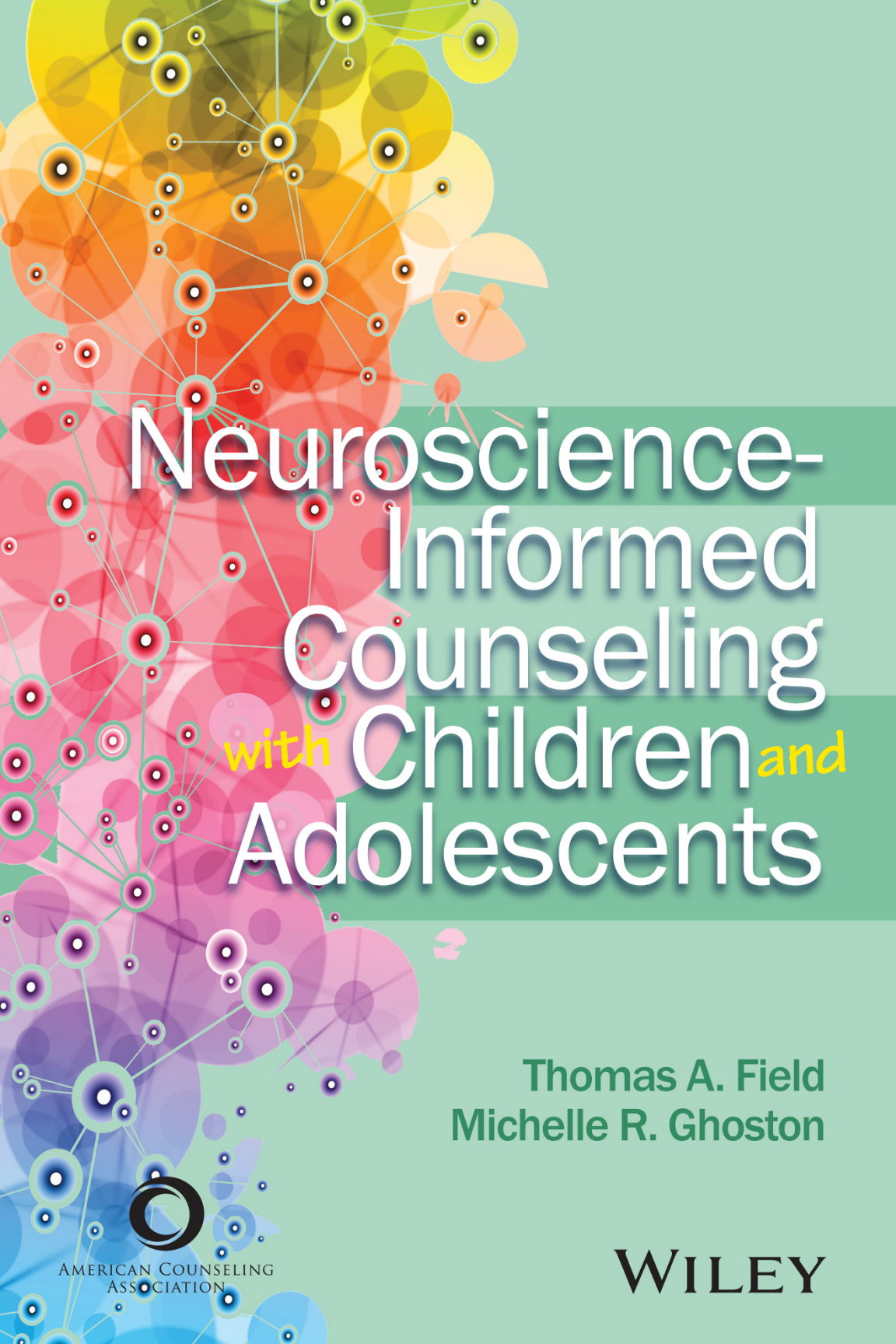
Neuroscience-Informed Counseling with Children and Adolescents
Thomas A. Field
Michelle R. Ghoston
American Counseling Association
WILEY

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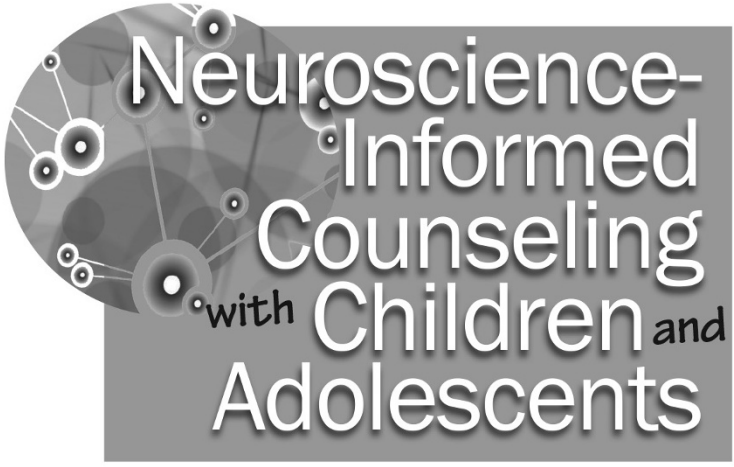

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Dedication

This text is dedicated to our shared mentor,
Professor Steve Nielsen.

