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Special Populations of Children and Adolescents Who have Significant Needs

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CHAPTER 13
SPECIAL POPULATIONS OF CHILDREN AND ADOLESCENTS WHO HAVE
SIGNIFICANT NEEDS

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“We must have a place where children have a whole group of adults they can trust.”

~Margaret Mead

Learning Objectives

- After reading this chapter, students will be able to understand the impacts of trauma and other stressful life experiences on children and adolescents.
- After reading this chapter, students will learn strategies and interventions that are appropriate when working with children and adolescents presenting with specific traumas and adverse life experiences.
- After reading this chapter., students will gain knowledge about the long-term impact of risk and protective factors present in the lives of children and adolescents.

Special Topics in Child and Adolescent Counseling

The periods of childhood and adolescence are times of physical, cognitive, and social growth. Numerous developmental needs are critical during this span of time. Parents/guardians, school communities, friends, and society have significant impact on the development of these youth. The extent of the presence or absence of positive support and healthy influences can have long-term consequences. Emerging capabilities, confidence, and capacities are nurtured throughout life experiences both during childhood and adolescence. However, a young person’s development can be disrupted with the presence of conflict, trauma, or other life events that can

be detrimental and require interventions and extra supports that can be met by helping professionals. This developmental time is charged with opportunity and hope, but can be equally complicated

Risk and Protective Factors

During child and adolescent development, healthy behavior can be modeled and nurtured by supportive families, peers, and community involvement. Understanding common risk and protective factors can assist counselors working with youth in making healthy behavior choices. Risk and protective factors include psychological, biological, family, social, and cultural characteristics, some of which are fixed (e.g., genetic predisposition, personality traits, etc.) and some that are variable and can change over time (e.g., income level, self-esteem, etc.).

Risk factors are defined as characteristics at the biological, psychological, family, social, community, or cultural levels that are commonly associated with an increased likelihood of negative life outcomes (Substance Abuse and Mental Health Services Administration [SAMHSA], 2015). Adverse childhood experiences (ACEs) contribute to risk factors that negatively impact youth development. The toxic stress caused by ACEs can impede the typical, healthy development of an adolescent, and each additional risk factor introduced into a youth's life increases the probability of developing a mental and/or substance use disorder.

Just as risk factors place an adolescent at higher risk for negative outcomes, *protective factors* help safeguard them by preventing problems or reducing the impact of a particular risk factor (SAMHSA, 2015). Examples of protective factors include parental/family support, positive adult relationships that model healthy behavior, opportunities to participate in meaningful participation such as athletics or arts programming, and positive self-image. Protective factors are commonly connected to the concept of *resilience*, or the ability to “bounce

back” or persevere following adverse events (e.g., trauma, tragedy, stressful life experiences, etc.). By focusing on the development of protective factors, resilience can be developed or enhanced in youth in an effort to help manage common stressors and counteract the effects of toxic stress.

Table 13.1 illustrates risk and protective factors common in childhood and adolescence, specifically linked to the three contexts most prevalent during these periods of life: individual, family, and school community/peers.

Table 13.1

Risk and Protective Factors

<u>Childhood</u>	<u>Risk Factors</u>	<u>Protective Factors</u>
Individual	Low emotional regulation Hyperactivity/ADHD Aggressive reactions Poor cognitive development	Mastery of academic basic skills (reading, writing, math) Ability to make friends Follow rules
Family	Permissive parenting Harsh or inconsistent discipline Child abuse/Domestic abuse	Consistent discipline and expectations Strong extended family connections
School Community/Peers	Low commitment to school Accessibility to illegal substances Lack of adequate resources at school	Positive and consistent teacher expectations Strong school to family partnerships High academic standards

Adolescence

Individual	Antisocial behavior Impulsivity Early Substance Use Rebellious behavior	High self-esteem Emotional regulation Conflict resolution skills Strong communication skills
Family	Substance use Poor attachment Untreated mental health disorder Lack of adult supervision	Firm boundaries Provides clear expectations Strong attachment with family Adult supervision
School Community/Peers	Poor academic performance for school Few close friends No postsecondary plans	Strong relationship with at least one teacher Participation in extracurricular activities Strong peer social support

(SAMHSA, 2015)

When counseling children and adolescents, it is important to not only identify existing risk and protective factors, but also work with clients to increase the number of protective factors in their lives. In some instances, clients may need encouragement to recognize existing strengths because their perspective can be easily clouded by the stress and trauma of their presenting issue(s). By helping youth understand their capacity to change the course of their lives, counselors can instill hope and resilience. Additionally, youth feeling a sense of connectedness with at least one adult is essential in equipping them with the necessary traits to overcome risk factors that may be present.

Section Summary: In this section, risk and protective factors are defined and described. Risk factors are characteristics that may inhibit typical growth and development as well as impede learning and social/emotional functioning. Protective factors are characteristics that act as

safeguards and improve the likelihood that youth will develop healthy behaviors and resiliency skills. Throughout this chapter, a variety of topics are discussed, most of which would threaten youth development and be considered risk factors. As you read each section, keep in mind how counselors may assist in fostering the development of protective factors to counteract challenging and traumatic life events that may impact the lives of young people..

Exercise: List 2 protective factors for both children and adolescents that will help build resilience.

Trauma

Traumatic events are those that are likely to be highly stressful and potentially threatening to a person's emotional and/or physical well-being. Outcomes of *traumatic events* include feelings of helplessness, anxiety, and concerns about safety. While there are many types of childhood trauma, the topics discussed in this section are among the most common and are associated with some of the most detrimental outcomes for children and adolescents.

Unfortunately, trauma is quite common in the lives of young people. According to data from the Adverse Childhood Experiences Study (ACE Study), nearly 60% of Americans are exposed to at least one traumatic event before the age of 18, with over 22% facing 3 or more such events during that time (Centers for Disease Control and Prevention [CDC], 2015). While significant trauma can stem from a single event (such as a disaster or exposure to violence), the most severe forms of trauma are those that occur repeatedly over time (i.e., physical/sexual abuse or neglect). These pervasive, ongoing traumas are referred to as *complex traumas*.

Regardless of the particulars, ACEs data indicate that each exposure to trauma increases a person's risk for a number of negative outcomes, including health ailments (e.g., asthma, stroke,

heart disease), mental health issues (e.g., depression, mental distress), and consequences at school and work (e.g., decreased educational attainment, academic achievement, and income). As such, it is clear that traumatic experiences during childhood are a serious barrier to well-being, and that all counselors must be prepared to recognize and respond to signs of trauma in young people. Complicating this issue is the fact that no two children are likely to respond to trauma in the same way. Even siblings who experience the same event might present with vastly different symptoms -- or none at all. This is because a child's unique demeanor, support systems, relationships, and coping strategies all influence resilience, which in turn influences trauma response. The most typical reactions to specific traumas are discussed in the sections below, but common symptoms among children and adolescents include anger, the need to control situations/maintain order, and problems with peers, including lashing out verbally, bullying, and/or hitting other children. Victims of trauma may also turn their anger inward and abuse themselves. These feelings can surface in a number of ways, including self-harm.

Therapeutic approaches to trauma vary widely based on children's responses. Many victims return to previous levels of functioning naturally, while others experience ongoing impairment and symptoms consistent with post-traumatic stress disorder (PTSD). Table 13.2 lists common responses to trauma by age and includes recommendations for counselors working with each population. While more specific guidelines for responding to various traumas are discussed throughout this section, the following apply to most:

- The therapeutic alliance is critical. Trust, respect, and rapport must be established before any healing can take place.
- A trauma victim's primary concern is generally safety and security. Spend time exploring feelings of safety at school, in your office, and at home. Help clients develop

safety plans to avoid future exposure to their specific trauma, and/or to respond when a traumatic event has taken place.

- Oftentimes, a victim has experienced more than one type of trauma over their lifetime. It may be helpful to screen for various types of trauma, as well as symptoms of PTSD before selecting a therapeutic approach.
- Do not push clients to share more than they are comfortable with. Carefully monitor their anxiety and avoid subjects or situations that elevate stress past a moderate level.
- Assess the presence of factors that contribute to resilience, such as emotional coping strategies and social connectedness. When necessary, teach the client ways to recognize and regulate emotions such as fear, anxiety, and anger through mindfulness, progressive relaxation, diaphragmatic breathing, and other relaxation strategies. Encourage positive social connections and involvement in enjoyable activities.
- Help clients identify *triggers* (e.g., people, places, and/or things) that are likely to remind them of the trauma and cause distress. When necessary, identify and/or teach the client coping strategies to deal with triggers.
- Especially with children and preadolescents, consider creative counseling approaches such as play therapy, bibliotherapy, and art therapy. Even among older teens, techniques such as music therapy and journaling can supplement traditional forms of talk therapy.

