ABSTRACT

CLARK, CORY WILLIAM. Developing a Competency System for Counseling Children: A Delphi Study. (Under the direction of Drs. Adria Dunbar and Marc Grimmett).

The purpose of this mixed methods dissertation study is to answer the following simple question: What is child counseling? There is a dearth of literature on the clinical competencies involved in child counseling. Additionally, there is little training specific to children in professional counseling. An introduction to the need for child counseling competencies is accompanied by a review of literature that includes discussion of the child counseling subfield, the training structure for child counselors, related ethical and legal issues in counseling children, and child counseling competency systems and theories. A framework is introduced from which to base a child counseling competency system. A mixed methods classical Delphi study was employed to engage a panel of 37 child counseling experts about what constitutes the practice of child counseling and what makes it unique. Initial items for a comprehensive child counseling competency system were illuminated.

This study resulted in 57 items that encompass child counseling competencies in the core domains of child counseling attitudes, knowledge, skills and actions. Additionally, participants ranked items for a final list of ten competencies in child counseling that including the following: (1) passion for children, (2) authenticity, (3) advocating for children, (4) evidence-based treatments, (5) knowledge of legal and ethical issues with counseling children, (6) using congruence, empathy and nonjudgment, (7) meeting children where they are, (8) multicultural competence with children, (9) speaking the language of the children, and (10) self-reflection. These competencies are arranged in narrative and figure form and discussions involve how they can inform future counselor training and licensure.
Developing a Competency System for Counseling Children: A Delphi Study

By
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DEDICATION

I dedicate this dissertation to my wife, children and parents.

For my wife, Kate Melillo, who supports and loves me unconditionally through all the times.

For my children Sebastian and Dawson, who represent my purpose in life.

For my father, William Clark, who gave me the drive to finish things when I start them.

For my mother, Deb Clark, who instilled in me the idea that I can do anything.

For my other parents Mark and Michele, who have always supported the academic in me.
BIOGRAPHY

Cory William Clark is a Licensed Professional Counselor Associate (LPCA) and a student in the Counseling and Counselor Education program at North Carolina State University. Cory also holds a Masters degree in Clinical Mental Health Counseling from NC State and a Bachelors degree from the University of North Carolina at Chapel Hill, where he graduated with honors in Psychology. Cory has spent several years in Asia as a child and adolescent behavior therapy consultant, working with children with externalizing behavior issues and associated diagnoses, such as ADHD, Oppositional Defiant Disorder and Autism Spectrum Disorders. His research interests are in the areas of child counseling competencies, counselor training, child psychopathology, family systems and multicultural counseling.

Cory has over ten years of experience working with a variety of clients but especially children and families. He has worked with children from preschool age through early adulthood. Cory’s love for serving children and families stems from his early experiences as an early childhood educator where he realized how deeply he could connect with children on an individual level. Cory believes that kids can intuitively sense the genuineness and level of comfort an adult has when interacting with them and Cory has had a natural rapport with kids for as long as he can remember.

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Cory’s passion is serving individuals across the lifespan in the areas of behavior issues, developmental disorders (ADHD, ASD, etc.), family and parenting issues, mood disorders, anxiety, relationship issues, life transition dynamics, trauma, abuse, self-esteem concerns, social skills issues and school issues.

Cory lives in Apex with his amazing wife, two young sons, and his two dogs. They love traveling, running/hiking together, creating their own business ventures, trying new foods and enjoying good movies!
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CHAPTER I
INTRODUCTION

There is little consensus about what constitutes child counseling in the professional counseling literature. The number of developmental changes and transitions happening from infancy through childhood are unparalleled by any later time in a person’s life, making childhood one of the most complex developmental phases. Child counselors must account for the uniqueness of this developmental period as they consider theories, techniques, and interventions to address issues that arise for their child clients. The purpose of this study is to highlight the uniqueness of counseling children and demonstrate the need for developing standards and competencies of child counseling. A specific list of competencies is proposed from which to base education, training and licensure considerations in the counseling field.

This mixed methods study identifies the core competencies of child counseling. Child counseling is a unique and challenging subfield of counseling in which many therapists do not feel adequately trained at the completion of their graduate level training programs (Sori, Maucieri, Bregar & Kendrick, 2015). Although child-focused post-graduate training exists in the form of specializations like child-centered play therapy or filial therapy, what is lacking is a set of competencies for counselors who work with children. To date, a set of competencies has not been established for counseling children between the ages of birth through 12. The purpose of this dissertation is to describe the rationale for the creation of such competencies, as well as to identify a list of key competencies recommended by experts in the field of child counseling.

Children’s Mental Health

Children are struggling with an array of mental health issues across the country. Poor mental health heavily impacts children and is a dominant cause of childhood disability (Halfon,
Researchers have long demonstrated how child mental health concerns have long-term negative outcomes, including lower educational attainment, lower income, lower likelihood of employment, and more criminal behavior (Delaney & Smith, 2012; Stabile & Allin, 2012). More importantly, the destructive impact of early mental health issues continues even if mental health and wellness later improves (Currie & Spatz Widom, 2010).

The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association [APA], 2013) recognizes a range of conditions that can uniquely affect children’s mental health. Some of the most common and prevalent disorders seen in childhood include the following diagnoses: (a) attention deficit/hyperactivity disorder (ADHD), (b) developmental disorders like autism spectrum disorder (ASD), (c) depressive disorders, (d) anxiety disorders, and (e) disruptive, impulse-control, and conduct disorders (American Psychiatric Association, 2013). Children receive mental healthcare, and their diagnoses, in a variety of settings, often starting in a pediatrician’s office, followed by a referral to a mental health professional working in a school or an outpatient setting. Children are also consistently treated in school settings by licensed school counselors (Burns et al., 1995).

Children from families living in poverty are especially at risk and need support from mental health professionals. The Center for Disease Control (CDC) analyzed data from the 2016 National Survey of Children’s Health (NSCH) on the relationship between mental health disorders and the use of federal assistance programs. The findings aligned with the results of similar studies conducted by Bitsko, Holbrook, and Robinson (2016), as well as Black, Nugent, and Vahhatian (2016), which compared children in higher-income households, with those in lower-income households. Those in lower income households were more likely to have received
a diagnosis of a mental, behavioral or developmental disorder (22.1% versus 13.9%), and less likely to have seen a health care provider in the previous year (80.4% versus 93.8%) (Cree et al., 2018). Among children living below 200% of the federal poverty level, who did not see a health care provider in the previous year, seven of ten were in families receiving at least one public assistance benefit (Cree et al., 2018). Not only is it important for child counselors to understand the mental health needs of children, but they must also be aware of socioeconomic factors that can impact children’s mental health, their access to mental health care, and potential patterns of diagnoses that result.

Evidence-Based Practice in Child Counseling

To secure managed care contracts and receive third-party reimbursements, child counselors are increasingly required to keep detailed records about specific interventions and outcomes of counseling sessions (Astramovich, 2016). However, the development of evidence-based treatments (EBTs) has helped counselors respond to the call for accountability from insurance companies (Herbert, 2003). Specifically, EBTs draw on empirical counseling research that examines specific counseling modalities with treatment manuals for specific client problems (Loesch, 2001). For example, cognitive behavioral therapy is one of the most widely used and empirically supported mental health treatments, and it is often used for a wide variety of client populations (Bishop & Trembley, 1987; Borkovec & Costello, 1993; Butler, Chapman, Forman & Beck, 2006). However, it is often unclear which EBTs are based on treatment with adults and children and which are appropriate for only adults. Counselors, therefore, do not have clear guidance regarding which EBTs to use with children. Kelly (1996) wrote of the urgency for mental health counselors to legitimize their profession to be on the same professional level as social workers, psychologists and psychiatrists. Kelly (1996) stated, “the ability to document
outcomes and identify treatments is, therefore, critical in furthering the professional identity of mental health counselors within the mental health professions (p. 197). One way that child counselors may document the effectiveness of their treatments may be through the use of a standardized competency system.

**Child Counselor Competencies**

There is a dearth of literature on the clinical competencies involved in child counseling. As Korfmacher (2014) states, there is some movement toward developing competency systems in infant, toddler, and preschool age mental health. An organization called ZERO TO THREE has emerged in recent years as a leader in promoting the social, emotional, and developmental needs of infants and toddlers, and they sponsored a call in 2008 for competency system development for addressing the mental health needs of infants, toddlers and preschool-age children (Korfmacher, 2014). Korfmacher (2014) presents important findings on similarities across different competency systems, including focus on the philosophical understandings of early child mental health as opposed to specific skills and abilities. However, there are yet to be developed a set of national standards or competency systems for addressing early to late childhood mental health needs in counseling.

Korfmacher and Hilado (2008) posited there are three main reasons to develop competency systems and standards for child counseling. Primarily, a competency system should establish a strong foundation for training programs (Kenny, Oliver & Poppe, 2002; Korfmacher, 2014). Additionally, a competency system can promote a professional credibility that the field of child counseling deserves (Dunlap & Fox, 2007; Finello & Poulson, 2005; Korfmacher & Hilado, 2008). Finally, competencies allow for gatekeeping for the profession as Korfmacher and Hilado (2008) stated, “if we assume that people who are endorsed as early childhood mental
health specialists through one of the different competency systems are (on average) more skills and competent than those who have not demonstrated these competencies, then these systems could be used as a way to establish quality control and to ensure that people hired by certain agencies or for certain roles have the qualifications to work with young children and their families” (p. 21).

The closest competency system related to child counseling that currently exists is through the American Board of Clinical Child and Adolescent Psychology (ABCCAP). The ABCCAP is responsible for establishing criteria related to the definition, education, training, competencies, and the examination leading to certification as a specialist in Clinical Child and Adolescent Psychology (abpp.org). The ABCCAP states the following: “clinical child and adolescent psychologists provide professional services related to the diagnosis, assessment, evaluation, and treatment of psychological, emotional, and psycho physiological, psychiatric, and behavioral disorders” (American Board of Clinical Child and Adolescent Psychology, n.d., p. 5). According to the ABCCAP, the specialty certification ensures the public and the profession that a clinical child psychologist has met the training and experience requirements and demonstrated them through advanced competencies in a peer reviewed examination. The examination and licensure involves the following core competencies: assessment and intervention, individual and cultural diversity, interpersonal competency relationships, science base and application, ethical and legal application, and commitment to and involvement in psychology (American Board of Clinical Child and Adolescent Psychology, n.d). Licensure also includes submission of two recordings of professional work representative of the psychologist’s current practice in addition to an oral examination that involves a critique of ethical case vignettes.
Statement of the Problem

A license to practice counseling is all that is required to work with children (Prout & Brown, 2007). Compare this to the medical model, where a general practitioner may work under certain conditions, but specialization in child care requires additional training in pediatrics (Berman, 1998). In the field of psychology, there are specific training, education and examination requirements to earn the specialty in child and adolescent psychology. In contrast, generally trained counselors often expect children to respond successfully to interventions designed for adults (Sommers-Flanagan & Sommers-Flanagan, 2018). This issue must be examined. There’s no specific required training that addresses the uniqueness of counseling children. Additionally, children’s mental health services remain underfunded, understaffed, and underused (SAMHSA, 2012). There is a widespread shortage of child counselors (Mellin, 2009). Shortages of professionals specifically trained to work with children have been reported across a variety of settings, including community agencies, hospitals and private practices (Korfmacher, 2014; Korfmacher & Hilado, 2008; Owens, Hoagwood, Horwitz, Leaf, Poduska, Kellam & Ialongo, 2002). Families are in need of trained child counselors more than ever before, yet there is no way for families to know that a counselor is properly trained and will follow best practices with their children. To account for this problem, a child counseling competency model must be developed.

Purpose of the Present Study

The primary focus of this study is to investigate the attitudes, knowledge, skills and actions (ASKAs) necessary for child counseling. In order to determine which of the ASKAs are most essential in child counseling, a consensus is needed from experts in the field. The ASKAs form the foundation from which to build a child counseling competency system. The ASKAs can
be used to identify how future and emerging counselors are trained in graduate programs. The ASKAs can also inform potential future licensing considerations such as making a specific counseling license that is based on the competencies outlined in the ASKAs.

Building upon experiences and knowledge of past and current experts in child counseling, the identification of ASKAs that are necessary for child counseling can be used to develop a better understanding of what should be included in the training of masters level counseling students. It is possible that the lack of generalizable understanding of what is necessary for child counseling may be a piece of why child counseling is so minimally emphasized in counseling graduate programs. The Delphi method was used to reach consensus about specific ASKAs that are necessary for child counseling. The Delphi method was created as a forecasting strategy to produce information about phenomena that lack an established knowledge base (Grisham, 2009; Ziglio, 1996). This method is characterized by an iterative process of questioning and controlled feedback designed to establish consensus among an expert panel (Linstone & Turoff, 1975; Ziglio, 1996). The Delphi method is an effective way to better understand complex phenomena and guide future practice (Grisham, 2009; Krell & Pérusse, 2012; Ziglio, 1996). Thus, the Delphi method is an advantageous technique to identify and describe the ASKAs for child counseling as a first step in building an understanding of specific areas for training future leaders in the child counseling subfield.

**Research Questions**

The overarching questions of this study ask, what is child counseling? More specifically, the study is designed to address the following research questions regarding the competencies (i.e., attitudes, knowledge, skills and actions (AKSAs) needed to counsel children:
1. What is child counseling?

   Research Question A: What attitudes do counselors identify as necessary for themselves as child counselors?

   Research Question B: What knowledge bases and understandings do child counselors identify as necessary?

   Research Question C: What best practices and skills do child counselors identify as necessary?

   Research Question D: What actions do counselors identify as necessary for their role as child counselors?

2. Of the attitudes, knowledge, skills and actions that are identified as necessary, what are the most necessary?

   **Significance of the Study**

   The American Counseling Association welcomed its 20th division in 2013 when it approved the Association for Child and Adolescent Counseling (ACAC) (Rudow, 2013). Founder of the ACAC Dee Ray said, “We were fairly certain that there were many counselors within ACA who worked primarily with children and adolescents but did not seem to have a home within the larger organization” (Rudow, 2013, para. 5). The ACAC holds its own publication, the Journal of Child and Adolescent Counseling (JCAC) and to date, this publication has over 60 published articles that cover a wide variety of child and adolescent counseling topics. Ray (2015) stated in the first editorial of the JCAC: “raising standards (of child and adolescent counseling) is a formidable goal and involves not only the world of ACAC but the industry of all mental health professionals who work with children and adolescents. JCAC serves as a channel through which mental health professionals across disciplines can share best practices, approaches...
and conceptualizations related to child and adolescent counseling” (Ray, 2015, p. 1). The work of the JCAC serves as a strong foundation for scholarly work, but there is yet to be established a guiding framework from which child counselors can operate. That is, it has not established the core competencies of child counseling. Preliminary core competencies are generated in this study from examining the attitudes, knowledge, skills and actions required for child counselors.

With an understanding of what specific ASKAs are needed for child counseling, graduate counseling programs could more adequately address training for future child counselors and better prepare students to take on positions in child mental health after graduation. By developing an understanding of the attitudes, knowledge, skills and actions that are necessary for child counseling, child counselors may better serve their clients and their communities, and they may continue the development and growth of the subfield overall.

**Delimitations**

There are undoubtedly limitations to every research design, so it is essential to make informed and intentional decisions to control for limitations whenever possible (Creswell, 2007). The subsequent chapters examine the methodology and limitations of this study in further detail, however, it is valuable to make a note of the delimitations of this study at this time. According to Ellis and Levy (2009), delimitations provide parameters for research designs which are determined by the choices made in the beginning of the study regarding what factors and variables will be excluded. Within the context of this study, several delimitations were considered, such as the rationale for ages of children under study, parameters of definitions, selection of supporting literature, research question construction, and participant selection.

There are many ways to define a child and childhood. The researcher determined the parameters and stages definition of childhood outlined by UNICEF and the American Academy
of Pediatrics were appropriate for this study. From a developmental perspective, there are major transitions that typically happen after an individual reaches the age of 13 and thus this study is about narrowing the focus to the phenomena of counseling children aged 12 and under. Additionally, the study focuses primarily on children from age 4 and older. As will be discussed later, infant and toddler mental health and corresponding competency systems have been developed extensively (Korfmacher, 2014). As such, this study is about filling in the gap for competency systems for older children.

There are many ways to review literature surrounding the topic of child counseling. From childhood diagnoses and child counseling modalities to child developmental theories, the child counseling literature base is a robust one. A review of all major child counseling modalities and child-dominated mental health diagnoses is beyond the scope of the study’s topic. Instead, the review of literature was narrowed to what makes children unique clients in counseling, and accordingly, Chapter 2 includes details on major child developmental theories.

