CHILD AND ADOLESCENT COUNSELING CASE STUDIES
Brenda L. Jones, PhD, LPC, CSC, NCC, is a licensed and certified professional school counselor (CSC), a nationally certified counselor (NCC), and a licensed professional counselor (LPC). She has a doctoral degree in counselor education and supervision. Currently, she is a clinical assistant professor at the University of Texas at San Antonio and is one of the professors on record for master’s level school counseling and clinical mental health courses. She is a member of numerous national, state, and local counseling professional organizations. Currently, she is the president-elect of the Texas Association for Counselor Education and Supervision. She has had several professional publications in counseling literature, made numerous peer-reviewed presentations, and has received awards from the American School Counselor Association High School Counselor of the Year Award, the Texas School Counselor Association Rhosine Fleming High School Counselor of the Year Award, and the South Texas Counseling Association High School Counselor of the Year Award. She has been profiled in a feature article on contemporary Black women published by *Ebony* magazine and was recognized in *Jet* magazine’s People section. She is an honorary life member of the Texas Parent Teacher Association. She serves on the editorial boards for the *Journal of Creativity in Mental Health* and the *Journal of School Counseling*.

Thelma Duffey, PhD, LPC, LMFT, is professor and chair in the Department of Counseling at the University of Texas at San Antonio and immediate past president of the American Counseling Association. Dr. Duffey was the founding president of The Association for Creativity in Counseling, a division within the ACA, and she served two terms on the ACA Governing Council. Dr. Duffey is a former president of the Texas Association of Counselor Education and Supervision and executive board member for the Southern Association of Counselor Education and Supervision. Dr. Duffey is editor for the *Journal of Creativity in Mental Health* and she served as guest co-editor for a *Journal of Counseling and Development* (JCD) Special Issue on Counseling Men and the JCD Special Section on Relational-Cultural Theory. Dr. Duffey, an ACA Fellow, has received numerous awards from professional organizations such as the Association for Counselor Education and Supervision, the American Counseling Association, the Texas Counseling Association, the Southern Association for Counselor Education and Supervision, the Association for Creativity in Counseling, and the Texas Association for Counselor Education and Supervision. She has over 60 peer reviewed publications; an edited book, *Creative Interventions in Grief and Loss Therapy: When the Music Stops, a Dream Dies*, and a co-edited book, *A Counselor’s Guide to Working with Men*.

Shane Haberstroh, EdD, LPC, is currently an associate professor and Doctoral Program Director in the Department of Counseling at the University of Texas at San Antonio. He served on the founding board for the Association for Creativity in Counseling (ACC) and as the ACC President and Treasurer. He is currently the Governing Council Representative for the Association for Creativity in Counseling and the Governing Council liaison for the research and knowledge committee of ACA. Dr. Haberstroh serves as the associate editor for the *Journal of Creativity in Mental Health*. He has published over 30 articles and book chapters primarily focused on Developmental Relational Counseling, online counseling, creativity in counseling, and addiction treatment & recovery. His collaborative research project on relational competencies won the 2010 Texas Counseling Association Research Award, and his collaborative publication on assessment practices in counselor education programs was recognized with the 2014 AARC/CORE Outstanding Outcome Research Award. Dr. Haberstroh began his career in 1992 as a residential technician in a 28-day drug treatment program and worked for many years as a counselor and supervisor in addiction treatment centers, private practice, and criminal justice settings. He has been a counselor educator since 2003 and he joined the faculty of the University of Texas at San Antonio in 2004.
This book is dedicated to children and adolescents who continuously encounter challenging issues while traversing life experiences. It is also dedicated to the many clinical mental health and professional school counselors, counselor supervisors, and counselors-in-training who serve as ready resources of guidance for children, adolescents, and related systems—family, school, peer, and community. A special dedication goes to all of the dedicated parents including Brenda Jones’s daughter, Nicole Jones, and Thelma Duffey’s son, Robert Duffey, who continuously foster healthy development for their children.
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CONTRIBUTORS

Norèal F. Armstrong, PhD, LPC-S, NCC, LCDC
Assistant Professor
Montreat College
Asheville, North Carolina

Katherine Bacon, PhD, LPC-S, NCC
Assistant Professor
University of Houston Victoria at Sugar Land
Sugar Land, Texas

Huma Bashir, EdD, PCC-S, LICDC
Assistant Professor
Wright State University
Dayton, Ohio

Lisa L. Beijan, MEd, LPC
Doctoral Candidate
University of North Texas
Denton, Texas

Caroline M. Brackette, PhD, LPC, ACS
Associate Professor
Mercer University
Atlanta, Georgia

Thomas Anthony Chávez, PhD, LMHC (NM)
Assistant Professor
University of New Mexico
Albuquerque, New Mexico
Ernest Cox, Jr., MS, CSC
Director of Guidance and Counseling
Judson Independent School District
Live Oak, Texas

Thelma Duffey, PhD, LPC, LMFT
Professor and Chair
The Department of Counseling
The University of Texas at San Antonio
San Antonio, Texas

Suzanne M. Dugger, EdD, LPC, NCC, ACS, LSC
Professor and Program Coordinator of Counselor Education
University of Mississippi
University, Mississippi

Stephanie Eberts, PhD, CSC
Assistant Professor
Louisiana State University
Baton Rouge, Louisiana

Tamarine Foreman, PhD, LPCC-S, NCC
Assistant Professor
Ohio University
Athens, Ohio

Kristopher M. Goodrich, PhD, LPCC (NM), ACS, NCGC-II
Associate Professor/Coordinator
University of New Mexico
Albuquerque, New Mexico

Shane Haberstroh, EdD, LPC
PhD Program Director and Associate Professor
The University of Texas at San Antonio
San Antonio, Texas

Maria Haiyasoso, PhD, LPC, NCC
Assistant Professor
Texas State University
San Marcos, Texas

Glenda S. Johnson, PhD, LPC, PSC
Assistant Professor
Appalachian State University
Boone, North Carolina
CONTRIBUTORS • xi

Brenda L. Jones, PhD, LPC, CSC, NCC
Clinical Assistant Professor
The University of Texas at San Antonio
San Antonio, Texas

M. Michelle Thornbury Kelley, MA, CSC
Coordinator, Secondary Counselor Services and Safe School Initiatives
Northside Independent School District
San Antonio, Texas

Alexandria K. Kerwin, PhD, LPC, NCC
Assistant Professor
University of Mississippi
University, Mississippi

Melissa Luke, PhD, LMHC, NCC, ACS
Associate Professor/School Counseling Coordinator
Syracuse University
Syracuse, New York

Jennifer Austin Main, LPC, RPT-S
Doctoral Candidate
University of Mississippi
University, Mississippi

