Inaugural ACAC National Conference!

ACAC’s very first national conference will be held July 20-21, 2017 in Arlington, VA. Please plan to join us for this historic event! See page 16 for further details.

Virtual Counseling

Layla J. Kurt and Krystel H. Chenault, University of Dayton provide guidance on how to navigate the world of virtual-base services. Please see page 2.

Parental Consultation

Krystal M. Vaughn, Ph.D., LPC-S, NCC, RPT-S, Louisiana State University Health Services-New Orleans and Allison B. Boothe, Ph.D., Tulane University School of Medicine share ideas about how to enrich the lives of children vis-a-vis parental consultation. Please see page 5.

Resilient Children & Adolescents

This issue of the ACAC Newsletter addresses a practice that child and adolescent counselors endeavor to engage in each day—helping clients to be resilient in all aspects of life. Creative and research-centric approaches will be addressed. We hope that you find this issue of the Newsletter both informative and inspirational!

Please consider writing a brief article for our Spring 2017 newsletter. Early submissions are encouraged, so if you have an article you are working on, or one that you wish to develop, please feel free to submit it now! We would love to include your voice! Please submit articles to mayfield.peggyc@gmail.com

Promoting a greater awareness, advocacy, and understanding of children and adolescents.
Building Relationships Online: Tips for Counselors Delivering Services in a Virtual Setting

Layla J. Kurt and Krystel H. Chenault, University of Dayton

Counselors have reported that online technologies have “blurred the line between home and work life” (Steele, Jacokes, & Stone, 2014, p. 134), especially since much of the interaction between students and counselors takes place when one or both of the parties is at their home or in some other comfortable, low-pressure environment. However, school counselors serving students in a completely or mostly online environment, such as an online school, report difficulty building relationships with students as one of the primary barriers to delivering quality counseling services (Kurt, 2016; Osborn, Peterson, & Hale, 2014).

To be sure, cultivating warm, open relationships without the benefit of facial expression, voice intonation, or body language can prove difficult, thus impeding a counselor’s ability to
properly assess students’ emotional well-being as well as provide a level of comfort in which students can open up about their needs or concerns. The following are tips and best practices that counselors who deliver some or all services online can use to help cultivate a sense of community and comfort in an often impersonal online setting.

- **Create opportunities for social interaction.** Palloff and Pratt (2007) posit that students more easily form quality social relationships in an online environment when they have a place to interact outside of academic confines and whatever baggage those may elicit. In addition to forums and/or chat rooms focused on specific counseling-related topics or classroom tasks, counselors can create spaces for students to interact without an expressed purpose beyond socializing for fun and becoming more comfortable expressing themselves in an online setting.

- **Create opportunities for inquiry.** Palloff and Pratt also suggest creating a separate designated space for students to simply ask questions related to all sorts of topics, whether they’re academic, social, career-oriented, or otherwise. Students may feel uncomfortable reaching out for any number of reasons, but if counselors maintain a designated space, or even a designated time (such as a “Question Day” once a week) for students to ask questions over any number of topics of the counselor and of each other, they may be more likely to seek out counseling if serious issues arise because they have learned their questions will always valued and addressed.

- **Do not attempt to replicate face-to-face interactions.** According to Lenning, Hill, Saunders, Solan, and Stokes (2013), attempts to recreate face-to-face settings online only highlight what virtual interactions lack. Therefore, rather than treating an e-mail conversation like a facsimile of a conversation taking place in a physical space, counselors can focus on the advantages of a conversation without facial expressions or tone. Through communicating online, even in “real time” chats, both counselors and students have the advantage of reflecting upon responses longer than in face to face interactions; students might even be more apt to open up about tough issues when they don’t have to say it to anyone’s face, so to speak, but rather only to their own computer screens. Counselors can take steps to consciously shape students’ perceptions of the online environment through deliberate use of emoticons, punctuation, sentence length, and word choice to build the tone they wish to pass on to students, whether it’s jovial, supportive, serious, etc.

