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Counseling Children and Adolescents: A Call to Action

Rebekah Byrd
Sacred Heart University, byrdr@sacredheart.edu

Chad Luke
Tennessee Technological University, cluke@sbu.edu

Sonya Lorelle
Northwestern University, sonya.lorelle@northwestern.edu

Emily Donald
Aligned Counseling and Supervision, PLLC, emily.donald@gmail.com

Jillian Blueford
University of Denver, jillian.blueford@du.edu

See next page for additional authors

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Counseling Children and Adolescents: A Call to Action

Abstract

The ACA *2014 Code of Ethics* clearly states the mandate for counselor competence in C.2.a. It is noted that “Counselor practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national credentials, and appropriate professional experience” (p. 8). Given the importance of competencies, ethical standards, and the emphasis on best practice, the paucity of these factors in regard to training and supervision for counselors working with child and adolescent populations is concerning. This article offers a conceptualization of the culture of childhood leading to the need for cultural competency. It outlines information specific to counselors working with a child and adolescent population and is a call to action for the field of counseling.

Keywords

competencies, child and adolescent, standards

Authors

Rebekah Byrd, Chad Luke, Sonya Lorelle, Emily Donald, Jillian Blueford, Charmayne Adams, and Edward (Franc) Hudspeth

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The purpose of this article is to address the myriad issues related to lack of competencies, training standards, and supervision specific to child and adolescent populations. This article accomplishes this in three ways: through a discussion of the need for competent clinicians specific to the child and adolescent population by addressing current ethical guidelines and training standards, or lack thereof; addressing the need for competencies by detailing the uniqueness of childhood as a cultural consideration while suggesting specific steps the profession can take now to move towards embracing child and adolescent work in a more deliberate and specific way; and outlining some of the issues specific to working with children and adolescent that call for specific training and supervision in this area that greatly differs from training for working with adults. Highlighting the importance of competencies specific to children and adolescents can grow the discussion and advance advocacy in this crucial area.

There are approximately 73.4 million children and adolescents ages 0-17 in the United States (U.S. Census Bureau, 2018), or 22 percent of the population. According to lifetime prevalence and age of onset distributions, 50% of lifetime mental health issues start by the age of 14 and 75% by the age of 24 (Kessler et al., 2005). Recent data showed a 30.5% increase in mental health diagnoses from 2011-2017 among children and adolescents (Tkacz & Brady, 2019). Furthermore, "the national prevalence of children with a mental health disorder who did not receive needed treatment or counseling from a mental health professional was 49.4%" (Whitney & Peterson, 2019, p. 369). Essentially, half of mental health disorders emerge by early adolescence, and while the number of mental health issues among children and adolescents is increasing, they have severely restricted access to treatment.

A Glimpse into the Problem

The needs of children and adolscents are unique and must be attended to in order to facilitate healthy growth and development (Landreth, 2012; see Byrd & Luke, 2021 and Luke & Schimmel, 2022 for reviews) in cognitive (Piaget, 1952), social (Erikson, 1968), and relational (Bowlby, 1969) aspects of life. The Institute of Medicine and The Research Counsel workgroup's (2012) 10-year reflection on progress in the area of child policy highlights how (a) All children are born wired for feelings and ready to learn; (b) Early environments matter and nurturing relationships are essential; (c) Society is changing and the needs of young children are not being addressed; and (d) Interactions among early childhood science, policy, and practice are problematic and demand dramatic rethinking, which suggest that this population is underserved.

Even when treatment is accessible, they may encounter counselors whose preparation for treating children and adolescents remains ambiguous. While legally minors, there is concern that these youngest members of the population are also minoritized, a term first used by McCarty (2002). In an era of growing demands for cultural competence (Hays & Erford, 2018; Sue et a., 2019), there are indications that this population has been systematically overlooked. The American Counseling Association (ACA) *2014 Code of Ethics*, for example, mentions children only twice, and those times in the context of their legal standing as minors (ACA, 2014). The practice competencies in the Council for Accreditation of Counseling and Related Education Programs (CACREP, 2015) standards related to counseling children and adolescents are narrowly focused on elements of development in the context of lifespan development – as if childhood were a stage of life like any other.