Taryne M. Mingo, PhD, NCC
Assistant Professor
Missouri State University
Springfield, Missouri

Ariel Mitchell, PhD, LPC-S, LMFT, NCC
Assistant Professor
Xavier University of Louisiana
New Orleans, Louisiana

Claudia Morales, MA, CSC
Professional School Counselor
Northside Independent School District
San Antonio, Texas

Jenn Pereira, PhD, LMHC-S, RPT-S, CCPT-S, CT
Clinical Assistant Professor
Arizona State University
Tempe, Arizona
• CONTRIBUTORS

JoLynne Reynolds, PhD, LPC, NCC, RPT-S  
Professor  
Regis University  
Broomfield, Colorado

Michelle Robinson, CSC  
Professional School Counselor  
Judson Independent School District  
Converse, Texas

Mona Robinson, PhD, LPCC-S, LSW, CRC  
Professor/Department Chair  
Ohio University  
Athens, Ohio

Eric Suddeath, MA  
Doctoral Candidate  
University of Mississippi  
University, Mississippi

Donna A. Tonrey, PsyD, LMFT, LPC  
Director of Counseling and Family Therapy  
La Salle University  
Philadelphia, Pennsylvania

Stacy Waterman, M.A., LPC, LCDC  
Doctoral Student  
The University of Texas at San Antonio  
San Antonio, Texas

Tammy L. Wilborn, PhD, LPC-S, NCC  
Assistant Professor  
University of New Orleans  
New Orleans, Louisiana

Angie D. Wilson, PhD, LPC-S, LSOTP, NCC  
Assistant Professor  
University of North Texas  
Denton, Texas

Natasha Young, MEd, LPC  
Clinical Supervisor  
The Parris Foundation  
Houston, Texas

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When I wrote the Foreword for Dr. Larry Golden’s third edition of *Case Studies in Child and Adolescent Counseling*, which was published in 2002, I commented about how many more challenges children and adolescents face as they navigate their developmental journey through childhood and adolescence. I noted that Dr. Golden had made a significant contribution to the field with that publication and although his dignified career ended with his death in 2012, Dr. Brenda Jones has recognized the significance of a book of this nature and has resurrected it with new case studies and relevant information that child and adolescent practitioners will profit from on multiple levels.

As I noted in the 2002 Foreword, my first year (1972) as an elementary counselor was a continual learning experience. There were no the Council for Accreditation of Counseling and Related Educational Programs (CACREP)-accredited programs, no internships, very little supervision, and no specific courses in counseling children and adolescents. Suffice it to say that it was a “baptism by fire” year! I will never forget being at a loss for words and thinking that my training had definitely not prepared me for the “real world” when I went into a fourth grade classroom to introduce myself and tell the children about the role of the counselor. I concluded my commentary with “and as your counselor, I am here to help you with your problems.” Suddenly a hand shot up and an adorable boy with curly blonde hair blurted out, “My mom’s been married three times and my dad has been married twice and now they are getting a divorce. Is this a problem you can help me with?” Now some of you may recall that in the early 1970s, divorce was pretty rare and most of the students I was working with had typical developmental problems that I felt comfortable handling.
But I was less certain about how to help this student. However, when he appeared in my doorway, I knew I had to figure it out by trial and error.

I have thought about that scenario many times, and upon reflection, I realize that “back then” there were so few resources, and what we did with children was basically extrapolated from approaches we would use with adults. It did not take me long to learn that that was extremely inadequate, and I am so thankful that the field has evolved such that today there are specific courses on counseling children and adolescents and a plethora of resources that can be accessed with the click of a mouse. Thankfully, our profession got “up to speed” with specific applications of theories and techniques that work best with the younger population because the problems they present with today necessitate more skill than ever before. In addition to normal developmental problems that all children experience to varying degrees, the number of children and adolescents who deal with emotional or sexual abuse, domestic violence, cyberbullying, homelessness, addiction, and other serious problems is sobering. Unfortunately, so many do not get the help they need and resort to self-destructive behaviors due in part to their sense of hopelessness, their powerlessness, their lack of support, and their developmental level that can impact their ability to fully understand the issues and cope with problems in a self-enhancing, rather than a self-defeating, manner.

Over the years in my private counseling practice, I saw many young clients who came from dysfunctional families and had few, if any, positive role models. Their problems manifested in behavior problems, self-harm, addictions, eating disorders, suicide attempts, and the like. On the other hand, I had clients from healthy families with good role models who were anxious, depressed, dealt with their pain by acting out, refused to eat, or abused alcohol and drugs to numb their pain. Clearly, effective counseling approaches that address not only the individual, but also the system, are needed more now than ever before.

As I read the case studies that Dr. Jones and her colleagues described, I have to admit that I felt some despair and, at the same time, appreciation for the counselors who put so much of their professional expertise to work in order to address the problems on multiple levels. It was disconcerting to read about what 8-year-old Beth had to contend with: her older sister was murdered; her father was incarcerated; her father’s friend abused her sexually; her schizophrenic brother physically abused her, and she was bullied at school. How sad to think that a child this age would even consider suicide, let alone attempt it, as an escape from all her problems.
Taryne M. Mingo wrote about her work with Jeffrey, a gifted child who at age 9 stuffed his throat with tissues until he passed out, and Brenda L. Jones described her work with 17-year-old Adam who began drinking at age 9, was using heroin by the time he was 15, and had been in trouble with the law since age 13. Stephanie Eberts presented the case of Darryl, an 8-year-old whose father was incarcerated for assault and was arrested in front of Darryl when he was only 5. His anger and confusion manifested itself in aggressive behavior. Clearly, Taryne, Brenda, and Stephanie recognized the importance of developing rapport with these troubled youth who need someone on their side to help guide them through their troublesome issues. They also consulted with the family and the school, which is critical in delivering effective treatment for young clients.

As I read these case studies, as well as the others in the book, I was impressed that these counselors were nonjudgmental, accepting their clients with their weaknesses and trying to help them find their strengths. They were respectful and mindful about cultural considerations and family characteristics and how these factors affected their clients. Furthermore, they drew from various theories, often integrating them to achieve a better effect. They recognized, as do I, the importance of “counseling outside the lines” and using the expressive arts in their work with these clients.

I appreciated reading the step-by-step description of the problem conceptualization, goals for treatment, and the actual process. I often found myself wondering if I would have arrived at the same conclusions these authors did and whether I would have used similar approaches to treatment. Reading about how the various authors decided on their plan of action was very insightful and thought-provoking, and underscores the notion that there is not “one solution” to a problem. As counselors, we often want what Larry Golden once said was the “magic cure,” which is a myth that our field perpetuates but, in reality, rarely happens. Those of us who work with clients on a routine basis know that the road to recovery is often long and winding, and we must draw from a multitude of perspectives and approaches as the authors in these case studies did.