Table 13.2

Childhood and adolescent trauma: Typical responses and suggestions for counselors

<u>Age Group</u>	<u>Typical Responses</u>	<u>Suggestions for Counselors</u>
Childhood (Elementary School)	Worries others will die or be injured Concerned about own safety	Simple, developmentally appropriate explanations

	Separation anxiety Sleep disturbances Fear of the dark Sadness Anger/irritability Reenacting trauma in play Developmental regression	Allow free play, including reenactment of the trauma Creative/expressive therapies: books, art, play, journaling, drumming Work with primary caregivers to assess safety, security, and support at home Teach basic coping strategies for anxiety, anger, etc.
Adolescents (Middle/High School)	Anger (arguments, fights) Mood swings Difficulty concentrating Withdrawal from friends, activities Headaches, stomachaches Depression Decreased school performance Increased risk-taking Questions about spiritual beliefs and/or state of the world	Establish trust, support, safety Active listening Monitor their anxiety in session and encourage, but don't push them to share Encourage connectedness and social support systems Assess triggers and develop coping strategies as necessary CBT Mindfulness Groups for those who have experienced similar traumas

The National Childhood Traumatic Stress Network (NCTSN; <http://www.nctsn.org>) maintains a database of promising practices for counselors, as well as organizations that deliver counseling and/or social services using a *trauma-informed* approach that trains staff members to understand, recognize, and respond to signs of trauma. Below is a list of evidence-based approaches for counseling survivors of trauma:

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

- Trauma-Focused Cognitive Behavioral Therapy for Traumatic Grief (TG-CBT)
- Parent-Child Interaction Therapy (PCIT)
- Child and Family Traumatic Stress Intervention (CFTSI)
- Trauma Affect Regulation: Guide for Education and Therapy (TARGET)

Section Summary: Traumatic events are fairly common, and are associated with a host of negative outcomes related to both physical and mental wellbeing. Common signs of trauma among young people of various ages were presented in this section. Keep these in mind as you read some of the upcoming sections related to trauma, but consider how each is unique with regard to impact, symptoms, and counseling approach.

Exercise: List 3 common symptoms of trauma in childhood and adolescence and discuss when you have seen these symptoms in people you know or clients you have worked with.

Grief and loss

It is natural that a young person's focus is on life and the infinite possibilities ahead. Death can be seen as the antithesis to this outlook. Grief is very personal and is as diverse as the student experiencing it. Despite the uniqueness of grief, there are common grief responses and a wide range of feelings often experienced during the grief process. The reactions to grief are not linear in nature, and emotions can vary both in frequency and duration. Some common grief responses in childhood and adolescence include anger, sadness, confusion, denial, questioning, and throughout time -- acceptance of the loss. It is natural for there to be a quick switch in emotional responses, where a youth may go from crying to becoming angry. Additionally, it is critical to keep in mind that it is typical for youth to re-grieve throughout each developmental stage in life.

Childhood grief.

Children in the early elementary years (typically until 9 years of age) often have an unclear idea about death. It is common that students in this age group may believe death is temporary and their loved one will return. Due to this belief, it is important to use concrete language when discussing the death experience rather than abstract terms. During the later elementary years (through 11-12 years of age), death begins to become more real and students can sometimes be curious about death and ask several questions about the details surrounding the loss. Regardless of the age of the child, it is common for *grief bursts* to occur throughout the grief journey. You may notice children playing and returning to normal activities following a death, yet during the play the child has frequent bursts of grief. The behavior of play allows the child to take needed grief breaks and, in a way, indicates the ability to engage in healthy self-soothing behaviors. Additional considerations when working with a younger child include the following:

- It's important not to use euphemisms when explaining the death of a loved one. Phrases like "went to sleep" or "left us" can be confusing and can cause even greater feelings of sadness, confusion, and fear for the young person. Another common response "went to heaven" may also have the opposite effect meant because the young person can begin to fear heaven or ask when their loved one will return home from heaven. Additionally, using this term has a religious connotation.

Encourage open expression of feelings. Bibliotherapy is an excellent tool to help students through the grieving process. While some youth may share emotions verbally, invite other outlets for emotional expressions (e.g., art, puppet play, sand tray, storytelling, etc.). Sample titles include [*The Invisible String*](#), *When Dinosaurs Die*, *My Yellow Balloon*, [*Tear Soup: A Recipe for Healing After Loss*](#)

- Involve parents/guardians and any other loved ones that support the child in their grief work in the therapeutic process. Adults often think that showing their own sadness or other emotions will only hurt the child more. In reality, children need to see their loved ones openly grieve and are open to talking and sharing about the deceased loved one.
- Help the child understand that grief is not an act that they will “get over” but instead is a lifelong journey.

Adolescent grief.

Kubler-Ross (1969) referred to adolescent grievers as the "forgotten ones." Adolescents represent a unique group of grievers that have particular developmental needs that confound the normal grieving process. Many times the adolescent grief experience is inaccurately described similarly to those of younger children or can also be assumed merely a less intense form of adult grief. Adolescents do uniquely express and experience grief, often times in ways that are intermittent and ensue over a longer period of time than that of adults. Adolescent grief may manifest in multiple forms that can include anger, confusion, exhaustion, emptiness, loneliness, sleep disturbances, and eating disturbances. What follows are examples of potential adolescent grief responses:

- *anger*: aggression toward others or loud verbal outbursts
- *denial*: withdrawal or fantasizing the deceased relationship;
- *denial* :can also be displayed as regression
- *bargaining*: may try to atone for past mistakes in hopes of bringing back deceased
- *depressive symptoms*: adolescents may display somatic symptoms
- *withdrawal*: may remove themselves from normal social activities

- *acting out*: engaging in risky behaviors or atypical behaviors such as aggression toward others

Youth entering into the acceptance stage of grief are able to discuss the death in a realistic and healthy way. They understand that death is inevitable, and they have adjusted their life patterns and routines to accommodate for their loss. While they will undoubtedly still feel strong emotions from time to time, they understand that this is a normal part of the grieving process, and they have developed healthy ways to cope.

Potential complications associated with adolescent grief may include heightened impulsivity leading to self-destructive behaviors (e.g., substance use, reckless driving, sexual promiscuity, etc.) or even suicidal ideation. It is important to foster an open discussion that includes causes for despair, reasons for hope, and the meaning of life.

Generally speaking, when working with grieving adolescents, encourage the open expression of feelings. Teens often work to hold in their emotions for fear of what others may say or think. Providing a safe and secure space that accepts each feeling and reaction as being valid is critical in the grief journey. Teens can especially benefit from group counseling to help normalize the grief experience (Perschy, M., 2004). It can be a relief for adolescents to learn that others of the same age share similar grief stories, responses, and coping strategies. Additionally, counselors should be cognizant of the resurfacing of grief feelings around the holiday times, anniversaries, the birthday of the person who died, or the death anniversary.

Specific counseling strategies include narrative counseling that allows the bereaved to share the grief story in a personalized way and over the course of time. It is encouraged to allow the story to be told over and over as the grieving process can evolve and change. Additionally, the meaning making process can be another helpful counseling strategy that is made up of the

content of the meanings discovered in the loss and are divided into three major categories according to Neimeyer and Anderson (2002): sense-making (exploring the “why” the death happened), benefit finding (discovering the “silver lining” in the grief experience), and identity reconstruction (developing a modified identity reflective of the grief process).

Regardless of the age of the grieving youth you are working with, it is important to be aware of your own potential triggers or countertransference. Grief affects everyone and working with a grieving teen can evoke the helper’s past loss so seeking supervision or personal counseling may be needed or beneficial.

Activity: Memory box: First find a box (can be any kind of box) that the child can decorate. Offer a variety of supplies to allow the child to make the box special and personal. Next, the child is encouraged to explore memory items of their loved one. This may include pictures, letters, artwork, death announcement, prized possessions, or any other items that the child connects with the loved one. These items are placed in the memory box as a way to honor the loved one. The memory box can be visited whenever the child wants to reconnect with the loved one and items can be removed or added at any time.

Exercise: Develop three creative counseling strategies for working with grieving children. Make sure to include strategies for both children and adolescents, and to create a reference list or supply list so others can easily replicate the strategies.

Section Summary: Grief is a personal and unique experience for children and adolescents. However, the section describes typical reactions as well as symptoms of complicated grief. Strategies and approaches are discussed to provide counselors skills and resources to be prepared to work with grieving youth. Grief can result from death but as the remaining sections describe, youth may have grief reactions when faced with other devastating life experiences.

Natural disasters

Disasters such as hurricanes, tornadoes, floods, and earthquakes strike various parts of our country on a regular basis. No community is immune to such events, and counselors everywhere must be prepared to respond to the needs of young people who have faced these traumas. While each disaster is unique, they share common traits with regard to their impact on the well-being of children and adolescents. In addition to the typical trauma responses listed earlier in this section, young people who have experienced a natural disaster are more likely to exhibit the following behaviors:

- Fears that another disaster will strike
- Worries that they will be suddenly separated from their loved ones
- In young children, clingy or regressive behavior
- In older adolescents, increased risk-taking based on irrational beliefs that they will either die soon or that they are somehow immune to harm

Counselors working in schools or mental health settings impacted by a natural disaster should be prepared to assess the extent to which the trauma has impacted each student/client. While many are likely to return quickly to previous levels of functioning with only normal social support, others will have experienced heavy losses such as the death of a loved one, destruction of their home, or damage to prized possessions. These children will likely require more intentional, prolonged support as they work to overcome both the mental strain associated with experiencing the disaster, as well as the secondary losses they might face, such as moving, changing schools, or making new friends.

