A Message From Our President

Le’Ann Solmonson, ACAC President

I was so excited to welcome the first day of spring yesterday, and it did not fail me. It was a beautiful, sunny, 72°, blue sky kind of day. And this morning I woke up to a cloudy sky and my morning weather report predicting severe storms with the possibility of hen egg-sized hail (I’ve never heard of hen egg sized hail). Doesn’t that just seem fitting given our last couple of years? Just when it looks like things are getting better in our world, another war breaks out, and we see the horror of the impact it has on innocent people. A new strain of COVID-19 is announced, and the stock market is really scary right now.

I don’t know of any profession that is better trained and prepared to handle unpredictability than counselors. We are masters at tolerating uncertainty because we deal with it daily as we work with our clients. Is the four-year-old going to be happy and engage in organized and predictable play, or are they going to destroy my playroom? Is the adolescent going to be on top of the world or is today going to be the worst day ever? We are prepared to deal with whatever is presented and work from there. We find the potential and the good in each client and help them see it in themselves.

This edition of our newsletter focuses on creative approaches to address the mental health needs of today’s children and adolescents. Because guess what? They live in the same world of uncertainty that we do. As I look through the list of titles selected by our fabulous editorial team, I see great content for counselors in schools and in clinical settings.
A Message From Our President

I am excited to see an article on Trust-Based Relational Interventions which is one of my all-time favorite topics. Social anxiety and suicide among children and adolescents are both on the rise, and we have articles to up your game in dealing with those issues. I am excited to learn about eco wellness and safe practices for play therapy during the pandemic. From neurodiversity to selective mutism, from drug court to storytelling to cope with housing insecurity, from creativity and play to storytelling, these articles focus on the diversity of clients we serve and the tools for providing effective treatment. Each article is focused on the continued professional development of our members.

If you're in Atlanta for the ACA conference, we hope you will stop by our booth in the exhibit hall and introduce yourself. We also hope you will join us on Friday, April 8th at 7pm for our reception. We will be holding our annual meeting, as well as recognizing our award and grant recipients. If you are unable to attend in person, we will be livestreaming the meeting and award ceremony. Watch ACA Connect and your email for information on how to join in from home.

As an Enneagram 7, I have a strong need to look for the good and the positive. So, I am excited as the confirmation hearings for Judge Ketanji Brown Jackson, the first black female nominee for the Supreme Court, begin today. I am excited about my vegetable and flower seeds that are sprouting with the promise of beauty and harvest to come. I am happy to reframe my client no show to an unanticipated hour to write this message and mark it off my to do list for the day. And I am looking forward to time with my ACAC friends and family in a couple of weeks. I hope you can find things to look forward to and bring you joy today. Thanks for being a member of ACAC. You are valued and appreciated.

Le’Ann L. Solmonson, PhD, LPC-S, CSC
ACAC President
What Animal Are You Today? Creative Emotions Check-Ins for School Counselors

Rebecca L. Mathews, PhD, LPC-S
University of North Carolina at Greensboro

COVID-19 has had a significant impact on humanity worldwide. The collective stress of this time, combined with individual, family, or community-based trauma, has an untold impact on this generation of children. Students have experienced constant changes in their schedules, inconsistent access to friends and community supports, and disruption in school. These changes have contributed to an increase in the experience of anxiety, depression, and suicide for children ages 5-12 (Hill et al, 2021). Children's rates of obsessive-compulsive disorder and tics have also increased (Stephenson, 2021). With the ever-growing mental health needs of children, the school counselor's role has never been more vital.

School counselors are mental health warriors in the school system. They operate as change agents for their district and community in providing education, structuring programming, and meeting the needs of individual children (Fudgedi, 2018). School counselors provide a necessary link in care by supporting students’ mental health at school, identifying warning signs that community-based treatment may be needed, communicating with caregivers, and making recommendations on where care can be found. To be effective in this role, school counselors must quickly understand the emotional pulse of a child. As most school counselors know, asking a child, "How are you?" will lead to the all-too-common response, "Good." School counselors are creative in identifying strategies to check-in with children.

Many emotional check-ins have been designed for adolescents or adults and then modified for children. However, fundamental cognitive and processing differences may make these modified solutions ineffective. Developmentally, children are learning to express themselves with the language taught in their home and school (Berger, 2020). Younger children especially must find ways to translate their inner experiences into words so that adults can understand (Landreth, 2012). Communication can be even more challenging when the child has mental health struggles (e.g., social anxiety, selective mutism, depression). The use of visual, vocal, and/or kinetic check-ins can support a child's ability to communicate their current emotional state without the cognitive load of translation. Below are some brief strategies that school (and community-based) counselors can use to gain insight into a child's inner emotional experience.

**Pictorial Check-Ins**
Show students a laminated sheet with pictures of different emotions to select. Some students may benefit from seeing scenes where an emotion may be experienced (e.g., spilling milk, being laughed at by peers, smiling in the sun, crying in the corner of a room). If emojis are used, provide an emoji sheet to families, and encourage them to display it on their fridge or in a common place in the home (Krupa, 2021). Alternatively, school counselors can use characters from well-known TV shows or movies (e.g., Daniel the Tiger, Spidey, Paw Patrol pups) as well. A child can point to the picture that best describes how they are feeling in that moment. When meeting virtually, students can use emojis embedded in the software. This approach can also be utilized to help students communicate what their needs are (e.g., take a deep breath, drink water, stuffed animal, hug, running outside). Provide students with the prompt, "What would help you feel safe right now?" and then allow them to point to what they need. Anytime pictures or images are used, it is beneficial to ensure the scenes represent a wide range of diverse identities across emotional states.

