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The Experiences of Professional Counselors Who Exhibit Exceptional Practice with Children and Adolescents in Nonschool Settings

Maggie E. Walsh
Georgia State University, maggie.e.walsh@gmail.com

ACCEPTANCE

This dissertation, THE EXPERIENCES OF PROFESSIONAL COUNSELORS WHO EXHIBIT EXCEPTIONAL PRACTICE WITH CHILDREN AND ADOLESCENTS IN NONSCHOOL SETTINGS, by MAGGIE WALSH, was prepared under the direction of the candidate's Dissertation Advisory Committee. It is accepted by the committee members in partial fulfillment of the requirements for the degree Doctor of Philosophy in the College of Education, Georgia State University.

The Dissertation Advisory Committee and the student's Department Chair, as representatives of the faculty, certify that this dissertation has met all standards of excellence and scholarship as determined by the faculty. The Dean of the College of Education concurs.

_____
Catherine Y. Chang, Ph.D.
Committee Chair

_____
Gregory L. Brack, Ph.D.
Committee Member

_____
Andrea Dixon, Ph.D.
Committee Member

_____
Kay D. Hutchinson, Ph.D.
Committee Member

_____
Date

_____
Brian Dew, Ph.D.
Counseling and Psychological Services Department Chair

_____
R. W. Kamphaus, Ph.D.
Dean and Distinguished Research Professor
College of Education

AUTHOR'S STATEMENT

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Maggie E. Walsh

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Maggie E. Walsh
4890 Hidden Branches Drive
Atlanta, Georgia 30338

The director of this dissertation is:

Dr. Catherine Y. Chang
Department of Counseling and Psychological Services
College of Education
Georgia State University
Atlanta, Georgia 30303 – 3083

VITA
Maggie E. Walsh

ADDRESS:
4890 Hidden Branches Drive
Atlanta, Georgia 30338

EDUCATION:

Ph.D. 2012	Georgia State University Counselor Education and Practice
M.Ed. 2007	University of Georgia Guidance and Counseling
B.S. 2005	University of Georgia Psychology

PROFESSIONAL EXPERIENCE:

February 2012- Present	Counselor, Odyssey Family Counseling Center College Park, Georgia
August 2011- Present	Adjunct Faculty, Kennesaw State University Kennesaw, Georgia
August 2008- Present	Instructor, Georgia State University Atlanta, Georgia
August 2008- June 2010	Counselor, Safe and Drug Free Schools - GIVE Center Gwinnett, Georgia
May 2009- September 2009	Counselor CHRIS Kids Atlanta, Georgia
August, 2008 - May 2009	Doctoral Level Intern, CHRIS Kids Atlanta, Georgia
January 2007 - May 2007	Group Facilitator, The Treehouse Winder, Georgia
January 2006 – May 2007	Clinical Intern, Advantage Behavioral Health Systems Child and Adolescent Services Athens, Georgia

PROFESSIONAL MEMBERSHIPS:
American Counseling Association (ACA)
Association of Counselor Education and Supervision (ACES)
Southern Association of Counselor Education and Supervision (SACES)
Association Specialist in Group Work (ASGW)
Association of Play Therapy (APT)
Association for Creativity in Counseling (ACC)

PRESENTATIONS AND PUBLICATIONS:
Chang, C. Y., & Walsh, M. E. (2012). Professional and social advocacy in clinical mental health. In J. C. Watson & D. S. Sheperis (Eds.). *Clinical mental health*

counseling: Fundamentals of applied Practice. Columbus, OH: Pearson Education, Inc. Under review

Michal, R. E., Walsh, M. E., Lorelle, S., & Davis, E. (2011, March). Applying, Surviving and Thriving in Graduate School: Practical tips for Masters and Doctoral Students. Presentation presented at American Counseling National Conference, New Orleans, LA.

Wynne, L., White, J., Walsh, M., & Wolfe, A. (2010, December). Play Therapy 102: More Principles & Strategies for School-Based Mental Health Professionals. Two Day training provided to Cobb County Department of Education. Marietta, GA

Gnilka, P., Wolfe, A., Eberts, S., & Walsh, M. E., (2009, October). CACREP Accredited Master Level Counseling Programs and Prejudice Levels. Poster presented at Association for Counselor Education and Supervision Conference, San Diego, CA

Gnilka, P., Eberz, M., & Hyun, J., (2008, October). The Ins and Outs of Doctoral Students and Liability. Poster presented at Southern Association of Counselor Education and Supervision Conference, Houston, TX.

Wolfe, A., & Eberz, M. (2008, March). Religion and Spiritual Issues in Counseling: A Multicultural Competency. Poster presented at Multicultural Competencies Conference, Georgia State University, Atlanta, GA.

Eberz, M., & Chang, C., (2007, November). The Importance of Assessing Racial Identity of Ethnic Minority Adolescent Clients. Presented at Association of Assessment in Counseling and Education National Conference, Atlanta, GA.

Eberz, M., McGee, N., (2006, October). Prevention Workshop: Elementary Drug Education. University of Georgia, Athens, GA.

Eberz, M., & Adams, K., (2005, March). Levels of Sociability Characteristics Measured on Multi-Rater Feedback and the Occurrence of Over-estimation. Poster presented at 28th Annual Convention of the Behavioral Sciences, Athens, GA.

Gentry, W., Eberz, M., & McCollum, R., (2004, April). Nonverbal Communication in Job Interviews. Presented at 27th Annual Convention of the Behavioral Sciences, Athens, GA.

ABSTRACT

EXPERIENCES OF PROFESSIONAL COUNSELORS WHO DEMONSTRATE EXCEPTIONAL PRACTICE WITH CHILDREN AND ADOLESCENTS IN NONSCHOOL SETTINGS
by
Maggie E. Walsh

One in five children and adolescents in the United States has a mental health disorder (U.S. Department of Health and Human Services, 1999) and 12.5% of children and adolescents receive treatment in a special mental health setting each year (Substance Abuse and Mental Health Services Administration, 2009). Children and adolescents have special needs in counseling, and applying adult based counseling skills and knowledge onto children is inappropriate and unethical (Lawrence & Robinson Kurpius, 2000). There exists no nationally recognized licensure, certification or training standards for professional counselors to work with children and adolescents in non-school settings despite the need for specialized skills. Several scholars have made recommendations for the training of professional counselors who work with this population including coursework and supervised clinical experiences. There has been no examination to date, however, of whether these recommendations are in line with the experiences of professional counselors who work with children and adolescents in non-school settings. It is essential that counselor educators advocate for the students, the profession and the youth by examining what training is necessary. This grounded theory study aimed to identify what the experiences of professional counselors who work with children and adolescents in non-school settings are as well as what training and clinical experiences these professional counselors have. There were 14 participants in the study all of whom had at least 5 years of experiences counseling children and adolescents in a non-school setting, currently practicing, and were perceived by their

peers as exhibiting exceptional practice. Data was collected using semi-structured interviews and data analysis included open, axial and selective coding. Trustworthiness was established using peer debriefing, progressive subjectivity, member checks, and detailed record keeping and was confirmed through the audit process. Authenticity was also established. Themes were identified and a theory of skill acquisition to work with children and adolescents in non-school settings was developed. With a greater understanding of the experiences of these professional counselors, counselor education programs can more appropriately construct training experiences thereby producing more competent and prepared professional counselors to work with children and adolescents in this setting.

THE EXPERIENCES OF PROFESSIONAL COUNSELORS WHO EXHIBIT EXCEPTIONAL PRACTICE WITH CHILDREN AND ADOLESCENTS

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ABBREVIATIONS

ACA	American Counseling Association
APA	American Psychiatric Association
APT	Association for Play Therapy
CACREP	Council for Accreditation of Counseling and Related Educational Programs
DISC	National Institute of Mental Health Diagnostic Interview Schedule for Children
C-GAS	The Children Global Assessment Scale
DSM-III-R	The Diagnostic and Statistical Manual of Mental Disorders Third Edition Revised
DSM–IV	The Diagnostic and Statistical Manual Fourth Edition
NCTSN	The National Child Traumatic Stress Network
PIR	Poverty index ratio
RPT	Registered Play Therapist
SAMHSA	Substance Abuse and Mental Health Services Administration
SED	Severe emotional disturbance
U.S. DHHS	United States Department of Health and Human Services
U.S. PHS	United States Public Health Services

CHAPTER 1

COUNSELORS WORKING WITH CHILDREN AND ADOLESCENTS IN NONSCHOOL SETTINGS

Approximately 4.5 to 6.3 million children and adolescents in the United States are currently diagnosed with a mental disorder (President's New Freedom Commission on Mental Health, 2003; U.S. Department of Health and Human Services, 1999). Costello, Messer, Bird, Cohen and Reinberz (1998) conducted a meta-analysis from data collected in Boston, New York, Pittsburgh, Puerto Rico and North Carolina in an effort to determine the prevalence of severe emotional disturbance in children and adolescents. They determined a global prevalence rate of 4.4% to7.4% with a median of 5.4%.

The needs of children and adolescents in counseling are distinctly different from that of adults. It is essential that professional counselors do not simply apply adult based knowledge and skills when working with child and adolescent clients (Lawrence & Robinson-Kurpius, 1999). Additionally, it is unethical for professional counselors to practice with this special population without first acquiring specific education, training and supervised practice (Lawrence & Robinson-Kurpius, 1999). While specialized training for working with children and adolescents is essential and ethical, there are no national or state training standards in place for professional counselors who work with children and adolescents in non-school settings. The accrediting organization for counseling programs, the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2009) makes no mention in the 2009 standards of training specific for working with children and adolescents in non-school settings for mental health programs. Currently, there are no standards for training professional counselors who work with this special population;

however, several organizations and researchers have developed recommendations for professional counselors who work with children and adolescents. These recommendations include coursework and supervised clinical experiences (see Association for Play Therapy (APT), 2009; Lawrence & Robinson Kurpius, 2000; Raimondi & Walters, 2004)

In this chapter, the author provides a literature review of the mental health status of children and adolescents, discusses the importance of specialized training to work with this special population, describes existing training and licensure requirements of professional counselors who work with children and adolescents in non-school settings and outlines training recommendations found in the literature.

The Mental Health of Children and Adolescents

One in five children experience mental health disorders and one in ten children and adolescents in the United States have a mental disorder that is severe enough to result in impairment (U.S. Department of Health and Human Services (U.S. DHHS), 1999; U.S. Public Health Services, (U.S. PHS) 2000). Many researchers have explored the prevalence of impairment in children and adolescents (Cohen et al., 1993; Costello et al., 1988; Costello et al., 1996; Costello et al., 1998; Costello, Farmer, Angold, Burns, & Erkanli, 1997; Merikangas et al., 2010; Shafer et al., 1996). Roberts, Attkisson, and Rosenblatt (1998) examined 52 studies that explored the prevalence rate of mental health disorders in children and adolescents. The studies ranged from the 1950s to the 1990s and took place in more than 20 countries. According to these studies, the prevalence rate of mental health disorders increases with the age of the child. More specifically, the mean prevalence rate of mental health disorders in preschoolers (1-6 years) was 10.2% (median=8.3%, range= 3.6%–24% *n* =10) and the mean prevalence rate for pre adolescents (6-12 or 13 years) was 13.2%

(median=12.2%, range=1.4%– 30.7%, *n* =21), while the adolescents (12 or 13 years and older) were found to have a mean prevalence of 16.5% (median=15.0%, range=6.2%–41.3%, n=12).

Costello et al. (1998) used seven data sets from studies that aimed to identify prevalence rates in localized areas in an effort to determine an empirically based prevalence rate of children with severe emotional disturbance (SED) in the United States. The authors followed the definition of SED as provided by the Federal Register of May 30, 1993:

> Pursuant to section 1912 (c) of the Public Health Service Act, as amended by Public Law 102-321 "children with a serious emotional disturbance" are persons:
> From birth up to age 18, who currently or at any time during the past year,
> Have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within DSM-III-R (or comparable criteria), That resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities (U.S. Government, 1993, p. 29425).

Costello et al. (1998) found a global SED prevalence rate of 4.4% to 7.4% with a median of 5.4%. Dysfunction was examined on three domains: social functioning, school functioning and activities. The prevalence rate of a disorder paired with dysfunction in one of three domains was 5.5% to 16.9% with a median of 7.7%. The authors found that between 1 in 13 and 1 in 20 children experienced SED using the global and domain specific criteria. According to these numbers, 3 million children and adolescents in the United States between the ages of 4-17 meet the global criteria for impairment, and 4.2 million children aged 4-17 meet the domain specific criteria.

Between 2001 and 2004, Merikangas et al. (2010) screened a sample of 3,024 children and adolescents between the ages of 8 and 15. The children and adolescents were evaluated in person using the National Institute of Mental Health Diagnostic Interview Schedule for Children (DISC) at the mobile examination centers of the National Health and Nutrition Examination Survey. Modules were given to the children and adolescents and/or the caregiver depending on the diagnosis (Shaffer et al., 1996). The prevalence rates of Attention Deficit Hyperactivity Disorder (ADHD) (8.7%), mood disorders (3.7%), conduct disorder (2.1%), panic disorder/GAD (0.7%), and eating disorders (0.1%) in a twelve-month period were found. Mood disorders were found to have a higher prevalence rate in females, and ADHD was found to be more common in males. Poor children and adolescents as defined by the poverty index ratio (PIR; family income/family poverty threshold level ratio on the basis of family size) were found to have higher rates of mental health disorders within the last 12 months and less likely to have anxiety disorder than those children and adolescents who were not poor according to the PIR. The only difference based on ethnicity was that the Mexican American children and adolescents in this sample were more likely to experience mood disorders than were White or Black children and adolescents (Merikangas et al., 2010).

The prevalence rates of mental health disorders in children and adolescents highlight how large populations of our children and adolescents are impacted by mental health disorders and are in need of mental health services. It is important that professional counselors are not only aware of the prevalence of mental health disorders in children and adolescents, but also that levels of impairment associated with mental health disorders may differ between individuals. The Children Global Assessment Scale (C-GAS) is used to

measure the psychological, social and school functioning of children and adolescents aged 6 to17. It is a widely used scale designed to synthesize different aspects of a client's functioning into a single index rating of the clients overall ability to function (Schaffer, et al., 1983). Individuals are given a score between 0 and 100 in ten point intervals with the lower scores indicting a lower level of functioning and a higher score indicating a higher level of functioning. More specifically, a score of 61-70 indicates that a youth has some difficulty in a single area but demonstrates overall good functioning. A score of 51-60 indicates an individual has variable functioning with sporadic difficulties and the individual's symptoms are present in multiple areas. A score of 41-50 indicates the individual has a moderate degree of impairment in most areas or a significant level of impairment in one area. Shaffer et al. (1996) reported a prevalence rate of 24.7% for 9 to 17 year olds who meet the criteria for a DSM-III-R mental health disorder diagnosis and a CGAS score of 70 or lower. With the same age group, a prevalence rate for those who met *The Diagnostic and Statistical Manual of Mental Disorders* Third Edition Revised (DSM-III-R) (American Psychiatric Association (APA), 1980) diagnostic criteria for a mental health disorder and also a C-GAS score of 60 or lower was 12.8% and a prevalence rate for those with a diagnosis and a score of 50 or lower was 6.2% of their sample. While many children and adolescents may meet the criteria for the same mental health disorder diagnosis, some may suffer a greater level of impairment as indicated by many children having a lower C-GAS score than other children with the same DSM-III-R mental health diagnosis.

Children and adolescents who experience a trauma are also at risk for developing social, developmental, and physical impairments (The National Child Traumatic Stress Network, NCTSN, 2008). Many of these impairments can affect the mental health of these

children and adolescents including social isolation, difficulty relating to and empathizing with others, difficulty in regulating emotion, difficulty identifying and verbalizing their emotions, poor impulse control, self-destructive behavior, aggression, disturbed body image and low self-esteem (NCTSN, 2008). The National Survey of Adolescents revealed that 39.4% of adolescents have witnessed violence, 17.4% had been physically assaulted, and 8.1% had been the victim of a sexual assault (Kilpatrick, Saunders, & Smith, 2003). The prevalence of these victimizations on children and adolescents may serve as an indicator of how many may be struggling with mental health issues as a result of these potentially traumatic experiences. Post-Traumatic Stress disorder has been found in 20-63% of children who were survivors of child maltreatment, 12-53% of children who were medically ill, 5-95% of children who survived a disaster (Gabbay, Oatis, Silva & Hirsch, 2004).

Despite these reported prevalence rates of mental health disorders in children and adolescents, it must be noted that there are challenges associated with reporting prevalence rates of mental health disorders in children and adolescents. Friedman, Katz-Leavy, Manderschied, and Sondheimer (1996) warned that while there is value in identifying prevalence estimates and ranges for the purpose of policy, there exists a risk in over simplifying a complicated situation. While differences exist in prevalence rates among ethnicity, race, age, gender, socio economic status, and communities, the literature does not provide the necessary data to fully understand these differences (Friedman et al., 1996). While many aspects of the prevalence of mental illness in children remain unclear, the vastness of the problem is evident.

Children and adolescents can be profoundly impacted by mental health disorders. Mental health disorders affect children and adolescents at home, at school and with their

peers (U.S. DHHS, 1999). If left untreated these mental health disorders can lead to a variety of negative outcomes for children and adolescents including school failure, family conflicts, drug abuse, and violence (Substance Abuse and Mental Health Services Administration (SAMHSA), 2003). Wagner, Newman, Cameto, and Levine (2005) found that students who experience severe emotional and behavioral needs are 44% more likely to drop out of school.

Suicide is a major mental health issue for children and adolescents (SAMHSA, 2003). Behind auto accidents and homicide, suicide is the third leading cause of death for those aged 10 to 24 years of age. Despite the staggering number of children and adolescents that complete suicides, there are many more that are suicidal and survive their suicide attempts (U.S. DHHS, 2008). In a national survey of public and private schools, 15% of students reported seriously considering suicide, 11% reported establishing a plan to commit suicide, and 7% reported attempting to commit suicide within 12 months of the survey (U.S. DHHS, 2008). The prevalence of suicide attempts demonstrates both the level of suffering by many children and adolescents with mental disorders and the critical need for quality mental health care for this population.

Mental health disorders can have lasting effects as symptoms may also lead to impairment as an adult if left untreated (Rapoport, 2000; U.S. PHS, 2000). Due to the implications that mental health disorders can have on children and adolescents and its potential impact on adulthood, it is critical that professional counselors be specifically trained to work with this population to address their specific needs (i.e., school or community agency).

Mental Health Services Provided to Children and Adolescents

It is estimated that while 11.5% of adolescents received services for problems with

behavior or emotions in a school setting within the last 12 months, 12.5%, or one in eight, adolescents between the ages of 12 and 17 received treatment in a specialty mental health setting. Slightly more than one in twenty adolescents (5.1%) received both services in both an educational and special mental health settings (SAMHSA, 2009). Of those who received services in an educational setting, 3.3% received special education services and 9.7% received services from a school counselor, a school psychologist, or had regular meetings with a teacher. Of the adolescents who received services in a specialty mental health setting, 2.5% receive these services in an inpatient or residential setting such a hospital (2.0%), residential treatment center (0.8%), foster care or therapeutic foster care home (0.4%). Outpatient settings made up 11.1% of the adolescents who received services in specialty mental health setting (SAMHSA, 2009). These settings included private therapist, psychologist, psychiatrist, social worker, or counselor (9.4%), mental health clinic (2.3%), day treatment program, (1.7%), and in-home therapist, counselor or family preservation worker (2.8%). While females are more likely to receive services in outpatient (males 9.1% females 13.3%) and educational settings (males 9.9% females 13.2%), males are more likely to receive services in an inpatient or residential setting (males 2.6% females 2.4%). Depression was found to be the largest reason for receiving services in both outpatient (50.4%) and inpatient (44.8%) settings (SAMHSA, 2009). Other reasons for receiving services include problems at home/family (outpatient 29.0% inpatient 14.9%), breaking rules or acting out (outpatient 24.7% inpatient 24.8%), suicidal ideation or attempts (outpatient 18.5% inpatient 44.9%), fearful or tense (outpatient 17.1% inpatient 17.9%), difficulty controlling anger (outpatient 16.7% inpatient 12/5%), problems at school (outpatient 17.0% inpatient 9.7%) problems with friends (outpatient 12.1% inpatient 5.3%), eating problems

(outpatient 9.3% inpatient 9.2%), and problems with people who are not family or friends (outpatient 8.8% inpatient 6.0%) (SAMHSA, 2009).

Using data collected from three national surveys between 1996 and 1998, Ringel and Sturm (2001) found that 5% to 7% of children use specialty mental health services in a given year. These findings were not equal across all age groups. Of preschool aged children only 1% to 3% use specialty mental health services in a year, 6% to 8% of children aged 6 to 11 years use services, and 7% to 9% of children aged 12 to 17 years. Children with private insurance were found to have more mental health specialty visits than their counterparts who are uninsured or hold Medicaid or public insurance. The authors also found differences across racial groups with Hispanic children having lower rates of service than both Black children and White children, with White children having the highest rates. This finding remained true even when controlling for the child's access to and type of insurance.

Merikangas et al. (2010) found supporting evidence that mental health services for children and adolescents has been increasing in recent decades. They found that 50.6% of children and adolescents who met The Diagnostic and Statistical Manual Fourth Edition (DSM–IV) (APA, 1994) diagnostic criteria for a mental disorder had received services for their symptoms. Of those with ADHD nearly half (47.7%) reported having received mental health services. Treatment was provided at a slightly less frequent rate for those meeting the criteria for Conduct Disorder (46.4%) and Mood Disorder (43.8%). Children and adolescents with Anxiety Disorders were found to have much lower rates of receiving services (32.2%). These rates were markedly higher than those reported by Costello et al, (1998) who found that only 22.8 % to 27.4% of children and adolescents who met the criteria for a diagnosis of a mental health disorder had received mental health services.

Thus, it is supported that children and adolescents are being provided mental health services in non-school settings (SAMHSA, 2009). These services are provided at different rates according to age (Ringel & Sturm, 2001), mental health disorder or presenting problem (Merikangas et al., 2010; SAMHSA, 2009), gender (SAMHSA, 2009) and ethnicity (Ringel & Sturm, 2001). Given that children and adolescents are receiving mental health services outside the school setting, it is critical that the services provided by professional counselors in non-school settings meet the special needs of this population.

