al. (2005) stated that as a result of complex trauma, individuals experience impairments in (a) attachment, (b) affect regulation, (c) behavioral control, (d) cognition, (e) self-concept, and (f) sensory and motor development. Treatment recommendations include (a) being developmentally sensitive, (b) building on the safety and security of caregivers and community (e.g., teachers), and (c) addressing affective and behavioral dysregulation.

Special Issue: Children with Special Needs and Circumstances

The articles in this special issue provide implications for counselors and ways that specific special needs and circumstances may be addressed with individuals, families, schools and communities.

In order to support the educational and emotional development of children and youth experiencing homelessness, Havlik and Bryan indicate that school counselors must first identify which students are experiencing homelessness in their school and then determine their specific needs. Some of these needs, to name a few, include violence, abuse, neglect, mental and physical health issues, and mobility issues. The authors note that once homeless children and their individual needs are identified, school counselors should engage the students within their schools and assist with collaborative efforts between school and community resources. Havlik and Bryan challenge schools counselors to seek out and participate in professional development regarding the policies related to individual needs of homeless students.

Geddes Hall states that less than half of school counselor preparation programs include content related to special education in their training. Geddes Hall encourages school counselors to have a comprehensive knowledge of the specific needs of those receiving special education services, and she offers precise

recommendations for how counselor educators can infuse special education content throughout a school counseling curriculum. She reflects that it is in the best interest of future school counselors, as well as the special students they will serve, to receive support and supervision during such experiences as they complete their programs.

Buss, Warren, and Horton provide in-depth coverage of the short- and long-term impact of trauma on the physical, mental, emotional and social development of traumatized children that includes associated trajectories to adult mental and physical health conditions. The authors indicate that early intervention and treatment can minimize the social and emotional impact of a child's exposure to a traumatic event. The authors also discuss the advantages of numerous evidence-based treatment strategies as well as the realistic limitations of these strategies. Across treatment methods, factors such as safety and attachment are paramount.

Liu and Hazler delineate differences noted among adoptees from various countries. These differences include behavioral, social and emotional characteristics, as well as the adoptees' proclivity to form an attachment with a primary caregiver. The authors demonstrate that pre-adoption characteristics are associated with smooth transitions during the adoption process as well as post-adoption integration. Liu and Hazler discuss ways that counselors may emphasize adoptee-parent relationships in which trust is a fundamental element. They provide specific recommendations for counselors and adoptive parents that ease the transition and support successful attachment.

Sheperis and colleagues acknowledge that counselors, whether working with children who have disruptive behavior or providing parenting training to families, should be knowledgeable of the application of various behavioral techniques in order to utilize them effectively and to teach them to parents. In their article, the authors review a wealth of research information related to one evidence-based method and demonstrate how this method may be useful when working with children with special needs. Sheperis and colleagues describe a session-by-session application of this model as well as report contemporary research about the model's application to working with children with special needs.

Leppma, Szente, and Brosch provide an overview of the current landscape of children's fears to help delineate a contemporary, adaptive and holistic approach to treatment. The authors convey an image of fear and anxiety development that can be physically and mentally paralyzing for individuals who experience these states. In their treatment section, the authors outline an approach that addresses affect regulation and development of positive emotions, as well as inoculating the client against stress and supporting the development of resilience. They report on several studies that demonstrate the value of play in the development of self-efficacy, optimism and positive affect.

Despite the fact that few within the world of counseling have written about the subject, Goodman-Scott and Lambert pull together many resources to conceptualize the special needs of children with sensory processing disorder (SPD). The authors provide a detailed description of the disorder and its subtypes and describe in detail appropriate assessment of the disorder. Goodman-Scott and Lambert recommend that counselors collaborate with occupational therapists in order to address the unique needs of children with SPD. They report that counselors can provide individual, group and family counseling modalities using solution-focused and cognitive-behavioral techniques to address children's mental health needs and co-occurring disorders.

Storlie and Baltrinic's article illuminates the impact of a chronic disease on the individual, the caregivers and the counselors working with the family. They indicate that counselors working with children and families affected by cystic fibrosis (CF) should consider the physical and psychosocial challenges facing this special-needs population. The authors encourage counselors to be knowledgeable about CF so that they will be sensitive to the

traumatic impact of this life-shortening disease on the child or adolescent with CF and caregivers. Storlie and Baltrinic offer suggestions for compassionate counseling as well as for avoiding compassion fatigue.

In a personal account of rearing a child with spina bifida, Richmond-Frank expresses both the successes and shortcomings that she has experienced over nearly 3 decades. The author provides a thorough account of her experience as a parent of a child with special needs, as well as what she has to teach others who may be working with a child with special needs. As a professional counselor, as well as a parent of a special-needs child, Richmond-Frank provides readers with specific and realistic suggestions. She shares that a systemic, strengths-based counseling model respects the inherent worth of the child with a disability by not presuming that he or she is the identified patient.

Conclusion

From the special issue editor's point of view, issues that are prolonged, intense and cumulative, and vary over developmental periods should be conceptualized through lenses that address the complexity of intermingled systems. By failing to see this complexity and all of its aspects, we fail to fully address the complexity of children with special needs and circumstances.

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Addressing the Needs of Students Experiencing Homelessness: School Counselor Preparation



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This study of 207 school counselors revealed significant relationships between types of counselors' training, number of students in counselors' schools experiencing homelessness, and counselors' perceived knowledge and provision of services regarding students experiencing homelessness. In-service training and professional development, but not graduate training, were related to counselors' knowledge of the McKinney-Vento Homeless Assistance Act and their advocacy for and provision of services to students experiencing homelessness. Differences also existed by school level and school setting. Implications of these findings are discussed.

Keywords: school counselors, homelessness, McKinney-Vento Homeless Assistance Act, advocacy, professional development

Homeless, although a difficult term to clearly define, refers to those who “lack a fixed, regular, and adequate nighttime residence” (U.S. Department of Education, 2004, p. 2). Families with children are the fastest growing homeless population in the United States, comprising one third of the homeless population (National Coalition for the Homeless, 2009). Twenty-two percent of all sheltered persons experiencing homelessness are under the age of 18, with over half of this group under the age of 6 (U.S. Department of Housing and Urban Development, 2010). Some live *doubled-up* with other families, in transitional housing such as shelters or in inhumane conditions (U.S. Department of Education, 2004). In 2012, the National Center for Homeless Education (NCHE) reported that 1,065,794 children in schools experienced homelessness, an increase of over 50% since 2007. The rapidly increasing figures, due in part to the economic recession in the United States, are cause for grave concern because homelessness is detrimental to the emotional, social and cognitive development and well-being of children (Coker et al., 2009; Grothaus, Lorelle, Anderson, & Knight, 2011).

Families who experience homelessness are more likely to experience separation from each other, violence and serious health conditions (National Center on Family Homelessness, 2011). Children experiencing homelessness may face high rates of abuse, neglect and mental health issues, as well as barriers that make it nearly impossible for them to succeed academically and emotionally without additional systemic supports (Buckner, Bassuk, Weinreb, & Brooks, 1999; Gewirtz, Hart-Shegos, & Medhanie, 2008; Swick, 2008; U.S. Department of Education, 2004). Due to the challenges of homelessness, students can be worse off academically and socially than their middle-class peers (Obradović et al., 2009; Shinn et al., 2008). Unlike most of their peers, they may lack supports such as before- and after-school services, mentors, transportation to and from school, and attendance support (Hicks-Coolick, Burnside-Eaton, & Peters, 2003; Miller, 2009; U.S. Department of Education, 2004). Higher levels of mobility and absenteeism make it difficult for homeless students to acquire a consistent education (Hicks-Coolick et al., 2003; Miller, 2009; Rafferty, Shinn, & Weitzman, 2004; U.S. Department of Education, 2004). Students experiencing homelessness, and those who

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are highly mobile, have lower reading and math scores from second through seventh grade than students living in poverty (Obradović et al., 2009). Further, relative to their peers, students experiencing homelessness are less likely to aspire to postsecondary education (Rafferty et al., 2004).

In response to the growing crisis among children experiencing homelessness, policymakers designed the McKinney-Vento Homeless Assistance Act (U.S. Department of Education, 2004) to provide access to education and remove barriers in order to ensure that schools address the unique needs of students experiencing homelessness. The provisions of the act require that school districts provide transportation to and from the school of origin for students experiencing homelessness, even when the students relocate to an area outside of their home school. Further, the act allows students to enroll in school immediately without the required paperwork (e.g., immunization records, educational records, lease or deed), assigns a homeless liaison to schools to ensure that provisions under McKinney-Vento are being met, and assigns a State Coordinator to coordinate services for students experiencing homelessness.

School counselors, teachers and administrators can help support students experiencing homelessness at the school level and ensure that the provisions of the McKinney-Vento Act are met. In their roles, they provide supportive services that address the academic, personal, social and career planning needs of all students (American School Counselor Association [ASCA], 2012). Interventions and services provided by school counselors include individual and group counseling, classroom guidance, academic advisement and planning, consultation with teachers and staff, collaboration with outside services, and parental support (ASCA, 2012). According to ASCA (2010), an important role of school counselors is to promote awareness and understanding of the McKinney-Vento Act and the rights of students experiencing homelessness. School counselors collaborate with other service providers in children's education to address the academic, career planning and personal/social needs of students experiencing homelessness (ASCA, 2010; Baggerly & Borkowski, 2004; Daniels, 1992, 1995; Grothaus et al., 2011). They should be knowledgeable about the issues faced by children and youth experiencing homelessness and be equipped to provide appropriate services to these students (Grothaus et al., 2011; Walsh & Buckley, 1994). In particular, school counselors must be aware of the McKinney-Vento program requirements (Baggerly & Borkowski, 2004) and understand how to advocate for their effective implementation. However, without knowledge of the policies that impact students experiencing homelessness and the interventions necessary to help them, school counselors may find it difficult to serve this population. In order to develop comprehensive school counseling programs that systemically address the needs of children and youth experiencing homelessness, school counselors need awareness of the policies that pertain to these students, and the emotional and educational issues they face.

To date, limited research exists concerning school counselors' knowledge of the McKinney-Vento Act, knowledge about the educational and emotional issues that homeless students face, and service provision for these students (Gaenzle, 2012). Also, limited research exists on whether school counselors receive training regarding homelessness and the source of that training, whether graduate training, in-service training or professional development. Further, little is known about the size of school counselors' caseloads of students experiencing homelessness and whether these caseloads differ in some locations (e.g., urban schools, high schools). Given that 77% of the homeless population is found in urban areas (Henry & Sermons, 2010), perhaps school counselors in urban schools face larger caseloads and greater demands for services from students experiencing homelessness. Exploring school counselors' knowledge, service provision and experiences regarding students experiencing homelessness would help to better focus service delivery at the school level to this student population. To this end, this exploratory study attempts to investigate school counselors' knowledge and service provision regarding students experiencing homelessness and to examine related variables (e.g., school level, school setting, years of experience, training received). The results of this study may help to guide

future research and improve counselor preparation and interventions regarding homelessness. The following questions guided this research:

1. What is school counselors' knowledge about
 - the McKinney-Vento Homeless Assistance Act?
 - the emotional and educational needs of students experiencing homelessness?
2. What services and interventions are school counselors providing for students experiencing homelessness?
3. What are the relationships of demographic and other variables (e.g., school type, school setting, school level, number of students in the school who are homeless, years of experience as a school counselor, type of training received and knowledge of location of homeless shelters) to school counselors' knowledge and provision of services related to students experiencing homelessness?

Methods

Participants

Participants included 207 respondents from a random sample of 1,000 school counselors who were listed in the ASCA member directory. Of the participants, 72 (36.4%) worked in elementary schools, 35 (17.6%) in middle schools, 86 (43.4%) in high schools and 5 (2.5%) in both middle and high schools. Fifty-nine (29.6%) of the participants worked in urban settings, 55 (27.6%) in rural settings and 85 (42.7%) in suburban school settings. Most respondents (185 or 93%) worked in public schools while 7 (3.5%) worked in private schools and 7 (3.5%) worked in parochial schools.

Instrumentation

The survey (see Appendix) was developed by the first author to assess school counselors' perceived knowledge of the McKinney-Vento Act and the needs of students experiencing homelessness as well as counselors' provision of services to these students (Baggerly & Borkowski, 2004; Strawser, Markos, Yamaguchi, & Higgins, 2000; Walsh & Buckley, 1994). The survey was piloted on 12 second-year master's-level school counseling students at a large East Coast university who were completing their internships at the time. After students completed a paper version of the survey, they provided feedback on the clarity and comprehensibility of the survey items. Minor adjustments were made to improve clarity on several items.

Demographic items. Three items assessed school setting (urban, rural, suburban), school level (elementary, middle, high) and years of experience as a school counselor. Years of experience was reported as a continuous variable with a mean of 9.35 years ($SD = 7.25$) and a range from 1–31.

Training. Two items assessed training. The first item assessed the extent of training in work with students experiencing homelessness and was rated on a scale from 1 (no training) to 3 (extensive training). The second item assessed type of training (i.e., in graduate school, in-service training at their school, required professional development outside of school, voluntary professional development outside of school, two or more sources of training, and no training).

Number of students experiencing homelessness. One item measured the number of students experiencing homelessness that counselors reported as enrolled at their schools. Participants were asked to select a category that best fit the amount. The categories were 0, 1–5, 6–10, 11–15, 16–25, 26–35, 36–45, 46–55 or over 55 students.

Perceived knowledge of McKinney-Vento and emotional and educational issues. Seven Likert scale items were written specifically to assess school counselors' perceived knowledge of the McKinney-Vento Act and the emotional and educational issues of students experiencing homelessness. Participants were instructed to rate their knowledge on a scale from 1 (no knowledge) to 5 (extensive knowledge). Items were designed to measure school counselors' perceptions of their knowledge on specific requirements under the McKinney-Vento Act, as well as their knowledge on general emotional and educational issues affecting students experiencing homelessness.

Provision of services. Two items focused on the services and interventions that participants reported implementing with students experiencing homelessness. One item prompted participants to report the frequency of their engagement in these interventions on a scale from 1 (not at all) to 5 (always), where *interventions* signified nine specific services to students experiencing homelessness. The second item required school counselors to indicate any of 25 interventions provided to students experiencing homelessness, including the option *I have not provided any services or interventions*. The services and interventions were selected based on the McKinney-Vento requirements and the literature on education and homelessness.

Procedures

Using Survey Monkey (www.surveymonkey.com), the survey was e-mailed to 1,000 randomly selected ASCA members selected via the ASCA member directory (www.schoolcounselor.org). Of the 1,000 surveys sent, 80 e-mails bounced back or were invalid, while 713 recipients did not reply and 207 responded. The total response rate was 22.5%, with 19.8% ($N = 182$) completing all sections of the survey. Completing the survey in its entirety included filling out one qualitative section (for results see Havlik, Brady, & Gavin, 2014). Several participants did not complete this section.

Data Analysis

Descriptive analyses. To answer research questions one and two, we examined frequencies and means of school counselors' responses to survey items.

Analyses of variance (ANOVAs). To answer question 3, we conducted four one-way ANOVAs: (1) one to examine whether elementary, middle and high school counselors differed in the extent of training they received for working with students experiencing homelessness; (2) a second to examine whether urban, rural and suburban school counselors differed in the extent of training they received for working with students experiencing homelessness; (3) a third to examine whether elementary, middle and high school counselors differed in the number of students experiencing homelessness at their school; and (4) a fourth to examine whether urban, rural and suburban school counselors differed in the number of students experiencing homelessness at their school.

Regression analyses. To answer the fourth research question, we conducted simultaneous multiple regression analyses to examine the relationships among the demographic variables (e.g., school setting, school level, number of students experiencing homelessness at school, years of experience as a school counselor, type of training received) and school counselors' knowledge and provision of services related to students experiencing homelessness.

Factor analysis. Prior to conducting the multiple regression analyses, we conducted a principal component analysis (PCA) of the seven items assessing counselors' perceived knowledge of McKinney-Vento and students' emotional and educational needs, and the nine items assessing the extent to which counselors provided nine specific services for students experiencing homelessness (see Tables 1 and 2). The PCA with varimax rotation was conducted as a data reduction method (Costello & Osborne, 2005) to determine how participants' responses

were structured. The components or factors derived from the PCA comprised the dependent variables in the study. Decisions to retain the factors were based on (a) the scree test, (b) eigenvalues greater than one (Kaiser criterion) and (c) the conceptual meaning of each item.

Post hoc analyses. One-way ANOVAs and Crosstabs analyses were used to take a closer look at any interesting findings from the multiple regression analyses.

Results

Descriptive Analyses

In Table 1, we present the means and standard deviations for the 16 items used to assess school counselors' knowledge and provision of services regarding students experiencing homelessness.

Question 1a: Perceived knowledge of McKinney-Vento. The average response to the five items that assessed school counselors' knowledge of McKinney-Vento was 2.90 ($SD = 1.38$), slightly below the midpoint of 3 on the 5-point scale (1 = no knowledge to 5 = extensive knowledge). More specifically, school counselors reported about average knowledge of the McKinney-Vento Act ($M = 2.86$, $SD = 1.47$). They also reported lower levels of knowledge of the role of the State Coordinator ($M = 2.04$, $SD = 1.19$), but slightly above average knowledge of the role of the homeless liaison ($M = 3.19$, $SD = 1.45$). Counselors reported above average knowledge of registration policies for students experiencing homelessness ($M = 3.45$, $SD = 1.25$), and about average levels of knowledge of transportation requirements ($M = 2.97$, $SD = 1.53$).

Table 1

Means, Standard Deviations and Factor Loadings of Knowledge and Provision of Services

Item	<i>M</i>	<i>SD</i>	Factor loadings		
			Component		
			1	2	3
Knowledge of McKinney-Vento ^a	2.86	1.47	.83	.16	.25
I review the McKinney-Vento Act policies to ensure homeless students' needs are being met ^b	2.77	1.54	.80	.35	.12
Knowledge of transportation requirements under McKinney-Vento ^a	2.97	1.53	.76	.16	.30
Knowledge of role of the State Coordinator ^a	2.04	1.19	.67	.26	.23
I have contact with my school's homeless liaison ^b	3.48	1.66	.59	.21	.40
Knowledge of the role of the homeless liaison ^a	3.19	1.45	.58	.15	.59
Knowledge of registration policies for homeless students ^a	3.45	1.25	.51	.24	.52
I assess the emotional needs of homeless students ^b	3.86	1.21	.08	.81	.33
I make contact with homeless families ^b	3.42	1.32	.20	.71	.33
I ensure that homeless students with whom I work have equal opportunities compared to their non-homeless peers ^b	4.31	1.00	.07	.68	.40
I assist with the registration of homeless students ^b	3.45	1.25	.26	.64	-.01
I ensure that homeless students have transportation to attend before- or after-school programs ^b	3.01	1.57	.35	.62	.12
I provide mentorship programs for homeless students at my school ^b	2.43	1.34	.15	.57	.08
I visit shelters where homeless students at my school live ^b	1.44	.88	.41	.46	-.11
Knowledge of emotional/social issues ^a	3.85	.97	.23	.16	.87
Knowledge of educational issues ^a	3.87	.96	.29	.25	.83

^a On these items the scale ranged from 1 = no knowledge at all to 5 = extensive knowledge.

^b On these items the scale ranged from 1 = not at all to 5 = always.

Question 1b: Perceived knowledge of emotional and educational issues. The average response to the two items written to assess school counselors' knowledge of emotional and educational issues faced by homeless students was 3.86 ($SD = 0.97$), above the midpoint of 3 on the 5-point scale used (1 = no knowledge to 5 = extensive knowledge). School counselors reported above average knowledge of emotional issues ($M = 3.85$, $SD = .97$) and knowledge of educational issues ($M = 3.87$, $SD = .955$), suggesting that counselors may perceive themselves as fairly knowledgeable about the emotional and educational issues faced by students experiencing homelessness.

Question 2: Provision of services and advocacy. The average response to the nine items written to assess school counselors' provision of services was 3.10 ($SD = 1.35$), slightly above the midpoint of 3 on the 5-point scale used (1 = not at all to 5 = always). School counselors provided responses close to average regarding their frequency of assisting with registration ($M = 3.20$, $SD = 1.58$). Their responses were above average for their frequency of assessing the emotional needs of students experiencing homelessness ($M = 3.86$, $SD = 1.21$). However, most school counselors reported infrequently conducting shelter visits ($M = 1.44$, $SD = .88$) or providing mentorship programs ($M = 2.43$, $SD = 1.34$). The highest average was of school counselors' reports on the extent to which they ensured equal opportunities for students experiencing homelessness ($M = 4.31$, $SD = 1.04$).

Types of interventions. In response to the item that requested for participants to report on their engagement in 25 types of interventions provided to students experiencing homelessness, nearly 70% of all participants reported making referrals to community resources (69.5%) and providing individual counseling (68.0%). Other frequent interventions reported included providing academic support (57.9%), teacher consultation (52.8%), parent consultation (50.3%) and advocating for homeless students (43.7%). Interventions infrequently reported included parent education workshops (6.6%), workshops/training for teachers (7.1%), behavioral skills training (13.7%), mentor programs (16.2%), communicating with shelter staff (17.8%), after-school programs (20.3%), college planning (21.8%), small group counseling (22.8%) and IEP (Individualized Education Program) planning (23.9%). Only 3% of counselors reported conducting shelter visits, while 13.2% of school counselors reported not providing any services at all to students experiencing homelessness.

ANOVAs

Question 3a: Training received for working with students experiencing homelessness. No significant differences existed among school counselors by school level or school setting in the extent of training received for working with students experiencing homelessness.

Question 3b: Number of students experiencing homelessness at their school. No significant differences existed among elementary, middle and high school counselors in the number of students experiencing homelessness at their schools. However, significant differences existed among urban, rural and suburban school counselors in the number of students at their schools experiencing homelessness, $F(2, 196) = 7.14$, $p = .001$, with a very small effect size, $\eta^2 = .07$. Urban school counselors had significantly higher numbers of students experiencing homelessness ($M = 3.09$, $SD = 2.34$) than rural ($M = 1.98$, $SD = 1.82$) and suburban ($M = 1.89$, $SD = 1.72$) school counselors. A rating of 3 is equivalent to 11–15 students, a rating of 2 is equivalent to 6–10 students, and a rating of 1 is equivalent to 1–5 students experiencing homelessness.

Principal Component Analysis

A PCA of the 16 items resulted in three components or factors, which were the dependent variables in subsequent regression analyses. A four-factor model was initially considered; however, the three-factor model was selected based on the scree test and eigenvalues greater than one. The Kaiser-Meyer-Olkin measure of

sampling adequacy was .88, indicating that factor analysis of these variables was appropriate. Barlett's Test of Sphericity was significant, indicating that the items were excellent candidates for PCA. The factor loadings of each factor are presented in Table 1. Factor 1, perceived knowledge of McKinney-Vento, comprised seven items with factor loadings ranging from .83–.51 with 24.2% of the variance explained and a Cronbach's alpha of .91. Items loading on this factor measured school counselors' perceived knowledge of McKinney-Vento and the policies that schools must implement under McKinney-Vento. Factor 2, advocacy and provision of services, comprised seven items with factor loadings from .45–.81 with 21.19% of the variance explained and a Cronbach's alpha of .81. Items on this factor described services and forms of advocacy that school counselors provided for students experiencing homelessness. Factor 3, perceived emotional and educational issues, comprised two items with loadings of .87 and .83 with 17.78% of variance explained and a Cronbach's alpha of .96. Factor scores were created for each factor using the regression method approach so that participants had a score on each factor. The factor score is a linear combination of the items that load on that factor and is a standardized score. Therefore, the three factors used in the following regression analyses were standardized variables, each with a mean of zero and a standard deviation of one.

Multiple Regression Analyses

Following the PCA, we conducted three simultaneous multiple regression analyses with each factor serving as a dependent variable in each regression. The B coefficients and standard errors for each regression analysis appear in Table 2.

Table 2

Regression Analyses of Variables Related to School Counselors' Knowledge and Service Provision Regarding Students Experiencing Homelessness

Variables	Perceived knowledge of McKinney-Vento		Knowledge of emotional and educational needs		Advocacy and provision of services	
	<i>B</i>	<i>SEB</i>	<i>B</i>	<i>SEB</i>	<i>B</i>	<i>SEB</i>
Intercept	-1.83***	.33	-1.44***	.30	-1.99***	.36
Elementary	.32*	.15	.22	.15	.15	.16
Middle	.19	.18	.10	.19	.21	.20
High (reference category)						
Public	.38	.30	.50	.29	.70**	.32
Private/parochial (reference category)						
Urban	-.12	.16	-.12	.16	-.23	.17
Rural	.13	.16	-.21	.16	.26	.18
Suburban (reference category)						
Years of experience	.01	.01	.01	.01	.00	.01
1–25 homeless students	.58*	.26	.52**	.24	.80**	.27
26–55 homeless students	.61	.34	.72**	.34	.87**	.36
55+ homeless students	1.08**	.40	1.13**	.37	1.37**	.40
No homeless (ref)						
Graduate training	.28	.25	.66**	.26	.58*	.28
In-service training	1.16***	.17	.83***	.18	.65**	.19
Professional development	.93***	.19	.54**	.19	.65**	.21
Two or more sources	1.11***	.20	.96***	.21	.82***	.23
No training (ref)						
<i>R</i> ²	.45***		.28***		.28***	
(adj. <i>R</i> ²)	(.41)		(.23)		(.23)	

****p* < .001. ***p* < .01. **p* < .05.

Perceived knowledge of McKinney-Vento. The independent variables explained 47% of the variability in school counselors' perceived knowledge of McKinney-Vento, $R^2 = .45$, Adjusted $R^2 = .43$, $F(23, 146) = 10.87$, $p = .000$. Participant grade levels, $\beta = .15$, $t = 2.18$, $p = .003$, numbers of students experiencing homelessness and training predicted knowledge of McKinney-Vento. Relative to school counselors who had received no training, responses of having received in-service training, $\beta = .54$, $t = 7.32$, $p = .000$, professional development outside of school, $\beta = .39$, $t = 5.65$, $p = .000$, and two or more sources of training, $\beta = .43$, $t = 6.03$, $p = .000$, predicted perceived knowledge of McKinney-Vento. However, no relationship with perceived knowledge of McKinney-Vento existed among those who received their training in their graduate program and those who had no training.

Perceived knowledge of emotional and educational issues. The independent variables explained 30% of the variability in school counselors' perceived knowledge of emotional and educational issues, $R^2 = .28$, Adjusted $R^2 = .23$, $F(12, 175) = 6.24$, $p = .000$. Number of students experiencing homelessness predicted participants' perceived knowledge of emotional and educational issues in schools with 1–25 students, $\beta = .32$, $t = 3.50$, $p = .001$, in schools with 26–55 students, $\beta = .22$, $t = 2.62$, $p = .010$, and in schools with more than 55 students, $\beta = .32$, $t = 4.00$, $p = .000$. Type of training received also predicted perceived knowledge of emotional and educational issues in participants who received their training in their graduate program, $\beta = .14$, $t = 2.11$, $p = .000$, as well as those who received in-service training, $\beta = .39$, $t = 5.13$, $p = .000$, professional development outside of school, $\beta = .27$, $t = 3.74$, $p = .000$, and two or more sources of training, $\beta = .36$, $t = 4.92$, $p = .000$.

Advocacy and provision of services. The independent variables explained 30% of the variability in school counselors' reported advocacy and provision of services, $R^2 = .28$, Adjusted $R^2 = .23$, $F(12, 151) = 5.31$, $p = .000$. Number of students experiencing homelessness in the school and type of training received both predicted school counselors' reported advocacy and provision of services. As expected, when compared to participants who reported having no students experiencing homelessness, the number of homeless students at each school predicted advocacy and provision of services from participants who reported having 1–25 students experiencing homelessness, $\beta = .39$, $t = 3.72$, $p = .000$, 26–55 students, $\beta = .24$, $t = 2.47$, $p = .014$, and 55 or more students, $\beta = .36$, $t = 4.02$, $p = .000$. Type of training received also predicted advocacy and provision of services. Compared to participants who had received no training on homelessness, training responses that included in-service training, $\beta = .31$, $t = 3.69$, $p = .000$, professional development outside of school, $\beta = .29$, $t = 3.61$, $p = .000$, and two or more sources of training, $\beta = .43$, $t = 4.06$, $p = .000$, predicted advocacy and provision of services. However, no relationship was reported in advocacy and provision of services among those who received their training in their graduate program and those who had no training on homelessness.

Post Hoc Analyses

To take a closer look at the significant differences between elementary, middle and high school counselors on perceived knowledge of McKinney-Vento, we conducted a one-way ANOVA, $F(2, 157) = 6.44$, $p = .002$, $\eta^2 = .07$. Elementary school counselors fell significantly above the mean on perceived knowledge of McKinney-Vento ($M = .33$, $SD = .91$), while high school counselors fell significantly below the mean ($M = -.27$, $SD = .97$). Middle school counselors ($M = -.10$, $SD = 1.06$) also fell below the mean, although the difference was not significant. To shed further light on this relationship, we conducted a crosstabs analysis with school level and source of training. Although the previous ANOVA (see research question 3a) revealed no significant differences in extent of training by school level or setting, a post hoc examination of the frequencies regarding source of training revealed that elementary school counselors (59.3%) were more likely than high school counselors (29.6%) or middle school counselors (11.1%) to receive training from two or more sources (i.e., from some combination of graduate school, professional development outside of school and in-service training). High school counselors (52.9%) were more likely to report that they had received no training from any source than were elementary school counselors (28.6%).

Discussion and Implications

This national study explored school counselors' perceived knowledge of the McKinney-Vento Act, perceived knowledge of the emotional and educational needs of students experiencing homelessness, and perceived involvement in advocacy and provision of counseling services. In general, school counselors in the current study appear to view themselves as less knowledgeable about the McKinney-Vento Act and its requirements, but more knowledgeable about the general emotional and educational issues of students experiencing homelessness. However, due to the general nature of the questions, reporting greater knowledge of emotional and educational issues may be a result of self-report bias, since specific knowledge was not solicited. A lower level of knowledge about McKinney-Vento is not surprising given that about 40% of school counselors in the study reported never having received training related to working with students experiencing homelessness. In addition, whether they had no or some training, school counselors reported working in various ways with students experiencing homelessness, including enrolling them in school and assessing their needs. However, regarding more collaborative services such as visiting shelters and involving students in mentoring programs, school counselors reported less involvement. As recommended in the school counseling literature on homelessness (Baggerly & Borkowski, 2004; Strawser et al., 2000; Walsh & Buckley, 1994), these school counselors appear to provide more services such as referrals, individual counseling and teacher consultation to students experiencing homelessness. Yet, Miller (2009, 2011) emphasized the importance of school personnel's collaboration with families and community stakeholders and building bridges to connect homeless students to after-school programs and community services to improve their academic and emotional outcomes. Previous research suggests that training specifically related to building partnerships is a prerequisite of school-community collaboration and that 40% of school counselors lack this type of training (Bryan & Griffin, 2010).

Overall, while 90% of school counselors in the current study appear to work with students experiencing homelessness, school counselors in urban settings appear to face larger caseloads of homeless students than counselors in rural and suburban schools. Yet, no differences exist between the surveyed urban, rural and suburban school counselors' levels of knowledge about McKinney-Vento and about emotional and educational issues or advocacy and provision of services. Given the increasingly large number of families experiencing homelessness in urban areas (Henry & Sermons, 2010), though a variable not investigated in this study, one might expect that with larger caseloads, urban school counselors would report higher levels of advocacy and provision of services. Provision of services and levels of advocacy are related to training. Without adequate training, counselors in urban schools may find themselves ill-equipped to perform the boundary-spanning role that is integral to providing these students with adequate support—that is, linking them to information, resources and programs (Miller, 2009, 2011). Note that the numbers related to participants' school location should be interpreted with caution due to the lack of specific percentages of students experiencing homelessness on their caseloads available for this study.

In general, elementary, middle and secondary school counselors appear to face similar situations regarding the numbers of students experiencing homelessness and their perceived training for working with this population. However, elementary school counselors reported above average knowledge of the McKinney-Vento provisions, significantly higher than high school counselors, although these groups do not differ in the perceived extent of training received. The findings suggest that their knowledge of McKinney-Vento may be attributed to the source or type of training they are receiving. Also, this difference may reflect the fact that most school counseling publications on students experiencing homelessness, although few, have focused on elementary school counselors (e.g., Baggerly & Borkowski, 2004; Daniels, 1992, 1995; Strawser et al., 2000).

According to the results of this study, training on homelessness is positively related to school counselors' knowledge of McKinney-Vento, knowledge of emotional and educational issues, and advocacy and provision of services. Overall, school counselors with no training regarding students experiencing homelessness reported less knowledge of McKinney-Vento and of their emotional and educational issues, and less advocacy and provision of services compared to counselors who with some training (with the exception of those who received their training in graduate programs). For the participants in this study, graduate program training regarding homelessness is only indicative of higher knowledge of emotional and educational issues of students experiencing homelessness when compared to counselors with no training. These findings suggest the need for an intentional focus in counseling graduate programs on the McKinney-Vento Act and its provisions as well as on specific practices for advocating and implementing service delivery to students experiencing homelessness. Graduate students in school counseling programs and related degree programs in education would benefit from specific training that helps them develop skills as effective boundary spanners and information brokers who function within and across the contexts of families and children experiencing homelessness (Miller, 2009, 2011).

Taken together, the relationships between the number of students experiencing homelessness, school counselor training, and advocacy and provision of services are particularly interesting. These findings suggest that school counselors' exposure to issues related to homelessness, through both training and direct contact with students experiencing homelessness, may compel them to learn about homelessness and to advocate for and provide recommended services to these students. Indeed, as their caseloads of students experiencing homelessness increase, school counselors may feel compelled to find resources and supports for these students. More importantly, for counselors who have caseloads with only a few students experiencing homelessness, these findings highlight the value of training and its implications for services. Perhaps these findings hint at the need to couple school counselor training on homelessness with direct exposure to students experiencing homelessness—that is, with immersion experiences. Intentional and coherent integration of service learning experiences with families and children experiencing homelessness into counselor education programs can provide school counseling trainees with appropriate and invaluable real-world learning experiences for developing the requisite skills for working with students experiencing homelessness (Baggerly, 2006; Constantine, Hage, Kindaichi, & Bryant, 2007).

Implications for School Counselor Practice

The findings of this study have several implications for the practice of school counselors. We recommend that school counselors (a) seek professional development to enhance their knowledge of the policies and needs related to students experiencing homelessness, (b) build relationships with the students experiencing homelessness in their schools, and (c) build partnerships with families experiencing homelessness, homeless liaisons, homeless shelters, and community organizations in order to better advocate for and provide services to students experiencing homelessness.

Professional development on homelessness. School counselors are required to promote awareness and understanding of McKinney-Vento and the rights of students experiencing homelessness and provide services aligned to meet their needs (ASCA, 2010). Based on the results of this study, school counselors who do not receive training regarding students experiencing homelessness may lack knowledge of McKinney-Vento. Without knowledge of policies that impact students experiencing homelessness and the interventions necessary to work with them, counselors may provide students with ineffective support.

School counselors must take the initiative to seek training on the McKinney-Vento Act and the specific needs and challenges faced by students experiencing homelessness. They may seek this knowledge by attending state, regional or national conferences on homelessness, and should advocate for the topic to be included at state,

regional and national conferences of counseling associations. In the absence of these opportunities, school counselors may arrange to meet with the local homeless liaison to discuss the provisions of the McKinney-Vento Act and the needs of students experiencing homelessness and to explore available services in the school district.

Build relationships with students experiencing homelessness. In order to support the educational and emotional development of children and youth experiencing homelessness, school counselors must first identify which students are experiencing homelessness in their school and then determine their specific needs (Daniels, 1992). Identifying students experiencing homelessness requires that all stakeholders, including teachers, know the variety of definitions that qualify students as experiencing homelessness (U.S. Department of Education, 2004; Zerger, Strehlow, & Gundlapalli, 2008). Educating all teachers and staff on the definitions of homelessness will allow them to quickly and confidentially report if they suspect a student is experiencing homelessness and recognize issues that may arise due to their housing status. When students and families are identified as experiencing homelessness, school counselors may then plan interventions accordingly to support their educational and developmental needs.