These case studies, albeit difficult to read because of the serious nature of the majority of the presenting problems, illustrated that counseling can make a difference in the lives of young clients. I predict that this book will be referred to frequently for ideas about how to address similar problems you have with your young clients, but also for inspiration.

Ann Vernon, PhD, LPC
Professor Emerita
University of Northern Iowa
The purpose of this book is to aid counselor educators, supervisors, and counselors-in-training in assisting children, adolescents, and their families to foster coping methods and strategies while navigating contemporary issues. Past life experiences of children and adolescents continue to shape their present. Counselors who work with children and adolescents serve as ready resources and sources of guidance to help youth traverse life’s unpredictable pathways. Developmentally effective counseling is crucial when working with children and adolescents; and when done effectively, provides meaningful, relevant, and transformative outcomes for youth, propelling them forward on paths conducive to mental health improvements. Equally important, effective counseling provides a relational foundation where the connections experienced in counseling teach youth how to relate with themselves and others in more productive ways.

The focal points of this book are not only congruent with national dialogues involving consistency in meeting ethical and accreditation standards, but also with accountability efforts and effectiveness in higher education. This book is designed to be used as a companion piece or supplement not only for child and adolescent counseling textbooks but also for a broad range of other courses in similar disciplines.

Consistent with the literature, this book was written to promote the essence of counselor growth. Case studies were written in contexts that reflect the fact that children and adolescents are part of larger systems—family, school, peer, and community. Systemic context, developmental and relational considerations, multicultural perspectives, and creative interventions were infused in the cases. Time-efficient methods, such as brief counseling, were used in some of the cases. The case studies selected highlight contemporary issues and relevant themes that are
prevalent in the lives of youths (i.e., abuse, anxiety, giftedness, disability, social media and pop culture, social deficits and relationships, trauma, bullying, changing families, body image, substance abuse, incarcerated family members, race and ethnicity, and sexual identity and orientation). These themes capture both the child and adolescent perspectives and are designed to provide breadth and depth during classroom discussions and debriefing. They also provide counselors-in-training in clinical mental health and professional school counselors hands-on, useful, concrete, and workable applications that will offer opportunities for skill and theory development.

An impressive roster of contributing authors submitted cases that offer a variety of professional and clinical perspectives. Contributing authors provided:

- An introduction and client background information (i.e., family history, dynamics, and aspects of the client’s life that honor diversity and the uniqueness of coping and healing; school and educational concerns; medical information and general health)
- Developmental and relational issues, and personal, social, and emotional status
- Conceptualization of the client’s presenting problems along with personal and client goals; theoretical approaches; and creative techniques, strategies, and interventions
- Counseling process describing step-by-step accounting of what happened in counseling sessions including the number of contacts made, with whom, and over what length of time. The counseling relationships were described and, in many cases, included areas such as progress, setbacks, and regressions
- Counseling outcome (i.e., describing results, creative strategies that worked or did not work and why; strategies that the authors would have done differently; and predictions or recommendations for the client)

Several contributing authors have written CACREP signature assignments that appear as appendices to the main text.

Inspiration for this book came from a former professor, colleague, and mentor, Dr. Larry Golden, who recently passed away. In 2002, Dr. Larry Golden wrote the third edition of Case Studies in Child and Adolescent Counseling, which served as the model for this book. Dr. Golden was a prolific contributor to the counseling literature. His books are still being used in counseling classrooms today. This book updates and expands Dr. Golden’s book and forwards his literary and instructional legacy by remaining responsive to the needs of the counseling field.
ACKNOWLEDGMENTS

Thanks is extended to Dr. Thelma Duffey and Dr. Shane Haberstroh, who have served as mentors for me and co-editors with me in my first book venture. Thanks is also extended to Nancy Hale, Editorial Director, and Mindy Chen, Assistant Editor, Springer Publishing Company. The process of editing this book was made easier by their expert assistance and their exceptional leadership, professionalism, and commitment.

Brenda L. Jones
CHAPTER 5

MICHAEL AND THE CAMOUFLAGE CRUTCHES

Jenn Pereira

Michael, a 4-and-a-half-year-old Caucasian male, lived with his mother and his 3-year-old sister. Michael’s mother requested counseling services due to growing concerns surrounding Michael’s medical condition, cerebral palsy (CP). She requested me as the therapist to provide emotional support for Michael. She also wanted my assistance in helping Michael understand his disability and the “limitations CP would present on his life.”

SYSTEMIC INFLUENCES

It became clear in discussing Michael’s issues with his mother that several components played a role in his difficulties. The family was generationally and currently of lower socioeconomic status, making acquisition of health care, therapeutic services, and disability education a struggle. Michael had also not been educated regarding his disability, which began to cause social and emotional difficulties for him. Additionally, it would be imperative that Michael’s mother, medical team, therapeutic service providers, and school work together to create an environment of consistent care and education.
DEVELOPMENTAL CONSIDERATIONS

Cognitive and Physical Development

The school diagnosed Michael via early intervention services with only a mild impairment of cognitive functioning. Michael’s preschool reported that although his early intervention assessments showed that he tested in the below average range of intelligence, he understood and practiced new concepts well, and he seemed able to assimilate information with visual examples and repetition.

Michael experienced complications early in his young life, including being born prematurely with a low birth weight. Additionally, a pediatrician informed Michael’s mother of a diagnosis of CP shortly before Michael’s first birthday after she discussed his numerous unmet milestones and muscular control issues. Michael’s mother recalled noticing feeding and eating issues around that time as Michael transitioned from baby food to solid food. Michael struggled with issues related to weak muscle tone and poor muscle control and coordination. He lacked the ability to walk with fluidity and struggled to control his arm movements. The school diagnosed him with a mild speech impairment; and Michael received speech and language services at home and, subsequently, at his preschool program.

Personal, Social, and Emotional Development

Michael’s teachers noted that when Michael began school, he seemed attentive and cooperative, displayed a good sense of humor, got along well with peers, and appeared to be a pleasure in the classroom. Michael’s primary teacher noted that although Michael appeared to be a “happy child,” over the past few months, he seemed to experience more frequent “down” or “sad” moods during which he refused to interact with the other kids at gaming and free play times. He cried frequently during the day. He became more and more inattentive during lessons and appeared to get frustrated easily. Michael commented to the school nurse that he found it difficult to play with the other kids “because his legs didn’t work like theirs” and he failed to understand why. Michael seemed to view his physical differences as “bad” and “wrong,” as though others saw him as defective in some way. He began to make negative comments about himself such as: “I’m dumb”; “I have stupid legs”; “the other kids don’t like me”; “I don’t have any friends and I can’t play right,” which the school staff feared to be signs of low self-esteem and possible depression. This negatively affected his ability to accept himself and engage with other children. At this point, the nurse and teacher held
a conference with Michael’s mother to share their growing concerns and reiterated that it might be helpful for him to better understand what appeared to be happening with his body. Other than the CP, Michael appeared in good health. He reportedly enjoyed a good appetite with the noted minor eating issues being managed by diet, and he slept well. Michael possessed a wonderful sense of humor, creativity, and curiosity.