There are different methods to define a set of competencies and standards in a field. Many competency models involve some combination of skills, knowledge and practice (Korfmacher, 2014; Marrelli, Tondora & Hoge, 2005). Although mental health competency models have been presented in literature for several decades now (Peterson & Bry, 1980; James & Roberts, 2009; Spuill, Rozensky, Stigall, Vasquez, Bingham & Olvey, 2004; Sumerall, Lopez & Oehlert, 2000), and there are other professional counseling competency models (Ridley, Mollen & Kelly, 2011), there is no model that is specific to counseling competencies for child counseling. One of the most widely supported models of counseling competencies is that of the Multicultural and Social Justice Counseling Competencies (MSJCC) (Ratts, Singh, Nassar-McMillan, Butler & McCullough, 2016). The MSJCC represent a gold standard for counseling
competence and were chosen for this study as the guiding framework for how competencies are structured.

In a Delphi Study, the selection of participants who best fit the subject needing consensus is essential. Child counseling is carried out in many ways across the world, and each country has its own laws, regulations, and expectations of professionals working with children. As a consequence, this study involved recruiting participants from the pool of experts working within the United States. Furthermore, to best address the research on this phenomenon, counselors and counselor educators who meet the definition of an expert made up the participants. To receive expert consideration in this study, a participant needed to meet one or more of the three following areas: (1) hold a membership with the Association of Child and Adolescent Counseling and have at least two years’ experience counseling children, (2) be a counselor education expert with a specialty in the topic and field of counseling children, or (3) be a mental health clinician in another field (e.g. psychology, social work, etc) who focuses on counseling children and has at least two years’ experience.

**Definition of Terms**

*Childhood* is defined as the developmental stage from the age of birth to 12 years old. The United Nations International Children’s Emergency Fund (UNICEF) extends childhood to the onset of puberty, which occurs generally around age 12 (UNICEF, n.d.). The American Academy of Pediatrics organizes childhood into four distinct stages: (a) baby (0-1 year), (b) toddler (1-3 years), (c) preschooler (3-5 years), and (d) grade schooler (5-12 years), which covers a person’s life from birth through 12 years of age (“Ages and Stages”, n.d.). These four stages are an indication of the unique developmental needs of children and how much these needs change in the early years. In the counseling and mental health literature, the phases are often
condensed into three developmental stages: (a) Birth-4 years (Berk, 2006; Greenspan & Wieder, 2006; Korfmacher, 2014; Troutman, Moran, Pelzel, Luze & Lindgren, 2011), (b) 5-8 years (Prout & Brown, 2007), and (c) 9-12 years (Barber & Olsen, 2004; Blume & Zembar, 2009). Sometimes these stages are referred to as infancy, toddlerhood and early childhood, middle childhood, and late childhood (Smith-Adcock & Tucker, 2017).

*Child counselor* is defined as a “professional who works with young children and their families who are experiencing or are at risk for emotional and behavioral challenges” (Korfmacher & Hilado, 2008, p.3). A child counselor can hold various titles from counselor or social worker to psychologist and as such, licensure and training backgrounds vary.

*Child counseling* is defined in this study as a psychotherapeutic process between a child client and mental health professional who is trained specifically to work with children (Korfmacher, 2014). The counseling considerations of children are unique in comparison to adults (Innerhofer, 2013). Additionally, the counseling needs of children vary significantly, depending on their ages and developmental levels (Korfmacher, 2014). Often times counseling children and counseling adolescents are grouped together when in fact, they are quite different populations (Kieling et al., 2011; Hoagwood et al., 2001). Developmentally, adolescents more closely resemble young adults than they do children (Smith-Adcock & Tucker, 2017).

According to Korfmacher and Hilado (2008), a competency system is “a detailing of areas of knowledge and practice required of a specialist” (p. 3). Competency systems have been established for various domains in counseling from infant mental health (Kenny, Oliver & Poppe, 2002), to spiritual counseling (Robertson, 2010), but perhaps the most empirically supported counseling competency system that has been established is for multicultural
counseling (Ratts, Singh, Nassar-McMillan, Butler, McCullough, 2016). The competency system and framework for multicultural counseling was chosen as a guideline for use with this study and will be described later.

Overview

This research dissertation is presented in five chapters. The first chapter has provided an introduction to the topic of child mental health and child counseling, competency systems, the need for child counselors, and a rationale for creating core competencies in child counseling through the consensus understanding of attitudes, knowledge, skills and actions of child counselors. Purpose of the study, statement of the problem, and need for the study are outlined in this chapter, as well as research questions and definitions of key terms. The second chapter contains a review of the literature as it relates to various child counseling issues and topics, child development theories and competency systems. The third chapter includes the methodology used in the study, including participants, sampling method and data analysis. The fourth chapter presents the results of both the pilot study and the main study. The fifth chapter provides a discussion of the results and implications of the research.
CHAPTER II
REVIEW OF THE LITERATURE

The purpose of this literature review is to explore the body of literature that currently exists related to counseling children and what makes children unique. The following sections contain theoretical, foundational and empirical research that will serve as a foundation on which to build future research in this area. Based on the premise that child counseling is unique, a review of literature supporting the development of competency standards is provided. An overview of the various child developmental theories is presented, including the integration of established counseling competency frameworks in the child counseling subfield.

The Need for Counseling Children

An estimated 15 million children can currently be diagnosed with a mental health disorder in the United States (“Why Is Children's Mental Health Important?”, 2018). According to the American Psychological Association, many are also at risk of developing a disorder due to risk factors in their biology or genetics; within their families, schools, and communities; and among their peers (“Why Is Children's Mental Health Important?”, 2018). There is a great need for mental health professionals to provide the best available care that takes into account the unique characteristics of the child (Brener & Demissie, 2018).

Historical trends. National attention began to be focused on problems in the country’s children’s mental health system following the publication of Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services (Knitzer & Olson, 1982; James & Roberts, 2009; Mellin, 2009). Despite this attention, however, little progress has been made in mental health service delivery. As a result, many children continue to receive inadequate care in this area (Tolan & Dodge, 2005). In a report from the Surgeon
General’s Conference on Children’s Mental Health (USPHS, 2000), former Surgeon General David Satcher stated:

Growing numbers of children are suffering needlessly because their emotional, behavioral, and developmental needs are not being met by those very institutions which were explicitly created to take care of them. It is time that we as a Nation took seriously the task of preventing mental health problems and treating mental illnesses in youth. (p.5)

Psychologists and social workers have responded to the call to improve mental health services for children and their families. Psychologists have demonstrated commitment to improving the children’s mental health systems through specific leadership and advocacy roles at the national level (Mellin, 2009). The American Psychological Association (APA) created the Working Group on Children’s Mental Health to respond to recommendations made in the Report of the Surgeon General’s Conference on Children’s Mental Health: A National Action Agenda (Hoagwood & Olin, 2002). The American Board of Clinical Child and Adolescent Psychology (ABCCAP) is responsible for establishing criteria related to the definition, education, training, competencies, and the examination leading to certification as a specialist in Clinical Child and Adolescent Psychology (abpp.org). This specialty involves a rigorous application and examination process including an oral examination and submission of counseling videos to a board of child and adolescent psychology specialists.

Social work professionals also respond to the specific demands of the children’s mental health service through workforce training and planning. The National Association of Social Workers (NASW) provides certification for professionals who practice primarily with children and families (NASW, 1981). The Certified Advanced Children, Youth, and Family Social Worker (C-ACYFSW) is a credential given to master’s-level social workers who have had a
minimum of 20 contact hours of children and family education and 1 year (1,500 paid hours) of supervised work experience with children and families, among other profession-specific requirements (NASW, 2005). In addition to these credentials, NASW created the Center for Workforce Studies (Parker-Oliver & Demiris, 2006). In 2006, this group produced a special report on social work services for children and families created from their study *Assuring the Sufficiency of a Frontline Workforce: A National Study of Licensed Social Workers* (Whitaker, Weismiller, & Clark, 2006). This work assessed professional preparation, practice, services to clients, and workplace issues among 5,000 social workers. The results of this study supported the assumption that there are not enough licensed professionals to meet the needs of children and families. Neither the American Counseling Association nor the American Mental Health Counselors Association has undertaken a similar effort. Compared to social workers and psychologists, counselors do not have specific calls to action to address the mental health needs of children in the age range of 5-12 years.

**Global trends.** Plans are in place to address the needs of children on a global scale. In May of 2012, the Sixty-fifth World Health Assembly adopted resolution WHA65.4, or the Comprehensive Mental Health Action Plan (Saxena, Funk & Chisholm, 2013). This plan is about “the global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level... taking a comprehensive and multisectoral approach, through coordinated services from the health and social sectors, with an emphasis on promotion, prevention, treatment, rehabilitation, care and recovery.” (Saxena, Funk & Chisholm, 2013, p. 1970). One of the core objectives is to provide mental health intervention services to children and adolescents. The resolution states that children and adolescents with mental disorders should be provided with “early intervention through evidence-based psychosocial and
other non-pharmacological interventions based in the community, avoiding institutionalization and medicalization” (Saxena, Funk & Chisholm, 2013, p. 1971). One of the primary targets for this resolution is that service coverage for severe mental disorders will be increased by 20% by the year 2020 (Saxena, Funk & Chisholm, 2013).

**Developmental Stages of Childhood (Birth - 12 years)**

Understanding developmental stages has been highlighted as an essential competency in child and adolescent psychology (American Board of Clinical Child and Adolescent Psychology), so an overview of these stages is necessary in this study. Children undergo substantial development from birth through late childhood. An overview of these changes follows as they yield basic markers for counseling with children in each stage. The stages that will be discussed are (a) infancy, toddlerhood and early childhood, (b) middle childhood, and (c) late childhood.

**Infancy, Toddlerhood and Preschoolers (Birth – 4 Years)**

Infancy is the time between birth and 1 years of age when infants experience explosive growth across all developmental domains (Berk & Myers, 1996). Toddlerhood is the period from 1 to 3 years old, and ‘preschoolers’ are those children eligible to be in preschool settings, generally around 3-4 years of age (American Academy of Pediatrics, n.d.). Many of the issues presented in clinical settings involving children aged birth to 4 years are related either to nontypical development in one or more domains (cognitive, psychosocial, biological) or to problems in parenting behaviors (Zeanah & Zeanah, 2009).

**Cognitive development.** Infants are born with most of their brain structures intact like those of adults (Berk, 2006). However, the connections among brain cells develop at a rapid rate in the first years of life (Sheridan & Nelson, 2009). This growth is rapid in areas related to
experience, sensation and affect especially during the first 2 to 3 years of life, while the nonverbal right brain is dominant (Sheridan & Nelson, 2009). In Piaget’s terms, toddlers make the transition from sensorimotor to preoperational thinking around age 2, when toddlers have difficulty understanding the point of view of others (Piaget, 1973).

**Psychosocial development.** Psychosocial development is most substantial between birth and age 4. Erikson (1963) marked this period through the categories of trust vs. mistrust, autonomy vs shame and doubt. Infants cared for by positive and effective caregivers will develop a basic sense of trust in others. Conversely, infants who are neglected may develop a fundamental sense that they cannot trust people to keep them safe or meet their basic needs (Bowlby, 1973; Erikson, 1963). Children gain a measure of independence from others during toddlerhood (Berk, 2006). However, the issue of independence in toddlerhood varies in importance across cultures, and it is important for counselors who work with toddlers and very young children to be aware of these respective cultural norms (Vernon & Clemente, 2005).

**Middle Childhood (5 – 8 Years)**

Physical and cognitive ability increases substantially with the advent of elementary school (Berk, 2006). Pretend play is replaced by more structured play and children make more intentional decisions about with whom and how.

**Cognitive development.** Children move into Piaget’s concrete operational stage and begin to think in more absolute terms in middle childhood (Piaget & Inhelder, 1973). Three key cognitive advancements seen at this time are reversibility, sociocentrism and decentration (Piaget, 1926). Reversibility is when a child can think about categorizing something in both ascending and descending order. Sociocentrism is when children see themselves as meaningfully connected to social groups, not just as independent people, which is essential for getting along
well with peers at school. Decentrism is when children think about multiple aspects of a problem at once rather than focusing solely on the most pressing aspect of an issue (Piaget, 1926).

**Psychosocial development.** Children begin to establish an internal locus of control during middle childhood (Cobb, 2001). Friendships made during this phase become more meaningful and intentional. Peer groups begin to form a sense of identity in relation to others (Vernon & Clemente, 2005).

**Late Childhood (9 – 12 Years)**

Children learn the values of their culture and attempt to integrate those values in their sense of self as they reach late childhood (Salkind, 2004). They are sensitive to others’ opinions and thus have more fragile self-esteem. They are also aware of how their behavior affects others (Salkind, 2004).

**Cognitive development.** By late childhood, children build upon skills gained in early and middle childhood and prepare for the next phase of cognitive development. Their reasoning is more rule based and they learn skills such as classification and forming hypotheses (Frost, Wortham & Reifel, 2001). While they are cognitively more mature than younger children, they still require concrete, hands-on learning activities (Martin & Fabes, 2008). Late childhood is a time when children may establish enthusiasm for learning, and when achievement can become a motivating factor as they work toward building competence and self-esteem (Martin & Fabes, 2008).

**Psychosocial development.** Children in late childhood experience increasing peer orientation and direction, but they are strongly influenced by family norms and behaviors (Smith-Adcock & Tucker, 2017). The social skills learned through these relationships, and children's ability to participate in meaningful interpersonal communication, provide a foundation
for the challenges of adolescence (Smith-Adcock & Tucker, 2017). The idea of ‘best friends’
becomes essential at this stage, and the skills and experiences gained in best friendships may
provide the building blocks for healthy adult relationships (Smith-Adcock & Tucker, 2017).

Clinical Settings

There are a wide variety of settings in which child counseling may take place (Prout &
Brown, 2007). Outpatient child counseling can be carried out on a short-term basis (Kaduson,
2006; Parsons & Alexander, 1973), or long-term (Forehand & Long, 1988). Settings may include
community mental health centers (Lyon & Budd, 2010), schools (Schmidt, 1999), private
practices (Baggerly, Ray & Bratton, 2010), or primary care hospitals (Cheng, DeWitt, Savageau
& O’Connor, 1999).

Child Counseling Diagnoses

Child counselors are expected to diagnose children according to The Diagnostic and
Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association
[APA], 2013). An detailing of all diagnoses in the DSM-5 related to children is beyond the scope
of this study but a brief overview is warranted. The practice diagnosing children and adolescents
has been examined in a survey of practitioners by Kazdin, Siegel, and Bass (1990). These
authors surveyed private practitioners, including those based in hospital, medical, and
community mental health settings. In descending order, conduct disorder, ADHD, affective
disorders, adjustment disorders, and anxiety disorders were the most common diagnoses received
by child and adolescent clients (Kazdin, Siegel & Bass, 1990). Practitioners in this study
commonly endorsed counseling modalities such as eclectic, psychodynamic, family, and
cognitive behavioral (Kazdin et al., 1990).
Child Counselor Training and Education

Typically, licensed counselors who work with children are trained in one of three approved specialty areas of the Council for Accreditation of Counseling and Related Educational Programs (CACREP): (a) school counseling, (b) clinical mental health counseling, or (c) marriage, couple, and family counseling (CACREP, 2016). The meaning of licensure and training in child counseling merits examination. Yet it is important to note that there is no specific counseling license or national certification that shows that someone is a child counselor aside from highly specialized certificates like those received from play therapy training.

Licensed Counselors

The title of ‘licensed counselor’ can carry different meanings and must be described clearly. Two words are commonly used in describing counselor credentials: license and certificate. Despite their differences, they are often incorrectly used interchangeably (Collison, 2001). Licensing almost always refers to distinctions made by a state. Certification may be a function of the state or a function of an organization or board that exists independently of governments. For example, while states may grant licenses to professional counselors; the National Board for Certified Counselors (NBCC) grants certificates to counselors (Collison, 2001). A certificate is an official acknowledgement of fact—a verification that a counselor has met certain qualifications of education or a certain score on a specified examination (Collison, 2001). A license is permission to either do a particular thing or use a particular title (Collison, 2001). In some states, it might be that anyone can call themselves a counselor, but only persons who have applied to and met the requirements established by a state agency can call themselves ‘licensed counselors’ (LCs) or ‘licensed professional counselors’ (LPCs). Licenses may
additionally define the functions a person is permitted to perform, for example, who may form psychological diagnoses, conduct psychotherapy, or perform counseling (Collison, 2001).