General guidelines for working with trauma victims apply to children and adolescents who have faced a natural disaster, including teaching targeted coping strategies based on

symptoms (e.g., progressive relaxation or diaphragmatic breathing for anxiety). In addition, it is important that counselors work with the adult caregivers of their clients to encourage the following:

- Monitor conversations about the disaster and carefully consider how much information to give children based on developmental level and coping skills. When young children are present, encourage adults to focus on the positives (“I’m thankful that _____”).
- Take breaks from media coverage of the disaster, as repeated exposure can heighten anxiety and/or re-traumatize victims. Young children watching the news may even believe the disaster is happening again.
- Maintain and/or establish a regular schedule, as routines can be helpful in establishing feelings of safety and security. Whenever possible, assign duties to children and adolescents so they feel like they are contributing to recovery efforts.
- Schedule breaks for enjoyable activities, including time outdoors.

In addition to the above, there are a variety of resources available to counselors working with disaster survivors. A partial list appears in the “Resources” section of this chapter.

Exercise: Identify the most likely natural disaster in your area and compile a list of resources you could use (or share) with families who survive such an event.

Case example

“Other people were leaving, but we stayed. We didn’t have money for a hotel or car trip. When it looked like it would be a direct hit, we were all scared. The power went out right away, so we didn’t have lights or TV. The wind was blowing so hard I thought our house would collapse. Windows were breaking. It was raining so hard. My little sister was screaming. But

we couldn't go anywhere. We were trapped. That night, you could see the water near our front door. What if we had to swim? Would our stuff be destroyed? I started wondering if we'd die."

This 16-year old client may have survived, but she and her family suffered heavy losses as a result of a hurricane. Their home, car, and possessions were destroyed, and they've been living in a makeshift shelter at a hospital for over a week. She has no idea what's next. They have no place to live. Her school was flooded, and most of the students are displaced. She has an aunt in a northern state, so they've talked of heading there, but how? She's barely slept since the storm. Everyone is so stressed, they're constantly bickering. Of course they're happy to be alive, but what will they do? She cries when she thinks about it.

As a mental health counselor working in the hospital, you have been talking with survivors, including this client.

- *What trauma symptoms are present? What others are likely to manifest?*
- *After drawing out the story and showing empathy, how might you support this client?*
- *Considering the client may relocate, what goals are realistic?*

Section Summary: Natural disasters can strike virtually any part of the country at any time.

Counselors should be prepared to work with survivors and their families on addressing feelings of safety, anxiety, fear, and helplessness. General tips for approaching this work were provided in this section, and a variety of other resources to support counselors can be found at the end of the chapter.

Violence

Findings from the most recent National Survey of Children's Exposure to Violence (U.S. Department of Justice, 2015) indicate that in any given year, children under the age of 18 experience (41.2%) or witness (22.4%) violence at fairly high rates. The numbers are even more

staggering when considering lifetime exposure to violence, as a majority (54%) of young people having experienced some type of assault, while 39% have witnessed violence such as physical assaults/intimidation, bullying or other types of relational aggression, or domestic violence. As with all traumas, each violent experience is unique and will manifest differently in the life of the survivor based on a number of factors. For example, witnesses to violent crimes resulting in death may simultaneously be grieving the loss of a loved one while worrying about their own safety. Like disaster victims, persons who experience violence may be dealing not only with the direct impact of the event (whether physical, mental, or emotional), but also secondary losses associated with it. For example, a person who experiences physical violence or bullying may withdraw from a friend group or extracurricular activity to avoid the perpetrator.

Victims of or witnesses to violence are at risk for the same outcomes as other trauma survivors, including decreased academic performance, mental health issues such as depression and anxiety, and substance abuse. And while no two children will respond to violence in exactly the same way, those who have faced this type of trauma are especially prone to the following:

- Constant worries about safety; always “on edge” or in “fight or flight” mode. May manifest as skittishness (e.g., jumps out of seat at a loud noise), irritability, and/or inability to concentrate.
- Anger, both towards the perpetrator and towards self for allowing it to happen.
- Physical symptoms such as stomachaches and headaches.
- Difficulty sleeping. May have nightmares related to violence.

In addition to the general guidelines for working with trauma victims given above, the following suggestions may be helpful when working with survivors of violence:

- Safety is often the primary concern. Establish safety in your therapeutic environment and help clients identify safe people and places in their lives. Help create safety plans to avoid or cope with dangerous situations.
- Teach relaxation techniques such as diaphragmatic breathing, mindfulness, and progressive muscle relaxation.
- Help clients identify and process their feelings about the event they experienced, being careful not to push them beyond a moderate level of anxiety at reliving the event. With younger clients, this often involves the use of play or other expressive techniques.
- Help normalize the experience through group counseling, bibliotherapy, popular media, or other ways of showing clients they are not the only ones to have experienced such a trauma.

Child abuse and neglect

Abuse or neglect of a child can take many forms. In the simplest terms, child abuse is commonly understood as physical or emotional battery, or sexual (see section below) contact that results in harm to a child, while neglect is a deliberate failure to provide care that is typically required by children of that age (e.g., food, shelter, clothing, medical care, education, etc.).

According to the Child Maltreatment Report (U.S. Department of Health and Human Services, 2016), state child welfare agencies took action in over 500,000 cases of neglect and 119,000 cases of physical abuse in 2014. In addition, the most recent ACEs data indicate that approximately 35% of those under the age of 18 have experienced emotional abuse in their lifetime (CDC, 2015).

Clearly, there are wide-ranging consequences for children and adolescents who experience abuse and/or neglect, up to and including death (2.13 per 100,000 children in 2014;

U.S. Department of Health and Human Services, 2016). In addition to any outward scars that abuse victims might carry as a result of physical harm or neglect of their basic needs, they must also wrestle with the mental and emotional repercussions of being hurt by adults who are meant to care for and nurture them. It is no surprise then that cases of child abuse and/or neglect are some of the most challenging for a counselor. While entire texts have been dedicated to these complex topics, below are some considerations for counselors working with these students, beginning with the impact of such traumas, including common symptoms and warning signs.

- Common signs of physical abuse include marks or injuries that cannot be explained (or are explained in ways that are not believable), and baggy or heavy clothing that is inappropriate for the season (to cover physical marks). Signs of neglect include poor personal hygiene, inadequate/tattered clothing, and frequent discussion of heavy responsibilities at home.
- Attachment disorders are common among this population. Because of the harm they have suffered at the hands of trusted adults, abuse/neglect victims are likely to have issues bonding with teachers and other adults.
- Typical trauma symptoms are likely, including anger and withdrawal. Children who have been physically abused may be anxious or startle easily.
- Children may talk around the abuse or neglect and provide vague generalities about difficulties at home. Probe for information when necessary, and do not be afraid to ask direct questions such as, “Is someone hurting you?” and “Who provides things like food and care at home?”

The following are suggestions for counselors working with children or adolescents who have experienced abuse and/or neglect:

- School counselors and other mental health providers are mandated reporters of abuse and neglect in all states. Become familiar with your state's specific statutes and reporting procedures at <https://www.childwelfare.gov>.
- Train teachers, primary care physicians, and other frontline service providers on the importance of recognizing and responding to abuse. Inform them of their duty to report (as applicable), and provide information about warning signs of abuse and neglect.
- When allowed by child welfare authorities, work directly with parents or caregivers in a partnership framework. Provide services in the home when possible, and work on multiple levels to first carefully understand possible reasons for the abuse or neglect, and then tailor services as appropriate. When you suspect issues such as severe mental illness or substance abuse, connect the adult with a service provider. When help is needed with necessities such as food, clothing, housing, childcare, transportation, etc., provide information about social services in the neighborhood, helping facilitate contact when possible. In cases of inadequate parenting skills, work with the parent to both recognize their beliefs about children and expectations for behavior (CBT/REBT), and train them on productive strategies for child-rearing, including appropriate discipline, positive communication, and methods for enhancing engagement/attachment.
- Recognize that trust is likely to be the client's main concern, following stabilization of physical needs and safety. Use basic counseling skills like empathy and positive regard to slowly establish rapport. Reassure the child that you want to help, and that there are other adults in the world who also want to help, such as teachers, law enforcement officers, child welfare workers, and health care providers.

- If a physical abuser still lives in the household, help the client create safety plans that include recognition of caregiver emotional state, and specific steps that can be taken to minimize the risk of harm in situations when physical or emotional outbursts are likely.
- Consider partnerships between schools and community organizations to provide food and other necessities for children and families in need.
- Assess the child's behavior patterns in various situations and put interventions in place to modify as necessary. While children are never at fault for abuse or neglect, their emotional or behavioral patterns may be contributing to caregiver stress.

Sexual abuse and sexual violence

Similar to other forms of abuse and neglect discussed above, sexual abuse and violence are highly damaging to children and adolescents, but are all too common in our society.

According to ACEs data, 15% of females and 6% of males experience sexual abuse or violence before the age of 18 (CDC, 2015). In total, over 58,000 cases of sexual abuse were acted on by child welfare agencies in 2014, representing 8.3% of all abuse/neglect cases handled that year (U.S. Department of Health & Human Services, 2016). As is the case with all types of child abuse, counselors are mandated reporters of sexual abuse and violence in all 50 states. For more specifics on reporting procedures and questions about what constitutes abuse in each state, consult <http://childwelfare.gov>.