Many years ago, both of us attended the master's-level counseling program at Lynchburg College (now the University of Lynchburg). We were in cohorts a few years apart. Steve served as our mentor throughout our master's program, during our doctoral studies, and beyond. Well known to the Virginia counseling community, Steve is well respected for his intelligence, humor, and commitment to serving the community. Both of us learned from Steve the importance of being involved professionally, remaining curious, and constantly seeking to improve as counselors. We hope to embody the warmth, professional commitment, and seemingly boundless wisdom that Steve epitomized. Although Steve did not contribute to this book formally, his spirit is felt throughout.

Table of Contents

Preface

We wrote this text with the intention of appealing broadly to new counselors and experienced practitioners. We also intended for this text to be useful to counselors in a variety of settings, such as schools, hospitals and residential facilities, and outpatient clinics. We cover general principles for counseling children and adolescents before moving into more technical information about neurophysiological development across childhood and adolescence and in-depth information about counseling approaches for different developmental stages. We divide the chapters into three sections. The first section provides a background of neuroanatomy and physiology. The second section focuses on neurophysiological development during childhood and relevant counseling approaches. The third section focuses on counseling adolescents. The concluding chapter explores the delivery of neuroscience education to clients utilizing information that is introduced throughout the text. Our intent for each chapter is to present a neuroscience-informed approach to counseling children and adolescents, and thus we often draw from neuroscience findings when presenting information about child and adolescent development and counseling approaches at different developmental stages.

We recognize that terms such as *childhood* and *adolescence* are difficult to define with regard to age, as children may mature earlier or later than others (e.g., secondary sex development). For the sake of clarity, we loosely define *childhood* as ages 0 to 11 and *adolescence* as ages 12 to 18. These are loose definitions, as experts such as Adriana Galván estimate that the range for pubertal onset is 9 to 16 years. We also recognize that adolescence often ends beyond age 18. We have decided not to differentiate middle childhood (i.e., preadolescence) from late childhood in this text because we see clearer distinctions between early childhood (0–11) and adolescence (12–18) when providing counseling. For example, we have led insight-oriented groups

with adolescents in which 12 or 13 is the cutoff age for inclusion. We have also successfully used insight-oriented approaches such as cognitive behavior therapy with youth ages 12 and older and have observed that play therapy is less useful with youth after approximately 10 years of age.

Text Features

Each chapter includes several text features that we hope will help you to better comprehend the content. **Key concepts** and **aligned Council for Accreditation of Counseling and Related Educational Programs standards** are identified at the beginning of the chapter to assist you in understanding the content and learning objectives of each chapter. **Quiz questions** are provided at the end of each chapter so you can test your knowledge of key concepts explored in each chapter. **Reflection questions** are embedded at different points in the chapter to prompt your own deep reflection on and processing of the content. **Case vignettes** are used throughout the text to demonstrate how to apply concepts to counseling work. Finally, we have included a comprehensive **neuroscience glossary** at the back of the textbook for you to review when you come across unfamiliar terminology.

Case Vignettes

We use pseudonyms for all of the cases in this text, and we sought to intentionally mask identifying information to preserve the identities of former clients. Often we merge the narratives of several former clients into one composite case. Although we have blinded the identities of the children, adolescents, and families we have previously helped, the specific details of the case information are mostly factually accurate. Most case vignettes are brief, although two cases (those of Brooke and Wayne) are more extended and are explored across several chapters. We wanted to use these elaborated cases to describe an in-depth application of key concepts to case conceptualization and treatment planning.

Integrating Neuroscience Into Counseling Practice

The counseling field is increasingly applying neuroscience to counseling practice and is increasingly in need of training opportunities for learning how to integrate complex information into work with clients. A large concern of ours is overreliance on applied models. These are treated as primary sources by some professionals, yet they are in fact interpretations of basic neuroscience anatomy and physiology. We felt that if we summarized these applied models to counseling practice,

we ran the risk of summarizing existing summarizations of neuroscience, which would have led us even further away from the primary source material of neural anatomy and physiology. Thus, you might be surprised to find that we rarely cite commonly known authors such as Daniel Siegel, Louis Cozolino, Allen Schore, and Stephen Porges in the text. We took seriously our charge of using primary sources (i.e., actual neuroscience studies) to provide accurate information about neuroscience and refrained from relying on applied models. We hope this text will increase your knowledge of basic neuroanatomy and physiology, which we believe is fundamental to applying neuroscience in your work.