Special Counseling Needs of Children and Adolescents

Children and adolescents are distinct from adults in that they have yet to complete critical stages of development. Individuals undergo significant growth both physically and cognitively during both the period of childhood and adolescence as they move toward adulthood. What is important to consider, however, is the manner in which children and adolescents function prior to these changes being complete. Where children and adolescents are on the continuum of growth and development can have a significant impact on the overall functioning of the child and thus, their needs in counseling.

There are numerous changes that occur within a child that may have impact on their functioning. Gross and fine motor development begins to occur during the period of infancy. Although there is significant gross motor development in very early childhood it is not until the age of four that a child can run and jump skillfully. At five years, they are able to balance on one foot and are proficient at skipping. By age six a child can jump rope or catch a small ball. As the child matures and moves towards adolescents these gross motor skills continue to improve (Broderick & Blewitt, 2010; Dacey & Travers, 2006). Children do not develop the fine motor skills necessary to copy the image of a square or hold a pencil or complete a

puzzle until the age of four (Broderick & Blewitt, 2010; Dacey & Travers, 2006). It is not until age five that children become able to fully dress and undress themselves or to color within the lines and not until the age of six that they develop the fine motor skills necessary to tie knots or use a knife to cut their food (Broderick & Blewitt, 2010; Dacey & Travers, 2006). Through middle childhood limbs grow steadily which can result in a clumsy period. This is overcome with the continued improvement of motor skills. While many of the tasks discussed above are easily completed by the average adult or adolescent, children at various stages of development lack the fine and gross motor skills required to complete them. Until their fine and gross motor skills are fully developed, they may simply be unable to complete tasks done so easily by the typical adult.

Adolescence is a time marked by several physical changes, many of which are associated with puberty. Rapid skeletal growth, appearance of body hair under the arms, and pubic areas, and growth spurts are common for both sexes. Females also develop breast tissue and begin menstruation while males will experience hair growth on their chest and face, an enlargement of their genitals and a deepening of their voice. There is a significant increase of hormones during the period of adolescence in place to sculpt neural circuits and conduct the processes responsible for puberty (Sisk & Zehr, 2005). These hormones can have a significant impact on the emotions and behavior of adolescents (Steinberg, 2009). These outward and inward physical changes are unique to this time of life for an individual and require special consideration when working with this special population.

As the brains of children and adolescents grow and develop physically, so do their cognitive abilities. Piaget describes those in early childhood as being in the preoperational stage of cognitive development. Those between 2 and 4 are within the preoperational sub-

stage, which is categorized by the beginnings of symbolic play and being able to think of an object that is not present by use of language. Those between the ages of 4 and 7 are typically in what Piaget refers to as the intuitive stage. Children in this stage lack reversibility and an understanding of the concept of conservation. Children during this period of development are likely to focus on one aspect of an object while ignoring other and have difficulties distinguishing a whole from a part. Children during this stage also experience egocentric thought (Piaget, 1962; Piaget 1972; Piaget & Inhelder, 1969). Children between the approximate ages of 7 and 11 are in what Piaget referred to as the concrete operational stage characterized by the appearance of conservation, reversibility, and classification in thinking. The ability to place items in order according to size emerges as does an understanding of numbers (Piaget, 1962; Piaget 1972; Piaget & Inhelder, 1969).

Children around the age of 11 are typically in the formal operational stage, which will continue into adulthood. During this stage children are able to combine many of the cognitive skills mastered in previous stages. Abstract concepts are able to be understood and there is an increase in logical thinking and critical thinking (Piaget, 1962; Piaget 1972). Due to high levels of egocentrism adolescents tend to experience what is known as an imaginary audience during which they experience the feeling that those around them are watching them as well as a belief in their invincibility (Adams & Jones, 1981; Alberts, Elkind & Ginsberg, 2006). As children and adolescents move through Piaget's stages of cognitive development their abilities continue to expand and improve. It is important to consider, however, that due to cognitive development's stage like progression, at various times through the period of childhood and adolescence individuals lack the cognitive skills found in normally functioning adults.

Kohlberg (1966) asserted that the moral development of individuals begins in early childhood and continues in a series of levels and stages. The initial level, preconventional, includes children between the ages of 4 and 10. The level is comprised of stage 1, where children obey rules in order to avoid punishment, and stage 2, where children obey rules but for the benefit of themselves. The conventional level includes children approximately 10 to 13 years of age. This level contains stage 3, during which children seek the approval of others and begin to judge actions based on intention and stage 4, in which children hold a law and order mentality focused on obeying authority and maintaining social order. The final level, post-conventional includes those 13 and older. This level consists of stage 5, where individuals are focused on the laws, as they view them as accepted by society as a whole, and stage 6, where they are guided by an informed conscience of right and wrong (Kohlberg, 1966). The manner in which a child or an adolescent will make choices, and the choices themselves will depend largely on where they are developmentally and these choices may differ greatly from the choices and logic held by an adult in a higher stage of development.

The child's concept of self is primarily positive and concrete before the age of four but as language and cognitive skills improve, so does their ability to examine their social and emotional characteristics (Harter, 1998). During middle childhood the sense of self continues to develop as they begin to compare themselves to others. By late adolescence individuals' perceptions of themselves are tied to their internal traits, beliefs, personal philosophy and moral standards (Damon & Hart, 1988).

This sense of self contributes to the overall identity of the adolescent. This identity development involves the integration of different dimensions of adolescent's life including, among others, spiritual identity, racial/ethnic identities, and vocational plans (Phinney,

1992).

The different placement of children and adolescents from adults on the development continuum results in differences within the counseling process (Prout, 2007). Given their stage of development of their cognitive abilities children and adolescents are less likely to understand the purpose and goals of counseling compared to adults. Prout (2007) warned that children and adolescents may be more likely than adults to have mistaken beliefs about counselors and the counseling process which may impact their expectations for the process and the roles of both clinician and client. Not only are children and adolescents bound by where they are in terms of cognitive development, they are also sometimes lacking the language skills necessary to fully express their feelings and thoughts which can have a large impact in counseling (Broderick & Blewitt, 2010; Prout, 2007). Language skills are still developing throughout childhood making verbal expression at certain stages limited, therefore, adults are more likely to engage in reflecting, talking and responding to questions than are children or adolescents (Prout, 2007). While children may have difficulty using language during this developmental period, they rely on play and other nonverbal methods for much of their expression (Broderick & Blewitt, 2010; Landreth, 2002). Children and adolescents are also more likely to be involuntary clients, being brought in by a caregiver or an outside system, which in turn may impact their motivation to participate in counseling (Prout, 2007).

Children and adolescents differ from adults physically and physiologically, as well as in their cognitive abilities and reasoning. These differences result in unique needs in counseling (Prout, 2007). Because overgeneralization of knowledge and skills from one population onto a population known to be different is inappropriate, applying knowledge of

adult psychotherapy onto children and adolescents is unethical. "[O]ne cannot simply borrow knowledge from adult psychopathology and apply it to children, nor can one transfer understanding of adult problems to understanding children's concerns" (Lawrence & Robinson Kurpius, 2000, p. 132). Because children and adolescents differ from adults in terms of motor skills, logic, reasoning, language and how they view the world, many approaches developed for use with adult populations are inappropriate and ineffective. Mental health issues impact children and adolescents both in and out of the classroom (U.S. DHHS, 1999), children and adolescents receive services in non-school settings (SAMSHA, 2009), and children and adolescents are distinct from adults (Piaget, 1962; Kohlberg, 1966); therefore, graduate counseling training programs must adequately prepare their counselor trainees to work with children and adolescents in non-school settings through specific training that addresses these needs.

Counselor Training to Work with Children and Adolescents in Non-school Settings

Given the ways in which children and adolescents are distinct from adults, it is critical that professional counselors working with this population receive specialized training (Geldard & Geldard, 1997). Adolescents and children are a special and diverse population; therefore, it is the ethical responsibility of professional counselors working with this population to receive specific training, education, and supervised practice prior to becoming independent practitioners (Lawrence & Robinson Kurpius, 2000).

The American Counseling Association (ACA) *Code of Ethics* highlights the importance of professional counselors having a thorough understanding of individuals across the lifespan; "ACA members are dedicated to the enhancement of human development throughout the life span" (ACA, 2005, p. 3). Lawrence and Robinson Kurpius (2000) warned

that those without knowledge of child and adolescent development are at risk of engaging in unethical practice as they have inadequate knowledge of their minor clients. Lack of specific training to work with children and adolescents can lead to professional counselors feeling uncomfortable or unprepared to work with this population. As a result of these feelings of discomfort working with children, it was found that counselors often avoided family therapy (Raimondi & Walters, 2004).

While the needs of children and adolescents are found to be distinct from those of adults there remains (Prout, 2007) no national standard of training that exists to work with this population. There is also an absence of specific licensure or certifications required to work with children and adolescents in non-school settings despite the need to specialized knowledge and experiences, as illustrated in the literature (Lawrence & Robinson Kurpius, 2000). There are no safeguards in place within the field of counseling that ensure that professional counselors have obtained training experiences that would indicate they have even a general readiness to work with children and adolescents in non-school settings. As most professional counselors will at some point in their career work with a child (Van Velsor, 2004), it is critical that they be trained to do so effectively.

Despite the lack of existing standards for knowledge and training experiences to work with this special population, several organizations have established credentials that pertain to specific techniques, approaches, or specializations (Appendix A). These credentials typically require extensive training, experience and supervision beyond a Masters level degree. These credentials, including those in the field of play therapy, distinguish which professional counselors are qualified to perform highly specialized interventions or techniques, but do not address a general readiness to counsel children and adolescents.

CACREP accredits 540 masters programs. Of those, 32 are Clinical Mental Health, 156 are Community Counseling, and 55 are Mental Health Counseling programs (CACREP, 2012). These programs train professional counselors who may work with adults and/or children and adolescents in non-school settings. Given the importance of CACREP to the field of counseling and its role in helping programs produce counselors who work with children and adolescents in non-school settings, it is important to note that the 2009 CACREP Standards section which details the requirements of Clinical Mental Health Counseling programs and graduates contains no mention of children or adolescents. The common core curricular section of the 2009 CACREP standards require human growth and development "studies that provide an understanding of the nature and needs of persons at all developmental levels and in multicultural contexts…" (CACREP, 2009, p. 11). Only briefly do the most current Clinical Mental Health Counseling standards address developmental levels of clients when it states that graduates should have the skills to differentiate "between diagnosis and developmentally appropriate reactions during crises, disasters, and other trauma-causing events" (CACREP, 2009, p. 35). Although the 2009 CACREP standards stress the importance of human growth and development coursework, there is no requirement that courses specifically discuss how to counsel children and adolescents. Graduates of CACREP Clinical Mental Health (2009 CACREP standards), Community Counseling and Mental Health Counseling programs (2001 CACREP standards) who work with children and adolescents in non-school settings are not required to demonstrate skills to effectively counsel this population, nor are they required to take any coursework specific to working with this population beyond what can be found in the common core human growth and development courses

Many scholars and organizations have provided training recommendations to work with children and adolescents in non-school settings despite the lack of national training standards (e.g. Association for Play Therapy (APT), 2009; Lawrence & Robinson Kurpius, 2000; Raimondi & Walters, 2004; U.S. Department of Health and Human Services, 1999). It is suggested that "offering specialized coursework and clinical experiences may be the most efficient method to improve counselor preparation for both basic and advanced skills for mental health counseling with youth" (Mellin, 2009, p. 151).

Numerous researchers and organizations have suggested specific coursework related to specialty areas (see APT, 2009; CACREP, 2009). One area of study that has received attention is child development (APT, 2009; CACREP, 2009; Lawrence & Robinson Kurpius, 2000; Raimondi & Walters, 2004; U.S. DHHS, 1999). Lawrence and Robinson Kurpius (2000) asserted that a thorough background in child development including ego identity development, moral development, psychosexual development, and cognitive development is essential to working with this population. Raimondi and Walters (2004) outlined specific recommendations for graduate training programs training professional counselors to work with families. While they recommend child development coursework, they also recommend coursework be aimed at the application of child development knowledge. As mentioned above, the only area where the CACREP standards address the importance of specific training to work with this population is when it states that students must be trained in "studies that provide an understanding of the nature and needs of persons at all developmental levels and in multicultural contexts" including "theories of individual and family development and transitions across the life span" (CACREP, 2009, p. 11).

In addition to a child development course, other courses have been recommended to

ensure competence to work with children and adolescents in non-school settings. Raimondi and Walters (2004) recommended coursework on appropriate techniques for working with children. During the Surgeon General's Conference on Children's Mental Health (U.S. PHS, 2000), the 300 participants developed a series of goals to improve the conditions of children's mental health in the United States. An action step to one such goal developed during the conference specifically focused on training of mental health professionals; "encourage professional boards for mental health specialists (e.g., psychiatry, psychology, social work, and nursing) to require training in: evidence-based prevention and treatment interventions; outcome-based quality assurance; competency-based assessment and diagnostic skills; principles of culturally-competent care; and engaging youth and families as partners in assessment, intervention, and outcome monitoring," (U.S PHS, 2000 p. 9).

While the Association of Play Therapy (APT, 2010) has many requirements for counseling professionals specific to play therapy techniques in order to earn the credential Registered Play Therapist (RPT), APT also requires those carrying their credential receive training in theories of personality, principals of psychotherapy, child and adolescent psychopathology, and legal, ethical, and professional issues specific to working with children. This recommendation demonstrates APT's belief in the importance having a solid foundation in child and adolescent coursework for those who work with this population.

Mellin (2009) suggested that counselors working with children be trained in the psychotropic drugs commonly prescribed to children as well as the potential effects these medications may have on children's moods and behaviors. There has been a dramatic increase in the use of psychotropic drugs by children in recent years, particularly stimulants and antidepressants (Olfson, Marcus, Weissman & Jensen, 2002; Thomas, Conrad, Casler &

Goodman, 2006) and the knowledge of these medications by professional counselors is becoming increasingly important.

Several scholars highlight the importance of learning the skills not only to work with the child, but also with the systems in which the child lives. Raimondi and Walters (2004) recommended coursework on counseling children and adults together. Mellin and Pertuitt (2009) asserted that counselors need to be trained to work across many systems including but not limited to family, school, and community. Counselors need not only a solid foundation of individual and group work skills specific to children and adolescents, but also interventions to work with families, schools and community levels (Mellin & Pertuitt, 2009).

CACREP (2009) requires that all graduates complete practicum and internship experiences. While the current standards contain requirements on hours and supervision, there are currently no requirements for those who work with children or adolescents in non-school settings to have completed any supervised clinical practicum or internship working with that population in that setting. It is essential that those working with a special population have supervised experience prior to working with the special population to ensure they are competent to do so. Lawrence and Robinson Kurpius (2000) recommended that counselors working with children and adolescents participate in supervised practice prior to becoming independent practitioners. This sentiment is echoed by Raimondi and Walters (2004) who suggested that programs provide opportunities to practice counseling skills with children and families as part of graduate training.

Hoge, Huey, and O'Connell (2004) recommended that those who plan to work with a special population, as is children and adolescents, need to train at locations that are known to excel in counseling that special population and that a general training will not suffice. Mellin

(2009) encouraged counselor education programs to develop a practicum and internship model that would replicate the shift in training made by Division of Child Psychiatry at the University of Maryland, where students are exposed to a wide variety of child mental health settings in order to better prepare them for potential future work settings. To mirror this mode,l Mellin (2009) suggested that mental health counseling students be placed in juvenile court, child welfare, and state hospital settings to provide a wider breadth of training experiences.

State of Current Child and Adolescent Mental Health Services

There has been a significant shift in the mental health service delivery for children and adolescents in response to reports that the mental health system for this population is in crisis. The Surgeon General Conference on Children's Mental Health identified this crisis and asserted that the organizations designed to care for children are failing to meet their emotional, behavioral and developmental needs and that children are suffering as a result of this failure (U.S. PHS, 2000). The President's New Freedom Commission on Mental Health's report Achieving the Promise: Transforming Mental Health Care in America (2003) also outlined suggested changes in the delivery of mental health services. The report called for significant changes in the clinical practice models and organization of services in order to better meet the needs of both adults and children and adolescents. There is an increasing concern that counselor training is not reflecting the changing trends seen in recent decades in the areas of service delivery, demands of the work of a counselor to children and adolescents, and the needs of the children and adolescents and their families (Meyers, Kaufman, & Goldman, 1999). The development of service delivery models has simply outpaced the preparation of service delivery workers, including counselors (Huang et al., 2004). While

changing curricula may be a challenge that counselor education programs are unable to meet due to constraints with accreditation, it is important that when this is the case counselor educators infuse children and adolescents centered content into existing courses and clinical experiences (Mellin & Pertuitt, 2009).

A significant contribution to the crisis of poor mental health services for children and adolescents is the shortage of and the lack of retention of professional counselors to work with children and adolescents in non-school settings (Huang et al., 2004; U.S. DHHS, 1999). As a result of this shortage there has been an increase of professional counselors working with children and adolescents that have no specific training to work with this special population (Koppelman, 2004). Staffing these positions with inadequately trained professional counselors puts the children and adolescents at risk for receiving ineffective or potentially harmful counseling services. Mellin and Pertuitt (2009) warned " the lack of preparation, professional development, and research specific to mental health counseling with youth likely contributes to problems in mental health services for children and adolescents" (Mellin & Pertuitt, 2009, p. 137).

While millions of children and adolescents suffer from mental health disorders (Costello et al., 1998; Merikangas et al., 2010; U.S. Department of Health and Human Services, 1999; U.S. PHS, 2000) and receive treatment for these disorders in non-school settings (SAMHSA, 2009), there exists no nationally accepted training standards for professional counselors who work with children and adolescents in non-school settings. Despite the fact that graduates of CACREP accredited Clinical Mental Health Counseling programs are permitted to work with children and adolescent clients, the 2009 CACREP standards for the program makes no mention of children, adolescents, or the appropriate

training necessary to work with this population (CACREP, 2009). This lack of training standards leaves counselors at risk to be ineffective or potentially harmful to children and adolescent clients, putting them at risk (Mellin & Pertuitt, 2009).

Numerous scholars and organizations have developed recommendations for training for counselors working with this population including specific coursework (e.g.; APT, 2009; CACREP, 2009; Lawrence & Robinson Kurpius, 2000; Raimondi & Walters, 2004; U.S. Department of Health and Human Services, 1999), classroom experiences (Mellin & Pertuitt, 2009), practicum experiences, (Hoge et al., 2004; Mellin, 2004). What is noticeably absent from the literature is research examining whether the recommendations for curricula changes are in fact in line with the experiences of professional counselors who work with children and adolescents in non-school settings. To date, there have been no published examinations of the experiences of professional counselors who work with children and adolescents in non-school settings. The education and training experiences that professional counselors feel contributed to their ability to effectively work with this population have not yet been identified. With this knowledge, counselor education programs can incorporate these experiences into their curricula, therefore producing more competent and prepared professional counselors to work with children and adolescents in this setting. As professional counselors and counselor educators we are obligated to advocate for the children and adolescents receiving mental health services by clinicians who have not been adequately trained. This advocacy can begin through the completion of research that will help to inform curriculum change.

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CHAPTER 2

EXPERIENCES OF PROFESSIONAL COUNSELORS WHO WORK WITH CHILDREN AND ADOLESCENTS IN NONSCHOOL SETTINGS

There is a growing concern related to the mental health of children and adolescents in the United States. This growing concern is partially based on the increasing number of children and adolescents who meet the diagnostic criteria for mental health disorders. In the United States, one in five children meets the diagnostic criteria for a mental health disorder and one in ten children and adolescents experience symptoms of mental health disorders which lead to impairment (U.S. Department of Health and Human Services (U.S. DHHS), 1999; U.S. Public Health Services (U.S. PHS), 2000). The prevalence of mental health disorders has been widely researched (Cohen et al., 1993; Costello et al., 1988; Costello et al., 1996; Costello et al., 1998; Costello, Farmer, Angold, Burns, & Erkanli, 1997; Merikangas et al., 2010; Shafer et al., 1997). Costello et al. (1988) conducted a meta-analysis of studies examining the prevalence of mental health disorders in children and adolescents in the United States and Puerto Rico. A global prevalence rate for youth with severe emotional disturbance, as defined by the Federal Register, was found to be 4.4% to 7.4% with a median of 5.4%. Costello et al. examined dysfunction on the domains of social functioning, school functioning and activities. Prevalence rates for youth with a mental health disorder and dysfunction within any one of the three domains was 5.5% to 16.9% with a median of 7.7%. These findings equate to 3 million children and adolescents in the United States between the ages of 4 and 17 meeting the global criteria for impairment. In a recent study, Merikangas et al. (2010) administered the National Institute of Mental Diagnostic Interview to 3,024 children and adolescents between the ages of 8 and 15 at mobile examination centers of the National Health of Nutrition Survey. Prevalence rates for specific

disorders were found including Attention Deficit Hyperactivity Disorder (8.7%), mood disorders (3.7%), conduct disorder (2.1%), panic disorder/general anxiety disorder (0.7%) and eating disorders (0.1%).

Friedman, Katz-Leavy, Manderschied, and Sondheimer (1996) asserted that clearly identifying prevalence rates is difficult and warned that there is a risk in over simplifying through the process of attempting to identify prevalence rates. Differences of prevalence rates exist across ethnicity, race, age, gender, socio-economic status and community; however, it is unclear in the literature as to why these differences are present (Friedman, et al., 1996). While the challenges associated with reporting prevalence rates of mental health disorders among youth must be acknowledged, the vastness of mental health disorders is clear.

The impact of mental health disorders in children and adolescents is evident at school, at home, and with their relationships with peers (U.S. DHHS, 1999). Children and adolescents with mental health disorders have been found to be at a higher risk for school failure, family conflicts, drug abuse, violence and suicide (Substance Abuse and Mental Health Services Administration (SAMHSA), 2003; Wagner, Newman, Cameto & Levine, 2005). Suicide is the third leading cause of death in individuals aged 10 to 24 years. Additionally, the number of suicide attempts far outnumbers the number of completed suicides (U.S. DHHS, 2008). According to a nation study conducted by the U.S. DHHS (2008), 7% of adolescents reported having attempted suicide within the last twelve months. Those who struggle with mental illness in childhood can see lasting effects into adulthood if the mental health disorder goes untreated (U.S. PHS, 2000; Rapoport, 2000). Because a failure to address the mental health concerns of children and adolescents can have a

significant impact on individuals across their lifespan, it is critical that professional counselors be adequately trained to work with children and adolescents.