Counselor licensing and associated issues continue to be a frequent item on many state legislative agendas. Across states, as of 2019, there are at least 16 different titles used for licensed or certified counselors, with Licensed Professional Counselors (LPCs) being the most frequently assigned (30 states) (National Board of Certified Counselors, n.d.). Licensed mental health counselors (LMHCs) and certified professional counselors (CPCs) both are used in five states (Collins, 2001). Several states use more than one title for counselors in their state regulations. Updated information about state license status is obtained from the NBCC Website (http://www.nbcc.org/states/key.htm).

National licensure. In addition to being licensed at the state level, counselors who work with children may also be nationally licensed. The National Board of Certified Counselors (NBCC) was incorporated in 1982 as a credentialing body (National Board of Certified Counselors, n.d.). It administers a certification system for counselors and provides information to other professionals and the public about who has met the necessary education and examination requirements to be certified (National Board of Certified Counselors, n.d.). NBCC traditionally has used the Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards to define the educational requirements needed for a person who applies for status as a nationally certified counselor (NCC). Persons who meet those requirements are entitled to use the “NCC” initials to publicly indicate their certification status (National Board of Certified Counselors, n.d.). To maintain status, NCCs must pay an annual fee, meet annual continuing education requirements, and remain in good standing with the counseling profession (National Board of Certified Counselors, n.d.). As of 2018, NBCC reports that 37 states and the
District of Columbia use the National Counselor Examination (NCE) as part of their licensure processes (National Board of Certified Counselors, n.d.).

In addition to the NCC designation, there are several specialty certification designations available from NBCC for those who meet the particular qualifications of each. Professionals may apply for specialty certification as school counselors, clinical mental health counselors, or addictions counselors (National Board of Certified Counselors, n.d.). Each of those specialties has its own title, with accompanying initials as designators. In this system, school counselors become nationally certified school counselors (NCSCs), mental health counselors become nationally certified clinical mental health counselors (NCCMHCs), and addictions counselors become master addictions counselors (MACs). Notably, there is no specialty license or title for the child counselor. There is a clear need for such licensure as the child population presents unique challenges to the general counseling approach.

**CACREP Accredited Training Programs**

The first place that future counselors are formally trained is generally at a counseling graduate program. The process of educating and training future child counselors is vital to the continuation and advancement of the profession. Compared to other mental health fields including psychology, psychiatry, and social work, counseling is a relatively young mental health specialty (Neukrug, 2011). Early counseling leaders within the Association of Counselor Education and Supervision (ACES) identified a need to standardize counseling training and education to ensure quality across education programs, and to create uniformity of educational practice (Hensley, Smith & Thompson, 2003).

The first educational standards were developed in the early 1970’s to allow for voluntary accreditation of counseling training programs (CACREP, 2009). These standards evolved into an
independent organization known today as the Council of Accreditation of Counseling and Related Educational Programs (CACREP). CACREP has functioned as the primary accrediting body for counselor education programs since its creation in 1981. Currently, 786 graduate degree counseling programs are accredited under either the 2009 or 2016 CACREP Standards (CACREP). According to the organization,

The vision of CACREP is to provide leadership and to promote excellence in professional preparation through the accreditation of counseling and related educational programs. As an accrediting body, CACREP is committed to the development of standards and procedures that reflect the needs of a dynamic, diverse, and complex society. CACREP is dedicated to encouraging and promoting the continuing development and improvement of preparation programs; and preparing counseling and related professionals to provide service consistent with the ideal of optimal human development. (CACREP, 2016, para. 3).

CACREP has eight common core curricular areas into which all counseling training programs must incorporate their curriculum (CACREP, 2016). These include (a) professional counseling orientation and ethical practice, (b) social and cultural diversity, (c) human growth and development, (d) career development, (e) counseling and helping relationships, (f) group counseling and group work, (g) assessment and testing, and (h) research and program evaluation. Additionally, CACREP has established six sections of standards by which programs must be aligned in order to be accredited.

Of interest in this study, Section 5, Entry-Level Specialty Areas, provides standards relevant to specialty areas offered by the program (CACREP, 2016). These include addictions; career; clinical mental health; clinical rehabilitation; college counseling and student affairs;
marriage, couple, and family; and school counseling. The closest commodity to specialty in child counseling is marriage, couple, and family counseling. In fact, the words child or children are only mentioned twice in the entire document of the 2016 CACREP Standards.

School counseling is another specialty area in the 2016 CACREP Standards. This section contains parts that address children such as with section G.2.h, “common medications that affect learning, behavior, and mood in children and adolescents” (CACREP, 2016, p. 18). However, this section is designed to address student needs in the school setting and does not include counseling children in the context of outpatient counseling.

Many therapists graduate from CACREP training programs but do not feel confident in their abilities to work directly with children. Sori, Maucieri, Bregar & Kendrick (2015) developed a child-focused course for therapists to address issues regarding how many young therapists feel unprepared to work with this population. The study authors examined students’ perceptions of the efficacy of this course in developing their knowledge and skills to treat children individually and in family sessions. A qualitative content analysis was utilized to explore participants’ written responses to open-ended questions on a questionnaire administered in the last class. Many reported increased comfort with children, and that they were more likely to work with them. This study showed the importance of child-focused counseling coursework to train counselors to feel comfortable with children.

Without a specialty in child counseling, programs have the choice whether to make a child and adolescent course a part of their degree plan either as a required or elective course. CACREP-accredited counseling programs must include a class on lifespan development, but not counseling children and adolescents (CACREP, 2016). The lifespan developmental course is primarily designed to teach students about human developmental processes, psychopathology,
and associated biological, cultural and social influences on behavior (CACREP, 2016). This
course may overlap in terms of child developmental theories and influences on children across
the lifespan, but it does not address the specialty and practice of counseling children.

After completion of CACREP training programs, counselors who choose to specialize in
working with children must pursue specific clinical, professional development, and supervision
experiences. Popular specialized trainings often focus on in play therapy, filial therapy or parent-
child interaction training (Smith-Adcock & Tucker, 2017). However, these trainings are often
extensive and even mirror some of the intense training of a CACREP graduate program. For
example, to become a registered play therapist, after graduating from a counseling program a
counselor must engage in 150 hours of play therapy-specific instruction from institutions of
higher education or APT-approved providers and then be supervised for 500 direct client contact
hours under the supervision of a registered play therapist supervisor (Association for Play
Therapy, n.d.). Although training processes exist for generally trained counselors who graduate
from programs without coursework or specialty training in counseling children, these training
processes are expensive, specific and potentially intimidating to an emerging counselor who
wishes to gain experience working with children.

Professional Development

Professional development of licensed counselors who work with children is linked with
the American Counseling Association (ACA). The American Counseling Association is a not-
for-profit, professional and educational organization that is dedicated to the growth and
enhancement of the counseling profession (American Counseling Association, n.d.). The ACA is
the largest association exclusively representing professional counselors in various practice
settings (American Counseling Association, n.d.). There are 19 chartered divisions within the
ACA. These divisions provide leadership, resources and information unique to specialized areas and/or principles of counseling (American Counseling Association, n.d.). Divisions chartered by ACA elect officers who govern their activities independently and carry a voice in national ACA governance.

**Professional Associations for Child Counselors**

**Association of Child and Adolescent Counseling.** The Association for Child and Adolescent Counseling (ACAC) of the ACA focuses on the training and support of counselors who work with children and adolescents (acachild.org, n.d.). The goals of the ACAC include:

(a) Promote a greater awareness, advocacy, and understanding of children and adolescents among members of the counseling profession and related helping fields; (b) Advance developmentally appropriate prevention and intervention strategies for counseling children and adolescents; (c) Support counseling and education with parents of children and adolescents; (d) Foster counselor consultation with caretakers and other professionals who are involved in the lives of children and adolescents; (g) Provide professional development activities to improve education and training of counselors who work with children and adolescents; (h) Disseminate educational and professional materials with the purpose of raising the standards of practice for children and adolescents in counseling, psychotherapy, and mental health; (i) Encourage involvement and communication of ACAC members to share knowledge and support for improvement of mental health services to children and adolescents. ([http://acachild.org/about-us/](http://acachild.org/about-us/), n.d., para. 3)

**Journals for Child Counseling.** The *Journal of Child and Adolescent Counseling* (JCAC) was developed to serve as a research hub specific for child counselors. The JCAC is the
official publication of the Association for Child and Adolescent Counseling (ACAC), providing a professional forum for the dissemination of research, theoretical, and clinical literature related to the counseling and mental health of infants, children, and adolescents (acachild.org, n.d.).

Launched in 2015, it represents a research hub for child and adolescent counseling that was sorely needed (Ray, 2015). According to the ACAC bylaws (2015), the mission of ACAC is as follows:

The mission of ACAC is to promote a greater awareness, advocacy, and understanding of children and adolescents among members of the counseling profession and related helping fields; advance developmentally appropriate prevention and intervention strategies for counseling children and adolescents; provide professional development activities to improve education and training of counselors who work with children and adolescents; and disseminate educational and professional materials with the purpose of raising the standards of practice for children and adolescents in counseling, psychotherapy, and mental health. (Ray, 2015, p. 2)

According to Dee Ray, Ph.D. (2015), editor of JCAC and one of its founding members, the goal of the journal is to “disseminate research, practice, and theoretical literature that raises the standard of practice among counselors and the broader mental health community...JCAC serves as a channel through which mental health professionals across disciplines can share best practices, approaches, and conceptualizations related to child and adolescent counseling” (p.1).

The JCAC is not the first journal to focus on child or adolescent mental health. For example, the Journal of Clinical Child and Adolescent Psychology (JCCAP), formerly the Journal of Clinical Child Psychology (JCCP) is the official journal for the Society of Clinical Child and Adolescent Psychology (Madisch & Hofmayer, 2018). The JCCAP examines issues in
clinical child psychology, theory, assessment, intervention, program development, and training. The focus of JCCP are the physical, social and developmental influences on childhood and adolescent mental health (Madisch & Hofmayer, 2018).

An even older and more broadly oriented journal is the *Journal of Child Psychology and Psychiatry* (JCPP). The JCPP was first published in 1960 by the Association for Child Psychology and Psychiatry (renamed the Association for Child and Adolescent Mental Health) (Berger & Hersov, 2009). The primary purpose of JCPP was to “bring together original papers concerned with the child, from such diverse disciplines as psychiatry, psychology, pediatrics, psychoanalysis, social case-work and sociology” (Berger & Hersov, p. 1). Journals like the JCPP and the JCCP serve a major purpose of connecting different child mental health disciplines with their overall foundation being in psychiatry and psychology, respectively.

**Evidence-Based Child Counselor Trainings**

Child counselors seek specialized and evidence-based training in techniques, theories, and populations (Smith-Adcock & Tucker, 2017). They require a unique skill set and approach that differs from working with adults, yet mental health programs often train master’s level counselors to work with older clients (Durlak & Wells, 1997). The Council for the Accreditation of Counseling Related Programs (CACREP) has established standards for how counseling programs should train and teach counselors, but there is little reference to the difference between treating children and adults (CACREP, 2016). Therefore, counselors graduate from counseling programs with the tools to treat children only as small versions of adults (Smith-Adcock & Tucker, 2017). Investigators have shown that, in fact, counseling graduates do not feel equipped to work with children, even in family therapy-oriented programs in which children may be more of a focus in counseling training (Sori, Maucieri, Bregar & Kendrick, 2015). The following
section highlights some of the most widely supported specialized child counseling modalities that counselors seek out after being trained as general practitioners.

**Child Centered Play Therapy**

Child Centered Play Therapy (CCPT) is one of the more empirically supported formats of child therapy training. It emphasizes a philosophically-determined therapeutic approach to working with children: “(it) is an attitude, a philosophy and a way of being with children rather than a way of doing something to, or for, children” (Landreth, 2002, p. 60). Play makes mutuality possible within the therapeutic relationship (Frankel, 1998). It is this relationship that is considered essential to the therapy process and subsequent change (VanFleet, Sywulak & Sniscak, 2011). The fundamental belief in this approach is that the child leads the way and that children have the ability to self-heal given the necessary conditions to do so (VanFleet, Sywulak & Sniscak, 2011). The aims of therapy are to bring about changes in close relationships and to bring the child’s emotional and social functioning level with their developmental stage (VanFleet, Sywulak & Sniscak, 2011). The therapist engages the child in their play, encouraging difficult feelings be expressed and safety maintained by symbolic distance (Landreth, 2012). Tsai and Ray (2011) found CCPT counseling to be effective in one of the largest studies on community mental health counseling with children. Using Child Centered Play Therapy (CCPT), the authors noted a moderate to large effect size of child counseling to decrease symptoms of internalizing problems, externalizing problems and total problems.

**Training to Work with Parents**

There are times when in order to best serve the needs of child and adolescent clients, a counselor must include the parent as the treatment focus (Smith-Adcock & Tucker, 2017). Two of the most common and empirically supported trainings that counselors seek for working with
parents in counseling are Parent-Child Interaction Therapy (PCIT) and Behavioral Parent Training (BPT).

**Parent-child interaction therapy (PCIT).** PCIT is a brief treatment created by Eyberg (1988) for managing behavioral problems in childhood. It has been empirically validated and can be considered a well-established treatment for disruptive behavior in children between the ages of 2 and 7 years (García & Velasco, 2014). PCIT involves two phases, child-directed interaction (CDI) and parent-directed interaction (PDI), in which therapists instruct and coach caregivers in play therapy and operant conditioning skills. The goals of the CDI phase are to “encourage warm, secure caregiver–child relationships, and the foundational skills in this phase include praise, verbal reflection, imitation, behavioral description, and enjoyment and are often collectively referred to as the PRIDE skills” (Lieneman, Brabson, Highlander, Wallace & McNeil, 2017, p. 239). The goal of the PDI phase is to increase child compliance and decrease disruptive behaviors. According to McNeil and Hembree-Kigin (2010), in order to “master” CDI, a caregiver must use a number of positive interaction skills, while PDI mastery involves correctly following through with directly stated commands.

Since its creation, PCIT has been studied internationally with various populations and has been found an effective intervention for numerous behavioral and emotional issues including ADHD, anxiety, Autism Spectrum Disorders (ASD) and depression (Lieneman, Brabson, Highlander, Wallace & McNeil, 2017).

**Behavioral parent training (BPT).** BPT is among the most widely used interventions for parents of children and adolescents with behavior problems (Forehand & Kotchick, 2002). Originating in the 1960s, behavioral parent training stems from clinical research using parents as the focus of intervention for the disruptive behaviors of their children (Bernal, Durgee, Pruett &
Burns, 1968, Patterson & Brodsky, 1966). According to Maughan, Christiansen, Jenson, Olympia and Clark (2005), BPT involves training parents to use behavior modification so that they can define problem behaviors accurately and implement assessment measures that predict the problem behavior accurately. BPT is based on the empirical and applied concepts of behavior therapy and principles of social learning theory. It continues to be studied and applied across clinical settings today (Forehand & Kotchick, 2002).

**Child Developmental Theories**

Counseling children is a unique process involving multiple concepts and dynamics that differ from counseling adults (Prout & Brown, 2007). Clarizio and McCoy (1983) offered an overview of some of the unique aspects of the child counseling relationship that warrant reference. Children bring a different motivation for treatment into the counseling environment compared to adults (Clarizio & McCoy, 1983). Whereas the adult is usually aware that a personal problem exists, the child may not agree or recognize that there are issues (Clarizio & McCoy, 1983). Although others may encourage an adult to seek professional help, in most cases, he or she will decide whether to enter treatment. The child is unlikely to voluntarily initiate therapy. This decision is usually made by an adult in the child’s life, with some varying degree of acceptance or resistance from the child (Clarizio & McCoy, 1983). The involuntary nature of the child client often may yield little or no motivation on their part to engage in a relationship with the therapist or not even an admission that any change is necessary (Smith-Adcock & Tucker, 2017). Thus, the first step in many interventions may be simply to establish a relationship with the child and come to agreement that change is necessary (Clarizio & McCoy, 1983). Without developing some motivation in them, it will be difficult to make significant progress in counseling.
In addition to acknowledging the basic differences in dynamics in counseling children and understanding the barriers to progress, it is essential to understand the foundational theories of child development in order to understand what it means to work with this population. This section provides an overview of the major theorists of B.F. Skinner, Jean Piaget, Erik Erikson, John Bowlby, Albert Bandura and Urie Bronfenbrenner. Specifically, these individuals and their ideas will be highlighted as well as the contributions each theory has made to the understanding of child development. Please see Table 1.1 at the end of this section for an illustration of the different developmental theories.