In our own journeys, we have found that neuroscience has not only supported how we think about counseling but also changed our perspectives entirely. As you read through this text, we encourage you to be open to neuroscience concepts that could change the way you conceptualize and practice counseling. For example, in the text we review the impact of chronic stress and traumatic stress on neurophysiological functioning and its relationship to a host of mental health diagnoses. We also identify strategies for reducing child and adolescent stress, which can be challenging because many of these stressors are not easily reduced and often cannot be removed (e.g., academic requirements, the social environment at school, relationships with parents or guardians). We recognize that the technical nature of the neuroscience terminology might be challenging for some readers. We highly recommend referring back to key terms defined in the glossary at the end of the text to better understand key neuroscience concepts.

Concluding Thoughts

In our favorite textbooks, the personalities of the authors resonate through the pages. We wrote this text with the intention that you will get to know how we think and feel about counseling children and adolescents. At times, our style of writing borders on the informal, to help you understand our own backgrounds and perspectives. At other times, the information is presented in a more formal and technical fashion. We have attempted to balance these two polarities in our writing. We hope that sharing our own experiences with the topic will humanize the neuroscience information and make it more digestible to you.

About the Authors

Thomas A. Field, PhD, is an assistant professor of psychiatry in the Mental Health Counseling and Behavioral Medicine program at Boston University School of Medicine. He has worked as a counselor educator since 2011. He also currently sees clients in private practice. Since 2006, Professor Field has worked with more than 1,000 clients in a variety of settings, including schools, inpatient psychiatric units, and outpatient private practice. He received his doctorate in counseling and supervision from James Madison University. In 2019, he received the Linda Seligman Counselor Educator of the Year Award from the American Mental Health Counselors Association (AMHCA). His primary areas of research are the integration of neuroscience into counseling practice and professional advocacy issues. He is currently the associate editor of the *Journal of Mental Health Counseling,* the coeditor of *Counseling Today*'s neurocounseling column, and chair of the AMHCA Neuroscience Interest Network and Neuroscience Taskforce.

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Michelle R. Ghoston, PhD, is an assistant professor at Wake Forest University. She has been a licensed counselor since 2006 and has worked as a counselor educator in some capacity since 2010. Professor Ghoston has worked with a variety of clients at many different levels and in many settings, including group homes, schools, hospitals, private practice, and intensive in-home treatment. Since entering the world of academia, she has consistently looked back on those early years of working with young people and how they have shaped who she is today. Her primary areas of research are social justice and equity, advocacy, and better understanding how neuroscience influences the work of counselors. Professor

Ghoston currently serves as a member of the editorial board of *Teaching and Supervision in Counseling* (the official journal of the Southern Association for Counselor Education and Supervision) and is on a number of taskforces, including the AMHCA Neuroscience Taskforce.

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Acknowledgments

We are grateful to our colleagues who supported us while we were writing this text and our supervisors from years past who helped us become better counselors. We would like to especially thank Rachel Chaney for her terrific work on several of the graphics used in this book. We also offer the following personal acknowledgments.

Thom: I am grateful for the loving relationships and support of my wife, Selina, and our two children, Elliott and Owen. Being a parent has given me a much richer perspective on child development and strategies for best meeting the needs of children, adolescents, and families.

Michelle: It is with a humble heart that I first give thanks to Thom for inviting me along on this journey. Many thanks to my mother and daughter, who put up with me needing to do a "little" work on this book during our vacation. Mom, you made it clear early on that education was a must—thank you! Lauren, you continue to amaze me with where your life continues to take you. I am beyond thankful and blessed!

We would also like to note that this book was written in the context of our belonging to a community that is dedicated to the integration of neuroscience into counseling. Belonging to this community has helped us over the years to cultivate our understanding of neuroscience-informed counseling. We are grateful for the ongoing impassioned discussions and projects that we share with our colleagues, who include (but are not limited to) Eric Beeson, Ted Chapin, Jamie Crockett, Kathryn Douthit, Mark Gerig, Gary Gintner, Penijean Gracefire, Sean Hall, Allen Ivey, Laura Jones, Chad Luke, Raissa Miller, Yoon Suh Moh, Morgan Riechel, Lori Russell-Chapin, Michael Russo, Eraina Schauss, and Carlos Zalaquett.