Online technologies are likely to become more and more pervasive in the educational landscape of the future, but that doesn’t mean that personal relationships must fall by the wayside. On the contrary, students are increasingly comfortable with virtual communication, and as long as educators work to facilitate that same level of comfort, students can continue to benefit from the same quality support they have always enjoyed.
References
Supporting and Enriching Children’s Lives through Parental Consultation

Krystal M. Vaughn, Ph.D., LPC-S, NCC, RPT-S, Louisiana State University Health Services-New Orleans
Allison B. Boothe, Ph.D., Tulane University School of Medicine

When a child is in need of mental health support parents may have apprehension about their role in the process of addressing their child’s needs and may be concerned about approaching a counselor. When they do seek counseling for their child, parents may enter into counseling services for their child feeling nervous, overwhelmed, or harboring self-blame. If the counselor employs relationship based parental consultation practices and views the parents as the expert in their child’s life, as suggested by Axline (1947), these fears and apprehensions can be subdued. It is also important for counselors to collaborate with other adults who spend significant amounts of time with the child. Johnston and Brinamen (2006) recommended that counselors approach additional caregivers (e.g., childcare providers, teachers, etc.) in a similar fashion to Axline’s approach. By understanding other caregivers’ subjective experience(s) of being with a child, the counselor can better support the child, family, and additional caregivers. Both Axline (1947) and Johnston and Brinamen (2006) promoted a strengths based collaborative approach to gain understanding of the child’s experience. A consultative approach can lead to support that enriches the lives of children and their caregivers. Play therapy research demonstrates that two factors are believed to promote positive outcomes: caregiver involvement and the therapeutic relationship (Phillips & Landreth, 1998).

Parental consultation may be offered in the beginning of child centered counseling, on an as needed basis, or scheduled throughout the duration of the child’s services. Lolan (2011) found that play therapists agreed that parental engagement leads to a positive outcome. When parental consultation begins prior to providing services for a minor child, parent engagement is given a primary role in the counseling relationship. To further enhance this relationship, the initial session may include the parent without the child and allow for relationship building with the parent (Ray, 2011). This practice allows the parent to provide information such as: parental concerns, challenging behaviors, developmental milestones, family medial history, etc. that may be discussed more freely without the child in the room. Ray (2011) suggested that counselors plan for this consultative meeting to last from 1 to 2 hours. Then counselors may discuss the clinics recommendations for parental consultations (e.g., as needed, on-going, etc.).

Scheduled planned parental consultation visits are recommended every 3 to 5 child sessions (Ray, 2011; Schottelkorb, Swan, & Ogawa, 2015), and should be individually scheduled appointments that are separate from the child’s counseling sessions. Parent consultation sessions may focus on changes in the child’s progress, treatment goals, parental skills or education, and planned termination (Cates, Paone, & Margolis, 2006). If during these consultation sessions parents find it difficult to remain focused on the child’s presenting issues, Ray (2011) recommends counselors consider the mental health needs of the parent, as he or she may be benefit from receiving individual counseling to focus on individual needs.
Information sharing between parental consultation sessions may also be necessary, and speaking about a child in front of the child is typically not viewed as beneficial. To remedy this, Dugan, Swanson, and Short (2011) suggested using a “caregiver feedback form.” Their form allows caregivers to provide weekly updates on: parental insights, home/school changes, areas of concern, and needs. This form respects the parents’ position as expert in the child, promoting parental reflection, communication, and a record of parental input.

In conclusion, when counselors use a relationship based approach to parent consultation with children receiving counseling, they are providing broad based support to the child and the child’s family. Caregiver involvement is key to counseling success for the child, and the counselor depends upon receiving timely and accurate feedback about the child when he or she is not in a counseling session. By consistently scheduling parent consultation sessions, counselor better serve the children in their care, and the children benefit from having their parent(s) and mental health support personnel working in tandem to support their growth and development.

References


The Role of Spirituality in Developing Resiliency in Children and Adolescents

Deedre Mitchell, PhD, LPC, NCC, Messiah College

As we now recognize spirituality as an important aspect of counseling by several of our professional organizations (Ogden & Sias, 2011), we must consider the importance of including this aspect of the person in our holistic approach to healing. The development of spirituality, separate or together with religion, can be viewed as the process of forming connections and finding meaning in life (Jackson, 2012). Josephson (2004) warns us of two errors that we can make when it comes to incorporating spirituality into clinical work. The first error is to overemphasize spirituality and religion in treatment, while the second error is to ignore it all together. Taking this comprehensive approach may be especially important when counseling children and adolescents and when striving to build resiliency factors in our youth.

As our younger clients are developing in various ways – physically, mentally, and emotionally – they are also developing spiritually (Jackson, 2012). This process involves forming life concepts such as creating meaning and building connections in an attempt to make sense of the world around them. When we consider resiliency from a systemic perspective, we see it as the complex interaction of the child and external supports that may buffer the effects of adverse situations (Prince-Embry, 2015). We may then postulate that developing resiliency can be achieved through the meaning-making process of spiritual development as one grows in their understanding of self and how they relate to others and the world around them. The growth of resiliency factors, such as the ability to cope with change or stress, hope and persistence in goal achieving, commitment to finding meaning in life, and optimism (Campbell-Sills & Stein, 2007), can be encouraged through opportunities for personal reflection and meaning attribution.