Children and Adolescents in Counseling

Children and adolescents receive services for behavioral and emotional problems both in school and non-school settings (SAMHSA, 2009). While 11.5% of adolescents between the ages of 12 and 17 received services in a school setting within the last twelve months, 12.5% received services in a specialty mental health setting. Children and adolescents received services in a variety of specialty mental health settings including hospital (2.0%), residential treatment center (0.8%), foster care or therapeutic foster care home (0.4%), private therapist, psychologist, psychiatrist, social worker or counselor (9.4%), mental health clinic (2.3%) day treatment program (1.7%) and in-home therapist, counselor or family preservation worker (2.3%). Merikangas et al. (2010) asserted that mental health services for children and adolescents have been on the rise in recent decades. The authors found that of those children and adolescents who met the DSM-IV diagnostic criteria for a mental disorder, 50.6% have received mental health services for their symptoms. These findings were markedly higher than those found by Costello et al. (1998) who reported that 22.8% to 27.4% of children and adolescents who meet DSM-IV diagnostic criteria received services.

Once in mental health services, children and adolescents have special needs in counseling. "[O]ne cannot simply borrow knowledge from adult psychopathology and apply it to children, nor can one transfer understanding of adult problems to understanding children's concerns" (Lawrence & Robinson Kurpius, 2000 p. 132). Children and adolescents have yet to complete many developmental milestones and thus are distinct form adults. This difference in development yields special needs within a counseling relationship.

Children and adolescents differ from adults physically (Steinberg, 2009) but they also differ in terms of their cognitive functions and abilities (Piaget & Inhelder, 1969; Piaget 1972) language development (Broderick & Blewitt, 2010; Prout, 2007) and moral development (Piaget & Inhelder, 1969; Piaget 1972). The ways in which children and adolescents think including the choices they make, the manner in which they make those choices, and the way they view the world will depend largely on where they are in terms of cognitive development. Each of these aspects of cognition may differ greatly from those held by an adult in a higher stage of development.

These developmental differences result in unique needs in counseling for children and adolescents (Prout, 2007). Children and adolescents are more likely to have mistaken beliefs about counseling and the roles of professional counselors and clients. They are also less likely to have a clear understanding of the purpose of counseling than their adult counterparts (Prout, 2007). During the period of childhood and adolescence individuals are bound not only by their cognitive development but also language development. Depending on their place on the developmental continuum of language, children and adolescents may lack the skills necessary to express their thoughts and feelings verbally (Broderick & Blewitt, 2010; Prout, 2007). For this reason, they are less likely than adults to engage in activities associated with talk therapy including reflecting, responding to questions, or sharing verbally (Prout, 2007). Instead, much of this expression is done via nonverbal methods including play therapy (Landreth, 2002; Broderick & Blewitt, 2010). Because adults are distinct from children and adolescents in terms of how they view their world, as well as their motor skills, logic, reasoning and language, it is inappropriate for interventions and approaches developed for use with adults to be implemented with children and adolescents. Because children and

adolescents are distinct from adults (Kohlbert, 1966; Piaget, 1962), have special needs in counseling (Prout, 2007, Lawrence & Robinson Kurpius, 2000), and receive services in non-school settings (SAMSHA, 2009), it is necessary that professional counseling programs provide training to work with this special population effectively (Geldard & Geldard, 1997; Lawrence & Robinson Kurpius, 2000).

Training to Work with Children and Adolescents in Non-school Settings

A clear understanding of individuals across the lifespan is essential to professional counseling (ACA, 2005) and a failure to acquire the necessary training to work with this population would put the counselor at risk for engaging in unethical practice as they may hold insufficient knowledge to work effectively with youth client (Lawrence & Robinson Kurpius, 2000). Despite this, no licensure, certification or national standards of training to counsel children and adolescents in non-school settings are in place. While there are credentials (e.g., Registered Play Therapist) that have been established by various organizations (e.g., Association for Play Therapy (APT)) that pertain to specific techniques or approaches, these credentials require extensive training and supervision beyond a master's degree and do not address a general readiness to counsel children and adolescents. No safeguards are in place to ensure that those working with children and adolescents have the training or the skills necessary to do so.

The Council for Accreditation of Counseling and Related Educational Programs (CACREP) accredits 540 masters programs including 32 Clinical Mental Health programs, 156 Community Counseling Programs and 55 Mental Health Counseling Programs (CACREP, 2012. The 2009 CACREP standards detailing the requirements of Clinical Mental Health Counseling programs do not contain any mention of youth, children or adolescents.

The only mention of topics pertaining to children and adolescents is in the discussion of the Human Growth and Development core which applies to all CACREP programs where the standards require "studies that provide an understanding of the nature and needs of persons at all developmental levels and in multicultural contexts…" (CACREP, 2009, p. 11). The standards only briefly discuss the importance of an understanding of developmental levels within the Clinical Mental Health program standards when it states that graduates should have the skills to differentiate "between diagnosis and developmentally appropriate reactions during crises, disasters, and other trauma-causing events" (CACREP, 2009, p. 35). While many graduates of CACREP programs will work with adults as their primary population, Van Velsor (2004) reminded us that nearly all counselors will work with a child at some point in their careers. Therefore, many graduates of non-school counseling CACREP programs will work with children extensively, and the CACREP standards simply to do not address the educational needs of these students.

Many scholars and organizations have made training recommendations for professional counselors working with children and adolescents in non-school settings. One such recommendation is the inclusion of specific coursework. Coursework in child development (APT, 2009; Lawrence & Robinson Kurpius, 2000; Raimondi & Walters, 2004; U.S. DHHS, 1999), appropriate techniques for working with adults and children together (Raimondi & Walters, 2004), psychotropic drugs frequently prescribed to children and their effects (Mellin, 2009) and working across systems (Mellin & Pertuitt, 2009) have all been recommended. The Surgeon General's Conference on Children's Mental Health (U.S. PHS), 2000) recommended that professional counselors encourage boards for mental health specialists to "require training in: evidence-based prevention and treatment interventions;

outcome-based quality assurance; competency-based assessment and diagnostic skills; principles of culturally-competent care; and engaging youth and families as partners in assessment, intervention, and outcome monitoring" (U.S PHS, 2000 p. 9). In addition to the play therapy specific criteria for earning credentials through the APT (APT, 2010), APT requires those carrying their credential receive training in theories of personality, principals of psychotherapy, child and adolescent psychopathology, and legal, ethical and professional issues specific to working with children. These requirements demonstrate APT's belief in the importance of those who work with children and adolescents to have a solid foundation of population specific coursework.

CACREP requires that a practicum and internship be completed by all students in their accredited counseling programs but does not require that those who intend to work with children and adolescents work with this population as part of their training. While not present in the standards, it has been recommended that professional counselors who work with youth in non-school settings have supervised experience with children and families (Raimondi & Walters, 2004) and that clinical experience with the population occurs prior to counselors becoming independent practitioners (Lawrence & Robinson Kurpius, 2000). Hoge, Huey, and O'Connel (2004) asserted that when training to work with a special population, such as children and adolescents, it is critical that training be done at a location known to excel in working with that population. Mellin (2009) encouraged counselor education programs work to expose students to the wide variety of non-school settings in which professional counselors may work and suggests that mental health counseling students be placed in juvenile court, child welfare, and state hospital settings to provide a wider breadth of training experiences.

Crisis in Child and Adolescent Mental Health Services

There is increasing concern that the services being provided to children and adolescents in non-school settings are inadequate, even in crisis, and that that children and adolescents are suffering as a result (Mellin, 2009; U.S. PHS, 2000). The President's New Freedom Commission on Mental Health's report Achieving the Promise: Transforming Mental Health Care in America (2003) called for significant changes in the clinical practice models and organization of services in order to better meet the needs both adults and youth. There is concern that counselor training is not reflecting the changing trends seen in counseling in recent decades including service delivery, work demands on counselors and the needs of the children and adolescents and their families (Meyers, Kaufman & Goldman, 1999). The development of service delivery models has simply outpaced the preparation of service delivery workers, including counselors (Huang et al., 2004). When challenges exist which make changing curricula impossible, such as meeting accreditation criteria, it is critical that counselor educators infuse child and adolescent centered content into existing courses and clinical practice.

Noticeably absent from the existing literature is research examining whether the recommendations for curricula changes are in fact in line with the experiences of professional counselors who work with children and adolescents in non-school settings. To date, the training and clinical experiences of professional counselors who work with children and adolescents in non-school settings have not been examined. The education and training experiences professional counselors feel contributed to their ability to effectively work with this population have not yet been identified. With a greater understanding of the experiences of these professional counselors, counselor education programs can more appropriately

construct training experiences, therefore producing professional counselors more competent and prepared to work with children and adolescents in these settings. Professional counselors and counselor educators are obligated to advocate for the children and adolescents that are receiving mental health services by clinicians who have not been adequately trained. It is important that counselor educators consider that "the lack of preparation, professional development, and research specific to mental health counseling with youth likely contributes to problems in mental health services for children and adolescents", (Mellin & Pertuitt 2009, p. 137). It is critical that counselor educators begin to see addressing the crisis in professional counselor training to work with this special population as advocacy for children and adolescents, for counseling students, and for the counseling profession. This advocacy can begin through the completion of research that will help to inform curricula change.

There has been a recent call for research exploring the training and competencies of counselors who work with youth in non-school settings (Mellin, 2009; Mellin & Pertuitt, 2009). Mellin (2009) asserted that there is a crisis in the children's mental health services in the United States and urged researchers to address these issues by identifying which content areas professional counselors report having adequate or inadequate levels of preparation. Her call for research also included identifying necessary competencies and using the education level and preparation programs to determine the level of impact training may have on the service outcomes for children and adolescents and their families.

Mellin and Pertuitt (2009) polled counselor educators and practicing counselors using the Delphi method to develop research priorities for mental health counseling with children and adolescents. The participants identified numerous research priorities including: "What do counselors primarily working with youth identify as their weakest knowledge and skills

domains regarding the counseling they provide?", and, "What amount of youth-specific counseling training comes from outside the graduate program?" (pg 145). These identified research questions serve as a call for research to address these questions. Given this call for research and the previous findings in the literature, the purpose of this study is to address the question 'What are the experiences of professional counselors who work with children and adolescents in non-school settings?' This main question has two sub-questions:

1. What are the training experiences of professional counselors who work with children and adolescents in non-school settings?
2. What are the clinical experiences of professional counselors who work with children and adolescents in non-school settings?

Method

Conceptual Context and Theoretical Orientation

It is critical to examine the experiences of experienced professional counselors who work with children and adolescents in non-school settings to better understand what training experiences are most significant in the development of competency to work this special population. By interviewing professional counselors who are working successfully with this population, it is the researcher's hope to identify commonalities between their experiences which may be helpful in the development of competencies as well as training standards for professional counselors who work with children and adolescents in non-school settings. A qualitative approach was the most appropriate method for these research questions because it it provides participants the space to share in detail their perspectives. The purpose of the grounded theory was to produce innovative theory grounded in data (Strauss & Corbin, 1998). The data from which the theory was derived was of the participants lived experiences

within a social context (Fassinger, 2005). Guba and Lincoln's (1989) Fourth Generation Evaluation was the guide from which the structure of the grounded theory was derived. Charmaz's (2000) constructivist approach provided the framework to interpret the participants' data.

Research Team

The research team was comprised of three members. The primary researcher is a Caucasian female doctoral candidate in a counselor education and practice program (CACREP accredited) at an urban southeastern university. At the time of the study, she had four years of clinical experience counseling in non-school settings including community based counseling centers and group homes. She also worked for two years providing individual and group counseling to adolescents within a school setting as a contract counselor.

The second member of the research team is a Caucasian male and a doctoral candidate in counseling psychology at an urban southeastern university. At the time of the study, he had five years of clinical experience counseling adults in a college and community setting. Having an individual on the research team who did not work with children was helpful in providing an alternative perspective. This team member has been a team member of numerous qualitative research studies.

The final member of the team is an African American female, Master's level student in professional counseling. During the time of the project the team member began seeing clients in private practice setting seeing adults, children, and adolescents. The team member had ten years experiences in the field of student affairs before beginning her career in professional counseling.

In addition to the research team, there were a dependability auditor and a confirmability auditor who were charged with the task of ensuring that the research team made methodological decisions that were appropriate (Guba & Lincoln, 1989). The dependability auditor examined the methods to ensure that all decisions made are appropriate and that method was carried out in the manner that is reported by the researcher. The dependability auditor is an African American Male with fifteen years of experience as a school counselor. He is also a counselor educator and has experience as the primary researcher in grounded theory studies as well as a member of several qualitative study research teams. The confirmability auditor reviewed the audit trail in an effort to identify any ways that the research teams' biases may have impacted the findings. The confirmability auditor examined the themes identified to by the research team to ensure those themes can be linked directly to the statements of the participants. The confirmability auditor is a Caucasian female counselor educator at a southwestern university. She has 11 years of experience as a school counselor as well as four years of experience working with children in non-school settings. She has experience as both primary researcher and research team member in qualitative research studies.

Participants

It was essential that participant selection be purposeful to ensure that the data collected was rich for in-depth study. The primary researcher implemented chain sampling in order to obtain a sample that is most appropriate for the study (Charmaz, 2006). In order to be eligible for this study, participants must have had a minimum of 5 years post masters experience counseling children and/or adolescents in a non-school setting, be counseling youth in a non-school setting at the time of the interview, be fully licensed and be a graduate

of a non-school counseling CACREP accredited masters program. During the recruitment process, it was determined that the criteria of holding a degree from a CACREP accredited masters program would disqualify professional counselors who were trained prior to CACREP's formation in 1981. In order not to eliminate professional counselors who were rich with experience and information and had been trained prior to this date from the research pool, the CACREP requirement was removed from the selection criteria. The requirement for participants to have graduated from a non-school counseling masters or more advanced degree program remained in place.

Demographic information for participants can be found on Table 1. Of the participants, 12 were women and 2 were men. Two identified as Latino/a, 1 identified as Angle and 11 identified as Caucasian. The ages of participants ranged from 33 to 66 with an average of 51 years. The participants averaged 18.6 years of counseling experience with a median of 17.5 years. Participants' experience working with children and adolescents averaged 17.8 years with a median of 17.5 years. The participants were located in five states including southeastern (12), northeastern (1) and southwestern (1) parts of the United States.

All participants were actively seeing clients at the time of the study. Participants spent an average of 70.3% of their clinical time with children and adolescents with median of 80.0%. The average time spent with adolescents was 22.6% with a median of 25% and the average time spent with children was 53.0% with a median of 50.0%. Ten participants currently worked in a private practice setting, 3 in a community based mental health center and one participant worked in both a community and private practice setting.

Table 1: *Demographics of Participants*

Participant	Gender	Licensure	Highest Degree Held	Setting	Years Counseling Children and Adolescents	Ethnicity
Ann	F	LPC, LMFT, RPT-S	M.Ed. Counseling	P	40	Caucasian
Jo	F	LPC	Ph.D. Child & Family Development	P & C	17	Caucasian
Kelly	F	LPC	M.S. Psychology	C	23	Caucasian
Elizabeth	F	LPC, RPT-S	Ph.D. Counselor Education	C	20	Angle
Kitty	F	Licensed Psychologist	Ph.D. Human Development	P	18	Caucasian
Katie	F	LPC, RPT-S	Ph.D. Counseling	P	11	Caucasian
Beth	F	LPC	M.Ed. Community Counseling	P	16	Caucasian
Mary	F	Licensed Psychologist	Ph.D. Clinical Psychology	P	13	Hispanic
Sarah	F	Licensed Psychologist	Ph.D. Clinical Psychology	P	20	Hispanic
Sally	F	LPC	M.Ed. Professional Counseling	P	7	Caucasian
Sam	F	LPC	Ed.S. Professional Counseling	C	5	Caucasian
LR	M	Licensed Psychologist	Ph.D. Clinical Psychology	P	25	Caucasian
Yolanda	F	LPC	Ph.D. Counseling	P	5	Caucasian
TB	M	Licensed Psychologist, RPT-S	Ph.D. Developmental Psychology	P	30	Caucasian

* LPC- Licensed Professional Counselor, LMFT- Licensed Marriage and Family Therapist, RPT-S- Registered Play Therapist Supervisor, P- Private Practice, C- Community Based Mental Health Center

The educational backgrounds of participants varied. Four of the participants held Masters Degrees only. One participant's highest degree was an Education Specialist degree and nine participants held Doctoral degrees. One participant's highest degree was an Education Specialist degree in professional counseling. The highest degree held by four participants was a Masters degree. These degrees were in counseling, psychology,

community counseling and professional counseling. The nine participants with Doctoral degrees graduated from programs in child and family development (1), counselor education (1), human development (1), counseling (2), clinical psychology (3), and developmental psychology (1).

Procedure

To identify participants that would meet both the selection criteria and who their colleagues viewed as demonstrating exceptional practice, the primary researcher contacted professional colleagues via email and included the following questions as adapted from Rice (2010):

1. Who do you consider to be a highly effective or experienced professional counselor of children and adolescents in non-school settings?
2. Who would you refer your child or relative to for counseling?
3. Who do you feel has exceptional counseling skills for working with children and adolescents in non-school settings?

Recruitment emails also included the inclusionary criteria for the study.

The primary researcher also sent email correspondence to professional counseling associations known to have a membership who work with children and adolescents including the Association for Creativity in Counseling and the Association of Children and Adolescent Counseling. These associations were contacted and it was requested that the call for research be placed on the association listservs or be emailed to their membership. Finally, the board members of the Association for Play Therapy were contacted and provided the same email sent to professional contacts to further identify participants who met selection criteria. Once a potential participant had been identified by one of the avenues listed above, the primary

researcher contacted and screened the participant to determine if he/she met the selection criteria at which point he/she was invited to participate in the study. After the completion of the interview, participants were asked if they knew of other professional counselors who met both the selection criteria and demonstrated what they viewed as exceptional practice. This process continued the chain sampling method. When participants provided referrals the referrals were contacted, invited to participate and screened to ensure they met selection criteria. This chain sampling through referrals continued until the completion of the data collection process.

After the process of referral and screening was completed, a total of 15 individuals met selection criteria and were interviewed. During the 13th interview the participant reported that while they did not graduate from a school counseling program, she completed a school counseling track within a general counseling program. With further inquiry it was discovered that she had completed school counseling coursework and completed a school counseling internship. In order to protect the validity of the study, the data from the interview was not used in the study. After the removal of the 13th participant, there remained 14 participants that were included in the study.

Before any interviews took place the primary researcher was interviewed by a member of the research team using the questions developed for the study to determine if the questions were appropriate and focused on the content intended. The bracketing interview also was completed to give the primary researcher the sense of what participants may experience while being interviewed. Copies of the interview were given to all research team members. In the first research team meeting, team members identified additional questions that should be added as well as prompts that would facilitate the interview appropriately. The

question, “What do you look for?” was added as a sub-question to “How do you determine what you want your interventions to accomplish?” to gain a better understanding of the processes the professional counselors engage in while working with clients. Additionally, it was decided to add the question “What particular strengths do you hold as a counselor of children and adolescents in non-school settings?” along with the sub-question of “Where do these strengths come from?” The question was added in an effort to learn more about what characteristics the participants feel are assets to their work. These identified characteristics may be an indication of the important characteristics necessarily to work effectively with children and adolescents.

Existing biases by all research team members were identified in an effort to keep these biases from impacting the collection and analysis of the data. The research team met prior to any participant interviews being conducted to discuss biases on the topic of non-school based counseling of children and adolescents. Topics discussed among the research team included what characteristics a professional counselor who is effective in working with this population holds, what training is necessary to work with this population in graduate work and as continuing education, and what did they expect to find. The meeting was audio recorded and transcribed by a volunteer research assistant and the research team was each provided a copy. Themes regarding biases held by team members were identified within the transcript. These biases included the belief, held by all members of the team, that specialized training is necessary to work with any special population, including children and adolescents. The team also held the bias that participants would report being lifelong learners who intentionally gain additional training after the completion of their formalized training. The team held a belief that participants, being identified by their peers as exceptional, would have

a working knowledge of child development as well as non-talk therapy interventions. They also held a bias regarding what training was necessary to become effective with this special population including supervised practicum, child development, cognitive psychology and non-talk based therapies. Additionally, the team held the bias that continuing educational experiences are necessary to remain effective with any population. As research meetings continued throughout the project, the team members remained aware of the biases held by themselves and the other members of the team and maintained a consistent dialogue regarding the ways in which biases may be influencing the manner in which the research process.

Data Collection

Data was collected through semi-structured interviews. Whenever possible, interviews were conducted in person. Six interviews were conducted face-to-face and eight interviews were conducted over the phone due the distance. Each participant was given a copy of the informed consent either in person or electronically, depending on the format of the interview (Appendix B). Each interview was audio recorded and transcribed. The participants completed a demographic questionnaire (Appendix C) which included information on sex, age, gender, race/ethnicity, education, and details of their counseling work with youth. The demographic questionnaire also asked participants to select a pseudonym to be used on all written materials associated with the study in an effort to protect confidentiality of the participants. The demographic questionnaire was collected in person or via email, depending on participant location.

Semi-Structured Interviews. The primary researcher conducted semi-structured interviews. The intensive interview method aimed at eliciting each participant's

interpretation of his or her experiences was implemented (Charmaz, 2006). A series of questions (Appendix D), designed to be open-ended and nonjudgmental to encourage unanticipated answers and stories from participants were asked including the changes made by the research team as a result of the bracketing interview (Charmaz, 2006). While the questions were asked of the participants during the interview, additional follow up questions were asked as needed to help the participant further articulate his/her meanings and intentions (Charmaz, 2006). The interviews and data analysis were recursive with data analysis being conducted following every two interviews.