**Body Pose**
"What does your body want to do when you feel this way?" This is a great question that allows children to move and create with their bodies while not translating their inner experience verbally. The school counselor can engage in the activity as well, modeling and labeling their emotion to support the child’s process. Students can also use dolls or figures to demonstrate the pose if they are hesitant to do it themselves.

**Animal: Sightsites & Sounds**
"What animal do you feel like today?"
Many children’s books use animals to describe emotions. A book by Clark (2019), Tiger Days: A Book of Feelings, uses animals to demonstrate different emotional states and what behavior is often paired with the emotion. This prompt allows the student to name the animal even when they may struggle to name the feeling. Use images from the books for students to point to if they struggle to find their voice in the moment. Students can also be asked what sound the animal may make.

There are many creative strategies that school counselors use every day to check in with children from drawing emotions and shaping feelings out of clay, to allowing students to select or sing a song that represents how they are feeling. Creative non-verbal feelings identification strategies can be especially effective at a time when overwhelming anxiety associated with the COVID-19 pandemic has silenced many tiny voices.

References


Examining the Versatility of Trust-Based Relational Intervention to Address Complex Trauma in Clinical Work with Children and Families

Marina G. Bunch and Sonja A. Welch
University of the Cumberlands

The Substance Abuse and Mental Health Services Administration (2022) reports that more than two-thirds of children have experienced at least one traumatic event by age 16. Early exposure to trauma puts children at risk for various adverse outcomes, and this risk increases with chronic exposure (Purvis et al., 2013; Razuri et al., 2016). Complex trauma is defined as “the experience of multiple, chronic, and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature” (van der Kolk & Courtois, 2005, p. 402). Complex trauma is particularly concerning due to the significant alterations of brain chemistry, resulting in deficits in attachment, affect regulation, behavioral control, cognition, physiology, social concept, and self-concept (Razuri et al., 2016; Purvis et al., 2013).

As mental health professionals, it is essential to consider how the COVID-19 pandemic exacerbates symptoms for children with a history of complex trauma in their various settings (Marques de Miranda et al., 2020). The pandemic has also posed challenges to service-delivery decreasing access to care for our most vulnerable populations. The Centers for Medicare and Medicaid Services (2021) report a steep decline in the utilization of mental health services for children since the onset of the pandemic. With this knowledge, we must consider treatment options that provide versatility and flexibility of service delivery to reach struggling children and families.

Trust-Based Relational Intervention® (TBRI®) is a versatile and systemic evidence-based approach to addressing the varying effects of complex developmental trauma for children of all ages (Purvis et al., 2013). TBRI® was developed at the Karyn Purvis Institute of Child Development at Texas Christian University and has been adapted for use in schools, residential homes, outpatient mental health settings, adoptive and foster homes, international orphanages, and groups (Purvis et al., 2013). TBRI® is especially relevant to today’s changing world of mental health as the approach has the flexibility of being delivered remotely (Razuri et al., 2016).

TBRI® is trauma-informed and grounded in attachment theory (Purvis et al., 2015). The approach aims to help adults learn strategies to build trusting and nurturing relationships with children who have experienced relational trauma (Reid et al., 2018). TBRI® is centered around three principles (Connecting Principles, Empowering Principles, and Correcting Principles) to enhance felt-safety, self-regulation, and connection (Purvis et al., 2015, p. 203). Each set of principles offers a practical set of strategies to understand and meet children’s needs, making this approach applicable to various settings.

There is promising evidence demonstrating the effectiveness of TBRI® in school settings (Reid et al., 2018). TBRI® in the school setting can offer teachers knowledge about the effects of complex trauma and tools to recognize and respond to behaviors resulting from trauma (Reid et al., 2018). This is hopeful given that children with a history of complex trauma exhibit challenging behaviors in the classroom and often struggle with executive functioning, problem-solving, and frustration tolerance, impacting the child’s ability to learn (Reid et al., 2018). In their study, Stipp and Kilpatrick (2021) found that teachers appreciated learning about the impact of trauma on children and reported that the practical techniques of TBRI® were beneficial. By providing a safe and nurturing environment, teachers can reduce the fight, flight, and freeze behaviors associated with trauma (Purvis et al., 2014).

TBRI® has also been shown to be effective through online delivery. This is particularly relevant to today’s society due to the growing need and popularity of telehealth services. Razuri et al. (2016) found that adoptive parents who received TBRI® training online reported a decrease in behavioral, conduct, and emotional problems compared to the control group. Children benefit when their caregivers learn about the impact of complex trauma and how to respond in ways that promote connection and self-regulation (Razuri et al., 2016). The ability to effectively deliver this knowledge online is exciting and decreases service-delivery barriers for families seeking support.
Clinicians can also implement TBRI® in outpatient mental health settings, residential facilities, and homes. The flexibility of the approach allows clinicians to implement TBRI® through caregiver-focused work, dyadic work with a child and caregiver, family-based work, caregiver training, and children’s groups (Purvis et al., 2015; Purvis et al., 2013, Howard et al., 2014). The holistic nature of TBRI® allows for versatility and flexibility to tailor treatment to various settings and in a cost-effective manner (Purvis et al., 2015). In addition, the concepts of TBRI® are applicable for children of all ages and risk levels (Purvis et al., 2013).