What does this look like in practice? First, we must explore of our beliefs to be sure that we are not imposing our own values on clients of any age. Next, we must assess where the child is so that we can be culturally sensitive to this domain of the individual. What are the family’s beliefs and influences? This knowledge can be gained through our intake process and in the techniques we choose to utilize in our sessions. Sentence completion activities, for example, or free association exercises will help us to learn of the child’s worldview and needs. These opportunities in a safe and trusting therapeutic environment will also allow the child to explore their own beliefs and grow in their self-awareness. Narrative techniques may be helpful as you assist the child in understanding how they perceive relationships in their lives, help them to build their sense of self, and help them to understand their place in the world around them. Play therapy will give opportunity to build understanding through symbolism and allow children to make concrete connections to abstract ideas.

Part of our job when working with young clients is to walk with them as they develop their sense of identity and how they relate to the world around them. Through the spiritual process of looking for
understanding, life skills that support resiliency can be developed. We must allow space for children to explore and to follow their lead. From career counseling to academic success to emotional wellbeing; focusing on the whole person will benefit our child and adolescents clients.

References


Fostering Self-Efficacy in Children

Leslie Contos, M.A., Governor’s State University

Counselors with a preventative and wellness centered approach, often work with children and their systems to increase the client’s personal protection factors. Taking time to collaborate with home and school to provide information about actions that increase self-efficacy, promotes environments which increase children’s resiliency.

Self-efficacy is a belief in one’s ability to be successful. Multiple studies have provided evidence for the four constructs which first appeared in Bandura’s (1997) seminal work positing the sources of input that shape a child’s sense of self-efficacy (Bandura, 2012).

- Mastery experiences
- Social modeling
- Social persuasion
- Physiological response

The role of the counselor working with parents and teachers is to help them understand the importance of self-efficacy and how to create the conditions at home or school that foster its growth. Perceived high self-efficacy is correlated with lower levels of stress, depression, and anxiety, and can be an important keystone in maintaining mental wellness because it “represents a personal resource factor that may facilitate efficient coping” (Parto & Besharat, 2011, p. 642). Studies have shown that perceptions of low self-efficacy are correlated with negative emotion-focused strategies such as denial, self-criticism, and isolation (Parto & Besharat, 2011). Counselors who help parents and teachers understand the sources of self-efficacy are impacting the child’s system in a positive way.
Discussion of the following concepts and role-playing examples will give adults an opportunity to learn and practice these new skills.

**Mastery Experiences** reflect a child’s recognition of success on a task. When a child succeeds, they develop self-efficacy for that activity.

- Provide appropriate challenge. Instructional learning is slightly above current performance level, and supported with guidance and strategies. Independent practice should be at current performance level (Margolis & McCabe, 2006).
- Increase motivation for learning. Mastery can be increased by allowing learners to utilize choice and by incorporating interests to increase engagement (Margolis & McCabe, 2006).

**Social Modeling** encompasses watching another person complete a task.

- Most effective when learner identifies with the person modeling. “Similarities can include age, race, gender, ability, interest, clothing, social circles, and achievement levels” (Margolis & McCabe, 2006, p. 221).
- Mastery models demonstrate the successful use of a skill or strategy for the child.
- Coping models provide examples of not succeeding at a task, but coping and understanding using factors under their control. For example, I did not do as well as I would have liked on the test, I probably need to find a better method of studying.

**Social Persuasion** refers to evaluative information provided by others in relation to the task. These can be words of encouragement, feedback, or judgements. It is important that the feedback is genuine, if a child hears “great job” after every task, it will cease to have meaning.

- Encourage trying, but make sure the level of the material is appropriate.
- Stress recent successes pointing out similarities to previous problems with which the child was successful.
- Clear instructions and expectations support high self-efficacy.
- Frequent, task specific feedback will support high self-efficacy.
- A successful formula for verbal feedback is to, “first, state why learners succeeded or failed, then state their degree of success” (Margolis & McCabe, 2006, p. 225).

**Physiological Responses** signify how a child feels physically and emotionally; before, during and after, a task. A high level of anxiety before an exam is likely paired to lower perception of self-efficacy.

- Relaxation techniques such as breathing or progressive muscle relaxation can be taught.
- Mindfulness techniques such as being present in the moment, or slowing down thoughts can be helpful.
• Cognitive-behavioral techniques such as identifying negative assumptions and replacing with positive alternate responses can provide support.