Memoing. The primary researcher kept a journal in which to memo throughout the research project. Within the journal the primary researcher documented conceptual, procedural, and analytic questions and decisions (Charmaz, 2006; Fassinger, 2005). The primary researcher recorded all details from research team meetings including all decisions made, questions that developed, and topics discussed. The primary researcher also implemented cluster and free writing memoing to develop a tentative map of relationships found within the data and to allow uninhibited reflection on the data, respectively (Charmaz, 2006). The primary researcher documented all categories as they were identified as possible themes along with any data that supports that category. A confidential electronic audit trail was established at the initiation of the study. This audit trail was made available to research team members as well as both the dependability and conformability auditors so that the documentation of the study could be viewed throughout the research process.

Data Analysis

The analysis of the interviews was recursive after every two interviews. Questions were finalized after the fourth interview, when no additional changes were found necessary

by the research team. Team members coded the data independently before research team coding meetings. All members of the research team had to agree on a code before it was assigned to data. Data saturation occurs when all new data fits into existing categories and no new themes emerge (Charmaz, 2000; Morse, Barrett, Mayan, Olson, & Spiers, 2002). While the research team determined that saturation had been met after twelve interviews, two additional interviews were completed to confirm saturation had been met (Johnston, Robertson, Glildewell, Entwistle, Eccles, & Grimshaw, 2010).

Open coding. Consistent with Charmaz (2006), three levels of coding occurred as a part of data analysis. Each member of the research team received a transcription of the interviews and independently completed line by line coding (Charmaz, 2006). This method allowed the research team to remain open to the data, see the nuances within the data, and develop new ideas for codes (Charmaz, 2006). The team then met and to discuss the data. As a team it was determined that in order for a code to be placed upon data the team must have all members agreeing to the placement of the code and this remained consistent during all phases of coding. Once all members of the team agreed upon a code, the data was coded accordingly.

Axial coding. The second step of coding was axial coding (Fassinger, 2005). After the second interview had been coded, a codebook was developed to reflect the relationships between the codes emerging from the data. The categorical dimensions and properties were specified. The categories were grouped into more encompassing categories comprised of several subcategories (Charmaz, 2006; Fassinger, 2005). The data was reassembled to give coherence to the emerging data in the form of categories and their interrelationships (Charmaz, 2006; Fassinger, 2005). The codebook was continually amended after each

research meeting to reflect the changes in codes as they emerged from the data and the relationship between codes as they become better understood.

Selective coding. Axial coding lead to selective coding during which central core categories were selected that were found to integrate the other categories. This formed the beginning of the theory. Once the core category and its story are identified the research team worked to define the relationships between the core category and other categories and constructs (Fassinger, 2005). The updated codebook was used to recode all fourteen interviews.

Verification

Rigor is essential for research to maintain its utility (Morse, Barret, Mayan, Olson, & Spiers, 2002). Due to the importance of rigor, a large amount of attention is focused on reliability and validity in research methodology. Guba and Lincoln (1989) refer to the parallel concept of rigor as trustworthiness. There are four criteria for trustworthiness: credibility, transferability, dependability, and confirmability, which are parallel to internal validity, external validity, reliability, and objectivity, respectively (Guba & Lincoln, 1989). Credibility occurs when the constructed realities of the participants match that of the realities constructed by the researcher and attributed to the participants. Of the many techniques (i.e., peer debriefing, progressive subjectivity, member checks, triangluation, persistent observation, negative case analysis) for establishing credibility, this study will implement peer debriefing, progressive subjectivity and member checks.

Peer debriefing is an extended and extensive dialogue during which the findings, conclusions, tentative analysis and field stresses are discussed. The peer debriefing meetings took place among the research team before each research team meeting throughout the data

collection and coding process. During the meetings members worked to identify possible ways in which the team members own posture and values may be impacting the study, identified additional methodological steps that could be considered, identified additional hypotheses, and provided a place for catharsis to occur (Guba & Lincoln, 1989). The primary researcher documented each of the meetings in the electronic audit trail as well as the topics discussed.

Progressive subjectivity is the process of the researcher monitoring their own constructions as they develop. Prior to interviewing the participants, the primary researcher recorded her a priori construction of what she expected to find in the study and included it in the electronic audit trail. The confirmability auditor reviewed the recorded constructions and confirmed the primary researcher did not afford too much privilege to the original or earlier developed constructions. It was determined the constructions of the other research team members or participants were considered and informed the primary researcher (Guba & Lincoln, 1989).

Member checking is the process of having participants examine the data, categories and interpretations to determine if they agree with the researcher and is considered the most critical technique used in establishing credibility in grounded theory research (Guba & Lincoln, 1989). All participants were given electronic copies of their transcripts to check for accuracy and given opportunity to make corrections where they saw fit. The participants were invited to provide any additional information that they feel was been missed in their interview after reviewing the transcript or to remove any information they feel was not an accurate representation of them. The participants were also electronically given a document (Appendix E) describing the identified themes and given an opportunity to report their

agreement or disagreement of the themes. They were also invited to provide comments regarding the themes (Guba & Lincoln, 1989). Six participants provided feedback via the member check process.

The primary researcher worked toward addressing concerns of transferability, or the extent to which a researcher is able to generalize his/her findings and how generally applicable the emerging theory may be, within the documentation of this study (Morrow, 2005). In order to establish transferability, the primary researcher reports all details pertaining to themselves, the research team, methodology, research context, and participants. It is the hope of the primary researcher that this disclosure will allow the consumers of research to determine how the findings may transfer (Guba & Lincoln, 1989; Morrow, 2005).

In an effort to establish dependability, the primary researcher kept detailed records of the methodological process including the decision making procedures and outcomes within the research team, data collection and analysis, emerging themes, categories and models and memos (Guba & Lincoln, 1989; Morrow, 2005). This record keeping marked the beginning development of the audit trail. Upon initial review of the data, the dependability auditor suggested that in order to ensure stated themes did in fact represent the data as a whole, that further collapsing of data be conducted if fewer than two participants' voices are represented in a theme. The primary researcher, with the approval of the research team, further collapsed the data and documented the changes in the audit trail. After the data was further collapsed, the auditor again reviewed the records and found no error within the methodology, thus establishing dependability. Confirmability was also established through the process of an audit (Guba & Lincoln, 1989). The confirmability auditor searched the research records for any indication that the biases of the primary researcher or the research team influenced the

emerging categories, theory or method. Confirmability was established if it is determined by the auditor that the researcher remained objective.

As trustworthiness addresses goodness of fourth generation evaluation through solely methodological criteria, additional verification is necessary. To address this, authenticity is assessed. Ontological authenticity, educative authenticity, catalytic authenticity, and tactical authenticity were all established using participant report of growth as a result of participation in the study (Guba & Lincoln, 1989). Ontological authenticity is the extent to which the participant's emic construction improves expands or matures as a result of the interview process. Educative authenticity is the ability of participants to better understand and appreciate the constructions of others. To like or agree with the constructions of others is not necessary (Guba & Lincoln, 1989). The extent to which the evaluative process simulates action is catalytic authenticity. Guba and Lincoln (1989) asserted that purpose of evaluation is to elicit action and that fourth generation evaluation cannot be complete without participants prompting action. Lastly, tactical authenticity is the extent to which participants and stakeholders are empowered to act. The final question of the interview "How was the experience of this interview for you?" was asked in an effort to capture what aspects of authenticity may have been established immediately after the interview. In an effort to capture ways in which reflection after the interview may have been impactful as well as to determine if any changes were made by participants as a result of the study two additional questions were asked of participants during the member check. These questions were (as adapted from Rice (2010) :

1. Since the interview in what ways has your approach to working with children and adolescents in non-school settings changed or evolved?

2. After reviewing the themes that emerged in this study, what insights did you gain that may influence the way in which you work with children and adolescents in non-school settings in the future?

Participants' responses to these questions indicated that participation in the study did impact the way in which participants viewed their own work, the way they understood the viewpoints of other participants, and the ways in which they will continue to work. This indicates that authenticity was achieved.

Ethical Considerations

There were numerous ethical considerations when conducting this study. It was essential that all precautions be made in an effort to protect the confidentiality of participant. As previously stated participants were provided an IRB approved informed consent to review prior to participation and were given a copy to keep in their records. This informed consent included the purpose of the study, potential risks and benefits, procedure for participation, confidentiality, and contact information for the researchers and the Office of Research Integrity. Participants were assured that participation was voluntary and that they were permitted to end participation of their study at any time. They were also permitted not to answer any questions throughout the interview process. Participants were sent copies of the transcriptions to allow them the opportunity to review the interview and remove or add any information they felt uncomfortable being including in the study for any reason. Participant names were not placed on any study materials and in its place was a pseudonym of the participants choosing. The key for the pseudonyms is kept separate from the interviews on the primary researcher's computer that is firewall and password protected. As an additional measure to maintain confidentiality any identifying material within the transcripts was

removed by the primary researcher. Additionally, no identifying information has been or will be presented or published.

Results

The grand question for this study was ‘what are the experiences of professional counselors who work with children and adolescents in non-school settings?’ This main question has sub-questions; ‘What are the training experiences of professional counselors who work with children and adolescents in non-school settings?’ and ‘what are the clinical experiences of professional counselors who work with children and adolescents in non-school settings?’ The first sub-question aimed at identifying what the experiences participants had that they felt were particularly impactful in their development as counselors of children and adolescents in non-school settings. The second sub-question aimed at identifying the ways in which participants approach their clinical work with children and adolescents.

The major themes related to the experiences of professional counselors who work with children and adolescents in non-school settings include: Path to the profession, clinical work, strengths, factors contributing to skill and strength acquisition, and master’s program recommendations. Below is a description of each of these major themes along with their subthemes. Following a description of the themes, is a description their experiences of the interview process.

Path to Profession

The first theme that emerged was the path that led participants to work with children and adolescents. There were four subthemes that emerged including personal experiences, prior related work experiences, training experiences and clinical experiences.

Personal experiences. Seven participants reported that a personal experience led them to work with children and adolescents in a non-school setting. Kitty reported that the death of a sibling and the impact of that death on her family drove her to learn more about how families work:

> Personally I know exactly why I'm doing this. I had a brother who passed away before I was born who had cerebral palsy and a seizure disorder and my mother was chronically depressed. And I was wondering what the hell is going on here. I didn't even know this kid so I didn't have grief of having loss. He was eight when he died so my brother and sister knew him, the entire family knew him, everybody was aggrieved and I think it was unresolved depression in my mother but my father was intact and I was just this outsider with this very intimate in my family and I think it was like oh I have got to find out about that one. I have got to really find out about that one.

Ann reported that the experience of reading a book as an undergraduate student was influential on her decision to work with this special population. Jo reported that the personal experiences that contributed to her path towards working with children and adolescents involved being a parent to her son with autism:

> The notion that I would specialize in children with special needs emerged because we are the parents of a 32 year-old son who has autism. This one, who in addition to autism has a doctoral degree and his beautiful, lovely wife and a 10 month-old daughter. He's a miracle. We did the whole thing, we started out with no language, no social skills, no anything. Every kind of perseveration and repetitive behavior you can possibly imagine and PT and all kinds of intervention therapies and blah, blah,

> blah. So, that's a whole other tale. But without [my son] I doubt seriously that I would have ever chosen to specialize in children with special needs. But that's the underpinning of how that evolved. It's not because I'm dying to spend all my time with little kids. I love them, but I like grownups too.

Prior related work experiences. Six participants reported that they had a prior related work experience that influenced them to work with children and adolescents in a non-school setting. LR reported that an internship during his years as an undergraduate was impactful in developing his passion to work with children. He stated:

> Oh boy, in my college senior year I signed up for an internship, an undergraduate internship in a child life program at a local hospital. I really fell in love with the idea of working with kids. It was such a special needs population and it was so eye opening. I had some interesting experiences with the little kids. I never turned back

Kelly's experience as teaching art to adolescents in a juvenile detention center inspired her to become a counselor. She stated, "I was a volunteer teaching art to delinquents like in juvenile lock up facility and realized they were talking to me more than they were talking to their therapists while they were doing art."

Training experiences. Eleven participants reported that a training experience led them to work with children and adolescents. Elizabeth reported that a play therapy course she took as a doctoral student was particularly impactful. She stated, "[I] got really intrigued with that and took the play therapy class from xxxx and became more intrigued with it and that was really how I decided to work with kids." Other participants, including Sam, reported that a desire to work with children and adolescents was strengthened through their training.

Clinical experiences. Seven participants reported that their clinical experiences led

them to work with children and adolescents. Katie reported that she became interested in working with children when she found connections between the experiences of child and adult clients through her clinical work. She stated:

> So I got all the way through my masters and specialists and worked mostly with adults, I had a couple of child clients that got peppered in practicum and internship and I felt really scared and nervous in working with them, cause I was never trained on how to work with them, it was all adult focused. But then at the same time I was working with adults and what I was figuring out about what they were sharing with that were struggling with as adults, I was always developmental in my approach with clients, and what I figured out was that the roots of what was going on with them, it was always something that happened in their childhood. I would look at them and they would be grown up 8 year olds, grown up 5 year olds, or grown up 18 year olds.

Kelly reported that her clinical experiences working with adolescents, children and families have shaped her role in working them:

> So I started working with adolescents and I loved them and that's where most of my work was, because they were old enough, they might have had horrible backgrounds, but they were old enough to make changes that were life-changing and it wasn't dependent on the environment so much that they went back into. Now that shifted as years later I learned more about working with families, then I added back the little ones because I could have an impact on the system they were in. But early on I didn't want to work with little ones because they were so affectionate and it was fun, but I felt like I was spinning my wheels and I wasn't getting anywhere. Once I had the skill set to work more in the environment, I did a lot of in home work, and

> community counseling, kind of treating within the community context, so when you do that, it's easier to work with the little ones because you are changing the environment they are in.

Clinical Work

The next theme that emerged was clinical work with children and adolescents. This theme refers to the many ways in which the participants work with children and adolescents in non-school settings. Within this theme seven subthemes emerged. The seven subthemes are role, techniques, counseling process, decision-making process, evaluation of effectiveness, barriers and challenges, and rewards and benefits. Each of the subthemes spoke to a specific aspect of working with this special population.

Role. Participants were asked how they viewed their role in the counseling children and adolescents in non-school settings. Six subthemes emerged: facilitator, therapeutic relationship, nondirective, theoretically grounded, mediator, and witness.

Facilitator. Six participants reported viewing their role as a facilitator. Mary states:

> I think, we in counseling are more like a facilitator and sometimes facilitating, trying to get their feelings. Trying to help them to identify their feelings, to process their feelings, and to be able to verbalize. You know sometimes it's hard for them to verbalize what they feel. Especially the younger ones. Helping them to verbalize what they feel and trying to get their needs met somehow once they are able to say what they mean. Hopefully we can facilitate that.

Jo also reported seeing her role as:

> … (V)ery much as a facilitator. I always tell parents when I'm introducing them to play therapy. This is never a situation where I'm going to bring your child in here and

say ‘today we’re going to do this’. That I’m the observer, I’m the facilitator.

Therapeutic relationship. Twelve participants reported that they viewed their role in counseling as being a part of the therapeutic relationship. As TB asserted:

> The primary role I see is the person who creates an environment and relate for them a relationship with them that enables them to connect up with and have available to themselves the resources for competent and helpful world view and self-view.

Three subthemes emerged within therapeutic relationship. Three participants spoke to the *power* that the relationship can change for the client. Kelly stated:

> I think to me change only happens in the context of relationship. You know I have worked in a lot of places with a lot of different types of people and I’ve supervised a lot of folks with different theoretical orientation, but have never seen change happen unless it was in the context of relationship. So to me, establishing that relationship is the most important thing.

A therapeutic relationship that is *egalitarian* in nature also emerged as a subtheme. This theme is demonstrated in Jo’s statement, “I insist that they decide what they want to work on so that this is a much more collaborative, egalitarian approach.” The final subtheme of therapeutic relationship was the *unique therapeutic relationship*. Many participants viewed the therapeutic relationship as unique from other relationships their clients may have. Ann described her role as “I offer them a relationship, which is different from every other relationship they’ve ever had before.”

Nondirective. The next subtheme of role that emerged was nondirective. Nine participants reported that they view being nondirective as their role. This view is seen through Jo’s statement, “I always tell families that I’m not in charge, I just work here. They

are in the driver's seat, they are driving the boat." On the other side of the continuum, participants reported that being directive was also part of their role when trying to meet the developmental needs of their clients. Jo stated, "if that's the situation I may use a more directive approach, I definitely will use a more directive approach in order to facilitate the development of age appropriate play skills and then if we're into adolescence, age appropriate social and communication skills."

Theoretically grounded. Being theoretically grounded was the next subtheme of role found within the data. Participants reported that they use their theoretical orientations as the foundation for determining their role in counseling. Elizabeth described this intentional use of theory in her role:

> But to establish a safe place, and to facilitate their own innate ability to move toward health. So that kind of classic Rogerian, I'm all about that, I'm also probably, my theory of choice is Adlerian, so still that same belief that the individual creates who they are to fit the environment that they are in, so if I can set a safe, therapeutic environment and just help facilitate them to get back on track developmentally and really process what's hindering that, then I think that is probably primarily my role.

Mediator. Two participants reported viewing their role as a mediator. They described the importance of mediating between their child and adolescent clients and their caregivers. Mary described this role as she stated:

> Sometimes being the mediator between the kids and their parents. Sometimes just trying to show the parents the needs and this is what we have to do. So we have to somehow get the parents at the same level that the kids are. And I think that's the hardest part, getting the parents to understand what is happening and how can we get

the kids what they need.

Witness. The final subtheme for role was that of witness. Two participants described their role in counseling as bearing witness to the experiences and feelings of their clients in session. Sarah described her role in working with her clients, many of whom have experienced trauma, "job is to bear witness to their pain." Kelly also discussed the role of witnessing, "We talk about letting people walk their own paths, the power of witnessing, the power of just creating a different experience for someone for a certain period of time, and the power of that."

Techniques implemented. Participants described many of the techniques they implement in session. Five subthemes of techniques emerged including play related, creative and expressive art, solution focused, projectives, and basic counseling skills.

Play related techniques. Twelve of the fourteen participants reported using a play related technique and three subthemes emerged: *play therapy, sandtray* and *games*. Eleven participants reported using *play therapy* techniques in session. Participants reported that play therapy is a critical approach to working with children. Jo emphasizes this as she states, "There are very few absolutes in this life and one of them is there is only one way to communicate with a child and that's get on the floor and play with them." Beth also expressed her belief in the importance of play therapy with children, "I have found that play therapy is just imperative. You have to do play therapy for younger children." Sam described her use of *sandtray* with clients, "I can use with kids play and sandtray and things that are geared toward kids that don't necessarily talk". Both Jo and TB reported using *games* in session after considering the developmental level of their clients. TB stated, "I just work to find something that will enable us to talk together or preferably, play together. Playing

checkers, playing Uno, just so they start to get comfortable."

Creative and expressive art techniques. Creative and expressive art techniques were reportedly implemented by eight of the participants. Subthemes of these techniques included *art therapy*, *bibliotherapy* and *role play*. Six participants reported using *art therapy* techniques. TB described the use of the mandala in session with an adolescent he had known to demonstrate avoidant behaviors:

> [I] had her pick out from a bunch of mandala pictures I had one that pleased her and that she said that she liked and then had her color it in and tell me about it, and what came out in that is the stuff that she talked about when I first saw her a number of months ago, and then she said things are ok now, it's not so ok and all the stuff got revealed and then again by questions got her in touch and be more comfortable with the fact that she was uncomfortable with this and be open to consider and to process by providing her this indirect modality

Sam reported using art therapy with younger clients, "I do a lot of drawings. I do drawing with most young kids the first couple sessions as an opening activity."

Both TB and Ann reported using *bibliotherapy*. Ann described her nondirective approach to bibliotherapy with her clients:

> It's not like I say 'okay today we are going to read this book on bullying'. I'm more likely to lay out the book, confessions of a bully, over there on the table and if then the child goes to the book then I'll say 'would you like me to read it?'

LR and TB both reported using *role play* techniques with their clients.

Solution focused techniques. Two participants reported incorporating solution focused techniques and language into their sessions. Kelly asserted that "If you come to them from

more of a solution based place, they respond."

Basic counseling skills. Finally, five participants reported using basic counseling skills in session. These techniques included the use of questions, reflecting, reframing, listening, and use of nonverbal cues. Kelly stated she finds it important to use "language that is kid friendly, using their metaphors, whatever they bring in, working within that metaphor". Katie described the importance of nonverbal as she stated, "I am warm and gentle, and encouraging and you see that in my posturing, my face, in my actions, in my words"

Counseling process. All participants described their counseling process. This process was unique for each participant but there emerged nine subthemes including forming and holding a therapeutic alliance, treatment goals and planning, viewing clients holistically, working with client's family, working with systems in which the client exists, empowerment, advocacy, faith in the counseling process, and feelings experienced in session. These subthemes can be found in Table 2.

Therapeutic alliance. Eleven participants reported that forming and holding a therapeutic alliance with clients and their families is critical to the counseling process. Mary described the importance she places on development of the therapeutic alliance. She stated, "usually what I do is first, of course, you have to see the kid. You have to see what is happening. You have to get to know him. You have to get him to trust you." Katie also described her emphasis on building a therapeutic alliance,

> That everybody has their own reasons and I don't think they are necessarily aware of them all the time, so that is helped by trying to create a relationship… having a relationship with them that they feel they can be vulnerable enough to disclose things that are hard for them or to hear feedback or suggestions about things that they could

shift or try a little differently, those kinds of things.

Table 2: *Counseling Process Subthemes*

Subthemes of Counseling Process
1. Forming/holding therapeutic alliance • Holding and demonstrating respect for client and family 2. Treatment goals and Treatment Planning 3. Viewing client holistically 4. Working with Client's Family • Family involvement in client treatment • Family Receiving treatment o Family Therapy o Couples Therapy o Children & adolescents are scapegoats 5. Working with systems the child exists in 6. Client and family empowerment 7. Advocacy 8. Faith in Counseling Process 9. Feelings and emotions experienced in session • Monitor own feelings • Feelings associated with job roles • Feelings associated with client/client's experiences

Eight participants emphasized the role of *respect* in the development of the therapeutic alliance. Elizabeth described the importance of respecting parents as she stated:

> I think the key is helping the parent feel that I respect them and that I believe that what they are going to do with their child is critically important, and that they are part of the solution not part of the problem.