RELATIONAL CONSIDERATIONS

Michael’s mother reported that Michael’s CP symptoms began to affect him more negatively on emotional, social, and academic levels, and she felt it necessary to share more details with him regarding his condition. She delayed informing Michael of his CP, telling him instead that his legs and arms seemed a bit weaker than other kids, causing him to sometimes need extra help. She worried that his diagnosis might “make him feel different or scared.”

Prior to beginning a preschool program at his local elementary school, Michael experienced limited interactions with other children aside from two mornings a week in a small day-care setting run by a family friend; therefore, his mother disclosed that she “did not see the point” of discussing his condition more fully with him. Michael recently began asking more questions about his condition and seemed to be searching for understanding.

MULTICULTURAL CONSIDERATIONS

Michael’s mother and I engaged in several conversations regarding the feelings of grief she experienced upon learning of Michael’s disability (i.e., her hopes and dreams for her son, her fears for him throughout his life, and her own concerns about her perceived ineptitude for parenting a disabled child). I learned that his mother failed to seek assistance from the doctor. She contacted the doctor 3 months prior to the doctor fitting Michael for leg braces and crutches that assisted him with coordination and muscle control. She also reported having difficulty keeping up with the physical therapy appointments; consequently, this caused Michael to miss numerous days of services.

Michael’s mother reported several concerns in addition to Michael’s issues. She selected the family’s struggle with poverty as the primary concern. Her financial issues impacted her ability to provide adequate services and care for Michael. She reported living in a “poor, rural farming community” where education appeared not to be a priority. She relied on her Christian faith and felt that it provided support and a caring
community during difficult times. The community and Michael’s school staff accepted his disability. Michael’s mother also reported that although she contacted her family on a limited basis, they provided emotional support for her and Michael. Several members of Michael’s family received a disability diagnosis. Because of this, his family seemed supportive of individuals with disabilities. This information provided insight into the personal and educational goals Michael’s mother held for her and Michael and her struggle to interact with Michael’s doctors and teachers. Eventually, she agreed to work with her own counselor and also began attending parent support groups for caregivers of children with disabilities.

CONCEPTUALIZATION

Michael struggled to understand the changes taking place in his body. His awareness of his mobility and muscle strength issues became more and more apparent, leaving him feeling frustrated and unsure of himself. Additionally, although his mother wanted to protect him from feeling “different,” he began to struggle with exactly that.

Goals and Target for Client Change

Assessing the type of information that seemed most helpful to Michael regarding CP and sharing the information in a way that appeared informative and child friendly became my first goals. Although this information did not alleviate Michael’s growing emotional difficulties, it provided a basis for his understanding and ultimately an acceptance of his disability. To aid in building relationships, another goal evolved to support Michael in learning to talk about his disability with his peers. In addition to helping Michael better understand his condition, the next goal focused on strengthening his sense of self and helping him understand that having CP did not necessarily mean living a limited life. Working with the school staff to make the environment more accepting and inclusive also served as a goal for me.

Although I designated Michael as my identified client, I felt it necessary to also spend an adequate amount of time with his mother, helping her talk through the worry, fear, and grief with which many parents of disabled children struggle. Embedded in the goal of aiding Michael’s understanding, I established an additional goal to help Michael’s mother gain further knowledge about CP throughout the life span. Michael’s mother reported feeling frequently overwhelmed and not knowing
what to do for Michael. I believed that these feelings could be alleviated if she worked more closely with the doctors. This, then, became an additional goal to assist Michael’s mother in building a support team of medical professionals (Michael’s pediatrician, staff psychologist, the physical and occupation therapists assigned, and the speech therapist) on whom she could rely. It would also be important for his mother to gain a better understanding of how CP could be explained to a child Michael’s age.

Goals and Strategies for Myself

As a therapist, this appeared to be a challenging case to accept. At the time, I needed a working knowledge of CP and how it might affect individuals over the course of their lives. As my initial goal, I gathered as much knowledge as possible, which required informational meetings with doctors and extensive reading on CP. It became imperative that a working knowledge of the issues and concerns surrounding CP be in place before I found ways to foster understanding for a 4-and-a-half-year-old. Also important, Michael’s mother and the school personnel needed to be on the same page when speaking to Michael regarding his disability; consequently, I created the following guidelines to approach communication with Michael about his disability.

Systemic Approaches

Working With the Parent

It became imperative that Michael’s mother respond empathically when Michael expressed feelings regarding his disability (i.e., “It really hurts you that you cannot run like the other kids; I wonder if we can think of some ways you could join”). It also became important for her to be honest, clear, and informative in conversations about disability. Saying “I don’t know” and “Let me see what we can do to find out together” is acceptable. I advised her to also consider Michael’s developmental and cognitive levels and his emotional abilities when providing information. To help normalize his experience, I encouraged her to provide Michael with examples of other people living with a disability (e.g., disabled actors, athletes, scholars, humanitarians, and artists). I informed her that she could extend his experiences by providing him with opportunities to engage in play, social, and academic activities with other children.
I. CASE STUDIES RELATING TO CHILDREN

Working With the School

Fostering a relationship of collaboration with Michael’s school became a main component in conceptualizing treatment. I found this necessary to boost Michael’s self-esteem and create relationships with his peers. I met with Michael’s teacher, professional school counselor, and school nurse; together, we created a plan for supporting Michael emotionally during his school day. The plan consisted of the following components: pairing him with a fifth grade peer buddy during free play and lunch several times a week; explaining his disability to the class and deciding the role Michael could play in this conversation; including him in a “Friendship Building Group” run by the professional school counselor; and providing him with “leadership” roles in his classroom where he could serve as an errand runner and morning greeter. We also developed opportunities that allowed Michael to participate successfully with his peers (e.g., scooter tag, partner or small group table games, and games that needed a referee/score keeper/command center). In an attempt to raise the level of awareness and acceptance of differences, the professional school counselor and I also created a series of puppet shows for the Pre-K and kindergarten classes on disabilities and diversity.