Although there is no prescriptive manner to deliver TBRI® in sessions, clinicians working with children and families in outpatient or in-home settings can begin the therapeutic process by providing initial training sessions to the caregiver(s). The goal of these initial caregiver-focused sessions is to provide psychoeducation on the impact of trauma and train caregivers on the three principles of the TBRI® model: Connecting, Empowering, and Correcting (Purvis et al., 2015; Howard et al., 2014). Each set of the TBRI® principles offers strategies to enhance connection and attachment, felt safety, and behavioral and emotional regulation (Purvis et al., 2015).

Once the caregiver(s) has knowledge of the principles and strategies of the TBRI® model, the child can be included in dyadic or family sessions. In these sessions, the clinician models the TBRI® principles to guide and support the caregiver(s) in implementing the principles and viewing the child through a trauma-informed lens (Nielson, 2014). For example, sessions centering around the Connecting Principle could focus on helping the caregiver(s) recognize the needs behind the child’s behaviors, teaching the child to maintain safe eye contact, encouraging the child to process feelings safely, helping the caregiver(s) actively listen to the child, and using playful engagement to enhance connection (Nielson, 2014; Purvis et al., 2015). The above strategies are mechanisms for building trusting attachment relationships, which is the heart of the intervention (Purvis et al., 2015). Once there is a foundation of connection between the child and caregiver(s), the clinician would incorporate the Empowering and Correcting Principles into the clinical work.

As mentioned previously, a strength of TBRI® is its flexibility of delivery and adaptability to various settings, therefore breaking down barriers for families. Today’s fast-changing world and current societal stressors call for mental health professionals to stay informed of the needs of children and families. We must also remain creative and flexible in considering alternatives to reaching our most vulnerable populations. TBRI® as a trauma-informed intervention has shown to be effective and versatile. As a relatively new intervention with growing popularity, there is still so much promise for reaching families around the country and the world.

References


Setting Kids up for Safety and Success: Play Therapy During the Pandemic
Caitlin Frawley, Molly Mesiano, and Mia Morales
University of Central Florida

During the COVID-19 pandemic, children experienced disruptions in school, extracurricular activities, and mental health services. Research suggested that nearly one third of children suffered increased depression, sadness, and loneliness during the pandemic (Lee et al., 2021). Additionally, children who experienced isolation from friends due to school closures exhibited increased levels of emotional reactivity (Larsen et al., 2021). As the COVID-19 pandemic continued, counselors attempted to return to normalcy and began seeing children in-person for counseling and play therapy treatment. However, children continue to face the long-term impacts of isolation, a lack of social support, and a lack of mental health services during the pandemic (Phelps & Sperry, 2020). Because children endured relational deprivation and social isolation during the COVID-19 pandemic, child counselors must consider the healing powers of the therapeutic relationship during this era. In Child-Centered Play Therapy (CCPT), the relationship between the child and therapist is the therapeutic change agent (Landreth, 2012).

Play Therapy Challenges During the COVID-19 Era

We (authors 2 and 3 of this article) faced unique barriers while seeing clients and utilizing play therapy for the first time during our master’s-level practicum experience. We noted challenges related to ensuring the health and safety of clients and ourselves, while also working to be effective counselors and deliver high-quality child mental health services. Working from a Child-Centered Play Therapy (CCPT) framework, we strived to create environments that provided children with safety (e.g., COVID-safe), as well as freedom to engage in self-directed exploration in a permissive, accepting, and empathic therapeutic relationship. We faced unique, COVID-related concerns, including: (a) limit-setting to ensure health and safety, (b) creating portable play kits that were easy to sanitize, and (c) integrating COVID-related toys for child exploration and mastery.

Limit-setting

Play therapists generally set limits to: (1) ensure children’s safety, (2) protecting the playroom, (c) preserve the therapist’s safety, and (d) protect the therapeutic relationship (Landreth, 2012). During the COVID-19 pandemic, limit-setting became somewhat of a gray area. Often, children asked us to take our masks off (to see our faces and feel closer in relationship with us). We believe that the best way to set this limit is to be reflective of the relationship while doing so. When children asked us to remove our masks, we engaged in A-C-T therapeutic limit-setting, which involves (1) Acknowledge the child’s wants and feelings; (2) Communicate the limit; and (3) Target alternatives (Landreth, 2012). For example:

Child: “I wanna see your face! Please take your mask off.”

   Therapist:

A: “You’d really like to see my smile,”

   C: “....but my mask is for staying on to keep everyone safe,”

T: “You can look in my eyes” (offers alternative point of connection)
Creating Portable, COVID-Friendly Play Sets

Play is the language of children and toys are their words, and through their play, children can process experiences and communicate their feelings (Landreth, 2012). Play therapists want to set children up for success and create play spaces that allow for child-directed exploration. At the height of the pandemic, portable play kits helped ensure that children had “tools” to explore and make sense of their current world, while also keeping each child safe who will use these kits. When seeing multiple children per day, we needed to create play kits that could be sanitized and dried. Below, we provide COVID-friendly materials for portable play kits, consistent with Kottman and Meany-Walen’s (2016) toy categories.