While children may display physical signs of sexual abuse, it is more likely that a counselor or other attentive adult would notice the following emotional and behavioral signs, some of which are unique to cases of sexual abuse, but many of which are common in other types of trauma:

- Unexplained anger, anxiety, or depression

- Dissociative symptoms
- Nighttime issues such as bed-wetting and nightmares
- Compulsions, such as frequent washing or masturbation
- Unexplained fear of certain people and/or places
- Loss of appetite
- Sexual symptoms, such as reenactment of the abuse, unusual interest in (or avoidance of) sexuality, and unexpected expression of sexual ideas in drawings and/or play.

Counseling victims of sexual abuse is delicate, challenging work. As is the case with other types of abuse, these children are often dealing with multiple physical and emotional wounds, and have likely suffered profound losses such as broken relationships with family and friends, shattered trust or faith in people -- even those they know well -- and a lack of interest in activities that used to be enjoyable. They are also likely dealing with intense feelings of anger, both at the perpetrator and at themselves for “allowing” the abuse to happen and/or not reporting it sooner. Below are general considerations for counselors:

- Report all suspected cases of sexual abuse to your local child welfare agency.
- As with other types of abuse, recognize that trust and safety are likely to be primary concerns. Slowly establish rapport through active listening and positive regard. Do not push the client to share too quickly or to discuss the abuse if it causes more than a moderate level of distress.
- Since survivors will respond to abuse in different ways, tailor your approach to each client according to their needs. Common issues include self-esteem, basic emotional coping skills, anger management, trust and attachment, depression/withdrawal, and

PTSD. No single counseling approach is “right” when it comes to sexual abuse. See the “Resources” section for NCTSN promising practices/interventions in trauma therapy.

- When the abuse is profound or beyond your realm of expertise, do not hesitate to refer to a therapist who is more experienced with this type of work.

Exercises:

- *List one critical consideration for working with a childhood abuse victim and explain how a counselor might approach the issue.*
- *Research your state’s procedures for reporting child abuse or neglect. Who are mandated reporters? What agency handles these cases? How does someone make a report? What information would a “screener” ask for? What are the likely outcomes given clear evidence of physical, emotional, or sexual abuse?*

Case example:

Marna is a 14 year-old female in the 8th grade. Over the past few weeks her family, teachers, and friends have noticed a change in behavior. She has been overly sensitive to touch (e.g., hugs from family and friends), easily agitated, and sleeping in class. Most recently she has refused to attend an upcoming family event that is usually one of her favorites, and she becomes extremely anxious around middle-aged men. On the recommendation of her mother, Marna reluctantly agrees to meet with her school counselor. After the second meeting, she breaks down and discloses that her uncle forced her to touch him and he also touched her breasts. She is embarrassed, feels ashamed and doesn’t want her parents to know. The school counselor reports the incident to Department of Child Services/Child Protection Services, contacts her family, and

provides a referral to a community mental health counselor that specializes in counseling victims of sexual abuse.

- *Upon meeting Marna, it is evident she is guarded and reluctant to share. How would you work to build rapport with Marna? What questions or strategies may be helpful to gather Marna's story?*
- *What counseling strategies might the mental health counselor employ?*
- *How should the school counselor follow up with the student? How can the school counselor provide support to Marna during the school day?*

Counseling Activity: Art therapy provides an outlet for emotional expression and provides opportunity for the child to process the abuse event witnessed and/or experienced.

Youth in foster care

Youth in *foster care* have been removed from their home due to experiencing some form of serious abuse and/or neglect or the loss of a parent. The placement process in foster care is a difficult and stressful life experience for any child. According to the Child Welfare Information Gateway (2016), 415,129 children were in foster care in 2014 with approximately 29% placed in relatives' homes and nearly half were placed in nonrelative foster care. Other foster care placements can include group homes, residential facilities, emergency shelters, and pre-adoptive homes.

Commonly, youth in foster care have experienced traumatic events that contribute to the likelihood of emotional, behavioral, and/or developmental problems. Physical health problems may also be present which add another layer of potential complications. The removal of the student from home is a risk factor in itself. Being removed from a parent represents the loss of an attachment figure, even though this attachment may be unsafe and harmful to the youth. Or,

youth may be experiencing loss of a parent while, at the same time, not able to find housing with relatives and subsequently entering the foster care system.

Most children in foster care experience numerous feelings, including confusion, fear of the unknown, loss, sadness, anxiety, and stress. These feelings and experiences must be addressed early to prevent or minimize poor developmental, academic, and mental health outcomes. In addition to the trauma experienced, children in foster care are further susceptible to further wounds if placed in unstable or unhealthy environments, increasing the risks of an already fragile and vulnerable group. The transition from foster care to early adulthood can be another complicated process. At age 18, youth age out of foster care and often find they have little to no adult support and struggle to find ways to be self-supportive.

Counselors in all settings can support youth in foster care by working to form a therapeutic relationship that demonstrates healthy boundaries, unconditional positive regard, and acceptance. It is important to screen for trauma and assess for mental health related disorders (e.g., post traumatic stress disorder, anxiety, depression), and to address those as needed via typical counseling interventions such as client-centered or cognitive-behavioral therapy. In schools, counselors can help advocate for ongoing mental health counseling despite if the youth in foster care has multiple placements and frequently moves. Additionally, considerations relevant to the school setting need to include number of schools attended by the student, truancy or high absenteeism, ensuring the student record is complete (e.g., special education services are being provided if applicable, all school transcripts are included so credits will be granted) to confirm all appropriate supports are in place for the student. Clinical mental health counselors working with youth in foster care may want to explore the use of trauma focused cognitive

behavioral approaches, as well as assess for attachment and connectedness issues possibly present in the youth's behaviors.

Section Summary: Youth in foster care often have exposure to traumatic experiences. They may have developmental delays and complications with secure attachment. An essential task of a counselor is to establish trust and rapport demonstrating to the foster youth acceptance and unconditional positive regard.

Suicide and Suicide Risks

The Centers for Disease Control and Prevention (2013) reports suicide as the third leading cause of death among persons aged 10-14 and the second among persons aged 15-34 years.

Although suicide deaths and attempts for children under the age of 10 is infrequent, there are at-risk students in elementary schools across the nation that need support and intervention.

Depression is the leading cause of suicide in teenagers; however, suicide is complex. There likely are several underlying or co-occurring disorders. In addition, the impulsivity common in adolescence is a tremendous added risk. Since the prefrontal cortex is not fully developed, a teen is more likely to make a rash, emotional response following a stressful life event (e.g., relationship break up, fight with parent/guardian, school problem, etc.). It is important to remember that the vast majority of teens who experience even very stressful life events do not become suicidal.

Suicide can be prevented. Early detection and appropriate mental health counseling are key factors. Advocating for comprehensive suicide prevention programming in schools and communities is a critical element in the prevention effort. In schools, all employees, parents, and students, need to receive training about both the risk factors and warning signs. Furthermore, suicide prevention training within emergency rooms, community clinics, and other community

serving organizations should be included to build capacity regarding suicide prevention and intervention. By providing accurate information to assist in early detection, referrals can be made to appropriate mental health professionals that can lead to appropriate diagnosis and mental health treatment as well as help reduce the stigma commonly associated with the topic of suicide. One communication tool that can help reduce stigma is explaining the best terminology to use when there is a death by suicide is to state “died by suicide” instead of “committed suicide”. The term, committed, carries a negative connotation that is often associated with committing a crime. Since suicide already places the bereaved in a heightened state of sensitivity concerning the death, using this updated terminology is best practice.

Both legal and ethical obligations apply when working with suicidal youth. Limits of confidentiality apply. Parents/guardians must be contacted when a young person discloses suicidal ideation and appropriate next steps should be discussed. In school settings, a student’s privacy needs to be protected. Teachers and other caring adults may have good intentions by asking about the details of a student situation but information about the suicidal student cannot be shared without the permission of the student or family.

A common myth about suicidal talk and suicide attempts is that it is merely a cry for attention and students often are dismissed as being dramatic. No matter how many times a student shares suicidal ideation, a threat of suicide should never be dismissed. Each situation needs to be taken seriously because it is important to respond to any threat of suicide and other warning signs in a thoughtful manner. Not all suicidal talk leads to an attempt, but it’s a chance counselors cannot take.

What factors do we know that increases the chance a young person may be at risk of suicide? What do we know about youth that die by suicide? What factors help protect youth

from suicide? Understanding the risk factors, warning signs, and protective factors that are associated with suicide is critical in our work. The majority of suicidal young people give warning signs of their despair. According to American Association of Suicidology (2016), a majority of those thinking about suicide let others know their intent because they are ambivalent and **want others to know** about their emotional pain and stop them from dying. A warning sign does not automatically mean a person will attempt suicide but it should be taken very seriously and treated as a call out for help.

When counseling a student presenting with suicidal ideation, it is vital to stay calm, stay with the young person at all times, and provide unconditional positive regard. Below are some important considerations when intervening.