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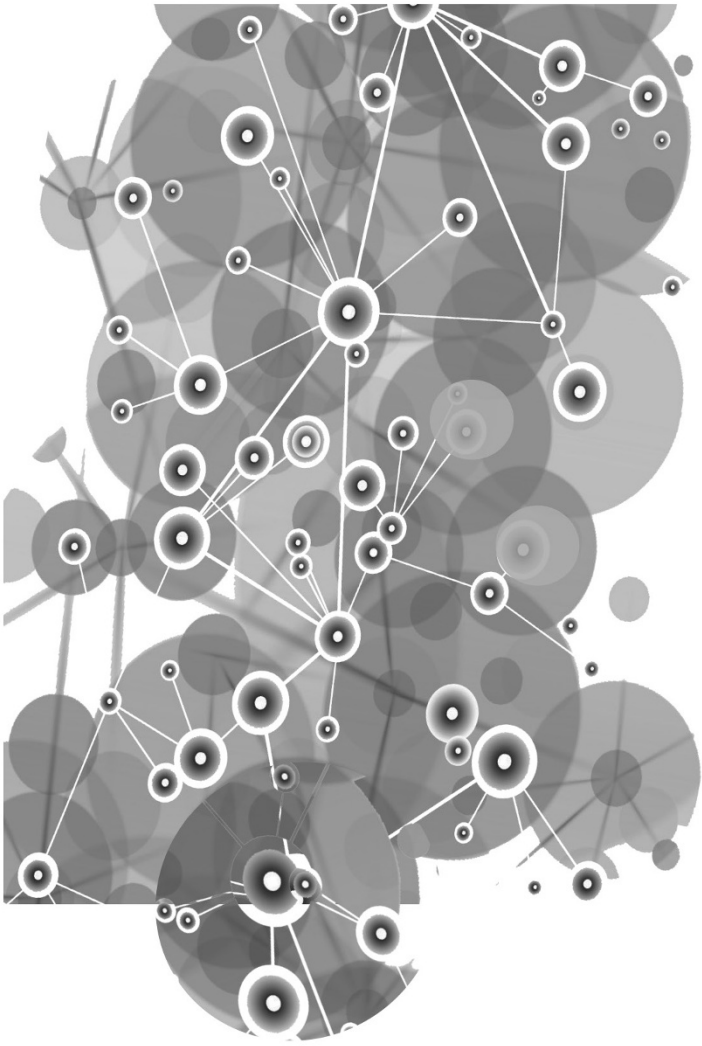


Section I

Foundations

Chapter 1

General Principles for Counseling Children and Adolescents

Key Concepts

- Content and process
- Deficit model of childhood
- Reinforcement association
- Self-efficacy
- Speaker-listener neural coupling

Aligned 2016 CACREP Standards

Standard 2.F.5.f. Counselor characteristics and behaviors that influence the counseling process

Standard 2.F.5.g. Essential interviewing, counseling, and case conceptualization skills

• • •

Both of us began our counseling careers working with children. In this chapter, we describe our background in counseling children and adolescents, discuss the lessons we learned, and propose principles for working effectively with children and adolescents from a neuroscience-informed perspective. These principles are generally consistent across clients.

Thom's Background

I began my counseling career as a behavior specialist at a school for children with severe disabilities. I worked primarily with a late adolescent who had multiple diagnoses, including autism, intellectual disability, Tourette's syndrome, bipolar disorder, and obsessive-compulsive disorder. This person was also taking multiple psychotropic medications, including an antidepressant, antipsychotic, anxiolytic, mood stabilizer, and atypical stimulant (i.e., the five major classifications of psychotropic medications). The experience was formative for me, as I developed a strong relationship with a person who had few words and could barely write their own name legibly. I came to know, respect, and cherish this person and understood who they were beyond their diagnosis or label.

During the 2 years I worked at the school, I volunteered with a local crisis hotline to see whether I would enjoy working with people in more of a counseling capacity (i.e., more active listening, less behavioral intervention). I then took a position as a mental health counselor at an inpatient psychiatric hospital for children and adolescents and worked at that hospital for the next 6 years throughout graduate school. I once did the math and tallied that I provided counseling to more than a thousand children and adolescents during that time period. As a result, I saw the gamut of mental health conditions. I observed the vital role of family and environment in supporting or detracting from a child's mental health. I also became familiar with using formal counseling techniques in individual and group counseling modalities. I had three supervisors, each with decades of experience, who identified with family systems therapy, cognitive behavior therapy (CBT), and psychodynamic therapy. I benefited greatly from that diversity of thought regarding client work.

When I took my first full-time academic job after graduating with my doctorate, I joined a group private practice and continued to work with children and adolescents. The transition from providing short-term counseling in an inpatient setting to providing long-term counseling in a private practice setting was easier than I expected. The issues that children, adolescents, and families faced were quite similar to the ones I saw in the hospital, except perhaps less acute. Many of the adolescents I worked with had strained relationships with their parents and were struggling to forge their own identities. I also often assisted parents and guardians in navigating their own role transition as their children became more independent and needed more support than direction.

