

5 Legal and Ethical Implications for Working With Minors

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Objectives

- Describe and define many key terms from this chapter as associated with legal and ethical concepts.
- Understand, in depth, the importance of beneficence and its far-reaching imperatives.
- Recognize the difference between legal and ethical issues, and when to contact a lawyer.
- Identify ways in which codes of ethics guide our ethical practice as counselors.
- Compare and contrast codes of ethics of organizations to which you belong.
- Examine information related to working with minors, upholding confidentiality, and understanding privileged communication.
- Apply aspects of ethical decision making to an ethical dilemma.
- Examine advocacy competencies and understand ways in which culture impacts ethical decision making.

Reflective Questions

- What are my current ideas about legal and ethical issues in counseling?
- What are my current conceptualizations about using ethical codes and ethical decision making processes to guide my practice?
- How might legal and ethical issues differ for minors and adults?
- How do I understand my own values, beliefs, and culture as a counselor, and how is understanding this essential for understanding others?
- What cultural implications for ethical practice am I currently aware of?

It is a difficult concept to grasp that ethically, the child or adolescent is the client, but legally, a counselor's responsibility is to the parents/caregivers. Counselors and supervisors struggle with this concept when working with minors. This is foundational to working with minors and must be understood. When considering ethical, legal, and best practice implications, critical thinking is needed to engage in and thoughtfully process complex ethical dilemmas.

This chapter will urge you to take this information seriously and cautiously – but not become fearful about the services you provide. Often, counselors become scared about legal implications and talk of lawsuits. This chapter seeks to equip you with the information, resources, and critical thinking skills necessary to feel confident in your ability to move through complex situations for the betterment of clients. This chapter recognizes that training programs often have an entire class on legal and ethical issues in counseling. However, too often, work with minors is barely a focus – if it is taught at all. This chapter seeks to bridge that gap and provide you with the necessary information for protecting clients and practicing ethically – as that is our obligation.

Kitchener and Anderson (2011) state that

ethics is a branch of philosophy that addresses questions of how people ought to act toward each other, that pronounces judgments of value about actions (e.g., whether someone ought to be praised or blamed for those actions), and that develops rules of ethical justifications (e.g., how we can justify holding one set of values over another). (p. 25)

Because people hold different beliefs and values that influence actions, many professional organizations have developed ethical codes to unify professions and provide a framework from which to practice. We will discuss the American Counseling Association (ACA) Code of Ethics and note other ethical codes for practice, but before we move into that, it is important to understand our guiding principles for ethical counseling practice.

Guiding Principles

The foundation of our ethical obligations lies in understanding five guiding principles. These principles are pivotal in providing ethical and best practice services. Beauchamp and Childress (1979) outlined four of those principles that are central to our counseling profession. Those are beneficence, non-maleficence, autonomy, and justice. The fifth guiding principle, fidelity, was added later by Kitchener (1984). Kitchener and Anderson (2011) wrote

we argue that the principles of beneficence, nonmaleficence, autonomy, justice, and fidelity suggest that each person and each problem ought to be considered from a perspective that would offer the appropriate respect for people's rights and dignity, including their privacy, confidentiality, and autonomy. (p. 45)

Beneficence

Beneficence means simply to do good. Counselors must approach ethical practice with the intentions and skills necessary to do good and promote well-being for the client. This bears repeating: counselors must approach ethical practice with the intentions and skills necessary to do good and promote well-being for the client – not what *you* think the client should do. Further, the ACA Code of Ethics (2014) preamble notes that beneficence also includes working for the good of not just the client, but also society. Kitchener and Anderson (2011) also discuss that “beneficence suggests there are positive obligations like helping others and maintaining confidentiality to the greatest extent ethically and legally possible” (p. 40). What follows is an ABCDE (Sileo & Kopala, 1993, pp. 94–95) guide to promoting beneficence when working with clients.

A = Assessment

1. What is the client's mental state?
 - a. What are his/her strengths, support systems, weaknesses?
 - b. Is a psychiatric/medical consult necessary?
2. How serious is the client's disclosure? Is someone at risk for physical harm?
3. Are there cultural values and beliefs which should be considered while assessing the client?
4. What are my values, feelings, and reactions to the client's disclosure?

B = Benefit

1. How will the client benefit by my action?
2. How will the therapeutic relationship benefit?
3. How will others benefit?
4. Which action will benefit the most individuals?

C = Consequences and Consultation

1. What will the ethical, legal, emotional, and therapeutic consequences be for:
 - a. The client?
 - b. The counselor?
 - c. Potential clients?
2. Have I consulted with colleagues, supervisors, agency administrators, legal counsel, professional ethics boards, or professional organizations?

D = Duty

1. To whom do I have a duty?
 - a. My client?
 - b. The client's family?
 - c. A significant other?
 - d. The counseling profession?
 - e. My place of employment?
 - f. The legal system?
 - g. Society?

E = Education

1. Do I know and understand what the ethical principles and codes say regarding this issue?
2. Have I consulted the ethical casebooks?
3. Have I recently reviewed the laws that govern counseling practice?
4. Have I been continuing my education through journals, seminars, workshops, conferences, or course work?

As you can see, this is a complex issue that requires critical thinking skills in many areas, and this is just one of our foundational principles! Often students in legal and ethical classes have said: “*Just tell me what to do! What is the right answer?!*” and in counseling, often the answer is “*it depends*”. Understanding how to thoughtfully process through ethical issues is imperative. As you can see from the preceding assessment, it depends on many factors that are specific to each client and each case. As you work your way through ethical decision making, use this information to inform your work and your approach.

Non-Maleficence

Non-maleficence means to do no harm. Non-maleficence also includes avoiding actions and practices that have the potential to cause harm (ACA, 2014; Jiggins & Asempapa, 2016). Counselors are beseeched to not only promote the welfare and mental health of their clients by doing good, we are also charged with making sure our actions or practices cannot in any way cause harm. Beneficence and non-maleficence are model ethical standards

that guide the counselor and work in harmony to protect the clients we serve (Jiggins & Asempapa, 2016). Further, Forester-Miller and Davis (2016) note that “weighing potential harm against potential benefits is important in a counselor’s efforts toward ensuring ‘no harm’” (p. 2). When weighing ethical obligations in the face of an ethical dilemma, counselors understand that non-maleficence is foundational to promoting welfare. If, in the course of ethical decision making, a counselor must choose between beneficence and non-maleficence, “the stronger obligation could be summarized as ‘in trying to help others, at least do not harm them’” (Kitchener & Anderson, 2011, p. 48).

Autonomy refers to respecting the rights and wishes of your client. Autonomy means that the counselor seeks to understand that which the client wants, believes, and values while offering the freedom for the client to control their own outcomes and purpose. It is important for counselors to understand where the counselor ends and where the client begins, meaning that it is essential for counselors to understand the differences between their values, beliefs, and desires, and those of their clients. Ethical counselors will work to promote the autonomy of their clients based on the clients’ freedom and decision making, certainly not based on that which the counselor believes and/or would choose for her/himself. We try to explain this in class to counselors by stating that if you find yourself conflicted about something your client is doing that you don’t agree with, there is a place you get to go to discuss your own ideas and beliefs – your own counseling! The client’s session is not based on the beliefs and perspectives of the counselor – it is based on the beliefs and perspectives of the client. Barring any legal mandate, at any point if you find yourself in a situation in which you believe your client’s actions or desires to be challenging to your own, you must seek supervision and/or counseling to discuss this, as the counseling session is about your client. Supervision and personal counseling about these matters will help to ensure that your counseling remains non-judgmental and safe for your client to explore options and exert autonomy.

Justice

Justice refers to fairness or rightness. The ACA Code of Ethics (2014) defines justice as “treating individuals equitably and fostering fairness and equality” (p. 3). Treating individuals equitably and fairly does not mean that a counselor treats every client the same. Kitchener (1984) noted that justice is about “treating equals equally and unequals unequally but in proportion to their relevant differences” (p. 49). For example, when working with a client for whom we use a translator, we would treat the client the same as every other client in other capacities. If we were to only consider fairness and treat every client the same, would we then need a translator for every client we see? Therefore, to apply the concept of justice, we must understand equity. In assessing ethical decision making, we must consider whether our actions treat all clients equally – and if the answer is no, then we must be able to justify that the variance in treatment is applicable to the specific situation at hand (Velasquez, Andre, Shanks, & Meyer, 2018).

Fidelity

Fidelity is about doing what you say you will do. Fidelity involves being true to your word, and being trustworthy and dependable. The ACA Code of Ethics (2014) states that fidelity “or honoring commitments and keeping promises, including fulfilling one’s responsibilities of trust in professional relationships” (p. 3). Fidelity is crucial to the therapeutic alliance. Since relationships are based on trust, it is vital that counselors honor this agreement between the counselor and the client (Kitchener & Anderson, 2011).

Codes of Ethics

Counselors use codes of ethics to guide and support ethical decision making in the field. Ethical codes came about to uphold best practice within the profession, set by those in the profession. Unlike laws that were set by the community for the community, ethical codes go above and beyond to outline what the profession says is acceptable – in order to protect others from impaired professionals, and also to provide best practice guidelines for those within the field. Our ethical codes provide counselors with an understanding of our collective identity and standards from which we practice (Jungers & Gregoire, 2013).

ACA Code of Ethics

The American Counseling Association Code of Ethics is the primary code of ethics for counselors. Since ethical codes endure revisions as needed, counselors understand that the code is a “living document” (Corey, Corey, & Corey, 2019, p. 9). The most recent revision of the Code of Ethics was released in 2014, making this the seventh version established by ACA (Remley & Herlihy, 2016). Counselors must stay updated and aware of the changes made to the profession’s ethical codes. As new information, advocacy efforts, and ethical issues come to light, codes are revised to reflect best practice and provide guiding principles for counselors. For example, one of the recent revisions to the code outlined information pertaining to distance counseling, technology, and social media – information not pertinent to earlier revisions. Counselors must have an understanding of the codes of ethics which they follow and stay updated as these codes shift in order to best serve and protect our clients.

Specialization Codes

As a counselor, you may hold multiple licensures or certificates, and must be aware of the multiple codes of ethics to which you are beholden. For example, the authors of this chapter are members of ACA, have licenses in different states (Tennessee, North Carolina, and Louisiana) and are members of multiple ACA divisions, while holding credentials as NCC (National Certified Counselor), RPT-S (Registered Play Therapist Supervisor), and ACS (Approved Clinical Supervisor). Associations, specialty groups, and other certification groups have also established codes of ethics for those members. For example, the American School Counseling Association (ASCA) has a code of ethics and many position statements addressing best practices and ethical obligations for school counselors (2016). The American Mental Health Counseling Association also has a code of ethics (AMHCA, 2015).

State Licensure Codes

Most states require counselors to apply for a license in order to practice counseling in that particular state. Most states also have a code of ethics guiding counselor practice. While some states have their own code (e.g., Alabama, Florida, Kentucky), other states subscribe to the ACA Code of Ethics as their guidelines (e.g., North Carolina, Tennessee, Louisiana). According to ACA (2016), this means that

ACA’s standards shall be used as aids in resolving ambiguities which may arise in interpretation of the rules of professional ethics and conduct, except that the board’s rules of standards of ethical practice and professional conduct shall prevail whenever any conflict exists between these rules and ACA’s standards.

(p. 127)

This means that when the state code and the ACA code may be in disagreement, the ACA code will serve as the code to uphold. ACA (2016) notes that 18 jurisdictions out of 52 have adopted the ACA Code of Ethics as of that year.

Certification Codes

The National Board for Certified Counselors (NBCC) is a national certification that is voluntary and not based on state licensure. The NBCC has a code of ethics that all nationally certified counselors must follow (2016). Another example of a certification code is the American Association for Marriage and Family Therapy. This association also has an established code of ethics to guide clinical practice (2015). As you can see, there are many codes of ethics to guide our practice.

Further, there are also associations with guidelines (not codes, per se) for members and those credentialed to know and understand but refer to the members' primary licensing board as authority. The Association for Play Therapy has established *Play Therapy Best Practices: Clinical, Professional, and Ethical Issues* for registered play therapists and members of their association (2016), but makes it clear that the guidelines do not "replace or substitute any laws, standards, guidelines, rules or regulations promulgated by a practitioner's primary licensure or certification authority" (p. 18). As counselors, we have to understand the multiple codes and best practice information that guide our work.

Counseling Minors

Because counselors of minors have legal obligations to the parents or guardians of the children they counsel, and at the same time have ethical obligations to their minor clients and a different set of ethical obligations to the parents or guardians of the minors, there are times when the legal and ethical obligations of counselors of children collide (Lazovsky, 2008; Orton, 1997; Salo, 2015). In most situations in counseling practice, legal and ethical obligations are parallel and complementary, but because minors have only limited legal rights in our society (Davis & Mickelson, 1994; Kramer, 1994), there are times when counselors of minors must seek legal advice to ensure they are not violating the rights of children or their parents or guardians. Counselors must understand both legal and ethical duties to working with minor clients.

Obtaining Legal Advice

When counselors are faced with ethical or legal dilemmas, the process for resolving the two are much different. Consulting ethical standards that are reviewed above is an important part of ethical decision making, and consulting with peers and experts is critical. Ethical decision-making models are reviewed later in this chapter. On the other hand, resolving legal questions often requires that counselors seek legal advice.

There are circumstances in which counselors in all settings have to seek legal advice. Some situations that require counselors to seek legal advice include the following: (a) a counselor receives a subpoena for records or for testimony and is unsure whether the information is privileged; (b) a complaint is filed with a licensure board or certifying agency regarding the actions of a counselor claiming unethical conduct; (c) a parent or guardian of a minor asks a counselor to come and testify at a child custody hearing that will determine who is awarded custody of the child; (d) a counselor is asked to give information to an investigator after filing a suspected child abuse report; (e) the parent of a minor client who attempted suicide sends a letter to the counselor alleging that the counselor is incompetent

and threatening to sue the counselor for malpractice; or (f) a minor client accuses a counselor of inappropriate touching during a counseling session and alleges sexual assault.

Sometimes it is difficult for counselors to determine whether they need legal advice. Generally, counselors are well-advised to seek advice from an attorney if clients are involved in legal proceedings and client records have been subpoenaed or counselors have been subpoenaed to appear at a deposition, hearing, or trial; if lawyers for clients or parents or guardians of clients have contacted counselors about the services they are providing; or if someone is accusing counselors of misconduct. In short, if you have been contacted by a client's lawyer, it is a good idea to contact one on your behalf to assist in navigating legal terrain.

Counselors of children or adolescents who have an independent private practice need to establish a relationship with an attorney so that they can pay for legal advice when it is needed. Private practitioners sometimes retain lawyers to help them set up their businesses and to advise them regarding practice contracts they might sign such as leases or contracts to deliver services to agencies. When counselors in private practice are seeking an attorney to hire for practice-related legal services, it often would be wise to ask other counselors or mental health practitioners in the community which attorney provides them with legal advice. Mental health services may not be understood by all lawyers, so it is beneficial to counselors to find attorneys who understand mental health and legal issues faced by counselors.

Counselors who counsel children and adolescents and who work in schools, agencies, hospitals, or are employed by some other entity have legal advice available to them as a result of their employment. When employed counselors have legal questions, they should inform their direct supervisors and request legal advice. Usually, employed counselors do not have direct access to attorneys who advise their employers, but supervisors have an obligation to obtain legal advice for counselors who request it and to pass the legal advice to their employees who are counselors. Sometimes employers will provide counselors with direct consultation with attorneys who are paid by the employer, but that is rare because of the high cost of legal services. Employed counselors who request legal advice should follow the advice they are given.

Rights of Parents and Guardians

An initial right of parents or guardians of children and adolescents is the decision as to whether to seek counseling for their child. When there is more than one parent or legal guardian, the permission of one is all that is required to initiate counseling, unless a court order specifies otherwise, as in a joint parenting decree. On the other hand, a second parent or guardian has a right to demand that counseling cease after it has been initiated. Counselors may accept a child for counseling with the permission of one parent or guardian but should terminate counseling if another parent or guardian objects. A parent or guardian who wants a child counseled over the objection of another parent or guardian could choose to seek a court order.