**Radical Behaviorism**

B.F. Skinner’s experimental findings continue to influence society today in terms of education, parenting practices and child counseling. In his research, Skinner (1938) established an experimental science of behaviorism that lead to a new system of psychology. In fact, Skinner claimed to have no ‘theory’, only a principle of reinforcement (Skinner, 1938). Skinner (1938) contended that most human behavior occurs at random. He believed that one should focus on the external, observable causes of behavior rather than internal thoughts and motivations. Skinner posited that the best way to understand human behavior was to consider the causes of an action and its consequences. According to Skinner (1938), feelings are the products of one’s experiences which are by-products of reinforcement. He emphasized this point by stating that humans do not cry because we are sad, but because something has happened.

**Operant conditioning.** At its core, radical behaviorism is about operant conditioning. Skinner (1938) described operant conditioning as a change in behavior based on reinforcements given after a desired response. There are three types of operants that may follow the behavior: 1) neutral operators, which neither increase nor decrease a behavior, 2) reinforcements, which can
be negative or positive and increase the likelihood of repeat behavior, and 3) punishment, which lessens the likelihood that a behavior will recur. (Skinner, 1938). Neutral operators are not useful in most cases as they do not correlate with any behavioral change.

Positive reinforcement. Skinner (1938) illustrated the concept of positive reinforcement through careful experimentation involving the highly documented “Skinner Box”. He placed a hungry rat in a box with a lever on one side. If the lever was accidentally pressed by the rat, a pellet of food fell into a small container next to the lever. The rats quickly learned to go straight to the lever after being in the box a few times. The consequence of receiving the food if they pressed the lever ensured that they repeated the behavior, thus illustrating the concept of a positive reinforcement schedule. Positive reinforcement strengthens a behavior by providing a consequence that the individual considers rewarding. For example, if a child is given a sticker or 5 minutes of game time when he completes a math worksheet, he is more likely to repeat the homework in the future, strengthening that behavior. Over the course of several decades, Skinner extrapolated the Skinner box experimental findings to be about human behavior.

Negative reinforcement. Skinner (1938) described how removing an unpleasant reinforcement (negative reinforcement), can also strengthen a behavior because the elimination of an adverse stimulus is a reward. Thus, negative reinforcement strengthens behavior by stopping or eliminating an unpleasant experience. It occurs in parenting when a parent tells a child that he or she can get up from the table (aversive stimulus) to go play only after eating two bites of broccoli.

Punishment. According to Skinner (1953), punishment is defined as the opposite of reinforcement, since it is designed to weaken or eliminate a response instead of increasing its probability. Punishment is an aversive event that diminishes the behavior that follows. As with
reinforcement, punishment can work either by directly applying an unpleasant stimulus or by eliminating a potentially rewarding stimulus. While reinforcement tells you what to do, punishment only tells you what not to do.

**Radical Behaviorism and Child Counseling Competency**

Behavioral based treatment approaches represent dominant modalities (cognitive behavioral therapy, behavioral parent training, behavioral analysis, etc.) in child counseling (Martin & Pear, 2015). Skinnerian principles continue to be applied decades after their introduction (Wyatt, Hawkins, & Davis, 1986). The outcome of ongoing qualitative assessments indicate that Skinner's psychology is alive and well and that radical behaviorism is still used in practice (Richelle, 2016). The behavioral movement has mushroomed to the point where numerous journals, books, workshops, and societies are devoted to the topic (Bansal, Waschbusch, Haas, Babinski, King, Andrade, Willoughby, 2018; Cohen, Deblinger & Mannarino, 2018). Child counselors are expected to hold a basic understanding of behavioristic principles.

Clinicians have long used behavior therapy as a framework for successful management of ‘problem’ behaviors (Bansal et. al., 2018). This approach distills concerns down to observable behavior. This is especially the case when working with children with limited verbal capacities such as those diagnosed with Autism Spectrum Disorder (ASD) (Reichow, Barton, Boyd & Hume, 2012). Behavior therapists employ what is called Applied Behavior Analysis (ABA), defined as a process in which behaviors are analyzed and interventions are applied systematically to improve socially significant behavior (Casey & Carter, 2016). With this approach, the child can gain a clear understanding of which problem-solving techniques result in the best payoff. In behavioral analytic terms, this concept is described as providing the child with skills to maximize
reinforcement (Casey & Carter, 2016). Johnston (2014) wrote *Behaviorism for ABA Practitioners*, arguing that qualified behavior therapists must be conversant with the philosophical rationale for radical behaviorism. Johnston (2014) suggests that radical behaviorist theory should inform the daily activities of behavior analytic practitioners, as well as provide an ideological infrastructure for their approach to clients' challenges. This premise is widely accepted within professional behavior analysis circles.

Another common form of radical behaviorism today can be seen in ‘token economies’, where tokens can be earned by ‘desirable’ behavior (Ayllon & Azrin, 1968). In radical behaviorism, a token becomes a conditioned reinforcer through its relationship to reward items like snacks, stickers, and small toys. Therefore, producing a token when a child shows ‘good’ behavior should strengthen that good behavior.

The response to a child’s behavior is often foremost from a child discipline perspective (Alvord & Cheney, 1994). That is, parents often think in operant conditioning terms (i.e. “My child just hit my other child, what should I do to make sure that doesn’t happen again and ensure I’m not reinforcing this behavior?”). This isn’t to say that this model of discipline is the correct way or even a healthy way to foster positive child development, only that it is utilized extensively in modern American society.

**Developmental Stage Theories - Piaget**

Development stage theories of Piaget and others are presented as a foundational competency in counseling children. Therefore, an overview of Piaget’s work is warranted along with others like Erikson’s (1963). Piaget’s (1936, 1952, 1970) theory of cognitive development is a description of cognitive development as four distinct stages: sensorimotor, preoperational, concrete, and formal. Piaget's theory focuses not only on understanding how children acquire
knowledge, but also on understanding the nature of intelligence and learning. For the purpose of the population of this study, only the first three stages will be considered.

**Sensorimotor stage.** In the sensorimotor stage (birth to 2 years old), an infant learns and builds an understanding of his or her world through interactions with the environment (Piaget, 1970). Major milestones in this stage involve learning to differentiate between self and other objects and that learning takes place through assimilation (categorizing information and absorbing into existing schema) and accommodation (when an object cannot be assimilated and must be modified to include a new object) (Piaget, 1970). Infants in this stage also learn about cause and effect and that objects continue to exist even when they cannot be seen (object permanence) (Piaget, 1970).

**Preoperational stage.** This stage (2 to 7 years old) witnesses a burst in language development (Piaget, 1970). Children learn to think symbolically and use words and pictures to represent objects. However, children in this stage cannot yet conceptualize abstract ideas and need concrete physical information (Piaget, 1970).

**Concrete operational stage.** Children in this stage (7 to 11 years) learn to think logically about events and begin to use the concept of conservation (i.e. the amount of liquid may be the same in two differently shaped cups) (Piaget, 1970). Children’s thinking in this stage is more logical and organized but also highly concrete. They also begin using inductive logic and the egocentrism of previous stages begins to dissipate (Piaget, 1970). Children in this stage understand that their thoughts are unique to them and that not everyone shares their feelings and opinions (Piaget, 1970).
Theory of Cognitive Development and Child Counseling Competency

Piaget’s theory of cognitive development has continued influence on how children are viewed and treated (Nurrenbern, 2001). The developmental stages have been influential in various educational domains from educational curriculum design (Hinde & Perry, 2007), to learning styles literature (Tourmen, 2016), to methods of instruction (Nurrenbern, 2001). As stated by Nurrenbern (2001), “Piagetian theory has had a profound effect on the way we think about learners and learning as well as the methods by which this dynamic development process is translated to learning environments” (p. 1110).

Conversely, as Feldman (2004) points out, Piaget’s stage design has been widely criticized as too broad, too vague and overly dependent on simple transitions across a child’s lifespan. Indeed, as other authors suggest, Piaget’s theory of cognitive development created the path to understand children but did not account for enough development beyond vague mental structures that Piaget outlined in his works (Barrouillet, 2015). Nonetheless, one cannot deny Piaget’s influence in bringing awareness and understanding to children’s learning and thought processes.

Development Stage Theories - Erikson’s Stages of Psychosocial Development

Erikson (1963) created an immensely influential psychodynamic theory of human development that, similar to Piaget, continues to thrive. Erikson (1963) proposed a theoretical framework for establishing connections between the various stages of human development and built his theory based on Sigmund Freud’s (1920) theory of psychosexual development and his own work with children and families. For Erikson (1963), the social aspects that influence child and human development are more significant in shaping personal identity. Although rooted in the psychoanalytic framework and his own clinical experience, Erikson’s theoretical framework has
Erikson (1963) believed that every child experiences a series of developmental stages from birth to old age. He posited “each human being must find his or her own sense of regulation as a result of the interplay between the inner voice of the child, the physiological and emotional urges of the individual, and the nature of social influences” (Batra, 2013, p. 259). Erikson visualized human development in eight sequential stages. These stages are not neatly arranged in a linear framework, but instead “emerge organically in the course of overlapping phases” (Erikson, 1982, p. 29). His eight stages are organized chronologically. For the purposes of this study, only the first four stages will be highlighted as they are the only ones dedicated to children.

**Trust vs mistrust.** The first Eriksonian stage is trust versus mistrust. The responsiveness and sensitivity of caretakers is the primary influence in the development of trust (Dunkel & Harbke, 2016). A basic sense of trust is imbued in a child through responsive caretaking. For a child born into a family where love, economic security, play and happiness are widely available, the child learns to live with the feeling of being trusted and in turn learns to trust others. Hope emerges as the basic virtue, instilling a feeling that life brings joy and happiness (Batra, 2013).

**Autonomy vs shame and doubt.** The second stage is autonomy versus shame and doubt. The importance of caregivers is seen in this stage as well. Erikson believed that if caregivers provided appropriately guided opportunities for a child to explore their world, a sense of autonomy develops (Erikson, 1963). Willpower and self-control emerge at this stage. Batra (2013) notes “where explanations about the possible consequences of her actions are patiently
provided, the young child learns to gradually experience autonomy within the boundaries of the social order” (p. 260).

**Initiative vs guilt.** Child-led self-direction and goal-orientation delineate the beginning of the third Eriksonian stage of initiative versus guilt. The virtues of hope and willpower provide ‘emotional strength’ to the young child such that he feels equipped to take initiatives that help him “decipher the scripts of life through play and widening social exchange” (Erikson, 1963, p. 66). The young child (3-6 years old) will pretend to play the roles of family and other adults such as teacher, coach, driver, firefighter, etc. The child will engage in play to discover the difference between reality and fantasy. Rates of goal pursuit, accomplishment, and failure determine the outcome of this stage. Children who successfully pursue goals develop a sense of purpose as opposed to feeling aimless (Erikson, 1963).

**Industry vs inferiority.** In the fourth stage, industry versus inferiority, children around ages 7-12 try to master important skills in self-confidence. They begin to develop a sense of what talents they possess and what separates them from other peers in natural abilities (Erikson, 1963). The honing of these talents and skills results in a sense of industry and competence.

**Erikson and Child Counseling Competency**

Compared with other stage theories and models of development, Erikson has one of the most influential and supported theories today (Cohen & Waite-Stupiansky, 2017). His theoretical insights or propositions have implications how children are treated in society, in homes and in clinical environments (Batra, 2013). Erikson believed in the goodness of people and that through clinical and ethical practice, the positive side of human nature can be nurtured (Erikson, 1963). Erikson also believed that children are extremely resilient and have the unique capacity to care for one another (Erikson, 1963). In sum, Erikson believed that children are inherently good, and
parents and caregivers have the power and influence to instill positive virtues (Erikson, 1982). These basic premises in Erikson’s eight stages have been widely supported in literature as researchers believe this model presents a more holistic view of development that accounts for elements other than cognitive development (Cohen & Waite-Stupiansky, 2017).

Other Theories Related to Child Counseling

In addition to the developmental stage theories presented above, three other theories are understood to be integral to the practice of child counseling. Child counselors must understand the basic concepts of attachment, social learning and systemic influences in order to understand and treat children. These three concepts are presented with their corresponding theories.

Bowlby’s Theory of Attachment

Bowlby’s attachment theory of social development (1949, 1969, 1973) posits that early relationships with parental figures and caregivers play a major role in healthy child development and continue to influence relationships and wellness throughout life. Bowlby suggested that children are born with an innate need to form attachments (Bowlby, 1973). Such attachments form the basis of survival by ensuring that the child receives care and protection, and that these attachments are characterized by clear behavioral and motivational patterns. Bowlby said in 1977:

What for convenience I am terming attachment theory is a way of conceptualizing the propensity of human beings to make strong affectional bonds to particular others and of explaining the many forms of emotional distress and personality disturbance, including anxiety, anger, depression and emotional detachment, to which unwilling separation and loss give rise (Bowlby, 1977, p. 151).
Bowlby (1977) thus explained that disruption of bonds between caregiver and child can lead to painful emotions and eventually psychopathology. Contextually, attachment theory was formed to clarify strict psychoanalytic theories of Freud (1920) and Erikson (1963) to focus on what Bowlby viewed as the most important influence on development and positive mental health: the bond between adult and child (Marrone, 2014). His theory can also be viewed as a rejection to Skinnerian (1938) behaviorism, which posited that attachment was learned behavior.

Bowlby (1973) outlined several key assumptions: (a) attachment behavior follows a recognizable pattern and predictable course in all human beings; (b) attachment behavior is usually initiated by specific conditions and terminated by others; (c) attachment behavior serves a survival function and an individual is more likely to survive difficult or adverse conditions if supported by another human being; and (d) attachment behavior can only function effectively within a social system and is part of that system.

The strange situation. Some of the major components of attachment theory are tied to the collaborative work of John Bowlby and Mary Ainsworth. Drawing from Bowlby’s theoretical assumptions, Ainsworth created the famous Strange Situation (Ainsworth, 1969). The Strange Situation is the standardized laboratory procedure part of a longitudinal study of the development of infant–mother attachments throughout the first year of life (Ainsworth, 1969). The procedure consists of several episodes involving the child, mother and a ‘stranger’ (a member of the research team), which develops in a particular room in which there are two chairs and some toys to which the child has access. These episodes are intended to activate and/or intensify the infant’s attachment behavior by means of introducing an unfamiliar situation (the adjective ‘strange’ denotes unfamiliar) (Marrone, 2014). The scenario calls for the child to enter the room with the mother, followed by exploratory play, then the entrance of the unfamiliar
adult, at this point, the mother leaves and returns three minutes later. Next, the mother leaves the room again and so does the stranger, leaving the child alone in the room. The stranger returns before the mother does. After the second reunion between mother and child, the procedure comes to an end (Ainsworth, 1969).

**Attachment styles.** The results of the *Strange Situation* lead to the development of the four styles of attachment: (a) secure, (b) avoidant, (c) ambivalent and (d) disorganized (Ainsworth, 1969). A securely attached child plays with the toys, shows signs of being upset when the mother leaves the room, interrupts his playful or exploratory behavior and somehow demands reunion. When the mother returns, he is easily comforted, settles and returns to play. Statistically, approximately half of the children observed react in this way (Ainsworth, 1969). The chief characteristics of their reactions include: greater ability to play and explore the environment with enjoyment, confidence and curiosity; greater ability to show distress as an appropriate reaction to separation and, finally, greater ability to be soothed (Marrone, 2014). It is assumed that children who have built an internal working model of their relationship with their mother as secure are more likely to respond in this way. An avoidantly-attached child (about 25% of sample) failed to cry or to be overtly upset when she left the room. When the mother returned, these young children actively avoided contact with her. Throughout the procedure, these children seemed to be more attentive to inanimate objects than to interpersonal events (Ainsworth, 1969). The third group, ambivalent attachment, or roughly 10 percent of infants, reacted strongly to separation (Ainsworth, 1969). When the mother returned, they actively sought reunion and comfort, but they also showed anger or passivity. They did not settle easily, tended to cry and failed to return to exploration (Ainsworth, 1969).
After Mary Ainsworth made her original description of three patterns of attachment, a Berkeley research team formed by Mary Main, Judith Solomon and Donna Weston found a fourth pattern, which they called disorganized (Main & Solomon, 1990; Main & Weston, 1981). The infants who fall into this category react to reunion with mother in a confused and disorganized way. The infants were disorganized in that they would display behaviors such as not paying attention to the mother and paying more attention to the stranger.

**Attachment Theory and Child Counseling Competency**

Research based on Bowlby’s attachment theory has multiplied. Attachment theory has been used to study the association between childhood attachment experiences and parenting behavior (George, Kaplan & Main, 1996); the impact of childhood attachment experiences on adult-adult relationships (Dainton, 2007; Mikulincer & Shaver, 2005) the role of child attachment in influencing thoughts, feelings and behavior in parenting and romantic relationships (Bretherton, 1990; Bretherton & Mulholland, 2008); the understanding of childhood trauma and its impact on adult mental health (Goldberg, Muir & Kerr, 2013; Schore & Schore, 2008); and the relationship between therapist and child client as a model of attachment and forming secure bonds (Parish & Eagle, 2003). It is essential that counselors incorporate a child’s attachment to caregivers when counseling children. If children show signs of a particular attachment style, such as anxious attachment to a parent, then particular treatment choices are indicated such as using family systems approaches.