During my counseling career, I had several experiences working with younger children. For example, I completed my doctoral internship at an elementary school counseling program. I recently decided to stop providing play therapy to young children in private practice

because I noticed that I had less energy for my own kids when I came home after my clinic day. I have learned that I have to take care of myself if I am to be helpful to others. I have found that play therapy with young children requires more energy and attention than regular talk therapy.

Today I see clients in individual private practice 1 day a week in addition to my academic responsibilities. My counseling work is refreshing and often the highlight of my week.

Michelle's Background

I began my career working as an assistant houseparent in a group home for troubled children. I physically lived at the group home Friday through Monday mornings (in my separate quarters). This allowed me to see the young men from the time they entered the group home until their discharge. I was their pseudoparent, administrator, and disciplinarian. These young men were typically between the ages of 12 to 19 (occasionally a young man decided to remain until his 21st birthday, but this was rare). I saw a multitude of diagnoses in this setting, including major depression, anxiety, obsessive-compulsive disorder, reactive attachment disorder, intermittent explosive disorder, attention-deficit/hyperactive disorder, bipolar disorder, substance use and addictions, and conduct disorder. Comorbidity, or having more than one diagnosis, was common. In addition, the young men typically came from dysfunctional homes, had received services in the mental health system for more than half of their young lives, struggled academically, displayed problem behaviors, and were involved with the legal system. They were also often taking psychotropic medication. My time at the group home was challenging yet rewarding. I learned a significant number of things from other mental health professionals, but most important from the young men themselves.

I remained with the group home until I went to work in a temporary emergency shelter for children. I later returned to the group home setting two additional times but in different roles: as a case manager and an independently contracted therapist. In the years that followed, I began to notice the systemic concerns surrounding so many young women and men being in the negative feedback loop of the social systems in which they resided (dysfunctional homes, trouble in school, trouble within the community, and ultimately legal troubles).

As I continued to work in various settings that focused on helping children and adolescents, I realized that I needed and wanted to support this population in a different way. Completing my master's degree while serving as a case manager at the same group home and getting licensed allowed me to take on a more significant role as an intensive in-home therapist. This work brought me face to face with families, extended families, school administrators, probation officers,

parole officers, judges, and community leaders. This crystalized for me the need for a holistic approach to meeting the needs of these young people. The levels of trauma, stress, disappointment, and inconsistency they often endured were off the charts. This did not excuse their behaviors, but it helped me understand their current problems rather than solely view them as being defiant and deviant. These experiences helped me develop the holistic approach that I take to the work I continue to do as a licensed professional counselor.

While pursuing my doctorate, I continued to work with young people as an independently contracted therapist. I worked at a residential acute stabilization setting in a hospital and also worked as a counselor at a community college, where I worked with emerging adults.

Today I am licensed in two states and plan to work with children and families in some capacity while continuing my academic responsibilities as a faculty member. If I can help one young person see that their life can change for the better, no matter the systemic barriers that person faces on a daily basis, my heart will rejoice!

Three Primary Principles for Working With Children and Adolescents

From our narratives, you may have already picked up on a few lessons that will become important in your own work with children and adolescents. In this section, we outline three major principles for child and adolescent counseling.

Principle 1: Seek to Know People Beyond Labels

Most master's-level counseling students are very excited to take their psychopathology course and to learn the grisly details of abnormal behavior. If we are honest with ourselves, there is an allure to learning about why people behave in dysfunctional ways. For decades, mental health professionals have relied on the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM;* American Psychiatric Association, 2013) to understand why people experience distress and declines in overall functioning. In today's current practice climate, counselors are required to use diagnostic codes from the *International Classification of Diseases* and the associated *DSM* symptom criteria to bill both public and private party health care reimbursement systems for counseling services. Often counselors are required to make a provisional (i.e., preliminary) diagnosis after only one session with a client to receive insurance reimbursement. The primacy of diagnosis in mental health services can be understood through the lens of the greater medical system. If you see a dentist to get a filling, the dental provider will diagnose the problem (tooth decay) and select an approved intervention that addresses the problem (composite filling). Counselors who

bill health care insurance companies for reimbursement of medical procedures must use diagnostic codes.

The use of diagnosis in counseling is often challenging, however, because clients do not present with exact diagnostic criteria. Because biomarkers for mental disorders (e.g., lab tests) have not yet been identified (Field, Beeson, Luke, Ghoston, & Golubovic, 2019), diagnosis can vary between mental health providers and feels subjective at times. For that reason, the National Institute of Mental Health (n.d., 2016) has proposed using a more comprehensive neuroscience-informed model for assessing mental health issues called the *Research Domain Criteria*. The Research Domain Criteria framework encourages the use of multiple physiological assessment methods, such as heart rate, cortisol level, peripheral skin temperature, and so on, in addition to self-reported information. Using such a comprehensive method for assessing children and adolescents is likely out of reach for most practicing counselors today, though it will likely become more feasible as technology and training become more accessible and more guidelines are published and circulated.