- **Family/Nurturing Toys:** All-plastic baby dolls (removed cloth clothing); plastic human figures (wide variety of gender, ethnicity, size); animal figurine families (i.e., two big lions and a cub); plastic or metal dishes, cookware, and pretend kitchen appliances

- **Scary Toys:** Plastic dinosaurs, dragons, rats, bugs, snakes, and other “dangerous” creatures

- **Aggressive Toys:** Foam swords; plastic dart guns; toy soldiers

- **Expressive Toys:** Construction paper (5-10 pieces per child, refreshed after each session); markers and crayons; scissors; glue sticks

- **Pretend/Fantasy:** *Doctor’s kit; pretend medical shots; plastic magic wand; plastic building blocks; rubber animal puppets; toy cars, trucks, and planes
  - **Doctor kits.** During the pandemic, child counselors should ensure that children have doctor kits that include instruments such as stethoscope, thermometer, blood pressure cuff, plastic syringe, and bandages. These toys allow children not only to make sense of COVID-19 and doctor visits that come with it, but it also allows children to engage in pretend (and often nurturing) play.
  - **Rubber Puppets.** Puppets are important toys to include in the playroom. Children can use puppets to externalize their experiences and distance themselves from trauma, or another experience that they want to play out. Many puppets are cloth and cannot be easily sanitized in-between sessions. Including rubber puppets in a portable play kit ensures that children still have access to these tools, as well as keeping children safe from other children that have been in the playroom.

While creating a portable play kit during the pandemic, play therapists may choose to intentionally avoid toys involving contact with the mouth. This means limiting things such as whistles, balloons, kazooz, and harmonicas to set children up for safety and success. However, this depends on the counselor’s resources and ability to fully sanitize such items between sessions. When you keep these kinds of items out of the portable pandemic-friendly play kit, “you can play with these toys, in almost any way you’d like” becomes a more honest statement.

**Conclusion**

During the COVID-19 pandemic, children experienced increased levels of loneliness and social isolation, as well as separations from important support systems (e.g., school, family, friends, community). During this era, CCPT is an appropriate treatment given the relational nature of children’s emotional wounds during the pandemic. Supervisors working with trainees in community and university-based practicum settings may discuss safety, limits, and portable play kits that allow children to express and explore the world through play.
Storytelling in Therapy: A Case Study of Coping with Housing Insecurity

Yu-Ching (Isabelle) Hsu
Elwyn Outpatient Behavioral Health Services
Philadelphia, Pennsylvania

Anabelle had never lived in a house big enough to have a guest room. She felt scared moving in, convinced it was haunted, and invited her friend for a first-night sleepover. The next day she discovered an old man in the basement who claimed to be the owner of the house. Anabelle called the police but the old man escaped before the cops got there.

Storytelling can catalyze profound shifts in therapy (Hutto & Gallagher, 2017). The eleven-year-old girl under the pseudonym, Eve, replayed memories, considered alternate outcomes and endings through creating Anabelle’s narrative. Notably, Eve as the storyteller could separate herself from her protagonist Anabelle and the problems she faced.

According to White and Epston (1990), “it is storytelling that determines the meaning ascribed to experiences” (p.10). Eve is an energetic African American girl, whose story about the haunted house allowed her to explore themes related to her own housing insecurity in early childhood. The stories that people develop in order to seek meaning in life are integrated with social constructs influenced by race, culture, and socioeconomic backgrounds. Therapists can encourage clients to externalize their problems towards identifying new strategies and outcomes. By negotiating the plight of story characters, the client exercises personal agency, develops mastery, and learns their impact which can generate hope and new possibilities (White and Epston, 1990). The therapist can provide a gradual framework, such as the Scaffolding Conversation Map (White & Morgan, 2006), to guide the therapeutic conversation by slowly identifying the problem(s) and the client’s impact on the situation. Eve explored her own issues of housing insecurity through the tale of Anabelle, who faced multiple identified problems, including a haunted house, a strange old man’s presence in the basement, and her own fear. Eve identified how these problems affected Anabelle and advised her protagonist on how to take actions.

Pehrsnon’s (2006) Co-story-ing technique invites the client and therapist to co-create stories as a way to build trust in the relationship. This approach helps therapists assess a client’s strategies in confronting challenges and introduce interventions by encouraging the fictional characters to try new things and take appropriate risks. Clients develop confidence and can then apply different problem-solving strategies in real life.

In storytelling, clients attribute personal meaning through imagery, symbolism, role plays, and character development. Veglia and Di Fini (2017) define 6 life themes that contribute to the definition of self and the world, including love, personal value, power, justice, truth, and freedom. In Eve’s story, home invasion gives form to her fear. Metaphors are used in stories as bridges to the unconscious to access deeper feelings and thoughts. In the tale of Anabelle, the police eventually apprehended the old man who escaped the house. As the story unfolded, Eve stated that the old man was a serial killer who was finally captured; she affirms her personal values of safety and justice.

Eve was referred to as therapy because of difficulties focusing at school and a history of parental neglect and housing insecurity. Her grandmother commented that she is a great storyteller. I asked Eve if she would like to create stories in our sessions. While I served as her scribe, she eagerly set the first story in a haunted house. There was a girl named Anabelle and she just moved into a house. Eve paused for a bit and looked at me. I asked: how do you think the girl is feeling? Eve commented: she was scared.

Together, Eve and I began to search for things that would help Anabelle feel better. She called one of her friends to stay with her for a day. The housing exploration started after the friend arrived and they went to the basement. What did they find? Eve smiled and whispered: An old man. I reacted with a shocked face while Eve giggled. So what should they do then? Eve paused and said: Anabelle asked what the man was doing there and if he could leave the house.
The story continued with the man proclaiming his ownership of the house and Anabelle’s growing confusion about the situation. Anabelle called the cops, Eve declared as we continued to explore ways to solve the situation. This is a significant step where she exercises agency by seeking external support. Her decision to confront the old man and to contact the police demonstrates healthy esteem and self-worth. Children typically have limited choices. Writing about Anabelle gave Eve a greater sense of agency and control.