**Bandura’s Social Learning Theory**

Another important theory that child counselors must understand is Albert Bandura’s social learning theory, which integrates behaviorism and cognitive theory (Bandura, 1962, 1969, 1971). Bandura’s aim was to explain how people learn to behave. He rejected the Skinnerian
view of behaviorism, noting that “although behavior can be shaped into new patterns to some extent by rewarding and punishing consequences, learning would be exceedingly laborious and hazardous if it proceeded solely on this basis” (Bandura, 1971, p. 5). To Bandura (1971), most behaviors are learned, either deliberately or inadvertently, though the influence of example.

There are two core concepts that form the foundation of social learning theory: observational learning and mental states. In a well-documented and widely acknowledged experiment, Bandura demonstrated that children learn and imitate behaviors they note in others (Bandura, 1978). The children in Bandura’s studies observed an adult acting violently toward a doll. When the children were later allowed to play in a room with the doll, they began to imitate the aggressive actions they had seen previously. From that experiment, Bandura (1978) identified three basic models of observational learning: (a) a live model which is a real person demonstrating a behavior; (b) a verbal instructional model, which involves descriptions and explanations of a behavior; and (c) a symbolic model, which involves real or fictional characters displaying behaviors in various media.

**Four principles of social learning.** A few important assumptions of social learning theory focus on attention, information and motivation. Bandura (1971) stated that individuals cannot learn if they are not focused on a task. If people see something as being new or unique, they are more likely to focus their attention there. In terms of retention, Bandura (1971) stated that individuals learn by internalizing information in their memory. People can recall information later when they are required to respond behaviorally to a situation that is similar than when they learned that information. Accordingly, people reproduce previously learned information when required and practice through mental and physical rehearsal often improves responses (Bandura, 1971). Lastly, people must be motivated to do anything, and motivation starts from observations
of someone else being rewarded or punished for something they did or said. Bandura (1978) considers mental states as an important determinant in whether a behavior is learned or not. While behavioral theories suggested that external reinforcers foster learning, Bandura suggests that reinforcement may be internal. He described intrinsic reinforcement as a form of internal reward, such as a sense of accomplishment or pride (Bandura, 1978).

Social learning theory has important implications for the understanding of child development. Child behavior is described as a product of consistent bidirectional interactions between social environment and traits of the child (Avan & Kirkwood, 2010). Children are more eager to repeat a behavior if it results in outcomes they value, the role model is regarded positively, and if the behavior has functional value (Bandura, 1971).

Social Learning Theory and Child Counseling Competency

Social learning theory can have a number of modern applications in child counseling. For example, it can be used to help counselors understand how aggression and violence might be transmitted through observational learning (Bandura, 1978; LaRose & Eastin, 2004; Singhal, Cody, Rogers & Sabido, 2003). By studying media violence, counselors can gain a better understanding of the factors that might lead children to act out the aggressive actions they see portrayed on television, movies, and video games (Akers, 2017). Additionally, social learning can also be used to teach people positive behaviors (Caprara, Barbaranelli, Pastorelli, Bandura & Zimbardo, 2000). This theory provides a framework for child counselors to understand the bidirectional interactions between environment and child personality traits.

Ecological Systems Theory

One of the most widely reported competencies in child counseling is having a deep understanding of how children operate in various systems. The theory that aids in the
understanding of children in the context of systems is ecological systems theory. Ecological systems theory of development was formulated by Urie Bronfenbrenner to explain the unique relationship of the child to all of life’s settings, from close to remote (Bronfenbrenner, 1986). Ecological system theory emphasizes the mutual interactions between the child and these various settings. Ecological systems theory suggests the child is surrounded by layers of relationships built upon one another to create five concentric circles. The systems outlined by Bronfenbrenner include: (a) microsystem, (b) mesosystem, (c) exosystem, (d) macrosystem, and (e) chronosystem.

**Microsystem.** The microsystem, the system closest to the child, refers to groups that have the most immediate impact on the child’s development. The microsystem encompasses structures to which the child has direct contact and facilitates significant face-to-face relationships. This would include those within the child’s family, school, neighborhood, or religious communities (Bronfenbrenner, 1986).

**Mesosystem.** The second system, known as the mesosystem, extends beyond direct relationships between the child and others. The mesosystem represents the connection or relationship between two aspects of the child’s microsystem. An example of the mesosystem could be interactions between the child’s teacher or daycare provider and the child’s parents, the child’s peer and the child’s sibling, or the child’s parents.

**Exosystem.** The third system, called the exosystem, encompasses factors that impact aspects within the child’s microsystem, thus indirectly impacting the experience of the child (Bronfenbrenner, 1986). An example of a factor within the exosystem might be the workplace schedule of the child’s parent. While the child does not directly interact with the parent
workplace or work schedule, it certainly impacts the child’s daily routine. The exosystem creates both positive and negative forces experienced by the child through indirect influence.

**Macrosystem.** The macrosystem is the fourth layer within the ecological systems theory. It encompasses the outermost segment in the child’s environment (Bronfenbrenner, 1986). This section is broad, representing cultural and societal context in the child’s lived experience. This may include gender role stereotypes or gender norms for toys. The defining aspect of this system is the societal messages that characterize and impact these larger cultural factors.

**Chronosystem.** The chronosystem is the fifth level and introduces the influence of time as it relates to a child’s development and lived experience. The impact of time incorporates factors such as historical events and presence or absence of various innovations and technologies (Bronfenbrenner, 1986). For example, the lived experience of a child in 2018 is very different from 1958 considering the role of technology in a child’s life in those eras.

**Table 1.1. Major Child Developmental Theories.**

<table>
<thead>
<tr>
<th>Perspective</th>
<th>Theorist(s)</th>
<th>Key Assumptions</th>
<th>Theories</th>
<th>Major Constructs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychodynamic</td>
<td>Erik Erikson</td>
<td>Development is determined primarily by how a child resolves internal and external conflict at different ages and stages</td>
<td>Psychosocial Theory</td>
<td>Trust, autonomy, initiative, industry, identity, generativity, psychosocial strengths</td>
</tr>
</tbody>
</table>
### Table 1.1 (continued)

<table>
<thead>
<tr>
<th>Behavioral</th>
<th>B.F. Skinner, Albert Bandura</th>
<th>Development is determined primarily by a child’s environment</th>
<th>Radical Behaviorism, Social Learning Theory</th>
<th>Operant conditioning, positive and negative reinforcement, punishment, extinction, imitation, social learning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social</td>
<td>Albert Bandura, John Bowlby</td>
<td>Development is determined primarily by a child’s relation to others</td>
<td>Attachment Theory, Social Learning Theory</td>
<td>Secure, ambivalent, avoidant and disorganized attachment, attention, retention, reproduction, motivation</td>
</tr>
<tr>
<td>Cognitive</td>
<td>Jean Piaget</td>
<td>Development reflects children’s efforts to understand the world</td>
<td>Theory of Cognitive Development</td>
<td>Sensorimotor, preparational, concrete operational, and formal operational stages, assimilation, accommodation, schema, equilibrium</td>
</tr>
<tr>
<td>Systemic</td>
<td>Urie Bronfenbrenner</td>
<td>Development is influenced by immediate and more distant environments, which typically influence each other</td>
<td>Ecological Systems Theory</td>
<td>Microsystem, mesosystem, exosystem, macrosystem, chronosystem</td>
</tr>
</tbody>
</table>

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**Child Counseling Legal and Ethical Understandings**

Counseling children involves ethical codes and guidelines that respect children’s autonomy while protecting their basic rights. The statistics cited in “Each Day in America for All...
Children” (Children’s Defense Fund, 2014) suggest a perilous position in which contemporary children live. According to the Children’s Defense Fund (2014), four children every day are killed by abuse or neglect, 187 are arrested for violent crimes, 408 children are arrested for drug crimes and 4,028 children are arrested for various crimes. Counselors who work with children must maintain an ethical code that ensures children are kept safe (Smith-Adcock & Tucker, 2017). Clinical decisions with young children can be complicated by their limited legal rights yet counselors must acknowledge that children are capable of making decisions and may benefit from having personal advocacy (Smith-Adcock & Tucker, 2017). Therefore, it is critical that counselors maintain a solid knowledge base about legal and ethical issues related to counseling children. This section will provide an overview of children’s rights, consent/assent, mandated reporting and ethical decision-making models.

Children’s Rights

There are basic tenets unique to counseling children of which counselors must be aware. The United Nations Convention on the Rights of the Child, or UNCRC (Unicef, n.d.) maintains that children should have basic human rights, including input on decisions that affect their lives. Outlining the basic rights of the child, the UNCRC states:

Governments have a responsibility to take all available measures to make sure children’s rights are respected, protected and fulfilled. When countries ratify the Convention, they agree to review their laws relating to children. This involves assessing their social services, legal, health and educational systems, as well as levels of funding for these services. Governments are then obliged to take all necessary steps to ensure that the minimum standards set by the Convention in these areas are being met. They must help
families protect children’s rights and create an environment where they can grow and reach their potential (Unicef, n.d., para. 4).

The UNCRC was adopted by the General Assembly on 20 November 1989 and has been ratified by 195 countries, making it the most widely acknowledged international human rights treaty in history (UNICEF, n.d.). As of 2018, only two countries have yet to ratify the landmark treaty – South Sudan and the United States (UNICEF, n.d.). The basic argument against ratifying this treaty is that it would legally bind the U.S. and the right of the states, and ultimately parents, to choose how to treat children (Mink, 2015).

The Health Insurance Portability and Accountability Act of 1997 (HIPAA) protects the privacy of any medical patient’s health records including those of children (U.S. Department of Health and Human Services, n.d.). The Family Educational Rights and Privacy Act (FERPA, 20 U.S.C. § 1232g; 34 CFR Part 99), provides for the confidentiality of students’ educational records and pertains to all schools that receive federal funds. Children in substance abuse treatment are protected by 42 CFR Part 2, which applies to the privacy of any records related to substance abuse education, treatment, or prevention programs related to or assisted by any department or agency of the U.S. government (Smith-Adcock & Tucker, 2017). FERPA especially provides legal guardians the right to view their children’s records, however, in some cases, HIPAA allows for minors’ individual rights to keep their health records confidential from parents or caregivers (i.e. when giving records could put the minor at risk of harm) (Smith-Adcock & Tucker, 2017).

Legal Consent and Assent

Consent is the ability to enter binding contracts and is afforded to adults at the age of majority (Smith-Adcock & Tucker, 2017). This means that children cannot enter into binding
legal contracts, including consent to counseling services. The age of majority is defined in the U.S. at the state level. Though children do not have the legal capacity to consent to participate in counseling, they should be involved in the process if they are able to assent by having counseling explained to them and/or by reading about it prior to entering a program. After understanding the counseling process, they may be able to provide their verbal choice about whether or not they want to participate. More specifically, counselors in any setting can secure assent by explaining the following: an outline of the counseling approach in developmentally appropriate language, what they will be asked to do and what is required of them (Hurley & Underwood, 2002).

ACA ethical codes address respect for both confidentiality and informed consent with children. Standard B.1.c states, “Counselors protect the confidential information of prospective and current clients. Counselors disclose information only with appropriate consent or with sound legal or ethical justification” (ACA Code of Ethics, 2014, p.7.). Confidentiality is an ethical imperative for all clients. However, there are some limitations for the expectation of confidentiality. ACA Standard B.1.d states that counselors must keep their clients informed throughout the counseling process about the conditions under which confidentiality may be broken. Limitations to confidentiality involve the protection of child clients from serious harm (ACA Code of Ethics, 2014). Wheeler and Bertram (2012) suggest that a variety of factors including “the age, maturity, and education level of the minor; relationship with parents or guardians; whether disclosure may reasonably be expected to help the situation or could cause harm” should be considered in making decisions as to whether or not to break client confidentiality (p. 89).

Standard A.2. of the ACA Code of Ethics (2014) illustrates the importance of informed consent in the counseling relationship. A.2.a states:
Clients have the freedom to choose whether to enter into or remain in a counseling relationship and need adequate information about the counseling process and the counselor. Counselors have an obligation to review in writing and verbally with clients the rights and responsibilities of both counselors and clients. Informed consent is an ongoing part of the counseling process, and counselors appropriately document discussion of informed consent throughout the counseling relationship (p. 4).

**Mandated Reporting**

Mandated reporting laws in each state identify persons who are required to report suspected child maltreatment or abuse (Kohl, Barth, Hazen & Landsverk, 2005). Child maltreatment means physical, emotional, and/or sexual abuse and neglect (Garbarino, Guttmann & Seeley, 1986). Neglect includes acts of omission, or a failure to take reasonable actions to protect a child from harm (Barnett, Miller-Perrin & Perrin, 2005). Counselors are among those mandated to report. Abuse is defined as the intent to inflict harm on a child (Kohl, Barth, Hazen & Landsverk, 2005). For example, though spanking is highly discouraged by child development experts (Gershoff, 2008), spanking is not always considered abuse and often will not be acknowledged by child protective services as a sign of abuse (Straus, 2000).

**Ethical Standards and Models**

Counseling children is a subspecialty of counseling, yet there are no ethical standards specific to counseling children. However, the ACA (2014) Ethical Code C.2.a offers the following about practicing within competency levels:

Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience. Whereas multicultural counseling competency is
required across all counseling specialties, counselors gain knowledge, personal awareness, sensitivity, dispositions, and skills pertinent to being a culturally competent counselor in working with diverse client population (p. 8).

Lawrence and Kurpius (2000) suggest that counselors who work with children develop specialized knowledge and training to become competent and ethical child counselors. These investigators contend that carelessly applying adult ethical decision-making models to children in the counseling realm is neither appropriate nor ethical.

Determining the right direction in child counseling is rarely clear. A decision-making model can be helpful when aspects of a situation seem particularly nebulous. Remley and Herlihy (2014) suggest the following steps: (a) identify and define the problem; (b) consider the principles and virtues; (c) acknowledge one’s own position; (d) consult with colleagues or experts; (e) involve the client in the decision-making process; (f) identify desired outcomes; (g) consider possible actions; (h) choose and implement a course of action. Another decision-making model is provided by Sileo and Kopala (1993) who outlined their Assessment, Benefit, Consequences and Consultation, Duty, Education (A-B-C-D-E) model as a means for tackling ethical dilemmas.

The preceding sections have illustrated the basic theories and ethical and legal concepts that a child counselor must understand and implement in practice. The following section will provide a framework from which to base a child counseling competency system. Although there are many established psychological or mental health competency systems, few provide practical and direct guidelines for how to implement competencies into clinical counseling practice. One of those few are the Multicultural and Social Justice Counseling Competencies (MSJCC), which are presented as a guiding framework for this study.
Framework for Counseling Competencies: Multicultural and Social Justice Counseling

The current study used the Multicultural and Social Justice Counseling Competencies (MSJCC) as a guiding framework to address topical research questions. In 2016, as a response to a lack of guidance for multicultural counseling, the MSJCC were created to serve as a framework to assess counselors’ multicultural competence. Multicultural counseling, similar to child counseling, is a subspecialty for which counselors receive generalized training. As opposed to other competency systems focusing on mental health (i.e. The Vermont Early Childhood Family Mental Health Competencies, 2007), the MSJCC focus on counseling competencies is an important distinction.

The MSJCC answered the call for more accountability and action in multicultural counseling approaches (Ratts, Singh, Nassar-McMillan, Butler & McCullough, 2016). The MSJCC, which revises the Multicultural Counseling Competencies (MCC) developed by Sue, Arredondo, and McDavis (1992) “offers counselors and psychologists a framework to implement multicultural and social justice competencies into counseling theories, practices, and research” (Ratts, Singh, Nassar-McMillan, Butler & McCullough, 2016, p. 30). Ratts et al. (2016) created a visual map detailing the competencies involved in multicultural counseling. Quadrants are used to show the intersection of various identities, statuses, and dynamics of power and privilege involved in the counseling relationship.

There are four developmental domains in the visual map including: “(a) counselor self-awareness, (b) client worldview, (c) counseling relationship, and (d) counseling and advocacy interventions…and embedded within the developmental domains of the MSJCC are the following aspirational competencies: attitudes and beliefs, knowledge, skills, and action (AKSA)” (Ratts et al., 2016, p. 3). The MSJCC represent a major step forward in multicultural
counseling in making professionals more accountable for their work and it makes clear statements regarding how to take action and be culturally competent in practice.