If a parent or guardian demands that counselors disclose information given to them in sessions with children or adolescents, a first step would be for counselors to attempt to win the trust of the parents or guardians by assuring them they would inform the parents or guardians of anything they need to know about their children to keep them safe. Children vary in their desire for privacy in counseling situations. Counselors should not assume that all of their clients who are children or adolescents do not want their parents or guardians to know what they have discussed in counseling sessions. Trice-Black, Riechel, and Shillingford (2013) have suggested that inquiries about counseling information should

be responded to differently depending on the age of the child and the setting in which the counseling is taking place. Certainly, children should be consulted regarding their preferences regarding private information. Younger children seldom express an interest in privacy, whereas privacy may be of extreme importance to adolescent clients (Corr & Balk, 2010; Huey, 1996; Isaacs & Stone, 1999). Generally, school counselors, especially those at the elementary level, tend to favor giving parents and guardians information about their child's counseling sessions, whereas community mental health counselors tend to believe that clients who are children or adolescents should have the same privacy rights as adult clients have (Hendrix, 1991).

Utmost Importance of Confidentiality

I (Rebekah) have often worked with children and adolescents who have told me that they refuse to talk. I can imagine this might make any beginning counselor and even some seasoned counselors nervous, but I tend to trust that the client has a very good reason for refusing to talk to me and I respect that. It is important for counselors working with children and adolescents to check your power (and ego) at the door. I have often seen counselors get into power struggles with children and adolescents over their decision to stay silent in a session. I will not try to coax a child or adolescent into talking, and I will certainly never guilt a child or adolescent into speaking with me. This does not promote the dignity of the client and certainly does not build a strong therapeutic alliance honoring safety, autonomy, and trust. In this text, we will discuss many techniques for working with children and adolescents that don't rely on talk as the main form of communication. We hope that these skills will help you feel confident to navigate a situation such as this.

It has been in many similar counseling experiences where a client refuses to talk that sometimes they reveal why – in many instances, a client has said that it is because their last counselor went and told their parent, teacher, coach (fill in the blank) exactly what they said, so why should they trust another counselor? I (Rebekah) have seen this myself in the school setting, the community agency setting, and in inpatient settings. I have often wondered why this is the case. Do trained clinicians forget confidentiality? Do counselors get scared when working with minors and reveal confidential information, even when unnecessary? Whatever the reason, it is imperative to understand confidentiality as it pertains to minors.

It is widely accepted and generally understood by counselors, ethical codes, and laws that confidentiality is to be broken when a counselor suspects child abuse or neglect, when a client is a harm to self, and also in instances when the client indicates harm to others in imminent danger (Mitchell, Disque, & Robertson, 2002). The ACA Code of Ethics (2014) discusses trust as a cornerstone of the therapeutic relationship. Further, confidentiality “should be guarded at extreme costs, lest the profession redefine itself” (Mitchell et al., 2002, p. 158). Additionally, school counselors and other counselors working in school and inpatient settings have to also consider other adults involved (e.g., case managers, school social workers, teachers, members of the treatment team) when making decisions of breaching confidentiality. The ASCA Code of Ethics (2016) defines confidentiality as “the ethical duty of school counselors to responsibly protect a student's private communications shared in counseling” (p. 9). The ASCA Code also states that

privacy that should be honored to the greatest extent possible, while balancing other competing interests (e.g., best interests of students, safety of others, parental rights) and adhering to laws, policies and ethical standards pertaining to confidentiality and disclosure in the school setting.

(p. 1)

This can often be confusing for counselors and school counselors working with minors – the work of seeking a collaborative relationship with parents while also maintaining the therapeutic alliance, rapport, and confidentiality of the minor involved (Lazovsky, 2008). A delicate balance exists between working with parents and minors. We need parent/caregiver involvement. If possible, we want to strengthen the relationship with the client and their parents. This serves as such an important protective factor and adds to the long-term success of the client. Of course, there are situations in which this might not be healthy, or even safe, but having parents/guardians involved in the life of their child or adolescent can serve many beneficial roles.

Confidentiality and Privileged Communication

Counselors who provide services to all ages of clients find ethical and legal dilemmas related to confidentiality to occur frequently and be the most difficult to resolve (Fisher, 2008, 2016). Confidentiality is an ethical principle and is related to the obligation of counselors to respect the privacy of clients and not to reveal private information they know about clients without their consent. Privileged communication is a legal concept.

In order for privileged communication to exist, there must be a state or federal statute that grants privilege to categories of counselors (for example, those licensed by a state) and their clients. If a privileged communication statute does exist, then clients are protected by law from having confidential communications with their counselors disclosed in a court of law without their permission (Garner, 2014). All 50 states have enacted some type of privileged communication statute for clients of mental health professionals (Remley, Herlihy, & Herlihy, 1997; *Jaffee v. Redmond et al.*, 1996). Because statutes are regularly changed, it is impossible to list all of the states that have privileged communication statutes that protect the clients of various types of counselors. In most states, clients of counselors who are licensed by the state have privilege with their counselors (Glosoff, Herlihy, Herlihy, & Spence, 1997; Glosoff, Herlihy, Herlihy, & Spence, 2000), and in a few states, clients of school counselors have privilege with the counselors. Some federal statutes grant privilege to clients of counselors who provide services in some substance abuse rehabilitation programs. It is important for counselors of children and adolescents to investigate their state and federal laws and to know whether their counseling relationships with their clients are privileged by statute.

One issue that concerns counselors of minors occurs when parents or guardians seek information about a minor client's counseling sessions and the minor client objects to providing the information to their parents or guardians. While many counselors who provide services to minors report seldom being faced with children objecting to their parents or guardians being given information about their counseling sessions, others report that it has been a problem for them (Mitchell et al., 2002). A method to address such situations has been suggested by Remley and Herlihy (2016) and basically involves keeping in mind that parents and guardians generally have a legal right to know the information, and attempting to resolve the conflict between the child and their parents or guardians.

Informed Consent and Assent

The foundation for the counseling relationship is trust. Informed consent is one of the first steps to establishing a relationship founded on trust and well-being. Simply stated, informed consent refers to the client's right to understand and have autonomy in selecting the counseling they will participate in. Informed consent means that the client has the information needed to make knowledgeable choices about their participation in counseling

services. Often, this information is noted in the counselor's Professional Disclosure Statement. It is the counselor's responsibility to provide adequate and updated information about the services provided and to discuss these with the client throughout the counseling relationship. The ACA Code of Ethics (2014, p. 4) states:

Clients have the freedom to choose whether to enter into or remain in a counseling relationship and need adequate information about the counseling process and the counselor. Counselors have an obligation to review in writing and verbally with clients the rights and responsibilities of both counselors and clients. Informed consent is an ongoing part of the counseling process, and counselors appropriately document discussions of informed consent throughout the counseling relationship.

When working with minors, parents and guardians must sign the informed consent document in order for the counselor to be able to provide services. However, children and adolescents also have the right to understand the counseling relationship, what is involved/expected, and to have autonomy in selecting the counseling in which they will participate. Assent refers to the process of involving the child and adolescent in decision making about counseling services provided. While legally, the parent or guardian must give permission for services, it is ethical and considered best practice to explain the process to the child or adolescent, and involve them in decision making as much as developmentally appropriate. It is also suggested to include a signature line on documentation for the child or adolescent, along with the signature for parents and guardians.

Recordkeeping

The types of records counselors keep who provide services to children and adolescents depend on the settings in which the counselors practice. For example, school counselors typically keep minimal records on the students they counsel because of the volume of their caseloads that are compliant with the Family Educational Rights and Privacy Act (FERPA); counselors in hospitals or other healthcare settings usually keep extensive records that are compliant with the Health Insurance Portability and Accountability Act (HIPAA) and are similar to records kept by the other healthcare professionals in those settings; counselors in colleges and universities might keep extensive records that are both FERPA- and HIPAA-compliant; counselors in community mental health, substance abuse, rehabilitation, or juvenile treatment agencies keep records that are dictated by their employer that could range from few to extensive records; and counselors who have independent private practices usually keep both business and clinical records for their clients. Much of recordkeeping is dependent on whether a third party is reimbursing clients for the counseling services they received. Health insurance payors usually require that clients receive a diagnosis and that a treatment plan is created. In addition, insurance companies usually require that progress notes are kept that chart the progress of clients toward reaching their treatment plan goals. Counseling recordkeeping varies widely from setting to setting, and agency to agency. Employed counselors should always follow recordkeeping practices required by their employers.

It is important to keep records. When I (Rebekah) was working in the school setting, I kept brief records because I saw so many students a day – sometimes for only 15 minutes or so. There was an instance when a student was said to be involved in an encounter off campus during the school day. The student said he was not off campus, but was in fact with me. If I had not been keeping proper records, I would not have been able to substantiate the time when the student was with me. Aside from the importance of school counselors

or school-based counselors using records to support data-driven initiatives, records protect you and the client.

Since the parents or guardians of clients who are children or adolescents are the legal clients of counselors, parents and guardians have a right to access the counseling records of the minors. Custody orders, suspected abuse situations, or state or federal statutes might alter the general rights that parents and guardians have to their children's counseling records, so legal advice should be sought when counselors are unsure whether parents or guardians should have copies of the counseling records of minors. Whether minor clients should be given access to their counseling records would depend on the evaluation of counselors whether the minors have the maturity to understand the records and have a legitimate reason for wanting to see the records. It is suggested that the counselor talk to parents, caregivers, and guardians about the issues with just handing over notes. In most cases, counselors can discuss with the child and adolescent what updates they can provide parents, discuss the importance of trust and the therapeutic alliance with parents, and acknowledge the parents' worries and concerns for their child or adolescent.

A very important part of recordkeeping for counselors who provide services to children and adolescents is documenting steps taken by counselors under difficult circumstances (Wiger, 1999). It is vital that counselors write details of actions they took in situations in which suicide or violence may be suspected, a suspected abuse report must be filed, or when clients, parents, or guardians complain about the services rendered by counselors. Despite the need for documentation in crisis situations, counselors must be careful to avoid routinely creating massive amounts of records, especially when the quality of counseling services rendered suffers due to time spent in recordkeeping (Kennedy, 2003; Remley & Herlihy, 2016).

Audio and video recordings of client sessions for the purpose of supervision are considered records. Students earning counseling degrees must record counseling sessions that will be watched or listened to by their clinical supervisors. In addition, after receiving their master's degrees, counselors must practice under supervision for a minimum of two years (and sometimes longer) before being eligible to obtain a state counseling license. Minor clients must know their counseling sessions are being recorded and must agree to the process. In addition, permission for recording must be obtained from a parent or guardian. Best practice suggests that permission from minor clients, a parent, or a guardian be obtained in writing.

All records kept by counselors must be kept confidential. Counselors must take reasonable steps to ensure that written or recorded records are kept in a way that unauthorized individuals do not have access to them. Written records should be kept in locked places and electronic records must be password protected. When records are transmitted electronically, the best method for privacy of clients is to encrypt the records so that they cannot be intercepted and read by any individuals who are not the intended recipients.

Managing Custody Disputes

It is not unusual for counselors of minors to find themselves caught in the middle of legal proceedings of parents or guardians who are involved in litigation regarding the custody of the counselors' clients. Counselors of minors should always focus on their role as counselors to children in such situations and should refuse to become an advocate for any one parent or guardian when custody is being disputed. When counselors are asked to provide letters of support or to attend court proceedings related to child custody, they should decline and explain that becoming an advocate would conflict with their responsibilities to be the child's counselor.

Minor clients are not well served if their counselors become an advocate for one of their parents or guardians in legal battles for child custody. Counselors must be able to maintain working relationships with all parents and guardians when a separation or divorce occurs. In addition, counselors of minors have very little information about the home circumstances of the children they counsel, so they are not in a position to be recommending custody by one parent over another one.

Even after refusing to attend child custody legal proceedings voluntarily, counselors of minors may receive a subpoena that requires them to be present. Responding to subpoenas generally is discussed in the following section, and legal advice should be sought. If counselors are forced through subpoenas to attend child custody hearings, they should maintain their neutrality and should refuse to give a professional opinion about child custody awards because they do not have adequate information to form judgments about who is the better parent or guardian. Even though counselors of children may have personal opinions based on their interactions with their child clients and the client's parents or guardians, a professional opinion would require that counselors have much more information than they possess. Professional child custody evaluators are given expert witness status in child custody legal proceedings, but before they render an opinion, the evaluators interview all of the parties individually, observe parents and guardians interacting with children, visit the homes of the parents or guardians, administer personality tests to all parties, and gather other information prior to making custody recommendations to a judge.

Responding to Subpoenas

When counselors receive subpoenas for records or to testify, they must obtain legal advice to ensure they do not respond when doing so would violate a client's privacy or fail to respond when they are legally required to do so (Borkosky, 2016; Gutheil & Drogin, 2013). The legal documents known as subpoenas require counselors to produce copies of records; appear at a deposition, court hearing, or trial; or bring their records with them when they appear in court (Barsky & Gould, 2002; Bowerbank, 2006; Childress-Beatty & Koocher, 2013; Cottone & Tarvydas, 2007; Levy, Galambos, & Skarbek, 2014; Palusci, Hicks, & Vandervort, 2001).

In some instances, the information counselors of minors have in their records or know of from sessions may be legally privileged, in which cases counselors are not allowed to provide information and subpoenas issued requesting information can be legally challenged. In other circumstances, the information may be legally available to the person who has caused the subpoena to be issued (Woody, 1988). Even when information is privileged, the person holding the privilege can waive it, or there are exceptions to privilege statutes that might be present. The only way to determine whether to comply with a subpoena is to obtain legal advice. The attorney you consult will tell you whether or not you are legally obligated to produce records or appear. The attorney you consult could request that the attorney who issued the subpoena withdraw it, might advise your client's parents or guardians to file a motion to quash the subpoena, or might advise you to comply with the subpoena.

Reporting Child Abuse

Child abuse and neglect are serious issues impacting many. The U.S. Department of Health and Human Services reported that there were 4.1 million referrals including 7.4 million children in 2016 (USDHHS, 2018). However, most of the child abuse and neglect victims are not determined (Bryant, 2009). This USDHHS report also noted that the child protective

services (CPS) investigation response or alternate response increased from 2012–2016 at a rate of 9.5 percent (2016). Further, in 2016, an estimated 1,750 children died due to abuse and neglect (USDHHS, 2018). It is also shocking to note that research examining the agreement between reports of abuse and CPS determinations suggests that rates of abuse were actually 4–6 times higher than stated in CPS official records (Everson et al., 2008).

Counselors are legally mandated to report suspicion of abuse and neglect. In all 50 states and U.S. territories including the District of Columbia, there exist laws that mandate child abuse and neglect reporting (USDHHS, 2018). Counselors should understand specific requirements and reporting procedures in their state. Statutes vary from state to state, and laws are changing continuously (Remley & Herlihy, 2016). Past abuse, current abuse, who must report, who is doing the abuse (caretaker, parent, sibling, etc.), and what is necessary to report are all factors to consider when reporting. Consulting state laws is imperative to understanding legal obligations in your state of practice (Remley & Herlihy, 2016).

Remley and Herlihy (2016) discuss four main reasons that counselors may be reluctant to report suspected abuse or neglect:

desire to avoid betraying the child's trust, fear that a child protective services investigation will be poorly handled, fear of retaliation from the alleged perpetrator, or hope of maintaining the counseling relationship with the family so that the abusing adults can be helped to learn more appropriate parenting skills.

(p. 273)

Important to note are protective clauses of mandatory reporting. These laws protect counselors who report child abuse and/or neglect in good faith. This means that if the counselor believes that the child abuse or neglect was occurring or previously occurred, they will be protected against potential lawsuits against them from those who were reported (Remley & Herlihy, 2016).

Duty to Protect and Warn

If counselors who provide services to minors determine that a client may be at risk of harm to self or others, the counselors must take any action necessary to prevent harm to their clients or to other parties. When unsure of whether a particular child or adolescent may be at risk for suicide or violence, counselors always are advised to consult with supervisors or colleagues (Sommers-Flanagan, Sommers-Flanagan, & Lynch, 2001). The privacy which counselors generally owe to minor clients and their parents or guardians does not apply when counselors believe clients may be at risk of harming themselves or other people, but only the minimum of confidential information that is necessary should be revealed. Dealing with clients who may be at risk for suicide or for harming another person is probably one of the most difficult situations counselors of children and adolescents will face (Corey et al., 2019; Miller, McGlothlin, & West, 2013).