Currently, neither the ACA *2014 Code of Ethics* nor the 2016 CACREP Standards include practice considerations (e.g., theory or techniques). Even within the specialty area of school counseling, there is only one mention of counseling techniques specific to working with a child

and adolescent population (CACREP Section 5.G.3.f. techniques of personal/social counseling in school setting). Childhood and adolescence are not developmental stages like any other. Critical periods of development define these stages of life; children's needs and development are unique, and counselors need to be attuned to these (Ray, 2019). This raises concerns that the standard of care for clients representing almost a quarter of the US population may be missing or lacking.

The American Psychiatric Association's (APA, 2013) *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*) contains examples of children and adolescents as a minoritized group. This theme is seen most clearly in the way children and adolescents are diagnosed and treatment is delivered. The *DSM-5* uses V-codes, and the ICD-10 (World Health Organization, n.d.) uses Z-codes to characterize features of a client's environment or experience that may warrant clinical attention (e.g., Problems Related to Family Upbringing, Child Maltreatment and Neglect Problems, Housing Problems, Economic Problems, Disruption of Family by Separation or Divorce, and High Expressed Emotion Level Within Family; APA, 2013). All of these represent environmental and experiential factors in a child or adolescent's life, about which they have little control; yet, when a child or adolescent is presented for counseling, any diagnosis considered for third-party reimbursement must locate the issue *within* the child or adolescent. Naturally, V- and Z-codes may be added, but these are not conditions of primary clinical concern, since the purpose of these manuals is to treat individual disease and disorder. Nevertheless, the child or adolescent who struggles, quite understandably, to cope effectively whilst living in a climate of poverty, violence, neglect, or other disruption, will carry the burden in the form of a diagnostic label. As a society, we seem to be saying to these youngest members, "while it is not your fault, you carry the responsibility for the results of your circumstances." A similar pattern can be seen in the way most minoritzed groups are treated (Singh et al., 2020).

The DSM-5 does, however, outline disorders that specifically impact children's mental health. For example, common childhood diagnoses include developmental disorders like autism spectrum disorder (ASD) and social communication disorder (SCD), attention deficit/hyperactivity disorder (ADHD), disruptive mood dysregulation disorder (DMDD), impulse-control, and conduct disorders (APA, 2013). There are also child and adolescent considerations made for depression, anxiety, and post-traumatic stress disorders. The treatment of these disorders, or lack thereof, has implications for healthy development into adulthood (see Prinstein et al., 2019). Children are not miniature (Landreth, 2012) or under-developed (Luke & Schimmel, 2022) adults, and must not be treated as such in counseling spaces (Byrd & Luke, 2021); therefore, it is important to challenge the assumption that the skills and interventions for adults can be directly and effectively applied to children (Sommers-Flanagan & Sommers-Flanagan, 2018).

A Glimpse into Opportunity

The counseling profession has an opportunity to declare its dedication and commitment to this population by emphasizing specialized education and training standards for working with children and adolescents. Authors have recommended that children and adolescents be viewed through the lens of culture – the culture of childhood and adolescence (Luke & Byrd, 2021; Luke & Schimmel, 2022; Luke, in press; Sommers-Flanagan, 2007), meaning that counselors have standards that account for this (which also directly impacts supervision). Standards also respect and promote unity in the profession rather than dividing through specialization. It is equally vital to consider the importance of training counselors to work with the uniqueness found within cultural groups (Peters & Luke, 2021). Given the lack of standards for counseling and supervising clinicians working with children and adolescents, the increasing mental health needs of this

population, the potential improvement of services that result from competencies for counseling children and adolescents, and the unique culture of this population, what follows is the use of a lens of culture in the consideration of standards.

Culture of Childhood and Adolescence

Many of the challenges that affect children and adolescents are out of their control, and occur in a unique developmental phase with a culture all its own, the profession may need to consider the culture of young people when creating competencies. At the time of this writing this manusrcipt, there were no published works on the use of multicultural orientation with children and adolescents. This provides a valuable opportunity for professional counselors to continue to explore how they meaningfully integrate and value the unique facets of children and adolescents' culture in therapy. Against this backdrop of MSJCC and multicultural orientation, we offer several considerations for the development of child and adolescent counseling standards. We echo Sommers-Flanagan (2007) in asserting that children and adolescents are a culture unto themselves, and in this they must receive appropriate respect and support.