Treatment goals and treatment plans. Having a conceptualization of the client, and developing treatment goals and a treatment plan was identified as a part of the counseling process for ten participants. Participants reported that developing treatment goals and a treatment was a collaborative process with the client. Sarah stated, "In consultation with my clients they determine what the goals are." Sam also reported, "I think the main thing is to have a good assessment of the child and a working treatment plan."

Viewing clients holistically. Four participants reported that making intentional efforts to understand all facets of the clients was critical to their counseling process. Sally emphasized the importance of learning about her clients and asking questions:

> Not just about the problems that are going on but just asking about them as a whole. All of their interests and all of the things going on. Trying to get a whole interest in the whole individual. Really getting to know them and understand them as a whole instead of just in the context of the problem.

Katie also expressed a commitment to view her client holistically. She described how assessment plays a role in learning about her client:

> I spend time doing assessment, a lot more time than I used to, not intelligence assessment, but trying to figure out the child's preferred ways of expressing themselves, what feels more comfortable to them, and I try to learn about them holistically, I am much more intentional about that now.

Working with family. All the participants stated they believed it critical to work with the families of clients including Katie who stated, "To me all child counseling is family counseling." There were several ways in which participants worked with these caregivers to their clients. Ten participants discussed the importance of *involving the families in client treatment*. Meeting with parents and caregivers to learn more about the client and their struggles, helping parent to feel like an important part of the treatment team, helping parents to continue change outside the therapeutic environment, completing psychoeducation on the clients' symptoms and parenting strategies were reported by twelve participants as ways in which they include parents in the treatment of clients. Beth reported using the parent an important resource of information about the child:

> If I am seeing the parents come in and they are reporting a lot of issues with the kids, then I do meet with the parents alone to break down what it looks like at home. They are with them all the time and I am with them an hour a week

Katie reported that she involves parents in the treatment of the client by giving the parent tools they can use at home with the child. She stated, "I ultimately gave that language to the parents, so when they found themselves in dog-related situations, they could help her deescalate in the same way I did so they wouldn't have to come back."

In addition to involving the family in client treatment, ten participants discussed the *families receiving treatment* as a part of the counseling process. At times, according to participants, parents and caregivers need more support than parent consultations and strategies for helping their child, and instead are in need of counseling services aimed at addressing more of their needs. Three subthemes that emerged from within families in treatment are family therapy, couple counseling, and children being used as scapegoats. Two participants reported that couple counseling is a part of their counseling process with families. Ann, who frequently does couples counseling with the caregivers of her clients stated:

> There are a large percentage of kids who I see for 3 or 4 months and the parents say they would like to see me too. So I'll get couples therapy going and I've got individual therapy going with the child. They'll send their child to therapy long before they'll come themselves. But once they develop a trusting relationship here, they come for their therapy

Two participants reported that parents sometimes use their child as a scapegoat for the problems within their family and send their child for services instead of addressing their own

issues. Sally stated:

> A lot of times the kids that are coming in are coming in because their parents want them to come in. The problem with that sometimes can be that the parents are a lot of times there's a family problem and the kids that are brought to me are kind of a symptom of the problem if that makes sense. So it can be very frustrating for the kids and the adolescents to say there's a bigger problem. They feel very, there is a lot of anger about coming here sometimes because they feel like they are the scapegoat. Let's look at her problem instead let's look at the entire family problem.

Systems. Five participants spoke to their practice of involving the many systems within which the client functions in an effort to address some of the systemic issues that may have a role in the client's functioning. Participants spoke to the importance of understanding that children and adolescents exist within systems and those systems both impact and are impacted by children and adolescents. Sarah echoed this sentiment when she stated:

> It's not just the children because you cannot change one aspect of one individual without it having repercussions and ripple effects throughout the entire family and systems with which these children function. So for me it's about understanding all of those systems and understanding how change is going to impact those systems and to make sure that their there to sustain that change once change can occur.

Participants reported working with school administrators, teachers, school counselors, pediatricians, nurses, and even friends in an effort to learn about the client and to help the client be better able to function within the many systems of which they are a part.

Empowerment. Client and family empowerment was reported by several participants to be an important part of their counseling process. In her work with adolescent girls, Sally

stated, “I work a lot with adolescent girls and one of my goals with the adolescent girls is to empower them to help learning how make their own.” Katie highlights that empowerment can begin at even a young age when she stated, “I am big about empowerment too. I think I do sort of bring that feminist, where I think that our clients should be empowered even as young children.”

Advocacy. Four participants asserted that advocacy was and important part of the counseling process. Participants reported advocating for their clients and their clients’ families. Additionally, participants reported teaching clients and parents self-advocacy. Jo highlighted the ways she frequently both advocated for clients and encouraged self-advocacy:

> I am very persistent and very stubborn in the context of fighting for what the child needs. I’ve developed an ability to come up with a pretty comprehensive picture of what would be helpful for a child in a kind of global sense so that when those things become apparent to me then I want that for the child and I want it now. So if the child is not getting something that he or she needs from the school system then I’m going to encourage the parent to go after it and to fight for it. I’ll go to an IEP meeting and say, “no, no we need this and this and this”.

Faith. Two participants reported that they have an overall faith in the counseling process and that their client’s will take the session where it needs to be. This point of view was seen in Yolanda’s statement, “I really do believe that kids can come to a session and work through whatever they need to work through.”

Feelings. The final subtheme found within the counseling process theme is the feelings that the participants experience in their work with clients. Six participants reported

actively monitoring their own emotions in session to better understand themselves and how they are reacting to the client. Additionally, participants asserted that monitoring of one's own emotions in session is critical to ensuring that those emotions do not negatively impact clients. Ann stated, "I monitor my bodily experiences to see what I am feeling. And, so my thoughts are not only monitoring the child but my reaction to the child." Participants reported that their emotions are impacted by the role of counselor and aspects of the job itself. Mary reflected on some aspects of the job of counselor that can impact how she feels:

> So you feel guilty, you feel sorry, you feel frustrated. Sometimes you feel anxiety because it's really sad. Sometimes there are many many. And sometimes you feel like there is nothing you can do. Especially with the population that I work with there are so many psychosocial stressors and environmental problems that sometimes I'm like what can I do with this if I can't really solve these. That's my main frustration sometimes. You can work with this child for 45 minutes or an hour but you can't change the environment. And then you try to reach out and encourage the parents to do this or do that

Often, according to participants, emotions are impacted both positively and negatively by the clients themselves. TB works to be aware of the many ways he is impacted by the clients in session, "there are times I'll even tear up and cry in a session, there are times I'm angry. Of course I have to control that. It's my issue, not theirs."

Decision making in session. Participants discussed the ways in which they made clinical decisions in session. These responses lead to five subthemes: theory, ethics, individualized treatment and intentionality, intuition and experience, and reason for referral and diagnosis.

Theory. Seven participants reported relying on their theoretical orientation when making decisions in session. Katie's training helped her to better apply her theory in session:

> My theoretical orientation for sure grounds me and organizes me and it really does I think structure how I am with kids. Even though I don't structure their time very much, how I respond is orally and predictable and I don't just drift all over the place doing this intervention and that intervention, and I think I maybe did early in my career but I think training has helped me with that. So my theory informs my practice.

Jo also reported relying on her theory to make decisions in session, "what informs my work is my commitment to being nondirective with children and allowing them to use the toys in the ways that make sense to them."

Ethics. Two participants reported that they first consider their professional ethics when making in session decision. Sally considers safety regularly when working with clients:

> What informs or drives [my] decisions? Well first of all I would say just my ethical. I have ethics to rely on…It depends on the actual decisions that I have to make. But ethics, relying on their safety, the children's safety while still having to give them some confidentiality in the sessions where they can feel like whenever I talk bad about mom and dad it's not going to be relayed back to mom and dad. Letting them feel like it is a confidential environment. As far safety, I'm very clear as far as when I have to jump in as far as safety, their safety, other people's safety. So that drives my decisions.

Individualized treatment and intentionality. Eleven participants acknowledged the

unique needs of each client; and therefore the need for intentionality in developing individualized treatment plans. When examining what the participants considered when developing their individualized treatment for their client's three subthemes emerged: *Meeting clients where they are*, *developmental levels,* and *abuse history.* When developing individualized treatment participants reported considering where each client is in the process of change and abilities and striving to meet them where they are, instead of expecting more from clients than they are able. TB works to take the time to learn what each child's range of normal is and works to adjust his expectations:

> Kids that have come in and are kind of wild versus kids that come in and are quiet. You have to be careful, if they are not destructive (the wild ones) they are just very active- that could well be in the range of normal. I have to accept kids where they are at.

Three participants reported evaluating the child developmental levels to determine interventions and approaches in session. Jo considered language development of clients when developing treatment and adjusted her typically nondirective style to meet the needs of these clients:

> A lot of times children with language delays are also missing imaginative play because play is their language and so often we'll see delays in age appropriate play skills in children who have language delay. If that's the situation I may use a more directive approach, I definitely will use a more directive approach in order to facilitate the development of age appropriate play skills and then if we're into adolescence, age appropriate social and communication skills.

Abuse history of clients is the final subtheme that emerged from the data in the theme of

individualized treatment and intentionality. Sam works to first understand the abuse history of clients in order to more appropriately make clinical decisions:

> I think understanding the problem they came in with, like if a child comes in with sexual abuse having some background in what helps sexual abuse and then also having a good treatment plan will guide what I'm going to do with a child.

Intuition and experience. Three participants reported that they relied on intuition. This intuition is informed with the past experience of the participants. Kelly described the relationship between intuition and experience as she stated "it's really for me more of my gut instinct of what's needed. Now I have to sit here and think about where that comes from. I think it comes from years of experience."

Referral. Lastly, six participants reported that the reason for referral or diagnosis will drive or inform their clinical decisions. Kitty stated "well the reasons for referral are important. I want to know what the family's standard of success would look like. I want to respect what they asked me to help them with." LR also reported that he considered the presenting concern when making decisions in session, "Usually the presenting concern, presenting complaint, presenting problem if you will. I guess also an attempt to reconcile what the parent thinks the problem is and what the may think or regard the problem to be."

Evaluation of effectiveness of treatment. Participants were asked how they determine if what they are doing with clients is working or effective and their responses resulted in seven subthemes. These subthemes are process of assessment, reports, play and expressive arts, therapeutic relationship, treatment plan and goals, outcome measures and behavioral assessment.

Process of assessment. Participants reported that they had a process of assessment of

effectiveness for their interventions. Elizabeth, one of the seven participants who reported that *consistent assessment* of effectiveness if important stated,

> It's that constant assessment in a session where I'm always thinking about what they are doing, what does that mean with their presenting problem, where are they in the therapeutic sequence or stages, it's that constant assessing I think that's really critical.

Five participants reported that they look to *multiple sources* for feedback to determine the effectiveness of their treatment including caregivers, clients, teachers and assessments. Yolanda and Kelly both report that *intentionally timing* their assessments is important. This is done in order to give themselves and clients a better perspective on any change that may have occurred.

Reports. Twelve participants relied on reports from individuals as a way to assess for effectiveness of treatment. Eight participants used *client self report*. Sam described her client self reports:

> You know most of the time I don't have a five year old come up to me and say 'I've changed, I'm different". But I had a session with one kid one time and we were practicing some breathing and she told me I was magic. I said, "Well why was I magic?", and she said, "Cause I tried that and I felt better." So sometimes you get that. That's why I love kids, they are just so smart and observant. They know everything that's going on.

Sally described the slightly more direct approach she takes with her adolescent clients to elicit a self-report on their progress:

> With adolescents I'll just directly ask them. Especially some of the older adolescents.

> And I check in with all my clients. How is counseling going for you so far? What kind of feedback do you have for me? Are we working on some of the things you want us to work on or do you feel like we're missing some things that we haven't talked about that you would like to talk about? So just directly asking them, "are you seeing the changes that you'd like to see here?"

Eleven use *reports from parents or caregivers* including Sarah who described how intentional dialogue with parents can yield a report on progress. Sarah stated her approach is, "Bringing in the parents every couple of sessions. What's happening? Where do you see change? Where do you see it affecting your family? Taking stock." Three participants also report using *reports from other members in the client system* such as siblings or a teacher. LR reported, "I may also reach out to a teacher to find out how a child is doing in school. Or meeting with siblings to find the impact on the family system."

Play and expressive arts. Play and expressive arts are also ways in which several participants assessed for effectiveness. Elizabeth described the way she looks for *play disruptions* to determine how clients are responding to her play therapy approach:

> That I don't have a lot of play disruptions. That the child is able to stay with that long-sequence of working play. When I do see play disruptions, I have to really self-assess to see if I said something that was too overwhelming for them that they had to leave it before they came back or are they really working at such a deep level that their own internal anxiety got so high that they are taking care of themselves and taking a breather and then they will come back.

In addition disruptions participants also report looking for *play themes* to assess for effectiveness of treatment as described by TB:

> I look at the kinds of themes in play that the child is presenting and looking for changes in that and making my best judgment about do these changes in what's happening in the room appear to me to represent someone who is in a more healthy line of development, and that varies from child to child.

Therapeutic relationship. Two participants reported seeing positive changes in the therapeutic relationship as signs of therapeutic progress and looked for these changes in session. Sam describes his view of progress:

> I look for if they're talking to me more than they used to be. You know if they started off kind of shy and not so sure. But they start opening up to me about things at home or things they've experienced. I view that as progress

Treatment goals. Three participants reported that they believe it is important to have treatment goals developed over the first several sessions. Participants then examined whether these goals are met throughout the counseling process. Kelly described this process as she stated:

> I think real treatment goals, not necessarily what's written on paper, cause those are done for outside monitors, but real goals, like in the first several sessions about what is it you want, how will you know when things are better.

Outcome measures. Three participants described the use of outcome measures to evaluate effectiveness. Kelly uses these measures to assess her client's responses to interventions. She reported that she uses, "things like the outcome ratings scale, I think that's really important every session for kids to show me with the smiley faces if they felt good about it or not, that's good." Other participants felt strongly against the use of outcome measures. Jo warned that while she sees the usefulness of the measures, they can feel

obtrusive to the client and their family. She commented:

> I think that's a useful thing to do when you're collecting data but I think it's obtrusive, or can be obtrusive. Because I did a quantitative study and collected a whole boat load of data in that way, that's not really something I want to be a part of my therapeutic process. Not that I'm opposed to doing it because we're all going to have to be evidence based because of managed care and all of that stuff

Behavioral assessment. The final way in which participants reported evaluating effectiveness was through the use of behavioral assessments. Four participants reported using various behavioral methods for assessing effectiveness of treatment including changes in body language, results of formalized behavioral assessments such as the BASC II and a reported decrease in problematic behaviors. Ann commented, "I have a form that parents fill out periodically. And I'll redo the BASC II, Behavior assessments. I'll have them redo the BASC II and have a teacher redo the BASC II and then compare."

Barriers and challenges. Participants were asked what makes working with children and adolescents in non-school settings difficult. From their responses four themes emerged: setting related barriers, barriers associated with families, resistant clients, and working with systems.

Setting related barriers. Ten participants cited some sort of barrier related to the work setting. Under setting related barriers are five subthemes including office tasks, lack of access to client, artificial environment, not being challenged and managed care. Two participants cited *office related tasks* as challenges to working with this population. Jo comments on how administrative work can make her work more difficult:

> I love my work, I hate the administrative part, absolutely hate it. If all I had to do was

> sit in one my various chairs and be with families I'd be the happiest person in the world if somebody else would do it

Ann also reflected on how office related tasks can become arduous, particularly the cleaning up process, "putting the toys away. Putting the toys away after each session is time consuming."

Six participants discussed that a *lack of access* to clients as being particularly challenging when working in non-school settings. While children and adolescents rely on adults to not only identify their need for services, they are also reliant on their caregivers to get them to each session. TB discussed that this unique barrier inherent in non-school based counseling work:

> Well, the more difficult thing out in the community versus school is I don't have a captive audience. As long as the kid is showing up to school pretty regularly they're there to come to session. I don't have to worry about. If I was to think, what a disadvantage outside is, I'm totally dependent on the caregivers to make sure the kid gets in the room.

Participants also reported that this lack of access is further complicated when the caregiver is unable to get the client to session regularly due to the clients' school schedule or the caregivers working schedule. Elizabeth discussed these barriers to access:

> Access to the client. Because I have to rely on parents actually bringing them. And so there are the no-shows, and there are other kids that are sick at home so the parent can't get away to bring them. So when you are in a school, as long as the kid is in school, you have access to them, typically.

Several participants discussed the non-school setting as being an *artificial*

environment which can become a barrier to the counseling process. Because non-school counselors are often unable to observe clients in a natural environment, such as a school, the clinician's ability to fully understand the client may be hindered. Mary described this barrier:

> I think something that we don't have here is just the part where you can see the child interacting in their own natural environment. If you want do that you would have to go to the school and watch them. I think that we don't have, we can have groups, but I think the school has this advantage over us that they can see the child.

While non-school settings are distinct from school settings in that they can lack opportunity for naturalistic observation, Beth discussed that the non-school setting is in stark contrast to that of client home environment as well:

> Well the only other thing I can think of that is difficult is that is this is an artificial environment. If I were at home and could see everything that was going on it would be easier to get in your mind what the problem is. But here, sometimes the child will be complete angels and not have a problem or you can't really grasp the whole mental health problem

In graduate school professional counselors are challenged and observed by professors who are aiming to continue their professional development. Four participants warned that after formal training ends, professional counselors are at risk for *not being challenged* by others and even by themselves. Participants warn that it is easy to find yourself doing in session what is routine without the checks from outside sources. Kitty warns that being isolated from other professionals can create loneliness and potential harm to clients, "you hurt people by being too isolated. You hurt people by never being challenged, your ideas never being challenged." Mary also discussed the risk of losing clinical skills due to

operating from a within a routine:

> That's the thing, in private practice you really have to try hard to stay updated and study and recycle yourself. It's easy to lose contact with that kind of a setting and then you don't know what exactly is happening. You really have to try to stay up to date because it becomes a routine and then you kind of lose your skills easily. You don't recycle and you don't study.

The final subtheme that emerged with regard to setting related barriers when working with children and adolescent in a non-school setting is that of *managed care*. Participants reported that at times their clients, and their work with clients, is negatively impacted by the mandates put in place by managed care. Of the many ways in which this can be done two themes emerged from the data: treatment planning and goals and restricting treatment. Managed care sets requirements on when the treatment plan and goals should be done, how it should be completed, and how progress made on treatment goals is documented. Kelly describes how these external mandates put in place by managed care are often not aligned with her beliefs about counseling and can even at times hinder her ability to be present with clients:

> [managed care] says you have to have a treatment plan done the first time you see a client. Well we all know that assessment goes on for quite a well, so it's almost ridiculous. But it's a mandate, and then it has to be measurable. So, it's not enough for the client to say "I feel better." But what does that mean. The child is depressed so the treatment plan might have something silly on it like the child will make one friend by May 12 as evidence by the friend coming and spending the night…Well, what happens is that if that is the first thing you learn and you know you have to

> document to those goals, you know, whatever is on that piece of paper, that's what has to be documented, so when you are sitting in session you instead of being present, you are thinking about that.

A second aspect of managed care that participants identified as challenging was the restriction of treatment. At times services were withheld from clients because their insurance company lacked mental health coverage, had limited mental health coverage, or had regulations on what kind of professionals could work with a client. Also, the requirement that clients have specific scores on specific assessments in order to qualify for services often resulted in children and adolescents being restricted from needed services. Kelly highlighted how mandates in place by managed care can negatively impact clients and her work with them:

> The thing that makes it the most difficult is all of these external mandates. The funding people, the people that think they can tell you what to do clinically when they are not clinicians, disrespectful, short-sided mandates. So, for example, if a child comes in here and has Medicaid HMO, and that changes, shifts from like AmeriGroup to Magellean or something else, the powers that be say only a certain clinician can see them. So you might have a child with huge abandonment and grief and loss issues connected with a therapist and without any warning, now they need a new therapist. They can't see the same therapist anymore. Or, as we all know, trauma clients, kids that have been abused frequently can be parentified, or become the over achiever, the over caretaker, so if those kids come in, their scores on the CAFAS are going to be low, but, it's because they are not dealing with the issue yet.

Barriers associated with families. The second theme that emerged as a barrier was the challenges associated with the family members of clients. Thirteen participants reported that working with the clients' family can be a barrier or challenge to working effectively with clients. While a rapport is built with any client, working with children and adolescents requires that professional counselors also form an alliance with the caregiver. This can prove challenging. Beth described some difficulty building rapport with caregivers who have been a part of the Department of Family and Child Services, as they are fearful or angry. Sally and Beth described the challenge of parents demonstrating resistant to the process or being disengaged. Three subthemes emerged under working with families including parent mental health issues, socioeconomic status of family, and family belief systems. At times, the participants reported, the parents themselves suffer from *mental health issues*, which can make working with their child and adolescent client more challenging. Elizabeth describes how a parent's mental health issues can impede their ability to act in the child's best interest:

> Because sometimes the parents have their own issues, and sometimes our responding to the child's trauma, which may have been their trauma as well, and so, you are really dealing with a client who is depending on another client to do what's best for them and sometimes that doesn't happen.

A family's *socioeconomic status*, or lack of monetary resources, was also viewed as a barrier to several participants. Participants described caregivers' inability to pay for counseling services, take time off of work or provide transportation as some ways that their finances may impact their work with clients. Katie described these factors and their impact:

> If it's not free, then you have enough money or the right insurance or a car or transportation, you know there are so many potential things, or time. To me, time is

> a privilege, I think people that have to work full time, or double time, I don't think it's because they don't love their kids, I think that they are, but it does create an access issue.

The next subtheme that emerged with respect to the ways a child and adolescent's family can serve as a barrier or a challenge was the *beliefs held by family members*. Parents may have mistaken beliefs about the counseling process itself or not believe it is worthwhile. Elizabeth describes that some parents' beliefs that counseling is ineffective or inappropriate are tied to their culture. She stated, "You have the cultural issues, you know, where you have populations that don't believe that counseling is effective or they shouldn't have to need counseling or shouldn't have to rely on that."

Resistant clients. Three participants reported that because children and adolescents frequently do not make the choice to come to counseling they can be resistant to the process. LR asserts, "Teenagers feel pressured to be there, so they see me as an ally of the parents. Teenagers can be very resistant to looking into parts of themselves that are quite going right and for that reason fight against me." Sally shared that view and highlighted how that resistance can impact therapeutic alliance. She stated, "sometimes the kids are very resistant and really don't want to be there. It's difficult for them and there are moments where you just can't. There's just not that connection."