This study is about creating accountability through the development of competencies in child counseling just as the MSJCC were created to foster accountability through the development of core competencies in multicultural counseling. Specifically, the MSJCC are organized into four distinct competencies, each of which is embedded within the domains of the model: (a) attitudes and beliefs, (b) knowledge, (c) skills, and (d) action (AKSA). Ratts et al. (2016) clarified the AKSA model in stating the following:

First, counselors must possess certain attitudes and beliefs to commit to practicing counseling and advocacy from a multicultural and social justice framework. Second, possessing knowledge of relevant multicultural and social justice theories and constructs is necessary to guide multicultural and social justice competence. Third, multicultural and social justice–informed attitudes, beliefs, and knowledge provide the background for counselors to develop cultural and change-fostering, skill-based interventions. Finally, taking action by operationalizing attitudes and beliefs, knowledge, and skills (AKS) is critical to achieving multicultural and social justice outcomes (p. 38).

The AKSA competency framework was chosen for this study because it allows for a clear foundation from which to base child counseling competencies. Child counselors need to know what is essential to do their professional work. That knowledge involves what traits makes a child counselor competent (attitudes and beliefs), what skills they possess and what actions they take to carry out their work.
Conclusion

This literature review supports the development of counseling competencies for child counselors. Per this review, children are unique and present distinct challenges in addressing their mental health needs. The professional literature supports the idea that child counseling is an exclusive process, separate and distinct from counseling adults. Researchers should strive to generate strategies to address the different mental health needs of children. Investment in a set of core counseling competency standards is critical for the future of the field of child counseling. The utility of the Delphi method for generating knowledge about complex phenomena is advantageous for comprehensively identifying the attitudes, knowledge, skills and actions of child counselors, and talking to the experts in the field of child counseling is necessary to understand and outline the competencies related to working with children.
CHAPTER III

METHODODOLOGY

This study is about building the basic standards for which child counselors to follow. The purpose of this study is to develop expert consensus of the attitudes, knowledge, skills and actions (AKSAs) necessary for counseling children through the Delphi methodology. Previous chapters outlined various concepts involved in child development and in child counseling. A detailed review of the literature indicates that there is a gap in literature in defining the scope of practice and counselor competencies in child counseling. This chapter describes the epistemological foundations underlying this study, as well as the study research questions and details on the methods, including the explanations of participant selection, sampling procedures, data collection procedures, data analysis and validity of methods. Lastly, the pilot study results are presented as they establish the content for building child counseling competencies.

Epistemology

Prior to discussing the methods in more detail, it is essential to describe the theoretical assumptions that form the foundation of the study (Creswell, 2007). One of the epistemological foundations in this study is constructionism, which philosophically lies between objectivism and subjectivism. Epistemology refers to beliefs about knowledge itself (Crotty, 2010). Indeed, it may be described as the “broadest, most philosophical stance in the research process” (Creswell & Plano Clark, 2007, p. 23). Objectivism posits that there is objective truth separate from human perception (Crotty, 2010). Accordingly, research can involve a search for absolute truths (Crotty, 2010). Conversely, subjectivism assumes that there are multiple truths and that humans are the ones responsible for assigning meaning to things (Creswell, 2007).
Constructionism

Constructionism posits that knowledge is neither innate nor derived solely from humans (Creswell, 2007). Constructionism also asserts that individuals create meanings as they engage in the world they are interpreting (Crotty, 2010). Truth is subjective in a constructionist viewpoint, which depends on the individual perspective of what is already there (Crotty, 2010). Constructionism suggests that individuals best gain knowledge through the active construction of objects (Crotty, 2010) and “includes the collective generation (and transmission) of meaning” (Crotty, 2010, p. 58).

The concepts of constructivism and constructionism are often misunderstood. Constructivism is a philosophical stance about how the individual constructs meaning rather than discovers it (Creswell, 2007) and focuses on the individual mind (Crotty, 2010). Constructionism differs from constructivism in that the former focuses on a group’s construction of concepts, while the latter centers on the distinct learning of the individual that takes place because of the interactions with the world (Crotty, 2010). Put a different way, constructivism focuses exclusively on the meaning-making activity of the individual mind, while constructionism focuses on the collective generation of meaning of individuals. According to Creswell and Plano Clark (2007), most researchers have chosen to adopt a constructionist paradigm for exploratory studies (Creswell & Plano Clark, 2007).

This study adopts a constructionist viewpoint, as it accounts for the collective contribution of expert-participants to the construction of reality. This study is about a group of experts constructing a child counseling model. There is no true and objective child counseling model that exists (objectivism), nor is there infinite child counseling models that every counselor can create on his or her own (subjectivism). Rather, there is a foundational system of
competencies that can be generated and constructed from experts in the field (constructionism) and used by all who do the work of child counseling.

Because of the dearth of research regarding child counselor attitudes, knowledge, skills and actions, a constructionist foundation is advantageous for illuminating child counseling within the broader context of mental health counseling. This study is based on the constructionist view and it is intended to reflect the collective knowledge of the expert participants. Through the theoretical lens of constructionism, each participating member has equal input in the negotiation of the construction of the child counseling AKSAs. In this study, each of the expert-participants provided their opinions, which were combined through the systematic process of the Delphi to construct the AKSAs necessary for counseling children.

**Methodology**

A study’s methodology describes the foundations, assumptions and philosophical understanding that relates to the entire process of research (Creswell & Plano Clark, 2007). While beginning to highlight the methodology of this study, it is important to differentiate this term from the research methods. The methodology of this study is mixed methods, with an exploratory sequential research design, utilizing a Delphi as the method of data collection and analysis.

**Mixed Methods Design**

The Delphi process is grounded in mixed methods research design. Mixed methods research is being used more often as a methodology in the health sciences to gain a fuller understanding of topics and hear the voices of participants (Guetterman, Fetters & Creswell, 2015). The rationale for mixing qualitative and quantitative data within one study lies in the fact that neither quantitative nor qualitative methods are sufficient, by themselves, to capture the
trends and details of a phenomenon (Ivankova, Creswell & Stick, 2006). The current study qualifies as a “qualitatively driven” mixed methods study, in which the qualitative portion drives the foundational principles of the study (Mason, 2006). The reason this study used a qualitatively driven approach is to “cast a wider net” and obtain a more comprehensive understanding of a phenomenon from differing perspectives (Hesse-Biber, Rodriguez & Frost, 2015, p. 8).

**Exploratory Sequential Design**

A specific type of mixed methods approach was used in this study called the exploratory sequential design. In this approach, qualitative data is first collected and analyzed, and themes are used to drive the development of a quantitative survey to further explore the research problem (Creswell & Plano Clark, 2011). Three stages of analyses are conducted: the primary qualitative phase, a secondary quantitative phase, and an integration phase that connects the two strands of data and extends the initial qualitative exploratory findings (Creswell & Plano Clark 2011). Below is a representation of an exploratory sequential design (see Figure 1.1) described by Hesse-Biber (2010).

![Figure 1.1. Sequential Exploratory Mixed Methods Design (Hesse-Biber, 2010).](image)

There are considerable challenges in using a sequential exploratory design. Creswell and Plano Clark (2007) note that there may be a considerable time commitment required for
participants. The researcher must also specify procedures at varying points in data collection and decide whether those committed to the pilot study are also going to be asked to participate in the main study. According to Cresswell and Plano Clark (2007), the Delphi methodology covers some of these issues because data collection can be undertaken remotely, thereby reducing the impact of the time commitment on participants.

The Delphi Methodology

The origins of the Delphi methodology can be traced back to the 1950s (Linstone & Turoff, 1975). During that time, an Air Force-sponsored Rand Corporation study (Linstone & Turoff, 1975, p. 10) used a technique of iterative questioning to generate consensus among a group of experts regarding technological forecasting and future protocol for national defense strategies. Since then, the Delphi method has been widely used in many domains of social and educational research because of its utility to generate novel ideas and knowledge surrounding complex questions (Landeta, 2006; Rowe & Wright, 2011).

Davidson (2013) described multiple types of Delphi studies (e.g., real time Delphi, e-Delphi, decision Delphi, disaggregated Delphi, and group Delphi). Each of these feature some procedural differences but their overall structure of them remains the same. The classical Delphi method was employed in this study as it is deemed most conducive to the research questions. According to Rowe and Wright (2011), the classical Delphi method is an efficient way to forecast the future, characterized by “anonymity, iteration, controlled feedback, and the statistical aggregation of group response” (p. 354). Hasson, Keeney and McKenna (2000) outlined the specific steps of the Delphi method, which follow: (1) a qualitative, exploratory round is conducted to collect participant comments and feedback about a topic of interest, (2) qualitative data from the first step are analyzed and compiled into a Likert-type questionnaire,
(3) the questionnaire is administered and data is collected from participants, (4) data are analyzed and compiled into a third questionnaire, and (5) the process is continued until consensus is reached.

In further detailing the Delphi method, Rowe and Wright (2011) described the general design of a classical Delphi study as two distinct phases: the exploration phase and the evaluation phase. The exploration phase, which is also referred to as the brainstorming phase, employs broad questions to gather information from participants to further understanding of the topic under investigation (Linstone & Turoff, 1975). The information gleaned is then distilled to construct a questionnaire, which is used for subsequent rounds of questioning (Ziglio, 1996). Following the exploration phase, the evaluation phase utilizes a series of systematic questionnaires to determine participants’ levels of agreement, disagreement, understanding, and opinions regarding importance, desirability, and feasibility of the previously acquired responses (Linstone & Turoff, 1975; Ziglio, 1996). This iterative, systematic questioning continues with controlled feedback and refinement of responses until a predetermined level of consensus is reached (Linstone & Turoff, 1975; Ziglio, 1996). The following (Figure 2.1) details the procedures and two phases that were used in the current study.
Figure 2.1. Phases 1 and 2 of Current Delphi Study

For the Delphi method to succeed in practice, a panel of experts must be assembled to give expert opinions and clinical judgments anonymously (Hsu & Sandford, 2007; Jorm, 2015; Powell, 2003; Wester & Borders, 2014). Qualifications of the experts are left to the discretion of the researcher. However, certain criteria should be in place to validate the most credible expert panel. The qualifications, selection criteria and recruitment strategies are outlined later.

The nature of the current study suits the Delphi methodology as it considers the attitudes, knowledge, skills and actions (AKSAs) essential for the child counselor. Current technology allowed the researcher to collect and organize data easily from a variety of panel experts in varying geographic and professional positions.

This study consisted of two phases. The brainstorming session in Phase 1 involved asking a panel of seven experts about the basic AKSAs of child counselors. These responses informed the initial items of the questionnaire completed in Phase 2. Phase 2 consisted of three rounds.
During each round, the panel of experts completed the open-ended questionnaire to reach consensus of the essential AKSAs.

**Research Questions**

The overarching questions of this study ask, what is child counseling? More specifically, the study is designed to address the following research questions regarding the competencies (i.e., attitudes, knowledge, skills and actions (AKSAs) needed to counsel children:

1. What is child counseling?
   
   Research Question A: What attitudes do counselors identify as necessary for themselves as child counselors?
   
   Research Question B: What knowledge bases and understandings do child counselors identify as necessary?
   
   Research Question C: What best practices and skills do child counselors identify as necessary?
   
   Research Question D: What actions do counselors identify as necessary for their role as child counselors?

2. Of the attitudes, knowledge, skills and actions that are identified as necessary, what are the most necessary?

**Population and Sample**

The population under study must be clearly defined prior to collecting data (Trusty, 2011). The following section describes the criteria by which experts were included in this study, followed by a strategy by which experts were recruited.
Selection Criteria

In this study, the researcher identified individuals who have specialized knowledge of the pertinent topic. The selection of experts generally presents a challenging task as the researcher must subjectively create the selection criteria (Linstone & Turoff, 1975). Goodman (1987) discussed finding professionals with enough interest to participate fully in the multiple rounds of the Delphi, but with not so much interest that their judgment is clouded by their own bias. Many researchers who utilize Delphi methods use rank, education, research experience, and clinical experience to define expertise (Jorm, 2015; Powell, 2003; Wester & Borders, 2014). A meta-analysis by Baker, Lovell and Harris (2006) found that common criteria for experts include knowledge, experience, and influence in the field.

A participant needed to meet one of the following two conditions to be considered an expert in this study: (1) hold a membership with the Association of Child and Adolescent Counseling and have at least two years’ experience counseling children, or (2) be a counselor education expert with a specialty in the topic and field of counseling children. School counselors who are members of ACAC were also included in this study. Criterion-based sampling was used in order to select participants based on specific criteria to control for unnecessary variance in the sample (Kaplan, Tarvydas & Gladding, 2014; Powell, 2003).

To select these individuals, the researcher considers that a combination of experts needs to encompass all those who specialize in the counseling of children, because counseling with children is carried out by a variety of professionals in a range of settings (Smith-Adcock & Tucker, 2016).
**Sampling Procedures**

The sample size of a Delphi study can range from 10 to 50 professionals depending on its scope and goal (Linstone & Turoff, 2002, Ziglio, 1996). Previous research by Kress and Shoffner (2007) suggests that eight to twelve participants may be used in a brainstorming session (Phase 1). In counseling-related literature, the number of participants ranges greatly but authors suggest recruiting between 20 and 40 participants (Davey, Duncan, Kissil, Davey & Fish, 2011; Davidson, 2013). The target sample for this study was eight to twelve participants for Phase 1 and 20-25 participants for Phase 2. The researcher recruited participants through criterion sampling, purposive sampling and snowball sampling (Creswell, 2007). A purposive sample is one that is based on the knowledge of a population and the purpose of the study. Snowball sampling involves the identification of participants through the recommendations of others (Creswell, 2007).

**Phase 1 Sampling.** To recruit experts for the Phase 1 brainstorming pilot study, the researcher read the biographies and member profiles of the ACAC directory (N= 767) to identify those who have extensive experience in counseling children and recruited them via email for Phase 1. Extensive experience includes at least 2 years of involvement counseling children or having held a leadership role in the field (Ziglio, 1996). In order to recruit participants who are counselor educators and professionals from other fields, the researcher conducted a thorough review of professional literature, conference presentations, professional websites, acknowledged experts in the counseling field, and consultation with research advisors. Specifically, professional literature was examined through a systematic review of various research databases including EBSCOhost, ProQuest and Google Scholar. Lastly, recruitment emails were sent to the Counselor Education and Supervision Network Listserv (CESNET).
**Phase 2 sampling.** After an initial sample of expert participants were recruited via purposive sampling for Phase 1, snowball sampling was used for Phase 2 to expand the professional resources (Creswell, 2007). According to Creswell (2007), participants selected through purposive sampling are likely affiliated with others who share common knowledge and expertise. Therefore, the researcher provided previously selected participants with an outline of the selection criteria, accompanied by a request to forward the researcher’s contact information and snowball sampling email to anyone they believed may meet the aforementioned selection criteria. Additional recruitment emails were also sent to the Counselor Education and Supervision Network Listserv (CESNET). Response rates and demographic information are recorded in Chapter 4 of this study.

**Data Collection and Data Analysis Procedures**

This study consisted of two phases, a pilot study (Phase 1) and main study phase of refinement of the attitudes, knowledge, skills and actions (AKSAs) necessary for counseling children (Phase 2). Phase 1 consisted of gathering an expert panel to participate in an online brainstorming session; where Phase 2 allowed experts to complete the questionnaire to develop consensus.

**General Procedures and Data Analysis**

A request to complete the study was approved by the Institutional Review Board at North Carolina State University. Participants were recruited via email. Recruitment emails were sent to the Counselor Education and Supervision Network Listserv (CESNET). The recruitment email can be found in Appendix A. Participants signed up for the study by following a link that directed them to a Qualtrics consent form (Appendix B). After signing the consent, all were notified of a date and time for the online meeting via the online scheduling platform Doodle.
Fifteen individuals participated in the Doodle poll. The researcher chose the day and time that was selected by the majority of individuals ($N = 9$). Two canceled the day before the brainstorming session.

Participants ($N=7$) attended a single one-hour online brainstorming session held via the online meeting website Zoom. Zoom includes several web-based tools including video and audio conference options, document sharing, direct messaging, and desktop sharing. Additionally, Zoom provides a whiteboard tool that allows the meeting facilitator to take notes or draw diagrams in real time. The researcher used the whiteboard tool to provide participants the research questions and definitions of attitudes, knowledge, skills, and actions. The definitions that were provided to participants can be found in Table 2. The group used the video and audio-conferencing tools as well as instant messaging tool throughout the session.