Counselors who conduct an assessment and determine that clients may be at risk for suicide or violence do not have to determine whether clients really are at risk. Instead, counselors must work to have clients who may be at risk evaluated by a physician or another health professional who has the ability to hospitalize the client, even against their will, if necessary. It is impossible to predict whether a particular client will attempt suicide or will actually harm another person, but counselors must ask questions that will help them to determine whether a client may be at risk (Capuzzi, 2002; Jacobs, Brewer, & Klein-Benheim, 1999; Laux, 2002; Myer, 2001; Rogers, 2001; Rogers, Lewis, & Subich, 2002; Schwartz, 2000; Schwartz & Cohen, 2001; Stanard, 2000). Although counselors do not

have a duty to determine whether a client is at risk for suicide or violence, they do have a duty to assess the client to determine whether the client may be at risk (Bursztajn, Gutheil, Hamm, & Brodsky, 1983; Drukteinis, 1985; Perr, 1985). There are accepted methods of performing such risk assessments that counselors of children and adolescents must know (Allen et al., 2002; McGlothlin, Rainey, & Kindsvatter, 2005; Morris & Minton, 2012; Shannonhouse, Lin, Shaw, & Porter, 2017). Counselors who did not learn how to assess for risk of suicide or violence in their graduate preparation programs must educate themselves through continuing education or readings (Daniel & Goldston, 2012; Linehan, Comtois, & Ward-Ciesielski, 2012; Meneese & Yutrzenka, 1990; Sapyta et al., 2012).

Literature is emerging on how counselors of children and adolescents should respond when they determine that a client is engaging in self-harm activities such as cutting, burning, self-bruising, etc. While some such activities are thought to be non-suicidal (Jagger & Sterner, 2016; Ross & Heath, 2002; Walsh, 2006; Zetterqvist, 2015), counselors of minors must assess the activities to determine whether their clients may be suicidal (Brausch & Gutierrez, 2010; Buser, Buser, & Rutt, 2017; Kakhnovets, Young, Purnell, Huebner, & Bishop, 2010; Nock, Holmberg, Photos, & Michel, 2007; Nock, Prinstein, & Sterba, 2010; Toprak, Cetin, Guven, Can, & Demircan, 2011; Wester, Ivers, Villalba, Trepal, & Henson, 2016; Wester & McKibben, 2016; Whisenhunt et al., 2014). Assessments for self-injurious behavior (Buser, Peterson, & Hill, 2016) and risk of suicide (Erickson & Abel, 2013; Lotito & Cook, 2015; McGlothlin, Page, & Jager, 2016) are available for counselors of children and adolescents. We will discuss this more in a later chapter.

Employed counselors should consult with their supervisors and must always follow any established policies or procedures when they determine that a child or adolescent client may be at risk for suicide or violence. Counselors in private practice should make sure that a parent or guardian of a minor who the counselor believes may be at risk for suicide or violence understands the counselor's concerns, agrees to take responsibility for the safety of the client, and agrees to submit the minor to a physician or qualified healthcare professional to be evaluated.

For self-protection, counselors of children and adolescents should always thoroughly document in their notes each time they assess a client to determine whether the client may be at risk for suicide or violence (Boughner & Logan, 1999; Gutheil, 1999). The reasons for deciding that either the client might be at risk, or probably was not at risk at that time, should be included in the documentation. When clients are minors, each time an assessment for suicide or violence is conducted by counselors, whether or not the assessment leads to a conclusion the clients are at risk, parents or guardians of the clients should be informed (Capuzzi, 2002).

If a counselor of children or adolescents determines that a client may be at risk of harming an identifiable person, then the ethical standards for counselors (American Counseling Association, 2014) plus the law in all states except Texas (*Thapar v. Zezulka*, 1999) require that counselor make efforts to notify the intended victim (Burkemper, 2002; *Tarasoff v. Regents of University of California*, 1976). If counselors believe they need to warn intended victims, they should consult with an attorney to determine what the law in their state requires, and should always involve supervisors when the counselors are employed.

Issues in the School

School counselors take on the role of parent substitute when they counsel children and adolescents in school settings. When parents and guardians send their children to schools, they expect the professionals in the schools to make sure their children are not harmed.

As a result, the duties of school counselors to parents and guardians are stronger than the duties of counselors in other settings.

School counselors consult often about students with other school personnel including principals, other administrators, teachers, social workers, and nurses. School counselors have to balance the privacy rights of their student clients and the parents and guardians of their students with the need of other school professionals to know information about the students in the school. Student clients and their parents and guardians should know when information is being shared with others, and what type of information it is. School counselors must adhere to FERPA regulations regarding private information.

Issues in Agencies and Private Practices

Counselors who provide counseling services to children and adolescents in settings other than schools have special concerns with which they must deal. Almost all non-school settings must follow HIPAA privacy rules and regulations. Counselors must secure permission to counsel minors, must provide information regarding the counseling to parents and guardians when they request it, and must discontinue counseling when requested. Counselors of minors in agencies and private practices often consult with others who provide services to their clients such as social workers, physicians, psychologists, and others. Shared information must be protected, and permission must be obtained from parents and guardians prior to consultations taking place.

Making Informed Decisions

Counselors are often faced with difficult situations involving ethics. It is imperative that counselors know how to critically think through situations and consider options for best practice. You will certainly encounter situations in which a decision is required, and you have multiple outcomes to choose from. How do you make the best choice possible? First, remember to consider the foundation of our ethical obligations, the five guiding principles discussed earlier: beneficence, non-maleficence, autonomy, justice, and fidelity. Consider each guiding principle in depth and in relation to the situation at hand. Next, it is critical to work through a model for decision making. This is not merely a suggestion for decision making, this is an ethical imperative. The ACA Code of Ethics (2014) is clear:

1.1.b. Ethical Decision Making

When counselors are faced with an ethical dilemma, they use and document, as appropriate, an ethical decision making model that may include, but is not limited to, consultation; consideration of relevant ethical standards, principles, and laws; generation of potential courses of action; deliberation of risks and benefits; and selection of an objective decision based on the circumstances and welfare of all involved.

(p. 19)

Model for Decision Making

Many models for decision making exist. The ACA Code of Ethics (2014) includes aspects of an ethical decision-making model for consideration by counselors. The ACA further does not endorse one specific decision-making model, but encourages counselors to utilize a model that is both reliable and can withstand public investigation (2014). You are encouraged to think through ethical decision making in a meaningful and critical way. The following is not a particular model per se, but will present aspects common in many

available models. Present in the following is a consideration for foundational principles, feminist approaches to decision making, multicultural considerations and ethics, social constructivism, and other specialty models (Remley & Herlihy, 2016).

Remley and Herlihy (2016) list the following items for inclusion in many ethical decision-making models. The items that follow are to be considered as a continuing process, and not a step-by-step model. Added to Remley and Herlihy's list is information from the Transcultural Integrative Model (Garcia, Cartwright, Winston, & Borzuchowska, 2003). This model was based on the initial work of Tarvydas (1998) and added to by Garcia et al. in 2003. This model is rooted in virtue ethics, principle ethics, relational method, and social constructivism techniques. What follows is not a complete or comprehensive discussion of this model. However, aspects of the Transcultural Integrative Model have been added to the concepts.

Identify and define the problem. Think about all aspects of the situation and gather more information as needed. It is important to decipher what is a legal issue and needs legal attention, and what is an ethical issue. Take your time, as permitted, to consider and define the situation at hand. You must also consider your attitudes and reactions to culture. What is your knowledge of the client's culture? What is your awareness of your own and the client's cultural identity? What is your awareness of cultural competency skills in this case?

Involve your client in the decision-making process. A collaborative, more holistic, and mutual approach to decision making involves the client, except in extenuating circumstances which are very rare. Counselors need to understand that involving the client is a part of the process throughout counseling and decision making. Walden (2015) discusses the importance of making decisions with clients:

Because of the potential for harm to clients, more attention must be given to understanding the client's perspective and to educating and empowering clients. Inclusion of the client in ethical considerations is not an attempt to "victim blame" or to shift the responsibility for ethical practice onto the client – the professional always bears the onus for maintaining professionalism and ethical practice – rather, inclusion of the client can be a strong asset to the counselor in resolving ethical dilemmas and can be a course of empowerment for the client.

(p. 63)

Review relevant codes of ethics and the professional literature. Although you must continuously be aware of the code of ethics which apply, a thorough and detailed examination is necessary when faced with ethical issues. As we discussed earlier, there may be multiple codes of ethics you need to review depending on your professional memberships, certifications, and licenses. It is not realistic to expect that you would have this information memorized. Understanding which codes apply to the situation at hand will assist you in thinking about the options available. Just as understanding and applying the codes is important, it is also important to understand relevant and recent literature. The Transcultural Integrative Model (Garcia et al., 2003) suggests making sure that relevant codes contain diversity standards. It is also important to examine laws, policies, and procedures that could be discriminatory in nature. Additionally, if conflicts between laws and ethics exists, it is necessary to determine whether these are a result of a cultural perspective.

Consider the principles and virtues. Counselors need to consider how moral principles can be applied to the particular ethical dilemma at hand. Considering both principle and virtue ethics assists in decision making and also in understanding what principles may conflict. Remley and Herlihy (2016) suggest ranking these in order of what is priority in each specific case, as these will certainly be different for each scenario.

Tune into your feelings. As counselors, we understand the importance of self-awareness. Being aware of your own feelings as related to the situation at hand can assist in understanding your decision-making process. Are your feelings influencing your process? Are your feelings related to your values and beliefs? “To what extent are you being influenced, for instance, by emotions such as fear, self-doubt, of an overwhelming sense of responsibility?” (Remley & Herlihy, 2016, p. 16). Acknowledging and being aware of your own feelings is an important step in ethical decision making.

Consult with colleagues or experts. Consulting is essential. We do not practice counseling in a vacuum, and we do not just make a decision rapidly, move on, and hope for the best. Consultation is not a suggestion; it is an ethical imperative. Consultation assists in helping us see aspects we may not have considered because we are an active member of the counseling relationship and therefore not objective. Consultation is a necessary step in decision making, supported by multiple codes of ethics, and important if your decisions are challenged in court (Wheeler & Bertram, 2012). Important in all consultation, as is outlined by the Transcultural Integrative Model (Garcia et al., 2003), is making sure that your consultation reflects professionals and supervisors in the field with relevant multicultural competencies and expertise.

Consider the context. Each counseling session and relationship is unique. Even in similar circumstances, not two situations are exactly alike. Considering the context specific to each case is necessary in ethical decision making. Your beliefs, values, and culture certainly play a role in how you understand the dilemma at hand, and the same is true for your client who has their own beliefs, values and culture that likely differ from yours (Remley & Herlihy, 2016). Counselors also need to reflect on consequences of decision making that involve not only the client, but the client’s family, community, and other professionals (Remley & Herlihy, 2016). Additionally, the Transcultural Integrative Model (Garcia et al., 2003) suggests gathering cultural information as it applies to the case (e.g., immigration information, family, community, and cultural values) and making sure this information is considered when analyzing the dilemma.

Identify desired outcomes and consider possible actions to achieve the outcomes. Often in the case of ethical dilemmas, many actions can be chosen, with many outcomes possible. You should carefully consider each action with the accompanying outcomes associated. Remley and Herlihy (2016) note that there could even be a number of desired outcomes, and counselors may need to prioritize these possibly having to make a choice for one over another. Further, the Transcultural Integrative Model (Garcia et al., 2003) of ethical decision making asks counselors to distinguish the worldviews involved in the identified outcomes. Do these reflect the worldview of the client, the worldview of the counselor, or the worldview of both? Ensure that the possible actions and outcomes mirror the culture of those involved, while considering both positive and negative consequences of each possible action or outcome.

Choose and act on your choice. After thoughtful consideration involving steps listed previously and more aspects of decision making, you eventually must decide what to do – and then you must do it. Remley and Herlihy (2016) suggest that counselors check their action (or series of actions) to see if they are congruent with their moral principles. Ethical decision making is not easy and involves many aspects important for consideration. Counselors should make sure their course of action and outcome reflects an agreement among the cultural worldview of the client and others involved in the dilemma, as discussed in the Transcultural Integrative Model. Further, when implementing a plan, counselors must also identify relevant cultural strategies and resources (Garcia et al., 2003).

After the decision is made, Stadler (1986) suggests that the counselor use the following self-tests. In considering justice, would you treat other clients the same in this situation?

In considering universality, would you recommend this same course of action to other counselors? In terms of publicity, would you stand by your actions and be willing to have them known by others/reported publicly?

As you can see, ethical decision making is not about telling counselors what to do, or telling them the “right” answer. Ethical decision making is about thinking critically about a complex issue and being able to consider many factors for ethical decision making. You must have a process by which you think through dilemmas. It is recommended that you consider the aspects presented in this chapter and apply them to your own development.

Multicultural Implications and Advocacy

As stated earlier, your beliefs, values, and culture certainly play a role in how you understand ethical issues. Culture impacts the ways in which counselors approach ethical decision making and critical thinking about ethical dilemmas (Pack-Brown, Thomas, & Seymour, 2008). As a profession, counseling is dedicated and deeply committed to multicultural competency, social justice, and advocacy efforts. This is a mission that extends to every facet of counseling and professional service.

The Transcultural Integrative Model (Garcia et al., 2003) of ethical dilemma resolution discusses that counselors should “anticipate cultural barriers such as biases, discrimination, stereotypes, and prejudices. Develop effective and relevant cultural-specific counter measures, for instance, culturally sensitive conflict resolution and support” (p. 273). The ACA Code of Ethics has been edited multiple times throughout our profession’s history to include and address issues of multiculturalism, advocacy, and ethical standards and it will continue to be edited as our profession develops. The 2014 Code of Ethics states that “honoring diversity and embracing a multicultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts” (ACA Code of Ethics, 2014, p. 2) is a core professional value. The Code of Ethics also makes clear the ethical imperative of counselors to advocate on behalf of our clients not just on the individual level, but as a group, institution, and society to address barriers and obstacles that hinder client access, progress, and development. Further, advocacy competencies were developed to assist counselors in advocacy efforts in many domains (Lewis, Arnold, House, & Toporek, 2003). We discuss multicultural competencies and advocacy throughout this text. It is up to you to continue on the journey of self-awareness and to always seek to address culture and advocacy throughout your life as a counselor.

Summary

Understanding the differences involved in working with minors as opposed to adults is essential for ethical practice. Counselors need critical thinking skills to engage in and think through complex ethical dilemmas. This chapter urges counselors to take this information seriously and cautiously – but not become fearful about the services provided. With updated information and resources, counselors can feel equipped and confident in their abilities to move through complex situations for the betterment of their clients. Much like in Chapter 3 of this volume, this chapter recognizes that counselors in training receive an entire class on legal and ethical issues in counseling. However, too often, work with minors is barely a focus – if it is taught at all. This chapter provided counselors with the necessary information for protecting their clients and practicing ethically.

Essential aspects of practice such as ethical obligations with discussions on multiple ethical codes was discussed. Understanding how to use multiple codes of ethics to the benefit of the client to promote beneficence is crucial. The importance of confidentiality,

privileged communication, and aspects related to working with minors were discussed. Informed consent and assent specific to working with minors was addressed. Record keeping and the importance of documentation followed. Counselors must be aware of child abuse reporting laws in their states, and abide by such laws while keeping with their ethical responsibilities. Importance is placed on assisting counselors in training in making sound, informed, and ethical decisions. Factors included in models for ethical decision making were presented. Multicultural understandings and advocacy efforts through ethical practice were also addressed.

Clinician's Corner

I am a fairly well-known counselor educator in the region in which I live and work. My wife and I have a wonderful daughter who suffers from a psychiatric disorder that at times has included hallucinations and delusions. These started when she was 13 years old, and in the eighth grade, she overdosed on Darvon because the inside of her was just too much to bear. After that, she saw a psychiatrist for a while who also met with my wife and me, but he was scrupulous in maintaining confidentiality. My daughter has had one other psychiatrist, and he, too, was scrupulous about maintaining confidentiality. I wish I could say the same for the school counselor who occasionally met with my daughter, the social worker who met with my daughter, and the child psychologist, who was the worst in terms of breaking confidentiality. Indeed, the psychologist was supposed to be the best in our area, and he never missed a chance to talk to my wife or me about things he and my daughter discussed. The social worker was a little better, but when she began to feel that our daughter was too much for her, she, too, met with us to discuss confidential information. By far, the school counselor leaked the most. She not only talked to us, but also to one or more of our daughter's teachers and to at least one administrator. I had my daughter stop seeing her within two weeks.