Working with systems. The final barrier to emerge from the data was that of working with systems. Six participants reported working with systems associated with the client can be a barrier. Children and adolescents often exist within multiple systems and participants describe finding ways to work effectively with all of them a challenge. Sam described how

this difference between working with children and adolescents and adults can be difficult if the systems fails to make change:

> When you're working with an adult, unless you're doing couples or family or something, you're just working with that person. If you're working with the child you're working with the parents, you're working with school systems, and if DFCS is involved, you're having to navigate them through that system. I think that's what makes it the most difficult. If you're working with the child and the child gets better and the system, the family isn't getting better or isn't receptive that can be difficult. That can definitely be difficult.

Rewards and benefits. As a part of the interview, participants were asked what made working with children and adolescents in non-school settings rewarding. Participants responses resulted in seven themes: change in client, professional and therapeutic relationships, children and adolescents are void of certain barriers, personal gains, preventions, characteristic of clients and interventions.

Change in client. Sam described one of the rewards and benefits for working with children and adolescents in non-school settings. She stated, "It's getting to know the kids and seeing them change." The change that takes place in clients was reported as a reward to the work they do by all participants. There were several subthemes to this change including therapeutic progress made by the client, client completion of treatment and making a difference in the lives of clients. The first subtheme was the *therapeutic progress made by clients*. Sally reported the reward to her work is "seeing the change. Seeing the symptoms getting better." Mary also discussed how seeing the progress in clients was rewarding:

> I think it's very rewarding when they actually trust you and they disclose important secrets to you. When they start saying that they feel better because they were able to use the stop, think and behave. When they are at home "I was doing this and it works". And they're so surprised that it worked because they were expecting that it wouldn't work

Also, a subtheme of change in client as a reward to counseling was that of *client completion of treatment*. Kelly described the moments when her clients report they have completed their goals for treatment and that they are ready to function independently of her and her services:

> What I love, and kids are great about this, they will come back and say, well I didn't do such and such this week or I did do such and such this week because I heard you in my head Miss Annie. It's like that moment, it's like YES, now they are doing it for themselves, and they don't need me anymore. I think what makes it rewarding is when kids don't need to come back and see you anymore, because they are ok, they are better, happier or have accomplished what they want.

Five participants reported that *making a difference in the lives of clients* was a reward this became the final subtheme. Beth stated, " I like kids, so to me working with kids is rewarding, to feel like you are making a difference with them, to feel like you are helping parents. " Kitty described how sometimes it is when she sees former clients who have grown that she realizes that she has had an impact on their lives:

> Really thinking you made a difference in their life is very rewarding. Very very rewarding. And as a developmental person the other really cool thing is that fast forward button, children change so quickly it's very gratifying. You know, now I've done it long enough that all of a sudden I'll see kids that I saw when they were five

> and they just graduated from college. And they'll go, "I remember when you told me 'blah, blah'". You know, it's amazing when you feel like you made a difference. That's pretty good.

Professional and therapeutic relationships. Nine participants reported that the relationship was a reward for working with children and adolescents. Some participants, including Elizabeth, reported that the therapeutic relationships with clients as rewarding. She stated:

> I find my relationship with the child clients very rewarding. The sense of trust that they give me to work through their issues. Their delight when they can't wait to come from one week to the next for a session. Just that sense of developing really great therapeutic relationships and just the ability to see the wonder of how children can deal with their problems and get healthy and go on with life. It's wonderful.

Jo reportedly viewed the relationship as a privilege, "the most gratifying thing is the privilege of that relationship and the important thing is remembering that it is a privilege." Kitty and other participants reported that an additional relationship that is rewarding is the professional relationship. With regard to the reward she noted, "Meeting interesting people. Working with wonderful colleagues."

Work is void of certain barriers. Many participants reported that the fact that working with children and adolescents in non-school settings is void of some barriers as beneficial. The two subthemes the emerged were void of barriers found in adults, and void of barriers found in other settings. Seven participants stated that children and adolescents lacked certain barriers found in *adult populations*. Jo stated:

> Children are very efficient in the therapeutic setting, they don't fool around like

> grownups do. They know what they need to do, they know why they're here. They may not be able to articulate but they do what they need to do because that's how they're put together. Whereas an adult will try to come in here and try to shoot the breeze and talk about the weather and avoid, kids don't do that. With parents and adults, they articulate that things are going better, that they're doing better.

Katie also commented on the differences between adults and children in counseling being a benefit to her work:

> Kids are so open. They are not as resistant as adult clients because the adults have spent their whole life honing that particular coping skill because it has probably worked in some settings and now they are in a place where it's not working. But kids are new and open and in many cases have more faith and that's nice in trying to focus on helping them stay that way and helping them get to be kids for a while without having to grow up to fast.

Four participants reported that the *non-school setting is absent of some barriers* found in the school counseling setting. Sarah discussed how school settings have rules in place not present in non-school settings:

> I like it better because I'm not bound by any school setting rules. I've worked in school settings. This is my practice and I do what I want to do, when I want to do it and how clients need to be defined. In school settings I think that there are a lot of rules

Personal rewards. Three participants reported experiencing personal rewards as a result of counseling children and adolescents in a non-school. Participants reported that they

had personal growth as a result of their work with clients. Kelly described her personal growth:

> I think for me, personally, what makes it rewarding is that I am deeply, what I have learned about myself, from being able to sit with other people in their process is invaluable, I don't know any other job where you can do such honoring work listening to people's stories, and honoring people's stories and continue to learn about yourself. It's just like a little miracle or something. So those are things that make it the most rewarding to me.

Participants also reported that being able to work with clients was a privilege. Jo stated, "The privilege is being allowed into their space, just like the privilege of being allowed into a child's play space. In many ways it's the same."

Prevention. Five participants identified prevention as a reward, which became the next theme. Katie reported that while working with adults she realized much of what her clients struggled with could have been prevented in childhood. She stated:

> Everybody has ups and downs in life. I think we can do some prevention, I don't think we can prevent everything, I don't think that is natural or realistic, but if someone can intervene in a meaningful way younger, in someone's life, I think it will reduce the long-term, large scale impact.

Yolanda shared this view and works to help her child clients develop the skills they need to effectively manage their lives as adults:

> If we can teach children that and help their parents with that at a young age, it's so much safer because if they make bad decisions they make small decisions and by the

> time they are adults and they are making decisions that are really important big decisions, they will have the skills to do that well.

Characteristics of clients and interventions. Seven participants cited characteristics of children and adolescents as a rewarding aspect of their work. Among the many characteristics of her clients she finds rewarding, Katie described the humor of her clients:

> Well, they say the funniest things. There are things that kids have said and done in counseling sessions with me that just crack me. To this day I still refer to sushi as "shooshi", because I have one kid that always said that. I mean just funny little moments of adlibbed hilarious, their view on the world is so innocent and sweet and hopeful… fun stuff.

Other participants described characteristics that were rewarding. Mary described children as "very honest" and Sam highlighted their innocence and that they "are just so smart".

Strengths

Participants were asked what strengths they held that they felt contributed to their ability to work effectively with children and adolescents in non-school settings. From the responses of participants emerged two themes: clinical skills and personal characteristics. No characteristic of a participant was coded as a strength unless participants themselves identified that characteristic or skill as a personal strength.

Clinical skills. Nine participants reported holding skills that they believe have contributed to their ability to counsel effectively with this special population. Subthemes included faith, knowledge base, reframing, knowing own limits and boundaries, and strength based. TB shared that his strength-based approach is a strength. He stated, "I work very hard not to make assumptions, I work hard to find the abilities, if I'm lucky even competencies of

the people I work with. I find reasons based in truth, very important, for them to be valued." Kelly reported that she is the "queen of groups" and views those skills as a strength.

Three participants reported that they view having *faith* in the counseling process as a strength and this emerged as the first subtheme. LR reported that he has a trust that the metaphor will develop is session, "I think that's my greatest skill, just sort of being in the moment and trusting that a metaphor will arise." Elizabeth also shared her faith in the counseling process: "with the child in the playroom, it would be my absolute belief that this child can be better, can work through their issues".

Kitty and Elizabeth both believe their *knowledge base* is a strength that helps them in their clinical work, a second subtheme. Kitty described her knowledge base as "wide" and Elizabeth stated:

> I think knowing the literature in the field. So with sexually abused kids, knowing the sexual abuse literature, as well as for when working with them in play therapy and knowing the play therapy literature in a broad way as well as sexual abuse.

Katie and Kelly both reported that the skill of *reframing* as particularly important in their ability to be effective. Katie tries to reframe clinical experiences with challenging parents into opportunities to better understand them. Rather than pathologizing the parent's behavior she instead focuses on "building the relationship and reframing and viewing people as coping as opposed to trying to ruin my day as a child counselor." Kelly viewed this skill as critical in her work:

> I am very good at reframing and that really helps in getting families to look at their children and their teens differently. I think that's a really important skill. By the time kids are brought in here, the families are usually pretty sick of them, frustrated,

> worried, concerned and to be able to reframe is a very important skill for a clinician who works with children and adolescents and I am really good at that.

Elizabeth, LR, and TB all reported that *understanding their own limitations and boundaries* as a strength. LR's experience with clients has caused him to develop more realistic expectations of his skills. He stated, "I think they have strengthened the sense of humility in me. And cut down ego a fair amount. I don't have these grand ideas that I'm going to save kids, that my methods are instant door openers." Elizabeth reported that she views her boundaries in knowing what her responsibility in session is and what is that of the client and their family as a strength. She stated:

> I think at some point I finally had to come to grips with, I am ultimately in charge and responsible for what's happening within the therapy session when I'm in therapy, and I can do the best I can with trying to get the parents to bring the child, but if they don't, that's ultimately their responsibility and not mine. So, I guess that would boil down to accept appropriate boundaries.

Personal characteristics. All participants cited at least one personal characteristic as a strength that contributed to their counseling effectiveness. Jo described her lifelong interest in the field, 'I have always been interested in mental health and I have no idea why." Elizabeth reported a desire to continue to learn more. She stated, "I never feel like I know enough- I always want to know more. That may be another strength - that I am always, I'm teachable, I'm always excited to learn more and learn new things."

Each participant identified a personality trait as a strength that contributes to their effectiveness with the child and adolescent population. This is the only subtheme of participant strengths. Several participants reported that they felt their innate strengths are

valuable. Beth asserts, “some of it is probably Myers-Briggs, you know, what comes naturally to me.” Mary shared this view, “I guess your personality is something that definitely helps.” Beth reported being patient as helpful. Sally and Kitty both reported being empathic and nonjudgmental as helpful. TB and LR both feel they are “a grown up child” in some ways, while Kelly thinks her “brain works a little bit like a kid’s brain work.”

Factors Contributing to Skill and Strength Acquisition

Participants were asked what experiences contributed to their ability to work effectively with children and adolescents in non-school settings. Participant responses resulted in two main themes including personal factors that contributed and professional factors that contributed.

Personal factors. Thirteen participants reported at least one personal factor that has contributed to their skill or strength acquisition. There emerged four themes including family support, personal therapy, life experiences and self-care.

Family support. Kitty was one of two participants who discussed how important family support has been to her development as she stated, “I‘ve had the luck of incredible support from people.” Jo also had support from her family and husband and credits them for her ability to be successful in her role as counselor:

> Yes, lots and lots of family support. Certainly it would be really hard to do what I do without the enormous amount of cheerleading and support and encouragement from my wonderful family and my awesome awesome awesome hilarious crazy husband who is just an amazing person, an amazing man. Certainly I would have never ever gotten this far without him.

Personal therapy. Two participants, Kitty and Ann, reported that receiving their own

counseling services has contributed to their ability to be effective in their work. Kitty reports that besides her clinical experiences, her own psychotherapy was "the most influential". Ann reported that because "your stability is the most important thing you bring to the therapy room," personal therapy is critical. She further asserts that, "you cannot be a capable therapist if you have not sat on the sofa as a patient for a long time"

Life experiences. Eleven participants reported that specific life experiences have led to the development of skills and strengths used in their work with children and adolescents in non-school settings. Elizabeth credited her life experiences for developing her belief system as she stated that what has been important are, "my own life experiences and out of that, my own belief system that has developed out of my life experiences." Sarah and Sally reported that the life experience of being a parent impacts their work. Sarah spoke to the ways in which parenthood altered her perspective on the caregivers of her clients:

> I think I was a very different clinician prior to having my own child. I had expectations of parents. I had expectations of children based on my exposure. But I think once you become a parent the whole paradigm shifts. What you expect of parents, particularly when you're doing cognitive behavioral work. There's so much that you expect from parents and children to do outside of the clinical setting. It altered, it shifted. Expectations became more realistic. There was a lot more, not that I wasn't compassionate before, but there was a lot more compassion.

Other participants reported life experiences that impact their work including LR and Jo, who experienced disabilities in childhood and adulthood. Jo reported that her experiences of having disabilities have allowed her to have insight to the experiences of clients and their caregivers:

> I know a big part of it is I myself have specific learning disability in two areas as well as Attention Deficit. Big time. I'm so old that there was nobody out there who knew anything about that or that it even existed. I told you I took Algebra 1 three times and that's the truth. I had two instructors in high school who understood that something was wrong. They didn't know what it was or what to call it but knew there was something wrong. Other than that across my entire academic career until I finally hit the wall academically, which was my freshman year of high school, I heard if you would just try harder, if you would just try harder. Growing up with a disability undiagnosed, untreated, and unaddressed is devastating emotionally for people.

Yolanda reported that her own experiences being parented have impacted the way she works with clients and her own children. She stated, "In some ways I am reacting to bad parenting experiences of my own and in some ways I am reacting to some good things that my parents did."

Self-care. The final theme that emerged as a personal factor that contributes to skill and strength acquisition is that of self-care. Three participants reported self-care as a factor for them including Beth who stated:

> I do self-care. Cause sometimes I will look at my schedule and I'll be like 4 children this afternoon- and I don't have the energy for that that day- it takes getting up and down off the floor, being a little more energetic and involved trying to pull information out or symbolism. Some days your energy level is a little low and you need a power nap or eat a granola bar to get your energy up.

Jo reported that learning to take care of herself through play was important in developing ability to be effective. She comment that "learning how to take care of myself. Playing.

Learning that playing is extremely important for grownups and carving out time for play. We play a lot."

Professional factors. Each participant reported there were training or clinical experiences that were impactful in the developing the skills and strengths they draw upon to work effectively with children and adolescents in non-school settings. Ten themes emerged including graduate coursework, non-degree related educational experiences, clinical experiences, supervision, superior educators, mentoring, specialization, research experience experiential activities with children, and voids in training.

Graduate coursework. Graduate coursework was the first theme to emerge. Eleven participants cited that there were specific classes that were instrumental for their development. Courses mentioned include play therapy, child development, family development, lifespan development, family therapy, assessment, diagnosis, art therapy, multidisciplinary approaches, and trauma. While there were many courses that were mentioned by participants, one course, *play therapy*, was mentioned by five participants, and emerged as a subtheme. What also emerged as a subtheme of graduate coursework was the participants belief that *coursework was not as important as other* experiences.

Mary described how she believes the coursework is far less important than clinical practice:

> What you learn in school is one eighth of what you have to apply in practice. I think you learn with every client. I think I have learned more in my practice than I have learned in all the years I went to school. You get the basics, you get the general idea but then when you start the internship or post doc is when you actually start applying those concepts

Non-degree related educational experience. Eleven participants asserted that non-degree related education was critical to their skill development. Within this theme exists three subthemes including continuing education training, independent reading and attending conferences. Nine participants reported that *continuing education* workshops and trainings were particularly helpful. Beth reported that these types of trainings were especially important in her development. She stated, "I would say that all my child and adolescent experience has come in continuing education and self-training." Because she sees their value, Mary attends continuing education trainings regularly. She reported, "Then there is continuing education and I try to go at least once a month to something." While many participants spoke to the importance of continuing education trainings in general, others gave specific examples of trainings or topics that proved helpful. Kelly discussed trainings in strengths based counseling and neuroscience as important. Sally, Sam and Katie reported play therapy continuing education trainings were impactful in their development.

Four participants reported *independent reading* was critical in helping them to develop counseling skills to be effective. Mary reported reading during the time left by canceled or missed appointments, while Elizabeth described herself as a "voracious reader" who is always reading relevant literature. The final subtheme of non-degree related educational experiences to emerge was *attending conferences*. Four participants reported it as important including Yolanda who attends regional conferences. TB reported that attending conferences is a way to combat the risks of not being challenged as discussed previously. He stated, "I have to be very careful in that I get into a flow of doing things and as soon as I have to go to conferences."

Clinical experience. The third theme of professional factors that contribute to skill or strength acquisition was that of clinical experiences. Thirteen participants described these experiences as particularly impactful. Sarah asserted that the more clinical experiences she has, the larger her "internal database" from which to draw upon in session, making her more skilled. Ann shared that gaining clinical experience is the biggest contributor to her ability to excel in her work. While many participants spoke about the importance of experience in general, from the data the two subthemes of work experience, and work with clients, emerged.

Five participants discussed that *work experience* at specific locations were impactful to them. Yolanda described her experiences as a college counselor as influential; "I spent 10 years working in a college setting and working with students there and seeing the issues those students had and recognizing that many of those issues are because of the way they were parented." Other participants discussed working in hospital settings as impactful.

Four participants reported that they *experience with clients* was impactful. Katie reported that her clients lead her to what training or learning is needed:

> The clincher is I learn a lot from kids. To me, once I had sort of the basics, and I had an initial sense of myself working with kids, the children took me to all of the other places where I needed to go with training."

LB stated that he has more realistic expectations for his impact due to his clients, "I think they have strengthened the sense of humility in me."

Supervision. The theme of supervision was the next to emerge out of professional factors that contribute to effectiveness. Nine participants reported supervision was impactful, including Katie, who stated that as important as clinical experience is, it is equally important

to talk about the experiences with a supervisor. Ann shared that sentiment as well as she described the importance of having supervision as you learn your way through the counseling process. She stated, “Most of it comes when you’re doing hands on and you’ve got a supervisor who can guide us through it.” The first of two subthemes to emerge from supervision was the *supervisory relationship.* Three participants reported this relationship was critical to their development. Sam reported that relationship is what helped her supervision to be effective. She stated, “I’ve known her since my internship. I think we developed a good relationship”. Ann discussed the supervisory relationship being critical, “the relationship is key and the support was huge. The relationship first, always.” The second subtheme of *peer supervision* was described by four participants. Katie remarked that informal peer supervision increased her opportunities to process her client interactions, and thus better understand them:

> I can’t tell you how many times I have benefited by just interacting with other play therapists talking about things that were hard and then we brainstormed and then a year down the road I was sitting across from a client that was like that. That wasn’t really formal supervision as much as it was peer supervision or peer consultation, supporting, keeping us all in the profession longer. Having a network of other child counseling professionals that I talk to.

Mary engages in online peer supervision where, “you can try to see what is happening with other people and try to change opinions and share whatever you feel about some specific topics.”

Superior educators. Ten participants asserted that they grew as a result of superior educators. These teachers and supervisors proved powerful for participants throughout their

training and careers. Elizabeth recalled her supervisors in her doctoral programs as effective due to their willingness to push her beyond her comfort zones:

> They really paid attention to helping me get better in those places where I stumbled. And really challenging me to go beyond the skill level that I had already gotten pretty comfortable with. So really pushing me. But watching where I needed, where I stumbled, so they knew where I could very specific where I could improve as an individual therapist and then continuing to challenge me more globally not to just be good enough, but strive to excel.

LR described that he benefits:

> When the trainer or presenter is not robotic and not rigid. Well, neither of those things. And I sense a real spark of creativity and warmth and love for kids. A trainer who's not afraid to think out of the box. I'm also enamored with trainers who are brilliant and at the top of their craft."

Jo reported that the research experience of the counselor educators of her graduate program were influential on her development. She stated, "I was very privileged to be a part of those classes and to be exposed to some of the premier researchers in the field." What emerged as a subtheme of superior educators was the *clinical experiences of educators* was impactful. Ann reported that she valued the many years of counseling experience her supervisor of 25 years had and that she grew as a result of those experiences. Katie reported that the reason certain educational experience were impactful was because of the experience held by the educators. She remarked, "We were taught by somebody that actually had years of counseling experience working with children. That had a huge impact."

Mentors. Five participants reported that mentors contributed to their ability to work effectively with children and adolescents and this became the fifth theme. Kitty reported that a saying frequently said by her mentor, "nothing feels better than being understood" has been influential in how she views counseling. Kelly also remarked on the influence of her mentor on her clinical work. She shared, "I will always be grateful to [her] for the time I spent with her cause she really taught me a lot about language, not only with children and adolescents, but with all clients."

Specialization. The sixth theme to emerge was that of specialization. Three participants reported that through the process of specialization they developed valuable skills. Elizabeth remarked that the through specialization she developed confidence in herself:

> I also think specializing in particular area for me was good, like sexual abuse, so really delving deeply into a particular area and how play therapy affects those children and getting good at that and seeing how a lot of those skills I developed and clinical understanding I developed in working with that population was then obviously useful in other populations. I think that confidence in developing that expertise and depth, so I think confidence was a big one.

Research experience. The research experience reportedly had by three participants emerged as the next theme. Kitty worked for more than two decades as a researcher with children and their families. From that experience she learned to not prejudge the families she works with. She also states:

> Because of my 23 years of research with control groups I had the opportunity of seeing typically developing children. As many typically developing children as I saw children who were at risk for not being typically developing so I know how huge the

> range of normal is. I don't think that's enough in education and I think was a gift that I got that.

Experiential activities. The final theme of professional factors that contribute to the ability to work with children and adolescents in non-school settings is experiential activities. Five participants reported that having hands-on experiential activities as a part of their training was critical to their development. Elizabeth reported that a course in which the professor incorporated experiential practice with a child was important to her understanding of the counseling process with children:

> (H)e builds into that class kind of a micro-practicum experience where you are just intensely, with two other people, you are intensely seeing the same child over and over and over again, and you really see how the process works over a short period of time. I think that was really important for me in kind of seeing a microcosm, or in a compressed view, how it works.