- Use active listening skills and seek to gain an understanding of the presenting problem. Additionally, assess to check if a plan is present and if the young person has access to the lethal means indicated in the plan.
- Explore if the student has any prior suicide attempts.
- Use reflecting skills to ensure you have an understanding of the client's information.
- Focus on the central issue. This is not the time to explore other aspects within the presenting issue. The focus needs to be solely on keeping the young person safe.
- Listen for ambivalent feelings about this decision. Seek to find at least one person, place, or thing that has kept the student alive to this moment.
- Work with the youth (and family members) to develop a safety plan that all persons supporting the youth agree to follow.
- Do not leave the youth alone and immediately involve parents/guardians.

Table 13.3 lists numerous risk factors, warning signs, and protective factors of adolescent suicide. The possibility of suicidal ideation increases when a youth has numerous risk factors yet presents with a low number protective factors.

Table 13.3

Risk and Protective Factors for Suicide

<u>Risk Factors</u>	<u>Warning Signs</u>	<u>Protective Factors</u>
Prior suicide attempt	Behavioral Cues <ul style="list-style-type: none"> ● Increase of substance use 	Effective communication skills
Family history of suicide	<ul style="list-style-type: none"> ● Giving away possessions 	Strong family and community connections
Recent death	<ul style="list-style-type: none"> ● Searching internet for ways to kill oneself 	Conflict resolution skills
Access to lethal means	<ul style="list-style-type: none"> ● Sudden withdraw from social group 	School connectedness
Substance use	<ul style="list-style-type: none"> ● Change in eating or sleeping patterns 	Access to effective health care (includes medical/physical, mental/psychological, and substance abuse)
Delinquent behavior – trouble with the law	Verbal Cues <ul style="list-style-type: none"> ● Talking about dying 	
School suspension or expulsion	<ul style="list-style-type: none"> ● “I can’t stand living anymore” 	
Undiagnosed, untreated or ineffectively treated mental disorder (depression is most common)	<ul style="list-style-type: none"> ● “ I wish I were dead.” 	
School failure—potential for school dropout	<ul style="list-style-type: none"> ● “I can’t go on.” 	
Impulsive and/or aggressive tendencies	<ul style="list-style-type: none"> ● “I wish I could go to sleep and never wake up.” 	
Other situational/stressful		

factors include:

- Target of bullying
- Victim of sexual /physical abuse
- Multiple adverse childhood experiences
- Breakup of romantic relationship
- Sexual orientation (e.g., coming out as LGBT in an intolerant environment)

Exercise: Discuss differences between risk factors and warning signs associated with suicide.

Post suicide intervention.

When an adolescent dies by suicide, surviving family members and friends are left with many unanswered questions and a range of emotions. Survivors are susceptible to developing symptoms of depression and posttraumatic stress. Grief associated with suicide is often complex in nature, may last longer, and is more intense. Multiple emotions can range in intensity and duration including anger, sadness, guilt, blame, and embarrassment. Other concerns associated to grieving suicide survivors include:

- Shame due to stigma
- Guilt and/or blame over inability to prevent death
- Difficulty understanding why/obsession with finding answers
- Relief
- Feelings of rejection/abandonment
- Uncertainty what information about the death to share with others due to stigma

Another factor, according to the American Foundation for Suicide Prevention and Suicide Prevention Resource Center (2011), to consider following a suicide is the possibility of contagion, the process by which one suicide may set off others. Adolescents are more susceptible to imitative suicide or cluster suicide, especially in cases where media has glamorized the death (e.g., Stack, 2003). In school communities that have experienced a student suicide, it is important to be on high alert and assess those students that have past suicidal ideation and/or attempts, referring to mental health providers if deemed at-risk. Another higher risk group to check-in with would be the peers in the same social group as the student that died by suicide.

Section Summary: Suicide is a leading cause of death among adolescents. Counselors in all settings must be prepared to recognize and respond to warning signs in young people, and to assist families, schools, and communities in responding when a suicide attempt or completion has taken place. This section covered risk factors, warning signs, and suggestions for intervening.

Non-Suicidal Self-Injury

Non-suicidal self-injury (NSSI) is highly prevalent and viewed as a significant adolescent social problem. Youth that self-injure intentionally destruct the body or skin. However, they do not have intent to end their life but rather are seeking a way to relieve stress or escape problems. Deliberate self-harm among adolescents—including such actions as cutting or scratching oneself, burning, hitting self, and biting—are among a few of the common self-harming methods. Although youth NSSI is not intended to be fatal, this behavior is a strong risk factor to suicidal ideation (Guan, Fox, & Prinstein, 2012).

Recent investigation into the etiology of NSSI has revealed there is not a clear profile of a youth that engages in this behavior. The complex nature of NSSI resulted in the disorder not being included in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) but instead appears in the research section so further investigation can be completed. Because NSSI is typically something adolescents work to keep secretive, it is difficult to have solid prevalence data. Current research estimates a variance between 15-30% of adolescents report engaging in NSSI yearly.

When working with a youth that is engaging in NSSI, it is important to be supportive and nonjudgmental. The focus of your interaction should not be on stopping the NSSI but instead helping the adolescent find alternative coping strategies. In addition to this communication, it's also important to conduct a thorough assessment that includes questions about methods of self-injury, places on body where harm has occurred, how the wounds are being cared for, and if the youth has ever required medical attention following the NSSI. In addition to these questions, it is also helpful to ascertain information about the precipitating factors or events that lead to the NSSI actions, including frequency and duration of these behaviors and the perceived benefits the youth gains from engaging in NSSI. Since NSSI is a risk factor associated with suicidal thoughts and behaviors, a suicide assessment may also be warranted.

Social contagion is often commonly associated adolescent self-injury behavior. Within a social group, the behavior becomes normalized or can even be glamorized. Social media adds another layer to the problem. Understanding social contagion is important so intervention strategies are individualized in nature and do not include group counseling or large scale school convocations to discuss this topic.

Case example:

Travis is a 12 year-old male in the 6th grade. Two of his friends met with the school counselor to express concern about Travis. They shared that he has been burning himself with matches and they have seen him use an eraser at school to rub his skin until it leaves burn marks. The school counselor meets with Travis and discovers he has been using burning as a way to cope with a stress and worry. The school counselor contacts his parents to discuss what she has learned. The school counselor plans to meet with Travis on a weekly basis but she believes Travis would strongly benefit from seeing a clinical mental health counselor outside of school. She offers the family a list of referrals for practitioners in the local community.

- *As the school counselor, how do you approach Travis? What questions do you use to engage in assessing what his friends of shared with you?*
- *What information do you share with his parents?*
- *What counseling strategies might the mental health counselor employ?*
- *How can the school counselor provide support to Travis during the school day?*
- *What information could be shared between the school counselor and the mental health counselor to best support Travis? What would be required to share information?*

Examples of evidence-based programs for children exposed to violence:

- Al's Pals: Kids Making Healthy Choices
- Child Parent Psychotherapy
- Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
- Functional Family Therapy (FFT)
- Motivational Interviewing (MI)

Bullying

Bullying is a repeated (or highly likely to be repeated) , unwanted, aggressive behavior where there is either a real or perceived imbalance of power (Gladden, Vivolo-Kantor, Hamburger, & Lumpkin, 2014) between the target and student exhibiting the *bullying behavior*. As you may have noticed, the term, ‘student exhibiting bullying behavior’, was used in the definition rather than labeling the student as a bully. This shift in terminology is important because labeling a student causes only more harm and can induce continued bullying behaviors as the student demonstrates the self-fulfilling prophecy of the label assigned.

Bullying behavior generally takes one of four forms: physical (e.g., hitting, kicking, breaking someone’s possessions, etc.), verbal (e.g., name calling, insults, threats, etc.), social (e.g., spreading rumors, exclusion, embarrassing someone, etc.), and cyber (e.g., fake profiles, social network posts, sending unwanted pictures, etc.). Despite educational and legislative efforts to address bullying, it remains a significant problem. Almost one in four students (22%) report being bullied during the school year (National Center for Educational Statistics, 2015b). Many potential reasons surround why a student may be a target of bullying including an overall perception of “being different” from peers, perceived sexual orientation, body shape, disabilities, and race. The person who is bullied may also be perceived as weaker or in a submissive position or status such as a student who is going through a break up or another student who might be adopted. Possible characteristics of a student exhibiting bullying behavior include aggressive tendencies, low parental involvement or attachment, views violence positively, and challenges authority. It is also plausible that students who display bullying behavior may have been a target of bullying previously (including by a sibling). One way to think about students that engage in bullying behavior is they are hurt and feel that lashing out on others will relieve their pain. The saying, “Hurt people, hurt people,” can be associated with bullying behavior. When youth have

been the recipient of peer maltreatment or other forms of abuse (i.e., verbal, emotional, physical), then these hurt and painful feelings may be turned outward by looking to cause harm to others.

In counseling children and adolescents on either side of this issue, it is critical to gain an understanding of the level of emotional pain associated with the bullying. The Center for Disease Control (2015) report that targets of bullying are at increased risk for poor school adjustment, sleep difficulties, anxiety, and depression, and youth who engage in bullying behavior are at increased risk for academic problems, substance use, and violent behavior later in life. Bullying sometimes is said result in suicide. However, this is not accurate. The prevalence of bullying is an additional risk factor to consider if assessing for suicidal ideation is necessary, but it cannot be said to be the only reason.