Parent and Counselor Educator

Answering Clients' Legal and Ethical Questions

I work in an Intensive Outpatient Program (IOP) environment with adolescents who have substance use disorder diagnoses. Many of them present to treatment at the recommendation of their probation officer ("P.O.") or their DCS (Department of Children's Services) worker, and they will often let me know early on in treatment that they are there "to get out of trouble" and they don't especially want to change the way they think about drugs or alcohol. During this initial period in treatment, the clients try not to say too much because they are worried about getting into more trouble. Clients who talk about still spending time with their risky peers, for instance, will recognize that perhaps they have said too much and will ask, "So you're gonna tell my caseworker/P.O. about this, aren't you?"

This is where real, therapeutic work can begin to unfold! I will often reflect that the client is asking a basic information-seeking question, and so I give them a factual answer. This invariably leads to other group members chipping in "what if" questions, testing the limits of confidentiality. After fielding fact-seeking questions for a few minutes, I will generally offer a reflection and say something like: "We spend a great deal of time together, and you all want to know whether or not you can trust me. It makes sense that you're concerned about me telling your referral sources everything you're doing, but that's not my job. My job is to be with you and keep what you say in confidence, so long as you aren't suicidal or homicidal and you aren't telling me about child or elder abuse".

In the spirit of transparency, I then tell my clients that if I think something warrants talking with their referral sources, we can talk with them together. In giving them the information they ask for, reflecting their need for trust and safety, describing my commitment to confidentiality while defining boundaries, and giving them the opportunity to work together, I find that the group experience tends to become more therapeutic and clients are more willing to engage in the therapy process.

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6 Family Counseling

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James Bitter as guest contributor

Objectives

- Describe and define many key terms from this chapter.
- Understand the importance of using family counseling approaches in multiple settings.
- Analyze the four models presented in the integrated approach.
- Evaluate the basic skills necessary for family counseling.
- Examine techniques for use in family counseling.
- Evaluate the importance of supporting caregivers and families.
- Understand multicultural considerations for family counseling.

Reflective Questions

- How prepared and willing am I to work with families?
- What is my current understanding of systems and family work in counseling?
- In what ways will I adopt an integrative approach to family work?
- What basic skills for family counseling do I need more practice in?
- How can I start understanding all family counseling as multicultural?
- How important do I believe caregivers and families are in the treatment of children and adolescents?

What Is Family Counseling?

The aim of this chapter is not to outline the history of family therapy, discuss theories in depth, or be used in place of training and coursework in that imperative area. This chapter will outline helpful information and provide assistance to counselors working with children and adolescents. We suggest that child and adolescent counselors take classes in family counseling even if not present in the core program of study. Child and adolescent counselors need training in this area in graduate coursework (core or elective classes), continuing education, and in an ongoing format.

Multiple types of family counseling exist. As opposed to individual or couples work, family counseling usually has other members of the family present and is systems-focused. Whole Family Therapy (WFT) discusses treatment with the whole family involved including parents/caregivers, children, and any siblings and can also include grandparents, friends, community members or extended relationships considered significant in the family system (Breunlin & Jacobsen, 2014). Relational Family Therapy discusses working with some subsystem of the family or even an individual family member, and can include working with the father and child in a larger family system (Breunlin & Jacobsen, 2014).

Children are born into a group, and many of them will never actually live outside of a group. That initial group, the family, regardless of how it is structured, will serve as a foundation for the child's development and as a model for how to live and function in the larger systems of society. Within the family, children learn to act and interact; to speak and to communicate; to walk and move – and to manipulate the environment; and to experience the joys and limits of freedom and the value of safety. Starting with nothing more than temperament and a striving for growth, they gain increasing access to the world and cobble together a sense of self and personhood, an understanding of and relationship with others. They also draw conclusions about self, others, life, and the world. Everything they learn and experience, they do relationally. Even their sense of self is a self-in-relationship.

Of course, none of this happens quickly. We now know that the adolescent brain is growing into young adulthood, at least until the mid-twenties (Araín et al., 2013). The quality of family life during these several decades is highly predictive of how these children and adolescents will develop, the opportunities they will have, and the trajectory of their adult lives.

Given this important information, what are the essential qualities of constructive families and how do they operate? What is the demarcation line between functional and dysfunctional? When children and adolescents are exhibiting problem behaviors or physical, emotional, or mental illnesses, how can interventions in families turn the tide, make a difference – and ensure that the difference made is a difference that matters?

The field of family counseling starts with the systemic perspectives that Alfred Adler applied to working with children, their families, and the schools that served them (Bitter & Byrd, 2017). In the 1920s, Adler and his associates started more than 30 child guidance centers in Vienna, Austria, in which they would conduct open-forum family counseling sessions in front of a community audience. By 1934, all of these centers had been closed by the Nazis.

Today, there are dozens of models and many hundreds of approaches to systemic family counseling and therapy (Bitter, 2020). Some of the most prominent are Bowen's multigenerational approach (Kerr, 2019; Titelman, 2008), Satir's human validation process model (Satir, Banmen, Gerber, & Gomori, 1991), Whitaker's symbolic-experiential therapy (Keith, 2014), structural family therapy (Minuchin, Reiter, & Borda, 2014), strategic therapy (Haley & Richeport-Haley, 2003), solution-focused/solution-oriented brief therapy (Ratner et al., 2012), and the postmodern, social constructionist approaches like narrative therapy (White & Epston, 1990), linguistic therapy (Anderson & Jensen, 2018), and reflecting teams (Andersen, 1991). There are cultural forms of family interventions, like NTU psychotherapy (Phillips, 1990), and there are feminist models of family counseling, too (Silverstein & Goodrich, 2003). Some models that started with a focus on the individual later developed more systemic approaches, including object-relations family therapy and cognitive behavioral family therapy. Like the field of psychotherapy in general, there are core factors across these models that account for success in therapy with the most important one under the control of the counselor being the quality of the relationship that the therapist forms with the family and its members (Sprenkle, Davis, & Lebow, 2009).

For the rest of this chapter, we are going to focus on parts of the theories and practices used in four models of family counseling, and we are going to use these models as a way to propose an integrative model to family counseling involving children and adolescents. The four models are: object-relations family therapy with its focus on attachment theory; Adlerian family therapy with its focus on teleology and the interactive nature of goals

in family interactions; Satir's human validation process model with its emphasis on self-esteem, communication, and the transformation of family rules; and McGoldrick's (2016) use of genograms in mapping the influences of multiple generations on children. We will also make use of a slight adaptation of metaframeworks (Breunlin, Schwartz, & MacKune-Karrer, 2001; Pinsoff et al., 2018) to look at systemic, developmental, cultural, and gender factors across models.

Basic Skills

For the purpose of presenting an integrative approach to family counseling involving children, the process is somewhat artificially broken down into four stages: (a) forming a relationship; (b) conducting an assessment; (c) creating shared meaning and goal setting; and (d) implementing change. The therapeutic relationships that are most effective are collaborative, and they are built on mutual respect and many of the qualities already addressed in this chapter. There are almost as many assessments as there are models of therapy, but here, assessment will focus on genograms (McGoldrick, 2016), mistaken goals, communication styles, and perspectives offered within metaframeworks (Breunlin et al., 2001). Shared meaning and goal setting require collaboration and reaching a mutual clarity about what is occurring, what is motivating it, and what needs to change. Such goal setting flows directly from a successful assessment, and both lay the foundation for the effective implementation of change.

Forming a Relationship

In systems therapy, forming a relationship is sometimes called *joining* (Minuchin et al., 2014), and in other models, it is the creation of a *holding space* (Scharff & Scharff, 2011). Successful therapeutic relationships rely first of all on empathy (emotional attunement) and careful listening. Caring about one's clients is ultimately a goal, but caring is not the first thing that occurs. Beginning sessions rely on the counselor's curiosity, interest, sometimes fascination, and a willingness to enter the system as a participant-observer. It is in the initial sessions that *presence* and focus are offered to the family and its members. Satir et al. (1991) call the first stage of family counseling *making contact*. It involves bring all of one's senses into the present moment, into the here and now, and to be able to sense not only the emotions but also the dynamics of the family. Such emotional attunement may even involve emotion coaching (Gottman & Gottman, 2018), or the process of helping parents and children gain access to what they are experiencing with each other.

The process and structure of family therapy are the responsibility of the counselor. From meeting the individual members and welcoming them into the therapeutic process to observing and intervening in family patterns and interactions, the counselor sets the tone, rhythm, and pace of therapy. Engagement, warmth, friendliness, and concern provide the first experiences of a holding space. Transition statements ("We will be moving from this waiting room two doors down to our consultation room") ground family members and give them control over initial movements. Very early in the first session, the counselor is observant, noting who sits where; who talks to whom about what – and in what tone; if the family is in immediate crisis or if there is time to get to know them; if there are alliances or isolations occurring in real time; and even who speaks first and what emotional experiences and needs are present. From the very beginning, the counselor is both engaged and ready to begin an assessment.

Conducting an Assessment

Many of the early pioneers in family therapy relied on family maps to keep the family members straight and to depict the relationships between them. In 1985, McGoldrick and Gerson brought the various mapping processes together in their creation of *genograms* (McGoldrick, Gerson, & Petry, 2020). While the process is too long to fully delineate here, a full genogram presents a multigenerational map of the family, including a marking of emotional and relational connections; the movement of the family through time and challenges, births to deaths and everything in between; and considerations of the impact of race, ethnicity, culture, religion, gender, affectional orientation, ability, age, and socio-economic status. In this sense, the genogram is an emotional/structural picture that leads into the stories of the family's life.

At a very basic level, men are represented in a genogram by squares, and circles represent women. The focus person in the family – the one about whom the family has come for help or the one experiencing problems – is called the Index Person or IP. This person is indicated in the genogram by either a double square or a double circle. Solid lines indicate a formal relationship while dashed lines note informal relationships. An initial start to an intake genogram is presented in Figure 6.1 for the family in the case study. A more complete genogram would evolve over several sessions, but most family counselors will start the genogram early in the first session.

Genograms also act as a foundation for investigating the perspectives offered in *metaframeworks*: Breunlin et al. (2001) developed six lenses that focus assessment from different perspectives – perspectives that would often be lost or overlooked if not specifically investigated. These lenses are called internal family systems; sequences; the organizational lens; the developmental lens; the multicultural (race, ethnicity, and culture) lens; and the gender lens.

Six Lenses

The internal family systems lens looks at each family member as a system of parts, some of which are relied on often, some of which are available but seldom used, and some of which are discarded or set aside. This first lens allows the counselor to consider what parts are present at any given time and how they interact with the parts of others in the family.

The sequence lens helps the counselor to track patterns of interaction among family members at four levels. Level 1 sequences are face-to-face interactions that occur between two or more family members. This is the level at which triangulation can be observed. Level 2 sequences are routines that family members use to support daily activity, while Level 3 sequences are broader processes that occur during the ebbs and flows of life. And finally, Level 4 sequences are transgenerational and often involve values and ways of behaving across time. Cultural sequences are Level 4 sequences.

Level 1 sequences are where the counselor can also consider the goals of children's misbehavior, because most of the time, misbehavior takes place in a face-to-face interaction. Young children who seek attention almost always seek that attention from a significant adult, parent, teacher, or childcare person in their lives. Dreikurs (1950) looks at both interactions and adult feelings to understand children's goals of misbehavior. When the goal is attention, *the child will often stop for a while* after being corrected, and in the midst of the misbehavior, the adult will feel *irritated, annoyed, or frustrated*. When the goal is a power struggle, *the mistaken interaction will continue* and may even intensify. The adult will feel *angry, challenged, or defeated*. When revenge is the goal,

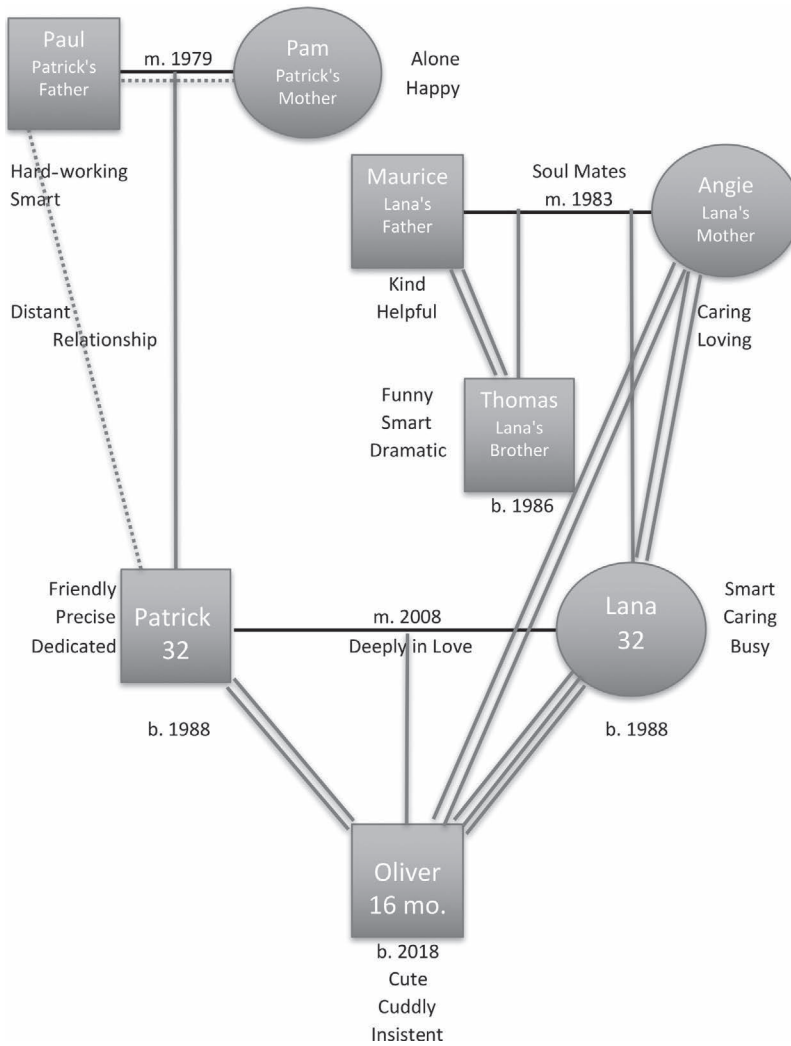


Figure 6.1 Genogram of Lana and Patrick's Family

the interaction may be intense and direct or indirect and vicious, all in an attempt to get even. The adult feeling is usually *hurt*. Dreikurs' fourth goal is indicated when *both the adult and the child seek to be left alone*, when they give up on each other. Both the adult and child will feel *despair*.

A simple interviewing sequence can often reveal the mistaken goals of both adults and children in negative interactions.

Counselor: Tell me the last time that the problem happened. *What did the child do?*

Adult: (The adult describes the child's misbehavior.)

Counselor: *And then what did you do – and what did the child do in response to you?*

Adult: (The adult gives a full description of the interaction.)

Counselor: And when you were in the middle of this sequence, how were you *feeling*?

It is while negative interactions (sequences) are being reported or demonstrated that the counselor can also listen for the communication stances that the various family members assume. Each of Satir's (1988) dysfunctional stances may be used singularly or escalate into sequence of different stances as distress increases. Dysfunctional communication stances always indicate that emotion coaching is needed, that congruence and I-messages need to be reinstituted and practiced, and that non-violent language will be a foundation for change and family leadership.

An organizational lens starts with the perspective that parents should be the leaders of the family, not the children. There are roles and responsibilities that exist in families and that facilitate family functions. It is the organizational lens that addresses the family subsystems and boundaries. The spousal subsystem contains the functions of the adult couple, often the marriage, and does not include a child. A parental subsystem may include more than one parent in interaction with a child or children, but it also includes the interaction at any given time between one adult and one child. Siblings, too, are their own subsystem with roles and activities that belong only to them.