The process of storytelling helped Eve to transcend perceived limitations, explore alternative outcomes, and develop coping skills to thrive in the face of adversity moving forward. Storytelling can be a great creative approach with children who experience trauma. When words are intimidating to communicate the traumatic experience, storytelling creates a safe space to explore difficult feelings with distance by empowering children to exercise personal agency and process trauma through the character.

**References**


Selective Mutism: Strategies for School Counselors and Stakeholders

Melissa R. Mecadon-Mann
Auburn University

Nadiya Boyce Rosen
Florida Atlantic University

Selective mutism (SM), located in the DSM-5 under anxiety disorders is identified by "total absence of speech in specific social situations while speech production appears to be normal in other situations" (Muris & Ollendick, 2021, p. 159). SM was originally thought to be a behavioral issue; speaking directly to a child with SM can cause a frozen reaction, and the frozen response can be mistaken as opposition (Lawrence, 2017). Recent research has shown that SM is more closely tied to anxiety and fear. SM has no association with communication disorders, speech disorders, or autism spectrum disorder (Muris & Ollendick, 2021). SM is a rare disorder that starts in early childhood and is identified, usually, around the time children begin attending school (Muris & Ollendick, 2021). It is, however, hypothesized that SM may not always be diagnosed or reported (Arlgiani et al., 2020). Diagnosis requires restriction of speech past the first month of school in order to rule out general social anxiety (Lorenzo et al., 2020). Associated features of SM include fear or anxiety surrounding social encounters which can present as social withdrawal, mild oppositional behaviors, and tantrums (APA, 2013).

Children with SM can have particular difficulty at school. Traditional education models require students to speak and interact with teachers and peers (Lorenzo et al., 2020). When children with SM begin school, they may experience higher anxiety levels due to the requirements to socialize with other children and communicate with teachers and school staff (Longobardi et al., 2019). Therefore, SM can negatively impact student personal and social progress as well as academic success (Lorenzo et al., 2020). This article provides strategies for counselors and educators working with students who have SM.

Strategies for School Counselors and Teachers

Cognitive Behavioral Therapy (CBT) is one of the most recognized clinical treatments for children with SM. Treatment includes psychoeducation, relaxation and coping skills, cognitive techniques, such as positive affirmations and reframing (Muris & Ollendick, 2021). Additionally, clinicians have been successful treating SM clients through play therapy interventions (Muris & Ollendick, 2021). School counselors are in the perfect position to bridge the gap between the clinic and school by providing strategies for teachers to implement in the classroom setting (Kovac & Furr, 2019).

To ensure continuity of care, it is recommended for all caregivers, school counselors, teachers, and school administrators to discuss the student’s needs regarding instructional/academic, social, and communication strategies and accommodations (SMA, n.d.). Supporting students with SM at the secondary school level may be more difficult, as there are more academic demands on these students (Lawrence, 2017). School counselors and teachers are encouraged to avoid singling out or pressuring students with SM to speak during class or in social settings (Johnson & Wintgens, 2016). Children and adolescents with SM benefit when allowed to speak when they are ready and when operating in familiar settings with people they know and trust. Adults should speak to these students in a warm, natural way and utilize non-verbal communication (Ex: head nod, a smile, e-mails or chat via Zoom, etc). Additionally, using yes or no questions and allowing students to elect to demonstrate activities or read aloud is also encouraged when supporting students with SM. If the child or student raises their hand or answers a question, adults should avoid publicly praising the student so as not embarrass them in a social setting. School counselors and teachers should seek to build positive rapport with students with SM and learn about the child’s interests (Johnson & Wintgens, 2016). Establishing a relationship with these students can facilitate a sense of safety in social settings, academic success, and development of social-emotional skills (Longobardi et al., 2019).

Children with SM can eventually become more comfortable in social settings and demonstrate more social behaviors when receiving treatment. CBT is a popular treatment modality for SM which consists of five major components including psychoeducation, physiological training (Ex: progressive muscle relaxation, breathing exercises), behavioral training, cognitive training, and parent training. Control trials have shown that children with SM who are receiving CBT-based treatment demonstrate a decrease in social anxiety and an increase in functional speaking (Muris & Ollendick, 2021). Additionally, trials indicated that children who had received CBT-based treatment demonstrated a reduction in the symptoms associated with the diagnostic criteria for SM compared to children who did not receive treatment (Bergman et al., 2013; Oerbeck et al, 2014). School counselors should attempt to collaborate with caregivers and the child’s therapist to support the student’s therapeutic progress while attending school.
References


Help Adolescents Combat Social Anxiety and Build Relationships with an Other-Focused Attitude

Deedre Mitchell, PhD, LPC, NCC, Certified School Counselor
Liberty University

Many school-aged children silently struggle with social anxiety, or a disproportionate fear of social situations (APA, 2013). Behavioral characteristics of this form of anxiety can be seen in an avoidance of speaking in class, lack of eye contact, fear of peer conversations, and an appearance of being on edge (Pearcey et al., 2020). Additionally, physical symptoms can include blushing, excessive sweating, trembling, a rapid heart rate, and dizziness. All conditions that make it easy for children and adolescents to miss social cues, and very challenging for them to connect with others and build positive peer relationships.