Katie was also impacted by being able to have practice with children in courses and be supervised on those experiences:

> Where I not only learned about theory, but I had the opportunities to work with children and receive supervision as part of my training. I didn't just learn about counseling children through a book, I didn't just learn about counseling children by hearing people talk about it. I got to actually do it. And work with kids and have supervision and talk about it and see lots of videos of people working with children. That was powerful.

Voids in training. While participants were not directly asked what experiences they felt were missing from their training, several participants discussed this topic during their interview. From their responses two themes emerged; coursework and adequate supervision.

Coursework. Sam reported that much of the coursework "was focused on adults" and did not thoroughly address counseling children and adolescents. With regard to the coursework to work children and adolescents Ann stated simply "there isn't enough of it." Jo and Sally both reported that they felt their training lacked child development coursework. Ann, Jo and Kelly reported that they felt training for professional counselors lacks coursework on how to appropriately work with families. Ann noted that, "supervisees who come here are not getting enough work in how to work with families... They need training in family play therapy… they aren't learning how to do family therapy in a productive way." Because Jo felt her training lacked sufficient focus on child development and how to work with families, she decided she "needed to fill in the blanks because I had kind of gotten the cart before the horse if I was going to work with children. So filling in the child development part, and the family development part."

Inadequate supervision. The second theme within voids in training was found to be inadequate supervision. Elizabeth noted that because her supervision group held less skilled students than herself, she was not adequately supervised in how she could continue to grow in her skills. She stated,

> especially in a grad program where they have many supervisees, their time and energy went to students that were struggling more than me, so I wasn't getting challenged to grow, I wasn't getting help in identifying areas I was lax in or insufficient in because they just said great job.

Although Katie did receive supervision in play therapy, which she found helpful, she needed more supervision beyond that of the introductory course. This was not offered through her graduate program.

Masters Program Recommendations

Participants were asked to identify what they felt professional counseling masters programs should include to better prepare professional counselors to work with children and adolescents more effectively. Participant responses yielded five themes: coursework, non-coursework experiences, important topic in counseling, personal counseling and all student receiving child and adolescent focused training. All participants had recommendations for additional training to better prepare counselors to work with children and adolescent. Elizabeth stated, "I think it's just unethical to expect someone to work with a population to which they've not been trained. You cannot apply adult talk therapy exclusively to teenagers and certainly not to young children."

Coursework. All participants named coursework as an important piece of training to be included in masters programs training counselors who intend to work with children and adolescents in non-school settings. Table 3 depicts the courses recommended and how many participants recommended the course. The participants expressed a need for more coursework specific to the need of children and adolescents in counseling. Katie stated, "I think the people that are going to work with children and adolescents need more opportunities to take course work and not as an elective. Let there be a certificate program in working with children."

Table 3: *Course Recommendations*

Course	Number of participants who	Participant quote

	recommend course	
Child Development	9	"A huge exposure to typically developing children to know what the range of normal is" -Kitty
Play Therapy	8	"1 think play therapy should be required if you work with children and adolescents it should be required" -Sally
Family Therapy and Family Assessment	6	"Family. Family would be a big thing. Family is probably the number one thing" Kelly
Child & Adolescent Counseling	5	"A view of what are some of the problems that they struggle with, what are some of the reasons they struggle with those problems and what are some of the most effective ways to handle them. In a very detailed, a whole class on that alone would be very helpful." -Sally
Expressive Art Therapy	3	"Let there be a certificate program in working with children and let it incorporate all that's good in play therapy and expressive therapy" -Katie
Art Therapy	2	"I would love for them to have some art therapy training. I do think that's a necessary piece of it." Ann
Neurology	2	"All of the neuroscience stuff that is coming out is going to be very important in terms of the impact of that as it interfaces with trauma, as it interfaces with abuse in the child and adolescent population."- Kelly
Basic Counseling Skills with Children	2	"Learning how to communicate with a child. Learning how to talk with a child. Learning how to not talk to a child." -Jo
Filial	1	"Filial therapy for sure because you want to impact he system, not just the child."- Kelly
Couples Therapy	1	"It needs to be included in their training. You can't work with the child if you're not also capable of working with a couple." -Ann
Marriage Counseling	1	"So, you understand that they need some art therapy, some play therapy, couples therapy, marriage therapy, and family play therapy."-Ann
Theory	1	"I think it's very important that not just a cursory glance, but a more medium look at nondirective, let me call it Rogerian work or more analytic or Freudian work vs. Jungian vs. Adlerian vs. Gestalt. That they get more look and that they compare and contrast." -TB
Sandtray	1	"I think sand tray work, not just sand tray in the play room, but sand tray work." -Kelly
Substance Abuse	1	"Substance abuse, you need to have knowledge of that. Kids are using at a much younger age." -Kelly
Assessment Methods	1	"Assessment methods class for working with children. That would be neat" -Katie
Creativity in Counseling	1	"Perhaps actively, aggressively nurturing students' creativity and playfulness."-LR
Psychological Disorders	1	"Just I think we are really lacking in kind of learning about ADHD, Autism, Asperger's...there needs to be more, there needs to be some more, we need to learn more skills on how to work with clients that present with those problems."-Sally
Parent Consultation	1	"let there be an advanced parent consultation class"- Katie

Non-coursework experiences. The second theme that emerged from recommendations is non-coursework experiences. Participant responses resulted in six subthemes. These subthemes were practicum and internship, supervision, experiential activities, shadowing, and attending conferences and workshops.

Practicum and internship. Seven participants recommended programs include more practicum and internship experiences for students. Jo recommended, "Internships and practica with small children, young children." Mary suggested that the practicum experiences involve students working with a counselor or a psychologist daily. Sarah recommended that the practica take place in varied settings:

> I think also a variety of practicum experiences. I do not believe that students should only be at the university clinic setting for all of their practicum. I think it's an incredible disservice and if students need to stay an extra year to finish their dissertation and work in other settings that that's what they need to do. And it's in their best interest in this economic time to provide themselves with as much experience as possible

Supervision. Supervision was the second subtheme to emerge under non-coursework experiences in training. Four participants reported that supervision on working with children and adolescents is an important experience to include. Katie and Elizabeth recommended that masters programs have *supervisors with experience in counseling children and adolescents*. Katie stated her belief that masters programs should provide their students with the option of selecting a supervisor who works has experience working with children and adolescents.

> I think that when people sign up for their practicum and internship experiences and they choose to be in settings where they will be seeing a majority of children and adolescents, there should be the option of being able to sign up with a university supervisor that has experience and training working with that population. That doesn't happen very often. I have a lot of people that call me to consult with me because they don't have the option of working with someone that's ever even had a

> session with a child. Or they think they have experience working with a child and what that means is in their practicum or internship they saw 5 or 6 kids to the 100 adults they saw.

Experiential activities. Seven participants recommended programs include experiential activities to teach the concept associated with working with children and adolescents. Kittty recommended that students have more experience with families in their homes. She stated, “Having to go to home visits and see where families are really living, what they are really doing. A huge exposure to typically developing children to know what the range of normal is". Jo encouraged, “lots of observation. Lots of hands-on observing in a preschool for an extended period of time.” She continued, “learning to work with children is hugely experiential. At the masters level, even though there’s an awful lot of stuff you have to do, there’s the intro class, there’s the ethics…If it’s in the context of working with children it needs to include hands on experience.”

Shadowing. Both Beth and Mary recommended programs incorporate a shadowing component to their programs. Beth asserted that this recommendation should apply to all students, even those choosing to focus on adult clients:

> it wouldn’t be a bad idea to have some sort of shadowing or interview of a child therapist or something where people could watch videos of different therapists doing things as a learning experience that way even if they don’t choose to work with people as young as 18 and under they will at least have an idea that they are not qualified to work with them unless they do these techniques.

Mary recommended that students be given the opportunity to shadow practicing counselors to get a sense of their approach:

> If you can shadow any therapist that would be really helpful. Letting people in training shadow another therapist. That's something that I think is the main thing. Doesn't matter what type of theory or technique that you use, just let them see what you do and let them practice. Let the see what you do and they do it.

Attending conferences and workshops. The final subtheme that emerged under non-coursework activities was attending conferences and workshops. Two participants recommended that programs encourage students to attend conferences and workshops in order to gain knowledge specific to working with children and adolescents. Sarah recommended:

> Individuals to go to conferences. I think students should start to go to conference from their first year. I think it's part of professional development. I think it's part of letting them know cutting edge. I think it's part of letting them know that whatever they read in books in an evolving science.

Important topics in counseling. Nine participants made recommendations for important topics in counseling to be covered by masters programs. Elizabeth recommended that students be trained on how to work within a setting where people have different views of how best to help children and adolescents and have different therapeutic approaches. Katie recommended that students learn how to work with adults in addition to working with children and adolescents. She stated she believed students, "need to have parallel training in working with children and adolescents in one group and they need equal parts training in working with adults." Sam recommended that students be instructed in working in non-school settings that are not the traditional office setting. She recommended:

> Working with kids in nontraditional settings, some training on that would be very useful because I don't remember having a lot of that kind of training. And a lot, there's quite a few agencies and companies that are hiring therapist and that's what they do. In home, in school, you're working with multiple agencies, with multiple disciples. I think some guidance on how to translate that would be helpful

From participant comments emerged three themes: how to respect clients, case management, and expectations for practice.

Respecting clients. Jo and Kelly recommended that programs include how to respect clients and families as a part of their training. Kelly stated:

> I think for a child and adolescent therapist to really have deep respect for family and operating from a belief that families want the best for the kids, they are going to do much better work. I think for many years, we did a disservice to families, I call it the orphanage mentality, and we are going to save these poor children. It's like you are not going to save these poor children unless you have a respect and you empower their families, cause that's who is going to save those poor children. That feels important to me. The respect can't just be for the kids.

Case management. Both Kelly and Mary recommended that student be trained in case management strategies and techniques. Mary encouraged programs to teach the mechanics of practice including:

> All that paperwork. When we are in the school setting somebody does that for you. It's just check here, check here. But then I think I don't know different programs exactly how they do it, but I think that's something that they need to learn, the practice of the whole structure. From the beginning, how do you contact the patient?

> We get some education how to network, but I think that's not enough. You need to learn everything from the beginning. Like how to get patients, what do you do when you get the patient, how do you do when you start working with the patient, all the paperwork that goes with that

Expectations for practice. Finally, three participants recommended including training on the expectations for practice. Participants warned that some students graduate without an accurate view of what counseling in non-school settings looks like and what their job prospects will be. Elizabeth stated:

> I know that some do this better than others, but to really help students see both the joys and hardship of doing a private practice or working in an agency. And again helping them to know what is available, obviously, at least in Texas, you can't be in private practice right away until you have your license. And the importance of ongoing support, like a consultation group. How to work in an agency where people might have a lot of different views on how treatment can occur. Just an awareness of what it is really going to be out there in the real world.

Personal counseling. Two participants, Kitty and TB, emphasized the importance of students to intend to become professional counselors and see clients complete their own counseling. TB discussed that while this is something that many programs claim to encourage, there is a lack of emphasis on the importance of undergoing your own self-exploration through counseling. He stated:

> If there's one thing I don't think enough time is spent on, it's been a lot of years since I've been in school but talking to people feels like one of the things that has never had a lot of time spent on is exploring the countertransference and helping students

> understand how important that is. They talk about if you're going to do therapy you should be in therapy yourself. Most programs say that, it almost feels like, okay, this is one of the required statements and let's move on. I think it's more true.

All student receiving child and adolescent focused training. Three participants, Elizabeth, Katie and Beth, asserted that all students should be taught how to work with children and adolescents, not just the students to intend to have children and adolescents and their primary population. Elizabeth noted that students who are not intending to work with this population can learn that working with this children and adolescents in a non-school setting is an option. She stated:

> I just think, one thing we have really discovered with our child and adolescent counseling class (cause I teach that class a lot), it's like light bulbs that come on over students head, it's like they never were even aware that this kind of counseling work was able to do. It's like, wow, this seems like a good fit for me, this seems like what I want to do. Without having that class, or somehow informing students, even if it were a couple of modules in another class, would be to really let students know the possibility of something more than the traditional marriage and family and adult counseling kind of things.

Katie also recommended that programs should encourage all students to study work with children and adolescents. Katie asserted that in order to be effective with either child and adolescent or adult populations, you must be skilled in both. She stated:

> Regardless of who you work with, adults have kids, even if you work with adults you might find yourself needing skills for parent consultation, it might be a sign of a symptom that creates huge stress for them in their daily life, lack of parenting skills

and you might need to do that, and I don't think you can effectively work with kids without having really strong skills with working with adults. And I think when that happens; I think everybody needs to be trained a little bit in both.

Experience of the Interview

At the conclusion of the interview participants were asked how the experience of discussing the topics above in the interview. This question was asked in an effort to establish authenticity. The responses resulted in six themes. These themes were fun, emotional, interesting, reflective, feeling valued, and difficult to generalize.

Fun. Four participants reported that they felt the interview was fun including TB who stated, "It's been fun, it's always nice to reset and think."

Emotional. Jo reported it was an emotional experience to speak of her son with disabilities and her own undiagnosed disabilities in childhood. She stated, "That is always challenging for me to be able to get through and keep my act together."

Interesting. Yolanda and Kelly reported the interview process was "interesting" for them.

Reflective. Six participants reported that the interview process was reflective for them. Kelly noted, "It's a lovely thing to reflect on why you do the thing you do. I am realizing in my own brain I am stumbling around and am like, why is that? Because after a period of years you kind of do it without really thinking about it, and I'm laughing because it gets me ready for my interns that will be here in two weeks. Every fall I feel like I am a lot more introspective and clear because I have to think about this stuff and then by spring I am all discombobulating again. I think they are really great questions."

Feeling valued. Katie reported that being a part of the interview made her feel as though the work she does with children is valued. Katie commented:

> It's nice to be asked. It makes me feel, there is a perception, people will say "Oh you counsel children?" What problems do children have? There is a minimizing by some people, that kids don't struggle or they will say you are play therapist, how fun for you! It's about as much fun as it is to hear about someone who has been raped, but they are 6 so they don't have the verbal skills to have a conversation about it. So I think there is a misunderstanding or a minimization in the way that kids are minimized. So when people ask how could people be better trained to work with kids or what do you think would be helpful or what have you done to maybe make kids' lives better it creates a conversation where it makes the work that child counselors do feel valued, that we are even talking about it at all.

Difficult to generalize. Finally, Mary and Beth expressed difficulty in generalizing all of their experiences to answer the questions accurately. Beth remarked, "For me I am never comfortable in pinpointing what the best thing is about this and the worst thing about that. It's fine. I think it's just hard for me to wrap it up into something that is succinct answer."

Discussion

The purpose of this study was to explore the clinical and training experiences of professional counselors who are perceived as demonstrating exceptional practice with children and adolescents in non-school settings. The grand question was, 'what are the experiences of professional counselors who exhibit exceptional practice with children and adolescents in non-school settings?" There were also two sub-questions: "what are the

clinical experiences of professional counselors who exhibit exceptional practice in non-school settings" and "what are the training experiences of professional counselors who exhibit exceptional practice with children and adolescents in non-school settings." The primary researcher hoped that by identifying the clinical and training experiences of exceptional professional counselors, we would gain insight into how to prepare professional counselors to work effectively with this special population. Consistent with the recommendations found in the literature, the participants in this study identified coursework, clinical experience, and continuing education as a part of their experiences (APT, 2010; Lawrence & Robinson Kurpius, 2000). Additionally, they identified specific personal factors that also contributed to their work with children and adolescents.

Based on the participants' responses, the primary researcher developed the following model for what experiences are critical to the development of professional counselors to work effectively with children and adolescents in non-school settings. The skill acquisition of professional counselors who work effectively with children and adolescents in non-school settings include: (1) master's training, (2) clinical experience, (3) continuing education, and (4) personal factors. This theory is depicted in Figure 1

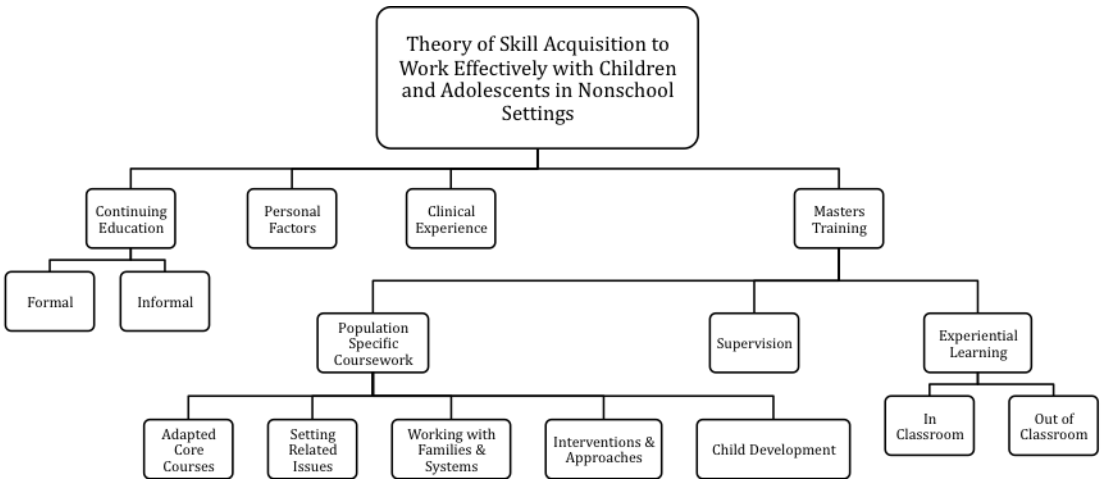

Figure 1. Theory of Skills Acquisition of Professional Counselors who Work Effectively with Children and Adolescents in Non-school Settings.

Masters Training

Participants discussed the importance of their master's training as well as what they felt should be included in a master's degree professional counseling programs to better prepare professional counselors to work with children and adolescents in non-school settings. From these responses, it is clear that certain factors within a training program are critical to counselor development. These factors are population specific coursework, experiential learning and supervision.

Population specific coursework. The participants identified five distinct courses that are critical to learning the necessary skills to work effectively with this population: child development, interventions and approaches, working with families and systems, setting related issues, and adapted core courses.

Child development. Participants believe that their child development coursework was critical to their own development as professional counselors and this course was the most

frequently recommended course. Participants asserted that to be able to effectively work with children it is critical that professional counselors have the background in child development necessary to understand the needs of children and adolescents and how to appropriately meet those needs. The inclusion of this coursework is consistent with the literature that suggests that child development coursework is essential to work with children and adolescents (APT, 2009; Lawrence & Robinson Kurpius, 2000; U.S. DHHS, 1999).

Interventions and approaches. Participants discussed many interventions and approaches that they implement in their work with children and adolescents and made several recommendations on the inclusion of coursework on the topics of intervention and therapeutic approach. Participants recommended that programs include a course specific to approaches to working with children and adolescents, a recommendation that is consistent with the literature (APT, 2010). Participants also strongly emphasized the importance of receiving training related to non-talk based approaches and interventions. Participants reported that play therapy training that occurred in graduate school and continuing education was particularly impactful in their development. Participants reported incorporating extensive non talk based approaches into their own work including play therapy, sandtray, games, role-play, bibliotherapy, and art therapy techniques in their own work with clients. Play-based techniques were also used for evaluating the effectiveness of treatment. Participants view this training as having been critical to their development and encourage masters programs to include them in their curriculum. Participants recommended that coursework include play therapy, art therapy, expressive arts therapy, and sandtray therapy.

Working with families and systems. Participants discussed the importance of working with the families of their clients as well as other systems (i.e., medical professionals,

teachers, public agencies) that are a part of their client's lives. Families played a significant role in the treatment of their child and adolescent clients whether it was through parent consultation, parent education, or parent's being a part of the intervention. Parental reports and reports from other systems served as the primary sources of information from which the participants evaluated the effectiveness of their treatment. Although, the participants recognized the importance of engaging the families in the counseling process, they also reported that working with families can be a barrier to effective work with clients.

In order to work effectively with children and adolescents, professional counselors need to have the knowledge and skills to work with families and systems, understanding how this systems approach can be both a support and hindrance. Participants reported that coursework in the areas of family development and family therapy were helpful in developing their skills and recommended courses in family therapy, family assessment, filial therapy, couples counseling, marriage counseling, and parent consultation be included in masters programs. The inclusion of coursework focusing on a systemic approach is consistent with the existing literature (U.S. DHHS, 1999; U.S. PHS, 2000; Mellin & Pruitt, 2009).

Setting related issues. Participants reported setting related issues acted as barriers in their work. These setting related barriers include: office related tasks, lack of assess to client, the setting creating an artificial environment in which to observe clients, not being challenged by peers, and managed care regulating treatment planning and restricting treatment. Given that these barriers are in place, it will be critical for professional counselors to have skills to address these barriers. Participants also believe it critical that professional counselors have training in case management to learn how to appropriately meet the needs of

the clients, families and managed care. Several participants reported that professional counselors are often under false impressions of the job role of professional counselors, earning potential and job opportunities creating a need for training to help create more accurate expectations for practice in students. Coursework on these topics will increase the overall effectiveness of professional counselors who work in non-school settings.

Adapted core courses. Too frequently, according to participants, coursework is aimed at adult populations and does not provide adequate training on how those concepts apply to child and adolescent clients. Participants asserted that all students, not just those who intend to work with children and adolescents, should be taught how to work with children and adolescents. Participants reported using the concepts typically found in core classes of masters programs in their work. Participants relied on their knowledge of theory, ethics, assessment and diagnosis to make clinical decisions and report that the development of treatment goals and plans as critical to their counseling process.

Participants reported that graduate coursework in trauma, diagnosis and assessment were impactful in their development. They also recommended that programs include coursework in neurology, basic counseling skills, theory, substance abuse, assessment methods, and psychological disorders. While all counseling students are in need of these core courses, professional counselors who work with children and adolescents are in need of adapted coursework which specifically discusses how these topics apply to work with children and adolescents in non-school settings. Inclusion of coursework in theory (APT, 2010), ethics (APT, 2010), psychological disorders (U.S. PHS, 2000), and assessment (U.S. PHS, 2000) are consistent with existing recommendations found in the literature.