The developmental lens functions at two levels. Each family member is in the process of individual development at the same time that the family as a whole is progressing through the family life cycle. The dual perspective of this lens helps the counselor to assess how members of the family are handling the challenges of change. Change, of course, is inevitable; indeed, change is life. That does not mean, however, that change is easy. This lens lets the counselor assess whether the individuals are able to develop effectively and whether the family is appropriately supporting growth and development. It also helps the family members to see how they are using their resources in relation to the challenges they all face together.

No individual (nor any family, for that matter) is culture-free. Even though members of the dominant culture often adopt the privilege of not having to pay attention to their own cultural background, those in marginalized cultures are usually quite clear about the impact of race, ethnicity, and culture in their lives. Again, Monica McGoldrick and her colleagues have led the way in the integration of this lens into family therapy (see McGoldrick, Giordano, & Garcia Preto, 2005). This is a very broad lens that considers immigration and acculturation, economic privilege or poverty, education, ethnicity, race, religion, culture, age, health and ability, regional background, and discrimination and oppression.

Because patriarchy affects all people in all cultures across the world and across time and history, gender needs its own lens. Over time, gender has become specified in roles and expectations that have been absorbed by families and individuals – often below awareness. Most of these roles and expectations have favored men and have too often had a negative and often dangerous effect on the lives of women. These roles and expectations evolve sometimes faster than either the individual or the family can handle the change, but noting where the family and its members are is part of this lens. What gender role is each family member assuming? What effect is patriarchy having on the family and its members? What ideas about gender need to be affirmed or challenged? What impact will the gender of the counselor have on the family? It is through this lens that the counselor also considers issues related to affectional orientation and discrimination experienced by families and members of the LGBTGEQIAP+ community.

Not all of these lenses are used with every single family. As you learn about the family, formulate a genogram, listen to the narrative of the family's life, some lenses will be more prominent than others, and some will not seem useful at all. Having these six lenses, however, provides an initial framework for investigation.

Shared Meaning and Goal Setting

None of the discussed assessments make a difference if they cannot be shared in a meaningful way with the family. The endpoint of assessment is always to help the family members understand where they are and to point toward a solution to their concerns or problems. Effective counselors share their new understanding tentatively, inviting the family members to consider possibilities without imposing or insisting on them. Adler (1931) noted:

Treatment itself is an exercise in cooperation and a test of cooperation. We can succeed only if we are genuinely interested in the other. . . . Even if we felt we had understood [them], we should have no witness that we were right unless [they] also understood. A tactless truth can never be the whole truth; it shows that our understanding was not sufficient.

(p. 72)

Some shared meaning will be offered in an attempt to help the family members gain a new perspective on how their family is working: what parts the family members are using often; how they interact and communicate; what their goals as individuals and as a family seem to be; how the family structure is working for or against them; and developmental, cultural, or gender issues that may be present. However the counselor enters into a sharing of meaning, this collaboration will be the foundation for choosing the goals for the family.

Especially with children, the disclosure of mistaken goals must be approached from a kind curiosity and a tentative guess. For example, with children who are constantly fighting, resulting in the parent telling them to stop multiple times, the goal disclosure might go like this.

Counselor: Do you know why the two of you fight with each other?

Child #1: Because he bothers me.

Child #2: No, I don't.

Counselor: That could be, but I have another idea. Would you like to hear it?

Child #1: Yes, okay.

Counselor: Could it be that you fight to see how many times you can get your father to tell you to stop?

Dreikurs (1950) suggested that when a tentative goal disclosure like this is used with young children (pre-adolescence), the most likely result will be what he called a *recognition reflex* or a little smile on the face and twinkle in the eyes. It is the look a child gets when knowing that you know what the child is seeking.

Just as the goal of attention-getting must be shared with children in concrete terms, so too must the goals of power, revenge, or assumed disability. The goal of a power struggle might be suggested as, "Could it be that you want to show them you are the boss?" or "Could it be that you don't want to do anything they want you to do?" The goal of revenge can be disclosed by asking, "Could it be that you feel oh so hurt, and you want to hurt them back, to get even?" And Dreikurs' last goal might be revealed in a question like, "Could it be that you just want to give up and be left alone?"

Implementing Change: Treatment for Families

Coming to an agreement about what is happening with the family and its members allows everyone to decide what they would like to change. Effective change is more than merely eliminating the presenting problem. It is change that seeks a preferred way of living, that invites connection and harmony, and that uses the best talents of everyone involved in meeting the challenges that the family faces. Broad goals like this need to be translated into concrete actions, but the ultimate end is to increase effective living for everyone involved.

Counselors know that nurturing families start with encouragement for the caregivers, helping each adult to feel like a leader or part of a leadership team and working in cooperative partnerships. This is certainly essential for school counselors, as having caregivers, families, and even communities involved in the schools can make a huge impact on a child's or adolescent's success in school and academic achievement (Van Roekel, 2008). Young children especially need presence, emotional attunement, and attachment from their caregivers, and emotion coaching, non-violent language, and congruent interactions may all have to be taught as part of therapy. Effective parenting is often different from the ways in which the adults were raised. In such cases, parent education may also be necessary (see Bitter, 2017).

When working with families, focusing on strengths and family resources builds a sense of resilience within the system. Change in small steps tends to be more easily accepted and enacted than large efforts. No matter how well a family implements change, there will be lapses and relapses. Gently predicting relapses can normalize them and help the family prepare to rebound again.

Counseling Session Using a Genogram

Lana is a 32-year-old psychologist who works in a counseling center at a college near her home. She is married to Patrick, and they have been married for 11½ years. Patrick is a baseball coach at Lana's college, and he is gone a lot at odd hours during the season and also when he is recruiting. After getting her bachelor's degree at the university where she met Patrick, Lana completed her graduate work in counseling psychology. They have a 16-month-old child, named Oliver. Most of the time, she feels content with the life they are building together.

An initial genogram of her nuclear family would look like Figure 6.1.

For the initial session, Oliver is in a play therapy room with a counseling intern who is staying emotionally attuned to him and is tracking his play and process. Lana is meeting with Jim, her counselor; Patrick was unable to attend the first session due to a conflict in his work schedule. After introductions, Jim and Lana create an initial genogram; he then asks her what she likes most about her life.

Jim (J): What do you like most about your life?

Lana (L): The balance.

J: The balance.

L: Yes. Enjoying my son greatly, and working part time, and then enjoying my professional life as well.

J: That's quite amazing, really. There are hundreds of people, including my own family, who would love to have balance, and have never seen it.

L: Well, some weeks, I don't. Many weeks, I do.

- J: If there's anything in your life you would like to see going better, what would that be?
- L: I would like to work on parenting. That is one thing I would like to see going better.
- J: So give me an example.
- L: My son has just begun to get into the stage of tantrum throwing. I'm a psychologist, and I have a lot of book information. But when he starts to tantrum, I feel like I'm at a loss.
- J: Okay.
- L: Translating that into actual parenting and doing that effectively . . . Again, I'm at a loss.
- J: Yes. You know, a tantrum is really an elegant thing. Most children I know don't want to waste them: I've never seen, for instance, a child all by himself, alone in his room, throwing a tantrum. (laughter) They almost always need something. What does he need?
- L: Lately, it's something that he wants that I won't allow him to have. It might be that he wants the TV on at that moment, and we don't watch TV in the evenings. Or he wants the remote control or he wants something that's breakable, and he wants it right now. I don't give it to him, or I won't allow him to have it. That's when it's the throwing back his head, the lying on the floor, the screaming: I mean all of it.
- J: Okay, cool! (smiling)
- L: (laughing too). Well, that's a nice way to put it.
- J: You don't feel like it's so *cool* sometimes.
- L: No. I get more alarmed. I think I've done something wrong (throwing up hands). I go more that way, but I never thought of it as a good thing.
- J: When you do this (throws up hands), how does it feel?
- L: Just at a loss.
- J: Yes. Like "Oh my God . . ."
- L: Yes, exactly.
- J: Now, has he gotten to the point where he's realized the terrific advantage of Walmart?
- L: No (she laughs). I don't know.
- J: Really great tantrums are even better in public – especially if *you're* wearing a T-shirt that says, "By the way, I'm a child psychologist".
- L: (laughter) Yeah.
- J: When did he first learn that you were a psychologist?
- L: I don't know if he yet knows.
- J: Oh, yes. He knows. There are three professions in which children can smell it. They come out of the womb [knowing]: psychologist/counselor is way up there, not quite as high as minister. But it's way up there. And then, of course, if you happen to be a teacher or an educator. Anything that requires a public life of perfection. Are you any good at perfection?
- L: Yes. I've been known to . . .
- J: So what's your best stuff? How would you do *perfect* if you were a perfect parent?
- L: Somehow, in my head, really I think if I were a perfect parent, my child wouldn't throw fits. Or he would sleep through the night. That would be a big one, or he would eat all of his meals. Those are the kinds of things I start to question myself about whether I'm doing a good job.

- J: So tell me the last time that he threw a temper tantrum and what you did.
 L: Okay. The day before yesterday. He does go to a friend of mine's house two and half days a week, because I work part time. So lately, when I have been going to the house, the transition has been tough for him. So I walk in, and he asked me for something, of course non-verbally. I was writing a check to her for a week. And he wanted my pen, and he wanted my wallet. And I probably said, "No, I'm using these", and he threw himself back, and he started to scream.
- J: Okay, and what did you do?
 L: Kept writing the check, and of course, it took me longer, because he was grabbing at the pen. My friend, Marcie, brought him into the kitchen to get him a cup of water, because he was still screaming. When I was done, I held him in my lap, and I embraced him, and he calmed down, and he then just sat with me for about five minutes. And it really amazed me, because he wanted to be with me. At first when he came in, he didn't. Then, he threw the tantrum, and then he just sat in my lap. And I did give him a pacifier as well, those two things.
- J: Okay, so how did that go for you?
 L: Two parts to it. The first part where I kept writing the check and didn't stop: I doubted myself. I thought maybe there's a better intervention. I was a little embarrassed, because it was in front of another adult, so that part was hard. But when I finished writing the check and took him in my lap, then that part seemed really good. I enjoyed him, and I enjoyed that time. So the first part, I questioned myself. Should I stop? Should I keep going? What's the best thing to do here? That's where I'd get anxious. (Jim: Un-hum.) When I'd start to say: "What's the perfect thing? What's the best way? Is there a best way, and I'm not doing it?" But the second part was really good.
- J: Okay, so the part of you that reached out to him, picked him up, held him – that part made you feel like you were competent.
 L: Yes.
 J: Caring.
 L: Yes.
 J: Loving.
 L: Exactly.
 J: Now, when did you get the idea that you could control other people? [checking on a mistaken goal that may be affecting her parenting approach]
 L: Umm, that's a good question.
 J: Thank you.
 L: I think for a very long time.
 J: Yes. So the hardest part you are going to have to get over is that. Because even though I will tell you the truth, you're not going to believe it. (Lana: Okay.) The truth is this – and you already know it – there's only one person you can control and that's . . .
- L: Me.
 J: That's right. You can choose you, and you can choose what you are going to do for you, but that's it.
 L: Okay.
 J: Now, let's just think this through. I'm going to make this up. Are you ready?
 L: Yes.

- J:* I like to put my name on things, so this is Jim's law of paradox. I don't actually believe much in paradoxical interventions, but I think life is paradoxical. So here it goes. Super responsible mothers are always surrounded by irresponsible children. (Lana: Umm.) Okay, here's another one. Mothers who want to make everything just so (who are neat and are careful) always have messy children. (pause) I say mothers because I am talking to you, but it goes for fathers, too. This is really neat about children: They can be one way with one parent, and another way with the other one. And some of them are so good that they can design one behavior that will irritate both parents in a different way.
- L:* Uh-huh.
- J:* Here's what I think your paradoxical position might be: a person who is devoted to balance always has a child who is out of balance.
- L:* Um-hum.
- J:* So what sends you into worry is when he starts to show himself to be out of balance. (pause) You would like [him to be like] my oldest daughter. You would like him to walk through life calm, serene, just slightly less comatose than Ghandi. (laughs)
- L:* Yes. I mean I don't, but emotionally, I probably do.
- J:* We don't have a lot of time. So based on what we have talked about so far, how are you feeling about all of this?
- L:* It makes sense to me. [shared meaning; time to play]
- J:* Oh, that's the worst. People never do anything that makes sense to them.
- L:* No, it challenges me.
- J:* Really? What could you imagine doing?
- L:* Well, the words *laid back* comes to mind, and really trying to just let him be who he is.
- J:* Okay. You really mean that?
- L:* I really mean it. Yes. I really mean that's what I would want.
- J:* Because boys, you know, come with testosterone.
- L:* See, then I think of balance again, because that's what I come back to. He can be what he wants, and still I'm his parent. I have a big role in his life right now, and how to balance that: how to let him be who he is and provide some structure for him.
- J:* Sure. Now, how are you feeling as you are saying that?
- L:* More heady.
- J:* What's happening in your stomach?
- L:* Tightness.
- J:* Yes. Just breathe into that. Let's go to your strength. So just imagine yourself being in a place where you feel really calm. (pause) When you go there, everything about you looks serene. When you talk about your son and his tantrums, everything looks and feels tight. So what would it take for you to stay in your calm place even while you are imagining your son throwing the world's greatest temper tantrum? (pause) What are you doing with your body when you do that?
- L:* Breathing. Concentrating on Oliver; picturing him throwing himself to the floor.
- J:* When you picture him throwing himself to the floor, what do you need at that moment in time?
- L:* Just a warm hand on my shoulder, and a kind word. Yes, a kind word.

- J: What would the word be? What would be said?
- L: It's okay.
- L: It's okay. Your partner (Lana: Patrick). Yes, Patrick. Can you feel his hand? [seeking to strengthen the partnership]
- L: Yes. That's who I would want.
- J: Yes. And you might even practice that for a while. Something where he puts his hand on your shoulder, and says, "Look, it's okay". Now, how does he do with your son's tantrums?
- L: We tend to both get anxious and uptight about it.
- J: You know, there is nothing better at a time like that than to have something to do, so it might help him to be able to put his hand on your shoulder and say "It's going to be okay".
- L: Yes.
- J: Now, what would your arms naturally do with a child who had calmed down?
- L: I would naturally embrace.
- J: So you have two things you can do. Is that right?
- L: Both have a hand on my shoulder and embrace? Yes, I can do that.
- J: So you would know what to do. How does that make you feel in terms of your own competence?
- L: Umm. (pause) I think positive. Yes. It's hard to know how to translate what I know to do into behavior.
- J: The reason it's hard is that very often when you are thinking about it, you are thinking about doing something to get your child to change. That, you can't do. But there is one person you can change, and that's you.
- L: Yes.
- J: Yes. It doesn't even matter what your child does. All you have to do is have an agreement with your spouse and partner.
- L: That's great.
- J: It is great.
- L: That's actually helpful.
- J: Now, I am going to tell you exactly when your son is going to give up throwing temper tantrums.
- L: Okay. (laughs)
- J: He will never throw another temper tantrum ever as soon as it no longer bothers you or your husband. (Lana: Umm.) He will only bring it out on grandma, and why not? She deserves it. (Both laugh.)
- L: Yes. That's right.
- J: Now, I am going to give you one other thing to do when you are all alone with him. One of the biggest mistakes that we make when we are with a child who is throwing a tantrum is that we talk.
- L: That's the biggest mistake? That we talk.
- J: Yes, because we can't talk without sounding upset. What do you think the purpose or goal of a tantrum is? [addressing mistaken goals]
- L: In some ways, it just looks like he wants to explore the fullness of himself?
- J: If that were true, he would be out in the middle of the yard screaming.
- L: Yeah. (laughs)
- J: He's not. He's screaming *with you*.
- L: I don't know. To get his way? To get what he wants?