When thinking about the characteristics of a culture, several features are apparent, as is their fit when considering children and adolescents. Slattery and Park (2020) highlighted the features of culture, which include attitudes, values, habits, norms, institutions, and experiences. This increases in significance given that many, if not most, models of cultural domains seem to leave out age (Luke & Byrd, 2021). Perhaps adults overlook this because for the first 18 years of their lives, they lived this culture, and may struggle to find perspective in viewing these stages of life as culturally bound.

Developing competence in counseling children and adolescents rests between recognizing the role of the client's context and culture in their life and presenting concern, while also

recognizing the characteristics that define them as individuals. Chiao (2018) asserted, "Culture influences the neurodevelopmental trajectory of mental processes and behavior. Cultural and biological processes alter the maturation of the mind and brain throughout development" (p. 81). Chu (2019) described the tension between individualized treatment that results in novel treatments for every conceivable cultural group, and more generalized approaches that appreciate culture in individualizing treatment. Woodside and Luke (2018) recommended a figure-ground approach to understanding the individual as a culture of one, against the backdrop of many levels of intersecting cultural factors.

One effort to understand this balancing act – between not assuming every presenting issue is culture-based and assuming it is not – has been the development of the Multicultural and Social Justice Counseling Competencies (MSJCC; Ratts et al., 2015). The MSJCC outlines four areas of competency - attitudes and beliefs, knowledge, skills, and action – which can inform competency development for working with children and adolescents. These are demonstrated across four developmental domains of practice: counselor self-awareness, client worldview, the counseling relationship, and advocacy and interventions. Luke and Byrd (2021) have applied the intersections of the competencies and domains to counseling children and adolescents. These manifest as questions for reflection by the counselor. For example, at the intersection of attitudes/beliefs and counselor self-awareness, counselors might ask themselves, "*What attitudes and beliefs do I hold toward a client who is a child or adolescent that I need to become more aware of?"* (Luke & Byrd, 2021, p. 251). This question is more complex than it first appears, as adults often carry into sessions assumptions about childhood and adolescence based on their own experience. Luke et al. (2020) referred to this type of assumption as projective sympathy, wherein a counselor may imagine how

they would feel (or did feel at that age) in a given circumstance, assume that is how the client is feeling, and respond based on that assumption.

Cultural competence models have received increased scrutiny and alternatives have been offered. One alternative or potentially complimentary frame is the multicultural orientation approach, proffered by Hook et al. (2017). Multicultural orientation is a framework to guide counselors as they work with diverse populations (e.g., Hook et al., 2017). The concept of multicultural orientation has been studied in both social work (Gottlieb, 2020) and in psychology (e.g., Hook et al., 2013) but has been sparsely integrated into the work of professional counselors or counselor-in-training curricula. However, there are important implications for working with children and adolescents.

Hook et al. (2017) referred to the three components of multicultural orientation as “pillars” (p. 29). These three pillars integrate self-reflection, the counselor’s actions in session, and an attunement to the physiological experience of engaging in conversations that are challenging for us. The first pillar is *cultural humility*, which is described as an intrapersonal and interpersonal experience of curiosity, humility, and reflection of our own cultural identity as it relates to those of our clients (Hook et al., 2013; Hook et al., 2017). For counselors working with children and adolescents, this means reflecting on our own experiences as children, our perspective on children and adolescents, and how those views are influenced by our context. Some questions counselors may want to consider are: *How was your experience as a child or adolescent, and how is your experience impacting your clinical work? What are my perspectives on children or adolescents such as their clothing, music trends, technology use or aspects of their cultue? How does the media I am exposed to impact my perspective on children and adolescents?*

The second pillar is *cultural opportunities,* which are times in session when you invite the client to talk about their culture (Hook et al., 2017). It is important that we view children and adolescents as having their own distinct culture with its own rules, norms, language, and rituals (Sommers-Flanagan, 2007). It is important for counselors to stay attuned during sessions and invite clients to truly bring their whole selves into that space; this will help clients feel heard and reduce the chance of microaggressions (Davis et al., 2016). Cultural opportunities allow all of the youth's identities to be a part of the counseling process especially those that the counselor is not as familiar with.