Build partnerships with stakeholders. One critical way in which school counselors can support the needs of students experiencing homelessness is by building collaborative relationships with partners in the community (ASCA, 2010; Grothaus et al., 2011). Determining student needs may require visiting shelters to find ways to connect with families and children. Given that shelters offer families a variety of resources that may or may not adequately meet their needs (Shillington, Bousman, & Clapp, 2011), it is important for school counselors to know what services local shelters provide in order to understand what additional supports are needed. For instance, determining what educational support is available at the shelter (e.g., whether there is allotted space for students to study) may help counselors determine what academic enrichment and support programs (e.g., tutoring, computer access, homework help) are needed at the school level.

As previously mentioned, McKinney-Vento requires that every local educational agency has a designated local homeless liaison. This person ensures that students experiencing homelessness are identified and have equal opportunities to be successful. Therefore, when coordinating services and planning interventions for students, counselors should collaborate with the assigned homeless liaison at their school (Grothaus et al., 2011; Strawser et al., 2000). Counselors and homeless liaisons can collaborate to plan appropriate interventions for meeting the identified needs of students experiencing homelessness. They also may partner to educate staff members about the emotional and educational challenges that homeless students face. In some cases, school counselors may be assigned as the local homeless liaison, which requires them to better understand the requirements of McKinney-Vento and initiate partnerships between all stakeholders.

School counselors also might partner with teachers and community stakeholders to provide supportive services for students experiencing homelessness. They may collaborate to coordinate tutoring or mentoring programs and to develop safe classroom and school environments for students (Bryan, 2005). They also can plan culturally sensitive classroom guidance units that relate to the personal and social issues faced by students experiencing homelessness. For example, a classroom lesson on the topic of developing social skills might be particularly beneficial for all students, including those experiencing homelessness (Baggerly & Borkowski, 2004).

Limitations and Future Research

The limitations of this study include self-report bias, sample bias, low response rate, and the validity and reliability of the survey itself. The survey measures participants' perceptions of their knowledge rather than their actual knowledge, which may have led to self-report bias in reporting levels of knowledge. Further, the

low response rate might render these findings ungeneralizable to all school counselors. The response rate may be due to the e-mail-only method of sending out the survey, which has been shown to generate lower response rates than mailing surveys (Dillman et al., 2009; Kaplowitz, Hadlock, & Levine, 2004; Kongsved, Basnov, Holm-Christensen, & Hjollund, 2007; Shih & Fan, 2009). For instance, one study suggested that e-mail surveys have a response rate approximately 20% lower than that of mail surveys (Shih & Fan, 2009). However, the response rate also may suggest that the counselors who chose not to participate in the survey did so because they did not have or were not aware of any students experiencing homelessness on their caseloads. Another limitation concerns the selection of respondents exclusively among ASCA members. Thus, this sample may not be representative of all counselors in the United States. As a caveat, the results of this study should not be interpreted in causal terms because the findings suggest relationships between variables, not specific causality. Finally, since the survey is newly developed, its reliability and validity should be considered with caution. Though there are several limitations, due to the exploratory nature of this study, the results provide insight into school counselors' work with students experiencing homelessness and guide future research on this important subject.

This exploratory study is one of only two studies (e.g., Gaenzle, 2012) to examine the relationship between counselor demographics and their knowledge, advocacy and provision of services for students experiencing homelessness. This initial information lays the foundation for further research on the topic. It is possible that other variables, such as actual (rather than perceived) knowledge, may predict school counselor advocacy and provision of services. The omission of certain variables may explain the low R squares (e.g., $R^2 < .30$) in some of the regression models. Future research should use a larger sample to explore school counselors' knowledge about and advocacy for students experiencing homelessness as well as examine additional variables that may influence school counselors' and other service providers' advocacy and service provision for students experiencing homelessness. Further, this study suggests a need for future research that examines the efficacy of current school counseling programs with students experiencing homelessness.

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The authors reported no conflict of interest or funding contributions for the development of this manuscript.

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Appendix

Knowledge and Skills with Homeless Students Survey Self-Administered Questionnaire

The following survey will be on the topic of homeless students. Please take some time to answer each item. The survey should take you 3–5 minutes to complete. You will not be asked for any identifying information. Therefore, all responses to this survey are anonymous.

This survey is about your work with homeless students. For your information, the following is the definition for homeless students:

The McKinney-Vento Homeless Assistance Act (U.S. Department of Education, 2004) defines homeless children and youth as those who are sharing housing of other persons due to loss of housing, economic hardship or a similar reason (sometimes referred to as *doubled-up*); living in motels, hotels, trailer parks or camping grounds due to lack of alternative adequate accommodations; living in emergency or transitional shelters; abandoned in hospitals; or awaiting foster care placement (p. 2). This additionally includes children or youth who reside in locations that are not suitable for humans and those who live in places such as in cars, substandard housing, or places like bus or train stations, and migratory children who fall into any of the above descriptions (U.S. Department of Education, 2004).

Please read carefully and respond to the following items:

1. For the following items, please check the category that **best** applies to you:

Your current school setting (select one):	<input type="checkbox"/> Urban	<input type="checkbox"/> Rural	<input type="checkbox"/> Suburban
Your current school type (select one):	<input type="checkbox"/> Private	<input type="checkbox"/> Public	<input type="checkbox"/> Parochial
Your current school level (select one):	<input type="checkbox"/> Elementary	<input type="checkbox"/> Middle	<input type="checkbox"/> High

2. Please fill in the blank: How many years have you been a school counselor? _____
3. Estimate the number of homeless students in your school. Please check the range that best fits (if you are not sure, take your best guess!):

<input type="checkbox"/> 0	<input type="checkbox"/> 11–15	<input type="checkbox"/> 36–45
<input type="checkbox"/> 1–5	<input type="checkbox"/> 16–25	<input type="checkbox"/> 46–55
<input type="checkbox"/> 6–10	<input type="checkbox"/> 26–35	<input type="checkbox"/> 55+

Training

1. Have you received training to work with homeless students (no training, some training, or extensive training)? Rate this item on a scale from 1–5, 1 being no training, 5 being extensive training:

No training 1-----2-----3-----4-----5 Extensive training

2. If you marked a 2, 3, 4 or 5, please answer the following question (if not, move onto the next section): Where did you receive training? Check all that apply.

☐ Graduate school
☐ In-service training while at my school
☐ Required professional development outside of school
☐ Voluntary professional development outside of school
☐ Other: _____

Knowledge

1. For the following items, please rate your knowledge on a scale from 1–5, 1 meaning that you have no knowledge and 5 meaning that you have extensive knowledge

No knowledge 1-----2-----3-----4-----5 Extensive knowledge

- ☐ The McKinney-Vento Act
- ☐ The registration policies for homeless students entering your school
- ☐ The role(s) of the local homeless liaison for your school
- ☐ The role of the State Coordinator for homeless services
- ☐ The transportation requirements for homeless students under the McKinney-Vento Act
- ☐ The emotional and personal/social issues (e.g., feelings of isolation, difficulty making friends, embarrassment) faced by homeless students in schools
- ☐ The educational issues that homeless students face in school (i.e., the academic issues)

2. Do you know the location of homeless shelters near the school where you work? Please check the category that **best** applies to you.

- ☐ I know none of them.
- ☐ I know some of them.
- ☐ I know all of them.
- ☐ There are no shelters near my school.

3. Can you identify the students who are homeless on your caseload? Please check the category that **best** applies to you.

- ☐ I can identify none of them.
- ☐ I can identify some of them.
- ☐ I can identify all of them.
- ☐ There are no homeless students on my caseload.

4. Do you know where homeless students in your school reside? Please check the category that **best** applies to you.

- ☐ I know where none of them reside.
- ☐ I know where some of them reside.
- ☐ I know where all of them reside.
- ☐ There are no homeless students in my school.

Interventions

1. What types of programs/interventions do you provide to homeless students and parents? Check all that apply.

- | | |
|---|---|
| <input type="checkbox"/> I have not provided any services or interventions. | <input type="checkbox"/> Tutoring |
| <input type="checkbox"/> Parent consultation | <input type="checkbox"/> Referrals to community resources |
| <input type="checkbox"/> Parent education workshops | <input type="checkbox"/> Provided workshops/training for teachers |
| <input type="checkbox"/> Teacher consultation | <input type="checkbox"/> Classroom guidance |
| <input type="checkbox"/> Community partnerships | <input type="checkbox"/> Career exploration |
| <input type="checkbox"/> Mentoring program | <input type="checkbox"/> Behavioral skills training |
| <input type="checkbox"/> Academic support | <input type="checkbox"/> IEP planning |
| <input type="checkbox"/> Small group counseling | <input type="checkbox"/> 504 planning |
| <input type="checkbox"/> Individual counseling | <input type="checkbox"/> Advocating for homeless students |
| <input type="checkbox"/> Communication with shelter staff | <input type="checkbox"/> Postsecondary planning |
| <input type="checkbox"/> Shelter visits | <input type="checkbox"/> College planning |
| <input type="checkbox"/> Home visits | <input type="checkbox"/> Other (please specify): _____ |
| <input type="checkbox"/> After-school programs | |

2. Is there anything else you would like to add about your interventions with homeless students? Please write below.

Knowledge and Experience

1. List the FIVE most important academic/educational, personal/social and career/college planning needs of homeless students. If you are unable to list 5, list as many as you can.

- a. _____
- b. _____
- c. _____
- d. _____
- e. _____

2. Please answer the following items on a scale from 1–5, 1 meaning not at all and 5 meaning always.

Not at all 1-----2-----3-----4-----5 Always

- ___ I ensure that homeless students with whom I work have equal opportunities compared to their non-homeless peers.
- ___ I assist with registration of homeless students.
- ___ I assess the emotional needs of homeless students.
- ___ I visit the shelter(s) where homeless students in my school live.
- ___ I ensure that homeless students have transportation to attend before- or after-school programs.
- ___ I have contact with my school's homeless liaison.
- ___ I make contact with homeless families.
- ___ I provide mentorship programs for homeless students at my school.
- ___ I review the McKinney-Vento Act policies to ensure homeless students' needs are being met.

The School Counselor and Special Education: Aligning Training With Practice



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The intent of this article is to discuss the importance of training school counselors in providing adequate services to students with special needs, as mandated by special education law and supported by school counseling standards created by the American School Counselor Association (ASCA). In addition, the lack of adequate and unified training for school counselors in this area will be explored. This article suggests implementing a more consistent school counselor education program across institutions that would include coursework and experiences in special education that are in alignment with the standards of ASCA, legal obligations, and daily counselor roles. Examples of ways to incorporate such experiences and assignments into courses across counselor training programs are provided.

Keywords: counselor education, school counselor, special education, counselor training, American School Counselor Association

The enactment of special education laws and mandates such as the Education for All Handicapped Children Act of 1975 (PL 94–142) and the Individuals with Disabilities Education Act (IDEA), which require schools to provide free appropriate public education to all students within the regular education setting, have immensely impacted the school counseling profession (Bowen & Glenn, 1998; Dunn & Baker, 2002; Milsom, 2002; Owens, Thomas, & Strong, 2011). The number of students identified as appropriate to receive special education services is growing (Dunn & Baker, 2002; McEachern, 2003; Owens et al., 2011). Therefore, school counselors are now required to provide equal services to more students with special needs within the regular education setting. Similarly, school counselors are required to take a more active role in the Individual Education Program (IEP) process, from identification to implementation, than what was previously expected in the past (Dunn & Baker, 2002; Milsom, Goodnough, & Akos, 2007; Owens et al., 2011). School counselors' involvement in special education is not only required by specific legislation, but also poses ethical considerations regarding to direct and indirect services for students with special needs. In response to legislation, the American School Counselor Association (ASCA) has advocated for school counselor involvement in special education and published guidelines for servicing students with special needs (Isaacs, Greene & Valesky, 1998; Myers, 2005; Studer & Quigney, 2005).

Despite a study conducted by Studer and Quigney (2003) which showed that school counselors are becoming more involved with special education by serving on teams that assist with disability identification and implementation of services, counselor education programs are not adequately training future school counselors to deal with changing roles and responsibilities included in servicing students with special needs (McEachern, 2003; Milsom & Akos, 2003; Romano, Paradise, & Green, 2009; Studer & Quigney, 2005). Additionally, there is a dearth of recent research in the literature addressing concerns that special education is not being adequately addressed in school counselor preparation programs. Although there is an increasing trend in school counselor training programs to include some instruction about special education (Studer & Quigney, 2005), no specific suggestions for implementing such content into the curriculum have been published to date. In response, this

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article provides ideas and recommendations for infusing special education content throughout the school counseling curriculum required by the Council for Accreditation of Counseling and Related Educational Programs (CACREP). Counselor education programs must recognize the importance of the school counselor in the lives of students with disabilities, and adequate training should become a priority.

Students with Special Needs, the School Counselor and the Law

Since the enactment of special education laws and mandates such as the Education for All Handicapped Children Act of 1975 (PL 94-142) and IDEA, the role of the school counselor has continued to evolve (Bowen & Glenn, 1998; Dunn & Baker, 2002; Milsom, 2002; Owens et al., 2011). The aforementioned laws require school counselors to provide services to students with disabilities and their parents, thus increasing the need for school counselor involvement with students who have been labeled as having special needs (Dunn & Baker, 2002; Owens et al., 2011). Findings by Studer and Quigney (2003) indicated that legal and ethical issues, participation in multidisciplinary pre-referral teams, and IEP development and review were among the top 10 activities involving school counselors. With the passage of IDEA, schools are now required to include students with disabilities within the school in the least restrictive environment through mainstreaming and inclusion. A greater population of students with disabilities within the regular education setting increases the likelihood of school counselor contact. An additional aspect of IDEA is that it requires transition planning for students in secondary schools. Therefore, it is logical for special educators to collaborate with school counselors when making such plans, as school counselors are trained in career and lifespan development (Milsom et al., 2007).

Students identified as needing special education services are estimated to account for 10–18% of the school population and are expected to increase (Dunn & Baker, 2002; McEachern, 2003). Schools are required to write IEPs for these students and implement appropriate supports and accommodations outlined in IEPs. School counselors are increasingly taking a greater role in the process of identifying students and developing IEPs, as well as implementing aspects of IEPs (Milsom et al., 2007; Owens et al., 2011). School counselors bring invaluable skills and knowledge such as understanding of group dynamics, facilitation of communication, awareness of community resources, and collaboration to IEP and pre-referral multidisciplinary teams (Milsom et al., 2007). School personnel roles and responsibilities within the team should be shared, in that the special educator should be viewed as the expert in content, while the school counselor should be viewed as the expert in process and transition services. School counselors also are equipped to make connections between student personal and social factors in relation to academic performance, which may come up in IEP meetings. Additionally, school counselors are viewed as leaders in the school and act as advocates for students, both directly and indirectly, and are therefore a notable asset to students and multidisciplinary teams (Owens et al., 2011).

In addition to legal responsibilities, school counselors also have a professional and ethical obligation to provide adequate direct and indirect services to students with special needs. Dunn and Baker (2002) stated that as members of multidisciplinary teams, school counselors are called upon to “engage in advocacy, consultation, diagnosis, assessment, development of delivery system, and provision of support services for students, parents and teachers” (p. 227). Therefore, it is clear that advocating and supporting students of all abilities in personal, social, academic and career domains are requirements for professional school counselors. Similarly, ASCA also supports professional and ethical guidelines concerning students with special needs.

ASCA Guidelines for Servicing Students with Special Needs

ASCA has delineated specific roles and responsibilities of school counselors regarding involvement with students identified as having special needs (Isaacs et al., 1998; Myers, 2005; Studer & Quigney, 2005). Roles

may include many tasks, from serving on multidisciplinary teams to providing direct counseling services to students. School counselors are required to participate in the identification of students with disabilities by serving on screening teams and assisting in evaluation where appropriate. By serving as a member of the multidisciplinary team, the school counselor is able to provide input on planning and placement for identified students. For example, school counselors may assist with the preparation of IEPs by discussing student levels of functioning in academic, personal or social domains. The school counselor also may provide services such as consulting with outside agencies to coordinate supportive services for families and students. Additionally, for students identified within the school, school counselors may provide direct services such as individual and group counseling. These services must be consistent with services provided for all students, regardless of ability. Indirect services include consulting with personnel about identified students' educational and affective needs as well as developing and implementing professional trainings for staff working with exceptional students. Moreover, ASCA encourages school counselors to advocate for students with special needs in the school and community.

Changing school counselor roles and responsibilities are evident in the literature. Studer and Quigney (2003) examined professional school counselors' time regarding students with special needs. Among the top five activities performed were the following: (a) providing individual counseling, (b) meeting with administrators or supervisors about students with special needs, (c) utilizing problem-solving and conflict resolution techniques regarding students with special needs, (d) scheduling classes, programs and services, and (e) providing career counseling and education. The role of advocate is infused into many of these activities, which is viewed by both professionals in the field and ASCA as an essential function of school counselors (Milsom, 2006; Myers, 2005; Owens et al., 2011).

School counselors are in a position to advocate for students with special needs in a variety of ways, both directly and indirectly. Through active involvement in the appropriateness of educational planning during the IEP process, school counselors give these students a voice and work to facilitate an understanding of students with special needs among school personnel. Raising awareness and understanding about disabilities among professionals in the school as well as among parents and students is another imperative role, since students with special needs are often stigmatized, which can create negative experiences and barriers for them (Milsom, 2006; Scarborough & Deck, 1998). Through activities such as assessment of systems, programs, policies and attitudes, school counselors can better support students with special needs academically, personally and socially by working to shift negative school climates and perceptions (Bowen & Glenn, 1998; Milsom, 2006; Quigney & Studer, 1998; Scarborough & Deck, 1998). Implementation of programs for both school personnel and students aimed at examining self-awareness of bias, increasing sensitivity towards differences, accepting others, and positively supporting students with special needs can assist in adjusting attitudes as well as school climates (Milsom, 2006; Quigney & Studer, 1998; Scarborough & Deck, 1998).

Additionally, school counselors can directly support and advocate for students with special needs through providing individual and group counseling, as well as classroom-based lessons and interventions. Such initiatives should focus on the areas of development in tolerance and respect, empathy, self-esteem, anger management, diversity, cooperation, as well as other anti-bullying and character education themes such as citizenship, fairness and caring (Milsom, 2006; Milsom et al., 2007; Myers, 2005). School counselors also should begin to help students with special needs develop skills that encourage them to eventually become self-advocates (Owens et al., 2011). Progress monitoring, as outlined in the ASCA Model's management and accountability sections, should entail collecting and measuring data for the interventions previously mentioned in order to assess areas of effectiveness, need and improvement (Myers, 2005). Along with these emerging roles and shifts in school counselor responsibilities, there is added responsibility for counselor educators and counselor education programs to adjust accordingly.

School Counselor Education Programs and Students with Special Needs

Although involvement of school counselors in the special education process and interactions with students who have special needs is increasing, there are findings suggesting that counselor education programs are not adequately training future school counselors to deal with these changes (McEachern, 2003; Milsom & Akos, 2003; Nichter & Edmonson, 2005; Romano et al., 2009; Studer & Quigney, 2005). McEachern (2003) found that less than 40% of school counselor preparation programs required students to take coursework that included special education topics and subjects related to students with special needs. In other studies, results indicated that school counseling programs are inconsistent regarding coursework pertaining to special education and that more programs are infusing such content into already required classes instead of creating additional required special education classes (Milsom, 2002; Milsom & Akos, 2003; Studer & Quigney, 2005). However, the types of content, how it is infused, and to what extent have not been revealed or regulated. Despite the increase in coursework pertaining to special education from 28% to 40% and the infusion of special education content into coursework, training programs for school counselors continue to fail to address the needs of today's students (Korinek & Prillaman, 1992; Nichter & Edmonson, 2005; Studer & Quigney, 2005).

Coursework and experiences related to working with students with disabilities have been shown to correlate with school counselors' perceptions of their readiness to work with this population (Isaacs et al., 1998; Milsom, 2002; Milsom & Akos, 2003; Nichter & Edmonson, 2005). Several studies have indicated that school counseling programs are not thorough enough in providing training regarding special education issues and students with special needs (Dunn & Baker, 2002; Milsom, 2002; Nichter & Edmonson, 2005; Studer & Quigney, 2005). School counselors have indicated a desire for more training in supporting students with disabilities from programs before graduation. A study conducted by Studer and Quigney (2005) revealed that only 5.9% of ASCA members surveyed had completed one or more courses about special education in their graduate programs and that 59% had never completed a course or taken a workshop about special education. Participants indicated that they did not feel prepared to support students with special needs. Areas that were viewed as receiving little attention in training included the following: (a) participation in development and review of IEPs, (b) collaboration with special education and general education teachers, and (c) consultation with outside agencies or professionals. These areas are all integral in educational programming and the success of students with special needs, and therefore should be addressed in school counselor preparation programs. A study conducted by Nichter and Edmonson (2005) produced similar results, indicating that 89% of counselors surveyed in Texas felt that more training in special education would help them feel more competent and prepared to work with this population. Topics reported as potentially helpful in additional training included the following: (a) special education law and legal issues, (b) disability characteristics, (c) techniques for working with students in special education, and (d) information about medication and side effects. Additionally, 82% of participants indicated that counselor education programs should require special education instruction. Counselor preparation programs appear to have similar concerns. Over 60% of counselor education programs, when surveyed by Korinek and Prillaman (1992), indicated needing adjustment in school counselor training requirements for their programs in order to increase student capability in working with special education requirements. Similarly, McEachern (2003) surveyed counselor educators at various universities and colleges across the country and 55% stated that their coursework needed improvements regarding providing special education curricula.

Several recommendations have been made to address the lack of special education coursework for school counselors. Studer and Quigney (2005) suggested that it may be advantageous for school counselors to enroll in a class designed for special education teachers in which essential information is taught about this population and the areas discussed above. Additionally, enrollment in a course with pre-service special education teachers

would provide school counselors the opportunity to practice collaborating with teachers. Recommendations also have been made for school counseling programs to increase coursework covering the ASCA Model and strategies related to students with special needs (Isaacs et al., 1998; Milsom & Akos, 2003; Studer & Quigney, 2005). Similarly, it is recommended that school counselor preparation programs require experiences with exceptional students to increase competency and positive attitudes (Milsom & Akos, 2003; Studer & Quigney, 2005).

Recommendations: Infusing Special Education into the School Counseling Curriculum

Students being trained in counseling programs to become school counselors can build their knowledge and experience related to special education throughout their counselor education coursework. An integrative approach may be provided in which material about special education is infused into required studies (Studer & Quigney, 2005). However, coursework must be organized and comprehensive across all courses in the program, including core courses and those specifically designed for school counseling students. Courses that lend themselves to infusion of special education activities and assignments include the following: learning and development, career, group, ethics, theories, multiculturalism, techniques, assessment, practicum and internship, as well as courses specifically designed for school counselors like introduction to school counseling or a leadership and advocacy course. Infusing activities will be discussed in depth below, and requires creativity and flexibility on the part of counselor educators in the field. Assignments and teaching styles may need to be adjusted to incorporate special education material into the standard counseling curriculum. It should be noted that when training school counselors in special education concerns, a combination of requiring specific disability coursework in conjunction with infusing such information into existing coursework is more effective (Milsom & Akos, 2003). Designing such a course is beyond the scope of this article; therefore, suggestions for infusing special education material into existing courses required by CACREP will be discussed.

Course Assignments Related to Special Education

Counselor educators can adjust class requirements for assignments to include aspects of special education. For example, students could compare and contrast typical child development and its implications regarding specific disability categories for children. School counseling students also could locate a specific student with special needs and formulate a case study about that child in which various aspects of developmental and learning theory would be identified. Assignments for a career course could require students to identify considerations for children with special needs when applying career theories and engaging in career planning (e.g., closely analyzing strengths and needs to align with viable career options when applying Holland's approach). Students would then design a career exploration activity with these considerations for a student with special needs in mind. When completing an assignment such as group counseling planning, students could design a group for children with special needs. The group would address specific issues that these children face and for which they may need support (e.g., self-esteem), and include appropriate activities that would be accessible for the children involved (e.g., for activities that require reading or writing, replace the language with pictures, or create activities based on reading ability). Additionally, school counseling students could design a group and discuss how they would make accommodations for students with special needs in a group consisting of regular and special education students (e.g., pairing students for activities or reading content aloud to the group). Likewise, when completing an assignment for a school counselor course, such as developing a classroom guidance lesson, school counseling students could learn about accommodations similar to those discussed above that would ensure that all students could fully participate to their ability level.

Laws and ethical issues surrounding special education can be addressed in a professional issues class, ethics course or course specific to school counselors through the discussion of case studies and scenarios. The cases used should depict various school counseling ethical and legal dilemmas involving students with special needs

(e.g., teacher is not following accommodations outlined in the IEP). Students would then apply ASCA special education guidelines and special education laws to issues presented, in order to illustrate how those involved are or are not acting in accordance with established professional mandates and what action should be taken. Additionally, students would then describe what the person in the scenario could have done differently and how the school counselor should intervene. In a theories class, school counseling students could critique the effectiveness of various theories for students who are identified as having special needs, through applying theoretical concepts, reviewing research, and considering qualities associated with different disability diagnoses that could impact treatment. A case study could also be developed, to which school counseling students would apply various theories to address issues faced by students with special needs (e.g., anxiety, depression). Similarly, in a techniques class, school counseling students could identify techniques that they found to be the most effective with special-needs students and practice applying them in class role-plays. Linking strategies to specific theories and disabilities may help school counselors feel more prepared and confident (Myers, 2005). Moreover, to increase competence and confidence, school counseling students should be exposed to assessments routinely used in the school setting with students identified as having special needs. During an assessment course students could practice utilizing and interpreting tools such as the Child Behavior Checklist (CBC), Behavior Assessment System for Children (BASC) and Connors Rating Scale through role-plays in pairs or small groups. School counseling students enrolled in the assessment course also could be required to look at mock IEPs and evaluation reports and discuss how accommodations and findings outlined in the documents would impact their services with the students.

The assignments described in this section can be used as in-class activities or outside assignments and also may utilize technology (e.g., slide shows, discussion boards). Requiring assignments such as those discussed above provides a foundation for infusing more experiential activities into other courses as well.

Exposure Activities to Enhance Student Learning About Special Education

Direct experiences with students who have special needs have been recommended in past research and is thought to increase school counselor competence, understanding and positive attitudes in working with this population (Bowen & Glenn, 1998; Isaacs et al., 1998; Milsom & Akos, 2003). Various interactive experiences with students with disabilities could be a required part of many courses throughout the school counseling program. Students could participate in interactive experiences both in schools and in community settings.

For example, students could be assigned to participate in an immersion experience for a multicultural class that would require students to spend an established amount of time with children who have been identified as having special needs (in schools or advocacy group settings). Students would then be required to reflect upon their experience, examine their own biases and stereotypes, and consider how their interactions had impacted their multicultural development. This assignment could be done through journaling (written or video), arts projects (e.g., collages, drawings, poems) or through a research paper tied to counselor professional development. Additionally, students could interview parents of these children or older children with special needs to gain insight into the barriers and discrimination that these individuals face because of their disabilities. School counseling students could volunteer at a local community agency such as a center for individuals who are deaf, blind, or developmentally disabled that offers services for teens with disabilities. Students would then use the information from their visit to outline and develop a specific program they could implement in the school to better support special-needs students and their families (e.g. partner with the special education teacher and provide a parent support night in which parents are able to discuss issues they are facing or provide representatives from various community agencies that support different needs for people with disabilities). Students also could visit a college campus center for student disability services and support. During the visit they could interview a staff member as well as a student seeking services in order to help develop a perspective on how to better serve individuals with special needs during high school and transition planning.

The experiences outlined above might help school counseling students become more sensitive to the needs and issues faced by individuals with special needs and might reinforce the need for advocacy in school counseling. Advocacy for students with special needs could be explored by requiring counseling students to take part in activities run by community groups for special populations, or to design a workshop presentation for school staff that raises awareness about disabilities, discrimination and attitudes. School counseling students also could work with a school counselor to develop a disability awareness week for the school that included activities such as a pep rally, guest speakers and classroom guidance lessons. Additionally, students could observe a school counselor during the transition planning process, attend a transition meeting and develop a transition plan as part of career course requirements. During this process they would be required to reflect upon how the school counselor acted as an advocate for the student.

Specific school counseling coursework and practicum and internship experiences also provide many opportunities for infusing the activities described above as well as others that will be discussed. Students involved in courses specific to school counseling could be required to observe a school counselor for a day and interview him or her about daily requirements involving special education, experiences with special education and suggestions for working with this population. Students should be required to attend a multidisciplinary team meeting and discuss the IEP process with a special educator or job shadow various special educators who serve students with different disability levels and categories. Requiring school counseling students to gain experiences during their practicum and internship with special-needs students should be a priority in school counselor training. These experiences provide an opportunity for school counseling students to interact with children in special education, while supervision is provided to effectively address issues that may be faced by this population (Milsom & Akos, 2003). Students should be required to log an established number of direct and indirect hours in which they are involved in the special education services that have been discussed throughout this article. Completion of a log, along with journal entries in which students reflect upon their experiences, could be used as a portfolio assessment upon graduation. Similarly, this documentation might be used for gatekeeping purposes or to measure student development in competency with special education and as a future school counselor.

Conclusion and Recommendations

Lack of coursework and experiences in special education can result in school counselors' limited self-efficacy, feelings of frustration and anxiety, erosion in morale, and interference with other counseling duties (Romano et al., 2009). Therefore, in an effort to unify the field and produce more confident and competent school counselors, it is imperative that school counselor education programs collaboratively reexamine, regulate, and redefine program requirements. Today, school counselors not only need a solid knowledge base, but also need to be given opportunities to develop skills involved in collaboration, referral, advocacy, problem-solving, team-building, leadership and working directly with students who have been identified as having special needs (Bowen & Glenn, 1998; Dunn & Baker, 2002).

As suggested by Milsom and Akos (2003), providing a combination of practical experience with coursework related to special education appears to be the most effective way to prepare future school counselors. It is in the best interest of future school counselors, as well as the students they will serve, to offer support and supervision during such experiences as they complete their programs (Korinek & Prillaman, 1992). If the professionals in school counseling would like to grow and develop in a way that is consistent with the state of the educational system today and beyond, then it is clear that changes in training at the counselor education level must be made. Additionally, more research must be done to assess present trends in school counselor education programs and preparedness of practicing school counselors regarding special education. Research in this area would be useful in examining what improvements have been made, if any, and where adjustments need to be made in school

counseling coursework. This article sought to provide specific recommendations to support change by outlining ways that counselor educators can incorporate special education training throughout their curricula. Including special education in counselor education programs must become a priority that is consistent across training institutions. This shift in counseling program requirements not only works to ensure adequate training for future school counselors, but also to provide exceptional services and support that special-needs children need and deserve.

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Trauma and Treatment in Early Childhood: A Review of the Historical and Emerging Literature for Counselors



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Young children are especially susceptible to exposure to trauma. Rates of abuse and neglect among this population are staggering. This article presents a review of relevant literature, including research findings specific to early childhood vulnerability to trauma, symptoms associated with traumatic events, diagnostic validity of early childhood trauma, and treatments for young children. In the past, misconceptions about the mental health of young children have hindered accurate diagnosis and treatment of trauma-related mental illness. Due to the prevalence of trauma exposure in early childhood, counselors are encouraged to become familiar with ways that clients and families are impacted and methods for treatment. Implications for future research also are presented.

Keywords: early childhood, trauma, treatment, mental health, mental illness

Children from birth to age 5 are at a particularly high risk for exposure to potentially traumatic events due to their dependence on parents and caregivers (Lieberman & Van Horn, 2009; National Child Traumatic Stress Network, 2010). Traumatic events are incidents that involve the threat of bodily injury, death or harm to the physical integrity of self or others and often lead to feelings of terror or helplessness (National Library of Medicine, 2013). The American Psychological Association (APA) Presidential Task Force on Posttraumatic Stress Disorder (PTSD) and Trauma in Children and Adolescents (2008) indicated that traumatic events include suicides and other deaths or losses, domestic or sexual violence, community violence, medical trauma, vehicle accidents, war experiences, and natural and manmade disasters. With more than half of young children experiencing a severe stressor, they are especially susceptible to accidents, physical trauma, abuse and neglect, as well as exposure to domestic or community violence (National Child Traumatic Stress Network, 2010).

Over 20 years ago, Straus & Gelles (1990) estimated that three million couples per year engage in severe in-home violence toward each other in the presence of young children. The Administration on Children, Youth, and Families (2003) reported that in 2001, 85% of abuse fatalities occurred among children younger than 6 years of age, and half of all child victims of maltreatment are younger than 7. More recently, the Child Welfare Information Gateway (2014) indicated that 88% of child abuse and neglect fatalities occurred among children 7 years of age and younger. Often, there is an overlap between domestic violence and child physical and sexual abuse (Osofsky, 2003). In addition to domestic violence, young children also are vulnerable to community violence.

A study conducted by Shahinfar, Fox, and Leavitt (2000) suggested that the majority of young children enrolled in Head Start experienced violence in their communities. Young children also are exposed to traumatic

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stressors such as accidental burns or falls resulting in hospitalization or death (Grossman, 2000). It is common for children to experience more than one traumatic event (APA Presidential Task Force on PTSD and Trauma in Children and Adolescents, 2008).

Young children birth to age 5 are especially vulnerable to adverse effects of trauma due to rapid developmental growth, dependence on caregivers and limited coping skills. However, despite decades of statistical data, counselors generally have limited knowledge of the impact of traumatic events on younger children in comparison to older children and adolescents (De Young, Kenardy, & Cobham, 2011). Reasons for this disparity in knowledge include a historical resistance to the notion that early childhood mental health is important and concerns about diagnosing young children with mental disorders.

Research in early childhood mental health has developed rapidly over the past 20 years. Practitioners and researchers who work with this population continue to contribute to the understanding of trauma and early childhood mental health. However, the broader counselor population seems less informed which hinders referrals for this vulnerable population of young children. For example, a counselor may work with a victim of domestic violence who has young children. However, due to the counselor's limited knowledge of early childhood trauma and the impact of domestic violence, the counselor may not consider support services for the children. The present article examines the history and diagnostic validity of trauma-related mental illnesses in young children, the symptoms of trauma in early childhood, the longitudinal impact of early childhood trauma, the protective and risk factors associated with trauma in early childhood, and current and emerging treatments for this vulnerable population.

Mental Health, Trauma and Young Children: A Historical Perspective

Historically, researchers have spent little time and energy researching the effects of trauma exposure in early childhood. A widely held misconception has been that infants and young children lack the perception, cognition and social maturity to remember or understand traumatic events (Zeanah & Zeanah, 2009). Additionally, mental health counselors have been hesitant to diagnose trauma-related mental illness as a result of the associated stigmas that plague young children. In some cases when a child is diagnosed with mental illness, society focuses on the diagnosis and not the child.

Today it is widely accepted that children have the capacity to perceive and remember traumatic events. From birth, the tactile and auditory senses of a child are similar to those of an adult, which suggests that a child can experience stressful events (De Young et al., 2011). At 3 months of age, a child's visual sensory development increases exponentially. A study by Gaensbauer (2002) suggested that infants as young as 7 months of age can remember and reenact traumatic events for up to 7 years. By 18 months of age, children begin to develop autobiographical memory; however, it is unlikely that memories from before that age can be recalled verbally (Howe, Toth, & Cicchetti, 2006). Researchers have demonstrated that infants and young children have the perceptual ability and memory to be impacted by traumatic events (De Young et al., 2011; Howe et al., 2006).