Cultural Differences may impact the weight of importance of mastery, modeling, social persuasion, and physiological responses across various populations. For white students, mastery experience and physiological state were most predictive of academic self-efficacy; while for African American students, social persuasion accounted for a greater variance than mastery. By gender, girls reported greater importance of social persuasion on perception of academic self-efficacy than boys. Usher and Pajares (2006) suggested that it might have to do with a greater perceived importance of attending to messages from others or a greater emphasis on relational importance.

References


Using Mindfulness Techniques with Students with Emotional and Behavioral Disorders in the Public Schools: A Team Approach with Students, Teachers, School Administrators, and Parents

Thomas DeGeorge, M.A., M.Ed., LPC, NCC

A student who has been identified as in need of specialized services due to emotional and behavioral concerns will have a behavioral plan in the Individualized Education Plan (IEP). The interventions in the behavior plan will be listed from least restrictive to most severe including the use of physical restraints. Research has shown (Fogt, George, Kern, White, & George 2008) that the use of physical restraints with students with emotional and behavioral disorders often is ineffective in building positive behaviors. The use of physical restraints also can lead to physical and emotional damage that can further trigger the student’s emotional dysfunction. Additionally, school personal is often ill equipped to appropriately implement a physical restraint. Further, research (Fogt, et al., 2008) also stated that the use of physical restraints is often used outside the realm of need and used for minor behavioral offenses.

Absent from many IEP behavior plans are alternative methods to address emotional and behavioral flare-ups from students. The behavior plans often state what to do when the behavior is exhibited, hence the progression to physical restraints. Other intervention methods only address positive rewards for displays of appropriate behavior as in stickers, tokens, and point systems. These
Interventions are effective for rewarding appropriate social behaviors but do little to address management of emotional and behavioral disorders before they occur. Building in effective strategies to reduce the emotional outbursts will increase the likelihood that these behavioral displays will decrease.

Mindfulness techniques have proven effective not only with adults but with children and adolescents. (Solar 2013; Viafora, Mathieson, & Unsworth, 2015). Consistent implementation of mindfulness techniques has not only shown a decline in behavioral interventions but has established a safe harbor for students to calm the explosions within their mental states. Building effective mindfulness techniques as a part of a student’s overall educational plan requires a coalition of support from teachers, students, parents, and school personal.

Prior to implementing mindfulness techniques in servicing for teachers and administrators needs to occur as to the benefits and proper implementation of its use. Monthly reviews should also occur to reestablish the goal and benefits of mindfulness in reducing inappropriate behaviors. Detailed records should be kept as to the effectiveness of the interventions as well as a daily schedule of mindfulness techniques appropriate for each age group.

Parental support for mindfulness techniques (Neece, 2014; Duncan, Coatsworth, & Greenburg, 2009) also has shown to be effective for their child and reducing their own levels of stress in parenting their children and adolescents. Having parents included in all school in servicing and being a part of the team approach will generate success across settings with the students.

Finally, the students need to buy into the intervention in order to be successful. The early stages of mindfulness need to be implemented by staff as opposed to recorded versions so students will see staff, school administrators and parents as partners in this technique. As the program progresses students will be able to show the positive results and take ownership of their growth. As part of the interventions adolescent students can aspire to lead groups in mindfulness activities to their peers and to younger students. This ownership in the approach will further entrench the mindfulness techniques into a student’s lifestyle.

References


Child Sex Abuse: Range of Mental Health Services vs. Barriers

By Lauren Chase, Georgia State University

There is a range of mental health services available to victims of child sexual abuse. These services include child protective services, law enforcement, child advocacy centers, psychologists, mental health counselors, social workers, and psychiatrists. These professionals are all responsible for protecting children under their care and should be trained to recognize signs of child abuse, neglect, and other maltreatment. According to Fong et al. (2016) “Most caregivers reported that they had little knowledge about MHS [mental health services] for child sexual abuse, even if they or their child had prior experiences with services. Despite this lack of knowledge, most caregivers believed that MHS were generally necessary for child sexual abuse” (p. 289).

These mental health services have benefits such as someone to talk to the child about what they were going through, teaching how to deal with what they went through, addressing their behavioral issues they may have as a result of the abuse, and preventing them from getting worse (2016). Some caregivers did not think their children needed mental health care after their abuse because “their child was too young, their case was unsubstantiated, they preferred to talk with their children themselves, or they did not receive sufficient recommendations or information about services,” (2016, p. 289).

When the child is too young to understand what is going on, they feel they may not benefit from talk therapy but could benefit from an alternative like play therapy in which a therapist could speak in their own language that the child understands. In a different way, group therapy is beneficial because children are naturally social beings and may thrive off of being in a group to work through issues. Play therapy is effective because the therapist is speaking the language of the child and is able to communicate with them better. Cognitive behavioral therapy is particularly helpful because it teaches problem solving skills and changes poor thinking and behavior. These children may have behavioral issues and act out due to the abuse and may exhibit poor self-esteem because of what has happened to them. This CBT therapy will focus on those key factors in order to improve the child’s condition.