The third and final pillar is *cultural comfort.* Cultural comfort is the physiological and psychological experience that happen for the counselor prior to, during, and after inviting the client to share their culture in session (Hook et al., 2017). Cultural comfort is what allows counselors to remain genuinely curious in session, without nervousness or feelings of shame for not knowing something about the client's culture blocking making contact. Counselors must remain aware of their feelings while in session, as well as how they invite or avoid asking the youth questions about their cultural experiences (Hook et al., 2017). Some questions that may be helpful are: *How comfortable or uncomfortable do I feel while asking my youth clients about their culture? Are my feelings of discomfort or shame keeping me from engaging with younger clients? What is my physiological (heart racing, sweating, dry mouth) and psychological (racing thoughts, second guessing, cloudy mind) experience when I begin to ask my child and adolescent clients about culture? How might I be avoiding asking about culture with my young clients because I assume it is unimportant? How might I be avoiding my own feelings of discomfort, and/or ashamed of admitting my lack of knowledge?*

Although not the only salient considerations, there are three intersectional categories of diversity that further affect the development, adjustment, and success of young people. They include, sex and gender, socioeconomic status (SES), and race and ethnicity. At this point, there is ample evidence from biology and neurobiology that there are fundamental differences between male and female (see Panksepp & Bevin, 2012, for examples related to the neurobiology of play). Further, the 51% of the United States population identifying as female make up the largest minoritized group of individuals. Despite similar aptitudes, skills, abilities to males, females are routinely placed in subordinate roles with disproportionate expectations (e.g., be the perfect mother plus successful career woman). These dynamics are not only on display for children and adolescents, but they play out in society with many individuals. Messages about gender, and by extension, gender expression and affectional orientation serve to perpetuate a difference-in-kind equals difference-in-value motif that affects resilience and mobility.

Second, socioeconomic status is a significant predictor of adjustment among children and adolescents (Thomassin & Hunsley, 2018). The lower the SES, the higher the risk for a variety of physical, academic, and mental health issues (Frankenhuis & Nettle, 2020). Socioeconomic status affects the social, biological, and neurobiological development of individuals (Farah, 2017), so given the number of children and adults living in poverty, along with the social characteristics of poverty and SES, it is a cross-cutting measure that is important for counselors to take into consideration (Sue et al., 2019). While counselors are careful not to blame parents or caregivers for their economic situation or lack of financial stability, they recognize the impact this has on treatment compliance and outcomes (Veitch Wolf & Kelly, 2018).

The third category, race and ethnicity, are tenuous constructs, as the history of cultural competence is replete with examples where learning about racial group characteristics has led to

racial stereotyping. The history of minoritized racial/ethnic groups (non-White, non-Western) is important in understanding the effects of race and racism on the development of children and adolescents. The effects of racial oppression and abuse can continue to emerge for generations, including elevated levels of cortisol that can lead to a change in basal stress rate (Pitts-Taylor, 2019). Therefore, it is important to incorporate cultural identities of young people in order to move beyond misguided, stereotyped approaches to children of color. This argument is situated in the ethical mandate for competence and existing ethical standards.

A Glimpse into a Way Forward

Once the conversation has been situated in the culture of young people, as well as their cultural identity, specific standards must be developed. Standards should address the nuances of working with young people with specific ethical and competence standards, including but not limited to, guidance on informed consent, boundaries, confidentiality, mandated reporting, and touch. One manuscript cannot contain comprehensive discussion of all facets of standards; those presented here are intended to advance the conversation around consideration of standards for addressing the culture of childhood and adolescence which will also guide supervisors in this important work.