THERAPEUTIC INTERVENTION: CHILD-CENTERED PLAY THERAPY AS A CREATIVE PROCESS

I chose the intervention and theoretical orientation, child-centered play therapy (CCPT; Landreth, 2012), because it provided an inherently creative approach to working with children. It allowed me to interact with Michael in a developmentally and culturally sensitive manner that enhanced his self-awareness through the use of experiential and creative means. CCPT, a nondirective therapeutic modality, respects a child’s ability to be fully in charge of the therapeutic process (Landreth, 2012; Pereira & Smith-Adcock, 2013). CCPT allowed Michael to lead, creating an open and engaging space in which he worked through issues in ways that provided personal understanding and insight. CCPT is built on the belief that children are innately capable of growth and personal insight when provided an accepting and supportive environment (Axline, 1947; Landreth, 2012; Pereira & Smith-Adcock, 2013). Within this nondirective orientation, therapists are charged with relying on the belief that children are innately capable of knowing what they need from the therapeutic process. The therapist communicates through words and actions that the child is acceptable as he or she is, allowing issues related to or surrounding a disability to take center stage. Children feel free to express their worries, concerns, anger, frustration, confusion,
and fear in ways that make the most sense to them, without the therapist imposing his or her views or beliefs on the child. As a play therapist, I felt that CCPT appeared to be an excellent match for Michael, due to his growing struggle with his sense of self, autonomy, and concerns regarding how he understood himself and his interactions with others. Rather than create specific interventions designed to target my perceptions of his difficulties with feelings of being “different” and lowered self-esteem, I wanted to allow Michael to navigate those issues at his own pace and in the ways that appeared most meaningful to him.

COUNSELING PROCESS FLOW

Over the course of our work together, Michael and I conducted 12 individual CCPT sessions and two family sessions where his mother joined us. This appeared to be an appropriate length of time for sessions and family work as the collaboration with the school system supported numerous aspects of the case as well. Michael easily engaged in counseling and the process of our relationship building went very smoothly. During Session 1, Michael asked, “Are you a medical doctor to help me with my legs?” to which I answered, “I am more like a ‘Feelings Doctor’ who helps people understand and work on their feelings and the things that upset them.” He seemed to like that idea and told me that there appeared to be “lots and lots of things that make me sad (and then whispered) and mad too! I get mad at my legs even,” to which I replied, “Wow, it sounds like there are things that feel really bad to you right now and make you mad and worried sometimes too, I bet. I would like very much to help you with those things.”

I chose one or two individual sessions with Michael to establish rapport before his mother and I sat with Michael to discuss his CP. We began sessions after the intake and I introduced Michael to the playroom with my standard CCPT opening: “Michael, this is a very special room. You can do almost anything in here. If there is something you cannot do, I will tell you, and you can say anything in here.” I did not modify the materials or playroom with regard to Michael’s motor difficulties (i.e., I did not pre-open the Play-Doh containers, move items to lower shelves, or put floor items up on the table) as I wanted Michael to experience navigating the room for himself, dealing with the successes and struggles that would come. The role of a CCPT therapist is to honor a child’s ability to develop the personal strengths and abilities inherent within him or her to find solutions to his or her concerns (Landreth, 2012; Pereira & Smith-Adcock, 2013), which in turn builds a sense of autonomy and personal capacity (Pereira & Smith-Adcock, 2013). Michael, in his first session, spent a great deal of time exploring
the materials and telling me how much he “loved his play room.” He seemed very interested in the shields and foam swords, excitedly announcing how cool they look, touching them and holding them, but choosing not to play with them. He experienced great difficulty navigating his arm crutches to hold the items, and then simply put them back on the shelf. In keeping with CCPT tenets, I reflected, “Those look pretty cool to you and you would like to try them, but it doesn’t seem as though you are sure about them yet. They seem tricky to hold,” to which he nodded. He, then, got down on the floor to play with a bin of animals, particularly a small giraffe and its family. After several minutes, he decided to draw a picture of us in the playroom, which is how he ended his time. Michael engaged in the same play during Session 2, spending more time exploring the room. At the start of the third session, Michael informed me of his thoughts about what the animals would be doing. All of the animals appeared on the “playground” running, playing games, and jumping, except for the little giraffe, which Michael placed off to the side. I commented on the little giraffe being left out, to which Michael replied, “Yes, but look at his little tiny legs; so he just stays over there.” I made a few more remarks like “So his legs look tiny and not very strong so you feel it might be better, safer maybe, for him to stay over there.” “The little giraffe is not even playing by himself. He is just standing watching the other kids play,” to which Michael stopped his play, looked at me, and said, “He is lonely. It makes him sad about his tiny legs. But when he grows up, he can have big legs like the kids.” After this exchange, I felt the next session would be well spent having a discussion about CP.

Following this conversation, the play themes in Michael’s next four sessions consisted of competency play (i.e., displays of knowledge, dexterity, and physical abilities), often leaving him frustrated and acting discouraged, and choosing aggressive play (i.e., battles between “good” and “bad” guys and battles where he needed protection while they attacked us). These battles frequently consisted of his not being able to win the battle, not having the “right” weaponry available, and thinking he killed the “bad guy” only to realize that the “bad guy” came back, leaving Michael needing a great deal of help and support.

During Michael’s eighth session, we engaged in another epic battle between good and evil. Michael and I became “holed up” in the fort that we built (to his specifications) for safety, throwing bombs (rolled and taped fabric balls) and shooting foam darts at the “enemy.” Michael decided to leave the fort to fight on his own, which resulted in his being “shot” repeatedly by the enemy. I came out from behind the barricade with the first aid kit to “fix him up and rescue him” when he hollered for me. After wrapping his head and leg with ace bandages as directed,
Michael said to me, “Jenn, even when we take this bandage off, my legs still won’t really work.” I responded, “Even though you are feeling pretty good about yourself lately, that is a tough thing for you to think about; it frustrates you and makes you feel very sad.” He nodded and instructed me to pull him to safety behind the fort where he decided to draw for the rest of the session. This theme of needing help continued for two more sessions. During a subsequent session, we constructed the fort again; however, this time Michael requested that I help him don the plastic breastplate and arm shields, as he held both his crutch and a sword. He decided to fight the battle outside the safety of the fort, telling me to “stay there where it’s safe; I can fight.” During the “battle,” Michael struggled to hold the sword and manipulate his leg braces to navigate around items on the floor. He fell several times, dropped his weapons, struggled with his braces and crutches, but would not allow me to assist. He fought alone—telling me he would protect the fort. He exerted so much energy in this session that he appeared red faced and sweaty toward the end. The battle came to a head with him “fighting the leader of evil—the last bad guy” whom he finally defeated. He emerged triumphant, prompting me to cheer for him and clap. He, then, suddenly turned to me and exclaimed, “Jenn! I’m strong! I’m a strong boy! My outsides might not work right—but my insides feel all fixed up!” We then formed a parade where all the “thankful villagers” cheered the hero for saving them. The remaining sessions consisted of competency play, where he strove to display skills such as drawing, counting, and reading. The aggressive play themes ended.