When working with youth that have been targets of bullying, ongoing individualized support is necessary. A counselor can help youth build resiliency through self-esteem skill development, finding healthy coping strategies, and increasing protective factors. Individual counseling that emphasizes empathy training, social/emotional skill development, positive communication, and aggression replacement training can be appropriate for youth exhibiting bullying behavior. Furthermore, counselors in the school setting need to advocate for systemic change that intentionally changes the culture of an entire school community. To do so, a comprehensive school-wide bullying prevention and intervention program needs to be implemented. This program would include training for all school professionals, students, and parents. Additionally, it is important to utilize all existing programs and resources available in the school such as restorative practices, culturally responsive positive behavior interventions and supports, character education, the parent-teacher organization, school-wide positive discipline

programs, social/emotional learning curricula, grade-level teams, professional learning communities, and any other meaningful supports to eliminate bullying from the school.

Below are various bullying prevention programs that can be implemented in schools to address bullying.

- Olweus
- Bully Busters
- Get Smart, Get Help, Get Safe
- The Kinder & Braver World Project
- Bully Safe USA

Exercise: What types of bullying have you witnessed? List a specific example of the four types of bullying as discussed above.

Section Summary: Bullying continues to be a problem for today's youth. It is essential to have an understanding of the definition of bullying as well as recognize symptoms of a student that has been both the target of bullying and the student exhibiting bullying behavior. Schools need to implement comprehensive programming to prevent and equip educators with the abilities to intervene if witnessing a bullying event.

Sexual Orientation and Gender Identity

Lesbian, gay, bisexual, or transgender (LGBT) youth commonly face challenges at home, school, foster care, and in the juvenile justice system. It is important to remember this topic is also applicable to young children. Aina & Cameron (2011) share gender identity expression begins between 3 to 5 years of age, and it is natural for a youth to have the first romantic crush around the age of 10. As early as kindergarten, students may hear derogatory comments about

LGBT students (Willoughby, 2012). *Gender variant* youth, children and adolescents who do not look or traditionally behave in ways that males and females are expected to behave by their families and by society, are at a greater risk of becoming the target of bullying and future school and social problems.

With the onset of puberty and feelings of emotional and sexual attraction toward others, adolescence can be a difficult time. This is perhaps no truer for any group than those who identify as LGBT. For many of these students, adolescence brings not only the typical developmental challenges, but also elevated risk for a number of serious issues related to physical, emotional, and mental health. While a complete rundown of risk factors is beyond the scope of this section, counselors should know that LGBT youth are statistically more likely than their peers to experience physical and verbal harassment and assault, decreased self-esteem, lowered GPA (Gay, Lesbian, and Straight Education Network [GLSEN], 2013), homelessness or “couchsurfing” (Ray, 2007), suicidal thoughts, ideations, and attempts (CDC, 2011), and a host of other issues. While many LGBT youth are able to navigate these challenges with the support of family and friends, some lack the necessary social connections and coping mechanisms and will seek the assistance of a counselor. The following are suggestions for working with the youth LGBT population:

- Maintain an open, nonjudgmental attitude. Both the ACA (2014, A.4.b.) and ASCA (2010, A.1.c.) ethical standards require counselors to respect the diversity of their clients and avoid imposing values/beliefs upon them. Like other youth who seek out counseling, LGBT youth want to be heard and empathized with, and as such, a great deal of healing can take place simply through the formation of a positive therapeutic alliance.

- Given the evidence of possible bullying of LGBT youth, it may be appropriate to scan for academic, social, behavioral, and emotional issues early in the counseling process. Counselors should also assess each client's current coping strategies and when needed, teach positive techniques for managing stress, anxiety, decreased self-esteem, and anger.
- Like all adolescents, LGBT youth benefit from positive, supportive peer relationships. Encourage clients to seek out like-minded peers and become involved in school or community activities. To promote these types of positive relationships, advocate for the formation of LGBT-affirming clubs such as Gay and Straight Alliance in your school or workplace.
- The process of "coming out" or telling one's family and friends about their sexual orientation or gender identity is a life-changing step for LGBT youth. Allow clients to make this decision in their own time when they are ready -- do not push them or "out" them without their knowledge. When a client is ready, offer your support in the form of brainstorming strategies for sharing, role-playing, or offering to be present for the discussion. Family support is a critical protective factor for LGBT youth, so it is important that counselors continually assess this area of a client's life and offer assistance when needed.
- Help make your school or work environment a safe place. Use inclusive language (e.g., partner instead of boyfriend/girlfriend), display LGBT-affirming materials, and do not tolerate slurs or offensive language. Encourage other staff to do the same. Additionally, support and/or lead efforts to change or institute inclusive policies around non-discrimination and inclusion. One example would be a bathroom and locker room policy that invites students to use facilities that most closely align with their gender identity.

- Some adolescents may ask about “reparative” or “conversion” therapies, which purport to change a person’s sexual orientation. Counselors should recognize that no rigorous scientific data exists to demonstrate that these therapies are ever successful, and in fact, they can have wide-ranging negative consequences for clients. Every major professional association for mental health practitioners (i.e., ACA, ASCA, APA, AAP, NASW) has issued a statement discouraging its members from attempting to change a client’s sexual orientation.
- Professional counselors are also called to advocate for systemic change that supports the rights and wellbeing of all marginalized persons, including LGBT youth (Ratts et al., 2015). Be on the lookout for policies, rules, laws, etc. that intentionally or unintentionally discriminate against this population, and speak up! Whether in your school, workplace, town, or state, your efforts can make a difference.

Exercise: Discuss several strategies counselors can use when working with LGBT youth at various levels: individual, school, community, and state.

Youth with Disabilities

In the most recent school year for which statistics are available (2011-2012), almost 6.5 million children and adolescents were being provided services through federally funded special education programs (U.S. Department of Education, 2015a). With this number representing roughly 13% of the total public student population, it is clear that a counselor providing services to children and adolescents is very likely to encounter a young person with a disability. As such, counselors must be familiar with the challenges faced by these students, as well as the laws and terminology that govern special education.

Federal oversight and funding for special education largely began in 1975 with the passage of the Education for All Handicapped Children Act, later renamed the Individuals with Disabilities Education Act (IDEA) upon its reauthorization in 1990. Although the legislation has been improved and renamed many times over the years, its core principles and requirements have remained largely unchanged. First and foremost is the requirement that schools provide a free appropriate public education (FAPE) to all students with disabilities. Prior to IDEA, it was not uncommon for public schools to either deny educational services completely, or to charge families the costs of educating students with disabilities. Schools are now required to not only educate all students, but also to do so in a manner that is consistent with state standards and tailored to a child's specific needs based on disability. Furthermore, IDEA requires that students provide this education in the *least restrictive environment* (LRE). This means schools educating students with disabilities alongside nondisabled students to the greatest extent possible, even when that means providing accommodations and modifications in the form of materials, assistive technology, and/or additional staff. Essentially, LRE is in place to ensure that students are not continually placed in "pull out" or "self-contained" special education classrooms or buildings when they are capable of learning in a general education setting with proper supports.

IDEA also requires schools to provide an appropriate evaluation for special education to all students who might benefit. Evaluation comes in many forms, including the administration of standardized tests and instruments, developmental interviews with the student and parents, and a review of school records. This process that must be completed within a specific timeline as specified by IDEA. It is typically carried out by a diverse team of specialists that includes special education teachers, a school psychologist, school nurse, school administrator, and school counselors. Many types of disabilities could potentially qualify a student for special education

services, but the most common are specific learning disabilities (e.g., a math or reading disorder), speech or language impairments, “other” health impairments (e.g., ADHD, asthma, epilepsy), and autism spectrum disorders. Once a student has been found eligible for services, IDEA requires the team to develop an individualized education program (IEP) for the eligible student. An IEP is the foundation for a student’s education. It outlines the impacts of the student’s disability on current levels of academic and social performance and sets concrete goals for future performance. It includes accommodations and modifications, either in the classroom or school environment, that will be necessary for the student to succeed, as well as services that will be provided by school staff to help the student meet his/her goals.

With such a wide variety of disabilities being fairly common among children and adolescents, it is difficult to give broad recommendations for counselors working with this population. That said, the following are general suggestions to keep in mind.

- Treat students with disabilities as individuals. Just as a mental health diagnosis does not define a person, neither does the presence of a disability. A “label” does not mean a child will act in stereotypical ways or experience the same challenges as another person with the same disability. Take time to get to know each individual, including exploring strengths and aspirations. When discussing challenges, try to focus on a client’s strengths when designing interventions that target specific areas of academic, emotional, and personal/social well-being. The needs of students with disabilities are as wide and varied as that of the general student population, and could include things like academic achievement/graduation, social issues, self-esteem, anger management, post-secondary planning and transition, etc.