Existing Ethical and Accreditation Standards

Counseling professionals refer to and rely on several ethical standards and guidelines to inform their practice. The more well-known counseling ethical standards (e.g., ACA, ASCA, AMHCA) address similar topics relevant to the counseling profession. The ACA *2014 Code of Ethics* is the primary code by which counselors abide. Ethics often forms the basis for state standards for licensed counselors and is the standard by which counselors are expected to practice and be supervised during training. Other codes by which counselors abide may include the

AMHCA (2015, 2020) *Code of Ethics*, for counselors with a clinical mental health focus, and the ASCA (2016) *Ethical Standards for School Counselor*, for those with a school counseling focus. Additionally, these ethical guidelines discuss counseling considerations for specific populations, such as couples and families (ACA, 2014); K-12 students (ASCA, 2016), and terminally ill clients (AMHCA, 2015, 2020). However, there is a significant gap in the current ethical standards regarding maintenance of ethical practice for mental health counselors engaging with children and adolescents. This gap includes the ASCA's *Ethical Standards for School Counselors* (2016), which do address counseling children and adolescents, but only through the school counseling lens. This can result in mental health counselors practicing without applicable ethical standards for their work with children and adolescents and without supervision geared towards working with children and adolescents as well.

As mentioned above, the ACA *2014 Code of Ethics* only includes only cursory references to children. One of the primary concerns in the code is with informed consent and the protection of the confidentiality of minors. Counselors are given guidelines about confidentiality in section B.5.a, where they are directed to follow "federal and state laws, written policies, and applicable ethical standards" (p. 7) and in B.5.c. where they are directed to seek appropriate consent to release information about minors (i.e., that of a parent or legal guardian). In A.2.d, counselors are advised to "balance the ethical rights of clients to make choices, their capacity to give consent or assent to receive services, and parental or familial legal rights and responsibilities to protect these clients and make decisions on their behalf" (p. 4). In B.5.b, counselors receive guidelines on working with parents and guardians, which also addresses confidentiality, in addition to the establishment of "appropriate, collaborative relationships with parents/guardians to best serve clients" (p. 7). Similarly, AMHCA (2015, 2020) cursorily mentions children in the context of capacity to give

informed consent (2.k.), establishing relationships with caregivers (2.b.), and clarifying relationships (3.a.). Brief coverage of similar topics are found in The American Association for Marriage and Family Therapy (2015) *Code of Ethics* and the American Psychological Association (2016) *Ethical Principles of Psychologists and Code of Conduct*. Training programs often have entire classes dedicated to ethical and legal issues in counseling. However, understanding the complexities of working with minors is certainly not a focus, if it is taught at all (Remley et al., 2021).

With so little mention of the ethical obligations of counselors to be trained in work with children, it is unsurprising that neither the 2016 CACREP Standards nor the 2024 CACREP Standards, draft 3, do not identify work with children and adolescents separately. Aside from a cursory mention in school counseling standards, children seem to only appear in an implied way in section "Section 2:F.3. Human Growth and Development" (p. 10-11). Yet addiction, career, clinical mental health, clinical rehabilitation, school, marriage, couple, and family, and college counseling (and student affairs) are recognized as distinct "entry-level specialty areas" (p. 2) deserving of separate competencies. If such sub-specialties in counseling require separate competencies for ethical practice or specialization, it seems remiss of the counseling profession to not also identify work with children and adolescents as a specialty in need of standards.

There exists a need for ethical standards specific to working with children and adolescents. There is a lack of attention on ethics in the literature. Yee et al. (2019) conducted a content analysis of 10 years of publications in the *International Journal of Play Therapy*, the *Journal of Child and Adolescent Counseling*, *The Family Journal*, and *Journal of Infant, Child, and Adolescent Psychology*. They found only four articles published on ethical issues. This is especially concerning given that ethical decision-making with children and families is complex and requires

specialized knowledge of both ethics and laws (Lawrence & Kurpius, 2000). Some of these important ethical and legal factors include, competence, informed consent, boundaries and roles, privacy and confidentiality, mandated reporting, and touch.

Competence

The ACA *2014 Code of Ethics* clearly states the mandate for counselor competence in C.2.a. “Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national credentials, and appropriate professional experience” (p. 8). Furthermore, C.2.b. indicates that counselors practicing skills in new competency areas must protect clients from harm that could result from the fact that they are not yet competent.