Experiential learning. Participants stated that experiential learning was critical to their development. While participants believe coursework is important to graduate training, many voiced the belief that the coursework only begins to be impactful once experiential learning takes place. Participants reported that in class experiential activities such as live demonstrations, practice using play concepts with children, and real case examples were important to their development of their counseling strengths and skills. Experiential activities with children and adolescents outside the classroom setting are also important. Participants asserted that practica, internships and other onsite experiential learning activities focused on work with children and adolescents were critical. Participants recommended that masters programs include shadowing, service learning, in class experiential activities, practica and internships in their curriculum. The inclusion of experiential learning components with children, adolescents and families is consistent with the recommendations found in the literature (Lawrence & Robinson Kurpius, 2000; Raimondi & Walters, 2004).

Supervision. Participants assert that supervision was critical to their development and should be included in masters program, a notion that is consistent with recommendations found in the literature (Lawrence & Robinson Kurpius, 2000). Participants reported that supervised practica, internships and in-classroom experiential activities provided them valuable feedback through which to grow. This supervision was reported to be particularly beneficial when the supervisors have extensive clinical experience counseling children and adolescents and are willing to challenge their students. Participants recommended supervisors of students working with children and adolescents should themselves have clinical experience with children and adolescents.

Clinical Experiences

When asked what contributed to their ability to counsel children and adolescents effectively, participants often described clinical experiences they had after their graduate training. Clinical experience allowed them to have a greater understanding of their clients, their role in counseling and the counseling process. Participants reported that having a wide variety of clinical experiences was important. While they learned from the process, they also learned significantly from the clients themselves. Many participants described specific interactions with clients that proved impactful in their professional and sometimes even personal growth. It was also noted that working with clients provided insight into areas where they needed additional training. Some participants also reported that gaining clinical experience in specific settings proved impactful, allowing them a greater perspective on those they work with.

Continuing Education

Participants' experiences indicated that formal and informal continuing education is necessary in order to remain effective with children and adolescents in non-school settings. Formal continuing education occurred at conferences, workshops and seminars for participants. These trainings allowed participants to remain informed on the current literature and remain current on innovative approaches to working with clients. Participants suggested professional counseling masters programs encourage their students to attend conferences, workshops and seminars, highlighting the importance participants placed on this form of education. Informal approaches included independent reading of texts and journals as well as participation in online forums. Participants warned that an intentional effort to remain current on training through continuing education was critical and that a failure to do so would result in becoming ineffective, or even potentially harmful to clients.

Personal Factors

Participants were clear that there are several personal factors that contribute to their ability to counsel children and adolescents effectively. Participants reported that feeling supported by their family was important in their ability to complete training and continue with challenging work. They also reported that many personal life experiences, including being a parent, having a disability, and experiencing a trauma contributed to their drive to work with children, adolescents and their families or helped them to develop personality traits they feel make them more effective in their work. Participants also reported that self-care is critical to being able to continue to work well with clients. Receiving their own personal counseling to help them cope with their own personal struggles allowed participants avoid personal issues having an impact their work with clients. It was also recommended by participants that counseling students engage in their own personal therapy for these reasons.

Implications

There are numerous implications for counselor educators, professional counseling masters programs, and professional counselors. This study provides support to previous literature which asserts that professional counselors require specialized training if they are to meet the needs of, and work effectively with, child and adolescent clients. This study expands upon the literature, however, by identifying the training components that are needed to ensure competent work with children and adolescents in a nonschool setting. There exists a distinct disparity between the training model presented in this study and current training standards for professional counselors. No training standards or certifications for professional counselors who work with children and adolescents in a nonschool setting are in place and the general training standards for professional counseling programs do not reflect the need

for population specific training as described by participants. Without such standards and mandates put in place by accrediting and licensing bodies, professional counseling programs are at significant risk for failing to meet the needs of students who intend to work with children and adolescents in nonschool settings. This results in inadequately trained clinicians in the community working directly with clients they are not competent to counsel. This study is a step towards the necessary development of training standards which specifically address the training needs of professional counselors who work with children and adolescents in nonschool settings and subsequently the needs of children and adolescents who are being served in these settings.

Regardless of the absence of external mandates placed on professional counseling programs, it is an ethical obligation of counselor educators to provide training to their students that will result in competence. It is therefore critical that counselor educators who train students to work with children and adolescents in nonschool settings incorporate the necessary training experiences into their curriculum. This training, as identified by this study, includes population specific coursework, experiential learning and appropriate supervision. Professional counseling students who intend to work with children and adolescents are in need of specialized child and adolescent coursework in the areas of child development, child and adolescent counseling, non-talk based interventions, working with families, working with systems and setting related issues. Additionally, students require the core counseling courses, but there is a need for these courses to be adapted to specifically discuss work with children and adolescents in non-school settings. Counselor educators must make necessary changes to their program curriculum to include coursework in these areas and to emphasize to their students the importance of practicing within the scope of their training.

Participant responses indicate that it is also critical that counselor educators incorporate experiential learning for students both in and out of the classroom. In classroom activities where students are given opportunities to practice skills and techniques are necessary and these experiences should involve working directly with children and adolescents. Practica and internships where students can gain valuable experience working directly with children, adolescents, and their families are needed in masters programs. Other out of classroom experiences can include practicing counseling skills with children, adolescents and families, completing case studies, and observing a practicing counselor who works with children and adolescents. Supervision of all experiential learning activities is essential and it is critical that those supervising students who work with children and adolescents have clinical experience working with this population in a non-school setting.

While the developed theory includes factors that do not take place in masters training programs, counselor educators have an opportunity to educate their students on the importance of these factors in their professional development. It is critical that students understand that in order to continue to effectively practice with clients they will need to complete significant continuing education training, obtain clinical experience, and consider how personal factors like self-care, family support and personal therapy may impact their work. Counselor educators are in the position to educate their students on the additional work that will be necessary for them to continue their growth as professional counselors, and counselor educators should consider it

There are implications also for professional counselors who are currently working with children and adolescents in nonschool settings. These professional counselors completed their graduate training without the above suggested training standards in place and

may be missing some critical experiences that would benefit their professional development. It is the ethical responsibility of professional counselors to examine their own training and clinical experiences and assess if additional training may be necessary to better serve their clients.

Limitation and Future Research

This study has several limitations that must be considered when interpreting the results. The demographics of the sample were largely homogenous in terms of gender, ethnicity and clinical settings. Participants were mostly women and the sample was primarily Caucasian. Additionally, the majority of the sample practiced in a private practice setting with few participants in other non-school settings. Professional counselors with other genders and ethnic backgrounds may have different experiences than the participants in this study. Also, those who do not work in a private practice setting may have different experiences than the predominately private practice sample in this study. Additional research is necessary to determine if the theory of professional counselor practice and training presented is accurate for other populations and across settings.

A second limitation to this study is that while efforts were made to establish credibility through member checks by having participants review the interview transcript and providing feedback on identified themes, no intense in depth follow up interviews were conducted. While participants were able to indicate that they did not agree with an identified theme, a lack of follow up interviews limits the amount of information the researchers had regarding participants reactions.

The recruitment methodology of this study also serves as a limitation. The researcher worked to recruit participants who demonstrate exceptional practice with children and

adolescents in nonschool settings by asking professional counselors to identify colleagues that they believe to be highly effective with this special population, who they would personally refer a relative to, and who has exceptional skills with this population. While this methodology aimed at identifying only professional counselors who are exceptional in the field, the study has no measures in place to assess the effectiveness of participants to work with this population, and thus the term of exceptional has been placed subjectively onto the participants. This is due, in part, to the fact that there currently exists no measure of effectiveness to work with children and adolescents in a nonschool setting. Future research should address this void within the literature.

A final limitation is that due to the qualitative nature of the study, the biases of the researchers may have impacted the results of the study. While efforts were made through the documenting of a priori constructions, bracketing meetings, peer debriefing, and confirmability and dependability audits, the biases in qualitative research are always present and may have impacted the study.

This study highlights the need for additional research in the training of professional counselors who work with children and adolescents in non-school settings. Given the lack of diversity within the participants with regard to gender and ethnicity, additional research should be conducted examining the experiences of more diverse populations. Future researchers may also want to seek out samples that practice in a wider variety of non-school settings to capture the voices of more professional counselors.

Given the exploratory nature of this study considerable future research is necessary on this topic. Participants of this study could be included in focus groups to further explore the responses to the member check. This could provide valuable insight into the reactions of

the themes identified during this study. Once additional research is conducted to further explore what training experiences are needed to work effectively with this special population, it would be important for qualitative research to be conducted exploring the approaches counselor educators and mental health counseling programs take toward educating professional counselors who work with children and adolescents in non-school settings. Identifying what courses are being taught and what experiences are being provided to students would be critical to determine if the needs of these students are being met.

It is recommended that a study be completed examining the training and clinical experiences of professional counselors with extensive clinical experience and those of less experienced professional counselors. It is essential to determine if differences exist between these two groups of professional counselors with regard to their recommendations for training, valued clinical experiences, and valued training experiences as it may have important implications for counselor educators and counselor education programs. Finally, given the emphasis that participants placed on supervision and experiential activities additional research is needed to determine how professional counselors who work with children and adolescents in non-school settings are being supervised and what experiential activities they are participating in as part of their graduate training and the impact that may have on their counselor development.

Conclusion

Given the lack of literature on this topic, this study was an important first step towards identifying what factors contribute the acquisition of skills needed to work effectively with children and adolescents in non-school setting. Subsequently this study also serves to identify what professional counseling masters programs should include in their

curricula to better prepare students to work with this special population. Counselor educators must continue to advocate for their profession, for their students, and for the children and adolescents receiving services by working to get their programs' curricula amended to reflect these training components and by conducting much needed additional research in this area of counselor education.

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APPENDIXES

Appendix A

Training Recommendations

Source	Coursework Recommendations				
U.S. Surgeon General Report (1999)	Child Development				
Lawrence & Robinson Kurpius (2000)	Child Development focusing on ego identify development, moral development, psychosexual development and cognitive development				
Raimondi & Walters (2004)	Child Development as well as coursework aimed at application of child development knowledge	Working with children and adolescent together			
US Surgeon General Conference on Children's Mental Health (2000)	Evidence based prevention and treatment interventions	Outcome based quality assurance	Competency based assessment and diagnostic skills	Engaging youth and families as partners in assessment, interventions and outcome monitoring	Principles of culturally competent care
Mellin (2009)	Psychotropic drugs commonly prescribed and the potential effects psychotropic drugs have on children				
Mellin & Pertuitt (2009)	Working across systems including family, school and community				
Association of Play Therapy (2010)	Theories of personality	Child and adolescent psychotherapy	Principles of psychotherapy	Legal and ethical issues specific to working with children	
	Clinical Training Recommendations				
Lawrence & Robinson Kurpius (2000)	Supervised clinical practice prior to independent practice				
Raimondi & Walters (2004)	Programs provide opportunities to work with children and families				
Hoge, Huey, & O'Connel (2004)	Train in locations known to excel at working with the population				
Mellin (2009)	Train students in settings that are varied and mirror what they may encounter in real world. (i.e., juvenile court, child welfare, state hospital)				

APPENDIX B

Georgia State University
Department of Counseling and Psychological Services

Informed Consent

Title: The Experiences of Professional Counselors Who Work with Children and Adolescents in Non-school Settings

Principal Investigator: Maggie E. Walsh – Student PI
Dr. Catherine Chang – Faculty PI

I. Purpose:

You are invited to participate in a research study. The purpose of the study is to investigate how professional counselors work with children and adolescents in non-school settings. You are invited to participate because you are a practicing professional counselor with at least five years of experience counseling children and/or adolescents in a non-school setting. A total of 12-15 participants will be recruited for this study. Participation will require approximately from one hour and 15 minutes to one hour and 45 minutes of your time over from July 2011 to December 2011

II. Procedures:

If you decide to participate in this research study, you will be interviewed individually for 45 min to 1 hour with a possible follow-up interview of 30 to 45 minutes. The interviews will take place at Georgia State University, at a secure place convenient to the researcher, or over the phone when distance prohibits interviews in person. You will be audio taped and the taped interviews will be transcribed. Your name will not appear on any written record of the interview, a pseudonym of your choosing will be used on the written data. The key to the pseudonym will be kept in a separate secured location from the rest of the records of this study. The remaining records will be stored in a locked cabinet in the researcher's home office.

III. Risks:

In this study, it is not anticipated that you will have any more risks than you would in a normal day of life.

IV. Benefits:

Participation in this study may be of benefit you personally. You may enjoy the opportunity to talk about your professional experiences in an uninterrupted environment. Overall, we hope to gain information about how professional counselors experience counseling children and adolescents in non-school settings.

V. Voluntary Participation and Withdrawal:

Participation in research is voluntary. You do not have to be in this study. If you decide to be in the study and change your mind, you have the right to drop out at any time. You may skip questions or stop participating at any time. Whatever you decide, you will not be penalized in any way.

VI. Confidentiality:

We will keep your records private to the extent allowed by law. We will use a pseudonym of your choosing rather than your name on study records. Only principal investigators listed above will have access to the information you provide. Information may also be shared with those who make sure the study is done correctly including the Georgia State University Institutional Review Board, the Office for Human Research Protection (OHRP). The information you provide will be stored in the researcher's locked filing cabinet. The pseudonym key will be stored separately from the data on a firewall and password protected computer. Your name and other facts that might point to you will not appear when we present this study or publish its results. The findings will be summarized and reported in group form. You will not be identified personally. It cannot be guaranteed that any data sent over the internet will be secure.

VII. Contact Persons:

Contact Maggie E. Walsh or Catherine Chang, Ph.D if you have questions about this study. Maggie E. Walsh may be contacted at (678) 773-4300 or Maggie.e.walsh@gmail.com and Dr. Catherine Chang, may be contacted at (404) 413-8196 or cychang@gsu.edu If you have questions or concerns about your rights as a participant in this research study, you may contact Susan Vogtner in the Office of Research Integrity at 404-413-3513 or svogtner1@gsu.edu.

VIII. Copy of Consent Form to Subject:

We will give you a copy of this consent form to keep.

If you are willing to volunteer for this research and be audio recorded, please sign below.

_____		
Participant	Signature	Date
_____		
Principal Investigator	Signature	Date
_____		
Student Principal Investigator	Signature	Date

APPENDIX C

Demographic Questionnaire

1. Name_____
2. Gender_____ Ethnicity_____ Age_____
3. Please list any licensure or certifications:
4. Years as professional counselor_____
5. Years as a professional counseling working with children and adolescents

   _____
6. Do you currently work with children and/ or adolescents? _____
7. What percentage of your clients are children? _____ Adolescents? _____
8. Describe the setting in which counsel children and adolescents (i.e. Community, residential, hospital, group home etc.)

   _____

   _____

   _____

   _____
9. What graduate degrees do you hold and from what type of program were they obtained?

   _____

   _____
10. Was your graduate degree from a CACREP accredited program? _____
11. What population did you work with during your graduate practicum and internships?

    _____

    _____

12. Describe the cultural background of the children and adolescents you counsel:

_____

_____

13. How are youth clients typically referred to you? _____

_____

14. What type of continuing education have you participated in? _____

_____

_____

APPENDIX D

Interview Questions

Grand Question: How do counselors in non-school settings approach working with children and adolescents?

1. How did you come to counsel children and adolescents?
2. What has contributed to your ability to counsel children and/or adolescents?
3. What is your role in helping children and/or adolescents move toward change?
    i. How does this look in your work with children and/or adolescents?
4. How do you decide what to do in your work, what informs/drives your decisions?
5. How do you determine what you want your interventions to accomplish?
    i. How do you know if what you are doing is working?
    ii. What do you look for?
6. How has your clinical experience(s) impacted the way that you counsel children and/or adolescents?
7. What emotions do you experience while working with this population?
8. What makes working with this population difficult?
    i. In what ways can these challenges be overcome?
    ii. How do you cope with these challenges?
9. What makes working with this population rewarding?
10. Describe the educational and/or training experiences that were most impactful in helping you to develop as a counselor of youth in non-school settings?
11. What particular strengths do you hold as a counselor of children and adolescents in non-school settings?

i. Where do these strengths come from?

12. What would you recommend masters programs include to better prepare counselors to work with children and adolescents in non-school settings?
13. How was the experience of this interview for you?

Appendix E

Member Check

Experiences of Professional Counselors Who Exhibit Exceptional Practice with Children and Adolescents in Non-school Settings

Themes and Subthemes Identified

Thank you again for your willingness to participate in this study. In total 14 interviews were conducted. From the data of those interviews the following themes emerged. At times, subthemes emerged from within themes. When this occurred, they are listed below the theme.

Please review the themes and subthemes identified by the research team below.

- If you agree with the theme or subtheme, please put a check mark in the box corresponding to the theme.
- If you disagree with the theme or subtheme, please but an "X" in the box corresponding to the theme.

Topic	Theme and subthemes
Role in working with children and adolescents in non-school settings	☐ Facilitator ☐ Holding a therapeutic Relationship ☐ Powerful relationship ☐ Egalitarian relationship ☐ Unique relationship ☐ Nondirective ☐ Theoretically grounded ☐ Mediator between child and family ☐ Witness to client's experiences and emotions
Techniques implemented in session when working with children and adolescents in non-school settings	☐ Play Related Techniques ☐ Play Therapy ☐ Sandtray ☐ Games ☐ Creative and Expressive Arts Techniques ☐ Art therapy ☐ Bibliotherapy ☐ Role Play ☐ Solution focused therapy ☐ Basic Counseling Skills
When counseling children and adolescents the counseling Process includes	☐ Forming/holding therapeutic alliance ☐ Holding and demonstrating respect for client and family ☐ Working with Client's Family ☐ Family involvement in client treatment ☐ Family Receiving treatment ☐ Family Therapy

	☐ Couples Therapy ☐ Children & adolescents are scapegoats for ☐ Working with systems the child exists in ☐ Client and family empowerment ☐ Treatment goals and Treatment Planning ☐ Viewing client holistically ☐ Feelings and emotions experienced in session ☐ Monitor own feelings ☐ Feelings associated with job roles ☐ Feelings associated with client/client's experiences ☐ Faith in Counseling Process ☐ Advocacy
Evaluation of the effectiveness of treatment	☐ Process of Assessment ☐ Consistent assessment ☐ Feedback from multiple sources ☐ Intentional timing of evaluation ☐ Reports ☐ Client self report ☐ Parent/guardian/family self- report ☐ Report from others in client system ☐ Play and Expressive arts ☐ Play disruptions ☐ Play themes ☐ Therapeutic Relationship ☐ Treatment plan and goals ☐ Outcome measures ☐ Behavioral assessment
What is considered when making decisions in session	☐ Theory ☐ Ethics ☐ Individualized treatment and Intentionality ☐ Meeting client where they are ☐ Developmental levels ☐ Abuse history ☐ Intuition and past experience ☐ Reason for referral and diagnosis
Barriers and challenges found in counseling children and adolescents in non-school settings	☐ Setting related barriers ☐ Office Tasks ☐ Lack of access to client ☐ Artificial environment ☐ Not being challenged to grow in skills due to setting ☐ Managed care ☐ Treatment planning ☐ Restricting treatment ☐ Barriers associated with clients client's Family ☐ Parent mental health issues ☐ Socio economic status of family ☐ Family belief systems regarding counseling ☐ Resistant clients ☐ Working with systems
Rewards and benefits in working with children and adolescents	☐ Change in client ☐ Therapeutic progress ☐ Client completion of treatment

	☐ Making a difference in lives of clients ☐ Professional and Therapeutic Relationships ☐ Work is void of certain barriers ☐ Children and adolescents are void of barriers found in adults ☐ Children and adolescents void of barriers found in other settings ☐ Personal rewards ☐ Personal growth ☐ Privilege to work with clients ☐ Prevention ☐ Characteristics of Clients and Interventions
Strengths that lead to effective counseling	☐ Clinical Skills ☐ Faith in therapeutic process and client ☐ Knowledge of literature ☐ Understanding limits and boundaries ☐ Reframing ☐ Strengths based ☐ Personal Characteristics ☐ Personality traits
What led counselor to work with children and Adolescents	☐ Personal experiences ☐ Clinical experiences ☐ Training experiences ☐ Prior related work experience
Personal Factors contributing to clinical skills and strength acquisition	☐ Family/Spousal support ☐ Personal therapy ☐ Personal Life experiences ☐ Self care
Professional Factors contributing to clinical skills and strength acquisition	☐ Graduate Coursework ☐ Coursework less is valuable than other training experiences ☐ Play therapy ☐ Non Degree Related Educational Experiences ☐ Continuing education and Post graduate Training ☐ Independent reading ☐ Attending conferences ☐ Clinical experience ☐ Work experience ☐ Clients ☐ Supervision ☐ Supervisory relationship ☐ Peer supervision ☐ Superior educators ☐ Clinical experience of supervisors ☐ Mentoring ☐ Specialization ☐ Research experience ☐ Experiential activities with children
Voids in your graduate training	☐ Coursework ☐ Development coursework ☐ Family coursework ☐ Adequate supervision
Recommended coursework	☐ Play therapy

for masters programs to prepare counselors to work with children and adolescents	☐ Art therapy ☐ Family therapy/assessment ☐ Filial ☐ Couples therapy ☐ Child Development ☐ Basic counseling skills ☐ Expressive art therapy ☐ Marriage counseling ☐ Neurology ☐ Child counseling ☐ Theory ☐ Sandtray ☐ Substance Abuse ☐ Parent consultation ☐ Assessment methods ☐ Creativity in counseling ☐ Psychological Disorders
Other recommendations for masters programs to prepare counselors to work with children and adolescents	☐ Non Coursework experiences ☐ Practicum and internship ☐ Practicum and internship in varied settings ☐ Supervision ☐ Supervisor with experience working with C & A ☐ Experiential Activities ☐ Shadowing ☐ Attending conferences and workshops ☐ Important topics in counseling ☐ How to respect clients ☐ Case management ☐ Expectations for practice ☐ Personal counseling for students ☐ All students should learn child and adolescent counseling skills
The experience of the interview	☐ Fun ☐ Emotional ☐ Interesting ☐ Reflective ☐ Feeling valued ☐ Difficult to generalize

Since the interview in what ways has your approach to working with children and adolescents in non-school settings changed or evolved?

After reviewing the themes that emerged in this study, what insights did you gain that may influence the way in which you work with children and adolescents in non-school settings in the future?