Counselors should be discerning and cautious when diagnosing children with mental health issues. Some mental disorders, such as autism and personality disorders, are considered persistent and chronic. Counselors must ethically consider the impact of a diagnosis before assigning it to a client (American Counseling Association, 2014). We recommend gathering significant assessment evidence before making a neurodevelopmental diagnosis such as autism or attention-deficit/hyperactivity disorder.

We have found diagnoses to be, by and large, fairly limited in their usefulness when working with people. Authors such as Sommers-Flanagan and Sommers-Flanagan (2007) and Hansen (2016) have criticized counselors' use of *DSM* diagnoses and their adherence to a mental health culture that stigmatizes clients and reduces their lived experience to diagnostic labels. People are much more than their diagnostic labels. A diagnostic label cannot tell you much about the character, personality, interests, and motivations of the person you are working with. A primary goal of your work as a counselor is to come to deeply know the client. Instead of reducing their clients to their diagnoses, counselors should wonder and inquire about their character and personality. What makes them tick? What do they think about most often? What deeply interests and moves them? Who matters most in their lives, and who are fringe characters? What (if anything) do they want out of counseling? If you can help a child or adolescent figure out the answers to these questions (often they do not know), you will make progress toward forming the kind of relationship that can be transformative. We recommend that counselors intentionally assign diagnoses for reimbursement services but largely refrain from using them to guide their work with clients. There are

exceptions to this: Treatment planning can and should be guided by some diagnoses, such as autism. In subsequent chapters, we try to balance the counselor's need to make differential diagnosis with a humanistic counseling approach that transcends diagnosis.

In most instances, there is no compelling evidence that counselors should rely on a diagnosis to identify the treatment approach when providing counseling to children and adolescents (Sommers-Flanagan & Sommers-Flanagan, 2007). The movement to directly address mental disorders with psychological treatments has been heavily criticized in the mental health community. Research teams led by Bruce Wampold (e.g., Wampold & Imel, 2015) have examined multiple studies to look at the overall effect of interventions (e.g., CBT) that directly address a specific diagnosis (e.g., generalized anxiety). Such studies, known as *meta-analyses,* have consistently found that the actual treatment method (i.e., counseling theory and technique) has very little influence on the outcome. People typically improve because of client variables (e.g., motivation) alongside other treatment variables (e.g., the counselor's skill and delivery, the client's relationship with the counselor, the client's belief and expectation that change will occur). Researchers have also failed to find evidence that specific components of an intervention are critical to the success of the overall intervention. For example, trauma-focused CBT places emphasis on the child or adolescent client identifying and retelling a trauma narrative. Yet trauma-focused CBT is just as effective without the trauma narrative being included in the counseling approach (Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011). Therefore, we do not propose one single theoretical approach for working with children in this text, and we attempt to cover several different traditions in our chapters on specific counseling approaches.

Principle 2: Form Effective Working Relationships

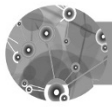
Counselors should be flexible in their approach to counseling children and adolescents. You should take the time to get to know the young person you are working with and be flexible in how you allocate time during meetings with them. Children will vary in what they need from the counseling process. In your counseling career, you will work with children, adolescents, and families from a range of backgrounds and cultures. You will work with people whose backgrounds are very different from your own. Even children and adolescents who have comparable backgrounds, cultures, and developmental stages may still need different counseling approaches. To paraphrase Irvin Yalom (2017), be open and willing to create a new counseling approach for each client.

Building effective working relationships with children can require a different approach and skillset than working with adults. We recommend considering the developmental age of the child or adolescent when allocating the amount of time spent in insight-oriented talk therapy.

The prefrontal cortex does not fully mature until approximately 25 years of age (Arain et al., 2013; Casey, Jones, & Hare, 2008), resulting in difficulties with valuing long-term versus short-term benefits and outcomes, limited attention spans, and struggles with verbalizing thoughts and feelings. Although adolescents of high school age are usually capable of sitting through a 50-minute counseling session, it is unrealistic for an elementary school child to do so. Insight-oriented processing with children should be kept to no more than 10 to 20 minutes at a time. For younger children with neurodevelopmental challenges, such as attention deficits or autism, even 5 minutes of talk therapy can overwhelm their frustration tolerance. It is important that the client view counseling as a positive experience, and thus respecting the limits of the child or adolescent is important.