While research findings have confirmed that traumatic events can impact children, clinicians without proper training in early childhood mental health may have difficulty diagnosing trauma-related mental illness in childhood. Children younger than 5 years of age typically experience rapid developmental changes that often are misinterpreted or not fully accounted for which hinders proper diagnosis and intervention (Zero to Three, 2005). Given time and insurance reimbursement constraints, there can be difficulties observing children's behaviors across settings (Carter, Briggs-Gowan, & Davis, 2004). Although verbal skills develop rapidly in early childhood, children may lack the communication skills necessary to accurately express their thoughts,

emotions and experiences (Cohen, 2010). When conducting assessments, mental health professionals rely on parental feedback, inventories and reports from multiple sources, thus increasing the accuracy of the assessment (Carter, Briggs-Gowan, Jones, & Little, 2003).

There is a lack of psychometrically sound diagnostic tools for directly assessing trauma symptoms in children (Strand, Pasquale, & Sarmiento, 2011). Those tools currently available do not appropriately consider the developmental levels of young children (Carter et al., 2004; Egger & Angold, 2006; Strand et al., 2011). However, there are well-designed instruments for early childhood that utilize indirect assessments such as clinician observations and parent/teacher reports (Yates et al., 2008).

Diagnostic tools and assessments developed for children over age 5 are not suitable for assessing young children. For example, young children may not fully understand the directions or the vocabulary used in certain assessment tools. Furthermore, the diagnostic criteria for specific mental health issues (e.g., PTSD) are not developmentally appropriate for children younger than 5 (Scheeringa & Haslett, 2010). The APA Presidential Task Force on PTSD and Trauma in Children and Adolescents (2008) argues that children are not being appropriately identified or diagnosed as having trauma histories and do not receive adequate help.

From a historical perspective, mental health counselors as well as society as a whole have hesitated to acknowledge the plight that young children face in terms of trauma exposure. Several historical factors have contributed to counselors' general lack of knowledge and expertise regarding this population. However, recent advances in research and in the counseling profession, such as the new American Counseling Association division, the Association for Child and Adolescent Counseling, have begun to broaden counselor knowledge in this area.

Symptoms of Trauma in Early Childhood

Trauma reactions can manifest in many different ways in young children with variance from child to child. Furthermore, children often reexperience traumas. Triggers may remind children of the traumatic event and a preoccupation may develop (Lieberman & Knorr, 2007). For example, a child may continuously reenact themes from a traumatic event through play. Nightmares, flashbacks and dissociative episodes also are symptoms of trauma in young children (De Young et al., 2011; Scheeringa, Zeanah, Myers, & Putnam, 2003).

Furthermore, young children exposed to traumatic events may avoid conversations, people, objects, places or situations that remind them of the trauma (Coates & Gaensbauer, 2009). They frequently have diminished interest in play or other activities, essentially withdrawing from relationships. Other common symptoms include hyperarousal (e.g., temper tantrums), increased irritability, disturbed sleep, a constant state of alertness, difficulty concentrating, exaggerated startle responses, increased physical aggression and increased activity levels (De Young et al., 2011).

Traumatized young children may exhibit changes in eating and sleeping patterns, become easily frustrated, experience increased separation anxiety, or develop enuresis or encopresis, thus losing acquired developmental skills (Zindler, Hogan, & Graham, 2010). There is evidence that traumas can prevent children from reaching developmental milestones and lead to poor academic performance (Lieberman & Knorr, 2007). If sexual trauma is experienced, a child may exhibit sexualized behaviors inappropriate for his or her age (Goodman, Miller, & West-Olatunji, 2012; Pynoos et al., 2009; Scheeringa et al., 2003; Zero to Three, 2005).

The symptoms that young children experience as a result of exposure to a traumatic event are common to many other childhood issues. Many symptoms of trauma exposure can be attributed to depression, separation

anxiety, attention-deficit/hyperactivity disorder, oppositional defiant disorder or other developmental crises (see American Psychiatric Association, 2013). It is important for counselors to consider trauma as a potential cause of symptomology among young children.

Long-Term Consequences of Early Childhood Trauma

Recently, researchers have focused on how trauma during early childhood impacts mental and physical health later in life. Symptoms of mental illness can manifest immediately after a trauma, but in some cases symptoms do not emerge until years later. PTSD, anxiety disorders, behavior disorders and substance abuse have all been linked to traumatic events experienced during early childhood (Kanel, 2015). The types and frequencies of traumatic events and whether they were directly or indirectly experienced also can have various effects on physical and mental health later in adulthood. In a review of literature, Read, Fosse, Moskowitz and Perry (2014) described support for the traumagenic neurodevelopmental model. This model proposes that brain functioning changes following exposure to trauma during childhood. These biological factors often lead to psychological issues and physical and mental health concerns in adulthood.

Mental health professionals are often challenged to accurately diagnose PTSD in early childhood, leading to inconclusive reports of the actual prevalence of post-traumatic stress (De Young et al., 2011). Still, there is a clear relationship between PTSD diagnoses and trauma experienced in childhood. For example, higher rates of PTSD are reported among children residing in urban populations where neighborhood violence is prevalent (Crusto et al., 2010; Goodman et al., 2012). Briggs-Gowan et al. (2010) found an association between family and neighborhood violence exposure and oppositional defiant disorder, attention-deficit/hyperactivity disorder, conduct disorder and substance abuse. Additionally, noninterpersonal traumatic events (e.g., car accidents, burns, animal attacks) are associated with PTSD as well as anxiety, phobias, seasonal affective disorder and major depressive disorder (Briggs-Gowan et al., 2010).

Violence exposure is associated with externalizing problems while nonpersonal traumatic events are associated with internalizing problems (Briggs-Gowan et al., 2010). In a more recent study, Briggs-Gowan, Carter, & Ford (2011) found that exposure to neighborhood and family violence in early childhood is associated with poor emotional health and poor performance in school. Low socioeconomic status and traumatic events in early childhood also are correlated with low academic achievement in school (Goodman et al., 2012). Similarly, De Bellis, Woolley, and Hooper (2013) found maltreated children demonstrated poorer neuropsychological functioning and aggregate trauma was negatively related to academic achievement.

According to Schore (2001a), children and adults who experienced relational trauma during infancy are often faced with the struggles of mental disorder due to right brain impairment (p. 239). More recently, Teicher, Anderson, and Polcari (2012) found exposure to maltreatment and other types of stress as a child impacts hippocampal neurons leading to alterations in the brain and potential developmental delays. Additionally, there is evidence of relationships between mistreatment, bullying and accidents in early childhood and the development of delusional symptoms in later childhood (Arseneault et al., 2011). Young children who experience trauma and later use cannabis in adolescence are also at a higher risk for experiencing psychotic symptoms (Harley et al., 2010). Other studies have shown a correlation between early childhood trauma and development of schizophrenia later in life (Bendall, Jackson, Hulbert, & McGorry, 2008; Morgan & Fisher, 2007; Read, van Os, Morrison, & Ross, 2005). Changes in the brain may mediate these relationships between trauma exposure and mental health, as suggested by Schore (2001a, 2001b) and others.

Infants exposed to trauma are often inhibited by emotional and behavioral dysregulation in childhood and as an adult (Ford et al., 2013; Schore, 2001a, 2001b). Dysregulation resulting from trauma is predictive and related

to substance use and functionality (Holtmann et al., 2011). For example, findings from a study by Strine et al. (2012) suggested that early childhood trauma and substance abuse are directly correlated. Children who had experienced more than one traumatic event were found to be 1.4 times more likely to become alcohol dependent. Strine et al. (2012) noted that females who experience trauma are more likely than males to abuse or become dependent on alcohol. The relationship between trauma and alcohol use and dependence often stems from untreated psychological distress (Strine et al., 2012).

In addition, there is ample evidence that early childhood trauma impacts later physical health. Some of the most well-known data on this topic come from the adverse childhood experiences study (Edwards et al., 2005). Multiple studies have found that early childhood trauma is associated with autoimmune disorders (Dube et al., 2009), headaches (Anda, Tietjen, Schulman, Felitti, & Croft, 2010), heart disease (Dong et al., 2004), lung cancer (Brown et al., 2010) and other illnesses. In fact, these studies often have found that the more frequent the exposure to early childhood trauma, the higher the risk of poor health outcomes in adulthood (Felitti et al., 1998).

Researchers have found clear evidence that children who experience traumatic events in early childhood are impacted well beyond their youth. Mental health disorders as well as alcohol and substance abuse emerge intermittently with age. Changes in brain functioning and physical health issues are also associated with early childhood trauma.

Risk and Protective Factors

Researchers have begun to explore factors that interact with trauma and the effects they may produce in young children. Environmental and demographic factors as well as parent–child relationships significantly impact outcomes for young children exposed to traumatic events (Briggs-Gowan et al., 2010). These factors may either insulate a child from adverse effects of trauma or increase the child’s risk for developing psychological distress.

Briggs-Gowan et al. (2010) found that symptoms of psychopathology and trauma were related to factors such as economic disadvantage and parent depressive and anxious symptoms. While ethnicity of the minor, parental education level and number of parents were associated with violence exposure, those factors were not associated with symptoms of mental illness. A more recent study found that young children exposed to a traumatic event along with a combination of socio-demographic factors (e.g., poverty, minority status, single parent, parental education less than high school, teenage parenting) are at greater risk for mental illness (Briggs-Gowan et al., 2011). Additionally, Crusto et al. (2010) found that high levels of parental stress are associated with adverse trauma reactions in young children. Parental dysfunction, family adversity, residential instability and problematic parenting can increase the impact of traumatic events as well (Turner et al., 2012). Young children exposed to chronic and pervasive trauma in addition to these risk factors are especially vulnerable to adverse effects (APA Presidential Task Force on PTSD and Trauma in Children and Adolescents, 2008).

There are factors that may help protect young children from the negative impact of exposure to trauma. Turner et al. (2012) found that nurturing familial relationships can insulate children from psychological distress associated with traumatic events. Other factors such as safety and stability also might serve as protective factors. Safety implies that the child is free from harm or fear of harm, both physically and socially. Stability indicates consistency in the family environment, while nurturing suggests availability, sensitivity and warmth of caregivers or parents. Well-established, secure parent–child relationships are likely to provide protection from negative effects of trauma experienced by young children. A secure parental attachment has been shown to help children effectively regulate emotional arousal (Aspelmeier, Elliot, & Smith, 2007). Emotional regulation may

be a mechanism that protects young children from extreme trauma reactions (De Young et al., 2011). Similarly, Crusto et al. (2010) found that caregiver support and healthy family functioning reduce the risk of psychological distress in young children after a traumatic event.

Treatment

Early intervention and treatment can minimize the social and emotional impact of a child's exposure to a traumatic event. Professional counselors should consider making referrals to counselors trained in providing early childhood mental health support. If the professional counselor has difficulties finding a referral source, the counselor's basic counseling skills can provide the foundation for a safe, secure and trusting relationship between the counselor, family and child. Demonstrating empathy, genuine care and acceptance also fosters rapport among stakeholders (Corey, 2009). Mental health counselors can emphasize strengths and resources for the child and family.

Incorporating existing coping strategies can serve to minimize family stress and foster rapport with the child. Providing information about community support groups or other mental health agencies and resources also can help support and encourage the family. Informing parents and caregivers about symptoms common to young children exposed to traumatic events can foster awareness and allow for adequate support during the treatment process. Counselors can help the family establish or reestablish routines that begin to restore stability for the child, minimizing the adverse effects of the trauma (APA Presidential Task Force on PTSD and Trauma in Children and Adolescents, 2008; Clay, 2010).

There are several evidence-based methods available to counselors treating trauma symptoms in young children. Evidence-based approaches are rooted in theory, evaluated for scientific rigor and tend to yield positive results (National Registry of Evidence-Based Programs and Practices, 2012). Trauma-focused cognitive behavioral therapy (TF-CBT) is a popular evidence-based treatment used with children aged 3–18. Based on cognitive behavioral therapy, humanism and family systems theory, TF-CBT includes many therapeutic elements for children and caretakers (Child Welfare Information Gateway, 2012). This form of therapy helps children develop different perceptions and a more adaptive understanding of the traumatic event (APA Presidential Task Force on PTSD and Trauma in Children and Adolescents, 2008). Caretakers learn parenting and communication skills as they play active roles throughout the TF-CBT process. Multiple studies demonstrate the effectiveness of TF-CBT in reducing symptoms of trauma in early childhood (see Cohen & Mannarino, 1996, 1997; Deblinger, Stauffer, & Steer, 2001).

While TF-CBT is an established treatment for children and adolescents, there are evidence-based treatments developed specifically for treating trauma in children between birth and 6 years of age. Child–parent psychotherapy (CPP), one of the most widely used interventions for young children, was created to address exposure to domestic violence, although it can treat a variety of traumatic experiences (Lieberman & Van Horn, 2008). In this form of dyadic therapy, the child and the caregiver reestablish safety and security in the parent–child relationship (Lieberman & Van Horn, 2008). CPP is one of the few early childhood treatments validated for use with ethnic minorities (Lieberman & Van Horn, 2008). The primary goal of CPP is to equip parents to meet the psychological needs of their child and maintain a secure relationship after treatment has ended.

Attachment and biobehavioral catch-up (ABC) is another treatment option that is designed primarily for use with young children who have experienced neglect (Dozier, 2003). This approach was developed specifically for low-income families and later adapted for use with foster families. ABC is based on the neurobiology of stress and attachment theory. The goal of ABC is to foster the development of the child's optimal regulatory strategies by equipping parents with tools for effective response (Dozier, 2003; Dozier, Peloso, Lewis, Laurenceau, & Levine, 2008).

Counselors also can utilize parent–child interaction therapy (PCIT) when working with traumatized youth. PCIT is a structured technique for children ages 2–8 years in which the counselor teaches the parent or caregiver how to interact with the child and set effective limits (Chaffin et al., 2004). In this form of therapy, the counselor often assumes the role of coach, instructing the client on specific skills. Counselors frequently use PCIT when working with children abused by a caregiver. PCIT has been implemented successfully with various populations including Hispanic and Latino clients (Chaffin et al., 2004). The focus of PCIT is on improving the quality of the parent–child relationship as well as child behavior management (Chaffin et al., 2004; McCabe, Yeh, Garland, Lau, & Chavez, 2005).

The treatment interventions previously mentioned are geared toward very young children, all incorporating play as a treatment modality. Since young children do not have extensive vocabularies, they often communicate information about themselves, their trauma and relationships with their caregivers through play (Landreth, 2012). Play therapy intervention research using samples with children between birth and 5 years of age is scant; however, several case studies indicate that play therapy is effective with trauma in early childhood. For example Dugan, Snow, and Crowe (2010) utilized play with a 4 year old exhibiting PTSD symptomology after experiencing Hurricane Katrina in 2005. Anderson and Gedo (2013) provided a case study in which play was used to treat a 3 year old with aggressive behaviors who was separated from his primary caregiver. There also are intervention examples of using play therapy with young children exposed to domestic violence (Frick-Helms, 1997; Kot, Landreth, & Giordano, 1998).

Finally, there are emerging approaches specifically for treating young children exposed to trauma. Tortora (2010) developed Ways of Seeing, a program combining movement and dance therapy with Laban movement analysis to create a sense of regulation and homeostasis for the child exposed to a traumatic event. The Ways of Seeing program does not yet have empirical evidence of its effectiveness. However, it is rooted in attachment theory, multisensory processing, play and sensorimotor psychotherapy. Counselors can use this program to determine how a parent and child experience each other, implement creative interventions for healthy bonding, and renew a sense of efficacy for the parent and child. While much more research is needed, this program appears to be a promising approach to treating trauma in early childhood (see <http://www.suzitortora.org/waysofseeing.html>).

Another emerging treatment, known as Honoring Children, Mending the Circle (HC-MC), is based on TF-CBT. The HC-MC approach was developed to address the spiritual needs of young Native American and Alaska Native children exposed to trauma. This method emphasizes preestablished relationships, wellness and healing during the treatment process. Spirituality is a critical component of healing and is integrated throughout the HC-MC approach. The goal of HC-MC is to help the traumatized child attain and reestablish balance (BigFoot & Schmidt, 2007, 2010). Additional research is needed on the efficacy of the HC-MC approach in working with Native American and Alaska Native youth.

A third emerging treatment, Trauma Assessment Pathway, is an assessment-based treatment that focuses on providing triage to young children exposed to traumatic events (Conradi, Kletzka, & Oliver, 2010). In this approach, the counselor uses assessment domains to determine the focus of treatment, provides triage to identify an appropriate pathway for intervention and establishes referrals to community resources if needed (Chadwick Center for Children and Families, 2009). The trauma assessment pathway method, which includes the trauma wheel, is a versatile mode of treatment available for the child and family. However, in many instances counselors may determine that an evidence-based practice, such as CPP, is the most appropriate mode of treatment (see Chadwick Center for Children and Families, 2009).

Each method of treatment offers specific strategies for working with traumatized young children and their families. However, findings from most studies investigating the effectiveness of these treatments are inconclusive (Forman-Hoffman et al., 2013). The strength of evidence for these and many other interventions are relatively low while the magnitudes of treatment effects are small (see Fraser et al., 2013). Common to the treatment models presented is the emphasis on system support, the importance of relationships in the recovery process and developmentally appropriate intervention modalities. These factors likely will serve as integral components of future methods focused on the treatment of traumatized young children.

Discussion and Implications

Young children are at high risk for exposure to traumatic events and are particularly vulnerable for several reasons. They are dependent upon caregivers and lack adequate coping skills. Children also experience rapid development and growth, leaving them particularly impressionable when faced with a traumatic event. Young children benefit from preventive psychoeducation aimed at teaching parents and caregivers about child development and parenting skills (McNeil, Herschell, Gurwitch, & Clemens-Mowrer, 2005; Valentino, Comas, Nuttall, & Thomas, 2013). Counselors who work with this population endeavor to increase protective factors and decrease risk factors while exploring preventive methods, which may reduce young children's exposure to traumatic events. Similarly, legislators can influence public policy related to enhancing childhood mental health. For example, legislation can address prevention and offer incentives to parents participating in psychoeducation focused on enhancing protective factors and reducing childhood trauma exposure.

In recent years research has emerged that provides an understanding of how trauma impacts young children. Researchers and clinicians know that infants, toddlers and preschoolers have the capacity to perceive trauma and are capable of experiencing psychopathology following a traumatic event. Although these children can experience mental illnesses often associated with older children, adolescents and adults, the symptomology can manifest in various ways. Additionally, professional counselors working with children in a variety of settings should consider the residual impact of traumatic events experienced in early childhood. School-aged children may experience behavioral problems and have difficulty learning and forming relationships as a result of early childhood trauma (Cole, Eisner, Gregory, & Ristuccia, 2013; Cole et al., 2005). A number of studies indicate that trauma is a strong predictor of academic failure (Blodgett, 2012). Therefore, school counselors serving as mediators between academics and wellness should explore ways to advocate for and support students with known or suspected exposure to traumatic events in early childhood. For example, the trauma-sensitive schools initiative provides school counselors with a framework for fostering schoolwide awareness and creating a safe and supportive environment (Cole et al., 2013). School counselors can easily embed these types of preventive measures as part of a comprehensive school counseling program. These efforts will presumably result in increases in student success, wellness and awareness, three outcomes that will benefit all children exposed to traumatic events.

While great strides have been taken recently in understanding and treating early childhood trauma, there are clear gaps in the dissemination of information to counselors. Professional counselors should receive training in specifically designed interventions and attempt to raise public awareness of early childhood trauma in hopes that young children will receive necessary treatment. The findings of this literature review suggest that various methods of treatment might effectively reduce symptoms experienced by traumatized children. Parent-child relationships and other environmental factors also can have significant influence on children's reaction to trauma.

A major purpose of this article is to educate counselors about the impact of trauma in early childhood and advocate for appropriate assessment and treatment of these traumatic exposures. While not all counselors choose to work with this vulnerable population, they often work with clients who have extended families with young children. Counselors who work with adult clients can provide psychoeducation about this important issue and initiate referrals to counselors trained to work with early childhood trauma. There is a body of information about trauma in early childhood available for further review. Sources include the National Child Traumatic Stress Network (nctsn.org), the California Evidence-Based Clearinghouse for Child Welfare (cebc4cw.org), and the Association for Child and Adolescent Counseling (acachild.com). Counselors interested in learning more about this issue can review these online resources.

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All Foreign-Born Adoptees Are Not the Same: What Counselors and Parents Need to Know



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International adoption provides U.S. families with parenting opportunities as well as with challenges accompanying adoptees' post-adoption adjustment. The literature indicates differences in adjustment outcomes between Chinese and other international adoptees. Differences are found in behavioral adjustment, attachment formation and social-emotional development. Pre-adoption circumstances, including the political and cultural reasons for adoption, institutionalization experiences, and family stress, are relevant factors for adoptees' post-adoption adjustment. A closer look at Chinese adoptees offers insights on components that may prohibit or contribute to post-adoption adjustment outcomes. Each component provides implications for professional counselors and the adoptive families they serve for nurturing the growth of international adoptees.

Keywords: international adoption, international adoptees, Chinese adoptees, post-adoption adjustment, professional counselors, adoptive families

International adoption, involving transferring children from a country of origin to a host country, creates a unique set of circumstances where adoptive parents and adopted children meet across lines of differences in biology, race, cultural heritage, nationality, socioeconomic status and more (Bartholet, 2006). World circumstances of war, poverty and lack of social welfare have created multiple scenarios in which countries now provide U.S. couples with additional parenting opportunities, while increasing infertility rates and other difficulties have reduced U.S. domestic adoption opportunities. These increases in international adoptions have both global significance and local importance for related countries, societies and communities (Hoshman, Gere, & Wong, 2006). Many advantages and challenges accompany the adoption process that counselors increasingly need to face in their schools, communities and private practices.

International adoption provides many opportunities for the countries involved, for the individuals wanting to adopt and for the children needing adoption; however, the post-adoption process is accompanied by multiple challenges for adoptive parents, professional counselors and human service agencies. A meta-analysis by Juffer and van IJzendoorn (2005) showed that internationally adopted children exhibit more behavioral problems and receive more mental health services than non-adopted children. Higher rates of attachment and social-emotional problems also were found among internationally adopted children when compared to non-adopted and domestically adopted peers. As such, this group needs to be considered an at-risk population deserving of specific attention (Barcons et al., 2011; van den Dries, Juffer, IJzendoorn, & Bakermans-Kranenburg, 2010).

Professional counseling journals currently provide little help to their readers about international adoptees and the resources needed to work effectively with them. Journal articles from psychology, social work, children and youth services, adoption, and sociology (e.g., Bruder, Dunst, Mogro-Wilson, & Tan, 2010; Cohen & Farnia, 2011; Pugliese, Cohen, Farnia, & Lojkasek, 2010) provide more information on these issues, and their findings

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can be utilized to meet the needs of professional counselors. This article will utilize the findings from related disciplines to demonstrate how professional counselors can more effectively support children and parents among this population.

International adoptees from China have been shown to have better adjustment outcomes in comparison with international adoptees as a whole, making them an important subgroup to examine (Cohen & Farnia, 2011; Tan, Camras, Deng, Zhang, & Lu, 2012; Tan & Marfo, 2006). China also is the largest country of origin of children for international adoption, accounting for over one fourth of the 242,602 U.S. international adoptions between 1999 and 2012 (U.S. Department of State, 2012). The post-adoption adjustment of international adoptees from China and the wealth of literature regarding them provide important sources of information on what influences an international adoption. Consequently, this article gives significant focus to Chinese adoptees and, where possible, compares that information to studies of adoptees from other countries. This article transforms the information into practical implications for counselors and parents with international adoptees and those who are considering an international adoption.

A Closer Look at Chinese Adoptees

Chinese adoptees deserve particular research attention because they show more positive post-adoption outcomes in areas such as personal-social development, problem-solving skills, behavioral adjustment, child-parent attachment patterns and academic achievement (Cohen & Farnia, 2010; Tan, Marfo, & Dedrick, 2010; Welsh & Viana, 2012). Cohen and Farnia (2010, 2011) found a common trend in that Chinese adoptees display rapid growth in overall development within the first 6 months after adoption and increased attachment 2 years later. Their preschool years contain fewer behavioral problems compared even to U.S. preschool-age non-adopted girls from the normative sample (Tan et al., 2012). Behaviors exhibited by Chinese adoptees are comparable to those of U.S. non-adopted peers, which means Chinese adoptees demonstrate no more internalizing (directed toward oneself), externalizing (directed toward the environment) or total problem behaviors than all children in a similar age range (Tan et al., 2012). Internalizing problems, externalizing problems and overall behavior problems are the three subscales of the Child Behavior Checklist that Tan et al. (2012) used to measure preschool-age Chinese girls' behaviors.

A study from another Western culture compared the academic achievement of 77 Chinese adoptees with those of 77 Norwegian-born children of similar age and found no significant difference between the two samples (Dalen & Rygvold, 2006). These results differ from results of studies on international adoptees from other countries, in which these adoptees have been shown to exhibit lower academic performance than non-adoptees (e.g., Miller, Chan, Tirella, & Perrin, 2009; van IJzendoorn, Juffer, & Poelhuis, 2005). The combined results consistently indicated better post-adoption results for Chinese children. These results raise the following question: What is it about Chinese children and the process of their adoptions that might account for such differences?

Politics and Culture

More than 90% of Chinese adoptees are female infants, a fact influenced by China's political and cultural characteristics. Adoption from China to the United States was greatly affected by China's one-child policy, first implemented in 1979. The policy was designed to control population growth by only allowing one child per couple. This policy, along with China's cultural emphasis on sons over daughters, has caused the abandonment of many infant girls (Johnson, 2004). This abandonment practice is one way for a family to have a second child but still be a one-child family. Most of the abandonments happen in rural areas of China where households without a son are likely to experience discrimination for potentially losing their family name in following generations (Chen & Li, 2009). Family name has great cultural importance throughout China, but rural

populations are the most concerned about these issues, making female children most vulnerable and more likely to be put up for international adoption.

The one-child policy impacts more than the number and gender of adoptees. It is believed that this policy is an indirect factor in Chinese adoptees' better physical and experiential conditions when adopted (Kreider & Cohen, 2009). The one-child policy, along with the cultural preference for male infants, indicates that healthy parents abandon the majority of Chinese children put up for adoption for poverty-related, political or cultural reasons, and not for health or disability reasons, as is often the case in other countries. Adoptees from Eastern Europe and Russia, for example, consistently experience pre-adoption adversities such as poverty and birth mothers' alcohol and substance use during pregnancy (Kreider & Cohen, 2009; Welsh & Viana, 2012). The physical and emotional pre-adoption environments for non-Chinese children understandably make a significant difference for their potential to successfully develop as they meet the multiple demands of the adoption process.

Pre-Adoption Institutionalization Experience

Approximately 85% of international adoptees have some level of institutionalization experience in their birth countries (Gunnar, van Dulmen, & the International Adoption Project Team, 2007). Along with pre-adoption parental quality and biological factors, the institutionalization experiences were found to be a significant factor in predicting post-adoption behavioral problems (Hawk & McCall, 2010; van den Dries et al., 2010). The quality of institutional care received by adoptees varies from country to country. The psychological aspect of institutional care is better in China because of the family-like atmosphere within institutions (Neimetz, 2010; Shang, 2002). A case study by Neimetz (2010) found that the director, codirector and other caregivers were called father, mother and siblings, respectively. This family-style psychological emphasis demonstrates recognition of a quasi-family environment aimed at counterbalancing the effects of the large number of children in an institution, which does not seem to appear in many other countries.

Risk Factors for Adoptee Adjustment

Cognitive Development

The status of adoptees' cognitive development at the time of adoption has been noted as predictive of attachment outcome and social-emotional reactivity. Recent literature has indicated a positive relationship between international adoptees' post-adoption adjustment and their cognitive level when they arrived in the host country (Cohen & Farnia, 2010). Cohen and Farnia (2011) found that mental development index scores are significant predictors of Chinese adoptees' later social-emotional activities and attachment outcomes, which in turn affect cognitive development. After 6 months, adoptees with higher mental development index scores were associated with better social-emotional adjustment and faster rates of forming attachment relationships with their adoptive mothers. Cohen and Farnia (2010) speculated that a lack of cognitive resources is associated with adoptees' difficulty in post-adoption adjustment.

Behaviors at Time of Adoption

Positive relationships have been found between rejection behaviors at the time of adoption and both internalizing and externalizing behavioral problems of preschool-age and school-age Chinese adoptees (Tan & Marfo, 2006). Rejection behaviors are adoptees' resistant behaviors toward adoptive parents during the initial period after adoption (Tan & Marfo, 2006). Tan and Marfo (2006) found that the behaviors present at the time of adoption were better predictors of later adjustment outcomes than adoptees' age on arrival. Therefore, initial behaviors are more influential for adoption outcomes than the maturity that comes with age (Tan et al., 2010).

Family Stress

Tan et al. (2012) studied the post-adoption adjustment of 133 preschool-age Chinese adoptees and found that the level of stress in the adoptive family positively correlated with the child's presenting behavioral problems. The higher the level of stress that a family encounters, the more behavioral problems are identified in the child. Maternal depression prior to adoption, as well as high parental expectations of problems (i.e., expecting a high rate of occurrence of the child's behavioral problems), were significant predictors for post-adoption family stress (Viana & Welsh, 2010). Familial stress is a significant factor in child-parent relationships and a risk factor for overall child psychopathology (Deater-Deckard, 1998).

Parental Sensitivity and Authoritative Parenting

Parental sensitivity refers to parents' ability to sense various cues that an infant exhibits and to respond to those cues consistently (Karl, 1995). Sensitive parenting provided by adoptive parents is related to better developmental growth following adoption (Palacios & Brodzinsky, 2010). Parents who are consistently sensitive in caregiving develop more secure attachment with adoptees, and changing from insensitive to sensitive caregiving results in a transition from insecure to secure attachment (Beijersbergen, Juffer, Bakermans-Kranenburg, & van IJzendoorn, 2012).

Parental sensitivity in the literature refers generally to parents' responsiveness to infants, but the concept of parenting styles takes on greater significance when it concerns young children. Baumrind (1978) proposed three primary parenting approaches: authoritative parenting, authoritarian parenting and permissive parenting. Authoritative parenting was highlighted positively for its emphasis on parents' setting up reasonably high expectations while showing support for children's interests. Tan et al. (2012) studied the role of authoritative parenting in adoptive families with Chinese children and found that authoritative parenting was associated with fewer behavioral problems in Chinese adoptees in the study.

A closer look at Chinese adoptees' pre-adoption circumstances and post-adoption protective factors offers insights about the critical components that may prohibit or contribute to positive adjustment outcomes. Political and cultural influences, institutionalization experiences prior to adoption, adoptees' cognitive development level, and parents' sensitive care and authoritative parenting in post-adoption all appear to be important factors in post-adoption adjustment. Each component provides implications for professional counselors and the adoptive families they serve in facilitating adoptees' development.

Implications for Parents and Counselors

Post-adoption protective factors such as parental sensitivity and appropriate parenting approaches can mitigate adoptees' adverse experiences and promote resilience (Barcons et al., 2011; Scroggs & Heitfield, 2001; van den Dries et al., 2010). The impact of pre-adoption conditions diminishes as the influence of the adoptive family becomes more salient (Gagnon-Oosterwaal et al., 2012). Studies showing significantly better results for Chinese adoptees' adjustment provide insights related to key issues deserving attention from professional counselors and their parent clients. Examining pre-adoption conditions and experiences of international adoptees can be a challenging issue due to the distance from countries of origin and confidential nature of the information.

Awareness of Gender Differences and Health Status

The availability of more female than male infants for adoption, created by China's one-child policy and cultural emphasis on males over females, is related to a healthier status of most adopted Chinese children (Kreider & Cohen, 2009). These gender and health differences provide insights into caregiving by adoptive parents and the counseling services offered to adoptive families. Designing and implementing preventative

and intervening approaches should be carefully examined and adapted based on considerations of male versus female adoptees, and of healthy children versus children with special needs.

Implications for parents. Parents need to understand the context of countries from which they wish to adopt a child. Families differ in their reasons for adoption, the countries they choose from which to adopt and characteristics of the child whom they wish to adopt. These differences make it important for parents to conduct a self-analysis and rationalize the adoption choice by specifying characteristics of an adopted child such as gender, age, race and health conditions prior to the international adoption process (Gunnar, Bruce, & Grotevant, 2000). Becoming familiar with the context of countries of origin facilitates the family's matching process with a potential child. For example, parents may choose to adopt from a country with more female infants on the waiting list, such as China, if they prefer adopting a female child and have no specific restrictions on other characteristics.

Parents also need to be aware of potential relationships between abandonment and the gender or health of the child so as to provide appropriate post-adoption care. Obtaining pre-adoption information about the child and the country of origin is an important step (Gunnar et al., 2000). Additionally, adoptive parents should understand that health and medical information, including family and prenatal history, is probably more comprehensive for a child from some countries than others. Families may follow up with the adoption agency by making specific requests for information that is more detailed than the standard information provided (Bledsoe & Johnston, 2004).

Implications for counselors. When considering the gender and health of the adoptee, two main types of services are suggested for professional counselors working with internationally adoptive parents and adopted children—information interpretation (Gunnar et al., 2000) and pre- and post-adoption counseling services (Welsh, Viana, Petrill, & Mathias, 2007). The connection between the adoption process and the individual characteristics of the child to each country's policy and culture make it necessary for counselors to take into consideration the context of the country of origin and to help families interpret adoption-related information (Gunnar et al., 2000). Quality interpretation increases the likelihood of the child's positive post-adoption development. At the same time, the interpretation of information also has the potential to prevent a child from being adopted due to possible physical and mental health concerns of the child, expenses involved, and additional requirements about parents' age, income or sexual orientation regulated by specific countries of origin (Gunnar et al., 2000).

Counselors may utilize pre-adoption information (e.g., health and behavioral information, diagnosis) in designing interventions for adopted children. Most counselors do not receive professional training in adoption or working with adoptive families and children, so establishing a professional network with adoption agencies, social workers and psychologists becomes essential. This network will provide more accurate information and ensure necessary referrals, access to available medical and health data, appropriate consultation, and professional collaboration that will best serve adoptees and families.

Recognizing Adoption-Point Behaviors

Tan et al. (2010) reported in a longitudinal study of preschool-age Chinese adoptees that behaviors exhibited at the time of adoption predict adjustment outcomes regardless of the age at adoption. Risk indicators were identified as refusal/avoidance and crying/clinging behaviors, and more internalizing and externalizing behavioral problems were found in children exhibiting more physical risk indicators at the time of adoption (Tan et al., 2012).

Implications for parents. International adoptive parents should be aware of the behaviors exhibited at the time of adoption by adoptees, which can be particularly helpful for recognizing potential adjustment issues. To deal with noncompliance and clinging related to problem behaviors and social-emotional learning, it is suggested that parents provide timely comfort and be attuned to the child's needs (Brennan, 2013). Parents also are encouraged to recognize changes from the environment of the adoptee's origin to a U.S. environment and consider preparing resources to help with children's transitions. These can include music or stories in languages of birth countries along with toys and other sources of origin environment comfort.

Implications for counselors. Professional consultation with adoption agencies can provide the basis for understanding specific behaviors that the child presents and how the behaviors can affect development. Some behaviors displayed by an adoptee may be related to his or her developmental stage, and frequently avoidance and clinging behaviors are identified as major symptoms of separation anxiety disorder in children (Ehrenreich, Santucci, & Weiner, 2009). Counselors may work with parents to track the frequency of the behaviors during the initial period after adoption. Appropriate interventions can then be designed and implemented according to the presentation of behaviors and/or specific diagnosis made by qualified professionals.

Facilitating Secure Attachment Development

Understanding the mutually influential factors of social-emotional reactivity and attachment security of adopted children are of practical significance (Cohen & Farnia, 2010). According to attachment theory, children with secure attachment are more likely to develop strong internal working models with salient self-efficacy, enabling them to be empathic and more capable of maintaining relationships, whereas children with insecure attachment may develop weak internal working models that lack social competency in relationships (Bowlby, 1969). Internationally adopted children experience a variety of transitions in culture, language and living environment, which present as separation and loss, adding difficulty to the development of attachment to new caregivers (Bowlby, 1969).