According to American Mental Health Counselors Association (AMHCA) “LCMHCs working with children and adolescents require specialized culturally competent knowledge and skills pertinent to the inter-related domains of development—cognitive, neurological, physical, sexual, and social development” (p. 32; 2021). In the latest edition of *AMHCA Standards for the Practice of Clinical Mental Health Counseling* (2021), four new sections of standards were added, one of which is entitled *Child and Adolescent Standards and Competencies*. These standards are listed under headings addressing knowledge and skills. Subheadings under each of these are as follows: Neurophysiological Development, Social, Cultural, and Familial Influences, Diagnosis and Treatment Planning, Academic, Vocational, and Career Development, and Legal and Ethical considerations. Specific competencies are outlined under each subheading: “Understand the role of gender and gender identity on development, including the influence of gender role socialization practices” (p. 32), “Implement developmentally-appropriate practices when counseling youth, such as using play therapy approaches” (p. 34), and “Demonstrate ability to assess and treat

attachment distress an relational patterns, including attachment-based disorders" (p. 35). While this information is lacking in 2016 CACREP Standards, similar competencies could be included easily and thoroughly integrated into future iterations.

Ethics dictate that professional counselors integrate evidence-supported assessments and interventions into practice. However, without explicit guidelines and foundational knowledge specific to children and adolescents, the ability to assess and evaluate competence in counseling children and adolescents seems challenging. Without this consistent reflection regarding one's current competence and needs for growth, professional counselors may miss opportunities to learn of best practice supportive of the social-emotional development of young people.

Work with children and adolescents requires more than what is covered in the general or school counseling curriculum. Counselors must possess a deeper understanding of development (neurological/cognitive, psychological, and biological) and specific techniques as well as a deep understanding of youth culture. This lack of standards and ethical guidelines leads to issues of competence in the field of counseling. Several areas of competence vital for training and supervision deserve attention.

Informed Consent

Informed consent is the process in which the client is educated about treatment, including the risks and benefits, and gives permission for this treatment. The ethical challenge for counseling children can be in determining who should and can give consent for treatment (Sori & Hecker, 2015). The legal age of consent can vary from state to state. How consent is given is also important; adaption of paperwork and explanation of services for children in developmentally appropriate ways is needed. Even when legal consent is not needed from children, *assent,* which is the agreement to services when legal consent is not required, should still be part of the ethical process

of engaging in services with children. When considering consent, parental custody for parents/caregivers who are separated or divorced can also add a layer of complexity. It is important to determine who has custody and to follow custody agreements. If there is joint legal custody, there is a need for both parents/caregivers to consent. If parents/caregivers are separated, the counselor may need to reach out to the non-custodial parent/caregiver.

Boundaries and Roles

Clarity in roles and responsibilities are also important considerations in working ethically with children, especially when divorce or custody issues arise in families. Parents/caregivers may request the services of a counselor, but may be hoping for an evaluator to assess parenting fitness, a guardian ad litem, a mediator to resolve disputes between parents/caergivers, or an expert who evaluates testimony of other mental health professionals (Woody, 2000). It is vital to clarify the role prior to treatment, and if the role has been established as a counselor, then opinions about custody should not be given in court (Sori & Hecker, 2015), even when lawyers press counselors for a professional opinion. Confusion of roles can create ethical dilemmas for counselors, and clarity of roles should be established in the ethical codes and standards.

Privacy and Confidentiality

When counseling children and adolescents there is always the dilemma on how much information to share with a parent or caregiver (Lawrence & Kurpius, 2000). Counselors must determine where the caregiver’s right to know ends and the child’s right to privacy begins. The legal and ethical guidelines for this balance may be in conflict. In general, decisions about disclosure are dependent upon the parent/caregivers’ ability to use the information appropriately, what is in the best interest of the child, emotional vulnerability, and physical safety of the child (Sori & Hecker, 2015). Limits of confidentiality can include situations when subpoenas and court

orders are given in custody cases, creating an ethical dilemma counselors face when working with children. Sori and Hecker (2015) outline a series of steps to take when deciding how to proceed on deciding whether or what information to release, including to read the subpoena thoroughly and explore the intention of the request, talk with the client or client's attorney with a written release to discuss options.