An important mental health service particularly focused on this population is the creation of the child advocacy center. These centers are focused specifically on children that are victims of some sort of abuse, mostly sexual, or neglect. In Georgia alone, there are 44 child advocacy centers. These centers offer forensic interviews, medical treatment, victim advocacy, and mental health services to victims of child abuse. The mental health services available include Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Parent-Child Interaction Therapy (PCIT), and group therapy. These centers offer therapy to the children completely free of charge so that there are no financial barriers for the families to get help.
There are a number of mental health services available to these victims but there are some barriers to getting this help. The main barrier is the parent or guardian failing to seek services. According to Fong et al., “While a few of these caregivers stated that they would have considered services for their child if they had received stronger recommendations or more information about services, others reported that nothing would have convinced them to pursue services for their child” (2016, p. 289). Children usually have to obtain permission from their parents or guardian in order to utilize these services. Other barriers include: available pediatric mental health care providers, scheduling appointments, lack of coordination and communication around children’s multiple providers, and turnover of mental health care providers (Fong et al., 2016). When children can find a pediatric mental health provider, it is sometimes hard to fit it in with their school schedules and parents or guardians may have trouble or lack of transportation to take them to appointments. Also, children may be seeing a social worker, mental health counselor, psychiatrist, and general doctor and all these providers may fail to coordinate with one another regarding the child’s care and the quality of care may suffer.

There are also barriers regarding disclosure of child sexual abuse. These barriers include fear of social stigma, threats by perpetrator, burdening their parents, not wanting the perpetrator to get into trouble, lack of trustworthy people to tell, and fear of not being believed (Münzer et al., 2016). Children are afraid of being labeled as “sick” or “gross” or “dirty” for being abused by the perpetrator so they keep the information to themselves. They might also fear that future partners might not want to be with them because they were touched by someone when they should not have been. Victims can also be threatened by the abuser not to tell. They may threaten violence or hurting the victim’s family if they tell. This threat might keep them quiet because they do not want the abuser to hurt them further.

Children also may not want to burden their parents with the information of the abuse. The abuser could be the breadwinner in the family so if they tell, their money might be cut short. The parents or guardians might not be able to handle the information that their child was hurt and might go after the abuser and the child may fear they will go to jail. The child might also feel there is no one trustworthy to tell. They might fear that person will hurt them or just do nothing about it or worse, confront the abuser. The victim already has trust issues from the abuse so risking telling someone is a big deal. One of the victim’s biggest fears is not being believed. The child might tell someone they trust and that individual may believe they are joking or exaggerating. This reaction for a trusted individual will isolate the victim more and make them feel as if they may never be helped out of the situation. There are a range of services available to child sexual abuse victims but there are also just as many barriers keeping them away from getting the help they need and deserve.

References

The Association for Child and Adolescent Counseling (ACAC)
A division of ACA

~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~

Inaugural National Conference
July 20-21, 2017
Arlington, VA

Trauma in Children and Adolescents
Keynote speaker: Deb del Vecchio-Scully, Sandy Hook Counselor & Trauma treatment expert
~CEUs available~

Register at:


Visit our Facebook page for details!

http://acachild.org

Follow us on Twitter!
@ACAC Child
Like us on Facebook!
ACAC Child
CALL FOR PAPERS

Spring 2017 ACAC Newsletter

Please consider submitting an article for our Spring 2017 Newsletter. We are currently accepting submissions. The theme for the newsletter will reflect the theme of our Inaugural ACAC Conference—Trauma in Children and Adolescents. Submissions should be scholarly-based articles of 1-3 pages focused on counseling children and adolescents. Send articles to mayfield.peggyc@gmail.com no later than February 14, 2017. Early submissions are strongly encouraged.

JOIN US IN SAN FRANCISCO

March 31- April 3, 2017
for the
ACA Conference and Expo

ACAC Sponsored ACA Presentations
Shanice Armstrong (90 minute presentation)-
More than just a “bad kid”: Exploring positive self-concepts with students

Emily Goodman-Scott (60 minute presentation)-
Counseling Children and Adolescents with Sensory Processing Disorder: Tips and Tools You Can Use

Amanda Rumsey (poster)-
Identifying and Addressing the Needs of Refugee Adolescents in Schools

Jennifer Pereira (poster)-
Can We Play Too: Including Children in Family Therapy