Implications for parents. Parental sensitivity, or providing appropriate, timely and consistent responses, is a major contributor to secure child-parent attachment. It is a protective factor for international adoptees and can counteract otherwise problematic pre-adoption risk factors. Parents can increase their sensitivity by utilizing a form of mind-mindedness as an effective strategy for helping infants form secure attachments (Meins, Fernyhough, Fradley, & Tuckey, 2001). The technique involves naming children's feelings, wishes, intentions and thoughts in situationally appropriate ways. The act of naming encourages active recognition of the need to respond to the child and the time to do so, thereby building a pattern of productive, sensitive, parental behaviors.

Implications for counselors. Counselors may emphasize adoptee-parent relationships in which trust is a fundamental element (Barcons et al., 2011; Tan & Camras, 2011). Parent training and psychoeducation based on individual family needs can help establish the necessary parental desire and skills required. Trust-Based Relational Intervention is one sample of a program developed for adoptive families of children with social-emotional needs (Purvis, Cross, & Pennings, 2009). This program emphasizes the following two main principles in developing a family-based program: (a) awareness (i.e., understanding adoptees' responses and feelings) and (b) engagement (i.e., interacting with adoptees in a way that makes them feel safe). Modeling eye contact and imitating the child's body position are recommended for working with internationally adopted children for whom extreme changes in culture, environment and other factors can make developing trust more difficult. Counselors should be cautious when using these strategies before getting to know the child and parents in-depth. Active eye contact and body gestures may intimidate children due to cultural reasons or previous traumatic experiences (Becker-Weidman, 2006).

Coping With Family Stress

Numerous studies have demonstrated a positive correlation between family stress and child psychopathology (Grant, Compas, Thurm, McMahon, & Gipson, 2004; Tan et al., 2012), and have shown that a significant sign of parental stress is maternal depression prior to adoption (Viana & Welsh, 2010). Parents must consider the parenting role differences in balancing family stress because parenting is not just the responsibility of a single parent.

Implications for parents. Parents must evaluate the impact of family stress that can inhibit family function, thereby increasing children's behavioral problems, and the family's ability to deal with those problems. In two-parent households, parents are encouraged to participate in a parenting process in which one parent provides more emotional support to children by encouraging them to be independent and to explore unknown things (i.e., proactive approach), while the other provides emotional support through sensitive caring and responding to the child's distress (i.e., reactive approach; Grossmann, Grossmann, Winter, & Zimmermann, 2002). Adoptive parents must consider a self-check on overall mental health as individuals, as a couple and as a family. Seeking support from a pre-adoptive preparation program focusing on evaluating self-wellness and promoting family resilience is an extremely valuable step (Viana & Welsh, 2010).

Implications for counselors. Meeting the needs of adoptive families often requires implementing techniques to help recognize and deal with the sources of family stress. Parents must have an understanding of the family stress issues before they can effectively move on to developing and implementing interventions for adoptees' behavioral problems, which can be exacerbated or even created by the stress. Counseling services for parental depression, anxiety, and other relevant feelings and symptoms are critical (Viana & Welsh, 2010).

Conflict within a couple's relationship is a key factor that predicts family stress because low-conflict couples are positively associated with satisfying parent-child interactions (Krishnakumar & Buehler, 2000). A variety of psychoeducational programs focus specifically on improving couple relationships for new parents (Halford & Petch, 2010). Counselors must consider the importance of parents' focusing on conflict management and pre-parental anxieties of internationally adopting prior to the child's arrival.

Cultivating Authoritative Parenting

Parenting and attachment are two parallel behavioral systems that facilitate effective caregiving and attachment relationships in adopted children (Roberson, 2006). Results of hierarchical multiple regression analyses by Kriebel and Wentzel (2011) indicated that adoptees' cumulative risk from pre-adoption circumstances is a negative predictor for later adaptive behaviors, whereas authoritative parenting is a positive predictor of children's adaptability. Authoritative parenting also was found to be associated with fewer behavioral problems in Chinese adoptees, whereas authoritarian and permissive parenting styles were correlated with more behavioral problems exhibited by the children (Tan et al., 2012).

Implications for parents. Cultivating authoritative parenting refers to promoting parents' supportive role accompanied by consistent rather than harsh discipline. Parents with an authoritative parenting style tend to show warmth, affection and responsiveness and support children's interests, but they also set up reasonably high demands and expectations for children (Baumrind, 1978). Inconsistent, overly harsh or emotionally vacant parenting has deleterious effects on children's development. A lack of parental control or consistency in discipline is associated with greater behavioral problems at all child developmental stages.

The concept of parenting styles is the same in all cultures, but its application may vary by race, culture or socioeconomic status. For example, Kisilevsky et al. (1998) maintained that parenting methods of Chinese parents differ substantially from those of U.S. parents, so adopted children from China experience different

parenting before and after they are adopted. Parents with internationally adopted children are encouraged to take all social and cultural variables of parenting into consideration (Kotchick & Forehand, 2002), while using an authoritative parenting style as the principal guideline.

Implications for counselors. Psychoeducational programs can be intervention strategies for counselors to better serve adoptive families' parenting needs. Programs may include a miniature of Baumrind's (1978) work with emphasis on how current parent themes align with the parenting typologies (i.e., authoritative, authoritarian and permissive). Counselors also may consider providing parenting examples; specifically, as suggested by Morris, Cui, and Steinberg (2013), they may provide examples related to intercultural parenting. Group counseling is another option that counselors can consider for families. Parental networks of families with children adopted from the same country of origin were found to be an effective intervention for post-adoption adjustment of families (Welsh et al., 2007), as international adoptive parents tend to listen to and seek help from informal networks whose participants have experienced similar challenges. Focus can be on feedback or experiences that families can gain from each other, while lessening the facilitating role of the counselor.

Conclusion

A close review of the unique international circumstances related to adoption from China draws attention to risk and protective factors of post-adoption adjustment. Parents of all international adoptees and counselors working with adopted children and adoptive families may want to take the multicultural characteristics of each child into consideration. There are vast differences within international adoptees as a group. Children's health, attachment and adjustment patterns vary based on their countries of birth, and each individual differs from others in the post-adoption adjustment process due to personal reasons other than cultural factors.

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Parent–Child Interaction Therapy for Children With Special Needs



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Parent–Child Interaction Therapy (PCIT) is an evidence-based method for reducing disruptive behavior in children and improving parent management of behavior. PCIT is a form of behavioral intervention that can be used in clinical, home and school settings. Although initially designed for intervention related to oppositional defiant disorder and conduct disorder, PCIT has been found to be a promising intervention for addressing behavioral issues among children with special needs. We present methods, research-based instructions and a case example of PCIT with a child diagnosed with autism. This article is intended to assist professional counselors in designing appropriate interventions for both children and parents.

***Keywords:* autism, parent–child interaction therapy, special needs, behavioral intervention, case example**

Counseling techniques for children stem from a myriad of theoretical perspectives, and professional counselors are often in the unique position to provide systems intervention and training to families when a child has disruptive behavior. Despite the seniority of behaviorism in the field of psychology, behavioral family approaches have only recently been acknowledged as an effective practice in professional counseling. According to Gladding (2011), the following three premises underlie behavioral family counseling: (a) all behaviors are learned, (b) maladaptive behaviors are the target for change and (c) not everyone in the family has to be treated for change to occur. With these assumptions, it is easily deduced that the following also are true: (a) behavior can be unlearned and that new behaviors can be taught, (b) underlying, unresolved issues are not the key components of treatment, and (c) positive changes for one family member will impact the entire family system and surrounding ecology.

When working with children of preschool or early elementary age, it is important to directly involve the child's caregivers. Parents' influence on their children is significant and some parenting practices may exacerbate some children's problems (McNeil & Hembree-Kigin, 2010). Behavioral family counseling models recognize the relationship between the child's behavior and the family system. One behavioral family counseling technique, Parent-Child Interaction Therapy (PCIT), helps families work together with their children in reaching therapeutic goals. PCIT involves teaching parents some fundamental relationship-building strategies, including therapeutic play techniques for parents to use in the home environment (Johnson, Franklin, Hall, & Prieto, 2000). The clinician typically teaches and models PCIT techniques for the parents over the course of 8–10 weeks.

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The purpose of this article is to demonstrate the practicality of PCIT as a component of behavioral family counseling, to facilitate the professional counselor's understanding of the model through a review of PCIT and to illustrate the utility of this model for children with special needs through a case study.

An Overview of PCIT

PCIT (Neary & Eyberg, 2002) is an assessment-driven form of behavioral parent training designed for families with preschool-aged children. We present a brief overview of PCIT, define the key components integral to the process, provide the framework for implementation and discuss the application of PCIT to special populations. The core of PCIT is twofold—to create nurturing parent–child relationships and to model prosocial behaviors while increasing a child's appropriate, compliant behaviors (Eyberg & Boggs, 1989). Play therapy skills are introduced to parents within the PCIT model to enhance the relationship between the parent and child. Additionally, PCIT cultivates problem-solving skills with parents who can then generalize gains made in the therapeutic milieu into the family environment. Similar to other models of family counseling, PCIT begins with the assessment process. Counselors using PCIT collect psychosocial information from the family through either structured or semistructured clinical interviews. Because PCIT is a behavioral model, family dynamics also are assessed through direct observation of clients. Once clinical interview and observational data are collected and evaluated, the counselor can explore family relationship dynamics.

PCIT counselors attempt to identify family roles, interactions and maladaptive disciplinary techniques (e.g., yelling, lack of follow-through, unrelated consequences) inherent in the system. The ultimate goal of these observations is to derive methods for replacing current ineffective parenting strategies with more adaptive ones, thus creating greater stability in the family system. Similar to other parenting approaches, family counselors using PCIT offer support and assistance in improving parent–child relationships without placing blame on the child or the parents (Webster-Stratton & Herbert, 1993).

The Benefits of PCIT

There are many benefits to PCIT; it is a brief, short-term family counseling procedure that teaches effective parenting skills and helps parents interact better with their children on a daily basis. Fundamentally, PCIT's two-tailed approach benefits both parents and children (Asawa, Hansen, & Flood, 2008) by reducing the internalization of problems and parent–child stress. Additionally, PCIT empowers parents through teaching positive interactive techniques that build parent–child rapport. PCIT fosters creativity and increases child self-esteem, decreases noncompliance or disruptive behavior, and increases the quality of parent-provided positive regard through developmentally appropriate play (Eyberg et al., 2001). These positive interactions effectively decrease problem behavior, resulting in a reduction or elimination of emergency counseling visits. One PCIT study reported that only 19% of participants in a randomized controlled trial with physically abusive parents re-reported physical abuse more than 2 years after the implementation of the PCIT model (Chaffin et al., 2004).

While PCIT sessions may focus on home and play, the behavioral skills that the parent learns can be generalized to other children and additional settings, building stronger interactions across a spectrum of familial and social settings. According to Urquiza and Timmer (2012), PCIT focuses on the following three essential non-fixed elements: (a) increased positive parent–child interaction and emotional communication skills, (b) appropriate and consistent discipline methods, and (c) direct scaffolding for parent training in the interventions. Thus, once the parent has mastered these skills in the session with the child and therapist, the parent is able to transfer the skills to any location or setting to maintain positive interactions, emotional communication and disciplinary consistency with the child.

The Effectiveness of PCIT

Eyberg and her colleagues have researched and published extensively on the efficacy of PCIT and have empirically supported the effectiveness of PCIT with children exhibiting a range of behavioral and emotional problems (Neary & Eyberg, 2002). Specifically, PCIT has proven effective with problems including attention-deficit/hyperactivity disorder (ADHD), conduct disorders, separation anxiety, depression, postdivorce adjustment, self-injurious behavior and abuse (Eyberg et al., 2001; McNeil & Hembree-Kigin, 2010). For example, Nietter, Thornberry, and Brestan-Knight (2013) conducted a pilot study with 17 families completing PCIT treatment and found a significant decrease in disruptive child behaviors as well as a decrease in inappropriate parent behaviors over the 12-week group program. This study was the first to deliver PCIT via group sessions. The researchers found that treatment effects remained in place for more than 6 months after the group's completion.

Eyberg et al. (2001) investigated long-term treatment outcomes of PCIT for families of preschoolers with conduct disorders over a period of 1–2 years, and found that treatment effects were sustained over time. According to the researchers, the study was the first of its kind to include long-term follow-up with families receiving PCIT treatment (Eyberg et al., 2001). Hood and Eyberg (2003) established further evidence in another follow-up study on PCIT treatment effects over a period of 3–6 years. In the study of treatment effects on families with young children diagnosed with oppositional defiant disorder, the researchers found that treatment effects and behavioral change were again sustained over time. Thomas and Zimmer-Gembeck (2007) conducted a review of behavior outcomes in 24 studies on PCIT and another parenting intervention, Triple P—Positive Parenting Programs. All of the studies involved children aged 3–12 and their caregivers. Meta-analyses revealed positive effects for PCIT as well as the other intervention, adding support within the literature on the efficacy of PCIT.

To demonstrate the effectiveness of PCIT for treating ADHD, Guttman-Steinmetz, Crowell, Doron, and Mikulincer (2011) examined the interactions of children with ADHD and their mothers. Their findings suggest that while Behavior Parent Training is useful in managing ADHD, PCIT may be highly effective in impacting the attachment-related processes during the child's later developmental stages. These researchers suggested that parents' successful adaptation of PCIT's verbal and behavioral skills during interaction with their child might increase the child's sense of security.

The effectiveness of PCIT has been expanded to other disorders such as separation anxiety. For example, Choate, Pincus, Eyberg, and Barlow (2005) conducted a pilot study involving three families with children 4–8 years of age diagnosed with separation anxiety disorder. The researchers found that the child-directed activities fostered children's sense of control and reduced separation anxiety symptomology to normative levels by the conclusion of treatment. Again, the treatment effects were shown to persist long after treatment ceased. This study was replicated by Anticich, Barrett, Gillies, and Silverman (2012), providing further support of PCIT's effectiveness in alleviation of separation anxiety disorder symptomology.

Individuals or populations with special needs also appear to respond positively to PCIT. Bagner and Eyberg (2007) found that mothers of young children diagnosed with mental retardation and oppositional defiant disorder reported a reduction in disruptive behaviors, increased compliance and less parenting stress after participating in a randomized, controlled trial study utilizing PCIT. PCIT also has been cited as a promising evidence-based intervention for autism (Agazzi, Tan, & Tan, 2013). Solomon, Ono, Timmer, and Goodlin-Jones (2008) conducted a randomized trial of PCIT for treating autism and found the same results as researchers studying other disorders have. PCIT was shown to reduce behavioral disruptions, increase adaptability and increase positive parental perceptions of child behavior. While PCIT was originally developed to address

behavioral disorders, it clearly serves as an intervention for various other disorders that impact parent–child interactions.

The impact of PCIT on parents. PCIT has been shown to have equally effective outcomes for parent-related issues as it does for child behavioral disruptions. For example, Luby, Lenze, and Tillman (2012) reported highly favorable results for using PCIT to reduce behavioral disruptions and improve executive function among preschoolers. However, PCIT also showed significant effects for parents. Specifically, PCIT interventions helped to reduce depression severity and parenting stress while increasing emotion recognition. Furthermore, Urquiza and Timmer (2012) found that parental depression decreases the likelihood that the child will complete the treatment course. However, if the parents are persuaded to continue until completion, their own psychological symptoms may be relieved.

PCIT has been shown to have positive effects on parents in a variety of circumstances. For example, Baker and Andre (2008) suggested that PCIT might offer a unique and promising advantage in the treatment of postdivorce adjustment issues in children. PCIT also has been found to be effective in working with abusive parents, many of whose histories included depression, substance abuse and violent behavior (Chaffin et al., 2004). Although still effective in reducing parenting stress and child behavior problems, Timmer et al. (2011) found that PCIT was less effective in foster parent homes than in non-foster parent homes. While PCIT is clearly an effective intervention for both children and parents, in cases with complex systems like foster care placement and abuse, PCIT could be used in conjunction with other interventions. The same is true for clients with special needs.

Diverse population efficacy. Although we recognize that one size does not fit all, PCIT has shown significant results with ethnic minorities and underserved populations. Different cultural and ethnic group parenting styles (strict vs. relaxed styles) vary across the United States. In addition to effectively increasing positive parenting behaviors and decreasing behavioral problems in children, treatment outcomes and efficacy studies support the notion that PCIT is culturally effective and produces robust modifications among diverse groups (see Bagner & Eyberg, 2007; Borrego, Anhalt, Terao, Vargas, & Urquiza, 2006; Matos, Torres, Santiago, Jurado, & Rodríguez, 2006; McCabe & Yeh, 2009). Additional literature and empirical research is available for review regarding work with specific populations such as African Americans and Asians. There also is promising evidence pointing to PCIT's efficacy in populations exhibiting neurological and behavioral disorders such as autism (Tarbox et al., 2009).

Efficacy through translation. Matos et al. (2006) conducted research in Puerto Rico with parents of children aged 4–6 with ADHD. The manual and handouts were translated into Spanish with a few modifications. Results showed significant decreases in behavior problems and hyperactivity. A recent follow-up study using the culturally adapted version further revealed that significant and robust outcome measures resulted from large treatment effect sizes. Mothers reported reductions in “hyperactivity-impulsivity, inattention, and oppositional defiant and aggressive behavior problems, as well as a reduced level of parent-child related stress and improved parenting practices” (Matos, Bauermeister, & Bernal, 2009, p. 246). Additionally, in a single-case study with a Spanish-speaking foster mother and a 3-year-old Mexican-Chilean-Filipina child, PCIT proved to be effective; reports from other family members noted substantive behavior improvement (Borrego et al., 2006). Thus, we can deduce that PCIT can be used effectively across cultural groups.

Key Components

There are three main components of PCIT: child-directed interaction (CDI), parent-directed interaction (PDI) and cleanup. Depending on the session being held, the components are presented in 5-minute segments with varying degrees of parent control required. CDI is characteristically the first stage in PCIT. Similar in approach

to filial play therapy, this first stage creates an opportunity to strengthen the parent–child relationship. Because PCIT is utilized in the context of dyadic play, it is conducted in a room conducive to play (McNeil & Hembree-Kigin, 2010). Thus, a room designated for CDI should contain a variety of toys, crayons, paper, modeling compounds and other developmentally appropriate activities for a child. As with other play techniques, in order to give children the opportunity to determine the rules by which they will play, games with rules are generally excluded from a CDI playroom. Children engaged in CDI should be allowed to play with any or all of the items in the room. Encouraging free play indicates to the child that he or she is the creator of the play, not the caregiver. This approach allows the time to truly be child-directed.

Within CDI, the establishment of a positive therapeutic relationship is a crucial step in building a foundation for the introduction of compliance training. Compliance training is simply teaching a child to mind or comply over a period of time, through small compliance goals set by the parents. To lay the groundwork for this process during CDI, the parents are instructed to praise, reflect, imitate and describe their child’s play, while not asking questions, placing demands or criticizing the activities that transpire unless harmful to the child (McNeil, Eyberg, Eisentadt, Newcomb, & Funderburk, 1991).

Another essential concept introduced during CDI, includes fostering the enthusiasm and willingness of the parent. Although responding positively to a child’s free play during CDI may appear simple, parents often need considerable practice to master this response set. For example, one of the toys in our clinic is a Mr. Potato Head. Young children can be very creative in their placement of the various accessories that come with the toy. Often they will place an arm on top of the head, lips on the ear hole or eyes over the mouth hole. In PCIT, we view this action as an expression of creativity. However, when we observe parents in free play with their children, we often witness the parents limiting their children’s creativity by redirecting the placement of the appendages on Mr. Potato Head. Parents often say, “No, honey, the lips go here,” or “That’s not where the arms go.” Instructing parents to refrain from making such comments is generally all that a PCIT counselor needs to do. PCIT counselors understand that this is a difficult skill for most parents to master, and they teach parents the acronym PRIDE for use during CDI as well as other elements of PCIT. PRIDE simply stands for praise, reflection, imitation, description and enthusiasm (Eyberg, 1999). Table 1 provides some practical examples of desired responses from parents during CDI using the PRIDE approach.

Table 1
Responses Using PRIDE model

Element	Example
Praise	Parent: “Thank you for putting away the toys.”
Reflection	Child: “I’m drawing a dinosaur.” Parent: “I see. You are drawing a dinosaur.”
Imitation	Child is playing with a car. Parent gets a similar car and begins playing in the same manner.
Description	Child is playing with a toy airplane. Parent says, “You are making the airplane fly.”
Enthusiasm	Parent: “Wow. Your drawing is very creative.”

In the second stage of PCIT, PDI usually is initiated once parents master CDI. Mastery is evidenced during the child’s play by the parents exhibiting proper implementation of the PRIDE responses. PDI also is conducted in the playroom or room selected for CDI. PDI consists of teaching parents how to manage their child’s behavior and promoting compliance with parental requests (Bahl, Spaulding, & McNeil, 1999). Parents should understand that PDI is more difficult for children than CDI and will likely be challenging for both the child and parent. When beginning PDI, parents must understand the importance of appropriate discipline techniques and

receive training in giving clear directions to their children. Because children require a great deal of structure, professional counselors emphasize the importance of consistency, predictability and follow-through in this training (McNeil & Hembree-Kigin, & 2010). In order to initiate compliance training, parents practice giving effective instructions to their child. McNeil and Hembree-Kigin (2010) offered several rules for giving good instructions as part of the parent training element of PDI that can be conceptualized in the following ways: Command Formation, Command Delivery and Command Modeling:

Command Formation

- A. Give direct commands for things you are sure the child can do. This increases the child's opportunity for success and praise.
- B. Use choice commands with older preschoolers. This fosters development of autonomy and decision making. (e.g., "You can put on this dress or this dress" rather than "What do you want to wear?" or "Wear this").
- C. Make direct commands. Tell the child what to do instead of asking whether they would like to comply (e.g., "Put on your coat").
- D. State commands positively by telling child what to do instead of what not to do. Avoid using words such as "stop" and "don't."
- E. Make commands specific rather than vague. In doing so, the child knows exactly what is expected and it is easier to determine whether or not the child has been compliant.

Command Delivery

- A. Limit the number of commands given.
 - Some children are unable to remember multiple commands. The child's opportunity for success and praise increases with fewer, more direct instructions given at a time.
 - When giving too many commands, parents have difficulty following through with consequences for each command. Additionally, the parent's ignoring some minor behaviors may be best.
- B. Always provide a consequence for obedience and disobedience. Consequences are the quickest ways to teach children compliance. Consistency when providing consequences is the key to encouraging compliance.
- C. Use explanations sparingly. Some children would rather stall than know the answer. Avoiding the explanation trap prevents children from thinking they have an opportunity to talk their way out of it.

Command Modeling

- A. Use a neutral tone of voice instead of pleading or yelling. Interactions are more pleasant in this manner and the child learns to comply with commands that are given in a normal conversational voice.
- B. Be polite and respectful while still being direct. This models appropriate social skills and thus interactions are more pleasant.

After teaching parents to deliver effective instructions and allowing time for *in vivo* practice, professional counselors introduce appropriate discipline strategies to be used in PDI. The *in vivo* coaching model utilizes an observation room with a two-way mirror and the ability to for the counselor to communicate with the parent via microphone. The focus on training includes communication and behavior management skills with additional homework sessions (Urquiza & Timmer, 2012). In a study by Shanley and Niec (2010), parents who were coached via a bug-in-ear receiver with *in vivo* feedback during parent-child interactive play demonstrated rapid increases in positive parenting skills and interactions. Of these strategies, timeout is the most common as it is "a brief, effective, aversive treatment that does not hurt a child either physically or emotionally" (Eaves, Sheperis, Blanchard, Baylot, & Doggett, 2005, p. 252). Furthermore, Eaves et al. (2005) wrote that timeout

benefits both children with problematic behaviors and those who view the technique being used on other children, in addition to those children and adolescents demonstrating developmental delays, psychiatric issues and defiance. However, for the parent to experience timeout's full benefit, the technique must be appropriately and consistently administered. Eaves et al.'s (2005) article, "Teaching Time-Out and Job Card Grounding Procedures to Parents: A Primer for Family Counselors" is an excellent article on timeout and why it is an effective intervention.

All aspects of timeout are reviewed with the parents, such as the rationale for timeout, where timeout should take place in the home, what to do when the child escapes timeout, what to do if the child does not comply with timeout, the length of timeout, what should happen right before timeout and what should happen right after timeout. Parents receive written instructions illustrating each step of timeout and offering guidance on how to implement the procedure. These discipline strategies may not be necessary if a child is motivated to be compliant. Determining compliance is often a very hard decision for parents to make. According to McNeil and Hembree-Kigin (2010) there are several rules used to help parents determine compliance or noncompliance.

1. Parents must be sure that the instructions are developmentally appropriate for the child. If the child is asked to bring the orange cup to the parent, one must know that the child can determine which cup is actually orange.
2. Parents should know that the request is completely understood by the child. If there are any questions about this the parents should point or direct the child to help him or her fully understand the request.
3. Parents should allow the child approximately 3 seconds to begin to attempt the task. If the child has not begun to attempt the task by this time it should be considered noncompliance.
4. Parents should state the request only once. If the child pretends not to hear the request, this should be considered noncompliance.
5. Parents should not allow the child to partially comply with instructions. If parents accept half-compliance then children will often repeat the negative behavior because they know they can get away with it.
6. Parents should not respond to a child's bad attitude in completing a request. As long as he or she completes the instruction, it is compliance.
7. Parents should consider it compliance if a child does what is asked and then undoes what is asked. Compliance is compliance no matter how long it lasts.

When a parent determines that a child is compliant, verbal praise should be provided. This praise should be given immediately and focus on the child's compliance.

Parents are encouraged to practice the skills of giving good directions by delivering multiple commands to the child. These commands are given during the playtime and may include requests to hand things to the parent (e.g., "Give me the red block") or play with certain toys (e.g., "Place the blue car in the box"). This activity allows the child to practice following directions, while also affording the parent the opportunity to practice praise (McNeil & Hembree-Kigin, 2010). The child begins to learn that when he or she follows directions, his or her parents are very appreciative and excited. After the small tasks are accomplished, parents begin to place demands on the child that are less desirable, such as cleaning up the toys or moving on to another task (McNeil & Hembree-Kigin, 2010). By assigning less desirable tasks, parents find themselves in a position to practice a timeout procedure with the child. The professional counselor is there to model timeout and coach the parents when practicing timeout.

The third and final component to consider is called cleanup, which occurs as part of PDI. This time during the PCIT process is exactly what one might think; it is intended to teach the child to clean up the toys at the

end of the parent–child interaction in both the counseling and home milieus. Cleanup should be done without the parents’ help but with the parents’ direction. Although this component may seem simple, it tends to be a challenging situation, as significant behavior problems often are displayed during this phase. The expectation is that this phase lasts 5 minutes, but time varies depending upon the behavior of the child (McNeil & Hembree-Kigin, 2010). Cleanup occurs only at the end of parent-directed play, not at the end of child-directed play, to avoid confusing the child about the role of parental help during cleanup. All three components—CDI, PDI and cleanup—are opportunities for behavioral observation and data collection.

Implementing PCIT

According to McNeil and Hembree-Kigin (2010), there are six steps in conducting PCIT with a family. These authors have briefly described the contents of each step as well as provided guidelines for the number of sessions typically devoted to completing the tasks within each step. Step 1 requires one to two sessions for the intake process, Step 2 requires one session to introduce and teach parents CDI skills, and Step 3 requires two to four sessions in which the parents are coached on these skills. Steps 4 and 5 introduce and coach the PDI and may take up to six sessions. The final session is the follow-up session. These six steps complete a 10- to 15-session triadic training program.

Step 1 is the initial intake and can be accomplished in one to two counseling sessions, unless classroom or other observations are warranted. These sessions consist of assessing family dynamics, obtaining the family’s perception of the presenting problems, probing for insights into the current disciplinary beliefs and methods held by the parents, and observing the natural interactions between parents and child. In addition to the information-gathering component, the clinician defines the parameters of the sessions as well as the rules and expectations. Certain parameters involve an understanding by the parents that this CDI time is designated for the child to lead and for the parent to follow—a time often described to the parents as *time-in* for the child. Thus, time-in is defined as a time when the child facilitates play by selecting the type of play and initiating all play interactions.

The initial informal observation usually takes place in a sitting area while the family is waiting to visit with the counselor. In this informal observation, the counselor looks for “the child’s ability to play independently, strategies the child uses to engage the parent’s attention, parental responsiveness to child overtures, parental limit-setting, warmth of parent-child interactions, and evidence of clinging and separation anxiety” (McNeil & Hembree-Kigin, 2010, p. 20). After this stage of observation, a more formal observation is completed using the Dyadic Parent–Child Interaction Coding System (DPICS; Eyberg & Robinson, 1983). This observation is typically accomplished in three 5-minute increments in which behaviors and verbalizations are marked on the DPICS sheet. The formal observation occurs over the three PCIT stages previously described—CDI, PDI and cleanup. Following the initial observations, a third observation may be executed as a classroom observation. This type of observation is done with students who attend day care, preschool or elementary school, and allows one to see the child interact within his or her daily environment. Observation occurring in an alternate setting increases the chances of obtaining normative behavior (McNeil & Hembree-Kigin, 2010).

In Steps 2 and 3, the counselor presents and provides coaching on the CDI skills. Step 2 typically requires one counseling session. During this time the parents are taught the behavioral play therapy skills of CDI. The third step, coaching the CDI skills, may take two to four sessions depending on how the family adopts these principles into their daily interactions with their child. Coaching is described as modeling the behavior for the family, allowing the family to practice in session with feedback and prompts as needed, assigning the family homework to practice, and then repeating these steps until the parents are comfortable and fluent in the process.

In Steps 4 and 5, respectively, the counselor teaches and coaches the parents about discipline skills. These skills include both PDI and compliance training. Step 4 is typically accomplished in one session. Coaching may last from four to six sessions. Again, coaching is described as modeling, in-session practice with feedback and prompts, assigning homework, and evaluating success.

Step 6 consists of having a follow-up counseling session. This session is an opportunity to assess the family's progress with proper implementation of each component of the PCIT model, gauge the strides made in compliance and assess the overall family satisfaction gained throughout the journey. Finally, one should use boosters to help parents maintain learned skills as they face new challenges with their children. Table 2 delineates the steps to implementing PCIT over a typical 10–15-session treatment plan.

Table 2

Implementing PCIT

Step	Number of sessions	Process
1	1–2	Informal and formal observation
2	1	CDI
3	2–4	Coaching CDI skills
4	1	Teaching discipline skills via PDI and compliance training
5	4–6	Coaching
6	1	Follow-up

Case Study

PCIT was selected for use in the treatment of Manny, a 6-year-old Hispanic male diagnosed with autism and noncompliant to his mother. Like many children with autism, Manny had difficulty with unpredicted changes and verbalization of concerns. As Manny's frustration with communication increased, he demonstrated stereotypies such as hand flapping and eventually progressed to tantrum behavior. The two goals of treatment were to increase the frequency of appropriate verbalizations and to decrease the frequency of inappropriate behavior including physical aggression, noncompliance and making noises. Manny was experiencing other issues related to autism, but his mother indicated that the behavioral problems were preventing him from making progress in other area.

As a result, we decided to conduct a functional behavior analysis prior to beginning treatment. This assessment of Manny's behavior indicated that some of the behavior disruptions were a means of seeking attention, and therefore it was determined that PCIT would teach the mother to provide more consistent attention for appropriate behavior and to encourage appropriate communication more effectively. If needed, the addition of the timeout component was available after the mother began adequately attending to Manny's appropriate behavior and ignoring inappropriate behavior.

Session 1

The counselor explained the procedure and rationale for PCIT to the mother, including CDI, PDI and timeout. CDI was modeled and demonstrated with Manny. The mother was uncomfortable about being judged on her parenting skills, so it was decided that she would practice the skills at home using the Child's Game nightly with Manny. The Child's Game is simply defined as any free play activity the child chooses. The family would return to the clinic in 1 week.

Session 2

The counselor reviewed CDI and had the mother conduct the Child's Game for 5 minutes. During CDI, the counselor observed and noted the mother's responses. The mother included 13 questions, one criticism and one demand in the 5-minute session. The mother praised Manny frequently, but did not use the other desired skills often. Manny was compliant with the demand that the mother gave and did not exhibit any of the disruptive behaviors. Following the CDI, feedback was given to the mother about increasing descriptions, reflections, imitations and praises, and reducing questions. The mother also was encouraged to recognize and praise communication attempts. Overall, the mother was directed to allow Manny to lead the play. When queried about CDI practice at home, the mother reported that the activity the family had used for the Child's Game was watching television. Because there is no inherent interaction in television viewing, the mother was directed to provide a choice to play with action figures or art materials, both indicated as reinforcing by Manny, in place of video games or television. The Child's Game was again given as homework.

Session 3

The professional counselor reviewed CDI and viewed the family during the Child's Game. The mother showed improvement using descriptions (16), reflections (3), imitations (1) and praises (15). She also limited her use of questions (6), criticisms (0) and demands (0). However, Manny exhibited disruptive behavior in 23% of the observed intervals. The mother also reported that Manny continued to be noncompliant and make noises at home. The professional counselor introduced PDI and timeout. Each was modeled with Manny, and his mother was allowed to practice and receive feedback. Homework was to continue the Child's Game, issue 10 demands throughout the day and follow through with the brief timeout procedure. Also, the mother was asked to develop five house rules to bring the following week. To keep a record of the number of instructions with which Manny complied before going to timeout, and the number of timeouts per day, the mother received a homework compliance worksheet to keep for 1 week. This log allows the parent to record the homework—in this case, using the Child's Game daily, issuing 10 demands throughout each day and recording the Manny's compliance to each, and using timeout as indicated.

Session 4

The counselor reviewed PDI, giving effective instructions and timeout to begin the session. The counselor then observed the family during CDI/PDI. The mother gave clear, concise instructions six out of nine times, only failing to wait before reissuing instructions when Manny did not immediately comply. Manny complied with all issued demands except when the mother reissued the demands too quickly. The mother followed Manny's compliant behavior with praise statements four out of nine times. Manny was put in timeout for disruptive behavior and the mother used the procedure correctly. Manny demonstrated disruptive behavior during 33% of the observed intervals. A review of the homework compliance worksheet from the previous week indicated that Manny complied with 10 out of 10 instructions on 5 out of 9 days, and nine out of 10 instructions the remaining 2 days. The mother was encouraged to continue generalizing the skills she had learned throughout the day. The house rules developed by the family over the previous week were discussed and worded in positive statements and then introduced to Manny. The rules were explained and both examples and non-examples were modeled. Homework was given to continue incorporating the Child's Game, issuing 10 demands in a brief period of time, using timeout as needed and recording compliance rates for 1 week.

Session 5

The counselor reviewed PDI, EID, timeout and the homework compliance worksheet. The mother indicated that Manny had been compliant before timeout 10 out of 10 times for 6 days and nine out of 10 times for 1 day. The mother also noted that Manny had been placed in timeout for breaking house rules. The mother reported that Manny's behavior had improved and he had had fewer tantrums related to schedule changes. She was encouraged to continue using the PCIT skills and adapting them to more situations. Because compliance was

increasing, it was not necessary to continue CDI and PDI in this session. The family was given homework to continue the Child's Game, PDI, using timeout as needed and recording compliance rates. This time, the family was to work at home for 2 weeks before the next session.

Session 6

The counselor reviewed the family's progress and addressed further generalization and concerns about daycare. The mother indicated that the child had been compliant before timeout on 10 out of 14 days. Two of the other days Manny had been placed in timeout 10 times and six times for violating house rules. The zero out of 10 compliance rating occurred during his birthday party, and the six out of 10 compliance rating was primarily the result of an unexpected trip to the grocery store. The family was again given homework to continue practicing generalizing CDI, PDI, using timeout as needed and recording compliance rates for 2 weeks.