One theme in the literature on social anxiety is that those struggling with this distress have a heightened awareness of self (Stein, 2015). Therefore, it could be that the disproportionate fear underlying social anxiety may be correlated to a disproportionate negative self-focus (Abraham, et al., 2013). On one level, self-focus may sound like a good thing. It allows one to consider their own needs, what they are doing well, and how they can improve. However, this is a self-focus that can become debilitating rather than productive and can result in rumination and adverse self-evaluation. For example, an adolescent may become consumed with negative thoughts over a social exchange either before or after it occurs: That was so embarrassing, I really blew it, I probably sounded so stupid, I wonder what they are saying about me, others will see me poorly, I must impress people, I must be perfect so they like me.

Regardless of how heightened self-focus behaviors develop, they are likely maintained as a coping mechanism that provides a sense of control in a situation perceived as threatening (Chansky, 2014). However, in the resulting avoidance, withdraw, and misplaced energy and attention; one stays ‘stuck’ in a pattern that maintains the social anxiety. For example, school counselors likely see students go to great lengths to avoid lunchtime, simply because they dread walking into the lunchroom. A common faulty thought process could be, everyone is looking at me, and so they avoid the experience altogether. However, they then miss opportunities to test and overcome their faulty thinking, to look beyond themselves, and to make connections with others. All things that could lead to new patterns of thinking and behaving, and a reduction in social anxiety.

Cognitive therapy techniques have proven effective in reducing the occurrence of worry and anxiety (Hanrahan et al., 2013). School counselors can utilize these tools to help students identify and challenge the faulty thought processes that contribute to their social anxiety. To begin, counselors can benefit students by bringing attention to the possibility of a heightened sense of self. Then, in line with the counseling technique of competing demands (Beck, 2020), one way to decrease their disproportionate sense of self is to encourage a focus on something other than self. Without sacrificing their own needs, adolescents can achieve a healthy balance of self and other awareness. Negative self-absorption will be minimized, and the outward focus may pave the way for them to make genuine connections with others and yield peer relationships. School counselors can encourage this shift with the following suggestions and activities to share with students.

**Contain the Self-Focus**
A first step may be to educate students on the concept of heightened self-focus, normalizing that a little is okay and perfectly normal. In fact, reminding them that most adolescents have a somewhat elevated sense of self due to normal identity development is a logical reminder that others are likely not negatively focused on them. Afterall, their peers may be just as self-conscious as they are. School counselors can then offer tips to minimize the time spent in negative self-focus and worry with a spin on the concept of worry containment (Chansky, 2014). Worry containment is a CBT tool that allows a student to gain control over the frequency of their worry. Allow 15 minutes a day to ruminate – and that’s it. During that time, the student can express all of their negative self-focus thoughts with a trusted adult. When worrisome self-focus thought enters their mind throughout the day, they can write it down to consider during their designated worry time. Then, they must move on and turn their focus to something different.

**Use All Five Senses**
When a student finds their mind wandering into unhealthy territory, school counselors can encourage the use of their five sense to bring them back to the present moment. Rather than allow the intrusive thoughts to enter, students can take control
and ask themselves: What do you see? What do you hear? What do you taste? What do you smell? What are you touching? Specifically, when a student is struggling with intrusive self-focus thoughts, encourage them to follow this up with a consideration of others around them. Who do you see? is a good lead-in to encourage an other-focus attitude. Students can be encouraged to really see others, including peers who may be looking to build a connection as well. Are there others sitting or walking alone? Maybe someone who also struggles with self-doubt? Perhaps someone even in need of help or a friendly smile? Again, when students’ minds are occupied with thoughts of others, it is more challenging for the negative self-focus to creep in.

Put Yourself in Someone Else’s Shoes
Whether it’s a trusted friend, the feared enemy, or simply another student sitting nearby; encourage your student to become curious and open their mind to the experience of the other person. Not only will this help to take their mind off their own negative self-talk, but it will also help them to build empathy and understanding for others. This is a good step in the direction of building a connection with a peer. Encourage them to consider how someone else’s day may be going. What might the other person be thinking and feeling (as unrelated to you)? When they find themselves wondering if someone is mad at them, talking about them, etc., encourage them to look for alternative explanations (Beck, 2020). They can consider the possibilities that the other person is having a bad day, not feeling well, or struggling with their own negative self-thoughts. All possibilities that are more likely to be true! Encourage this a step further and ask a student to consider what they would say to someone who shared the same negative self-defeating thoughts. Ask your student, what would you say to this person? It’s likely that this exercise will help them to take a different perspective and realize that their own negative thoughts are truly unrealistic and unwarranted. Hopefully, rather than seeing themselves on an isolated island, they will begin to see a room full of friends with similar struggles and desires.

Be a Good Listener
Often times, an individual struggling with social anxiety will only have the capacity to partially engage in conversations. This is because they tend to overthink how they are perceived with thoughts such as: I hope I look okay. What am I going to say next? I don’t want to sound stupid. Their narrow focus limits their awareness and ability to engage in one-on-one and group conversations. As school counselors, we can bring their attention to this and teach them how to be an active listener. Encourage them to do more than go through the motions and silently wish the conversation to end. Rather, remind them to be observant of their peers, be curious, and ask follow-up questions. If we pay attention to cues, there is almost always an opportunity to take a conversation deeper. Have them practice with you. If they find their own intrusive thoughts entering, remind them of their self-focus worry time – those negative thoughts will just have to wait!