OUTCOME

Providing Michael with information on CP allowed him to better understand what came to light about his body and why he experienced difficulty. He enjoyed hearing stories about disabled athletes and their ability to engage in many physical activities. He also seemed very excited that his mother agreed to his birthday request, “camouflage-colored” leg braces and crutches; and helped us wrap them with camouflage grip-tape in session. He gained a lot of positive attention from his peers at school, and he appeared very proud of his braces. During the course of the 5 months of treatment, Michael experienced changes in the school environment as well. Michael began to engage his peers in the classroom and his teachers noted that he became invested in the school day and learning activities. He cried less and less frequently, with no tears at all during the last month; invited classmates to play with him; and seemed included by his peers, thanks to the efforts of the
teachers in building a wonderfully inclusive atmosphere. The puppet shows performed by the professional school counselor and me helped the children talk about disabilities in more positive ways and displayed helpful behaviors (i.e., helping Michael carry things and choosing him to participate in games). The professional school counselor continued to run the Friendship Building Group, which he reported helped Michael further his skill development.

Michael’s mother, after the initial conversation with Michael regarding CP, became much more comfortable attempting to respond to his questions and providing information, contacted the doctors when she faced questions or concerns of her own, made a concerted effort to be sure Michael received his physical and occupational therapy services, and felt better able to advocate for him. Michael, over the course of therapy, began to understand and integrate his diagnosis with his sense of self. He continued to become frustrated at times when he seemed unable to do all the things his peers did, but he found success and pride in his current abilities and activities. As Michael’s frustration and anger lessened, his sense of humor became more present, as did his very engaging personality. Michael displayed an ability to note his own successes; and when unsuccessful, he remarked positively on how hard he tried. He became interested in testing limits to discover his physical capabilities, and came up with alternate behaviors that seemed easier. He felt positive about that. Michael’s statement about his insides being “all fixed up” appeared to be a poignant cue that he understood the permanence of his disorder but possibly also felt that this did not define him as a person.

I recommended Michael engage in the counseling process as he grows older so that additional support during future developmental and life-oriented milestones can be provided. It is crucial that the services be continued to further develop fine and gross motor skills as well as manage the effects of his speech impediment. Additionally, Michael and his mother would benefit from this continued support so that they can best advocate for Michael’s needs as he grows and matures.

REFERENCES

Upon approaching my retirement as a professional school counselor, I decided to become a licensed professional counselor in clinical mental health. A supervisor at the County Juvenile Detention Center referred Adam, a 17-year-old Hispanic male, to me for counseling. Before being placed in detention, Adam resided with his mother, father, an older adult brother, and a 7-year-old sister. Four other brothers lived elsewhere. This case study highlights the interplay of systemic, developmental, relational, and multicultural influences, and the many risk factors (i.e., low social, emotional, personal, and educational support) that ultimately contributed to Adam’s delinquency. The therapeutic interventions used in this case study diminished these risk factors and fostered growth.

SYSTEMIC INFLUENCES

Adam defined himself by his life experiences. He indicated that his behavioral and legal concerns started at approximately age 13. His history of legal troubles included referrals for several public intoxicated, theft, and violations of probation, resulting in referrals for expulsion, child in need of supervision (CINS) assessment, and contempt of court. I found limited information in the files on Adam’s family. Although Adam valued his relationship with his parents and siblings, and verbalized strong emotional ties, I discovered disconnections in the family dynamics. His parents seemed far removed from his behavioral and legal concerns and did not respond to consultation requests regarding Adam. His family lived in an economically deprived neighborhood where the home living conditions stifled Adam’s personal, social, and
emotional development. Adam’s brothers and friends remained an influence in his life and frequently led him to unhealthy courses of action. One of his brothers happened to be incarcerated. The prison recently released another brother on parole. His two oldest brothers modeled violent tendencies and socialized him into a peer gang and drug culture. Although Adam denied gang involvement, his records noted that he associated with known gang members. This, along with his parents’ lack of guidance, negatively impacted Adam’s decision making and social behavior.

DEVELOPMENTAL CONSIDERATIONS

Cognitive and Intellectual Development

Adam’s file noted no history of placement in special programs in the school system. The file referenced Adam as a regular education student who failed to succeed academically, mostly due to lack of attendance. He reported to be a junior but failed to give the total number of high school credits earned toward graduation. Although 17, he appeared to be in Piaget’s concrete operational developmental stage due to his limited problem-solving skills and his inability to consider other possible solutions when crucial choices needed to be made (Piaget, 1967; Wadsworth, 2003).

Personal, Social, and Emotional Development

Adam, a study in contrasts, appeared to hold a good understanding of social norms and appeared to understand the inappropriateness of much of his behavior. However, developmentally, he appeared lacking in experience and understanding in this area. Many times, he lacked skills that connected his choices and behaviors to possible alternatives or consequences. Although it appeared that he could exercise good judgment, it also appeared that he often chose to not do so (or appeared influenced to not do so) when it required compromising his desires or perceived needs. As a result, Adam seemed ill equipped to understand and respond effectively to the myriad of problems he faced. Many of his choices seemed self-sabotaging. He frequently found himself in situations that spiraled him out of control. Consequently, he established a history of truancy, defiance, and, at times, verbal aggression toward teachers, school administrators, and campus police.

Mild to moderate levels of depression, along with moderate to severe levels of anxiety, as evidenced by psychological testing done at
the detention center, compounded Adam’s personal, social, and emo-
tional development. Previous evaluations revealed substance-related
factors that impacted Adam’s depressive symptoms. He reported that
he tried marijuana at the age of 9, began drinking alcohol and using
cocaine at age 13, and began using heroin at age 15.

On the morning of our first counseling session, I remembered being
apprehensive about my initial efforts to counsel an incarcerated youth.
Through his nonverbal cues, he projected a tough guy image that could
potentially set a negative first impression. He strutted toward me, with
streetwise-type strides. He showed prominent facial acne scars and
multiple tattoos on his neck and arms. Both of his eyebrows projected
fragmented diagonally shaped slashes. A tattooed teardrop drooped
from the corner of his left eye. His nonverbal cues appeared to project
an attitude of “I-dare-you-to-counsel-me.” The images he projected fed
my apprehensions.