Session 7

The counselor addressed concerns including the beginning of school in a few weeks and provided suggestions to ease the transition. While the mother indicated that Manny had been compliant before timeout on only 4 of the previous 14 days, a review of the compliance rates revealed that on the other 10 days, Manny was compliant no less than 80% of the time. These compliance rates from various family settings were indicative of behaviors being generalized across settings. The mother also showed evidence of her generalization of skills by adapting the house rules to address new problematic behaviors. The family was encouraged to begin reviewing material learned in the previous session and work on behavioral skills such as sitting for appropriate lengths of time. The mother was instructed to continue both the use of her attending skills in order to reinforce appropriate behavior, as well as the use of the timeout procedure to diminish inappropriate behaviors.

Session 8

For the final follow-up session, the counselor reviewed the family's progress and determined that treatment goals were met. Concerns about how to get other family, friends and teachers to use PCIT skills with Manny were addressed in this final session. The family noted the improvements made as a result of PCIT and felt equipped to maintain the behavioral changes gained as a result of this counseling approach. Termination of the PCIT intervention was appropriate at this time; the case provided clear evidence of the application and utility of the PCIT model. Manny's mother was offered the opportunity to continue interventions related to the other autism-specific issues that Manny was experiencing.

Conclusion

Professional counselors, whether working with children who have disruptive behavior or providing parenting training to families, should be knowledgeable of the application of various behavioral techniques in order to utilize them effectively and to teach them to parents. Researchers have proven that when implemented appropriately, PCIT procedures are effective in reducing undesirable and problematic behaviors in children and adolescents. Furthermore, it is clear that PCIT can be effectively applied to behavioral issues faced by children with special needs. We suggest that counselors who are interested in PCIT seek additional training to develop mastery of the techniques.

PCIT is a complex process that is often mistakenly viewed as simplistic. Thus, counselors who use PCIT without appropriate training will likely provide ineffective parental coaching. This point is especially poignant when working with children who have special needs. These children often present with numerous significant issues and deserve appropriate application of evidence-based intervention. We strongly suggest that counselors complete the web-based training provided by the University of California at Davis Children's Hospital. The

training is free and can be accessed at <http://pcit.ucdavis.edu/pcit-web-course/>. Given that PCIT is an effective approach and that the effectiveness of the model increases with appropriate education, professional counselors who further educate themselves on PCIT's uses and applications can benefit their practices and the families they serve through the correct use of this empirically validated method of behavioral family counseling.

Counselors who are interested in PCIT also should consider advancing research related to counseling applications. While PCIT has been shown to be an effective intervention for autism and other disorders, more research is needed. We encourage counselors to consider implementation of studies that determine outcomes of PCIT for various child disorders and to conduct program evaluation for PCIT-based clinics.

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Advancements in Addressing Children's Fears: A Review and Recommendations



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Media and societal conditions affect fear development in youth; thus, counselors must remain current in their understanding of these fears in order to meet children's health, educational and developmental needs. Because of the changing content and course of children's fears, it is imperative that treatment approaches evolve concurrently. Therefore, there is a need for a review and expansion of the current understanding of children's fears and anxiety and related treatment considerations. This article aims to connect research and literature regarding children's fears with current conceptions of emotions, affect regulation and resilience in order to advocate for a holistic and modern approach for addressing fear in children.

Keywords: affect regulation, anxiety, children, fears, resilience

More than a century of research confirms the need for professional counselors to remain current in their understanding and treatment of the fears of children and adolescents (Burnham, 2009; Hall, 1897; Jersild & Holmes, 1935). When discussing youths' fears, the literature includes the terms *fear*, *anxiety* and *anxiety disorders*. Fear is defined as a distressing emotion resulting from a real or perceived threat, and anxiety is the anticipation (i.e., fear) of a potential future threat (American Psychiatric Association [APA], 2013). The terms fear and anxiety are often used interchangeably or in tandem in the literature as they appear to reflect similar underlying neurobiological processes. Anxiety disorders are included in the discussion because they are psychological disorders that are viewed as developmentally inappropriate or as reflecting pathological levels of fear and anxiety (APA, 2013; Klein, 2009).

While the content and severity of children's fears varies greatly, the evidence is clear that as society changes, approaches to treating children's fear and anxiety must be adapted (Burnham, 2009). Burnham (2009) concluded that contemporary fears of today's youth are influenced by global events (such as natural disasters, war and terrorism), societal changes, and television and media exposure. Stress and negative events contribute to heightened fear responses in children (Ollendick, Langley, Jones, & Kephart, 2001). Any stressful incidents that children experience have the potential to generate fear-related disorders (Robinson, Rotter, Robinson, Fey, & Vogel, 2004). Because of the ever-changing nature of society, it is essential for counselors to remain cognizant of the impact that current events might have on the children with whom they work, particularly in relation to their fears and coping mechanisms.

Current literature points to positive emotions and affect regulation as means of increasing resilience (Fredrickson, 2001; Fredrickson, Cohn, Coffey, Pek, & Finkel, 2008; Hannesdottir & Ollendick, 2007). Resilience, or the ability to overcome adversity, is an essential component of coping with fears and anxiety effectively (Masten, 2001). The increase in adversities during the past decade, such as terrorist attacks, war,

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hurricanes and school shootings (Burnham, 2005, 2007, 2009), warrants a renewed focus on children's fears and the promotion of resilience (Burnham, 2009; Tugade, Fredrickson, & Barrett, 2004).

Fears, worries and other stressors (e.g., academic issues, conflict, change) are typical aspects of human development; however, children often do not learn effective or appropriate skills to help them cope with these challenges (Robinson et al., 2004). Although children may develop coping mechanisms in the absence of direct instruction, these are often avoidant mechanisms that lead to poorer outcomes (Abei, Giger, Plattner, Metzke, & Steinhausen, 2013). Maladaptive fear responses can lead to the development of anxiety disorders (Kiel & Buss, 2014). Anxiety is the most prevalent childhood disorder and a strong predictor of adult psychopathology (Weems & Silverman, 2006). Thus, teaching children helpful ways to cope with fears can promote healthy development.

The need for developing effective coping skills in children is most evident during times of natural disasters and global crises (Burnham, 2009). During these periods, children are at increased risk for developing situation-specific fears. For instance, children who witnessed the September 11th attacks became more fearful of war and terrorism as a result (Burnham, 2007). This increased fearfulness also is the case for children who experience natural disasters such as earthquakes, wildfires and even lightning strikes (Dollinger, O'Donnell, & Staley, 1984).

In addition to dealing with global crises or natural disasters, counselors must be able to help children with everyday problems such as graphic media coverage of war and disasters, teasing, bullying, family conflict, economic problems, and academic failure (Burnham, 2009). For example, Robinson, Robinson, and Whetsell (1988) found that children's fears of people and of being alone have increased since early research began on children's fears in the 1900s. While the causality behind this change is unknown, the authors suggested possible associations with increased exposure to violent media coverage, changes in family structure and the rise in programs teaching about stranger danger. There is increasingly more evidence that television and other media contribute to children's fears (Burnham, 2009; Burnham & Hooper, 2008; Lahikainen, Kraav, Kirmanen, & Taimalu, 2006). Furthermore, children's fears are not relegated only to realistic or plausible events. Elementary school-aged children, in particular, have a limited conception of the world and tend to confuse reality and fantasy, which can lead to unnecessary fears and distorted assumptions (Moses, Aldridge, Cellitti, & McCorquodale, 2003). This confluence presents children with a vast range of potential fears, and their inability to cope with such fears can have devastating effects.

It follows, then, that counseling approaches for fear-related problems in children should evolve commensurately with contemporary society, and professional counselors must improve their current practices for the treatment of children's fears. The first step in this process is to identify areas that can be improved in order to accentuate current treatment modalities. The purpose of this article is to provide an overview of the emerging research relevant to the fear and anxiety experienced by school-aged children and adolescents. More specifically, this article aims to bring together new research and theory on positive emotions that can aid professional counselors in cultivating resilience and affect regulation in the children with whom they work. To this end, the following article explores the following: factors related to fear development in children and adolescents (*children* throughout this paper refers to *children and adolescents*), issues related to treatment, and implications for counselors.

Fear Development

Considerable literature exists outlining the normative progression of fear development in children (e.g., Burnham, 2005, 2009; Driessnack, 2006; Elbedour, Shulman, & Kedem, 1997; Lahikainen, Kirmanen, Kraav,

& Taimalu, 2003; Lahikainen et al., 2006; Robinson, Rotter, Fey, & Robinson, 1991; Robinson et al., 2004; Sayfan, 2008). Research over the decades has indicated that common fears of children include the broad categories of animals, darkness, death and the supernatural. However, research also demonstrates that the content of youth's fears changes along with the advancement of technology, incorporating elements that have become socially relevant and discarding those that have become obsolete (Burnham, 2009).

The fear response consists of three components: thoughts, emotions and physical sensations (Hannesdottir & Ollendick, 2007; Robinson et al., 2004). Distressing events stimulate fear and anxiety in children, but fears also can arise when a child anticipates possible risk of injury, pain or loss (Burnham, 2009; Robinson et al., 1991). As an upsetting event proceeds from either a real or imagined threat, this anticipation of injury, pain or loss can evoke a fear response in a child. Thus, fear can develop from actual events or from beliefs and perceptions.

While excessive childhood fears are correlated with adult psychopathology, it should be noted that fear is a normative aspect of childhood development, so fears themselves are not considered the problem (Moses et al., 2003; Robinson et al., 1988). In fact, there are positive aspects of fear, such as self-preservation, galvanizing of internal coping resources, improved focus and an increased sense of vitality (Goud, 2005; Robinson et al., 1988; Robinson et al., 1991), but the negative effects of children's fears can be serious. Fears may disrupt sleep, create exhaustion and hinder performance (Cartwright-Hatton, 2006; Robinson et al., 1991). Moreover, children suffering from fear often exhibit diminished academic achievement because fear interrupts motivation and the ability to concentrate (Moses et al., 2003; National Scientific Council on the Developing Child, 2010).

Researchers still do not completely understand the etiology of childhood fears and anxiety (Ollendick et al., 2001). It is likely that fear development involves some hereditary predisposition and genetics (Eley, Rijdsdijk, Perrin, O'Connor, & Bolton, 2008; Klein, 2009). There is evidence that children's characteristics and temperaments influence their fear development (Weems & Silverman, 2006). For example, Muris and Ollendick (2005) found a link between fearful or inhibited temperament and childhood anxiety disorders. Overall, research indicates that there is a moderate correlation between genetics and fear-related symptoms, but fear and anxiety appear to arise from a complex interaction among a variety of factors (Weems & Stickle, 2005). Researchers believe that behavioral (Ollendick et al., 2001; Weems & Stickle, 2005) and social learning also play a part.

Behavioral and Social Learning Factors

The behaviorally based factors in fear acquisition include (a) exposure to negative stimuli, (b) conditioning through negative experiences, (c) social learning through others' modeling or (d) exposure to upsetting information (Muris, Merckelbach, Gadet, & Moulaert, 2000; Ollendick et al., 2001). For example, Dubi, Rapee, Emerton, and Schniering (2008) found that toddlers indicated fear of objects based on their mother's positive or negative reaction to the object, regardless of the child's temperament, which supports a social learning aspect to fear acquisition. There is additional empirical evidence that fear acquired indirectly through social observation, with no personal experience of the aversive event, engages similar neural mechanisms as traditional behaviorally based stimulus-response fear conditioning (Olsson, Nearing, & Phelps, 2007). Field, Lawson, and Banerjee (2008) found support for the effect of verbal information on persistent fear acquisition in children. These studies reinforce the notion that fear can be acquired through behavioral and social learning factors. Fears resulting from behaviorally based factors have been correlated with anxiety, phobias (fearful or anxious responses to, or avoidance of, specific objects or situations; APA, 2013), and behavior problems in children (Gao, Raine, Venables, Dawson, & Mednick, 2010).

Cognitive Factors

In addition to behavioral and social learning explanations of fear acquisition, there is evidence for cognitive-based fear development. Research indicates that some fears are associated with maladaptive thinking patterns

(King, Muris, & Ollendick, 2005). Maladaptive thoughts can take the form of negative self-appraisal, negative self-talk or dysfunctional evaluation of circumstances (King et al., 2005). Sayfan and Lagattuta (2008) found that children between the ages of 3 and 7 are more aware than previously believed regarding the relationship between fears, beliefs and knowledge. Fearful children experience numerous cognitive distortions such as a tendency to doubt their ability to cope, overestimation of the likelihood of adverse consequences and interpretation of threatening information in a distorted manner (Prins & Ollendick, 2003). This habitual negative assessment of circumstances is associated with elevated fear and anxiety (Ollendick et al., 2001). Schell, Dawson, and Marinkovic (1991) suggested that fear development is a complex process that includes autonomic conditioned responses in addition to cognitive and emotional components. Cognitive factors, therefore, play a clear role alongside behavioral and social learning explanations of fear development.

It is important to note that children's fears can intensify over time if they are not addressed appropriately (Moses et al., 2003). Gao et al. (2010) found 3 to 8 year olds' fear conditioning increases with age, with the most substantial increase occurring between the ages of 5 and 6. Unresolved childhood fears may have deleterious effects on development and contribute to adult mental illness (Moses et al., 2003; Saavedra, Silverman, Morgan-Lopez, & Kurtines, 2010). This information suggests that addressing and treating fears in childhood may be an effective means of preventing fear-related psychopathology in adulthood.

Treatment

Cognitive-behavior therapy (CBT) is the most widely used and empirically supported treatment for fear-related disorders. Research demonstrates that CBT is effective for 60–70% of children, leaving about one-third of the population who do not respond to CBT (Hannesdottir & Ollendick, 2007; Trost, Buzzella, Bennett, & Ehrenreich, 2009). Because a sizeable number of children do not appear to benefit from CBT, it seems worthwhile to examine additional approaches or adjuncts to traditional CBT that may be effective in treating fearful children.

Affect Regulation

Awareness of emotions is the foundation of affect regulation (Suveg, Hoffman, Zeman, & Thomassin, 2009). Affect regulation, as defined here, is the intentional process that an individual employs to modify emotional states in order to achieve desirable social and individual goals (Eisenberg & Spinrad, 2004). This definition refers to controlling both negative and positive emotions, and encompasses understanding and expressing emotions (Hannesdottir & Ollendick, 2007; Ursache, Blair, & Raver, 2012). Research suggests that absence of emotion regulation skills often lead to the development of anxiety disorders (Esbjörn, Bender, Reinholdt-Dunne, Munck, & Ollendick, 2012; Hannesdottir & Ollendick, 2007; Weems & Silverman, 2006). This research on the role of emotion regulation in fear development is relevant to counselors working with the contemporary fears of children and adolescents.

Consequently, research indicates that the missing link in CBT approaches for working with fear-related issues in youth is greater emphasis on affect regulation (Hannesdottir & Ollendick, 2007; Suveg & Zeman, 2004). In other words, children who do not respond successfully to traditional CBT may need a more extensive education and greater focus on regulating emotions beyond feelings of anxiety. Children with fear-related issues tend to experience more negative thoughts and feelings than neutral or positive ones. Learning to correctly identify emotions across varying situations (both positive and negative) helps children gain a sense of control over their feelings (Hannesdottir & Ollendick, 2007). Thus, as an adjunct to CBT techniques such as relaxation training and cognitive restructuring, counselors can teach children and adolescents how to identify and manage their full range of emotions.

Emotional dysregulation is defined as a limited ability to control and modulate feelings in order to allow successful functioning in social relationships and emotional well-being (Hannesdottir & Ollendick, 2007; Ursache et al., 2012). Fearful children tend to avoid experiencing anxiety-provoking situations as well as discussing the associated negative emotions. This avoidance behavior is believed to contribute to emotional dysregulation because it denies opportunities for successfully managing triggered emotions (Hannesdottir & Ollendick, 2007). As a consequence, anxious and fearful children lack a sense of mastery over their internal emotional reactions (Weems, Silverman, Rapee, & Pina, 2003). Exposure therapy is an important and effective component of CBT that addresses avoidance behavior by behaviorally desensitizing children via gradual exposure to a hierarchy of fears until the fear response subsides (Hannesdottir & Ollendick, 2007; Trosper, Buzzella, Bennett, & Ehrenreich, 2009). While exposure helps children acclimate to anxiety-provoking situations or objects, it is unknown whether exposure improves children's ability to cope with associated emotions (Hannesdottir & Ollendick, 2007). In those cases where the child does not appear to respond successfully to exposure therapy, or regresses to pathological reactions, counselors can consider additional affect regulation strategies and interventions.

In one example of an affect regulation intervention, the counselor and client each choose an emotion they are experiencing from a feelings chart. Next, the counselor models for the child a discussion of how he or she knows they are feeling that way and why. Finally, the child is given the opportunity to do the same. This process helps the child understand specific emotions, normalizes the experiencing of emotions and models effective communication about emotions. Another suggestion is to utilize vignettes or stories to elicit specific emotions, process these emotions with the client and then brainstorm ways to manage the emotions (Suveg, Kendall, Comer, & Robin, 2006). Bibliotherapy also has been shown to be particularly helpful when working with fearful children (Moses et al., 2003; Robinson et al., 2004).

Interventions such as these help children acquire a repertoire of emotion regulation skills (Suveg et al., 2006). Fearful children must learn to become aware of their internal emotional states and then express or discuss their emotions effectively (Ursache et al., 2012). Building upon children's emotional awareness can be a useful adjunct in enhancing other skills training that counselors provide in their sessions with fearful children and adolescents. Suveg et al. (2006) suggested that treatment for fear-related issues should encompass all emotions that children may have difficulty regulating, not solely fear and anxiety. Learning to correctly identify emotions helps children and adolescents gain a sense of control over their emotions and self-efficacy to change their emotional state (Hannesdottir & Ollendick, 2007).

Researchers posit that explicitly targeting affect regulation would improve treatment outcomes for youth with fear-related disorders (Hannesdottir & Ollendick, 2007; Trosper, Buzzella, Bennett, & Ehrenreich, 2009). The ability to self-regulate emotion incorporates autonomy, self-efficacy, adaptability, positivity and prosocial behavior (Hannesdottir & Ollendick, 2007; Ursache et al., 2012). In addition, current research suggests that professional counselors should provide interventions and psychoeducation on positive emotions to promote emotion regulation and resilience in children and adolescents (Gloria & Steinhardt, 2014; Hutchinson & Pretelt, 2010).

Positive Emotions

Fredrickson's (1998, 2001) broaden-and-build theory of positive emotions provides a framework for understanding the role of positive emotions in fostering resilience. Negative emotions, such as fear and anxiety, narrow one's focus and attention as a survival mechanism in preparation to either confront or avoid a perceived threat. This is known as the *fight or flight* response. However, this type of narrow, focused response also can cause people to become stuck by limiting flexibility and creativity in finding new solutions (Hannesdottir

& Ollendick, 2007; Hutchinson & Pretelt, 2010; Tugade et al., 2004). Negative emotions are central in the development of psychopathology because they tend to foster higher levels of arousal than positive emotions (Suveg et al., 2009). This information is relevant to working with youth experiencing fear-related problems, because “people have limited ability to think of and evaluate different solutions when they are overwhelmed by negative emotions in a stressful situation” (Hannesdottir & Ollendick, 2007, p. 286).

The cultivation of positive emotions such as joy, gratitude, hope, serenity, interest and inspiration builds resilience in the form of enduring internal and social resources that one can draw upon when necessary (Fredrickson, 1998). Positive emotions help discard old negative patterns of thought and behavior to pursue novel ideas and actions (Fredrickson, 2001; Isen, 2009). Positive emotions also are a source of human strength that facilitates flexibility, creative problem-solving and more efficient and open-minded thinking, all important factors in resilience (Fredrickson, 2001; Isen, 2009). Experiencing positive emotions broadens individuals’ perspectives and reduces self-focus, allowing for a greater variety of behavioral responses (Isen, 2009). Moreover, experiencing positive emotions creates an upward spiral wherein positive emotions build upon each other to foster emotional and psychological well-being. Positive emotions also facilitate broad-minded and flexible thinking, which in turn, increases coping and problem-solving ability. Successful coping then leads to more positive emotions (Tugade et al., 2004). Furthermore, successful coping and problem-solving cultivate self-worth in children, which fosters a sense of self-efficacy and belief in their capacity to successfully handle stressful situations (Cloitre, Morin, & Linares, 2010; Robinson et al., 2004).

Positive emotions build physical, social, emotional and intellectual capacity to confront and overcome obstacles (Fredrickson, 2001; Tugade et al., 2004). For example, the positive emotion of joy prompts play, motivation and exploration. There is evidence that play contributes a wide array of resources for children (Trice-Black, Bailey, & Riechel, 2013). Imaginative play provides a safe environment for pretending and experimenting with emotional expression, which is important to developing emotion regulation (Lester & Russel, 2010). In fact, Hoffman and Russ (2012) found a relationship between imaginative play, positive affect and emotion regulation in 5- to 10-year-old girls ($n = 61$). Furthermore, the pushing of limits and exploring that occurs during play increases a child’s sense of self-efficacy and provides new information about the environment (Lester & Russel, 2010). Play can build physical resources of agility, coordination and strength. Play also promotes social resources such as connection, bonding and social skills (O’Connor & Stagnitti, 2011). In addition, play fosters the intellectual resources of problem-solving, creativity and the learning of new information (Fredrickson, 2001; Lester & Russel, 2010; Trice-Black et al., 2013). Finally, play cultivates psychological and emotional resources such as optimism, goal-orientation, a sense of identity (Fredrickson, 2000, 2001), and increased self-worth (Hippe, 2004). Thus, the positive emotions involved in play promote a number of factors that build resilience.

The resources developed from joy and other positive emotions such as love, gratitude, awe, amusement, interest and hope can become adaptive features that may enhance resilience in the face of future adversity. Repeated experience of these positive emotions builds internal and social resources that accumulate over time and can be drawn upon in times of need (Fredrickson, 2001). Positive emotion-based coping strategies, such as positive reappraisal and infusing meaning into experiences, have been shown to buffer against stress (Folkman & Moskowitz, 2000). There is additional evidence that cultivating positive emotions during times of adversity also may replenish the ability to cope (Tugade et al., 2004).

In addition to buffering against stress, generating positive emotions seems to have an *undoing effect*. In other words, positive emotions appear to serve as an antidote to the effects of negative emotions such as fear and anxiety (Fredrickson, 2003) and therefore can reinforce resilience. For example, Fredrickson and Levenson (1998) demonstrated that the elicitation of positive emotions increased the speed of cardiovascular recovery

following a distressing event. This increased resilience to a distressing event is an encouraging sign that positive emotions, which can be achieved through emotion regulation, have a beneficial effect during times of distress. Thus, cultivating positive emotions may improve youths' responses to negative or stressful situations and counteract the effects of chronic worry or fear (Hannesdottir & Ollendick, 2007).

The key for counselors is to fill their therapeutic toolboxes with interventions that directly target the spectrum of emotions and affect regulation. It is important to remember that affect regulation requires the ability to distinguish between all emotions. Interventions should include teaching skills for generating positive emotions as a means of building internal and social resources. Fredrickson (2009) proposed a positivity ratio of three positive emotions for every negative emotion to develop resilience. In other words, experiencing a greater quantity of positive emotions over time helps to buffer against, and undo, the negative effects of stress.

Resilience and Emotions

Burgeoning research points to the importance of understanding the relationship between fear-related disorders and emotions in order to promote resilience in children. Esbjørn et al. (2012) cited evidence of a link between anxiety symptoms (e.g., overwhelming fear, worry, agitation, heart palpitations) and lack of emotion regulation skills. Moreover, fearful children tend to have an even more limited understanding of emotions in general than their normative peers (Hannesdottir & Ollendick, 2007; Suveg et al., 2009). Research findings have suggested that children diagnosed with anxiety disorders also report experiencing higher levels of emotional intensity and somatic symptoms in response to emotions than children without anxiety disorders (Suveg et al., 2009; Suveg & Zeman, 2004). Finally, there is evidence of a relationship between the inability to regulate emotion and heightened levels of negative emotion (Esbjørn et al., 2012; Suveg & Zeman, 2004). Conversely, research indicates that resilient people demonstrate greater positive emotionality (Tugade et al., 2004). These findings all suggest that emotions and emotion regulation play an integral role in the development, course and potential modulation of fear-related disorders as well as the development of resilience.

In fact, Gloria and Steinhardt (2014) found, in a sample of 200 postdoctoral fellows, that positive emotions were directly related to greater resilience. Their findings suggested that positive emotions were positively related to adaptive coping and negatively related to maladaptive coping. In addition, resilience moderated the relationship between stress and trait anxiety and depressive symptoms. The authors concluded that positive emotions may have the potential to build resilience in individuals experiencing stressful situations, and resilience may in turn increase positive emotions, thus providing support for Fredrickson's (1998, 2001) broaden-and-build theory. These results further support the notion of emphasizing the cultivation of positive emotions in helping children to build resilience.

Children develop resilience when they successfully manage stressors throughout daily life (Cloitre et al., 2010). Resilience improves youths' ability to cope with fear and anxiety and mitigates some of the adverse effects of fear-related experiences (Burnham, 2009). As mentioned earlier, resilience is a set of qualities that empowers people to successfully adapt or bounce back when facing some type of adversity (Burnham, 2009; Tugade et al., 2004). Examples of resilient qualities include self-efficacy, internal locus of control, adaptability, flexibility, self-worth, optimism, positivity and social connectedness (Burnham, 2009; Grotberg, 1995; Hutchinson & Pretelt, 2010; Robinson et al., 2004; Tugade et al., 2004). Research indicates that resilient individuals possess a positive attitude toward life and are curious and open to new experiences (Masten, 2001). Although the cultivation of resilience is a natural process in child development, it can be inhibited by traumatic events, temperament, and societal or environmental conditions (Masten, 2001). Improving affect regulation can help build resilience in youth, which may in turn minimize the negative effects of fearful or anxious experiences.

Implications and Recommendations

We have provided an overview of the current landscape of children's fears to help delineate a contemporary, adaptive and holistic approach to treatment. Based on a review of the current literature, we recommend that counselors incorporate interventions that specifically teach emotional awareness when working with fearful or anxious children. While many CBT interventions implicitly address emotions, we are suggesting that counselors provide explicit psychoeducation concerning emotions, in order to explain the purpose, importance and range of emotions. This approach promotes affect regulation skills by helping children to become more aware of how they are feeling and why, and to adjust their emotional state to allow for a more beneficial outcome. Affect regulation is crucial as it provides children with tools that may be generalized across various situations and stressors. The major implication is that this broad-based approach equips children with the ability to counteract future stressors without the need for continued situation-specific interventions.

In addition to a direct emphasis on emotional awareness and regulation, we recommend incorporating interventions that cultivate positive emotions. While CBT is generally inclusive of the way that thoughts and feelings are interconnected, there is often little time devoted to the effects of positive emotions in relation to fears and anxiety. The development of skills that cultivate positive emotions, in addition to challenging negative thoughts and emotions, can improve resilience to future stressors. Developing skills related to positive emotions can help fearful and anxious children to maintain an outlook that is more conducive to normative functioning and resilience than techniques such as cognitive reframing can accomplish alone. This information is particularly relevant as many CBT approaches focus on the specific presenting fear such as spiders, heights or social situations. An approach that targets a wider range of emotions with the goal of creating more positive emotions helps children not just overcome their immediate fears, but may prepare them to adequately confront and manage future fears.

This focus on positive emotions has the intended benefit of promoting resilience. As children learn how to cumulatively produce positive emotional states, they build resilience that will buffer them against potentially distressing stimuli. There is burgeoning evidence that generating positive emotions builds resources, broadens one's ability to respond to stressors and has an undoing effect on emotions such as fear and anxiety. Research in the area of positive emotions and positive psychology provides a rich assortment of techniques for building strengths and resilience (e.g., Seligman, Steen, Park, & Peterson, 2005). We recommend that counselors incorporate this information into their work with fearful children.

The premise of this paper is that counselors can help fill the current gaps in treatment methodology with a focus on developing increased resilience in children by teaching affect regulation and positive emotions. Incorporating these constructs into a counselor's current approach provides him or her with the widest range of treatment options in a way that allows children to confront current and future fears in a holistic fashion that is both specific *and* generalizable. Giving children access to these tools can prepare them for a range of potentially fear-inducing experiences in a way that allows them to cope effectively and draw upon their internal resources. This process continually expands client resilience and self-efficacy, preparing clients to confront a variety of stressors effectively.

This concentration on affect regulation, resilience and positive emotions appears to be an effective means of expanding upon current treatment approaches. Further research is recommended in the arena of adjunctive counseling modalities that are inclusive of resilience, affect regulation and positive emotions in order to determine their efficacy for those who are unresponsive to CBT. It also would be worthwhile to examine how these concepts affect treatment when used alongside CBT for those who do respond well to traditional CBT.

By focusing on these constructs in conjunction with other empirically supported treatments, it is our belief that children's outcomes will improve and they will be better prepared to confront not only specific fears in the present, but myriad potential stressors in the future.

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Professional Counseling for Children With Sensory Processing Disorder



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Sensory processing disorder is a complex neurological disorder affecting approximately 5–17% of the population, yet professional counselors often misunderstand and misdiagnose this disorder. A child's academic, emotional and social functioning can be substantially impacted by sensory processing disorder; early diagnosis and treatment is crucial. In this article, the authors describe the disorder, discuss its impact on children and their families, and provide recommendations and resources for both mental health counselors and school counselors to utilize when serving this unique population with special needs. A case study is included, in addition to suggestions for treatment collaboration and advocacy on behalf of clients with sensory processing disorder.

***Keywords:* Sensory processing disorder, special needs, children, school counselors, mental health counselors**

Children experience the world through their senses—the sound of the air conditioner running in their classroom, the feel of a chair under their legs, the sight of a colorful wall, the smell of food cooking, the muscle movement used to pick up a toy. The typical child can accurately perceive, process and respond to the myriad stimuli in their environment, focusing on important stimuli, such as a parent's voice, and filtering out unimportant ones, such as a humming refrigerator. For other children, the same environment and accompanying stimuli can be uncomfortable, overwhelming, unnoticeable and even frightening. Researchers estimate that approximately 5–17% of the population has sensory processing disorder (SPD), a neurological disorder in which sensory input is irregularly sensed, processed, organized, and responded to, creating sensory challenges that negatively impact daily functioning (Ahn, Miller, Milberger, & McIntosh, 2004; Ben-Sasson, Carter, & Briggs-Gowan, 2009). As a result of poor sensory processing, individuals with SPD may overreact or underreact to stimuli (Byrne, 2009; Dunn, 1997, 2001; James, Miller, Schaaf, Nielsen, & Schoen, 2011; Katz, 2006; Miller, Anzalone, Lane, Cermak, & Osten 2007; Walbam, 2013; Withrow, 2007). SPD is a lifelong disorder; while typically developing children gain the ability to increasingly suppress stimuli with age, children with SPD tend to struggle throughout their lifetime (Davies & Gavin, 2007), particularly if SPD is unidentified, misdiagnosed or inaccurately treated.

Professional counselors are called to accurately diagnose and treat clients' mental health and co-occurring disorders (American Counseling Association [ACA], 2014). However, SPD is widely unrecognized and misdiagnosed in the counseling field (Collier & Falls, 2010; Katz, 2006; Murphy, 2011; Withrow, 2007). With increasing research supporting the legitimacy of the SPD diagnosis (e.g., Chang et al., 2014; Davies & Gavin, 2007; Owen et al., 2013), counselors can be on the forefront of screening and providing counseling services to children with SPD. This article will provide readers with background information on SPD, implications for clinical mental health and school counseling practice, a case study example, and recommendations for future professional education, advocacy and research. In the literature, SPD has been referred to by similar terms such as sensory integration disorder or categorized by subtype (e.g., sensory modulation disorder). However, the term

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sensory processing disorder (SPD) will be utilized in this article, since SPD is the most prevalent term used in recent years (Miller, Nielsen, Schoen, & Brett-Green, 2009). Similarly, we will use the term sensory processing to also encompass sensory integration, as they are often used interchangeably in the literature.

Background

The most commonly known senses are auditory (sound), olfactory (smell), tactile (touch), visual (sight) and gustatory (taste); two less known senses are proprioception and the vestibular sense (James et al., 2011; Katz, 2006; Withrow, 2007). Proprioception is a sense found in muscles, tendons and joints that deciphers bodily awareness and coordinated movements. The vestibular sense is located in the inner ear and provides sensory input regarding one's balance and gravity. Sensory processing is a complex neurobiological process in which individuals' seven senses perceive information or stimuli from the environment, sending data to the brain to interpret, process and respond to; the senses and brain are constantly engaged in a process of perceiving, interpreting, processing, and responding to environmental stimuli (Byrne, 2009; Katz, 2006; Miller et al., 2009; Parham & Mailloux, 2015; Walbam, 2013; Withrow, 2007). Sensory processing is a developmental process, and thus especially crucial in the children's first 10 years of life (Ayres, 1979). In summary, a typically developing child may easily and accurately perceive and process environmental stimuli, yet this is not the case for all children.

Sensory processing has been well studied in the occupational therapy profession during the last 50 years, beginning with the groundbreaking work of Dr. A. Jean Ayres, occupational therapist, psychologist and neuroscientist (Parham & Mailloux, 2015). During the last several decades Ayres and others discovered patterns of atypical sensory processing in children, which have collectively come to be labeled as SPD. "Sensory processing disorder is a heterogeneous condition that includes a variety of subtypes. Individuals with the disorder have impaired responses to, processing of, and/or organization of sensory information that effects [sic] participation in functional daily life routines and activities" (Miller et al., 2009, p. 1). Further, Parham and Mailloux (2015) described SPD as "patterns that emerge developmentally . . . and are thought to reflect subtle neural processing differences involving sensory and motor systems" (p. 266). Thus, children with SPD struggle with the neurobiological cycle of receiving, sending, processing and responding to stimuli, and they experience a severity that negatively impacts their daily functioning (Ayres, 1979; Davies & Gavin, 2007; Owen et al., 2013; Parham & Mailloux, 2015). As a result of skewed sensory processing, individuals with SPD may overreact or underreact to stimuli, perceiving stimuli to much greater or lesser degrees than peers (Byrne, 2009; Dunn, 1997, 2001; James et al., 2011; Katz, 2006; Miller et al., 2007; Walbam, 2013; Withrow, 2007). For example, a crowded indoor playground could be loud to one child, but frightening or even physically painful for a child with auditory sensitivities. While a typical child may get dizzy from spinning around, a child with an underdeveloped vestibular system may rarely become dizzy and seek spinning to feel soothed.

Although children with SPD may have neurological similarities, SPD is a highly individualistic disorder that presents differently in each child and can be described by corresponding subtypes (Dunn, 1997, 2001; James et al., 2011; Murphy, 2011; Walbam, 2013; Withrow, 2007). While there is consensus on an overarching definition for SPD, there is not a consistent nosology for describing the subtypes (Miller et al., 2009). Proposed nosologies of SPD subtypes typically include hyposensitivity, hypersensitivity and sensory-seeking subtypes (Ayres, 1979; Dunn, 1997, 2001; Interdisciplinary Council on Developmental and Learning Disorders, 2012; James et al., 2011; Katz, 2006; Miller et al., 2007; Walbam, 2013; Zero to Three, National Center for Infants, Toddlers and Families, 2005).

Subtypes

Those with hyposensitivities, one subtype of SPD, often have a high threshold for sensation, are under-sensitive, and receive or process too few stimuli (Dunn, 1997, 2001; James et al., 2011; Katz, 2006; Walbam, 2013; Withrow, 2007). A child with hyposensitivities may seem to have poor social skills and miss social cues; some behavioral examples include not hearing a teacher calling his or her name, being unaware of food on the face, or lacking culturally appropriate personal space. Social skill deficits can negatively impact children's friendships and group participation in both academic and social environments (Dunn, 1997; Kranowitz, 2005; Withrow, 2007).

Children with hypersensitivities, a second subtype of SPD, have a low threshold for sensation and may receive an overwhelming amount of stimuli, be unable to prioritize their sensory messages and be easily overstimulated (Dunn, 1997, 2001; James et al., 2011; Katz, 2006; Walbam, 2013; Withrow, 2007). As a coping technique against stimuli perceived as uncomfortable and even painful, children with hypersensitivities may have heightened alertness, act aggressively toward others in response to perceived threats, and engage in behavioral outbursts and rigid routines in attempts to avoid or escape stimuli (Dunn, 1997; Withrow, 2007). These children may be described as generally anxious, aggressive, distracted or unfocused, or as picky eaters.