- Advocate for the needs of students with disabilities. Educate yourself on IDEA and state rules, regulations, and processes that are in place to protect these students. Speak up when something is not right or someone is being treated unfairly.
- Special education team meetings can be overwhelming. Offer to meet individually with parents and students, ensuring they understand what is happening in meetings, what is contained in the IEP, and what their rights are with regard to IDEA.
- Connect with other important adults in the student's life, including teachers, coaches, and the school-assigned case manager. Offer to help in any way you can, including as a service provider on the IEP when it is appropriate.
- When called up to counsel these students, focus on empowerment strategies. This could take many forms, but is frequently focused on helping a student build self-advocacy skills working to discover own needs and find solutions to presenting challenges. Teaching a client counseling approaches such as Solution-Focused Brief Therapy, CBT, and/or mindfulness could be appropriate.
- Differentiate classroom lessons and group sessions to effectively reach all learners and to specifically accommodate the needs of students with disabilities. For example, counselors might need to prepare large print copies of materials for a student with a vision impairment. Check with teachers in advance of classroom lessons to become aware of any needs and adjust lessons accordingly.

Exercise: Think about your high school experience. What types of interactions did you have with students with disabilities? Did you share classes, play sports, or socialize with these students?

Discuss with a peer.

Military Families

There are approximately 2 million youth under 18 living with a parent or primary caregiver in the military. These children and adolescents typically face numerous challenges unique to military life, and while most are able to cope with these issues in developmentally appropriate ways, others may require additional support. Below is a brief overview of the two most common challenges faced by military families, followed by suggestions for counselors working with this population.

- **Frequent relocation:** Military families are often required to relocate every few years, or even more frequently during times of conflict. These moves may take families to new states or even overseas, causing children to experience both emotional strain and losses such as friends, schools, homes, neighborhoods, and routines. In extreme cases, children may exhibit attachment issues or an unwillingness to engage peers or school staff after a move. Others may be depressed or anxious before or immediately after a move. Adults may notice typical trauma symptoms such as anger, “clinging” or developmental regression, and difficulty concentrating.
- **Deployment of a loved one:** In times of conflict, it is not unusual for a military member to be deployed for weeks, months, or even years at a time. Families typically endure three stages of deployment, each of which brings unique challenges. During the pre-deployment stage, families typically try to draw closer, but it is not unusual for at least one member to pull away in an attempt to prepare for the extended absence. Anxiety and tension may also run high as arrangements are made for things like child care and finances, and as the non-deploying parent begins to imagine the burden of an increased workload at home. During the deployment, the primary concern is typically safety, both for the deployed parent and for the family left behind without their “protector.” Children

may also exhibit typical signs of separation anxiety during this time, ranging from bedwetting and unexplained fear or crying in younger children to physical complaints (stomachaches, headaches) and decreased school performance in older children and adolescents. Post-deployment, the immediate joy of being reunited can sometimes be overshadowed by the challenges of readjusting to life as a family. These challenges might include difficulties the deployed parent is having with a return to civilian life, including coping with traumas experienced in a combat theater. During this time, young children may have trouble reconnecting with the deployed parent, and may even have difficulty recognizing them or submitting to their authority. Older children and adolescents may resent the deployed parent for having left them, made them worry, and may lament the return to old parenting routines and modes of discipline.

Suggestions for working with military children:

- Counseling strategies for coping and resilience are generally enough to support a child before or after a move or parental deployment. Creative methods such as play, bibliotherapy, art, journaling, and music could be helpful ways to facilitate sharing. For example, a family took one photo per day while a parent was deployed and created an album that both recognized the strength and resilience of the family during this time and also celebrated the parent's return. Writing letters or emails to old friends or a deployed parent can be therapeutic. Group counseling or other organized opportunities for kids to process these challenges with their peers can also be extremely helpful.
- Emphasize confidentiality since military families frequently worry that seeking out counseling or therapy could be a detriment to the service member's career. It is part of the military culture to be strong in the face of challenges, so even seeking out the help of

a counselor can be a difficult step. Reassure children and families that you will remain impartial, keep their information confidential, and stand at the ready to be helpful in any way possible.

- Do your best to learn military acronyms, jargon, and ways of life. While military families frequently appreciate the opportunity to interact with those outside the “chain of command,” it can be frustrating for them to adjust the language and behavior to do so. The more misinformed a counselor is, the more of an “outsider” they will seem to the family -- and the more difficult it will be to establish rapport.
- Since children frequently take emotional cues from adults during difficult times, counselors may do well to connect with a child’s caregivers during times of transition to remind them that a positive outlook and attitude could be one way of helping their child cope. When faced with a move, parents might emphasize the positives, such as the perks of career advancement and opportunities to experience a new culture (seeing new places, trying new foods, meeting different types of people, etc.).

Case Example: You are working in a community with a large military population and have been asked by the principal of the local elementary school to set up supports for K-5 students who are having social, academic, or behavioral difficulties.

- *What might be your primary concerns with this population?*
- *What types of interventions might you set up to address these concerns?*
- *How would your interventions look difference with older students, such as those in high school?*

Section Summary: The previous three sections discussed three unique groups of young people (LGBT, youth with disabilities, and those in military families). While many children and

adolescents belonging to one of these groups are leading perfectly healthy and well-adjusted lives, each group is susceptible to various negative outcomes with regard to academic, social, and mental wellbeing. Counselors should be aware of the typical needs and risk factors of these groups, and should provide interventions and/or advocate on their behalves as needed.

Chapter Key Points

- **Risk and Protective Factors:** Risk factors are life circumstances that threaten to harm the physical or mental wellbeing of a person. Protective factors (such as family and social support, high self-esteem, and emotional coping skills) can instill resilience, or the ability to “bounce back” after experiencing difficulties in children under 18. Counselors should assess for risk factors as well as resilience, continuously working to increase the presence of protective factors in each client’s life.
- **Trauma:** Trauma is highly prevalent in childhood and adolescence, and its negative impacts on the physiological and emotional wellbeing of survivors is well documented. Counselors should be aware of these facts and ready to recognize and assess the symptoms and impacts of trauma.
- **Grief and Loss:** Grief is a personal response and unique to each person. However, counselors need to be able to recognize typical responses to grief for children and adolescents that include grief bursts expressed by anger, sadness, confusion, denial and questioning. It is common for youth to re-grieve as they reach each developmental milestone.
- **Natural Disasters:** Natural disasters can strike virtually any community at any time. In addition to the direct impacts of the disaster, young people often experience secondary losses such as their community of residence or school friends. Various nonprofit and government agencies such as the Red Cross and FEMA provide a plethora of resources for helping survivors cope.
- **Violence:** Over 40% of persons under the age of 18 experience some form of violence in any given year. Survivors are at risk for a variety of outcomes, including anxiety, anger,

and insomnia. A good first step for helping professionals is establishing safety and trust in the counseling office, and helping the client identify strategies for doing so at home and school.

- **Abuse and Neglect:** Child abuse and neglect takes many forms, from physical or emotional battery to sexual abuse to failure to provide for basic needs. Counselors should be on the lookout for signs of abuse and neglect, such as physical marks, clothing worn to hide certain body parts, and attachment issues. Counselors should be frank in asking about abuse and should never hesitate to report suspected cases of abuse/neglect to the proper authorities.
- **Sexual Abuse and Violence:** 15% of females and 6% of males experience sexual abuse or violence before turning 18. While outward physical signs are rare, counselors may suspect such abuse when clients present with nighttime issues (bed-wetting or nightmares), unexplained fear of certain adults or places, and certain sexual symptoms. Counseling survivors of sexual abuse is difficult, delicate work. Counselors should report all suspected cases of sexual abuse and refer these clients to trained professionals if they feel the work is beyond their scope of practice.
- **Youth in Foster Care:** Young people in foster care are likely to have had exposure to a traumatic event. They may have challenges with trust, attachment, and engaging in healthy relationship practices. By providing unconditional positive regard and acceptance, counselors can begin to build an effective and productive therapeutic relationship allowing the counselor to address any mental health concerns.
- **Suicide and Suicide Risks:** Suicide is a leading national problem facing our youth. Suicide is preventable and having knowledge and skills for early identification (including

risk factors and warning signs) is vital. Depression is the leading cause of suicide in teens. When counseling a student presenting with suicidal ideation, it is vital to stay calm, stay with the young person at all times, and provide unconditional positive regard.

- **Non-Suicidal Self Injury (NSSI):** Youth that are demonstrating non-suicidal self-injurious behaviors may be engaging in behaviors such as cutting or scratching oneself, burning, hitting self, and biting (a few of the common self-harming methods). Counselors need to approach these youth with openness and withholding judgment. The focus should be on building relationship rather than on stopping the NSSI behavior.
- **Sexual Orientation and Gender Identity:** Young people who identify as lesbian, gay, bisexual, or transgender (LGBT) are likely to face many difficulties during their school years, including bullying, decreased self-esteem, and drops in school performance. All counselors are called to be non-judgmental and to work to form a healthy therapeutic alliance with LGBT students. Possible issues to address include self-esteem and identity formation, “coming out” to family and friends (when the client is ready), and advocating for fair practices and systemic change as needed.
- **Youth with Disabilities:** Almost 6.5 million school-aged youth receive federally funded special education services. The Individuals with Disabilities Education Act (IDEA) protects the rights of these students and provides guidance and mandates for public schools who educate them. Students who are assessed and found to be eligible for protections under IDEA are entitled to a Free Appropriate Public Education (FAPE) in the Least Restrictive Environment (LRE), and with a course of education designed to meet their needs via an Individualized Education Program (IEP).