After introductions, we went into the designated room. He appeared
to be very guarded and displayed subtle signs of suspicion. The majority
of his responses appeared somewhat superficial, not revealing much
about his current thoughts, feelings, or concerns. After several failed
attempts to establish rapport, I decided that a creative metaphoric inter-
vention might encourage his engagement and disclosure. After he agreed
to participate, I explained to him that an intruder in the room inter-
fered with our attempts to engage in counseling. I gave this intruder a
name, “Mr. Booth”—an analogy of the old telephone booths once used
to make phone calls at public facilities. Callers enclosed themselves in
the booth, inhibiting others from entering. I explained to Adam that
something similar seemed to be happening in this session, in that “Mr.
Booth” surrounded Adam and kept him from engaging in counseling
with me. I asked him if he agreed with my assessment and became
astonished when he did, considering the tough guy image that he pro-
jected earlier. I, then, asked him to pick up “Mr. Booth” and place him
in the corner of the room, away from the counseling session. To my
amazement, he did just that! When he returned to his seat, I said, “Now
I can see you clearer. I see a potentially hurt and vulnerable individual
who might need my help.” Adam, who displayed a tough guy exterior,
began to cry profusely. After crying for a while, I asked him to tell me
the full story surrounding his detention, which he did. At that moment,
I witnessed the beginning of a newly formed partnership. His partici-
pation suggested to me that the tough lines that he carefully crafted
seemed not so firmly drawn. He exposed his vulnerabilities. At the end
of the first session, I reminded Adam to pick up “Mr. Booth” on his
way out, which, also to my surprise, he did. Before doing this, he asked
me to verify that he left no evidence of his crying. After I did so, he
strutted out of the room as he came in—proudly carrying “Mr. Booth.” The metaphorical use of “Mr. Booth” fostered insight for Adam in that it illuminated, through visualization, an awareness of his impact in counseling. It also helped him to think flexibly and to find his voice, which provided a platform for the start of healthy expressions (Belmont, 2013).

### RELATIONAL CONSIDERATIONS

To foster progress, I conceptualized Adam’s presenting concerns from a contextual frame and better understood him from a relational-cultural perspective. Adam lacked trust in most individuals outside his family and peer systems; consequently, he initially appeared uncomfortable in our first session. His lack of trust caused him to experience inadequate connections with me that would enable him to know that I would provide enough support for him to express himself authentically. In essence, he used “Mr. Booth” as an asset—a defense for survival. He hid the true Adam and displayed inauthentic ways of being. Unknowingly, he created disconnections in the therapeutic relationship as he did many times in other situations (Powell, 2004). A working relationship started to emerge with “Mr. Booth” clearly being the catalyst. “Mr. Booth” needed to be included (not dismissed) in my initial contact with Adam in that Mr. Booth subsisted as a product of many of Adam’s life experiences, served many purposes, and provided many benefits for him in and out of the detention center. After this session, “Mr. Booth” did not need to be removed before starting a session. Adam and I easily maintained rapport over the course of subsequent sessions. At first glance, I did not recognize the true potential in Adam. With this activity, Adam created a new perception of himself and I created a more objective perspective about counseling Adam. Although I did not fully gain his trust, this served as the beginning of trust building in this therapeutic relationship.

### MULTICULTURAL CONSIDERATIONS

Remaining cognizant of the uniqueness that Adam brought to counseling—his ability to cope and survive in a challenging environment—continued to be an important consideration. Equally important, a continuous examination of my own convictions remained crucial in avoiding inaccurate assumptions about Adam. Many of Adam’s beliefs and perspectives derived from specific life experiences, not only from being an ethnic minority male, but also, as he stated, from being a member of a close-knit family system where his identity and self-worth...
closely aligned with their opinions and approval. Specific family characteristics (living in a neighborhood characterized by poverty, being labeled as a CINS, sibling incarceration, gang and drug involvement, and exposure to violence in various contexts) fostered his socialization and promoted his engagement in problematic behavior. The challenge for me evolved into bringing him to a level of awareness that would be the impetus to promoting change without minimizing his family system that he valued and considered supportive.

CONCEPTUALIZATION

With Adam, I found myself working against ingrained habits resulting from a myriad of negative influences. Adam admitted to having inhibitions in social settings. His lack of trust stemmed from a habit of believing his negative thoughts surrounding impending interpersonal relationships. He also realized that his choices, many times, did not result in good consequences. Although he remained aware of what he needed to do to correct his behavior, he stated that he could not resist the temptations brought on by his substance abuse. Adam’s stay at this detention center happened to be temporary. He realized that he could not resolve his concerns alone. Adam agreed to stay in treatment with his on-site substance abuse counselor. Consequently, my goals, interventions, and strategies encompassed continued collaboration with this counselor.

Goals and Targets for Client Change

Adam sometimes stated that “the world was out to get me.” Consequently, increasing his awareness of self became my goal to promote connections with his trust and anger issues to his choices and behaviors.

Strategies for the Client

It became important to progress incrementally in a short time frame. Adam possessed great potential for growth, but his skill sets, social and emotional developmental levels, and systemic influences showed potential to hinder interventions and progress. It appeared that many of his struggles stemmed from a lack of awareness of his own personal strength, so I started an empowerment strategy to foster his social, emotional, and cognitive skill building. I wanted to inspire him to be a part of the process by having him become aware of, draw inspiration from, and capitalize on his strengths apart from others who also held influences over him.
Goals and Strategies for Myself

Adam presented complex problems, and a sense of appreciation for the diverse life experiences that he brought to counseling became essential. With this, I diminished the influence of my own personal values and beliefs regarding counseling an incarcerated youth. I became objective in my approach and framed his problems in workable terms. This laid the foundation for us to build a strong counselor–client relationship.

I designed my goals and strategies to provide developmentally and culturally appropriate activities that: (a) elevated Adam’s level of awareness; (b) minimized his impulses, thereby enabling him to connect his choices and behavior to an array of possible alternatives; (c) assisted him in clarifying his goals regarding his problem situation; (d) helped him in addressing emotional and behavioral concerns to include increasing his sense of responsibility for his own behavior; (e) enhanced his communication skills by conducting role-play activities that assisted him in acquiring more effective and appropriate ways to express his feelings, while simultaneously assisting him in disputing self-talk that served as a catalyst for his lack of trust and poor interpersonal relationships; (f) fostered academic and career guidance by using my experience as a former professional school counselor; and (g) worked in collaboration with the substance abuse counselor allowing Adam, in an open, honest, and culturally appropriate manner, to serve as an integral partner in the treatment of Adam’s personal drug use.