Lastly, some children with a third subtype of SPD crave and actively seek sensory input and increased stimuli (Dunn, 1997, 2001). These children may seek constant movement to receive sensations from their environment, and exhibit behaviors including running, jumping, chewing, tapping, humming and squeezing (Dunn, 1997, 2001). Individuals with sensory-seeking behaviors may appear impulsive, unpredictable, and have inappropriate personal space which may negatively impact academics and social relationships. Children who seek sensations may be described as rambunctious, aggressive, or bouncing off the walls (sometimes literally). They may seek spicy foods and not be bothered by intense flavors.

Sensitivities and sensation seeking occur on a spectrum from mild to severe (James et al., 2011). Furthermore, these variations can present differently in each of the seven senses (Dunn, 1997, 2001), and children can even experience both hypersensitivities and hyposensitivities within the same sense (Withrow, 2007). This circumstance may baffle parents, who question how a child can watch a movie at a loud volume at home, yet be unable to tolerate the noise of a crowded restaurant. Children and the adults around them may need assistance recognizing children's placement on the hyposensitivity, hypersensitivity and sensory-seeking spectrums before, during and after an event which can facilitate children successfully coping and thriving in various settings.

Prevalence

Researchers have estimated that SPD occurs in approximately 5–17% of children (Ahn et al., 2004; Ben-Sasson et al., 2009). In one study examining the prevalence of SPD in children 4–6 years old, the parents of incoming kindergarten students in one U.S. school district ($N = 1,796$) were asked to complete the Short Sensory Profile, a parental-report screening tool used to determine parents' perceptions of SPD correlates (Ahn et al., 2004). Approximately 14% of those who completed the survey (with a 39% return rate) met the criteria for SPD. However, researchers conservatively estimated that if all non-responders were free from meeting the SPD criteria, then approximately 5% of this population would meet the screening criteria for SPD. Thus, the number of incoming kindergarten students who met the criteria for SPD based on parental perceptions ranged from 5–14%. Similarly, Ben-Sasson et al. (2009) used a longitudinal birth cohort sample of children to study sensory over-responsivity (SOR) and related correlates. They found that nearly 17% of the 7–11 year olds in their study ($N = 925$) had clinically significant elevated SOR scores. However, these researchers believe the number to be a conservative estimate of the population, as children with diagnosed medical and developmental conditions were excluded from the study.

Secondary Symptoms

All areas of a child's life can be impacted by SPD (Walbam, 2013; Withrow, 2007). In addition to children presenting primary symptoms of the disorder, they often face a host of secondary emotional and behavioral difficulties as a result of the disorder, such as frustration, loneliness, low self-esteem, a greater risk for strained peer relationships, discouragement, and social, emotional and academic challenges (Champagne & Koomar, 2012; Katz, 2006; Miller, Nielsen, & Schoen, 2012; Walbam, 2013; Withrow, 2007). Also, those with SPD tend to be more likely to struggle with depression and anxiety than their typically developing peers (Miller et al., 2012) and may need assistance with self-regulation (Katz, 2006). These secondary symptoms may result from attempted self-regulation due to negatively perceived sensory stimuli as well as feelings of isolation and being misunderstood due to undiagnosed, untreated and mistaken symptoms (Miller et al., 2012; Withrow, 2007). In this article, we describe the experiences of children with SPD as comparable to those of children with special needs including disabilities and chronic illnesses.

Diagnosis and Treatment

Early SPD diagnosis and treatment is crucial in assisting children with both primary and secondary SPD symptoms (Ben-Sasson et al., 2009; Byrne, 2009; Miller, 2006). SPD diagnosis and treatment early in life is highly impactful on a child's developing brain and behavioral symptoms (Ben-Sasson, et al., 2009; Miller, 2006). While occupational therapists (OTs) are charged with diagnosing and treating the primary symptoms and underlying conditions associated with SPD, counselors need to be aware of SPD in order to appropriately screen for, avoid misdiagnosing, make appropriate referrals for, and treat the secondary symptoms related to SPD.

Occupational therapy. Typically, OTs evaluate for and treat SPD (Castaneda, Olson, & Radley, 2013; Champagne & Koomar, 2012; Katz, 2006; Parham & Mailloux, 2015; Walbam, 2013). Children are often referred to OTs by parents, teachers and physicians (Parham & Mailloux, 2015); however, before making an OT referral, physicians need to rule out medical conditions and medication side effects. OTs assist people with daily living and occupational skills, and they are trained in mental and physical disorders (Castaneda et al., 2013). Since school is “work” for children, OTs help children with SPD to function more effectively in their academic work and social living skills. OTs can be school-based or work in community or hospital settings (Castaneda et al., 2013).

OTs use several strategies to assess for SPD, including interviews and questionnaires, direct observations (e.g., naturalistic and structured clinical) and standardized testing (Parham & Mailloux, 2015). SPD diagnoses often begin with the use of a screening tool to determine the existence of symptoms signifying possible sensory irregularities. The Sensory Profile 2 (Dunn, 2014) is a standardized, parental-report tool for evaluating children's sensory processing patterns in various environments and requires a B-level qualification to administer (Dunn, 2014). The Sensory Integration and Praxis Tests (SIPT) is a popular, recommended and standardized comprehensive test for measuring sensory integration and requires a C-level qualification to administer (Ayres, 1989). The SIPT was normed on approximately 2,000 children in North America and is considered a valid and reliable assessment.

The sensory integration approach to occupational therapy is commonly used to treat SPD; the overarching goal of this intervention is to enable a child's nervous system to more efficiently process and respond to sensory information (Parham & Mailloux, 2015). Occupational therapy is highly specialized based on the child's unique needs and diagnosis. Further, occupational therapy also may include the use of a sensory diet—an individualized program for children with sensory challenges including a specific combination of sensory activities throughout the day (Parham & Mailloux, 2015). A sensory diet provides a wide range of sensory input; for example, activities may evoke the senses through music, new smells, visual stimulus, as well as “movement, heavy work, or tactile stimulation” (Hall & Case-Smith, 2007, p. 212).

Clinical diagnosis. The occupational therapy profession has treated SPD for decades. Furthermore, the SPD Scientific Work Group, including approximately 40 interdisciplinary research scientists from various specialties (e.g., neurology, pediatrics, occupational therapy, psychiatry, autism, psychology) has regularly met since 2002 with the aim of studying SPD; members' efforts have been funded through both the Wallace Research Foundation and National Institutes of Health (SPD Foundation, 2014). However, much controversy has existed regarding SPD as an independent disorder, particularly in the psychiatry and psychology professions, whose members have raised the following criticisms: "(1) an absence of formal diagnostic criteria, (2) high prevalence among children with developmental disorders such as autism spectrum disorders . . . (3) unknown etiology, and (4) lack of epidemiological evidence related to this condition" (Ben-Sasson et al., 2009, p. 706). These criticisms will be addressed in the subsequent paragraphs.

Diagnostic criteria. Sensory disorders are found both in the *Diagnostic Manual for Infancy and Early Childhood* (Interdisciplinary Council on Developmental and Learning Disorders, 2012) and the *Zero to Three's Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood-Revised* (Zero to Three, 2005). For example, the Zero to Three was created by an interdisciplinary group of researchers and clinicians to complement the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders (DSM)* with a specific focus on the unique development of and disorders found among infants and young children. This nosology includes two sensory-related disorders: Hyposensitive/Underresponsive (420) and Sensory Stimulation-Seeking/Impulsive (430), describing the sensory reactivity patterns, motor patterns and behavioral patterns of each disorder (Zero to Three, 2005).

The APA reviewed SPD for consideration in the *DSM-5* (Levingston, 2014; Murphy, 2011) and groups such as the SPD Scientific Work Group lobbied for its inclusion (SPD, 2012, 2014). The full diagnosis of SPD was not included in *DSM-5* reportedly due to lack of research (Levingston, 2014). However, the new Avoidant/Restrictive Food Intake Disorder does recognize that sensory aspects of food can cause a significant food disturbance (e.g., texture, smell, spiciness; APA, 2013). Further, in the *DSM-5* the APA recognized sensory issues as a part of autism spectrum disorder (ASD), including: "hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment" (APA, 2013, p. 50). While the *DSM-5* does not recognize SPD as an individual disorder, we find it promising that SPD was considered for inclusion and that sensory issues were added to the most recent *DSM*. The *DSM* has evolved and will likely continue to evolve based on research advances (APA, 2013) and we are hopeful that SPD will be considered for inclusion in the next edition of the *DSM*, especially with recent research advances (e.g., Chang et al., 2014; Owen et al., 2013).

In addition to the *DSM*, the 10th revision of the *International Statistical Classification of Diseases (ICD-10; World Health Organization, 2013)* and the *ICD-9 (Centers for Disease Control and Prevention, National Center for Health Statistics, 1991)* are other commonly used nosologies. Although the *ICD* does not specifically identify sensory issues, OTs may use the following codes to diagnose clients: lack of normal physiological development, unspecified (783.40; *ICD-9*); other symptoms involving nervous and musculoskeletal systems (781.99; *ICD-9*), and unspecified lack of expected normal physiological development in childhood (R62.50; *ICD-10*; E. Smolak, personal communication, January 15, 2015). Thus, professionals can use *ICD* codes related to SPD.

SPD research. Researchers have determined distinct patterns among children with SPD varying from those among their typically developing peers. Specifically, when comparing children with clinically determined atypical sensory processing to their typically developing peers, researchers found that the former exhibited differences in their physiological responses to sensory stimuli (McIntosh, Miller, Shyu, & Hagerman, 1999), parasympathetic nervous system functioning (Schaaf et al., 2010; Schaaf, Miller, Seawell, & O'Keefe, 2003), and differences in both behavioral and physiological measures (Schoen, Miller, Brett-Green, & Nielsen, 2009).

Additionally, Davies and Gavin (2007) and Gavin et al. (2011) found differences in brain activity between children with and without SPD using electroencephalography. In fact, “brain activity correctly distinguished children with SPD from children who were typically developing with 86% accuracy” (Davies & Gavin, 2007, p. 176). Finally, in a recent study ($N = 40$), Owen et al. (2013) found neurological differences in brain structure between children with and without SPD, specifically stating:

Children with SPD show specific reduction in the white matter microstructure primarily affecting posterior cerebral tracts. . . . These findings suggest that children with SPD have a specific imaging biomarker for their clinical disorder and the pattern of their shared structural difference. (p. 850)

Significant sensory abnormalities (e.g., SPD) can be comorbid with several childhood clinical disorders such as ASD, attention-deficit/hyperactivity disorder (ADHD), anxiety disorders, depression, Fragile X syndrome and obsessive-compulsive disorder (Ghanizadeh, 2011; Goldsmith, Van Hulle, Arneson, Schreiber, & Gernsbacher, 2006; Tomchek & Dunn, 2007; Van Hulle, Schmidt, & Goldsmith, 2011). At the same time, researchers are suggesting that SPD is a separate and distinct disorder. For example, when studying youth with ASD and SPD, Schoen et al. (2009) demonstrated differences in sympathetic nervous system functions and sensory-related behaviors between children in the two samples, while Chang et al. (2014) reported differing patterns of brain connectivity in adolescents with the two separate diagnoses. In addition, Miller et al. (2012) studied differences between youth with SPD, ADHD and the two dual diagnoses by using several parental-report instruments and measuring physiological reactions to sensory stimuli by electrodermal response. They found that participants with ADHD had greater inattention and participants with SPD had the most sensory issues, while those with both diagnoses experienced inattention and fewer sensory issues than those who only had SPD. Further, participants with SPD had greater physiological or electrodermal reactivity to sensory stimuli than participants with ADHD (Miller et al., 2012). Overall, differences seem to exist between participants with SPD and those with similar but varying clinical diagnoses (e.g., ADHD and ASD), suggesting SPD as an individual disorder.

Etiology. While the etiology of SPD is still largely unknown, several researchers believe that SPD may have a genetic basis (e.g., Goldsmith et al., 2006; Miller et al., 2009; Owen et al., 2013; Van Hulle et al., 2011). For example, Goldsmith et al. (2006) studied the tactile and auditory defensiveness, temperament, and behavior problems of toddler-aged twins as determined by parent reports. Researchers determined moderate genetic influences with tactile defensiveness, leading them to suggest more research investigating the heritability of SPD and sensory issues.

Overall, although SPD is controversial, there is substantial evidence for SPD as a distinct disorder in children. According to the APA (2013),

A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. (p. 20)

Based on the literature review, we believe that SPD meets the APA's criteria for a mental health disorder, due to an irregular neurological pattern of receiving, sending, processing and responding to stimuli, which results in impairment to an individual's regular behavioral and emotional functioning.

Professional counseling. SPD has received some, albeit limited recognition in the counseling field (e.g., Collier & Falls, 2010; Katz, 2006; Withrow, 2007), including an article featured in *Counseling Today* (Murphy,

2011). However, SPD seems to be widely unrecognized in the counseling profession. Counselors may often misdiagnose this neurological condition due to clients' highly individualized presentations, as well as SPD symptoms mirroring those of other disorders (Collier & Falls, 2010; Katz, 2006; Murphy, 2011; Walbam, 2013). SPD can present as ADHD through impulsive and inattentive behaviors; ASD through social deficits, rigidity and sensory symptoms; and depression and anxiety through withdrawn and lethargic behaviors. Well-known author and OT Carol Kranowitz wrote the following:

Many parents, educators, doctors, and mental health professionals have difficulty recognizing SPD. When they don't recognize the problem, they may mistake a child's behavior, low self-esteem, or reluctance to participate in ordinary childhood experiences for hyperactivity, learning disabilities, or emotional problems. Unless they are educated about SPD, few people understand that bewildering behavior may stem from a poorly functioning nervous system. (2005, p. xxiv)

SPD and sensory challenges are often unrecognized, misdiagnosed and considered solely behavioral, psychological or emotional issues (Parham & Mailloux, 2015).

An accurate diagnosis is imperative for client treatment and is included as follows in the 2014 *ACA Code of Ethics*, section E.5.a.: "Counselors take special care to provide proper diagnosis of mental disorders" (ACA, 2014, p. 11). Counselors are ethically required to thoughtfully consider mental diagnostic possibilities and to accurately diagnose clients. However, medical and mental disorders can be commonly misdiagnosed, especially when many disorders have similar symptoms and overlapping criteria (Pollak, Levy, & Breitholtz, 1999). Misdiagnoses may have long-term ramifications for individuals, including ineffective treatment and secondary concerns due to unmet needs, such as anxiety, depression, low self-esteem, and poor academic and social functioning (Katz, 2006; Kinnealey & Fuiek, 1999; Miller, 2006; Miller et al., 2012; Withrow, 2007). Lack of an accurate diagnosis also can lead to poor use of resources and harmful or even fatal client outcomes (Pollak et al., 1999). In order to uphold the ACA's ethical standards for accurately diagnosing clients, as well as to meet clients' needs, it is imperative that counselors are aware of SPD and work in tandem with other service providers when warranted in order to ensure that each client receives an accurate diagnosis and treatment.

Counselor Implications

All Professional Counselors

Given the prevalence of SPD, counselors are likely already working with clients who have SPD. Thus, counselors across settings need to be aware of SPD and related counseling implications. Since early intervention is preferred, counselors who work with children should be at the forefront for recognizing and addressing SPD in session. This section will focus on the following: awareness and education, screening and diagnosis, treatment team, treatment goals, counseling strategies, and counseling accommodations.

Awareness and education. First and foremost, counselors must possess knowledge of SPD as a neurological disorder and awareness of SPD characteristics in children. There is limited counseling-related SPD literature (e.g., Collier & Falls, 2010; Katz, 2006; Murphy, 2011; Withrow, 2007), and in our experiences as counselor educators and practitioners, we have seen very little SPD information in counseling textbooks or at counseling conferences. Thus, counselors may need to seek educational and training opportunities outside the counseling field in order to stay abreast of SPD.

Screening and diagnosis. Counselors can screen for SPD through the process of differential diagnosis to see if the symptoms (a) are part of a separate mental health diagnosis, (b) indicate SPD misdiagnosed as another

disorder or (c) are co-occurring (Byrne, 2009). Screening and diagnosis are complicated due to SPD often co-occurring with other mental health disorders (Walbam, 2013). Additionally, context is critically important when counselors identify diagnostic criteria, as well as triggers and antecedents to emotional and behavioral responses. For example, a child who presents characteristics of ADHD (e.g., impulsiveness and hyperactivity) also should be considered for SPD, as this child could lack physical stimulation and seek sensory input to self-modulate. Dr. Roianne Ahn, a licensed psychologist, SPD researcher and staff member at the Sensory Therapies and Research Center provides training to mental health clinicians regarding recognizing SPD in clients. When clinicians suspect that a child has sensory abnormalities, Dr. Ahn encourages them to use a parental-report screening checklist (e.g., Appendix A: Sensory Processing Disorder Checklist or the Sensory Profile 2) to initially screen for SPD symptoms and then recommend a formal occupational therapy evaluation (R. Ahn, personal communication, November 7, 2014). With the high prevalence of SPD, professional counselors may want to consider including a screening checklist in initial client paperwork.

Treatment team. Counselors can consult and collaborate with stakeholders through the use of a treatment team (Katz, 2006; Murphy, 2011; Walbam, 2013). The purpose of the treatment team is to collaborate on the child's needs and treatment across various settings, gaining the perspectives of diverse stakeholders. A treatment team can be comprised of the counselor (e.g., school counselor, mental health counselor), OT, parents or caregivers, and teachers. The treatment team may include the child's pediatrician and potentially a nutritionist when appropriate. Counselors can play a vital role as part of a treatment team by coordinating the interdisciplinary team. Also, family involvement is crucial—parents or caretakers often know their child best, children are heavily impacted by their families, and parents or caretakers often advocate for their child on a long-term basis.

Through the collaborative treatment team, counselors can identify and advocate for resources for children with SPD and their families in order to improve their daily functioning (Walbam, 2013; Withrow, 2007). Treatment teams can discuss children's needs, accommodations and resources, ensuring that stakeholders are working collaboratively to serve the child. For example, one function of the treatment team may be consultation to discuss the child's sensory diet in multiple settings, such as chewing gum to remain attentive in class or receiving calming deep pressure before school in the morning (Parham & Mailloux, 2015).

Treatment goals. Counseling treatment goals can incorporate suggestions from the treatment team. For instance, counseling treatment goals may focus on children's emotions, cognitions and behaviors pertaining to SPD (Kranowitz, 2005). Children with SPD may have a number of mental health concerns including anxiety, depression, low self-esteem, poor social skills and frustration (Champagne & Koomar, 2012; Katz, 2006; Miller et al., 2012; Walbam, 2013; Withrow, 2007). Similar to those with chronic illness (Cheu, 2013), children with SPD may have additional concerns including fear, grief, shame, anger or frustration. Furthermore, children may misunderstand SPD; thus, educating children and normalizing their experiences may be appropriate treatment goals (Withrow, 2007).

Other treatment goals can include the child adjusting to the diagnosis of SPD and identifying strategies for coping in social situations when SPD symptoms often occur (Murphy, 2011). For example, although home environments may be easily controlled to meet the child's sensory needs, children with SPD may need to cope with uncontrolled environments, such as a crowded grocery store or an odorous and loud public restroom. Thus, counseling treatment may include systematic desensitization—children increasingly coping with uncomfortable stimuli through increased exposure. Counseling can assist with behavioral, social and emotional symptoms related to SPD (Kranowitz, 2005), in addition to other disorders that may co-occur including anxiety, depression, ASD, attention-deficit disorder and learning disorders (Ostovar, 2009). Further, one disorder can

exasperate another (i.e., the child may have difficulty adjusting to a new environment if there is a change in sensory input, such as street noise by the child's bedroom window).

Counseling strategies. Counselors can provide individual, group and family counseling modalities (Withrow, 2007) using solution-focused and cognitive-behavioral techniques to address children's mental health needs and co-occurring disorders. For example, through individual counseling, children may increase their coping skills and self-esteem; through group counseling, children can improve their social skills. Further, counselors can assist clients to understand their disorder (Withrow, 2007), adjust to their limitations and capitalize on their strengths (Miller, 2006). Through the use of psychoeducation and bibliotherapy (see Appendix B), counselors can educate children about SPD, normalizing their experience. Further, by focusing on the child's strengths, counselors can emphasize the positives of SPD. For example, children who seek sensory input from spinning may excel in gymnastics or ice skating, while those who need physical input may thrive in contact sports.

Some mental health issues, such as children's anxiety, can be exacerbated by contextual factors like an unpredictable environment that may occur in everyday life situations as well as at special events (Ostovar, 2009). Taking a systems approach, counselors can work with family members and other service providers (e.g., teachers) to increase the predictability and children's understanding of their environment (Withrow, 2007). Thus, counselors can assist in identifying sensory triggers and establishing accommodations, while simultaneously addressing secondary emotional and behavioral symptoms that occur in various settings and situations.

Counseling accommodations. In conjunction with the treatment team's recommendations, counselors can make a number of small accommodations during their counseling sessions to support children with SPD as they engage in the counseling process (Withrow, 2007). First, counselors should be mindful of environmental stimuli in their offices, such as bright lights, highly decorated offices or intense smells, which may be distracting for a child with SPD. Counselors can keep smells to a minimum, for example, by not wearing perfume and asking office mates to refrain from using incense or scented candles. Next, varied seating options can increase children's comfort, as their needs may vary from firm to soft cushions and from smooth to more textured upholstery.

Similar to OTs (Kranowitz, 2005), counselors working with young children typically have numerous toys and materials to use in therapy (Landreth, Ray, & Bratton, 2009). Counselors may find that covering a shelf and only displaying a couple of items at once reduces children's feelings of being overwhelmed. Likewise, many children may enjoy a variety of arts and crafts materials, yet some children with SPD may not be able to tolerate getting glue or paint on their hands. Using a paintbrush for glue application and using hand wipes or a nearby sink to clean their hands may allow children to fully engage in the activity. In consultation with an OT, alternative materials can be selected. Based on the client's needs, therapeutic putty could be substituted for a regular modeling compound to provide more sensory input; a dry food box (e.g., uncooked rice, beans, pastas) could be substituted for a traditional sand tray to provide more tactile input through different textures; and markers with or without scents could be used as part of a child's sensory diet.

In consulting with the treatment team, the counselor may learn of the child's need to implement other movement strategies as part of a sensory diet to increase his or her participation during counseling. These movements may include use of a rocking chair, proprioceptive exercises or a fidget. Balancing counseling interventions with attending to sensory inputs may help the child best focus during counseling sessions.

Mental Health Counselors

Play-based strategies. Children, particularly young children, express their emotions, thoughts and experiences through the language of play (Trice-Black, Bailey, & Riechel, 2013). Children with SPD may have qualitatively different playing styles, which may affect their social development (Cosbey, Johnston, Dunn, & Bauman, 2012). Counselors can foster the achievement of social development therapeutic goals by examining the nature of children's play and the activities that children find most fulfilling. Cosbey et al. (2012) reported that children with SPD tend to participate in more solitary play, less complex play and greater overall conflict in play when compared to peers' play. Therefore, social development and play strategies may be a focus of counseling for children with SPD. Furthermore, Cosbey, Johnston, and Dunn (2010) recommended three potential goals in working with children with SPD: (a) identify activities that bring joy and meaning to the individual child, (b) strategize ways that the child can successfully engage in the activity, and (c) use these activities to build his or her social circles with peers. Similarly, counselors may use such activities to assist children with SPD in improving relationships and interactions with family members.

Family counseling strategies. A substantial aspect of serving a child with SPD involves working with and supporting the people important in the child's life, such as parents, siblings and other family members (Parham & Mailloux, 2015). When working from a family systems perspective, counselors should recognize the adjustment process for both parents and siblings. Just as children with SPD need to adjust to the diagnosis, so do their family members. The SPD diagnosis may bring a sense of relief to parents who have spent a long journey attempting to find an accurate diagnosis for their child (Parham & Mailloux, 2015). Some parents may feel grief and loss when their child is diagnosed with special needs, guilt for not obtaining the diagnosis sooner, and overwhelmed by navigating a new world of treatment expenses and accommodations (Anderson & Davis, 2011; Grossman & Okun, 2009; Marshak, Dandeneau, Prezant, & L'Amoreaux, 2010). Gourley, Wind, Henninger, and Chinitz (2013) found that parental stress was positively correlated with SPD severity, and that parents whose children had SPD had greater stress than those who had children without SPD. Thus, counselors can assist parents in processing their emotions, learning coping strategies, developing a plan of action and gaining a better understanding of SPD. Through psychoeducation (see suggestions in Appendix B), parents can learn about SPD and counselors can teach parents how to advocate for their children in various settings and situations (e.g., birthday parties, classroom activities, family gatherings; Ostovar, 2009; Withrow, 2007).

Another of the counselor's essential tasks may be providing support for parents (Cohn, May-Benson, & Teasdale, 2011), which can be accomplished through a local support group for parents of children with SPD or through family therapy. As the severity of SPD increases, so does the level of support needed by parents (Cohn et al., 2011). Cohn et al. (2011) found a significant correlation between an increase in a child's SPD severity and a decrease in parents' perceived parental competence. Informing parents about the benefits of proper treatment may not only increase the likelihood of children receiving the needed treatment, but also decrease parents' stress and anxiety related to parenting a child with special needs. Finally, family counseling may include treatment goals that center on establishing balance for the family system, as many families may have spent a large amount of family time and resources seeking an accurate diagnosis for their child (Gladding, 2015).

Siblings of children with special needs such as SPD may be negatively impacted in various ways, including greater likelihood of psychological or behavioral concerns, stressed relationships with parents, and missing parental attention (Anderson & Davis, 2011; Cohen, 1999). Engaging siblings in counseling can assist all the children in the family with adapting to the new family norms, routines and rules. For example, siblings can benefit from learning more about SPD (Parham & Mailloux, 2015) and processing their reactions to the SPD diagnosis, treatment and changes to the family system. Depending on the siblings' ages and developmental levels, understanding SPD and the related issues may be difficult for them to comprehend. For example,

siblings' interactive play may change significantly once triggers are identified for the child with SPD. Siblings may need to process their emotions in their own space; thus, a referral to a sibling support group or individual counseling may be warranted.

School Counselors

According to the American School Counselor Association (ASCA, 2013), school counselors are charged with serving all students, including students with disabilities and special needs. School counselors can serve students through increasing their own awareness of SPD, consulting and collaborating with stakeholders, advocating for necessary student services and accommodations, and providing students with individual and small group counseling (ASCA, 2013). Thus, school counselors can apply these strategies to their work with children who have SPD.

Education, consultation and collaboration. To serve students with SPD, school counselors should educate themselves about the disorder and be vigilant about the signs and symptoms. School counselors can consult with other school professionals such as the OT and parents or caretakers if they suspect SPD. As teachers and family members may possess little knowledge of SPD, school counselors can educate, consult and collaborate with these stakeholders (ASCA, 2013) to increase their understanding of the disorder and to learn to best support the child with SPD.

Accommodations. The 2008 amendments of Section 504 of the Rehabilitation Act of 1973 constitute a “federal law designed to protect the rights of individuals with disabilities in programs and activities that receive Federal financial assistance from the U.S. Department of Education” (U.S. Department of Education, 2013, Introduction, para. 2), including students in public schools. To be eligible under Section 504, students must have a confirmed physical or mental impairment that substantially impacts their functioning (U.S. Department of Education, 2013). If a student's SPD significantly impedes his or her school participation and learning, that student may be eligible for Section 504, including relevant accommodations, supports and a documented plan. School counselors can advocate for students receiving services under Section 504, as well as assist students and parents in navigating the educational system as they seek services.

To promote academic performance and social and emotional functioning in schools, 504 services vary based on the unique needs of each student. Accommodations should be individualized and based on information gathered from the student, family, teacher and diagnosing professionals. Once the student's sensory triggers are identified, the school counselor can examine each aspect of the child's day for potential triggers and modifications; small changes can make a significant difference. SPD accommodations in the classroom may include preferential seating, possibly with a larger personal space circumference (e.g., the student's own table for classroom work and testing), sensory breaks in the classroom, “heavy work” (e.g., delivering books to the library), increased time for assignments and tests, and a quiet location for testing. Some students with poor muscle coordination may require accommodations for underdeveloped fine motor skills, such as using a mechanical pencil for short assignments, a computer for longer writing assignments and pencil grips. In coordination with an OT, other accommodations may include a weighted vest or lap pillow, a balance ball chair instead of a traditional seat, and fidgets or stress balls to help increase attending behavior, reduce stress and increase hand muscle strength. If available and as needed, students can meet with a school-based OT to further address SPD symptoms in the classroom.

In addition to focusing on student accommodations for accessing the core curriculum, students with SPD may struggle with the elective or “specials” classes, unplanned situations, transitions and unstructured time outside of the classroom. While many children love playing tag during recess or physical education (P.E.), a student who is sensory defensive may dread this and similar activities. Thus, a P.E. accommodation

may be engaging in a different noncontact sport. Alternatively, children who need sensory input may have accommodations to complete additional jumping jacks or wall pushes beyond P.E. class. In addition, a child with gross motor skill challenges could receive accommodations to strengthen and develop those areas without being penalized for failure to meet grade-level expectations. With any sport, an OT can assess a child's physical strengths and challenges, working with P.E. teachers, coaches and parents to select appropriate individual or group activities based on the SPD presentation in each child (Kirkpatrick, 2012).

As previously mentioned regarding play-based techniques, some creative arts activities may be troublesome for children with SPD. Accommodations in art class should ensure that students with SPD participate to the best of their ability, and receive modified assignments and grading protocols (e.g., extra time to complete assignments). Likewise, students in music class may need to utilize their noise reduction headphones. Finally, school counselors should be mindful of students' schedules, advocating for "specials" classes to be spaced out and at the end of the day when possible, as children with SPD who have multiple triggers are apt to have challenges concentrating once back in their regular classroom.

Children with SPD may be fearful of unexpected situations due to concern that a sensory trigger will occur. Providing students with advance warning can assist them during these situations. For instance, students can receive advance notice for fire drills and prearranged substitute teachers. The school counselor can check on the students during such triggering events to determine their reactions and ensure that accommodations are implemented. The school counselor can coach children to advocate for themselves in these situations, for example, by asking a substitute teacher to reduce the classroom noise level, or wearing noise-canceling headphones during fire drills.

Students with SPD may benefit from accommodations assisting them with daily school transitions. For example, a visual reminder (e.g., written schedule) may help reduce students' anxiety surrounding transitions. To preserve personal space when transitioning between classes, younger students can receive preferential order in line, while older students can receive permission to walk in the hallways immediately before or after their peers.

Children with SPD may find unstructured school time to be difficult due to the magnitude of overwhelming sensory input. School counselors can assist students with SPD by collaborating with them and other stakeholders to create modifications for unstructured school times (e.g., recess, lunch, school assemblies, class parties, bathroom breaks, transportation to and from school). Accommodations may include preferential seating, noise-canceling headphones and decreased time in such situations. Further, students should be provided a safe place to decompress when overstimulated.

When annually reviewing 504 plans and adjusting accommodations, school counselors need to be aware that students' triggers and challenges may change at different developmental and chronological ages. For example, high school students with SPD may require unique accommodations in various situations such as the following: during driver's education (e.g., not driving with other students in the car), while dissecting frogs in biology or when using odorous chemicals in chemistry. Biological changes in adolescence produce new and potentially triggering smells, such as the P.E. locker room at the secondary level. Thus, school counselors may need to (a) advocate for accommodations to counter these scenarios that may emerge in middle and high school, and (b) further address the emotions related to dealing with SPD symptoms in the classroom and in social situations with classmates that may occur with the onset of adolescence.

Counseling. In addition to assisting with accommodations, school counselors can conduct individual and small group counseling for students with SPD in order to help them succeed in school (Collier & Falls, 2010).

School counselors can provide counseling to address students' emotional and mental health concerns, which may include anxiety, depression, low self-esteem, poor social skills and frustration (Champagne & Koomar, 2012; Katz, 2006; Miller et al., 2012; Walbam, 2013; Withrow, 2007). School counseling may address students' anxiety about school transitions and school-related sensory reactions by teaching students coping skills. School counselor-led counseling can normalize the experience of children with SPD, combating potential feelings of self-consciousness and isolation. Through the use of bibliotherapy and psychoeducation (see Appendix B), students can learn improved self-regulation and organization skills as well as self-advocacy and assertiveness. For example, students can learn to advocate for themselves by participating in their 504 plan meeting, as well as learn to develop strategies for communicating with teachers when becoming overwhelmed by sensory stimuli.

When students with SPD receive accommodations and counseling, classmates may express jealousy or frustration, similar to siblings. The school counselor can help process these situations and role-play social interactions in individual or group settings. Further, school counselors can assist teachers in offering sensory modulation strategies for an entire class, in order to prevent the child with SPD from being singled out. The following is a case study of how a counselor can intervene with a child who has SPD.

Case Study

Euna is a 6-year-old, second-generation Korean American attending her first year of school as a first-grade student in public school. Her parents are professionals, and she is an only child who had an in-home nanny and no formal preschool. At school, she shows little variation in affect and rarely speaks to peers. However, she and her parents speak at home, often in quiet voices. Euna flinches when touched and her parents describe her as a picky eater and uncoordinated. She does not like school; at home she has daily outbursts prior to departing for the school bus. Euna does not have reciprocal friendships in school and often sits alone in the cafeteria during lunch. Often she requests to visit the nurse to avoid the cafeteria during lunch.

Euna visits a mental health counselor for anxiety; this counselor has basic awareness of SPD. After the intake and initial counseling session with Euna, the mental health counselor suspects SPD and gathers additional background information from Euna's parents as well as a release of information to speak to Euna's teacher and school counselor. Next, the mental health counselor gathers background information from Euna's school counselor and teacher about her school functioning. After completing screening checklists (e.g., Appendix A: Sensory Processing Disorder Checklist or the Sensory Profile 2), the mental health counselor and school counselor provide Euna's parents with an OT referral for formal evaluation and recommend that her parents first speak to the pediatrician; the counselors obtain a release of information to be able to speak with the OT and pediatrician. The OT determines that Euna does have SPD, and through the physical examination, Euna's pediatrician rules out other potential physiological causes for symptoms. The pediatrician also provides a referral to a nutritionist who can ensure that Euna is obtaining proper nutrition and gradually increase the types and textures of food in Euna's diet.

After consulting with the OT and pediatrician, the school and mental health counselors work together to provide bibliotherapy resources for the family, education for the teacher and school staff, and coping strategies for Euna in school, at home and in the community. They collaborate with the OT to incorporate sensory strategies that will enhance counseling sessions with Euna. Lastly, the school counselor invites the OT and mental health counselor to participate in the development of the 504 plan to provide accommodations for Euna to be successful in school.

During the last several years, authors have presented variations of the Euna case study to audiences in counseling classes and conferences, asking for participants' thoughts on a preliminary diagnosis for further exploration. Common participant responses include trauma, anxiety and school phobia; this is not surprising, as SPD can be easily misdiagnosed as other disorders.

Summary and Recommendations

SPD is a neurological disorder that impacts the daily functioning of children across settings. Thus, to advocate on behalf of children with SPD in mental health and school settings, counselors need to increase their SPD-related education, advocacy, screening, treatment, stakeholder collaboration and research. First, counselors should become increasingly knowledgeable about and advocate for an increased awareness of SPD within the counseling profession. We recommend that counselors advocate for the inclusion of SPD in diagnostic standards, such as the future edition of the *DSM*, and in counselor education, professional development and counseling literature. By increasing the counseling profession's knowledge of SPD, counselors can provide children with more appropriate and earlier treatment interventions.

Next, counselors need to effectively screen for SPD and collaborate with parents and other professionals to treat the primary and secondary needs of children with this disorder. Also, counselors can educate stakeholders on SPD, including teachers and parents. By further demystifying and clarifying SPD for professionals and family members, these stakeholders can best support children with SPD, improving their quality of life and achieving treatment goals.