**Table 2.1**. Category Definitions of Attitudes, Knowledge, Skills and Actions.

<table>
<thead>
<tr>
<th>Category</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Attitudes</strong></td>
<td>Personal characteristics, views and perspectives associated with counseling children</td>
</tr>
<tr>
<td><strong>Knowledge</strong></td>
<td>Specific information, understanding of facts, and memorizations acquired through education and subsequent experience in counseling</td>
</tr>
<tr>
<td><strong>Skills</strong></td>
<td>The learned or innate abilities and techniques a child counselor holds</td>
</tr>
<tr>
<td><strong>Actions</strong></td>
<td>The techniques counselors employ in session and the actions they take both in and out of sessions to best support clients.</td>
</tr>
</tbody>
</table>

**Brainstorming session.** The researcher facilitated discussion during the pilot study’s brainstorming session, beginning with an outline of the meeting's agenda and an overview of the research study. Discussion centered on participants' perceptions of essential attitudes, knowledge, skills, and actions, respectively. The researcher listed the AKSAs identified during the discussion on the whiteboard for all participants to see and verify. Approximately 10 minutes were spent talking about each aspect of counseling children (10 minutes for each category). The
session concluded after a little over one hour of discussion with an open invitation for participants to email further ideas or questions to the researcher. The interview questions and prompts for the brainstorming session appear in Appendix C.

Data analysis. Data analysis was based on the video of the brainstorming session, which uncovered shared characteristics among the research categories. Given guidelines provided by Saldaña (2013), the researcher analyzed the data obtained from the pilot study round of questioning into distinct parts, closely examining them, and comparing them for similarities and differences.

The researcher independently examined the responses of each participant by constant comparison to construct categories based on the similarities within each unit, such as interchangeable words, techniques, attributes, or practices (Saldaña, 2013). Using this method, the researcher systematically examined participants’ responses between cases (i.e., comparing the responses of each participant to those of other participants) to construct similar groups of information, which in the context of this study, were the AKSAs of counseling children. The researcher thus organized and developed responses into four separate lists in each of the four AKSA categories, thereafter, choosing keywords pertaining to specific attitudes, knowledge, skills, and actions to be included in each list.

Phase 1: Pilot Study

As posited by Ziglio (1996), the pilot study (Phase 1) of the Delphi method is crucial for orienting participants to this research process. At the start of the first phase, the researcher invited experts to share their knowledge regarding the AKSAs of counselors who work with children. This phase is typically completed through open-ended questionnaires or discussion groups, the latter of which was chosen for use in the current study (Linstone & Turoff, 2002;
Powell, 2003). Specifically, an online discussion group with seven experts was utilized to allow the counseling experts to brainstorm AKSAs together (Linstone & Turoff, 2002). This phase may not be necessary if there is already enough research to develop the questionnaire without additional input (Linstone & Turoff, 2002). However, a dearth of information about AKSAs specific to counseling children made this phase necessary for this study.

**Questionnaire Development**

The Delphi model allows researchers to utilize a combination of expert panels, previous literature and research to build questionnaires (Hsu & Sandford, 2007; Powell, 2003; Wester & Borders, 2014). This topic of this study has not been well researched or examined, therefore limiting data to guide the questionnaire content. Fortunately, the researcher was able to recruit strong expert participants to establish the questionnaire content. Using the data analysis procedures listed herein, the researcher identified consistencies between the items developed during the brainstorming session. All the keywords were filtered into one list and entered into a single questionnaire in Qualtrics. Care was taken throughout the analysis and questionnaire development process to maintain the language provided by participants whenever possible to retain the intended meaning of their responses. Each item was reworded as an action verb congruent with the overarching research questions guiding the study.

**Phase 2: Main Study**

The main study (Phase 2) required identifying and recruiting additional experts. This group participated in three rounds of data collection. Central tendency and dispersion were determined between each round and the data were used in the questionnaire for Rounds 2 and 3.
Sampling Procedure

The researcher emailed the Counselor Education and Supervision Network Listserv (CESNET). The recruitment email for Phase 2 can be found in Appendix D. Twelve participants signed on within five days of the first email, so the researcher sent another email requesting participants. After that second attempt (the same email template was used), 30 participants consented in total. The consent form for Phase 2 can be found in Appendix E. The email to initiate data collection for Round 1 can be found in Appendix F.

**Round 1.** In order to identify the most robust and essential features of counseling children, the researcher sent an online questionnaire via Qualtrics to the expert panel. Similar to the first round of participants, they were invited via email containing a description of the study and instructions for how to access a link to a Qualtrics consent form and demographics form. Participants completed the questionnaire in addition to the demographics in Qualtrics and the questionnaire included questions about email contact information. Email was used to communicate with participants and provide directions to each subsequent round of the study. Questionnaire responses of others in the study were kept confidential. The questionnaire asked participants to rate the importance of each item for counseling children. A Likert-scale ranging from 1 (not necessary at all) to 7 (extremely necessary) were provided for each item. Participants who completed all rounds of the Phase 2 study were entered into a random drawing to receive one of two Amazon gift cards (50$).

**Round 2.** Participants who responded to Round 1 received an email containing their responses to the Round 1 questionnaire and instructions on how to complete Round 2. This questionnaire was available for one week. Participants were informed that the completion of the questionnaire indicated their consent to participate in the study. The questionnaire again asked
participants to provide contact information for the subsequent round. This questionnaire consisted of only those items for which consensus was not reached during Round 1 or items in which a median of 7 was not reached. Each item included its respective median and interquartile range (IQR) from Round 1. The median and IQR were defined in the questionnaire instructions. Median identifies the middle of the distribution and is thus sensitive to extreme scores. The IQR is calculated by dividing the data into four parts and is defined as the distance between the first and third quartile, providing a measure of dispersion that describes the middle 50% of the scores but is not influenced by extreme scores. The researcher asked participants to re-rate each item, given consideration to the measures of central tendency and dispersion provided as well as their previous responses. In the instructions for completion, the researcher asked participants to provide their reasoning if they chose a rating that is different from the median. An open-ended format for statement of reasoning was included for each item.

**Round 3.** The final round followed the same format and procedures as Round 2. Prior to Round 3, the participants who responded to Round 2 received an email with their responses to Round 2 and instructions on how to access and complete the questionnaire for Round 3 via the Qualtrics platform. The questionnaire remained available for one week and a follow-up reminder was sent after three days. During the third and final round, questionnaires only consisted of the items for which consensus was not reached during the second round. The questionnaire, again, included the same descriptive statistics as in the previous iterations. All participants were given the opportunity to re-rate and comment on their rating of these items, regardless of whether or not they had chosen to rate with the median. Finally, participants were asked to choose the most necessary core competencies of counseling children as defined by the list created by the brainstorming group participants.
Data analysis. The goal of the study was to reach consensus on the perceived importance of the attitudes, knowledge, skills and actions (AKSAs) for child counselors. Therefore, analysis was conducted between each round, and the median and IQR were calculated. Only items with an IQR of greater than 1.0 and a median of less than seven were included in Round 2 and only items with an IQR of greater than 1.0 were included in Round 3. The descriptive statistics and measures of dispersion for each item were reported to the expert panel in Rounds 2 and 3 next to each questionnaire item.

Previous researchers in mental health literature have suggested that items with an IQR of 1.5 or less should be retained (Jorm, 2015; Wester & Borders, 2014). Researchers have also recommended keeping only items with a median rating of 6 or higher on a 1-7 Likert scale (Jorm, 2015; Stone, Fish, & Busby, 2005). Therefore, a conservative IQR of 1.0 or less were considered indicative of consensus. In order for items to be included in the final list of necessary AKSAs, items needed to have a median score of 7. Other items that fell short of the median of 7 were reviewed later in the discussion. Finally, participants were asked to choose the most essential AKSAs of counseling children. Responses were analyzed to determine the percentage of participants who chose each item. A final list of necessary AKSAs were created.

Validity

A separate and distinct section about validity of procedures and methods is often essential in research reports that incorporate mixed methods (Cresswell, 2007). Cresswell and Plano Clark (2007) note that validity is “the ability of the researcher to draw meaningful and accurate conclusions from all of the data in the study” (Creswell & Plano Clark, 2007, p. 146). In this section, the researcher will discuss the strategies to address the potential threats to validity.
**Delphi Method**

The Delphi method bears specific threats to validity that must be considered. Generally, researchers tend to account for threats by recruiting sufficient sample sizes and selecting participants based on justifiable selection criteria (Hasson et al., 2000). The researcher recruited sufficient number of participants and controlled attrition and response rates by thoroughly explaining the time commitment to the experts during the initial email contact. As recommended by Hasson and colleagues (2000), communication with the participants were consistent throughout the process with clear expectations for when responses were due and when the participants could expect the next round. Also, the researcher sent reminder emails to the participants reminding them of the importance of the study and their participation. Additionally, the selection criteria were justified through careful discussion and deliberation with the researcher’s advisor before and during recruitment.

**Qualitative validity.** Validity in mixed methods and qualitative research is commonly known as trustworthiness (Creswell, 2007). There are two main criteria that account for trustworthiness in qualitative research: credibility (or internal consistency) and confirmability (assumption of subjectivity) (Linstone & Turoff, 2002). In this study, the researcher achieved trustworthiness through the iterative process of feedback used in the Delphi method. The surveys allowed members to check and recheck their responses and those of the group. This process of member checking is one of the hallmarks of trustworthiness in Delphi research. In addition to member checks in the main study, the researcher needed to assess personal beliefs regarding child counseling. In the following researcher stance, the researcher discusses beliefs and potential biases regarding this topic.
**Researcher position.** It is important to establish my position as a researcher in this exploratory study as Creswell (2007) stated, “all writing is positioned within a stance (p. 179). My cumulative experiences influence the lens through which I view the topic under study. Outlining my position as researcher represents reflexivity in writing, a practice in which authors acknowledge their position on the topic of investigation and their stance within the research process (Creswell, 2007). It is imperative to recognize one’s own bias and the limitations of one’s actions and contributions to the field. Awareness of subjectivity and positioning forms the foundation of my stance as the principal researcher. All research begins from a starting point that is unique to each investigator (Crotty, 2010). Therefore, it is important to acknowledge my position in the specialty and the vantage point from which this study was conceived.

I am a White American male who is 33 years old. I am roughly 6 feet and 2 inches tall. I weigh around 240 pounds and I typically have a large, thick, red beard. I must consider this physical presentation in the context of counseling children. According to Western cultural norms, I do not look like I should be someone who spends much time with children let alone makes a living out of supporting them emotionally. Even when I was younger and looked less traditionally masculine, I was a large male in a heavily female dominated context when I worked with children. I see this as a reminder of my responsibility in representing what men can do to counter cultural norms.

Traditionally, men are *supposed to* hide emotions and be strict disciplinarians with children. When a child is misbehaving, the common narrative used to be “wait until dad comes home”, as a threat to children to change their behavior or risk punishment when dad sees them. In school contexts, men are more likely to be seen in principal or disciplinary roles than they are to be early childhood teachers. In counseling, there are very few male counselors. I want to
counter all of these harmful stereotypes. I am a highly emotional and nurturing father. I cry in front of my children. I model that I experience strong and deep emotions at times. I sit with my children and let them feel and express their feelings in a safe and calm environment. When children come into my therapy room, I want to provide a space where they can see a large, masculine figure who shows deep empathy, support and calm assurance that their feelings are valid and important.

My ability to connect deeply with children stems from a perceived ability to relate well to them at an early age. I have always connected with the experience of those around me. My first experience using my empathic and personable skills with children came in high school, working as a student teacher. I was assigned to a 6th grade glass (I was in 10th grade), assisting in reading and math classes several days a week. In retrospect, I subsequently realized that those children who, for several reasons, made the strongest impression on me, were likely those with a history of trauma, abuse, or neglect.

I continued to work as a teacher in fulfillment of a college work-study assignment in a preschool, where I continued to meet children who were struggling emotionally, behaviorally, socially and otherwise. This experience reinforced what I perceived as a calling to help children. I come from a loving and supportive large family and I want to be a part of supporting other children like I was throughout my childhood. I decided that being a child and family counselor was an appropriate and well-suited profession.

I pursued studies in clinical mental health counseling at a large university and trained to become a licensed professional counselor. During the didactic portion of the graduate program, I learned about counseling theory, multiculturalism and research methods. I also received clinical training and benefitted from practicum and internship experiences, where I sought out training in
child-centered counseling. Regrettably, these child-focused options proved limited, and clinical experiences were devoted to training as general practitioners (or being able to work with adults).

My stance for this research is that of a skeptic. When other fields allow for deep specialization in working with children (i.e. the medical model and the designation of pediatricians or the psychology model of clinical child and adolescent psychologists), I sometimes doubt that the counseling field will do the same. In terms of licensure, counselors can be licensed clinical addiction specialists (LCAS), which shows potential clients that they are trained to work with substance abuse issues. There is no designated license that identifies a counselor is trained to work with children. Child counselors hold the same title as one who has never treated a child. From a didactic standpoint, child counseling classes are typically seen as electives if they are offered in CACREP accredited programs. Neither is there a CACREP subdivision of counseling children similar to that of school counseling. I believe all of this needs to change, both philosophically, and for the good of the profession.

There needs to be a definition of what constitutes child counseling and what makes it different from other forms of counseling. Child counselors must advocate more strongly for their respective populations to achieve an independent designation and receive more attention in training programs. The most qualified individuals to answer these types of inquiries are the acknowledged experts in this field of child counseling. Thus, the fitting methodology for these inquiries is the exploratory sequential design and the Delphi method.

Other Threats to Validity

Three other threats to validity in this study were selection bias, researcher bias and compensatory rivalry. Given the highly purposeful selection of the participants, this study did not cover the appropriate variety of professionals with expertise in counseling children. To minimize
this threat to validity, the researcher utilized multiple avenues to identify the expert-participants to ensure that the sample met the criteria of an expert as set forth previously in this chapter. These avenues included the member directory of the Association of Child and Adolescent Counseling (ACAC), counselor listservs, literature searches in mental health of child and snowball sampling among initial experts in the field.

Researcher bias presented another potential threat to internal validity. As discussed in the researcher stance, it is acknowledged that personal opinions and bias may affect the feedback provided to expert-participants. This could have unintentionally impacted their responses. The researcher managed this by monitoring the controlled feedback provided to the participants and asking them to address each other rather than engage heavily in an individual dialogue with the researcher during the brainstorming pilot study. The goal was for the data to be derived directly from the participants.

The issue of compensatory rivalry may not be ignored. Creswell (2007) defines compensatory rivalry as the social competition among experts to attempt to reverse or reduce the effects of the desirable treatment levels. Compensatory rivalry is evident by a lack of consensus after several rounds of quantitative data collection. In order to reduce this potential threat, the researcher provided controlled feedback, including exposure to descriptive statistics, and regular reminders to participants of the purpose of the study.

External validity must also be addressed. Delphi studies are at risk of producing reactive effects among participants, which are when contributors know they are taking part in an experiment and react to it in a certain contrary to how they would otherwise react. These reactive effects could potentially include participants’ unwillingness to move toward consensus. To control for this threat, the researcher provided the participants with a thorough explanation of the
purpose of this study. The researcher also emphasized participants’ respective role in reaching consensus at the beginning of the study.

**Phase 1 Pilot Study Results**

The first phase of this study involved an exploration of the issue or topic during which individuals were given the opportunity to contribute their opinions regarding that topic (Linstone & Turoff, 2002). This phase may be completed through open-ended questionnaires or a discussion group (Linstone & Turoff, 2002; Powell, 2003). In this study, an online discussion group with a small number of representative experts from the larger panel was assembled to allow the counseling experts to brainstorm AKSAs together (Linstone & Turoff, 2002).

**Participants**

Seven participants provided input to the pilot study. They were selected based on the fact that they were licensed counselors with at least two years of full-time experience; they worked extensively with children aged 4-12 years, or were counselor educators who taught a Masters level course on child counseling subject matter, or had authored a child counseling book; and they were outpatient, inpatient or school based counselors. Demographic information can be found in Table 3.1.

**Table 3.1. Pilot Study Demographic Data.**

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Value</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Female</td>
<td>7</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-39</td>
<td>3</td>
<td>42.86%</td>
</tr>
<tr>
<td>40-49</td>
<td>2</td>
<td>28.57%</td>
</tr>
<tr>
<td>50-59</td>
<td>2</td>
<td>28.57%</td>
</tr>
</tbody>
</table>
Table 3.1 (continued).