The counselor should consider the child's or adolescent's developmental stage and age when selecting a counseling approach. For example, younger children may prefer play-based work, whereas older adolescents may feel that play therapy is demeaning and prefer more structured talk therapy approaches. In this text, we review counseling approaches by developmental age. Note that some children will be developmentally older or younger than their stated age, and this should be considered when selecting counseling modalities.

Compared to adults, children often have less interest in discussing their life narratives and the meaning of life events in intimate detail. Many adults, even mandated clients, are motivated to address the immediate problems facing them. Adults can appraise time spent discussing tangential topics as distracting from the task at hand. In comparison, children are often motivated to talk about topics of interest to them, such as favorite hobbies or activities. When the counselor talks with a child about a topic of interest and demonstrates a familiarity with the topic, the child is more likely to become interested in the counselor and eventually become more open to discussing other topics. We like to call this *reinforcement association*. To engage in reinforcement association successfully, counselors must often spend time researching topics in popular culture. For example, when working with children and adolescents, we have intentionally sought to keep up on current knowledge of new musical acts, video games, television shows, social media applications, fictional book series, and sports players and teams. In addition to preferred hobbies and activities, adolescents are often motivated to discuss peer relationships that are important to them, especially dating relationships and friendships. We therefore strongly believe that counselors should take an open and flexible approach with children and adolescents. A balance must be struck between discussing these topics of interest and addressing the pressing issues for which counseling was initiated. A brief case example illustrates the importance of flexibility. Thom once worked with a 12-year-old girl named Kelsey and uses first-person narrative to describe the counseling process. See Case Vignette 1.1.



Case Vignette 1.1 Kelsey

Kelsey was a 12-year-old girl who independently asked her mother whether she could attend counseling. In my experience, this was fairly unusual for a child of middle school age. Kelsey struck me as a very mature 12-year-old whom I could have mistaken for a 15- or 16-year-old had I not had the case file. Kelsey had been experiencing symptoms of depression, and her mother had a history of depression. In our first meetings, I often tried to steer the course of the dialogue toward Kelsey's depressive symptoms and her occasional insinuations that she was restricting her eating. Each time I brought these topics up, Kelsey would become annoyed and shut down the conversation. She consistently insisted that she "just wanted to talk." We spent most of the next 18 months discussing topics that spanned friendships, romantic interests, her athletic experiences, and academic work. Very rarely did we address her symptoms directly. Occasionally I would ask her how she was feeling overall. She often reported feeling much better and was grateful that counseling afforded her the space to talk freely about her life experiences with someone who was not a parent or friend. After 18 months, Kelsey reported that her depression had largely subsided and she felt better able to handle her depression when it did occur. We mutually decided to conclude counseling.

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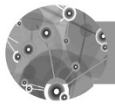
When working with Kelsey, Thom clearly veered toward the extreme end of the spectrum, allowing the child to lead the session with fairly infrequent addressing of the presenting concerns. In Thom's defense, he became convinced early on during the counseling process that Kelsey would stop coming to counseling if he enforced more structure than she was willing to tolerate. Kelsey's story is a helpful example of how a child's developmental age is often different from their actual age, and it highlights the importance of taking a flexible approach to the counseling process when working with youth. Kelsey's need for autonomy and her exploration of identity through discussions of important relationships and activities were more typical of an older adolescent and are fairly unusual for a 12-year-old.

There are several important principles for forming effective counseling relationships with youth in addition to being open and flexible. In particular, it is crucial for the counselor to demonstrate curiosity and bracket assumptions, listen to the underlying meaning and message, respond with genuineness and candor, and demonstrate respect. The

following case vignette demonstrates these principles. Thom once worked with a 17-year-old girl named Amber and uses first-person narrative to describe the counseling process. See Case Vignette 1.2.

We can glean a couple of important lessons from this story. When meeting with Amber, it was very important to hold a not-knowing stance and enter into the dialogue with a genuine curiosity about why she thought and felt the way she did. Counselors must work hard to avoid assuming the meaning of a person's statement or behavior. Often there is a deeper meaning and context to *why* people think as they do or behave as they do. Thom could easily have assumed that Amber was being unnecessarily defiant or unreasonable or attempting to provoke her parents' ire as he entered into the dialogue with her. Doing so would have limited his search to understand her thoughts and feelings.



Case Vignette 1.2 Amber

After several years of working in an inpatient psychiatric hospital, I earned my master's degree in counseling and was given additional responsibilities to provide individual, group, and family counseling to a caseload of children and adolescents whose length of stay was approximately 4 to 6 days. The unit had three full-time primary therapists for a total census capacity of 20 children. During one afternoon, a fellow therapist approached me with a dilemma. He was working with an older female adolescent and had reached an impasse. The adolescent had already been in the hospital for longer than our typical length of stay yet was still refusing to go home. She was adamant that she would attempt suicide if she were discharged back to her family.