Conducting and publishing counseling-related SPD research can add professional credibility and recognition of SPD. In the future, researchers should investigate the following: (a) counselors' awareness of SPD; (b) mental health, school, and family counseling interventions used for children with SPD; (c) consultation practices with other service providers to serve children with SPD; and (d) perceptions and outcomes of clients with SPD receiving counseling services in an effort to develop future evidence-based best practices. Also, researchers can explore the psychometric properties of instruments used to screen for SPD, perceptions regarding these instruments, and effectiveness of counselors using these instruments. Finally, counselors can conduct interdisciplinary research with OTs, as future SPD research areas outlined by the American Occupational Therapy Association (2014) are related to counseling treatment goals pertaining to SPD (e.g., social communication, anger management, academic performance, behavior issues). When counselors and researchers engage in self-education and professional education, more accurate screening, evidence-based counseling treatment strategies, stakeholder education and collaboration, and research, they advocate for children with SPD across settings and have the potential to dramatically improve the lives of many children.

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Appendix A

Sensory Processing Disorder Checklist

© Sensory Therapies And Research (STAR) Center, 2006
Retrieved from <http://spdfoundation.net/library/checklist.html>

Many of the symptoms listed in the following categories are common to that particular age group. Where more than a few symptoms are found in a child, we recommend you talk to your doctor or check the SPD Foundation's Treatment Directory for a professional experienced with treating Sensory Processing Disorder.*

Infant/ Toddler Checklist:

- ☐ My infant/toddler has problems eating.
- ☐ My infant/toddler refused to go to anyone but me.
- ☐ My infant/toddler has trouble falling asleep or staying asleep
- ☐ My infant/toddler is extremely irritable when I dress him/her; seems to be uncomfortable in clothes.
- ☐ My infant/toddler rarely plays with toys, especially those requiring dexterity.
- ☐ My infant/toddler has difficulty shifting focus from one object/activity to another.
- ☐ My infant/toddler does not notice pain or is slow to respond when hurt.
- ☐ My infant/toddler resists cuddling, arches back away from the person holding him.
- ☐ My infant/toddler cannot calm self by sucking on a pacifier, looking at toys, or listening to my voice.
- ☐ My infant/toddler has a "floppy" body, bumps into things and has poor balance.
- ☐ My infant/toddler does little or no babbling, vocalizing.
- ☐ My infant/toddler is easily startled.
- ☐ My infant/toddler is extremely active and is constantly moving body/limbs or runs endlessly.
- ☐ My infant/toddler seems to be delayed in crawling, standing, walking or running.

Pre-School Checklist:

- ☐ My child has difficulty being toilet trained.
- ☐ My child is overly sensitive to stimulation, overreacts to or does not like touch, noise, smells, etc.
- ☐ My child is unaware of being touched/bumped unless done with extreme force/intensity.
- ☐ My child has difficulty learning and/or avoids performing fine motor tasks such as using crayons and fasteners on clothing.
- ☐ My child seems unsure how to move his/her body in space, is clumsy and awkward.
- ☐ My child has difficulty learning new motor tasks.
- ☐ My child is in constant motion.
- ☐ My child gets in everyone else's space and/or touches everything around him.
- ☐ My child has difficulty making friends (overly aggressive or passive/ withdrawn).
- ☐ My child is intense, demanding or hard to calm and has difficulty with transitions.
- ☐ My child has sudden mood changes and temper tantrums that are unexpected.
- ☐ My child seems weak, slumps when sitting/standing; prefers sedentary activities.
- ☐ It is hard to understand my child's speech.
- ☐ My child does not seem to understand verbal instructions.

School Age:

- ☐ My child is overly sensitive to stimulation, overreacts to or does not like touch, noise, smells, etc.
- ☐ My child is easily distracted in the classroom, often out of his/her seat, fidgety.
- ☐ My child is easily overwhelmed at the playground, during recess and in class.

- ☐ My child is slow to perform tasks.
- ☐ My child has difficulty performing or avoids fine motor tasks such as handwriting.
- ☐ My child appears clumsy and stumbles often, slouches in chair.
- ☐ My child craves rough housing, tackling/wrestling games.
- ☐ My child is slow to learn new activities.
- ☐ My child is in constant motion.
- ☐ My child has difficulty learning new motor tasks and prefers sedentary activities.
- ☐ My child has difficulty making friends (overly aggressive or passive/ withdrawn).
- ☐ My child gets stuck on tasks and has difficulty changing to another task.
- ☐ My child confuses similar sounding words, misinterprets questions or requests.
- ☐ My child has difficulty reading, especially aloud.
- ☐ My child stumbles over words; speech lacks fluency, and rhythm is hesitant.

Adolescent/Adult:

- ☐ I am over-sensitive to environmental stimulation: I do not like being touched.
- ☐ I avoid visually stimulating environments and/or I am sensitive to sounds.
- ☐ I often feel lethargic and slow in starting my day.
- ☐ I often begin new tasks simultaneously and leave many of them uncompleted.
- ☐ I use an inappropriate amount of force when handling objects.
- ☐ I often bump into things or develop bruises that I cannot recall.
- ☐ I have difficulty learning new motor tasks, or sequencing steps of a task.
- ☐ I need physical activities to help me maintain my focus throughout the day.
- ☐ I have difficulty staying focused at work and in meetings.
- ☐ I misinterpret questions and requests, requiring more clarification than usual.
- ☐ I have difficulty reading, especially aloud.
- ☐ My speech lacks fluency, I stumble over words.
- ☐ I must read material several times to absorb the content.
- ☐ I have trouble forming thoughts and ideas in oral presentations.

**While this checklist can't diagnose a child with SPD, it can be a helpful guide to see if additional testing should be done. When filling out this checklist, think about the child's behavior during the past six months.*

Appendix B

Abbreviated List of Sensory Processing Disorder Resources

Resources for Parents, Teachers and Counselors

- *Answers to Questions Teachers Ask about Sensory Integration: Forms, Checklists, and Practical Tools for Teachers and Parents* by Jane Koomar, Carol Kranowitz, Stacey Szklut, Lynn Balzer-Martin, Elizabeth Haber, Deanna Iris Sava
- *Building Sensory Friendly Classrooms to Support Children with Challenging Behaviors: Implementing Data Driven Strategies!* by Rebecca A. Moyes
- *The Out-of-Sync Child Has Fun, Revised Edition: Activities for Kids with Sensory Processing Disorder* by Carol Stock Kranowitz
- *The Out-of-Sync Child: Recognizing and Coping with Sensory Processing Disorder, Revised Edition* by Carol Kranowitz and Lucy Jane Miller
- *Parenting a Child with Sensory Processing Disorder: A Family Guide to Understanding and Supporting Your Sensory-Sensitive Child* by Christopher R. Auer
- *Raising a Sensory Smart Child: The Definitive Handbook for Helping Your Child with Sensory Integration Issues* by Lindsey Biel and Nancy Peske
- *Sensational Kids: Hope and Help for Children with Sensory Processing Disorder* by Lucy Jane Miller and Doris A. Fuller
- *Sensory Parenting, From Newborns to Toddlers: Everything is Easier When Your Child's Senses are Happy!* by Britt Collins and Jackie Linder Olson
- *Sensory Parenting, The Elementary Years: School Years Are Easier when Your Child's Senses Are Happy!* by Britt Collins and Jackie Linder Olson
- *Sensory Processing Disorder Foundation: <http://www.spdfoundation.net/index.html>*
- *Starting Sensory Therapy: Fun Activities for the Home and Classroom!* by Bonnie Arnwine
- *The Survival Guide for Travelling with a Sensory Kiddo: From Amusement Parks, to the Beach or a Weekend Road Trip to Visit Relatives...Sensory Help is Here!* by Angie Voss
- *Too Loud, Too Bright, Too Fast, Too Tight: What to Do If You Are Sensory Defensive in an Overstimulating World* by Sharon Heller
- *Understanding Your Child's Sensory Signals: A Practical Daily Use Handbook for Parents and Teachers* by Angie Voss
- *Your Essential Guide to Understanding Sensory Processing Disorder: When You See a Child Through Sensory Goggles... It ALL Makes More "Sense"!* by Angie Voss

Sensory Processing Disorder Checklists

- <http://www.sensory-processing-disorder.com/sensory-processing-disorder-checklist.html>
- <http://sinetwork.org/library/checklist.html>
- <http://www.sensationalbrain.com/sensory-activities-6-quick-ideas/>

For Children

- *The Adventures of Sensory Avoider Allie: Allie Only Eats Three Foods* by Angie Voss and Dillon Seglem
- *Arnie and His School Tools: Simple Sensory Solutions That Build Success* by Jennifer Veenendall
- *Ellie Bean the Drama Queen: A Children's Book about Sensory Processing Disorder* by Jennie Harding and Dave Padgett
- *I'm Not Weird, I Have Sensory Processing Disorder (SPD): Alexandra's Journey (Growing with Love)* by Chynna T. Laird
- *Meghan's World: The Story of One Girl's Triumph over Sensory Processing Disorder* by Diane M. Renna and Regina Stark
- *Picky, Picky Pete* by Michele Griffin
- *Sensitive Sam: Sam's Sensory Adventure has a Happy Ending!* by Marla Roth-Fisch
- *Squirmy Wormy: How I Learned to Help Myself* by Lynda Farrington Wilson
- *This is Gabriel Making Sense of School: A Book About Sensory Processing Disorder* by Hartley Steiner
- *Why Does Izzy Cover Her Ears? Dealing with Sensory Overload* by Jennifer Veenendall

Counseling Children With Cystic Fibrosis: Recommendations for Practice and Counselor Self-Care



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Cystic fibrosis is a progressive, chronic disease that affects approximately 30,000 adults and children in the United States. Counseling children with the special needs specific to cystic fibrosis can be overwhelming for mental health professionals due to the progressive and deteriorating nature of the illness, long-term contact with clients, and discouraging prognosis. Being exposed to long-term therapeutic relationships with chronically ill children and witnessing treatment failure can contribute to burnout, compassion fatigue and vicarious trauma in counselors, highlighting the need for targeted literature addressing holistic self-care strategies. The purpose of this manuscript is to provide a review of the current literature illuminating the challenges facing children with cystic fibrosis and to provide targeted self-care suggestions for professional counselors working with this population.

Keywords: children, chronic disease, compassion fatigue, cystic fibrosis, self-care

Cystic fibrosis (CF) is a chronic, terminal disease targeting most organ systems (Withers, 2012) and affects approximately 30,000 children and adults nationwide (Cystic Fibrosis Foundation [CFF], 2014a). CF primarily affects the gastrointestinal and respiratory systems (Withers, 2012), and although the life expectancy has greatly improved, CF is fatal and there is no known cure (CFF, 2014a). Counseling children with chronic illnesses, such as CF, presents special challenges for mental health professionals (Sidell, 1997), including professional counselors. As the nature and severity of clients' problems impact levels of counselor burnout or compassion fatigue (Figley, 2002), it is essential that professional counselors working with children with CF maintain healthy self-care practices.

There is an abundance of information examining the physiological aspects of CF that clients experience throughout the disease progression (CFF, 2014a; Pearson, Pumariega, & Seilheimer, 1991; Sawicki, Sellers, & Robinson, 2009; Sawicki & Tiddens, 2012). However, there is limited literature on the special considerations that need to be taken when counseling children with CF. Furthermore, there is a paucity of counseling literature targeting how professional counselors can foster personal self-care while working with young clients with special needs and chronic conditions. The purpose of this manuscript is to provide a review of literature that illuminates the challenges facing children with CF and provides a primer for self-care suggestions for professional counselors who work with these children.

Special Needs of Children with Cystic Fibrosis

Physiological Challenges Facing Children with Cystic Fibrosis

Professional counselors need to be knowledgeable of chronic diseases affecting their clients in order to be sensitive to the traumas experienced by children and families coping with illness (Thompson & Henderson,

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2007). CF is most commonly diagnosed during newborn screening and severely affects the exocrine system (CFF, 2014b). Within the exocrine system, there is a lack of appropriate enzymes available during digestion, so children with CF are unable to properly digest their food and absorb essential nutrients for healthy growth and development. They experience recurrent gastrointestinal distress such as issues of diarrhea and constipation with foul-smelling stools due to poor absorption (CF Living, 2014). As such, children with CF often suffer from malnutrition and an inability to maintain a healthy weight. However, the most notable signs and symptoms affecting children with CF result from chronic lung and respiratory infections that lead to frequent coughing spells to clear the lungs of thick mucus. This inability to clear the lungs requires multiple episodes of daily chest physiotherapy (Berge & Patterson, 2004). Over time, the respiratory infections produce lung damage that appears cyst-like, giving name to the disease cystic fibrosis (CFF, 2014a).

Children with CF can spend hours per day on medical treatments such as nebulizer treatments to improve breathing, medications prior to meals to improve digestion, and oral, inhaled or intravenous antibiotics to treat respiratory infections (CF Living, 2014). However, disabilities from CF are not often visibly apparent until later stages of the disease. Decreased mobility and debilitating side effects from long-term medications, along with decreased lung capacity, all contribute to clients with CF requiring oxygen therapy for survival (Withers, 2012). The later stages of CF are inundated with frequent hospitalizations. Treatment during end-stage CF is palliative rather than curative (Lowton & Gabe, 2003), and without lung transplantation, CF remains a fatal disease due to respiratory failure (Hayes, Anstead, Warner, Kuhn, & Ballard, 2010). Nevertheless, medical breakthroughs have increased the survival rate of children with CF (Blum, 1992) and now many children are living into adulthood. Advanced clinical drug trials, aggressive antibiotic medications and innovative gene therapy research have been successful with CF clients of all ages. In 1955, children with CF were not expected to live to attend grade school. Children born with CF in this decade are projected to live into their 40s (CFF, 2014a). With this increase in life expectancy, health care teams are faced with unique challenges specific to the turbulence of adolescence and treatment compliance (Withers, 2012). Although there has been a predominant focus on treating CF based on medical science (Chesson, Chisholm, & Zaw, 2004), there is a strong interconnection of the psychosocial and physical challenges facing children and adolescents with CF. As such, professional counselors are called to increase their knowledge, skill and awareness of not just the physical challenges affecting children with CF, but also the emotional obstacles facing this population.

Psychosocial Challenges Facing Children with Cystic Fibrosis

Emotional and behavioral health disorders affect approximately 20% of all children and adolescents nationwide (Canning, Haner, Shade, & Boyce, 1992), and children with chronic illness may exhibit even higher incidences of mental health and psychosocial issues (Barnes, Eisenberg, & Resnick, 2010). For example, children with CF may experience extreme psychological challenges (e.g., depression, hopelessness, suicidal ideation) and physical complications (e.g., poor lung functioning, malnutrition) throughout the progression of their chronic condition. Taken together, these comorbidities contribute to the complexity of supporting an intense treatment modality (Anderson, Flume, & Hardy, 2001; Withers, 2012) that also promotes healthy psychosocial development and family system functioning (O'Haver et al., 2010).

In order to provide evidenced-based practices to clients with CF, as well as their families and loved ones, professional counselors need to be current on mental health research related to this special population. Studies have identified that children with CF may be predisposed to psychological issues and attachment and behavioral problems (Berge & Patterson, 2004) that may require additional training for professional counselors to effectively and efficiently counsel this population. When compared to healthy peers, children with chronic health conditions also have been found to have a slightly higher risk of attempting suicide (Barnes et al., 2010). Grief and loss, internal and external stress, negative body image, and difficulty managing emotions are common challenges experienced by children with CF (Berge & Patterson, 2004; Withers, 2012). In managing

these difficulties, internalizing behaviors and anxiety also have been found prominent among this population (Berge & Patterson, 2004). Younger male children with CF have been found to exhibit higher levels of anxiety (Bregnballe, Thastum, & Schiøtz, 2007) and female children with CF have demonstrated internalizing behaviors by expressing less anger than female children without CF (Bregnballe et al., 2007).

Although research supports the idea that individuals with chronic illnesses are at increased risk for depression (Quittner et al., 2008), studies conducted on individuals with CF have provided mixed results (Pearson et al., 1991; Thompson, Hodges, & Hamlet, 1990). Berge and Patterson (2004) identified higher incidences of depression among youth with CF, whereas Tluczek et al. (2014) found that patients with CF report similar psychosocial functioning as their healthy peers. One possible factor affecting the mixed reports of depression among children with CF may include the level of disease acceptance. Previous investigations have identified that the level of disease acceptance among youth with CF can significantly lessen levels of anxiety, depression and disability in adolescents with CF (Casier et al., 2008). Nonetheless, depression and depressive symptoms have been shown to impact the progression of chronic diseases, such as CF, by increasing the likelihood that clients will be less compliant with treatment regimens and partake in risky behaviors (Quittner et al., 2008; Withers, 2012). Hence, we recommend assessing and screening for depressive symptoms frequently and examining the level of disease acceptance in clients with CF. Professional counselors working with children with CF will need to further tailor interventions based on the client's symptom patterns (Chesson et al., 2004), while accounting for changes typical of childhood development.

Recently, scholars have researched the experiences of adolescents with CF in their transition to adulthood. This turbulent time (Withers, 2012) may need special consideration by professional counselors. Qualitative research on the experiences of adolescents with CF who were transitioning to adulthood generated the following three emerging themes: treatment compliance, health-related problems and future outlook concerning their disease (Berge, Patterson, Goetz, & Milla, 2007). Male participants described being more independent with treatment compliance, whereas females desired an accountability partner for their treatment regimen. Female participants expressed issues with depression, negative body image and fear of diabetes as a complication from CF, whereas males only disclosed their fear of acquiring diabetes as the disease progressed. Interestingly, both male and female participants expressed a positive outlook concerning CF regarding identity and acceptance of the disease (Berge et al., 2007). Identifying and maintaining a positive outlook while dealing with a chronic and debilitating illness can be a challenge for children with CF and their parents and families. Professional counselors working with youth with CF need to consider these findings. Special attention may be given to issues of treatment compliance, further physical complications from CF and maintaining a positive outlook.

Regarding risky behaviors (Quittner et al., 2008), teenagers with CF have admitted to using alcohol and drugs to seek relief from the challenges of CF (Vaeth & Martins, 2015). As such, professional counselors working with children with CF need to tailor interventions to the individuals' symptom-specific patterns (Chesson et al., 2004) and be mindful of behaviors that may hasten the disease process. The use of alcohol and drugs may hasten the disease's progression because of the ways in which these substances can interact with the client's current prescription medication regimen. Alcohol use may result in pancreatitis and a hypoglycemic reaction (Withers, 2012). Likewise, clients who smoke legal and illegal substances contribute to the deterioration of lung functioning. We recommend frequently assessing and screening for substance abuse and depressive symptoms and exploring the level of disease acceptance among youth with CF in creative, developmentally appropriate ways. Importantly, professional counselors preparing counseling interventions for children with CF need to account for the added psychosocial and developmental challenges that are typical in childhood development.

Special Considerations When Counseling Children with Cystic Fibrosis

Many children share similar psychological and developmental needs as they grow (Thompson & Henderson, 2007). However, children with chronic illness may struggle to be emotionally mature, while simultaneously managing the physical symptoms of their conditions (Dahlbeck & Lightsey, 2008). Furthermore, the psychosocial complexities and the chronic nature of CF may create unique challenges for professional counselors providing services to children and their families, such as the deteriorating nature of CF, frequent hospitalizations and the life-threatening prognosis (Frels, Leggett, & Larocca, 2009; Morison, Bromfield, & Cameron, 2003). Counseling professionals' increased sensitivity to the progression and impact of this disease can help guide their intervening efforts (Chesson et al., 2004) by leading them to consider the physiological and psychological trauma caused by CF. Professional counselors must ensure that they have developed rapport with the child as an individual, instead of a child with a disability (Thompson & Henderson, 2007).

Counseling interventions for children with CF begin with recognizing that children with CF are not adults with CF. Therefore, treatment and counseling efforts need to allow for special consideration of childhood development and understanding (Chesson et al., 2004; Geldard & Geldard, 2008). Chesson et al. (2004) offered suggestions for meeting the needs of children with chronic illnesses through counseling. First, counselors need to obtain the child's understanding of counseling (e.g., what it is, how it will help, roles, communication). Although parental support and involvement is important when counseling children (Geldard & Geldard, 2008; Morison et al., 2003), relying solely on parental reports is not a replacement for exploring the child's perspective of counseling (Geldard & Geldard, 2008). Chronic illnesses such as CF impact the whole family system (Kirk et al., 2013). However, within the therapeutic counseling relationship, children with CF must feel as if they are the experts on their lives and their mental health, regardless of age.

Second, counselors working with children should limit the amount of talking they do in session (Chesson et al., 2004) in favor of engaging children through natural modes of expression such as play, drawing and games. We recommend structuring counseling sessions to include discussions alongside an activity, versus a sole reliance on face-to-face conversation, in order to improve rapport building within the therapeutic relationship. Children engaging in healthy interdependent relationships with counselors can begin to develop a sense of independence and trust (Juntunen & Atkinson, 2002) within the counseling process, despite the tumultuous times during the disease progression. The adverse impact of chronic illness on social functioning (Last, Stam, Onland-van Nieuwenhuizen, & Grootenhuys, 2007) can lead to social withdrawal (Dahlbeck & Lightsey, 2008), which can be intensified when there is a concentrated focus on the child via adult approaches to counseling (e.g., making the child the center of attention to discuss his or her illness). As such, we recommend that professional counselors make age-appropriate and developmental adjustments to the counseling session and consider instituting group counseling modalities to counter the regularity of social isolation among these children.

Third, professional counselors developing a therapeutic relationship with a child experiencing CF must incorporate interactions that address the traumatic impact of living with the illness. Children with CF undergo physically stressful and painful experiences during medical treatment. Geldard and Geldard (2008) suggested that professional counselors clarify the nature of counseling and differentiate it from medical treatments. They also suggested maintaining an environment that provides acceptance and invites free disclosure. Professional counselors are urged to explain the distinction between counseling and medical procedures (e.g., there are no needles or painful medical procedures in counseling). Professional counselors also are encouraged to engage children in activities and play to reduce their level of anxiety and guardedness (Chesson et al., 2004). These targeted counseling strategies can promote resiliency factors such as self-efficacy and empowerment so that

children may cope with adversity throughout the illness (Dahlbeck & Lightsey, 2008; Luszczynska, Gutiérrez-Doña, & Schwarzer, 2005). Chesson et al. (2004) further suggested that counselors gradually establish the therapeutic relationship over a number of shorter sessions in order to establish trust with the child. We caution against rushing the counseling relationship-building process and encourage professional counselors to listen openly in order to understand the child's world.

As children struggle with chronic illnesses such as CF, acute emotional reactions are invariably triggered, which may increase the propensity for children to act out in self-injurious ways (Vaeth & Martins, 2015). The counseling process requires consistency and transparency when discussing how a child's treatment progress will be shared among adults. Accordingly, a fourth special consideration needs to be illuminated—the limits of confidentiality. Professional counselors must illustrate the circumstances when parents will be notified of instances of self-harm or suicidal and homicidal ideation. Given the susceptibility of children with chronic illnesses to depression (Quittner et al., 2008) and suicidal ideation (Barnes et al., 2010), coping with the challenges and effects of CF are constantly in the minds of these children. Rebecca Mueller (2001) illustrated this point as a young person struggling with the illness as follows:

All the information I have about my disease has been dispersed in small pieces over time. The idea that [when] a child with CF reaches a certain age, truth and honest answers should suddenly be given is awful. With the many different sides and aspects of CF or other diseases, the information needs to come out over time, giving the person time to react and contemplate. (p. 43)

Professional counselors working with children with CF understand the need for a collaborative approach in supporting individuals and families experiencing the trauma of chronic illness. Children with chronic diseases are involved with multiple treatment professionals (e.g., dietitians, respiratory therapists, physicians, nurses, case managers, mental health and school counselors). Chesson et al. (2004) recommended that counselors assist children with understanding the decisions made by their parents, doctors and other professionals about their treatment. This task can be done by assessing the child's knowledge of the disease process and treatment and initiating family sessions or sessions with other health care professionals when warranted. Ultimately, children who protest treatment interventions can be overridden by a caregiver's decision. When children have a history of adult-driven decisions related to life-preserving medical treatments, this experience can make behavioral counseling interventions difficult. We suggest that counselors make every effort to respect the feelings and wishes of children with CF, including helping to "coordinate services, rearranging physical environments, removing barriers and inconveniences, and securing special equipment and materials" (Thompson & Henderson, 2007, p. 713). Professional counselors can further facilitate this supportive process by empowering children to identify and articulate their perspectives on medical treatments, given their limited choices (Chesson et al., 2004; Morison et al., 2003).

Family Involvement

Family involvement is critical to all aspects of treatment of children with CF, starting with diagnosis. Parents and families are significantly affected when their child is diagnosed with a chronic illness (Anderson et al., 2001; O'Haver et al., 2010). Thompson and Henderson (2007) explained, "The demands for energy, time, and financial resources may add a heavy burden of stress to families" (p. 602). It is essential to note that families and children face myriad stressors related to the "uncertainty and uncontrollability" of chronic illness, along with "restrictions on their freedom" (Last et al., 2007, p. 102). However, family members (particularly parents) are often responsible for providing an environment in which children can develop resiliency and independence. Family members provide a supportive environment and help to promote children's sense of self-worth and ability to cope with challenging life situations (Juntunen & Atkinson, 2002). These tasks may be especially difficult for parents of children with CF in that they too are more vulnerable to higher incidences of depression

(Quittner et al., 2008; Tluczek et al., 2014). Hence, we recommend that professional counselors working with the family system ensure that parents of children with CF have access to the emotional supports necessary to sustain family functioning and equilibrium, including participation in their own counseling as needed (Tluczek et al., 2014). Similarly, professional counselors may find it necessary to provide parent education about the CF disease process in order to help parents identify strategies to enhance resiliency in their child (Juntunen & Atkinson, 2002).

Counseling children with CF involves implementing prolonged and gradual approaches to relationship building, increasing one's knowledge of the illness, adapting treatment approaches to account for the impact of invasive medical procedures, and involving parents, guardians and other professionals in the counseling process. Above all, honoring the perspective of the child is central to success in counseling this population, which can be easier said than done. The chronic and complex nature of CF and its treatment requires a great deal of effort and presents additional clinical challenges for professional counselors. Over time, the challenges of working with children with special needs can affect the wellness of professional counselors providing services. Therefore, it is important for counselors to recognize the factors contributing to impairment and burnout, particularly among counselors who work with children experiencing chronic illnesses like CF.

A Self-Care Primer for Professional Counselors

Professional counselors and other health professionals engaged in prolonged therapeutic contact with clients with CF are vulnerable to burnout, compassion fatigue and vicarious trauma (Coady, Kent, & Davis, 1990; Lewiston, Conley, & Blessing-Moore, 1981; Savicki & Cooley, 1987), potentially leading to impairment. Counselors have an ethical obligation to recognize their state of wellness and potential impairment (American Counseling Association [ACA], 2011), which may be impacted by burnout, compassion fatigue or vicarious trauma while working with children experiencing chronic conditions (Angerer, 2003; Kalliath, O'Driscoll, Gillespie, & Bluedorn, 2000; Najjar, Davis, Beck-Coon, & Doebbeling, 2009; Sexton, 1999) such as CF. Such occupational risks may be heightened when professionals work with clients with a poor prognosis associated with chronic illness, including CF (Coady et al., 1990).

Counselors and other mental health professionals experience occupational stressors such as long working hours, work with challenging clients, poor interdisciplinary support and poor supervision (Coady et al., 1990). Lewiston et al. (1981) examined burnout among health care providers working with clients experiencing CF. They found high levels of emotional exhaustion and client depersonalization (i.e., a sense of inability to impact clients' improvement while watching clients' illness progress), and a lower sense of accomplishment among health care providers working with this population. The implications of these results are intensified because "psychotherapists who work with chronic illnesses tend to disregard their own self-care needs when focusing on the needs of clients" (Figley, 2002, p. 1433).

Children with CF and their families are survivors of both medical and psychosocial traumas. Frequent trips to the emergency room, an inability to breathe, surgeries, and understanding the unpredictable and fatal progression of CF are among the traumas endured by this special population. Professional counselors who hear these traumatic stories within the therapeutic milieu must understand that vicarious trauma can occur for even the most experienced counselor. Sommer (2008) clarified that vicarious traumatization is not inadequacy on behalf of the counselor or emotional damage of the client but can be considered an "occupational hazard" (p. 52). Vicarious trauma, defined as "a traumatic reaction to specific client-presented information" (Trippany, Kress, & Wilcoxon, 2004, p. 32), also may occur among professional counselors working with children who have CF due to the erratic and terminal progression of the illness.

Professional counselors serving the CF community must recognize their vulnerabilities to burnout, compassion fatigue and vicarious trauma. Given the realities of clinical practice and responsibilities of everyday living (e.g., busy schedules, high caseloads, supervision barriers, family responsibilities, maintaining relationships), poor self-care and wellness may be easy to identify but difficult to change. In order to prevent issues of burnout, compassion fatigue and vicarious trauma, the following self-care strategies are suggested for professional counselors who work with this special population.

Self-Care Strategies for Professional Counselors

Although counselors are taught to utilize a developmental and wellness approach when working with clients (Myers & Sweeney, 2005), they often neglect their own health and well-being. Self-care strategies embedded in a wellness philosophy may help to prevent incidences of burnout among those working with the unique emotional and psychosocial stressors affecting children with CF and their families. Myers and Sweeney (2005) identified wellness as both a process and an outcome in that it is an “overarching goal for living and a day-by-day, minute-by-minute way of being” (p. 9). Self-care strategies involve managing stress in ways that limit the impact on the individual (Young, 2005). Within the counseling literature, wellness is depicted as incorporating social, emotional, physical, intellectual and spiritual dimensions (Roscoe, 2009). Counseling wellness models have been empirically supported in the counseling literature (Myers & Sweeney, 2005; Myers, Sweeney, & Witmer, 2000; Sweeney & Witmer, 1991; Witmer & Sweeney, 1992) and inform individuals about methods to limit their stress and maintain a healthy sense of well-being. Hence, we recommend that professional counselors use multidimensional, holistic self-care strategies to maintain a sense of wellness when working with youth experiencing special needs. The following section provides physiological, cognitive and spiritual wellness strategies for professional counselors to use while working with children with CF and other chronic conditions.

Physiological self-care strategies. Professional counselors are accustomed to working with clients regarding wellness and self-care but may not always practice their own healthy suggestions. Self-care strategies that are body-focused may help alleviate the impact of stress (Young, 2005), particularly among those working with children with special needs such as CF. Young (2005) recommended approaches such as progressive relaxation, balanced exercise and nutrition, and adequate rest to assist with integrating a wellness focus and enhancing self-care. A healthy diet and physical activity are readily known to prevent physical and mental health conditions, while also increasing energy levels. Furthermore, “minding the body” and having adequate sleep and bodily rest are additional suggestions for restoring self-care as a priority for professional counselors (Norcross & Guy, 2007, pp. 64–65). Professional counselors interested in implementing physiological self-care strategies to address potential issues of vicarious trauma while working with children diagnosed with CF may consider simple tasks such as taking a brisk walk during their lunch break, joining a gym, or being more intentional with their diet and bedtime routines. In addition to focusing on physical health and wellness, self-care in the cognitive domain is equally important for fostering a sense of well-being.

Cognitive self-care strategies. Stress from occupational risks accumulated through working with youth with special needs may be further prevented if counselors utilize cognitive approaches to support their own self-care. Professional counselors interested in improving their self-care in cognitive ways may consider cognitive restructuring to formulate new thinking patterns and assertiveness training to bring about direct changes in behaviors that may have been impacted by stress (Young, 2005), which often accumulates during the long-term therapeutic relationship with children and families affected by CF. Moreover, the use of guided imagery may provide both cognitive and physical benefits in helping to create a cognitive break from daily stress inside and outside the workplace. Notably, cognitive self-care strategies begin with self-monitoring, insight and self-awareness (Norcross & Guy, 2007). Despite counselors’ close therapeutic connection to clients with CF and their families, healthy boundaries are imperative to prevent issues of burnout and compassion fatigue. Norcross and Guy (2007) noted that “setting boundaries consistently emerges in the research as one of

the most frequently used and one of the most highly effective self-care principles” (p. 94). Due to counselors’ innate desire to help others, they often take on too many clients or are mandated to do so by agency policies. Counselors may provide extra time to ancillary responsibilities and have unrealistic expectations of themselves. As such, we recommend that professional counselors obtain good supervision to help manage and maintain work–life balance, particularly when working with children with special needs. In addition to the benefits of physical and cognitive self-care strategies, spirituality also has been shown to enhance levels of wellness and thus decrease the potential for burnout and compassion fatigue.

Spiritual self-care strategies. Spirituality comes in many forms and there is no finite definition of how one engages in his or her spiritual self. Many counselors and psychotherapists identify their own career path as a calling to care for others and commitment to growth and self- knowledge (Norcross & Guy, 2007). Research supports that spirituality, prayer and meditation are positive manners in which to promote wellness and augment self-care (Cashwell, 2005). Spiritual beliefs, practices and experiences are intricately connected and may continue to foster support from communities and individuals, along with reinforcing healthy emotions. While working with children experiencing the later stages of CF, professional counselors’ spirituality may help them connect with clients on a more meaningful level. Taking a spiritual perspective can further shape counselors’ perspective on life events (Young, 2005), particularly when they are grieving the death of a child with CF. In seeking a spiritual connection to a higher power, the negative responses to stressful events may be limited (Young, Cashwell, & Shcherbakova, 2000), strengthening one’s wellness and ability to care for oneself. These actions, along with discussing spirituality with the child and family affected by CF, may further model healthy practices during difficult times in the disease process.

Spiritual self-care can include the use of mindfulness, which can be viewed as the nonjudgmental awareness of one’s own inner suffering (Birnie, Speca, & Carlson, 2010) and reflections on self-compassion (Neff, 2003). Birnie et al. (2010) described self-compassion as the awareness of “feelings of caring and kindness towards oneself in the face of personal suffering” and the “recognition that one’s suffering, failures, and inadequacies are part of the human condition” (p. 2). When counseling children with CF, professional counselors may consider routinely expressing self-compassion as part of their inner dialogue. The following mantra used by the second author may be of assistance to professional counselors implementing spiritual self-care:

Suffering is part of life. My clients suffer, but did not choose this illness. They are walking in its wake and I will walk alongside them. I will extend loving kindness in all the work I do, despite the pain and suffering I experience and witness.

We highlight the following three essential components of self-compassion: (a) extending kindness and understanding toward oneself rather than harsh judgments or criticism, (b) recognizing that suffering (even chronic illness) is a part of the larger human condition, and (c) not overidentifying with the awareness of one’s painful thoughts (Birnie et al., 2010; Neff, 2003). By engaging in self-compassion and mindfulness, professional counselors may help to prevent incidences of compassion fatigue while working with children and families affected by CF by recognizing that this illness has a role in their humanity.

Conclusion

Professional counselors working with children and families affected by CF should consider the physical and psychosocial challenges facing this special-needs population. With the discouraging nature of the disease progression, professional counselors must have a basic understanding of the client’s chronic condition (Thompson & Henderson, 2007) and how the progression of the illness affects the child’s emotional state. Professional counselors must further explore how to limit the impact of occupational stress that may lead

to burnout, compassion fatigue and vicarious trauma. This article provides a primer on the physiological, psychosocial and special needs specific to youth with CF and offers targeted self-care strategies for professional counselors. Children with CF are a special population and professional counselors are called to implement these special considerations in their thoughtful practice. There is an abundance of literature examining the physiological aspects of CF (CFF, 2014a; Pearson et al., 1991; Sawicki et al., 2009; Sawicki & Tiddens, 2012). However, more research is warranted to examine the salient factors that affect the therapeutic relationship between professional counselors and children with CF. Meanwhile, professional counselors can develop and implement individualized, multidimensional self-care strategies to counter the effects of this difficult yet rewarding work.