- **Youth in Military Families:** Approximately 2 million youth live with a parent or primary caregiver who is part of the military. These families face numerous challenges, including frequent relocation and deployment. Counselors can support these youth before, during, and after transitions such as these by forming support groups and using creative strategies such as bibliotherapy, art therapy, letter writing, etc.

Glossary

- **Complex trauma:** Severe, pervasive trauma that accumulates over time through repeated exposure to traumatic events such as abuse or violence.
- **Foster care:** Placement when a youth has been removed from their home due to experiencing some form of serious abuse and/or neglect.
- **Gender variant:** Children and adolescents who do not look or behave the way that girls and boys are expected to behave by their families and by society.
- **Grief bursts:** a sudden feeling and expression of grief, typically lasting short periods of time.
- **Least restrictive environment (LRE):** A requirement of IDEA that schools educate students with disabilities alongside their nondisabled peers to the greatest extent possible.
- **Non-suicidal self-injury:** Act when youth intentionally destructs the body or skin but does not have intent to end one's life but rather is seeking a way to relieve stress or escape problems.
- **Protective factors:** Conditions or attributes that mitigate or eliminate risk and can increase the health and well-being of individuals.
- **Resilience:** Adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress -- the ability to "bounce back".

- Risk factors: Characteristics at the biological, psychological, family, social, community, or cultural level that are commonly associated with an increased likelihood of negative life outcomes
- Trauma: Emotional or physical harm resulting from exposure to highly stressful events.
- Triggers: People, places, and things that are likely to cause distress by reminding a trauma victim of previous experiences.
- Warning Signs: Cues that can be observed, heard, or viewed in behavior or social changes that commonly connect to suicidal attempts.

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Additional Resources

Risk and Protective Factors

- Search Institute: Provides research and resources regarding the 40 Developmental Assets.

<http://www.search-institute.org/research/developmental-assets>

- youth.gov: Website offering information and resources specific to the mental health needs of youth. <http://youth.gov/youth-topics/youth-mental-health/risk-and-protective-factors-youth>

General Trauma Resources

- American Counseling Association (ACA) Traumatology Network:

<http://www.counseling.org/aca-community/aca-groups/interest-networks#Traumatology>

- The National Center for Trauma-Informed Care (NCTIC): NCTIC is a division of the Substance Abuse and Mental Health Services Administration (SAMHSA) and provides training and support to a wide variety of community organizations who serve trauma victims, including community mental health agencies. <http://www.samhsa.gov/nctic>
- The National Childhood Traumatic Stress Network (NCTSN): An organization that provides data sheets, reading lists, and a variety of other resources for trauma victims, their families, and those who provide service to them.
 - Database of trauma-focused service providers: <http://www.nctsn.org/about-us/network-members>
 - Promising practices in trauma treatment: <http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices>
- Books for bibliotherapy:
 - “A Terrible Thing Happened”^[1] by Margaret M. Holmes
 - “Reactions”^[1] by Allison Salloum^[1]
 - “Why Did it Happen?”^[1] by Janice Cohen^[1]

Grief and Loss

- The Dougy Center: The National Center for Grieving Children and Families: The national center provides tremendous grief resources, information, books and training. <http://www.dougy.org>
- Mental Health America: Helping Children Cope With Loss: This site provides tips and other resources for grieving children. <http://www.mentalhealthamerica.net/conditions/helping-children-cope-loss>
- Center for Grieving Children: <http://grievingchildren.org/grief-resources/>

- National Alliance for Grieving Children (NAGC): <https://childrengrieve.org>

Disasters

- NCTSN, Natural Disasters: <http://www.nctsn.org/trauma-types/natural-disasters>
- SAMHSA, Disaster Distress Helpline: <http://www.samhsa.gov/find-help/disaster-distress-helpline#sthash.f1zKF1ER.dpuf>
- Red Cross, Disaster Response Training (including disaster mental health):
<http://www.redcross.org/take-a-class/disaster-training>

Violence

- NCTSN, Community and School Violence Reading List:
<http://www.nctsn.org/resources/online-research/reading-lists/community-and-school-violence>
- NCTSN, Interventions for Children Exposed to Domestic Violence:
<http://www.nctsn.org/content/interventions-children-exposed-domestic-violence-core-principles>

Abuse and Neglect

- **Prevent Child Abuse America:** <http://preventchildabuse.org/resources/>
- *Sexual Abuse and Violence*
 - NCTSN, Sexual Abuse Reading List: <http://www.nctsn.org/resources/online-research/reading-lists/sexual-abuse>
 - NCTSN, Sexual Abuse Resources: <http://www.nctsn.org/trauma-types/sexual-abuse#q9>
- *Physical abuse and neglect*
 - NCTSN, Physical Abuse Reading List: <http://www.nctsn.org/resources/online-research/reading-lists/physical-abuse-and-neglect>

Foster Children

- Child Welfare Information Gateway: Website providing information, resources, and tools to best support foster children. <https://www.childwelfare.gov>
- Foster Care to Success: Reading and Resource List:<http://www.fc2success.org/knowledge-center/resources-for-students-state-workers/>

Suicide

- American Association of Suicidology: <http://www.suicidology.org>
- Columbia Suicide Severity Rating Scale (C-SSRS):
<http://www.cssrs.columbia.edu/index.html>. Anyone, anywhere can use the C-SSRS. Hospitals, schools, jails, armed forces and many other public health settings are using the scale for suicide risk identification. The C-SSRS has been administered several million times and has exhibited excellent feasibility – *no mental health training is required* to administer it.
- National Suicide Prevention Lifeline 1-800-273-TALK:
<http://www.suicidepreventionlifeline.org/>. The National Suicide Prevention Lifeline's mission is to provide immediate assistance to individuals in suicidal crisis by connecting them to the nearest available suicide prevention and mental health service provider. It is the only national suicide prevention and intervention telephone resource funded by the Federal Government.

Non-Suicidal Self Injury

- Self Injury Outreach & Support: A non-profit outreach initiative providing information and resources about self-injury to those who self-injure, those who have recovered, and those who want to help. <http://sioutreach.org>

- The Cornell Research Program on Self-Injury and Recovery: A website that provides links and resources to self-injury information.

<http://www.selfinjury.bctr.cornell.edu/index.html>

Bullying

- U.S. Department of Health & Human Services: <http://www.stopbullying.gov>
- National Bullying Prevention Resources: <http://www.pacer.org/bullying/resources/>
- Violence Prevention Works! Safer Schools, Safer Communities:
http://www.violencepreventionworks.org/public/bullying_prevention_resources.page
- Connect Safely: Smart Socializing Starts Here:
<http://www.connectsafely.org/cyberbullying/>
- Association for Behavioral and Cognitive Therapies (ABCT): ABCT provides fact sheets, podcasts, and other helpful strategies specific for mental health counselors working with bullied youth.

http://www.abct.org/Information/?m=mInformation&fa=fs_BULLYING_PRO

Sexual Orientation and Gender Identity

- American Psychological Association (APA), Promoting Resiliency for Gender Diverse and Sexual Minority Students in Schools: <http://www.apa.org/pi/lgbt/programs/safe-supportive/lgbt/resilience.aspx>
- Gay, Lesbian, and Straight Education Network (GLSEN): GLSEN provides research and resources to support students, educators, and community members interested in creating positive, affirming school environments: <http://www.glsen.org>

Youth with Disabilities

- Understood.org: 15 nonprofit agencies banded together to create Understood.org to provide support and tools for parents raising a child with a learning or attention difficulty:
<https://www.understood.org/en>
- U.S. Department of Education, Office of Special Education and Rehabilitative Services:
<http://www2.ed.gov/about/offices/list/osers/osep/index.html>

Military Families

- Military Kids Connect: A place for children of military members to learn from and connect with one another online. Includes groups for all age categories:
<http://militarykidsconnect.dcoe.mil/>
- NCTSN, Childhood Traumatic Grief Resources for Military Children and Families:
<http://www.nctsn.org/trauma-types/traumatic-grief/military-children>
- National Military Family Association: Resources for families of military members. Includes tools for a wide range of topics including healthcare, education, scholarships, support during deployment, etc.: <http://www.militaryfamily.org/>
- Sesame Street for Military Families: Includes many resources about relocation, deployment, injuries, grief, etc.: <http://www.sesamestreetformilitaryfamilies.org/>

Post-test: Five Multiple Choice Questions

1. _____ is defined as emotional or physical harm resulting from exposure to highly stressful events.
 - a. Risk factors
 - b. Resilience
 - c. Grief
 - d. Trauma
 - i. Correct answer: d

2. A concern that sometimes happens when a student dies by suicide and then other suicides follow in that area/school community is called:
 - a. Repetition.
 - b. Contagion.
 - c. failure to protect.
 - d. Coincidence.
 - i. Correct answer: b

3. What is the leading cause of suicide death in teens?
 - a. Anxiety
 - b. Stress
 - c. Depression
 - d. Post-traumatic stress disorder
 - i. Answer: c

4. An example of an “other” health impairment that would qualify a student to receive special education services is:

- a. asthma.
- b. reading disability.
- c. speech impairment.
- d. math disability.

i. Answer: a

5. All are examples of individual protective factors during childhood or adolescence except:

- a. high self-esteem.
- b. academic mastery.
- c. ability to make friends.
- d. harsh or inconsistent discipline.

i. Answer: d