- J:* Yes, it looks like this (Jim pounds on his chest). It's a very powerful stance, isn't it?
- L:* Yes.
- J:* You will do what I want or . . .
- L:* Yeah.
- J:* Power often hooks up with a parent's need to control. The fastest way to take you out of that equation is to get you to walk away. No one throws a tantrum without an audience. So where could you go?
- L:* Oh, easily to another room, to a different part of the house.
- J:* And he would be safe? (Lana: Yes.) And what will he do when you take off?
- L:* Come after me? (laughs)
- J:* Sure. So where can you go so he can't get to you until he's done?
- L:* In my bedroom.
- J:* Does it lock?
- L:* Well, we're re-doing it so it doesn't have a doorknob, but it will.
- J:* Okay.
- L:* The bathroom would be another place.
- J:* And when would you come out?
- L:* When he's done. When he's finished.
- J:* And what would you do when you come out?
- L:* I would just reassure him that I love him.
- J:* And what would you say?
- L:* I love you . . . (she moves her arms almost like she would reach for him)
- J:* What would your arms do?
- L:* I think I would embrace him.
- J:* Sure. So could you do that without talking? (pause) Here's what's going to happen if you talk. You are going to take him in your arms and you'll say, "Oliver, mama loves you", and then there will be in your voice even if you don't say it, "but"
- L:* Okay. Okay.
- J:* But I need you to stop your tantrums or something else like that.
- L:* Yes.
- J:* So you are just gone, and you've had some time by yourself. You haven't done anything terrible. You come out. You embrace him for a short while, and you get on with the rest of your day. (pause) Now, do you think his tantrums will stop then?
- L:* Not right away.
- J:* Not right away. It will get a little worse before it gets better. And that's when I want you to feel a hand on your shoulder and hear the words: "It'll be okay". This is about taking care of you, deciding what you will do, not what he will do. And right now, you are looking like this is something you feel you can do. [looking for commitment to change]
- L:* Yes, this is good.
- J:* Okay.
- L:* Thank you.
- J:* You're welcome.

The second session with Jim was not until a month later. During the intervening time, Oliver continued to meet with the play therapist intern who also worked with Lana on empathic responding to Oliver while he played (Filial Therapy). When next Jim met with

Lana, the temper tantrums had greatly reduced – maybe once or twice during the month, “maybe when he’s tired”, Lana suggested.

Family Counseling in the School Setting

We believe that school counselors are uniquely suited to conduct meaningful family work in the school setting and in the home setting when the school counselor conducts home visits. Often, counselors come to their work with children and adolescents while claiming a lack of desire to work with adults. We have heard this many times from students in training and caution counselors from adopting this viewpoint, as child and adolescent counselors must be trained in and have a desire to work with adults, as well. “The first and most essential support system for a child is his or her family” (Paylo, 2011, p. 140). Supporting the families of the children and adolescents with whom you work is essential and necessary for success and provides a protective factor for children and adolescents.

School counselors or school-based counselors can assist families in meaningful ways. The ASCA Ethical Standards for School Counselors (2016) discusses the importance of supporting families and further recognizes the significant role of parents/caregivers and families. Further ASCA School Counselor Professional Standards and Competencies (2019) address work with families as a part of the mindsets and behaviors of professional and competent school counselors. Yet many school counselors never received training in family systems or family counseling work (Perusse, Goodnough, & Noel, 2001). We believe child and adolescent counselors can design their programs of study to include family counseling and systems training if it is not a requirement. When we have worked in schools, we have noted countless times when caregivers did not feel free or encouraged to be involved in the schools on behalf of their children. Throughout the years, caregivers have expressed their beliefs about only being contacted by the school when something was wrong or something was needed from them. We have made it a point to contact parents for many reasons (notifying of success, achievements, opportunities, and general appreciation) so that we can start to change how parents view the school, their child, and their involvement. Parents may feel hesitant to be involved in the school, whether it is a result of cultural implications, language barriers, or their own experiences with a school system (Van Roekel, 2008). It is imperative for school counselors and school-based counselors to work with families in supporting the academic, social, and emotional development of each student.

Home-Based Family Counseling

Home-based family counseling (HBFC) services have been growing over the last few decades. It started as a response to assisting in crisis situations and with at-risk youth as a possible option or alternative to placements made outside of the home (Macchi & O’Conner, 2010). It seems to be expanding beyond this, as more agencies are providing these services and giving opportunities for families to be helped in their homes instead of expecting families to come into an (often) artificial office setting. When providing in-home services, it is often such a rich, organic, holistic, and realistic view of the family’s real daily life and has provided an opportunity at times to get into deeper issues quicker than in the sterile, contrived office setting. After all, the home is where this family lives, grows, develops, argues, and functions on a daily basis. Family members are able to be their real selves in their daily environment in a way we can’t replicate in a clinical mental health setting.

By being in a family’s home, counselors are also a part of their world and observing their behaviors in ways we never get to do in an office. By being in a home-based setting, however, there are often other considerations counselors need or need elaborated on

for this type of work. Examples of those are family intake training, advanced culturally sensitive interventions for in-home work, and assessment skills in both trauma and crisis (Hammond & Czyszczon, 2014). Counselors considering working in clients' homes should seek additional training in this area. Graduate programs and professional organizations need to address the increase in counselors working in home settings and include training opportunities (Bowen & Caron, 2016), as there are currently no professional guidelines for HBFC services (Hammond & Czyszczon, 2014).

Multicultural Implications and Advocacy

As noted, no family is culture-free. Therefore, all counseling is multicultural and all family counseling is multicultural. When working to involve families in counseling in myriad settings as discussed in this chapter, counselors need to understand and address the influence of culture in a family system. It is also important for counselors to consider ways in which families from non-dominant groups may be obligated or required in some ways to modify their lives, and what seems natural to them, when interacting with dominant culture (Hendrick, Bradley, & Robertson, 2015). Multicultural family counseling includes training in knowledge, awareness, and skills of multiculturally competent counseling, as counseling graduate trainings programs employ. Multicultural family work also consists of gaining skills and self-awareness of how to build rapport with families in the context of both the family's and the counselor's multidimensional reality while understanding privileged identities, as well (Thomas & Rastogi, 2009).

Summary

Family counseling is imperative for working with children and adolescents in multiple settings. This chapter focused on family therapy with children and adolescents. Counselors seeking to work with children and adolescents must understand a systems perspective and how it is necessary for family work. An integrative approach to family counseling involving children was presented in four stages: (a) forming a relationship; (b) conducting an assessment; (c) creating shared meaning and goal setting; and (d) implementing change. Assessment focused on genograms (McGoldrick, 2016), mistaken goals, communication styles, and perspectives offered within metaframeworks (Breunlin et al., 2001). Utilizing Adlerian family counseling and the focus on the goals and purposes of family interactions and Virginia Satir's human validation process model to focus on effective communication in families, an integrative model for effective interventions in families was discussed, along with basic family counseling skills across models. A multiple-lens model was proposed as part of assessment to ensure consideration of issues related to gender, affectional orientation, race, ethnicity, culture, age/development, ability, physical/mental health, and socioeconomic status. Counselors are encouraged to seek training and integrate continuing education in multicultural family therapy so as to best serve clients in multiple settings. Understanding how to engage families in counseling is important for the success of children and adolescents.

Clinician's Corner

I tell this story that I heard because parents often show up objectifying their child and want them to change their behavior and talk about them as if they aren't even there.

A mother and father go into a restaurant with their child and a waitress asks the child what they would like to eat. The child says a milkshake, some fries, and a piece of pie. One

of the parents says, “No. Bring them a glass of milk, a grilled chicken sandwich, and a piece of fruit”. The waitress comes back with the food and serves the child the milkshake, fries, and pie. The child pauses, looks at the waitress, then back at the parents and says with surprise, “she thinks I’m a real person”.

Sometimes people come in with a concern that can be handled with just a strategic intervention.

A father came to see me with his daughter saying that she had seen a couple of counselors and nothing seemed to be helping her. She was waking up with a repeating nightmare and wasn’t able to go back to sleep unless he spent the rest of the night in the bed with her. I got the details from the daughter about how there was a scary monster that would show up and then she had to yell out for her dad until he would come into her room and spend the night. When I asked why the monster left her alone for the rest of the night when her dad was there, she said the monster looks in the window and sees him there wearing his football jersey. The monster then just keeps on going and doesn’t try to come. I ask if she would be willing to trick the monster. She likes this idea and agrees that she will start wearing her dad’s football jersey to bed and the monster will think that it is her dad and just keep moving on. The dad called and told me his daughter had slept with no problems in his jersey every night for the last week.

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7 Parents, Caregivers, and Supportive Adults

Rebekah Byrd and Chad Luke

Objectives

- Recognize the different parenting styles and their impact on child/adolescent wellness.
- Identify parent/caregiver involvement in schools.
- Describe the U.S. Centers for Disease Control and Prevention (CDC) recommendations for connecting parents/caregivers with schools.
- Identify patterns of engagement of parents/caregivers with agencies.
- Learn to engage both child/adolescent and their parent/caregiver in understanding while respecting confidentiality.
- Describe the limits of confidentiality effectively in ways that keep children/adolescents and parents/caregivers engaged.
- Identify resources for helping empower parents/caregivers.
- Explore resources for supporting parents/caregivers in managing their relationship with the child/adolescent more effectively.

Reflective Questions

- What are my own beliefs about parenting?
- What parenting style did my parents/caregivers exhibit? How might this affect my attitudes toward the parents of my clients?
- How might I balance my allegiance to my client – child/adolescent – with the need to keep parents/caregivers engaged?
- What were my parents'/caregivers' interactions with my schools like?
- How might I support increasing the quality or quantity of my client's parents/caregivers in school?
- What barriers do I anticipate in engaging parents in the therapeutic process, especially if I am young, do not have a child, or have limited experience?
- How can I engage with parents in ways that build trust and confidence?
- What tools will keep handy to help empower parents/caregivers?

Importance of the Parent/Caregiver Relationship

As discussed in Chapter 4 on attachment and developmental aspects, the parent/caregiver-child relationship is extremely important in healthy development. To reiterate, the relationship with a primary caregiver lays down a neural template for adaptive skills, like emotion regulation, problem-solving, and healthy attachment. Having a healthy and

positive parent/caregiver–child relationship is important for many reasons. Some of these include:

- Young children who grow with a secure and healthy attachment to their parents stand a better chance of developing happy and content relationships with others in their life.
- A child who has a secure relationship with his or her parents learns to regulate emotions under stress and in difficult situations.
- Promotes the child’s mental, linguistic, and emotional development.
- Helps the child exhibit optimistic and confident social behaviors.
- Healthy parent involvement and intervention in the child’s day-to-day life lay the foundation for better social and academic skills.
- A secure attachment leads to a healthy social, emotional, cognitive, and motivational development. Children also gain strong problem-solving skills when they have a positive relationship with their parents.

(Parenting NI, 2018, para 3)

We have to admit that as parents, we often feel confused, overwhelmed, and unprepared for parenting even though we both have doctoral degrees in counselor education and we are child and adolescent counselors (Rebekah is a play therapist, as well). Additionally, I (Rebekah) have been working with children in varying capacities (on my own) since I was around the age of 10/11. I think about that now and it scares me that anyone ever left a me – a 10-year-old – alone with their children. However, I was very responsible (everyone says that, right?) and it was a long time ago (not that long, though!). Now as a parent I read book after book on parenting (for my personal benefit and to assist my clients in finding resources they connect and identify with), and sometimes I want to throw my hands up in despair and futility.

Parenting Styles

In today’s world, parents/caregivers are inundated with information (often conflicting) on how to raise children. Parents/caregivers are told the best ways to communicate with their children to get them to listen. Parents/caregivers are told what foods are good and what are bad. We are told what car seats are safe and which ones we should buy. We are told not to hover, or we are called helicopter parents. We are told not to give our children too much freedom, or we are called free-range parents. We are told how to put our children to bed and how often they should sleep and what to do about . . . *Every. Little. Thing*. One popular blog about parenting/caregiving discussed the mixed messages parents – specifically mothers – receive:

Give your kids limits, but let them make their own choices. Teach them independence, but make sure they know you’re in charge. Meet your kids’ emotional needs, but don’t coddle them. Be your child’s advocate, but don’t fight their battles for them. Make sure your kids feel confident in their abilities and comfortable in their own skin, but don’t praise them unless you praise them in exactly the right way using exactly the right words at exactly the right time.

(Reneau, 2019, para 13)

Often mothers specifically are blamed for errors in child rearing leading to shame, self-doubt, feelings of inadequacy, and more. Further blaming mothers/women in these contexts “deflects

attention from social solutions for ensuring the well-being of children” (Garey & Arendell, 1999, p. 2). Even though we are overwhelmed with the information and messages coming at us constantly, what parents/caregivers often have very little of, is support and encouragement. Counselors may be the only people to provide parents/caregivers with this important assistance.

Parenting/caregiving styles have been discussed in the literature and research for decades. These styles have been found in research to even predict well-being in many areas (i.e., academic achievement, degree of problematic behavior, and social skills) among children and adolescents (Rosenthal & Fetherling, 2006). Many are aware of the four general types of parenting styles. They are generally referred to as authoritarian, authoritative, permissive, and uninvolved.

Authoritarian

Rosenthal and Fetherling (2006) discuss authoritarian parents/caregivers as being very controlling, firm, and strict. These are parents/caregivers who believe in rules, justice, obedience, and punishment (Rosenthal & Fetherling, 2006). These authors also note that authoritarian parents/caregivers are not very responsive to their children, but they are highly demanding of them. Further, they discuss that children of authoritarian parents/caregivers may have higher anxiety, lower self-esteem, poorer social skills, and higher levels of depression. While the results of authoritarian parenting may be effective in the short term, long-term effects on youth are troublesome, including depression (King, Vidourek, & Merianos, 2016)

Authoritative

Authoritative parents/caregivers are not too strict (like authoritarian) or too lenient (like permissive) – this style is just right and focuses on positive reinforcement and building upon capabilities and characteristics of the child (Jadon & Tripathi, 2017). Rosenthal and Fetherling (2006) discuss that while authoritative parents/caregivers do uphold a degree of control and authority, they are not controlling and strict like authoritarian parents, and they are warmer and seek to communicate with their children – they are both responsive and demanding. These authors further discuss that authoritative parents/caregivers strive for balance between their child’s/adolescent’s wish for autonomy, independence, and freedom to express themselves, and the parents’/caregivers’ needs to be heard and understood. Additionally, authoritative parenting/caregiving is “one of the most consistence predictors of social competence” (Rosenthal & Fetherling, 2006, p. 24).

Permissive

Permissive parents are lenient, make few demands, and avoid conflict (Rosenthal & Fetherling, 2006). Children of parents/caregivers who are permissive may end up feeling entitled, use substances, be more likely to have problem behavior, experience lower success/performance in school (Rosenthal & Fetherling, 2006), and display increased impulsivity and lack discipline (Jadon & Tripathi, 2017). Further, permissive parenting has been linked with various forms of high-risk behavior (Jinnah & Stoneman, 2016), high delinquency, and having deviant peers (Mann, Kretsch, Tacket, Harden, & Tucker-Drob, 2015).

Uninvolved

Rosenthal and Fetherling (2006) note that an uninvolved parenting style is “low in both demandingness and responsiveness. At worst, it can verge into neglect” (p. 23). It is also said

to be low in sensitivity and emotional warmth (Konopka, Rek-Owodzin, Pelka-Wysiecka, & Samochowiec, 2018). Uninvolved parents do not seem to exhibit unprompted interest or pay unsolicited attention to a child – instead they respond only when attention is demanded or when it is the expectation to respond (Konopka et al., 2018). These researchers also noted that “Among risk the factors predisposing the child to depression are the following: negative parental attitudes such as emotional coldness, rejection, distance and lack of parental support as well as excessive criticism, over controlling and uninvolved parental style” (p. 927). Counselors can assist parents/caregivers in adopting new ways of being with their child/adolescent. Counselors can provide support for challenging behavior, discuss developmental considerations, and normalize parental/caregiver struggles. Parents/caregivers who feel understood and supported are more likely to be those things for their children/adolescents.

Parent/Caregiver Engagement in Schools

The U.S. Department of Education (2019) notes that in 2019, there were 56.6 million children and adolescents in the United States who attended elementary, middle, and high schools. Estimates from the U.S. Department of Education (2004) suggest that children and adolescents spend roughly 6.7 hours at school per weekday and on average around 180 days per year at school. It is important for those working in the school setting to consider the impact of parental involvement on the lives of children and adolescents spending so much time away from parents/caregivers.