Make Time for Others
Making time for others often takes a backseat when one is consumed with overwhelming thoughts and fears. Also, our students will likely wait for someone else to take the first step, forgetting that the other person may be experiencing a similar struggle. If your student is desiring opportunities to connect with others, encourage them to take the first step. This likely feels threatening, so brainstorm small steps that can be taken in this direction. For example, is there an individual they enjoy connecting with who feels less threatening? If so, have them set a goal to ask for a phone number, plan an activity, or offer to help them with a task or a chore. It can even be as simple as starting a conversation, giving a compliment, making eye contact, or sharing a smile and a hello. Have them practice it, do it, and consider the results. Then have them try it all over again.

Engage in Problem Solving
Sometimes a self-focus attitude is maintained because it is what is known. In these instances, it could be that the student would like to connect with peers but lacks the skill to do so. Through questioning and reflection, discover the roadblocks and then help your student work through them. Use your individual counseling time to identify the areas of needed growth and then share your expertise and help them practice. Whether it’s starting conversations, learning to listen well, or considering the needs of others, you can address this with psychoeducation, bibliotherapy, and role play. Since most students would benefit from this, consider adding this to group counseling sessions and classroom guidance lessons for all. When adolescents let go of a self-focus grip, they can have experiences that test and minimize their negative thinking and maximize their opportunities to build connections with others. A new cycle can be created... one that builds bridges and hope, rather than distance and despair. We may even see a movement from an other-focus to a together-focus – something that will benefit all of our schools and students!
References


SCHOOLS AND JUVENILE TREATMENT DRUG COURTS: A POTENTIAL TREATMENT AND SERVICE HUB FOR COURT INVOLVED YOUTH

Jennifer Smith Ramey, Ed.S., LPC
Fred Volk, Ph.D.
Liberty University

The national data suggests that 15% of high school students have used an illicit drug (i.e., cocaine, inhalants, heroin, methamphetamines, hallucinogens, or ecstasy), and approximately one in 14 students reported misusing them during the past 30 days (CDC, 2020). Unfortunately, treatment for school-aged youth is limited for the estimated 10-15% of students who meet the criteria for a substance use disorder (SUD). In addition, many school systems are not equipped with adequate resources to provide evidence-based SUD treatment to students (Benningfield et al., 2015). In many communities, resources for treatment and support for youth are available across a range of social services, education, or criminal justice sectors, each with its unique focus on delivering on their primary tasks (e.g., home placement, delivering curriculum, or law enforcement). However, these efforts are often disconnected or loosely connected through personal relationships among the community of helpers, including counselors, who serve in roles in all of these sectors. This suggests that counselors may have an opportunity to advocate for cross-sector client-centered interventions that improve outcomes for those school-aged youth that meet the SUD diagnostic criteria.

Cross-sector collaboration between schools and community counseling agencies is associated with positive outcomes for youth in improving access to care, academic and social measures, and school attendance (Swick & Powers, 2018). Research suggests some of the benefits of these partnerships include connecting students to counseling and direct communication with a counselor to share information to ensure that school and community-based services complement each other (Kaffenberger & O’Rorke-Trigiani, 2013). To address the limited availability of SUD treatment for adolescents in schools, a natural extension of the school and community counseling collaboration is the addition of the juvenile court service unit in the partnership. Inclusion of the legal sector is indicated as the current response to student substance use, distribution, or possession in schools may include disciplinary infractions (i.e., suspension, expulsion) and legal involvement. Legal involvement may result in youth being placed on court supervision or monitoring, with a risk of out-of-home placement. However, juvenile treatment drug courts offer a different approach to the punitive role of the judicial system—drug courts couple treatment (i.e., counseling) with judicial oversight as an alternative to prosecution or sentencing. Key components of drug courts include judicial oversight, screening and comprehensive assessment of youth needs and development of an individualized plan of care, evidence-based treatment and case management, and monitoring outcomes for effectiveness (OJP, 2016). A meta-analysis revealed that juvenile treatment drug courts produce fewer rates of participant recidivism than youth who followed traditional adjudication procedures (Stein et al., 2015). Furthermore, a randomized controlled trial of six juvenile drug courts (JDCs) that incorporated evidence-based treatment (e.g., contingency management with family therapy) demonstrated a reduction in youth substance use and criminal behavior as compared to JDCs who provided treatment as usual (Henggeler et al., 2012).

To address the need for JDCs as a treatment alternative for court involved youth, we propose a shift in the delivery model of JDCs to the school as a focal point of services. The current model of JDC involves the courtroom as the mainstay of activity with counseling and case management provided at community agencies. As financial and transportation barriers are often cited as obstacles to treatment, the schools and the juvenile court system have a unique opportunity to provide evidence-based treatment and case management onsite at the schools, thereby reducing a significant access barrier. With the school as a primary context for service delivery, counselors may also communicate with probation officers assigned to work with youth enrolled in JDC, as well as other ancillary JDC team members (e.g., school counselors). This proposed model signifies a shift in operations from the courtroom as a focal point of operations to the school as a hub of counseling and case management for youth involved in JDC. To address a JDC key component of judicial oversight, the court service unit can explore offering court hearings before or after school to support youth in maintaining school attendance and engagement with school-based treatment. Counselors, who play an integral role in JDCs providing evidence-based treatment, may provide in-person or telehealth services through embedded programming in the schools. This approach builds on previous research highlighting the strengths of cross-sector collaboration, including leveraging shared resources, collective action toward a common goal, and improved learning opportunities (Provan & Kenis, 2008; Provan & Lemaire, 2012; Smith, Ramey, & Randall, 2020).
Implications for counselors include an opportunity to provide leadership and advocacy, as counselors are well-positioned to play a leading role in providing evidence-based treatment to youth with an SUD. A significant part of our role as counselors and clinical supervisors involves advocating for matrices of services that reduce treatment barriers and increase treatment initiation and adherence. Developing a school-based hub of SUD services recognizes the importance of working across organizations and sectors toward a unified vision of health and wellness for the youth we serve. Opportunities to rethink programming and delivery of care models infuse valuable solutions to reach at-risk youth with the highest needs. Furthermore, targeted efforts to share resources and form collaborative networks offer rich and lasting benefits to our community, with counselors leading the charge as advocates and leaders for individuals in our community with the greatest need.