Mandated Reporting

One of the major limits of confidentiality is when there is a threat to the safety to the child and counselors must report abuse and neglect by law. According to Child Welfare Information Gateway's State Statues Series entitled Penalties for Failure to Report and False Reporting of Child Abuse and Neglect (2019), mandatory reporters who willingly or knowingly fail to report suspected child abuse will face penalties in many states. Failure to report is classified as a misdemeanor in 40 states (2019). Additionally, "even in states granting privilege to the PSC (professional school counselor) student relationship, the duty to report suspected abuse supersedes privilege and confidential communication. Therefore, PSC's must report suspected abuse in all circumstances" (Lambie, 2005, p. 252).

Counselors need to understand that failure to report can lead to liability on the part of the counselor. A study conducted on school counselors and child abuse reporting found that school counselors cited the main reason a suspected case of abuse went unreported was due to a lack of evidence (Bryant, 2009). It is imperative to reiterate that child abuse statutes do not require mandated reporters to have evidence of abuse, it is only necessary for them to have reasonable suspicion. A child should *never* be asked to provide evidence for, or document their own abuse; in 2010, a middle school counselor in Texas was arrested for instructing a student, who reported sexual assault, to video record the assault (Stone, 2011). AMHCA standards suggest counselors

should "understand physical and emotional signs of child abuse and neglect, interviewing, procedures, and appropriate steps required to report such abuse/neglect within timeframes established by state law" (2021, p.33). Such information is vital to training ethical counselors.

Supervision

Teufel (2007) addressed the lack of competencies and information in the literature regarding supervision of counselors working with children and adolescents. Teufel noted much information in the field of play therapy supervision but called out the the lack of research related to supervising counselors. Neill (2006) also addressed the lack of attention child and adolescent supervision has received in the field. This seems to still be the case in the literature 15 years later. Teufel also noted that the supervision process is vital in addressing training considerations, maintaining standards for best practice in the profession, and inevitibily promoting client welfare. How is our profession still perpetuating such a deficit? To adequately prepare counselors in training for their future roles as professionals in the field, counselor educators and supervisiors will need to first advocate for specific competencies for working with the child and adolescent population. It is not until competencies are established that we could expect to navigate training guidelines, accreditation standards, gaps in research, and specific supervision needs.

Touch

Touch in counseling children is another area that needs to be considered in ethics. Children often will initiate touch in counseling and it may be hard to avoid touch completely when working with children (Sori & Heckler, 2015). The Association of Play Therapy notes in "Paper on Touch: Clinical, Professional and Ethical Issues":

> When a child experiences touch from a benevolent and safe caregiver(s)/legal guardian(s), many things happen to promote healthy growth. Children develop a sense of self and the

> ability to relate to others; they learn to modulate affect, regulate their behavior, and develop a belief in their own self-worth and ability to master their environment….Touch is considered essential to the human experience and, when use appropriately, can promote growth and provide healing. (p. 1, 2022)

There are also some models of interventions, such as Theraplay®, that incorporates the therapeutic benefits of touch. Ethical issues around touch can include issues of whether counselors have been trained to use touch, what was covered in the informed consent, documentation of intention and use of touch, supervision received, and cultural considerations.

Conclusion

Understanding that childhood and adolescence in not a stage like any other, it is vital that counselors are appropriately trained to meet competency standards in best practice, ethical considerations, and multicultural considerations for working with children and adolescents. As of this writing, the 2024 draft three of the CACREP standards persist in their omission of clinical training standards for counseling children and adolescents. The lack of these factors in regard to training is disturbing. The counseling profession has an opportunity to declare its dedication and commitment to this population by emphasizing education, training, and informed supervision in this area. A competency system for childhood mental health providers can improve training, improve professional credibility, and encourage effective and quality services (Korfmacher, 2014). The need for competencies and ethical standards is clear and long-standing. The time to eliminate this major deficit is now.

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