My colleague had tried many different interventions, none of which had been successful. He approached me with a request that I meet with the adolescent to see if I could provide a helpful perspective and second opinion. I met with Amber that afternoon and explained my reasons for meeting with her. I informed her that I knew she was still suicidal and felt she was not ready to go home. I mentioned that her current therapist had asked me to meet with her. I opened up the dialogue by asking her to describe to me why she felt so suicidal. Amber explained that she felt we were not taking care of the earth, that our natural environment was "going to hell," and that she did not want to live in a world where humans continually degrade the environment.

(Continued)

Case Vignette 1.2 *(Continued)*

I was stunned. Her response was quite unusual and not what I expected. We continued to discuss further why she cared so deeply about the natural world and sustainability. Amber shared that she voraciously read books and articles about pollution, their effect on the ozone layer, the warming of the polar ice caps, and so on. Toward the end of our brief dialogue, I asked her whether she had ever considered doing something about it. She clearly cared deeply about the earth; had she considered how she could be part of the movement to reduce pollution, waste, and carbon emissions? I mentioned in passing that we *needed* people with such a passion.

The meeting concluded, and I did not have a chance to talk with Amber further. Within a few days, she was discharged from the hospital and did not return. In the inpatient world, the staff typically only hear about their patients' outcomes if they are readmitted to the unit. Thus, no news is often good news. In this case, I had the good fortune to run into Amber once more. A few years passed. I was sitting down to dinner at a local Chinese restaurant with my wife. When the server approached, I recognized Amber immediately. The inpatient hospital was in a small town of approximately 75,000 inhabitants, and it was not unheard of to run into old clients in the community. Amber apparently recognized me too and wanted to chat briefly. I walked away from the table, and Amber mentioned to me that she had completed high school and had enrolled in a sustainability program at the local community college. Clearly, our meeting had an impact on her life direction.

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Sharing responses genuinely was important to the outcome of this dialogue. Amber needed to know that Thom was surprised by her response, that it seemed she had a clear reason for living, and that the world needed more people with such convictions about sustainability. Janet Edgette (2002) wrote that using candor is crucial to connecting with adolescents in counseling. Adolescents are particularly sensitive to disingenuous or scripted responses and yearn for more authentic dialogue.

Not all active listening is of the same quality. Optimal active listening involves the counselor attending to the underlying meaning and message that the person is communicating. In listening closely to

what Amber was saying, Thom became aware that there was a deeper meaning to her persisting suicidality. It became clear that inside her suicidality was a deep care about the planet and natural preservation.

Uncovering Amber's reasons for living was a crucial component of the intervention. Research teams led by Marsha Linehan (e.g., Linehan, Goodstein, Nielsen, & Chiles, 1983; Osman et al., 1998) have recommended assessing reasons for living when working with suicidal adolescents to detect potential protective factors against a suicide attempt. Linehan created a Reasons for Living Inventory that was subsequently revised for adolescents (Osman et al., 1998) to assist with this assessment. Amber's disgust toward human degradation of the environment and valuing of sustainability were important reasons for living and major protective factors against a future suicide attempt. Although one of the main drivers of suicide attempts is psychological distress and the desire to end psychological suffering (Shneidman, 1998), in this case Amber's suicidal ideation came from desperately wanting things to be different rather than from a desire for nonexistence.

Content and Process

Uncovering the hidden meanings and messages in a child or adolescent's story can be a challenge at first. Beyond the *content* of their verbal communication, we can understand the underlying meaning and message of this communication by attending to the *process* by which this information was communicated. For example, we attend to children's nonverbal communication during the session. Do they become more defensive in body posture? Do they avoid eye contact? We also wonder about the reason for their sharing this information. How might they expect the counselor to respond? And how might they ideally want the counselor to respond? Asking these questions helps to move the conversation to a deeper level.

Imagine that you are working with a defiant child who is intentionally justifying their physical aggression toward a sibling because the sibling "deserved it." If you merely attend to the content of the child's verbal communication, you might get drawn into a power struggle. For example, content-based questions and statements such as "Tell me how you think they deserve it" are likely to be met with unsatisfactory answers, if the child's goal is to elicit a reaction from you. At some point, you will need to address the interpersonal process that is happening to take the dialogue to a deeper level. To illuminate the interpersonal process, you might say, "I feel drawn to counter you, which will get us into conflict. Could we explore that?" or "What reaction are you expecting from me, and what reaction would you ideally want?" You might add later, "How do people typically respond when you justify your aggression? How would you like them to respond?" Addressing the child's attempt to initiate a power struggle will help