

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



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Cassandra A. Storlie
Eric R. Baltrinic

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,

Cassandra A. Storlie, NCC, is an Assistant Professor at Kent State University. Eric R. Baltrinic is an Assistant Professor at the University of Toledo. Correspondence may be addressed to Cassandra Storlie, 310 White Hall, PO Box 5190, Kent, OH 44242, cstorlie@kent.edu.

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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