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Because “Mama” Said So: A Counselor–Parent Commentary on Counseling Children With Disabilities



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This article, written by a parent of an adult child with spina bifida, invites counselors into the life experiences of children with handicaps and their families. The description of these experiences highlights current problems with the stigma this population experiences. The author describes the varying disability identities and orientations that have evolved within the disability culture and wider society. Counselors are encouraged to use unbiased terminology in both research and clinical work with children with disabilities. Solutions are offered for counselors to implement in practice and research to further overcome stereotypes, develop disability awareness and provide helpful counseling. The author provides practical interventions for a variety of challenges where counselors may be useful to children with disabilities and their families.

Keywords: children, disabilities, stereotypes, stigma, handicaps

I am a counselor, a life coach and the parent of an individual with a disability. Since entering the disability community 28 years ago with the birth of my daughter, I have attended both workshops and seminars designed to assist parents concerning children with disabilities or chronic illness. In 2005, I attended eight monthly sessions of Partners in Policymaking, a national leadership training program for people with developmental disorders and family members of young children with disabilities, designed to achieve productive partnerships between people needing and using services and those who make public policy and laws. In this article, I provide information about children with disabilities and their family systems and offer recommendations for counselors working with children with disabilities and their families.

Disability Identity and Orientation

I use the term *disability* in this article, while the preferable word to describe differences is *variation*, a more neutral term that lacks negative connotations for children in society. Variations provide richness and diversity in life that can be noted without being denigrated or overemphasized. Depending on how children or adults identify with and orient themselves to the impact of their disabilities, both personally and with respect to society at large, they may have varying preferences for acceptable terms. The reader can consult Gilson and DePoy (2004) for a discussion on disability identities and orientations.

The saying “Nothing about us without us” is an informal one within the disability community. Hahn (1993), a social scientist with over 10 years of research experience in the disability field and personal experience using crutches and a wheelchair since the age of 6, has spoken of a minority model of disability that has its origins in a sociopolitical model. This model arose when individuals with non-transient or lifelong disabilities stated that research using prior models did not seem relevant to their lived experience. Thus, policies and services that arose from these models did not result in meaningful life improvements. Attitudinal variation has arisen

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within the disability subculture regarding identities and orientations toward disabilities. A sociological ideology for conceptualizing individuals with disabilities and their families has emerged, which varies from the older entrenched medical model that regards disability as illness, tragedy or a negative situation requiring treatment and rehabilitation. Using the medical model, people with disabilities and their families are conceptualized based on their acceptance of and adaptation to disabilities. The sociological model focuses on the larger society or system and its reaction to the individual, rather than examining the person with the disability as the identified patient. Impairment and dysfunction are conceptualized as part of the larger system, with its handicapping environment and public attitudinal barriers, rather than within the individual who has varying abilities and is referred to by this larger system as a person with a disability.

A wide range of models have evolved to the point that Darling (2003) proposed an exploration of disability orientations that include normalization, crusadership, affirmation, isolated affirmation, situational identification, resignation and apathy. Familiarity with these orientations will help counselors understand the disability identities and orientations of their clients and their family members. It is beneficial to acquire a clearer understanding of disabilities and their actual rather than imagined impact on clients in order to improve one's diversity awareness.

Eliminating Ableism and Pity

Professionals entering the multilayered maze of counseling children with disabilities must honestly explore their positive and negative preconceptions about people with disabilities. Counselors should understand and confront *ableism*, defined as “the discrimination or prejudice against individuals with disabilities” (Ableism, 2015). Furthermore, counselors should examine and challenge their own disability stereotypes prior to entering the counseling room with clients impacted by disability. Scope (2014), a disability-related charity in the United Kingdom, challenges *ableism* in the initiative “End the Awkward” found on their website (<http://www.scope.org.uk/awkward>). This site allows readers to take an informal quiz to see if they are an “ambassador of cool” or a “captain awkward” around people with disabilities and also a link to watch short television advertisements designed to decrease awkwardness around individuals with disabilities. Helping professionals need to internally clarify the distinction between empathy and sympathy. Counselors can invite open discussion about the disability, as they would invite clients to share information about any subculture, so they feel free to clarify pertinent aspects of their lives and disability in counseling that might otherwise go unaddressed.

Helping professionals also should use non-handicapping language to affirm the individuality and personhood of clients. The *Publication Manual of the American Psychological Association* (American Psychological Association, 2010) has provided the following recommendations for unbiased terminology in research and academic writing:

The overall principle for “nonhandicapping language” is to maintain the integrity (worth) of all individuals as human beings. Avoid language that objectifies a person by her or his condition (e.g., *autistic, neurotic*), that uses pictorial metaphors (e.g., *wheelchair bound* or *confined to a wheelchair*), that uses excessive and negative labels (e.g., *AIDS victim, brain damaged*), or that can be regarded as a slur (e.g., *cripple, invalid*). Use people-first language, and do not focus on the individual's disabling or chronic condition (e.g., *person with paraplegia, youth with autism*). Also use people-first language to describe groups of people with disabilities. For instance, say *people with intellectual disabilities* in contrast to *the retarded* (University of Kansas, Research and Training Center on Independent Living, 2008).

Avoid euphemisms that are condescending when describing individuals with disabilities (e.g., *special, physically challenged, handi-capable*). Some people with disabilities consider these terms patronizing

and offensive. When writing about populations with disabilities or participants, emphasize both capabilities and concerns to avoid reducing them to a “bundle of deficiencies” (Rappaport, 1977). Do not refer to individuals with disabilities as *patients* or *cases* unless the context is within a hospital or clinical setting. (p. 76)

Children with Disabilities and the Family System

The family of a newborn diagnosed with a disability attempts to become acquainted with the infant and gain parenting skills, while still in a bustling neonatal intensive care unit. The family may be experiencing what McHugh (1968) called *anomie*, which is the idea that life is no longer normal, does not make sense, and is out of one’s control. The family’s experience may include focusing on the physician’s words, hearing the startling news that their child is receiving the diagnosis of lifelong disability, and considering what impact the disability will have on their child and family. Simultaneously, numerous specialists and nurses may be verbally giving the parents large amounts of vital, unfamiliar information in complex medical terminology, while evaluating how the parents are adjusting. The parents may be asked to make urgent life-altering medical decisions about surgeries that will affect their child’s well-being. Helping professionals must realize that parents need time to adapt to this life-changing situation.

Normalization

Parents who have not lived with a disability as a part of their lives need time to absorb the impact of the disability on their child and family as they move through *anomie* into the period that Seligman and Darling (2007) called *normalization* and resume the activities that were punctuated by the adjustment to the disability. Families acclimate to a new normal that contains a member with a disability. Gradually parents become capable of a knowledgeable dialogue with the medical community and may even inform physicians of promising treatments for their child, eventually realizing that they and their child(ren) are capably managing the practicalities of the disability, gaining needed services, and coping when unexpected changes and challenges arise.

During normalization, family members strive to help each other, and they build satisfying experiences and memories as they travel through the family life cycle. This process is neither easy nor quick; it can be gut-wrenchingly painful. However, it can produce much personal growth, the shifting of previously held values and priorities, and the satisfaction of a job well done. The process of normalization is not, as some assume, an insurmountable burden to bear, but rather a growth-producing challenge that can be met, sometimes joyfully. Counselors should beware of assuming that all children with disabilities and their families contain pathology. Many families have the internal and external resources to adapt to the disability over time without the need for professional intervention. Helping professionals should avoid referring to these families and children as *special*, as this term minimizes and unintentionally disrespects the effort required by ordinary people who face extraordinary challenges while meeting the other demands of daily living.

Parents’ Adjustment to the Diagnosis

People assume that parents whose children receive a disability diagnosis at birth are grieving the loss of an ideal perfect child. I suggest that the parents have grown to love the child prenatally and are grieving what their actual child is experiencing or may experience throughout life. The parents may struggle with the pain of relaying the diagnosis to siblings, grandparents and extended family members. Olshansky (1962), one of the initial researchers of families of children who have cognitive disabilities, recommended that chronic grief is an expected reaction of a caring parent to parenting a child with a disability and much more useful than the oversimplified idea of acceptance or rejection.

Some developmental disabilities are discovered prenatally or shortly after birth, or result from premature birth. Some disabilities are diagnosed later in childhood, as parents notice missed developmental milestones or the child loses previously-acquired skills through illness, accident or physical abuse. Other parents may suspect a disability in their child prior to receiving an official diagnosis. Counselors should remember that the pang of sadness a parent may feel when his or her child misses a developmental milestone or experiences social stigma is normal and does not mean that parents are coping poorly.

Parents who are trying to be hopeful are not necessarily denying the disability. Automatically applying diagnoses from the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013) to the parent's reaction to an initial diagnosis of disability in their child can add additional stress to the family system. Family members of children with disabilities may be inclined toward mental health difficulties that do not interfere with normal life functioning until the additional stress of the disability and the requirements for managing it overload the person's coping skills, either temporarily or over time. The process of normalization takes time to unfold. Helping professionals should build a caring relationship with the family at the time of diagnosis and be available later if mental health issues begin to interfere with normal functioning. Counselors should use their clinical skills of differential diagnosis to understand and unearth the interplay between the parent's orientation to disability and his or her conceptualization of disability identity to avoid framing a mindset as a mental health disorder.

The child's parents or siblings may have psychiatric diagnoses or relational difficulties that predate the child's disability diagnosis. Such issues may interfere with family resilience and the process of normalizing the disability and promoting healthy child development. Addictions, anxiety, depression, adult attention-deficit/hyperactivity disorder and other diagnoses can impede parental well-being and effective parenting. Thompson and Gustafson (1996) suggested that improved child development and adaptation to chronic childhood illness are associated with parental social support, adjustment and decreased stress. Elman (1991) suggested the need for counseling depressed family members. Crnic and Greenberg (1990) indicated that decreased competence in children is related to parental personal stress that interferes with effective parent-child communication. After many years of counseling families, I have come to believe that the family system can operate more smoothly if the individual members address mental health issues that impede marital satisfaction, family cohesion, conflict resolution, stress management, child rearing, medical management and other positive coping skills.

The birth order of a child with a disability can change the future family structure as the parents contemplate whether to have additional children. If the child with a disability is the parents' firstborn and the disability has a genetic component, additional children may share the same disability, in a milder or more severe form. Parents may consult geneticists to explore the probabilities of a recurrence of the disability while they consider their ability to incorporate various scenarios into their lives. Childhood disabilities have direct and indirect psychosocial and financial costs for families. Seligman and Darling (2007) discussed direct costs of adaptive equipment, therapy and child care, and indirect costs like fees for housing modifications, work absences, and parental difficulty for career advancement. Sometimes one parent chooses not to work outside the home in order to be available for tasks related to managing the disability, a decision that reduces the family's income. Regardless of the counselor's or geneticist's viewpoints, the decision to pursue additional children can be a complex, grueling decision for individuals whose convictions do not give them the option of attempting to conceive and then terminating a life prenatally if a disability is detected, especially for parents who already love a prior child with that or another disability.

Self-Concept Development among Children with Disabilities

The child with the disability develops opinions about the family and himself or herself. Children create a sense of self from the reflections they see in their interactions with others. Unfortunately, people with cognitive,

emotional or physical differences encounter distorted mirrors daily. The communication they have with others often is filtered through an unspoken screen of ableism and stigma. In *Disability Is Natural: Revolutionary Common Sense for Raising Successful Children with Disabilities*, Snow (2001) described the Euro-American history of disability and myths. When the child encounters a person who has not had close friendships with anyone with disabilities, the person may display uncomfortable, awkward behavior around the child. The person may stare, avoid eye contact, treat the child with pity, act like the child is “special,” speak to the parents instead of the child or act in other confusing ways that pose barriers to intimacy. Children with disabilities sometimes do not question the interpretations of others and may begin to believe that anomalies are bad and that they are inherently bad, rather than just different. Children with disabilities also may not realize that the awkwardness in the room arises from discomfort in the other person and may wonder what is wrong with them.

Though people with disabilities are a natural part of society, they continually encounter barriers to full participation in society. In a society containing environmental and attitudinal barriers—for example, the lack of ramps or curb cuts necessary for people in wheelchairs to navigate their community—the simplest of tasks can be continually inconvenient.

Counselors must recognize that the disability is the child’s constant companion, 24 hours a day, 7 days a week, which may include a complex medical condition that affects various parts of the body and its functions, possibly resulting in pain. The vocabularies of children with disabilities may include medical terminology and treatments that are complicated to understand and time consuming to accomplish. The child may have a visible disability that is always on display for others’ comments and stares; alternatively, the child may have a disability that is hidden and misinterpreted by people in the community. Until one accompanies a person with a visible disability in public, one does not even realize what a luxury it is to go about daily tasks without others stopping to look for extended amounts of time with expressions of wide-eyed shock or curiosity. Counselors can teach children without disabilities to react less awkwardly around children who have disabilities.

Counselors should remember that each child and family is unique, but be aware that children with disabilities are more like children without disabilities than they are different. They simply vary in some way. The child may be in counseling because of internal challenges resulting from the disability or external emotional, social, attitudinal, educational or physical barriers to inclusion. However, the child may be in counseling for a difficulty that would arise even if there were no disability. It is helpful for children with disabilities to realize that some of the struggles they encounter are common to all children.

The Emotional Toll of Services

Community services, such as Respite Care and Individual Education Plans, are available to assist children with disabilities and their families with some of the challenges presented by the disability. People are vetted to see if they qualify for services and terms from the medical model of disability are utilized. Unfortunately, in order to receive services designed to maximize potential, children with disabilities must interact with agency staff members who discuss and emphasize deficits and rehabilitation in their presence. Children with disabilities may find the language and terminology insulting and demoralizing, considering that they have not had an accident and do not feel the need to be compared or repaired.

The disability subculture is not homogenous. Developmental disabilities include spina bifida, cerebral palsy, diseases of the muscles and bones, neurological disorders, craniofacial deformities, metabolic disorders, endocrine disorders, seizure disorders, cleft palate, cleft lip, visual impairment and blindness, hearing impairment and deafness, mental retardation, attention-deficit/hyperactivity disorder, learning disabilities, autism, chromosome and genetic disorders, and numerous others, including those that are extremely rare and possibly unnamed. Children and families in these various subgroups have some experiences in common and

other distinct differences due to the various traits, challenges, onset and societal reactions to their particular disabilities.

Complex Client Group

Counseling children with developmental disabilities is like working a complex three-dimensional puzzle. Each individual child is as distinctive as a fingerprint. The child is a member of a family that has its own characteristics, rules and roles. The child and his or her family members' temperaments affect reactions to a disability. Within any given family, there may be varying opinions among members about how to handle the disability or avoid dealing with it, which can impact family interactions. Children with handicaps come from a variety of ethnic cultures and heritages that influence the adjustment of the family members' reactions to the child's differences.

Spirituality

Counselors should not underestimate the benefits that some children with disabilities and their families derive from strong connections to their faith or other forms of spirituality, if they are not part of a religious community. Seligman and Darling (2007) wrote that some religious communities contribute a great deal of support to the families of children with disabilities. Poston and Turnbull (2004) discovered that other families have difficulty finding a religious group that will incorporate their child and family into the faith community. They reported that having a child with a disability, at times, is the precipitating factor to the development of spirituality in family members. Schiele (2000) and Parham (2002) proposed that aspects of the Afrocentric service models are beneficial when working with African Americans since these models incorporate interdependence, collectivity, affect and spirituality. These benefits may be generalizable to other ethnic groups. McCarthy (1995) encouraged counselors to explore and use spiritual ideas and techniques to benefit the physical and mental well-being of clients.

Belief in a benevolent power or ideological concept can sustain exhausted, discouraged individuals when situations are beyond their control despite their sincere proactive efforts. During those moments when they feel that they cannot continue without despair, they can let go and allow God, a higher power or whatever spirituality they cling to for sustenance intervene. For example, when sending their day-old neonate into spinal surgery, religious parents may draw comfort from the belief that a divine being continues with their infant and the surgeon beyond the operating room doors that separate them from their child. Children whom physicians predict will die continue against all scientific evidence to live and thrive; sometimes parents have supernatural theories about these outcomes. Turnbull, Turnbull, Erwin, and Soodak (2006) referred to spirituality as the way that people derive meaning in their lives and interact with the sacred. According to Skinner, Correa, Skinner, and Bailey (2001), spirituality can influence whether a family considers the addition of a member with a disability to be a blessing or retribution for an offense (Chan, 1998; Chan & Lee 2004; Rolland, 2003). Frisco (as cited in Seligman & Darling, 2007) indicated that the majority of the grandparents surveyed reported that religion and belief in God helped them more comfortably accept a disability in their grandchild.

Multiple Interconnecting Systems

The child and his or her family have multiple interconnecting systems to navigate, while attempting to achieve the normal activities of being a family and helping the child accomplish typical developmental tasks, without reducing this goal to a tedious, life-draining behavioral chart that devalues the child's personhood and the spontaneity and freedom of childhood. Nichols (1984) considered an open system to be a group of interconnected parts of a whole that interact with each other and the larger environment around information, material and energy. General systems theory and cybernetics provide concepts that assist counselors in studying the multiple elements that constitute the collective experience of living with a disability. These systems may include physicians, therapists, schools, tutors, insurance companies, respite care services, disability advocacy

and support groups, community activities, neighbors, playmates, extended family, and other groups of people who make up the ever-evolving gears of an interacting environment that contains the child and his or her nuclear family subsystem. Miller (1995) affirmed that a well-functioning psychosocial environment is vital to the child's healthy maturation, and counselors can work with children and their families to reduce feelings of being overwhelmed.

Disabilities are not as inherently stressful as what parents go through while trying to help their child with optimal growth and development. Acquiring adaptive equipment, services, educational accommodations and community participation can be tedious and frustrating. Parents often are required to contact busy physicians, educators, automated insurance provider telephone messages and agency coordinators to get documentation for equipment that they need in order to accomplish simple tasks that the dominant culture takes for granted. Normal activities like comfortable body positioning, eating, toileting, ambulating and being integrated into school classrooms can be prolonged, inordinately exhausting, emotionally draining and time consuming.

Once services and equipment are acquired, the family unit may become part of a large, complex, constantly evolving system including, depending on the particular disability, educators, adapted physical educators, therapists (e.g., physical, occupational, speech, respiratory), tutors, dieticians and medical specialists (e.g., pediatricians, gastroenterologists, orthopedic surgeons, cardiologists, urologists, audiologists). Many disabilities require adaptive equipment that is initially unfamiliar to the family. Medical professionals tell parents and their children about assistive health devices that others with similar disabilities have found helpful. The family may need time to adjust to the reality that their child has to use the device, to examine the risks and benefits of equipment and treatments for the disability, and to find someone who provides the service locally.

Health devices are often expensive and must be paid for through insurance, government programs or private payments. Obtaining the equipment may be a lengthy, convoluted process that involves repeated negotiation with insurance providers and resubmitting payment requests or searching out alternative funding sources if insurance payment is denied. Once the adaptive equipment arrives, there are often therapy appointments to individualize the fit of the equipment to the child, teach the parents and child how to use the product, coax the child to use the aids, and check to see that the product is doing no harm to the child. It can take weeks of trial and error to modify equipment that is problematic. This process may repeat often as the child grows older.

Children may want to participate in activities that are outside the realm of the Americans with Disabilities Act. Parents may find themselves having to reassure and encourage the people who run these programs to include their child. This process may involve educating Scout leaders, religion teachers, preschool staff, parents of the child's classmates, camp staff and others about the disability and how to make modifications to include the child, and also may involve calming fears that it will be too difficult for the staff or the child to manage or too dangerous for the child to participate. Most children with limitations want the same independent adventure opportunities as other children; to try new experiences; risk, fail, try again and succeed; and sometimes surpass others' expectations for them.

It is important to help families see that their child needs to be surrounded by a support system that has challenged negative assumptions about people with disabilities. Children with an observable disability do not have the gift of anonymity that most people take for granted. They need comfortable places to just be themselves, recharge emotionally and exist as a member of the group. They need the enduring support and friendship from others who are easy, normal and natural in their interactions with the children, to inoculate them against assaults to their worth that they can encounter in the larger society. On some level, children may think that their parents are giving them affirmation because of their roles as parents. Children need to know that people other than their parents also acknowledge their skills, temperament, accomplishments and personhood.

Children need interactions with people who allow them to be authentic and respond genuinely and honestly; thus, children learn how to be in healthy relationships.

Interventions to Disable Ableism and Promote Friendships

Parents of children without disabilities sometimes tell their children not to stare at children with disabilities but may not make a suggestion for a replacement behavior, like saying, “hello.” Thus normal opportunities to interact are missed and taboos that encourage shunning and bullying continue. This behavior can contribute to unnecessary adjustment problems in adulthood that Cadman, Boyle, Szatmari, and Offord (1987) and Rutter, Tizard, and Whitmore (1970) have suggested are related to experiencing social rejection early in one’s life. To promote integration and change attitudes, it would be helpful for school counselors to offer diversity training concerning disabilities for students and parents throughout the school population. Informational sheets could be sent home in the beginning of the school year or brief presentations could be included at parent meetings. Some of the child’s classmates may grow up and one day become parents of children with disabilities.

Social Skills Development

Miller (1995) reminded us that the peer social system is the main area where children develop and hone relationship-building and social problem-solving skills. However, some children with disabilities have trouble forming relationships with their peers for a variety of reasons. They may lack the opportunity to socialize with peers in a regular setting or have trouble ambulating to where children are playing. They may have a human aide who impedes normal peer interactions, tagging along to manage a healthcare issue. They may not understand the social mores of others their age because of so much time spent with parents and adult health care providers or due to aspects of their disability. In addition, service providers may talk to parents about the child as if the child is not present. Parents can learn to redirect physicians, nurses and other service providers to speak to the child in age-appropriate language.

Tovray and Wilson-Portuondo (1995) suggested that children may need formal help to learn social skills for developing friendships if they do not notice or understand social cues and nonverbal messages from others. Children with disabilities may struggle with nonverbal learning issues or characteristics on the autism spectrum, making engaging or understanding others difficult. They also may have behavioral disabilities that alienate other children or result in the continual loss of recess privileges. They may have medical therapies after school and daily tasks to complete between visits. Children with disabilities may spend an unreasonable amount of time trying unsuccessfully to complete homework assignments. Counselors can help a child with a disability by making a referral to a neuropsychologist to determine strengths and weaknesses, and then the counselor, parents, neuropsychologist, teachers and tutors can help the child develop more effective study and executive functioning skills that match his or her temperament and learning style. Parents and counselors can work together so that children with disabilities have opportunities to *be* and not just *do* activities.

Educating Peers to Reduce Isolation

Sometimes children ask questions undiplomatically. For example, a preschooler with spina bifida might be asked, “*Why do you walk weird?*” Some parents of children with disabilities visit the school on the child’s first day and speak to the child’s classmates in an attempt to decrease painful queries that can invite social anxiety. Preparing the class as a group also frees peers from being preoccupied with unanswered questions. If professionals help the child and family create and practice an elevator speech, perhaps these unhelpful questions will occur less often. The elevator speech can be a few sentences to explain the disability when meeting new people, which could prevent the disability from becoming a taboo subject. Talking openly can relieve other children’s unrealistic fears of catching the disability.

Returning to the previous example of a preschooler with spina bifida, the child could introduce herself by name and say something to let her classmates know what they have in common, like, *“I am 5 years old. I have a brother and sister, and two dogs. Who else has a brother and sister? Does anyone else have a dog? I like to play, read books and eat ice cream. I am looking forward to being your friend.”* After this joining statement, she could then give a brief age-appropriate description naming her disability and saying how it affects her and others, as follows: *“I have spina bifida, so some of the nerves in my back don’t talk to my legs to tell them to feel or move. The other parts of my legs have to work harder, so I walk differently. I’ll pass around my old braces, like the ones I wear to help me walk. Please don’t mess with my wheelchair unless I ask for help. You can’t catch spina bifida like you do a cold. I don’t run so please walk slower, so I can keep up. Let’s talk and see how we can all play together.”* Sometimes the child may not have the social or cognitive skills for public speaking or may simply prefer that the parent give the elevator speech. However, the child can learn self-advocacy by sharing some part of the elevator talk. After the elevator speech, the parent can ask if anyone has any questions. Parents sometimes ask educators to send a letter home to the parents of their child’s typical classmates with a brief description of the disability so that parents understand and include the child in after-school invitations that are extended to the rest of the class. Then the child and peers can begin the school year ready to focus on getting to know each other, forming friendships and learning classroom content.

This introduction could reduce the isolation of children with disabilities by demystifying their differences and allowing them to assimilate into the group. Children with disabilities, their classmates, school staff and families need practical skills for dealing with bullies. Parents can search for schools that take bullying and violence prevention seriously and have a school strategy in place to discourage bullying. Bullies may try their unacceptable behaviors on various class members; however, they tend to choose people who are alone to be their victims of repetitive bullying. Children with disabilities can learn strategies for standing up to the bully. Classmates of children with disabilities can acquire the information necessary to become friends and allies for the student in areas where there may be less adult supervision such as the lunchroom, bathrooms, hallways, or on the playground. They can help intervene to include the child with a disability in pleasant encounters with children from other classrooms and also speak on behalf of their friend when others ask questions or make nasty comments. Counselors can work with the school staff, parents and children to develop school-wide anti-bullying campaigns that teach children to counteract bullying and become allies for one another.

Preventing Isolation by Building Peer Support

The child and family may share their culture, religion and other signs of unity and cohesion. However, if the child’s exceptionality is not inherited, he or she may have the difficult experience of being the only member of his family with the anomaly. The child may benefit from the support of peers with the same disability to spend time with and compare experiences; or just be with colleagues who are already familiar with the disability and do not require explanations. Counselors can help parents find camps and support groups for both the family and child that include both children with disabilities and typical peers. Children need older, successful role models with disabilities who inspire them to persevere when they are discouraged. They need mentors, with and without disabilities, who challenge them to dream and make continual progress to accomplish their dreams.

Recommendations for Counselors

Counselors can be more aware of areas in which they can be quite helpful. Counselors can intervene in the medical system to provide newborns with disabilities and their parents with natural settings that allow relaxed time together to promote attachment and bonding. Counselors also can operate from a systemic, strengths-based model in order to best respect and support the child and family. Throughout the child’s development, counselors and families can collaborate to promote the development of age-appropriate skill acquisition, protective yet permeable personal boundaries, self-awareness, positive self-esteem, social skills, relationship development, the

ability to be resilient in the face of stigma, and the opportunity to transition to the adult roles of employment, independent living, dating and family formation.

Systemic, Strengths-Based Counseling Models

Allen (1994) indicated that counselors and theorists operating from various individually oriented counseling perspectives assume that the origin of dysfunction and self-destructive behaviors in an individual is an internally defective self, psyche or physiological flaw. Hahn (1993) noted that the medical understanding of disability relates to organic pathology or impairment. Counselors who operate from a family systems model believe that difficult individual behavior is best understood as one piece of a larger interacting whole, such as the family or society, which is greater than the sum of its parts. The behaviors of individual members of the system are considered reflections of what is happening in the larger system. Rather than identifying the individual as a patient to be fixed, Nichols (1984) stated that the system should be explored to identify pathology in the interactions between people. Oliver (1996) did not believe that disabilities are intrinsically bad, and Linton (1998) reported that many people have disability pride. Disability pride refers to recognition that society is enriched by the distinctive positive voices, identities, thoughts, awareness, lifestyle examples and literature produced by individuals with disabilities. Seligman and Darling (2007) suggested that professionals who adopt a medical model of pathology may presume that the birth of a child with a disability will lead to maladaptive family functioning and therefore the implementation of intrusive, undesired interventions from service providers. I advocate the use of a collaborative, systemic, strengths-based counseling model due to the complex interconnected systems that make up the environment of children with disabilities and because it is more respectful of the child and family's disability orientations and ability to prosper within a complicated context. It is erroneous, unkind and disrespectful to label a child who is capably using his resources to the best of his ability as unhealthy simply because he varies from the norm.

A systemic, strengths-based counseling model also respects the inherent worth of the child with a disability by not presuming that he or she is the identified patient. He or she is incredibly resilient in the face of daily challenges that would make many adults cower and yet gets up each day with renewed hope and moves forward into the future. Not only does this child face the same developmental tasks of childhood as his or her peers, but he or she must use additional thought, energy and time to develop and implement strategies to compensate for personal variations that may make the accomplishment of these tasks extremely difficult and time consuming.

One goal of counselors working with children with disabilities is to acknowledge the personhood and accomplishments of the children and their incredible inner fortitude, without categorizing them as more special than any other child. In a society where people are compared to a perceived norm, this child was either born with or acquired a variation that has been characterized as less than the norm, and labeled a disability, impairment, handicap or developmental disorder. The terms are pejorative; the connotations of the words just mentioned are as follows: not able, broken, defective, of lesser quality and developing incorrectly.

Counselors might also wonder how separation experiences impact attachment and bonding from the child's perspective. Does the child experience feelings of abandonment and fear at a time when he or she lacks the ability to conceptualize or express them? A question for counselors and researchers to consider is whether there is an enduring impact from these experiences. Some parents initially reject the child with a disability or fear that they will not be able to manage the infant's medical needs. Family members who have access to each other usually bond. Seligman and Darling (2007) reported that attachment can be difficult for some parents when aspects of the child's disability interfere with the baby responding positively to his or her parents' overtures.

Parents and counselors can help children with disabilities develop a healthy sense of self and determine what behavior is acceptable in others, and under what conditions. With so many people entering and leaving the

child's life, it is helpful for parents and counselors to help children understand different types of relationships and what to expect from them. They need to be protected from physical, sexual and emotional abuse and learn refusal skills in situations where their trust and cooperation are exploited.

Promoting Self-Awareness

Children with disabilities need self-awareness. Counselors have the opportunity to assist parents of young children with disabilities by suggesting that parents play games with their toddlers to help them learn body parts and their functions, including the terms that name their disability since it is also a natural part of them. It is not a defining part, but rather an aspect of themselves that they can become aware of and discuss, such as being adopted or having green eyes. Once the disability is assimilated into the family, family members go about the business of life; their child with a disability is just another member of the family.

Helping Children with Disabilities, Siblings and Parents Deal with Stigma

Siblings can help children with disabilities begin to interact differently with peers by accustoming them to the support, disagreements and jealousy common between brothers and sisters. Children with disabilities encounter people within the larger community who may not be familiar with disabilities or the concept that disabilities occur among regular people. Children with disabilities and their siblings need to be prepared ahead of time for ableism so that they are not surprised or heartbroken by the reactions they receive from people outside their home. At home, no one stares at children with disabilities, mocks their disability-related differences or calls them negative names. Unfortunately, well-adjusted children with disabilities may encounter cruelty from other children whom they meet outside their homes and primary social networks. They need to know that the dysfunction in these interactions does not originate in them, but rather are due to a lack of knowledge in other people. Children, parents and siblings need help interacting with the larger society around issues of being different and educating others about their disabilities. Sibling groups can be helpful for children who sometimes feel torn between conflicting emotions about their sibling with a disability. Goffman (1963) said that family members of children with disabilities sometimes receive courtesy stigma when they are in public with their family member who has a disability. Children have reported feeling embarrassed by their sibling or guilty for excluding them or not defending them. At other times children have been shunned for standing up for their sibling. Siblings may sometimes be jealous of the extra attention their sibling's disability requires, assist with their sibling's care or operate independently.

The Importance of Being, While Also Acquiring Skills

Children need time for unstructured play to develop their imagination, gain independence, explore hobbies and experience leisure. They need opportunities to develop the daily living skills necessary to achieve autonomy by adulthood. In addition to learning to prepare food, clean, do laundry, manage money, monitor appointments and keep a home from dissolving into chaos, they will need to gradually take over the medical management of their disability if they intend to maintain their health. Children with disabilities and their families need extreme time-management skills in order to accomplish this herculean task. Counselors or life coaches can help families develop a long-term family vision. They also can help the child and family develop short-term and long-term goals for the child with the disability and problem-solving skills to overcome obstacles to their vision and goals. Parents and children may find it helpful to learn assertiveness skills so they can coordinate homework tasks assigned by support services and say no to excessive demands from numerous systems that add up to more than a 24-hour day.

Helping Adolescents Progress to Adulthood

When a disability is added to the list of difficulties Haley (1997) described, one may discover additional requirements for launching a young adult with disabilities. Some states require adolescents with disabilities to be evaluated before they can apply for a driver's license, and their vehicles may need costly accommodations.

Some people with disabilities are refused the opportunity to obtain a driver's license and must make other plans for transportation. A young person with a disability needs a plan for vocational career development, job training, higher education or some means of financial support. Plans for independent living, a group home, or a nursing home, must be made prior to leaving the family home. Such plans often include meetings with a team to develop an individual education transition plan during secondary school, and meetings with rehabilitation counselors after high school to plan for college, vocational training or employment. Parents and students spend additional time and energy to acquire the documentation required to obtain these services. Counselors and life coaches can help the family members prioritize the various activities competing for their time, energy and financial resources. Professionals may encourage creativity around informal methods of achieving formal goals that do not require the child and family to expend more energy acquiring and maintaining the services than warranted by the potential relief obtained from the services.

Other Counseling Services

Counselors have so many tools to offer children with disabilities and their families throughout the family life cycle. They can offer concepts and techniques to deal with grief and anomie at the initial diagnosis of a disability, the chronic grief that emerges when a developmental milestone is missed, repeated encounters with ableism, or unsuccessful operations and physical therapy. Some childhood disabilities and chronic illnesses end in death at an early age. Counselors and hospice staff can help families prepare for this untimely departure.

Relaxation exercises can be helpful to families after a busy day of preoperative medical appointments, immediately prior to a surgery or while waiting for a surgery to end. A child having a painful medical procedure or frightening experience like Magnetic Resonance Imaging also can use relaxation as a method to cope. Cognitive therapy can help children and families reframe complex medical issues and disabilities from seemingly overwhelming tragedies to neutral manageable situations within their capabilities. Reframing can allow parents who regret missing work to spend hours in physician's offices, X-ray labs or therapy appointments to see the experiences as valuable times—opportunities to really get to know the child and bond around lived experiences.

Learning to use communication skills allows parents to request that nonurgent operations and treatments be scheduled at times that do not interrupt other activities, such as birthdays, weddings and exciting field trips with classmates. Counselors can teach communication skills that can be used within the family to explore rigid roles that may not allow members the flexibility to effectively cope with the added chores that accompany a disability without sacrificing the real needs of any one family member.

Counselors can assist families and children in learning vital time-management and decision-making skills. They can help parents see that self-care is useful and that it is fine to ask for help from each other and use resources outside the family to relieve caregiver stress. Counselors can help families learn to develop a stress management plan that utilizes positive rather than negative coping skills during times of extreme stress. If families and children learn assertiveness skills, they may be able to release passivity or aggression. Counselors can help children and families reduce anxiety and depression throughout the lifespan, cultivate humor and gratitude, and juggle a variety of activities and emotions in the pursuit of a balanced life. Counselors may use their own creativity to generate original ideas for assisting children with disabilities and their families.

Conclusion

This article provides significant ideas to consider when working with individuals with disabilities and their families; there is much to learn through exploring relevant research and anecdotal information regarding disability awareness. An understanding of systemic theory is invaluable when working with the complex

interconnecting systems that make up the environment of a child with a disability. Counselors may explore disability identities and orientations within the individual with a disability, the family and society. Professionals can consider interventions concerning identity formation in the person with a disability by promoting self-awareness, boundary development, and the understanding of and externalization of ableism for both the child and family members. Mental health professionals have the opportunity to confront the stigma associated with disabilities and service acquisition. Counselors can use reframing to normalize variations within students and decrease pity. They can partner with the child and his or her parents to educate the child's classmates and their parents, school personnel, and community about the disability and inclusive practices that prevent social isolation and encourage interactions that disarm bullying and myths about people with disabilities. Counselors can offer practical help to children who may struggle with social skills, study skills, communication, assertiveness, stress management, spirituality, transitioning from childhood to adulthood, and the importance of being or experiencing one's humanity rather than just accomplishing tasks. In addition to using the introductory ideas provided in the article, counselors are invited to creatively adapt additional theories and techniques to support children with disabilities and their families.

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