Parental/caregiver engagement in the school life of their child or adolescent is seen as an encouraging, promising, and reassuring protective factor (CDC, 2012). Many benefits exist for parental/caregiver involvement. Having engaged parents/caregivers has been shown to decrease the likelihood that children and adolescents will participate in activities such as tobacco use (Guilamo-Ramos et al., 2010) and substance use (Hayakawa, Giovanelli, Englund, & Reynolds, 2016). Myriad research has noted that having parental/caregiver engagement in the school is highly linked to successful student behavior, including improved social skills (El Nokali, Bachman, & Votruba-Drzal, 2010). Further, when parents/caregivers are involved, children and adolescents also exhibit higher academic performance and achievement (Jeynes, 2007). Counselors are in a strong position to advocate for ways to involve parents/caregivers.

The U.S. Centers for Disease Control and Prevention (CDC, 2012) recommended three main ways to be involved and continue to engage parents/caregivers in the school lives of their child or adolescent: connect, engage, and sustain. The CDC (2012) offered that connection is an essential place to start before schools can start to engage parents in offered programs or activities. If parents/caregivers feel uncomfortable, unwelcome, or otherwise disconnected, it will be difficult or even impossible to promote engagement. What follows is a sample of a few of the ideas for connection with parents/caregivers offered by the CDC (2012). These were slightly modified, and counselors can take note of these ideas to apply to school, community, or other work settings.

- Does the school mission reflect the importance of parent engagement and establish a foundation for parent engagement in schools?
- Does the school have a well-planned program for parent engagement?
- Are policies and procedures in place to maximize parent engagement in the school's activities, services, and programs?
- Does the school have a friendly, welcoming environment for parents?
- Does the school welcome parents to participate in and contribute to the school's activities, services, and programs?

- Is there a district-level parent involvement and engagement plan that can guide the development of a school plan for involving parents in school health activities?
 - Does the school have a dedicated committee of teachers, administrators, and parents (such as an Action Team for Partnerships) that helps the school plan, implement, evaluate, and continually improve its outreach to parents and the quality of parent engagement activities?
 - Are school staff members provided with opportunities to learn how to increase parent engagement in school, including in health activities?
 - What simple changes or modifications would make the school's physical environment more pleasant, accessible, and safe for parents and community members?
- (p. 10–11)

The CDC explained that connection is the first essential step and next suggested ideas for types of involvement, expanded from researchers Epstein et al. (2009), that schools (or other settings) can offer as ways to engage parents/caregivers.

1. Providing parenting support.
2. Communicating with parents.
3. Providing a variety of volunteer opportunities.
4. Supporting learning at home.
5. Encouraging parents to be part of decision making in schools.
6. Collaborating with the community.

(2012, p. 12)

Finally, the CDC (2012) noted the importance of continued parental/caregiver engagement from the beginning and how this will likely result in continued engagement and sustainment. The CDC has outlined some ideas to assist in solving common barriers to sustained engagement (this is not a comprehensive list). These ideas can be utilized in a variety of settings.

- Schedule meetings and activities to match varying parent schedules.
- Provide incentives to encourage parents to attend at-school meetings and events.
- Provide alternative ways for parents to access information and communicate with school staff, aside from attending meetings and activities on school grounds.
- Provide transportation.
- Hold events off site or online.
- Provide opportunities for parents to get to know about the school and school staff in nonthreatening ways.
- Implement programs that are culturally sensitive and that reflect the social and environmental aspects of a community influenced by race/ethnicity, socio-economic status, locale (rural, suburban, urban), and culture.
- Provide translation services for non-English-speaking parents.
- Reduce barriers to understanding information.
- Provide professional development opportunities for school staff that focus on strengthening parent engagement.
- Develop strategies for working through staff resistance to change, turf issues, and power struggles that might hinder [staff]-parent interactions.

(2012, pp. 20–23)

Counselors can modify, add to, and adjust the previous suggestions to match their specific site and population needs. These are excellent recommendations for parent/

caregiver involvement that promote the success and welfare of our children and adolescents.

Parent/Caregiver Engagement in Agencies

A review of the literature reveals that only a minority of children and adolescents with mental health needs are able to access treatment (Reardon et al., 2017). We should be doing everything we can to support parents/caregivers so as to promote engagement with treatment. From working in schools and agencies over the years, I have observed that when the parent/caregiver is disrespected or feels disrespected, they often discontinue treatment. Kerkorian, McKay, and Bannon (2006) found that parents were roughly six times more likely to doubt the usefulness of treatment as a barrier to future services if they had experienced feeling disrespected by their child's previous mental health clinician. As it is, many barriers to treatment exist already without our agencies being unwelcoming or unsupportive. If parents are protective factors in school life, it makes sense then that they are essential to the process of treatment in agencies, as well. One study found that "the quality of the therapeutic alliance with parents and children, as well as parents' etiological beliefs regarding their children's mental health difficulties, also influence child mental health treatment engagement" (Gopalan et al., 2010, p. 191). Since parents/caregivers are often "key gatekeepers to treatment access" (Reardon et al., 2017, p. 623), counselors need to understand and work to address these barriers so that parents/caregivers can be engaged and work to support their child/adolescent.

Reardon et al. (2017) conducted a meta-analysis to examine the barriers parents experience when seeking mental health services. Their study revealed barriers such as "(1) systemic/structural issues, (2) views and attitudes toward services and treatment, (3) knowledge and understanding of mental health problems and the help-seeking process; and (4) family circumstances" (p. 623). These main four barriers included many themes and subheadings. These are worth considering, but are not a conclusive list. Systemic/structural issues included factors like services costs and financial considerations, waiting times for appointments, access to services including location and space, and availability of appointments. Views and attitudes toward services and treatment included barriers such as whether the professionals were supportive or dismissive, social stigma, and fear of diagnosis, labeling, or hospitalization. The main theme of knowledge and understanding of mental health programs and the help-seeking process revealed that the parent's understanding of the child's issue, acuity level, and knowledge about the help-seeking process were some of the issues related to this barrier. The last main barrier, family circumstance, included considerations for the family and its support network, and also understanding other demands and responsibilities which families must juggle. These factors are imperative for any counselor to consider when working with parents/caregivers.

Working With Parents/Caregivers in Counseling

Many counselors in training, both in school and mental health, planning to work with children and/or adolescents may be drawn to these populations – at least in part – due to an aversion or general lack of desire to work with adults. The reality, of course, is that most children and adolescents are tethered to an adult – at least one, and often more. Like many of you reading this, we really enjoy our time working with children and adolescents, and at times struggle more to connect and empathize with the parents/caregivers than with our client. However, all our clients who happen to be children/adolescents are part of a family system. Our work with them is 1 hour per week – if we're lucky – out of 168. If we want

to see the advances in counseling continue, we must engage with parents/caregivers. Often, the child/adolescent is a symptom of system struggles, so change in the child/adolescent will be short-lived without also engaging the system at some level.

One way to approach working with parents/caregivers in counseling is to know the population. John and Rita Sommers-Flanagan (2011) offer a practical way to think of parents as a unique clinical population. They advise counselors recognize at least four characteristics of parents: first, they are adults looking for counseling to address non-adults; second, typically, parents are seeking advice or solutions or practical tips, so having resources on hand may be important; third, they may be skeptical of inexperienced counselors or of solutions they have already heard from other parents/teachers; and fourth, acknowledging the need for and then seeking help is difficult for parents/caregivers, which makes them feel vulnerable, yet defensive. These four observations can lead counselors of all experience levels to better empathize with parents/caregivers, leading to greater trust and more investment in the process.

There are myriad presenting problems in counseling, and even more strategies for addressing these problems. Therefore, we have assembled a sampling of the resources available online for counselors to use in working with parents, and also to share with parents to help them help their child or adolescent. It is important to communicate the legal status of confidential (privileged) communication, as well as the ethics of the profession.

Including Parents/Caregivers While Maintaining Confidentiality

We have said it before, but it bears repeating: whether or not you are a parent yourself, it is not possible for the counselor to be as hooked in to the child or adolescent client as a parent or caregiver. What this means in practice is that these parents/caregivers are very invested (there are exceptions, of course) and want to know what is happening in the counseling room. This may range from an inquisitive look to an assertive statement about expecting you to report what is said in counseling. These are anxiety-provoking situations for counselors in training and even at times for seasoned counselors. Legally, parents have rights to their children's records (this will vary by age of the child or adolescent by state, so please consult your state's laws regarding parents' rights). We think many of these potential conflicts can be addressed before they even arise by meeting with the parents and the child/adolescent for part of the first session. One of the most practical resources we have seen is from John and Rita Sommers-Flanagan (2007), in the second edition of their excellent text, *Tough Kids, Cool Counseling*. In it, they offer a sample of how counselors might approach the topic of confidentiality with parents/caregivers and children/adolescents. Here is an excerpt:

I won't talk about what either of you say to me outside of here, except in a few rare situations where I legally or ethically have to speak with someone outside this office. For example, if any of you are a danger to yourself, or to anyone else, I won't keep that information private. Also, if I find out about child abuse or neglect that has happened or is happening, I'll work with you to get the best help possible . . .

Now (the counselor looks at the child/adolescent), one of the trickiest situations is whether I should tell your mom and dad about what we talk about in here. Let me tell all of you how I like to work and see if it's okay with you. (Looks back at parents) I believe your son (daughter) needs to be able to trust me. So, I'd like you to agree that information I give you about my private conversations with him (her) be limited to general progress reports. In other words, aside from general progress reports, I won't inform you of details of what your child tells me. Of course, if your child is planning or

doing something that might be very dangerous or self-destructive, I will tell your child (turn and look to child) that he (she) is planning something I feel very uncomfortable with and then we'll have everyone (turn back to parents) come in for an appointment so we can talk directly about whatever dangerous thing has come up. Is this arrangement okay with all of you?

(pp. 30–31)

Approaching the topic of privacy keeps counselors out of the role of secret-keepers. Secrets are things you know you should share but feel pressure not to. Privacy, on the other hand, is the dignity-respecting dimension of building trust, and as such, it is vital to build with both the child/adolescent and with the parent/caregiver. Depending on the age of the child and the setting in which you work, it is often appropriate to meet with the parents/caregivers without the child or adolescent present to do intake, ask questions, and discuss the counseling relationship. The previous conversation about confidentiality can occur at the first meeting, with the child or adolescent present.

Empowering and Encouraging Parents/Caregivers

There are many considerations to keep in mind when working with children/adolescents. Whole books have been written about teaching parenting techniques, teaching positive discipline, and teaching parents/caregivers how to encourage rather than use empty praise. In addition, there are also many resources on supportive adults, consultation, and collaboration. We have assembled a list of resources to enable readers to find the one that suits the clinical situation, rather than trying to say everything in a few short pages. Readers are encouraged to peruse these sites and to make notes, use bookmarks in their browser, or otherwise take ownership of these resources, including adding your own to the list. This way, the resources will be available to you during a session, and you can pull one up without the pressure of remembering the site or its content.

Sample Resources

www.parenttoolkit.com

From the website:

Parent Toolkit is a one-stop resource developed with parents in mind. It's produced by NBC News Learn and supported by Pearson and includes information about almost every aspect of your child's development, because they're all connected. Healthy, successful children can excel in many areas – in the classroom, on the court, and in their relationships with peers and adults. Our advice also covers important topics for navigating life after high school.

www2.ed.gov/parents/landing.jhtml

From the U.S. Department of Education, resources on education-related topics: reading, learning, disability, school success, and college preparation.

<http://parents.nea.org>

The National Education Association's parents/guardians page, a one-stop shop for parents/caregivers on topics like keeping kids curious, providing emotional support, parent & educator partnerships, and education innovation and policy.

[*www.childcareaware.org/families/*](http://www.childcareaware.org/families/)

Recourses for parents/caregivers related to childcare. Resource categories include types of childcare, selecting childcare, regulations, costs, engagement for families, and fee assistance and respite.

[*www.pbs.org/parents/*](http://www.pbs.org/parents/)

Resources for education, engagement, social/emotional ideas, and activities for parents/caregivers to children of all ages.

[*www.sleephelp.org/childrens-sleep-guide/*](http://www.sleephelp.org/childrens-sleep-guide/)

Guide to all things sleep-related to aid parents/caregivers in knowing the sleep needs of their child/adolescent, and providing for them.

[*www.childwelfare.gov/topics/preventing/prevention-programs/parented/education-resource/*](http://www.childwelfare.gov/topics/preventing/prevention-programs/parented/education-resource/)

Comprehensive guide to parent education, including national parent helpline. Examples of resources include links to:

[*https://centerforparentingeducation.org*](https://centerforparentingeducation.org)

Includes resource list of books on parenting, list of articles covering many parenting-related issues, and a rich resource directory of curated sites for a host of parenting topics.

[*www.changingchildrensworlds.org*](http://www.changingchildrensworlds.org)

Information on and resources for parents/caregiver training model, International Child/Parent Development Program (ICDP)

[*https://childdevelopmentinfo.com/#gs.5mou11*](https://childdevelopmentinfo.com/#gs.5mou11)

From the website:

The mission of Child Development Institute is to become the “go to” site for parents for information, products and services related to child development, psychology, health, parenting, learning, media, entertainment, family activities as well as to connect with other parents, professional experts organizations and other useful websites.

It contains thousands of links to resources for parents/caregivers on most topics of concern related to effective parenting.

[*www.cdc.gov/ncbddd/actearly/index.html*](http://www.cdc.gov/ncbddd/actearly/index.html)

The U.S. Centers for Disease Control and Prevention site, designed to help parents and caregivers identify and track milestones, and resources for how to intervene if they are not on track.

[*http://the-parenting-center.com/support-advice/*](http://the-parenting-center.com/support-advice/)

The National Parenting Center’s resource page of support and advice that ranges from pregnancy to adolescence.

[*https://npen.org/members-books-and-publications/*](https://npen.org/members-books-and-publications/)

Book list for parents/caregivers from the National Parenting Education Network that covers everything from discipline strategies (that do not include spanking, time-outs, or bribery) to parenting in the media age.

<http://parentsanonymous.org>

Parents Anonymous is a national organization building healthy parent-child relationships, in part through support groups, as well as countless online resources to support parents/caregivers through the challenges of parenthood.

www.nationalparenthelpline.org

National Parent Helpline offers advocacy and support to parents. From the website:

A trained National Parent Helpline® Advocate is ready to: listen to you, offer emotional support, help you problem-solve, support you in creating your own solutions, encourage you to take care of yourself, work with you to get connected to local services, explore new resources for your family, and help you build on your own strengths and continue to be a great parent!

[www.childwelfare.gov/catalog/serieslist/?CWIGFunctionsaction=publicationCatalog&\\$ain.dspSeriesDetail&publicationSeriesID=2](http://www.childwelfare.gov/catalog/serieslist/?CWIGFunctionsaction=publicationCatalog&$ain.dspSeriesDetail&publicationSeriesID=2)

Links to 30 fact sheets for practitioners to guide their work and also to share with parents/caregivers to support effective parenting.

www.nationalcac.org/for-parents/

The National Children's Advocacy Center website, with myriad resources for parents/caregivers and practitioners to use in supporting safe and healthy environments for children.

www.childhelp.org/resources-parents/

ChildHelp website with downloadable parenting resources with practical tips for dealing with difficult behaviors, as well as for promoting health parent-child relationships. Includes a "Helpful Links" page for parents: www.childhelp.org/story-resource-center/helpful-links/

www.attachmentparenting.org/aboutus/whatwedo

Whether a parent or counselor agrees with this specific model, it is filled with useful resources for parents/caregivers and counselors. From the website:

Attachment Parenting is an application of sensitive responsive parenting. Attachment Parenting is based in the practice of nurturing parenting methods that create strong emotional bonds, also known as secure attachment, between children and their parent(s). This style of parenting encourages responsiveness to children's emotional needs, enabling children to develop trust that their needs will be met. As a result, this strong attachment helps children develop the capacity for secure, empathic, peaceful, and enduring relationships that follow them into adulthood.

Multicultural Implications and Advocacy

All counseling is multicultural. Working with parents, caregivers, and supportive adults is no different. Counselors must remember to also have a strengths-based approach in the work we do with the important adults in the lives of the child or adolescent. Every family has its own unique culture, and many families have other diversity and cultural influences to consider when providing competent, supportive, and best practice care.