COUNSELING PROCESS FLOW

I assumed an integrated approach to counseling with Adam, in that it gave me a range of possibilities for framing his problems and treatments. It also afforded me the opportunity to display varied counseling styles based on Adam’s presenting needs. I found most of Adam’s problems to be centered on all-consuming, paralyzing thoughts that continued in his daily life without verification. While disclosing his past experiences to me, he unknowingly demonstrated patterns of thinking that inhibited trust and healthy communication with others. Using skills from person-centered therapy as the core therapeutic foundation, I found aspects of other theoretical models such as rational emotive behavioral therapy (REBT), reality/choice therapy, and gestalt therapy to also be valuable. The active stance of confrontation practiced in gestalt therapy and REBT appeared effective. The cognitive aspects of REBT seemed to complement the affective nature of gestalt.
Infusion of Creativity

Along with these concepts, I enjoyed combining gestalt therapy with the utilization of a counseling approach called impact therapy. These approaches combined creative counseling techniques and experiments with my integrative approach. Infusing impact therapy in each session enabled me to keep counseling sessions active with the clients constantly thinking, seeing, and experiencing (Jacobs, 1992). These techniques promoted a more time-efficient session, eliminated unnecessary talk, and increased deeper level disclosure, when appropriate, through the use of props and expressive arts (Jacobs, 1992; Vernon, 2009).

Adam and I met for 10 sessions. The initial session dealt with the client and me getting acquainted and building trust. Person-centered therapy techniques enhanced Adam’s ability to tell his story with minimal interruptions and no judgment.

The second session started the abatement of Adam’s wall of defense, enhancing two-way communication. Although he related to me in a polite and straightforward manner, nervous laughter became a defense used when he became uncomfortable. Using relational culture techniques, I worked with Adam on self-awareness so that he could begin to bring himself out of a place of chronic disconnection to one of authenticity, support, and enjoyment (Powell, 2004). Prompting him to remember “To Booth or Not to Booth” promoted his engagement. I also realized the importance of transparency in earning his trust and became open to sharing notes taken during our sessions.

I used REBT and choice therapies during the third and fourth sessions to assist Adam in becoming aware of his self-imposed barriers—the negative thoughts about impending consequences. This caused him to worry, which increased his stress levels and resulted in increased anxiety and depression. I also wanted him to become more open-minded, and take responsibility for his behavior. I conceived the acronym PACT, planning against counterproductive thinking, to use as a working model to integrate for Adam an REBT-type framework.

<table>
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<th>PACT</th>
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<tr>
<td>Adam’s thoughts about situations at hand and the impending consequences.</td>
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<tr>
<td>Adam’s verification of whether these thoughts appeared true or counterproductive.</td>
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<tr>
<td>Adam’s exploration of other viable, productive options and solutions if the thoughts seemed untrue.</td>
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PACT enabled Adam to alter his cognitions about situations that he perceived to be threatening. I continued to bring his inhibiting thoughts
to the forefront so that they could be challenged. Through verification, he distinguished between thoughts and impending consequences that stood out as true and those that seemed counterproductive, especially when dealing with situations that related to his systemic, relational, and developmental issues. This fostered his ability to choose based on facts. This also increased his ability to assume more ownership and responsibility for his choices and options (Ellis & Harper, 1975).

The fifth and sixth sessions focused on enabling Adam to get in touch with his low self-esteem, which contributed to his social awkwardness and depression. He responded in writing to three items on a personal inventory regarding how he felt about himself, and he later verbalized them to me. This provided more dialogue and disclosure. I used videos to normalize Adam’s experiences and to promote engagement during discussions about the effect of his drug use and the drug culture in his community. We also examined the roles that his brothers played in his life experiences. Again, Adam made connections between his beliefs, feelings, and choices.

Adam’s trust issues interfered with his self-improvement and relationships with others. Planning became a vital first step in building trusting relationships. We agreed that the seventh session would focus on working with Adam on improving his interpersonal relationship skills so that communication and trust could be established to increase his comfort level when seeking social support from others. As a strategy, I used videos chronicling testimonies from people who faced challenges similar to his. Other modalities used during this session to teach positive interpersonal relationship skills involved the creative use of role-play and visualization. I assigned Adam homework, which required him to talk effectively to detention center staff about a situation that he needed to problem-solve and seek out social support. I asked him to report back to me at the next session. As we approached the end of this session, I broached the topic of termination to ease him into that realization. I made him aware that three more sessions remained.

Self-doubt and uncertainty about his level of education, skills, and preparation for adult independence, in comparison to what he described as his more focused and goal-oriented peers, gave rise to his anxiety. During the eighth and ninth sessions, I wanted Adam to assess his strengths and start building on them. After a thorough discussion of his homework assignment, I introduced educational and career possibilities and goal setting, which really sparked his interest. Through the use of the teaching tool of reality/choice therapy—wants, doing, evaluate, and plan (WDEP)—I provided a platform that assisted Adam in assessing his situations, choices, need-satisfying behaviors, and
outcomes so that a more specific, attainable, and productive plan of action could be established (Glasser & Wubbolding, n.d.; Wubbolding, 2000).

The 10th session involved the termination process in which we summarized and reemphasized all of the components of the previous nine sessions, and looked forward to using the many coping and problem-solving strategies learned. Adam and I focused on his repeat offending and he defined the issues that served as some of the reasons for his offenses (including systemic and relational influences). A combination of his drug abuse, low self-worth, and his inability to manage his anger and make good choices also served as major reasons for his offenses.

OUTCOME

The therapeutic relationship between Adam and me solidified. I believed that this young man could change. He responded well to the counseling interventions, which appeared to be conducive to his level of readiness and development. He appeared to be more reflective and open-minded to suggestions from others to improve his situation. He made progress in understanding the power of his beliefs and connecting them to his feelings, choices, and behaviors. The concepts, PACT and “To Booth or Not to Booth,” challenged his faulty thinking and beliefs. This assisted him in heightening his awareness and being more present centered. He began to find his personal strengths, minimize his lack of trust and disconnections with others, and became engaged in the process of fostering his own social, emotional, and cognitive growth. Through the use of PACT and REBT, he also started to take responsibility for his actions, mainly making better choices and handling his anger. Through the use of WDEP and postsecondary occupational information, Adam explored his expressed interest in welding.

The detention center transferred Adam to another facility outside his home city. Regretfully, I did not see him again after the transfer. Because of his age, longstanding habits, and lack of family support, Adam requires comprehensive services and interventions at his next detention facility. This is central to his continued rehabilitation. Adam needs to remain in counseling in order to sustain his confidence, self-worth, and ability to make appropriate choices, thereby minimizing his depressive tendencies. I assisted the substance abuse counselor in completing a treatment plan that followed Adam to his next facility. In addition to personal and substance abuse counseling, I recommended that he be given an opportunity to complete his credits for graduation.
or obtain a General Education Development (GED) diploma and vocational training. Although more work will be needed regarding his chemical dependency, Adam enthusiastically used many of the intervention strategies that the substance abuse counselor and I provided as he worked toward change and toward minimizing his depression.

REFERENCES