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Connecting to EcoWellness Practices to Support Children & Youth Experiencing Climate Anxiety

Debbie C. Sturm, PhD, LPC
Anne Erickson, MA, LCMHC

Children and youth are among the most vulnerable populations uniquely impacted by the climate crisis (Benevolenza & Derigne, 2018; Martin et al, 2022). When children lack access to safe supportive physical and social environments, development and learning are impacted. The health of our air, water, extreme weather events, and the resilience of social systems, impact children’s health, mental health, development, cognitive functions, and coping (Burke et al, 2018; Eichler, 2015; Hickman et al, 2021).

In addition to threats from the changing physical environment, children and youth are also faced with a myriad of emotions that can have profound implications for overall mental health. Several recent studies have brought to light significant evidence that children and youth are experiencing negative impacts on their mental well-being and emotions due to their growing awareness of a planet under threat (Hickman et al, 2021; Martin et al, 2022; Thompson et al., 2021). Among these emotions are anxiety and frustration, negative expectations for the future, feelings of powerlessness, and a sense of betrayal toward those systems purposed with preserving their safety and future security. In a survey of over 10,000 youth in eight countries, Hickman et al. (2021) discovered that 60% of respondents felt “very” or “extremely” worried about climate change and more than 45% of children and youth said these feelings negatively impacted their daily lives. More than half the respondents reported negative emotions such as feeling sad, afraid, anxious, angry, powerless, helpless, and guilty. The least often reported emotions? Optimism and indifference.

So, what can counselors do? First, it is important to hold space for any children or youth who want to talk about climate change. For them, it is an important indicator of the stability of their future as well as a logical and rational concern over a very real problem often minimized by adults. Second, provide them a listening ear as they consider ways in which it impacts them and their sense of efficacy to create change. And finally, counselors working with children and youth experiencing eco-anxiety and climate distress can help foster positive nature connection with clients through practices of EcoWellness (Reese, 2018; Reese & Myers, 2012)). EcoWellness is defined as “as one’s sense of appreciation, respect for, and awe of nature resulting in greater feelings of connection to nature and holistic wellness” (Reese et al., 2019, p. 2). As counselors, we may not always have access to natural spaces and therefore engaging in EcoWellness practices may come in the form of family “assignments”, “homework” suggestions, or collaboration with those who can engage in these practices with the children and youth. Ways to include EcoWellness as you support children and youth in your practice include:

- Providing physical access to the natural world, either through natural areas in your school or practice, natural elements in your space, or encouraging significant adults to share nature-based experiences with them.
- In the absence of natural spaces, know that indirect exposure to nature, through images, sounds, scents, and anything else of a sensory nature could be valuable. Consider nature scenes in your space, water elements, plants, open windows with fresh air, tactile engagement with sand or water.
- Explore the emotional and cognitive connections children and youth have with nature through positive memories, early recollections, and relationships with significant people in their lives. This may also bring a sense of solistalgia, longing for something that no longer is, but it is a meaningful opportunity to help them explore how nature is part of their story.
- Explore opportunities for nature-based self-efficacy, or their ability to engage in protection of the natural world. Self-efficacy is a critical component, as mentioned above, to counter the feeling of helplessness and hopelessness. Imagine ways children and youth can make a difference and engage significant adults in removing barriers.
- Finally, foster a sense of connection through spirituality and community. Spend time understanding how your young clients find meaning and a sense of belonging. Explore ways in which experiences can incorporate the natural world, significant adults, and actions toward combating their fears about the changing climate.
A study by Thompson et al. (2022) involving qualitative interviews of youth age 14-18 in the UK shared some themes that could benefit from the attention of counselors. The youth reported increased protection of greenspaces, nature, and fresh air by leaders on the local level helped them feel safe and connected to their own environment. Strengthening a sense of efficacy among youth, in partnership with influential adults, can help counterbalance the sense of powerlessness they feel. Youth also expressed the belief that so much damage has already been done and they fear that it will be their responsibility to address it to create a safe future. Counselors can encourage the engagement of adults in conversations, practices, and actions alongside youth to make a difference personally, locally and on a larger scale when possible.

The most important thing is to listen, understand, and validate the experiences of children and youth as they process their lived experienced on the cusp of serious climate-related impacts. Return to the work of Hickman et al. (2021) and others who remind us that more than half of children and youth are experiencing very real emotions – heavy emotions – about the trajectory of climate change, the perceived inaction around them, and the impact on their future. It is important we create space for them to process this and consider interventions to strengthen their sense of efficacy and hope for a different future.

References


The Association for Child and Adolescent Counseling (ACAC) is committed to the principle that all children and adolescents (ages birth through adolescence) have equal access to a full array of mental health services, regardless of ability to pay or insurance coverage.

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ACAC Newsletter Editing Team

Dr. Michelle Hollenbaugh, Editor
michelle.hollenbaugh@tamucc.edu

Dr. Donna Hickman, Associate Editor
donnahickmanlpc@gmail.com

Jordan Mann, Associate Editor
jmann@ego.thechicagoschool.edu