Data have substantiated that the mental health profession is failing to provide proper care for children, adolescents, and families of diverse backgrounds (Alegria, Atkins, Farmer, Slaton, & Stelk, 2010). The American Academy of Child and Adolescent Psychiatry noted the importance of cultural competency stating that the following are important for consideration in family life:

- Behaviors that are common and “normal” in one culture even when they are not in others
- Ways to manage everyday problems that can occur between a child and parents or others
- Religious beliefs, practices and events
- Family customs and traditions
- Conflicts that arise between parents and children if the child is spending more time with friends than with family
- Different ways of expressing emotions and problems

(AACAP 2019, para 3)

Further, AACAP (2019) discussed that mental health professionals can do many things to provide culturally competent care such as working with cultural, religious, or community organizations of families from different cultures if the family permits, including important family members who may not be blood related but are important nonetheless, in treatment if requested by the child, adolescent, or family to do so. The counselor must also understand which techniques and theories work best with different cultures. Counselors must also recognize their own biases and how this can impact treatment and the therapeutic alliance for all involved.

Summary

The role of parents, caregivers, and supportive adults in the child’s or adolescent’s life is not to be understated. The chapter discussed parenting styles and included information on how to assist parents/caregivers in the school setting and in agency settings. The onus is on the counselor and other staff to make sure these places are not only supportive and safe for our clients, but multiculturally sensitive. The chapter discussed ways in which counselors in training can empower and encourage parents/caregivers, as it is critical to remember that when parents/caregivers are unsupported and feel devalued, they often struggle to assist their children. This chapter discussed and provided resources for many techniques to teach parents and caregivers positive discipline and support them in meaningful ways. Multicultural implications and advocacy work are essential to address barriers to mental health services.

Clinician’s Corner

I used to emphatically say that I would not go back through childhood and adolescence, even if you paid me millions of dollars. And for a long time, I was satisfied with this dogma. Then, my wife and I had our daughter. It turns out, as nature and a trickster universe would have it, I am going back through childhood and adolescence for free . . . I wish I had taken the millions! I think one of the hardest things for new counselors is getting “the question”: “Do you have kids?” This is always a trap of sorts because there really is no right answer (except the truth, of course). The counselors I train and supervise often struggle with saying: “No, I don’t have kids”. The fear caregivers have is that there is no way this childless

20-something could understand how difficult parenting can be. So, I offer a description of parenthood based on my experience:

Take everything that is valuable to you: sense of safety, security, confidence, money, love, your heart, your brain, etc., and place these things into a container that is completely unaware of its contents. Then, watch as this juggernaut of a container does its best to wreck these treasures, precariously holding your treasures, all completely unselfconsciously. Oh, and while you're at it, stop sleeping, stop doing what you want when you want, and embrace fear as a lifestyle. Oh, and recognize that you would not trade it for the world.

In my early days of working with parents (before being wracked with the terror and guilt of parenthood), parents seemed to cut me slack if I sought to understand their experience. Eventually, they stopped asking me if I was a parent because I think they didn't need that information to be able to trust my investment in them, not just their child or adolescent.

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8 Trauma and the Child and Adolescent Brain

Chad Luke and Rebekah Byrd

Objectives

- Learn about the general structure, systems, and functions of the human brain.
- Begin to differentiate stress from trauma and how the distinctions are more academic than actual.
- Be able to apply the eight-factor model of human phenomena to stress and trauma.
- Identify neuroscience axioms for working with trauma in children and adolescents.
- Become familiar with the neuroscience of adverse childhood experiences (ACEs).

Reflective Questions

- What are my beliefs about trauma in childhood and adolescence?
- What biases might I hold about someone who has experienced trauma?
- Where is trauma in the brain, and how can this inform my work with children and adolescents?
- How can an enhanced understanding of the brain and trauma assist me in my own personal growth and development?

Summarize Structures, Systems, and Functions of the Brain

The content in this section is modeled after Chapter 2 from *Neuroscience for Counselors and Therapists* (2nd ed) (Luke, 2020) because there is a lot to learn about the brain and nervous system, but it has been described numerous times and in multiple ways. One way to conceptualize neuroanatomy (structure) and physiology (function) is a 1-2-3-4-5 heuristic, which is intended to provide counselors with a quick way to conceptualize structures, systems, and functions of the brain, and in a way that can be safely shared with parents and other caregivers. This material provides a basic foundation for further understanding the brain and trauma, but for a more in-depth exposition, readers might consult Field, Jones, and Russell-Chapin (2017).

1. *Brain*

First and foremost, the brain is best understood as a whole unit rather than a collection of independent regions or structures, and this holistic view is most usefully viewed in the brain's connection with others. So just as the whole brain must be understood as an integrated system of systems, an individual brain is also best understood as one part of a larger system in relation to other brains (human relationships). For example, while the amygdala is thought of as the center of fear and emotion, is merely plays its role in larger

systems, like the limbic system, which connects the hindbrain to the midbrain, but also has a direct connection to the forebrain. While it is true that the amygdala plays a specific role, it is its relationship to other structures and systems (or lack thereof) that defines its identity and purpose. Likewise, an individual client is part of a series of systems – broken, damaged, or nonexistent as they may be – which helps us understand the function and purpose of the individual. Without an understanding of the whole individual, who is part of larger systems, we can only ever have an incomplete picture of that child or adolescent. Researchers have identified previous limitations of brain research in the study of a brain in isolation, one at a time, when the most meaningful data on brain function can come from studies of a brain in relationship to others. Likewise, working with a child or adolescent as if that person were an isolated being misses the larger picture of what functioning can look like. This matters whether the relational context for the child/adolescent (and their brain) is explored in terms of rupture or of repair.

2. *Hemispheres*

There are so many parallels to therapy in general, and with children and adolescents in particular that come from an understanding of the two hemispheres of the brain, that this section will barely scratch the surface. To start, it is helpful to clear up some confusion regarding brain hemispheric function. It would be inaccurate to describe a person as left-brained or right-brained. While it is true that each hemisphere has its own specialization, because the majority of structures in the forebrain, midbrain, and limbic system are bilateral (structures in one hemisphere are mirrored in the other hemisphere), both hemispheres are necessary for healthy functioning. It is accurate to understand the specialization of each hemisphere, and equally so to understand the way the two hemispheres communicate with one another. The left hemisphere can be understood through what Siegel (2012) calls the four Ls: language, linearity, literalness, and logic. In contrast, the right hemisphere directs emotion, creativity, and relationship. Here is a sample application with an adolescent named Jemma who has a history of trauma and struggles with anxiety and anger: the work of the counselor is to assist Jemma to integrate these two hemispheres. Because of the bilateral nature of the brain's structures, Jemma's amygdala and hippocampus exist in each hemisphere, but because the two hemispheres process information and experiences differently, Jemma's anxiety does not make her left- or right-brained. Instead, how she experiences and then expresses her anxiety may vary depending upon the mode through which she is processing (Siegel [2015] calls this left-mode and right-mode processing). In other words, at times, Jemma's anxiety may be expressed verbally and at other times emotionally. Neither are right; neither are wrong. However, the ability to choose one's mode of processing may be critical for post-traumatic growth. For example, we may use left-mode processing to verbalize a concept like anxiety, but for someone who has never experienced severe anxiety, this word may have very limited meaning. Or, in Jemma's case, feelings were not allowed to be openly expressed by the children in the home, so talking about feelings (left-mode processing) is not only foreign but triggering. Instead, Jemma stays emotionally activated as an expression of her past and present anxiety (right-mode processing) so she never feels as if she can manage those emotions. Jemma's trauma keeps her feeling overwhelmed due to limited access of left-mode processing (in essence, thinking logically, in a linear fashion about her trauma). This is not the same as trying to use cognitive therapy to bring her emotions under the control of rational cognitions; it is about harmonizing between the hemispheres to allow for a complete experiencing and processing of the past trauma and current anxiety. In the brain, the structure responsible for this harmonizing, or horizontal integration, as Siegel puts it, is the corpus callosum. This high-density nerve

bundle works to unite and integrate the processing of each hemisphere. In counseling, the therapist is the equivalent of the corpus callosum, bringing together into unified experience, the intolerable facets, as well as the strengths, of a client's existence.

3. *Levels of Functional Governance*

In 1990, Paul MacLean proposed the triune brain, an understanding of the brain based on its evolutionary development, from the inside out, across three layers: the reptilian, paleomammalian, and neomammalian brain. The reptilian, or lizard, brain is a primal layer that houses basic life functions and evolved to react to the environmental stimuli in order to survive. It is purely stimulus-response in nature. Luke (2020) refers to this as *survival of the individual*. Next in the evolutionary-developmental sequence was the development of the paleomammalian, or rat, brain. This includes the limbic region which connects the midbrain with the cortex neocortex. This stage of evolutionary brain development involves what Luke refers to as *survival in community*. Last to develop was the mammalian, or monkey, brain and is the part of the brain – the neocortex – with a large percentage devoted to social functioning (Purves et al., 2018). It is in this functional level that allows survival in a relational context or *survival and connection* (Luke, 2020). The nature of evolutionary development is that organs or parts of organs and systems remain long after other faculties have emerged. For counselors, this is important in assessing the functioning of the child or adolescent in order to understand how they are moving through their world: lizard, rat, or monkey. Likewise, from a systems perspective, the family unit from and in which the child lives can also be said to function at one of these three levels. It is not difficult to imagine a reptilian type of family system wherein all members are merely reacting to environmental stimuli, while others in the paleomammalian type system are emotion-driven, or in the neomammalian type family system in which connection and relationship are more probable. It is also, therefore, easier to understand which type of system might promote resilience and post-traumatic growth in a brain that has experienced trauma, and the ones that do not.

Clients can be invited to set their goals for counseling related to living based on survival of the individual (reptilian), survival in community (paleomammalian), or survival and connection (neomammalian). In other words, would clients prefer to live by reflex alone, instinct, or relationship?

(Luke, 2020, p. 44)

4. *Cortical Lobes*

Many of us may be familiar with the four main lobes of the cortex: the frontal, temporal, parietal, and occipital lobes. These lobes represent relatively discrete areas of functioning. For instance, the occipital lobe is the primary visual cortex and governs seeing, as well as meaning-making of sight. For example, Erik Wiehenmeyer is the first blind person to summit Mount Everest. He demonstrated the use of a device called brainport that uses a camera mounted in a pair of sunglasses that projects an image to a computer, which then digitizes those signals and sends them to a pad on the tongue. This pad contains about 300 sensors to recreate the visual data allowing him to “see”. In counseling, this can be used to assist clients in understanding that our eyes may receive input from our environment, but we actually see using our brain, and the occipital lobe in particular.

The temporal lobes are referred to in the plural form because unlike the other three lobes, these lobes are located on opposite sides of the brain. The auditory cortex is found in the

temporal lobe and processes complex sounds. The parietal lobe contains the somatosensory cortex, which processes information coming in through the skin and touch, for example, pain, pressure, and temperature. It is also where language comprehension is located, also known as Wernicke's area. Speech comprehension is governed by the frontal lobe, which is where Broca's area is also located. This makes sense in that speech involves movement, and the frontal lobe contains the primary and secondary motor cortices. The prefrontal cortex is also located in the frontal lobe, and governs conscious sensations, abstract thought, reasoning, planning, and working memory (Luke, 2020). The lobes are important for a number of reasons, but perhaps the most salient and relevant for treating trauma is that sensory experience does not make meaning; the brain region that processes sensory signals does.

5. *Systems for Self-Regulation*

There are myriad systems in children and adolescents that could be listed, but this review focuses on five major systems that serve as a starting place for understanding the impact and clinical implications of trauma and the brain: the central nervous system, peripheral nervous system, autonomic nervous system, sympathetic nervous system, and parasympathetic nervous system. The central nervous system (CNS) includes the brain and nervous system, and directs all conscious (and non-conscious) cognitive and behavioral functioning. The peripheral nervous system, in contrast, regulates most non-conscious biological functioning. It is made up of the somatic and autonomic nervous systems. The autonomic nervous system is the focus of this review, as it is made up of the sympathetic and parasympathetic nervous systems, responsible for fight/flight/freeze and rest/digest responses, respectively.

The sympathetic nervous system (SNS) is responsible for preparing the body and mind for response to threats. It does this by increasing heart rate, dilating pupils, slowing or stopping digestion, stimulating adrenal glands, and constricting blood vessels. These processes promote survival; for example, we do not need to digest that burger from lunch if we are about to die. Likewise, adrenaline provides the burst of energy needed to take self-protective action. A key to understanding this system's function is that it takes over in the presence of a *perceived* threat, regardless of whether the threat materializes. Better a false positive that just makes us aware and afterward tired, than a false negative whereby we relax, only to be harmed unexpectedly. In other words, "perception creates real bodily experiences" (Luke, 2020, p. 48).

SAM and HPA

Two networks that are part of the autonomic nervous system make up the core of the neurobiology of trauma in children and adolescents, and have significant implications for clinical practice. The sympathetic-adrenal-medullary (SAM) axis is a stress network that drives the initiation of the sympathetic nervous system's stress response as previously described. Jones, Rybak, and Russell-Chapin (2017) summarize it best: "the hypothalamus sends messages down to the adrenal glands . . . to release epinephrine and norepinephrine" (p. 66). This leads to sympathetic system slowing non-essential system functioning (like digestion) and redirects resources (blood, oxygen, glucose) to systems essential for self-protective functions, like fight/flight/freeze responses. Life-threatening situations – real or perceived – require some action, even if that action is stillness, not contemplative responding. For this reason, instinct and reflex take over rational problem-solving.

The second step in responding involves the hypothalamic–pituitary–adrenal (HPA) axis. Jones et al. (2017) again puts it most clearly:

[HPA] is the functional connection between three endocrine glands. The hypothalamus releases corticotropin-releasing hormone to the pituitary gland. This hormone stimulates the pituitary gland to release adrenocorticotrophic hormone (ACTH). ACTH then travels down to the adrenal glands, which sit on top of the kidneys. The ACTH activates the adrenal cortex . . . to release glucocorticoids, in particular cortisol. The function of cortisol is to help restore homeostasis after stress, and is essential to life. (pp. 13–14)

But as we know, if the trauma or stressor does not abate or if the individual is incapable of tolerating or resolving the stressor, cortisol stays in the limbic region for too long. This can result in decreases in hippocampal volume, leading to disrupted memory function. Readers are directed to the practical discussion of this process in greater detail in Jones, Rybak, and Russell-Chapin (2017).

To express the process succinctly, we present the description proffered by Luke, Redekop, and Jones (2018) and paraphrased by Luke (2020):

The HPA axis is comprised of the hypothalamus, pituitary gland, and adrenal glands. The hypothalamus is the midbrain/hindbrain border structure that controls a host of involuntary life functions, such as digestion, sleep, temperature, and perhaps most notably, “emergency responses to stressors in the environment” (Saper & Lowell, 2014, p. R1111). This means that, initiated by the role of the amygdala in threat detection (perception), the hypothalamus plays a key role in threat response through its influence on the pituitary gland (Garrett & Hough, 2018). The pituitary gland controls hormone production and release. In times of stress in particular, the pituitary gland triggers the production and secretion of adrenocorticotrophic hormone and serves as the primary chemical conduit between the pituitary and the cortex (outer portion) of the adrenal glands. The adrenal cortex releases cortisol, which functions as a glucocorticoid. As such, cortisol speeds up metabolic processes related to sugar (and proteins) to provide fuel for the body to perform at peak exertion during high-stress periods and increase mental acuity, at least for short durations (LeDoux, 2012). This is also the system that releases the endogenous opioids. The SAM system engages the SNS, which triggers the interior of the adrenal glands (adrenal medulla) to release noradrenaline (norepinephrine) and adrenaline (epinephrine). Norepinephrine functions as both a hormone and a neurotransmitter, especially in response to stress, by activating attention and arousal related to the environment. Enoch (2011) identified the role of early stress-filled environments as hampering the development of stress resilience in the brains of children. This increased developmental vulnerability appears also to translate into susceptibility to addiction (Enoch, 2011).

(pp. 225–226)

The critical matter for clinicians working with children and adolescents is what happens in the brain prior to trauma and stress. The larger – and quickly expanding – body of neurobiological research on both humans and non-human animals demonstrates the importance of genetic, relational, and environmental factors on the developing brain (Kindsvatter & Geroski, 2014). These early relational contexts are vital to the development of the SAM and HPA axes, and promote the resilience of the individual.