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>White American</td>
<td>4</td>
<td>57.14%</td>
</tr>
<tr>
<td>African American</td>
<td>2</td>
<td>28.57%</td>
</tr>
<tr>
<td>Asian American</td>
<td>1</td>
<td>14.29%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Work Role</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Counselor</td>
<td>2</td>
<td>28.57%</td>
</tr>
<tr>
<td>Counselor Educator</td>
<td>5</td>
<td>71.43%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Years Experience Counseling Children</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>6-10</td>
<td>2</td>
<td>28.57%</td>
</tr>
<tr>
<td>11-15</td>
<td>1</td>
<td>14.29%</td>
</tr>
<tr>
<td>16-20</td>
<td>3</td>
<td>42.86%</td>
</tr>
<tr>
<td>More than 20</td>
<td>1</td>
<td>14.29%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Counseling Licenses Held*</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed Professional Counselor</td>
<td>7</td>
<td>100%</td>
</tr>
<tr>
<td>Registered Play Therapist</td>
<td>6</td>
<td>85.71%</td>
</tr>
<tr>
<td>National Certified Counselor</td>
<td>5</td>
<td>71.42%</td>
</tr>
<tr>
<td>Counselor Supervisor</td>
<td>5</td>
<td>71.42%</td>
</tr>
</tbody>
</table>

*Note: all participants held more than one active license. N = 7

Results. The researcher developed a list for each of the AKSA categories based on the keywords. The number of items that emerged for each dimension ranged from 10 in the actions domain to 26 in the knowledge domain. A total of 77 items was generated from the brainstorming of participants. It is important to note that the researcher did not change the items to match a different category from that in which it was initially reported. For example, if an expert stated that something was a necessary skill, that item was placed in the skill category even if it could be argued that it belonged in a different category.
Table 4.1. Results: Pilot Study Phase 1.

<table>
<thead>
<tr>
<th>Attitudes</th>
<th>Knowledge</th>
<th>Skills</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. It’s important to view presenting issues through client’s perspective</td>
<td>1. Adlerian therapy</td>
<td>1. Play therapy</td>
<td>1. Self-care</td>
</tr>
<tr>
<td>2. Meet children where they are</td>
<td>2. Child-centered therapy</td>
<td>2. Activity therapy (using structured activities)</td>
<td>2. Seek supervision</td>
</tr>
<tr>
<td>3. Everything should be at the child’s level in a room</td>
<td>3. Developmental stage theories (Piaget, Vygotsky, Erikson)</td>
<td>3. Parent consultation</td>
<td>3. Advocate for children’s rights and health</td>
</tr>
<tr>
<td>4. There is meaning in a child’s behavior</td>
<td>4. Bronfenbrenner’s Ecological theory</td>
<td>4. Teacher consultation</td>
<td>4. Educate others about child behaviors and the therapeutic process and play</td>
</tr>
<tr>
<td>5. Behavior is communication</td>
<td>5. Foundations of play therapy</td>
<td>5. Interact with child without infantilization</td>
<td>5. Collaborate with others involved in child’s life (schools, families, doctors, etc.)</td>
</tr>
<tr>
<td>6. Children are more than the products of their behavior</td>
<td>6. Developmental psychology and cognitive development</td>
<td>6. Respect child autonomy and independence</td>
<td>6. Make referrals appropriately</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>7.</td>
<td>Strengths based approaches are better than problem centered ones</td>
<td>7.</td>
<td>Use creativity in counseling (i.e. using music, art, media, etc.)</td>
</tr>
<tr>
<td>8.</td>
<td>We need to see children more holistically</td>
<td>8.</td>
<td>Basic counseling skills</td>
</tr>
<tr>
<td>9.</td>
<td>Children have their own language and we must speak that</td>
<td>9.</td>
<td>Ability to tailor basic skills to be appropriate for children</td>
</tr>
<tr>
<td>10.</td>
<td>Children can have mental health issues and get better</td>
<td>10.</td>
<td>Screen and assess children</td>
</tr>
<tr>
<td>11.</td>
<td>Children are resilient</td>
<td>11.</td>
<td>Atypical child development and risk factors</td>
</tr>
<tr>
<td>12.</td>
<td>Children want to play</td>
<td>12.</td>
<td>Diagnostic systems and developmental psychopathology</td>
</tr>
<tr>
<td>13.</td>
<td>Children are unique and we as therapists can help them get better</td>
<td>13.</td>
<td>Ethical standards relating to children</td>
</tr>
</tbody>
</table>

Table 4.1 (continued).
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>14. Take a nontraditional stance and allow children to express themselves however they feel comfortable</strong></td>
<td><strong>14. The difference between play therapy and free playing</strong></td>
<td><strong>14. Allow a variety of mediums for children to be able to express themselves</strong></td>
</tr>
<tr>
<td><strong>15. You have to like kids</strong></td>
<td><strong>15. Difference between nondirective and directive play therapy</strong></td>
<td><strong>15. Match the developmental needs of a child to a specific intervention</strong></td>
</tr>
<tr>
<td><strong>16. Don’t ask a child to do anything you wouldn’t ask an adult to do</strong></td>
<td><strong>16. Child assessment and treatment planning</strong></td>
<td><strong>16. Educating adults, parents and caregivers on child practices and research</strong></td>
</tr>
<tr>
<td><strong>17. Always be curious about the child and all the things involved in his/her life</strong></td>
<td><strong>17. The intersection of identities in a child’s life</strong></td>
<td><strong>17. Write behavior plans</strong></td>
</tr>
<tr>
<td><strong>18. It’s important to be present and mindful of the child without distractions</strong></td>
<td><strong>18. Basics of family systems and associated theories</strong></td>
<td><strong>18. Read and interpret Individualized Education Plans and evaluations</strong></td>
</tr>
<tr>
<td><strong>19. Kids are embedded in a community and their families</strong></td>
<td><strong>19. How to involve families in child therapy</strong></td>
<td></td>
</tr>
<tr>
<td><strong>20. It is essential to acknowledge and understand a child’s relationships</strong></td>
<td><strong>20. Medical knowledge of child development</strong></td>
<td></td>
</tr>
</tbody>
</table>
Table 4.1 (continued).

| 21. Be warm and open to a child from the beginning | 21. Maternal and paternal mental health |
| 22. Have an “outside the box” attitude | 22. Parenting practices |
| 23. Children are inherently good | 23. Resources in the community for children |
| 24. Evidence based practices for each developmental stage and population | 25. Child behavioral models and theories |
| 26. The DSM-5 sections relating to child diagnoses |

Limitations

The researcher defined study dimensions at the beginning of the brainstorming session. Overlap between the dimensions occurred during the discussion wherein participants provided items that, by definition, may overlap. For example, they identified several knowledge areas when prompted for skills. Providing definitions one at a time may have focused participants’ attention on the dimension being discussed.

Additionally, it was expected that the group would take approximately ten minutes to discuss each of the four aspects of attitudes, knowledge, skills and actions and that the session would proceed in that order. However, the order was changed to fit the flow of the conversation.
and what emerged through the brainstorming. Therefore, the skills domain was discussed last and had less time devoted to it than the others. Additionally, all of the participants were female. This could have resulted in skewed results based on gender identity. Of the 27 individuals who consented in the study, only two were male and none signed up in the Doodle poll. Approximately 73% of counselors are female and 27% are male, but the percentage of child counselors who are female is likely higher (Data USA, 2017). Nonetheless, it would have been more ideal to have a more representative sample with at least one male expert participant.

**Conclusion**

This chapter presented the methodology and procedures of this study, the purpose of which was to develop expert consensus of the attitudes, knowledge, skills and actions (AKSAs) necessary for counseling children. In the previous chapter, the researcher reviewed the literature pertaining to various facets of counseling children as well as how counseling research has included the development of competency systems. These competencies are meant to set a standard for counselors to use in practice. In this chapter, the researcher detailed the plans that were used to conduct a Delphi study to create competencies for child counseling.
CHAPTER IV

RESULTS

The purpose of this Delphi study is to answer the following research questions:

1. What is child counseling?
   
   Research Question A: What attitudes do counselors identify as necessary for themselves as child counselors?
   
   Research Question B: What knowledge bases and understandings do child counselors identify as necessary?
   
   Research Question C: What best practices and skills do child counselors identify as necessary?
   
   Research Question D: What actions do counselors identify as necessary for their role as child counselors?

2. Of the attitudes, knowledge, skills and actions that are identified as necessary, what are the most necessary?

   This chapter will present results of the Phase 2 Main Study, in which a separate, larger sample of counseling experts completed a series of three questionnaires asking them to evaluate the AKSA (attitudes, knowledge, skills and actions) items for child counseling. More specifically, in Phase 2 Round 1, expert participants completed a questionnaire in which they were asked to assess the list of items that were formed from Phase 1. There were over 90 items in that first questionnaire. In Phase 2 Round 2, expert participants were asked to re-evaluate their responses to items upon which consensus was not reached (IQR>1.0), given the median and IQR for each item calculated from Round 1. Participants were asked to provide justification for their response if they rated the item as anything other than the median score from Round 1.
The final section will present the results from Phase 2 Round 3, in which the expert participants were again asked to reconsider their responses to items upon which consensus was not reached, given the median and IQR for each item calculated from Round 2. Participants were asked to provide their justification for their rating regardless of whether or not they scored the item as anything other than the median score from Round 2. To address Research Question 2, participants were presented with the 10 items that had been established as most necessary in Phase 1, and were asked to rank the items 1 through 10.

**Phase 2: Main Study Results**

The main study (Phase 2) was intended to determine the level of participant agreement pertaining to the relevance of the items generated in the brainstorming session (Linstone & Turoff, 1975; Ziglio, 1996). The process required identifying and recruiting additional experts. That sample was over three times that of the group in the Phase 1 pilot study. These participants were active in three rounds of data collection over a period of six weeks. Central tendency and dispersion were determined between each round and the data were used in the questionnaires for Rounds 2 and 3.

**Phase 2 Demographics**

The main study included a larger, more representative sample size ($N=30$) compared to the pilot study ($N=7$). The researcher intended to recruit between 25-30 participants to follow the suggestions of Delphi research (Fish & Busby, 2005). Demographic data was collected at each of the three rounds (Table 5.1). However, there were only differences of 2-3 participants per round which yielded little change in the overall demographic breakdown by each round. Therefore, the table with all participant demographic information are presented for Round 1 but not for Rounds 2 and 3.
Table 5.1. Demographic Information of Main Study Participants.

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Value</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>3</td>
<td>10.71%</td>
</tr>
<tr>
<td>Female</td>
<td>25</td>
<td>89.29%</td>
</tr>
<tr>
<td>Age ($M=40.75$)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-39</td>
<td>16</td>
<td>57.14%</td>
</tr>
<tr>
<td>40-49</td>
<td>7</td>
<td>25.00%</td>
</tr>
<tr>
<td>50-59</td>
<td>5</td>
<td>17.86%</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White American</td>
<td>20</td>
<td>71.43%</td>
</tr>
<tr>
<td>African American</td>
<td>5</td>
<td>17.86%</td>
</tr>
<tr>
<td>Asian American</td>
<td>3</td>
<td>10.71%</td>
</tr>
<tr>
<td>Work Role</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional Counselor</td>
<td>15</td>
<td>53.57%</td>
</tr>
<tr>
<td>Counselor Educator</td>
<td>9</td>
<td>32.14%</td>
</tr>
<tr>
<td>Other (both, school counselor, PhD student)</td>
<td>4</td>
<td>14.29%</td>
</tr>
<tr>
<td>Years Experience Counseling Children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2-5</td>
<td>4</td>
<td>14.29%</td>
</tr>
<tr>
<td>6-10</td>
<td>8</td>
<td>28.57%</td>
</tr>
<tr>
<td>11-15</td>
<td>9</td>
<td>32.14%</td>
</tr>
<tr>
<td>16-20</td>
<td>5</td>
<td>17.86%</td>
</tr>
<tr>
<td>More than 20</td>
<td>2</td>
<td>7.14%</td>
</tr>
<tr>
<td>Counseling Licenses Held</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Licensed Professional Counselor</td>
<td>23</td>
<td>82.14%</td>
</tr>
<tr>
<td>School Counselor</td>
<td>10</td>
<td>35.71%</td>
</tr>
<tr>
<td>Registered Play Therapist</td>
<td>8</td>
<td>28.57%</td>
</tr>
<tr>
<td>National Certified Counselor</td>
<td>11</td>
<td>39.29%</td>
</tr>
<tr>
<td>Counselor Supervisor</td>
<td>8</td>
<td>28.57%</td>
</tr>
<tr>
<td>Practicing Geographic Locations*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>North Carolina</td>
<td>5</td>
<td>17.86%</td>
</tr>
<tr>
<td>Texas</td>
<td>3</td>
<td>10.71%</td>
</tr>
<tr>
<td>Other (ten different US States)*</td>
<td>20</td>
<td>71.43%</td>
</tr>
</tbody>
</table>

Note: all participants held at least one active professional license. $N = 28$

*The following States were reported: WA, TN, FL, SC, MI, LA, IA, IL, KY, GA, VA, PA, DE

Phase 2 Round 1 Results

The Phase 2 Round 1 questionnaire included 77 items addressing the attitudes, knowledge, skills and actions that may be necessary for child counseling (Appendix G). The
questionnaire included demographic questions and involved questions about the necessity of the AKSAs of child counseling on a Likert Scale of 1 (not necessary at all) to 7 (very necessary). Results were compiled into a descriptive analysis table that includes the median and interquartile range (IQR). Consistent with Delphi studies, the median and IQR were utilized to indicate the level of agreement and consensus for each item (Jenkins & Smith, 1994; Stone, Fish & Busby, 2005). The median is essential as it is not affected by extreme scores and it indicates the score that is at the 50th percentile. In the current study, only items with a median score of 7, which indicates that the item is very necessary for child counseling, are included in the final list of necessary attitudes, knowledge, skills and actions. The IQR is calculated as an indication of the variability of the scores and is utilized to establish consensus among a panel of participants. To calculate the IQR, the distribution is divided into four equal parts utilizing quartiles. The IQR is defined as distance between the first and third quartile, providing a measure of dispersion that describes the middle 50% of the scores and is not influenced by extreme scores (Gravetter & Wallnau, 2000). In the current study, scores of 1.0 or less indicate high consensus. Items with a median score of 7 and an IQR of 1.0 or less were not included in the following round and they were included in the final list of necessary attitudes, knowledge, skills and actions.

Of the 32 individuals consented to participate in Phase 2 Round 1, 28 (88%) responded to the first questionnaire. Median scores varied between 5 and 7. IQR scores varied between 0 and 3. Of the 79 items, consensus about essential items (IQR ≤ 1) and a median of 7 was reached for 41 items (51% of all items). The researcher decided to include items that reached consensus (IQR ≤ 1) but had not reached a median of 7 so that participants could have the opportunity to discuss their reasoning for their choice in the next round. Some Delphi studies include eliminating a questionnaire item after the first time a consensus has been reached whereas others
have allowed for items to be included in subsequent rounds if they are close to consensus. Here items were included in subsequent rounds if it reached a median score of 6 or higher even if it had an IQR score of 1 or less. Table 6.1 depicts the total number of items in Round 1 for each AKSA domain.

The last task involved participants reading the top 10 ASKAs developed in the brainstorming session and choose those they found were most necessary. This task was calculated differently because it required participants to list all the items they felt were most necessary. If one of the top 10 options was chosen by fewer than half of participants (>14), the item was discarded. Three items were thus eliminated, including: (a) the Axline principles of play therapy, (b) curiosity and willingness to explore, and (c) know how to play. These three items were replaced with elements that captured the essence of what participants were suggesting to be added in their responses. The items that were added to this question addressed: (a) multicultural competence working with children, (b) passion for children, and (c) knowledge of legal and ethical issues in counseling children. The item receiving the most selections from this round as the most essential ASKA was “authenticity”.

**Table 6.1.** Distribution of Pilot Study Items by Domain

<table>
<thead>
<tr>
<th>Domain</th>
<th>Total # of Items</th>
<th>Total # of Items with Consensus and Median of 7 after Round 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitudes</td>
<td>25</td>
<td>12</td>
</tr>
<tr>
<td>Knowledge</td>
<td>24</td>
<td>9</td>
</tr>
<tr>
<td>Skills</td>
<td>20</td>
<td>11</td>
</tr>
<tr>
<td>Actions</td>
<td>10</td>
<td>9</td>
</tr>
</tbody>
</table>

Table 7.1. Round 1 – Median and IQR for Attitudes, Knowledge, Skills and Actions

Questionnaire Responses

<table>
<thead>
<tr>
<th>Attitudes</th>
<th>Median</th>
<th>IQR</th>
</tr>
</thead>
<tbody>
<tr>
<td>It's important to meet children where they are</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Children's issues are relative and it's important to not diminish their concerns</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Everything needs to be at a child's level in the therapy room</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>There is always meaning in a child's behavior</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>All behavior is communication</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Children are more than the products of their behavior</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>A strengths-based approach is better than a problem centered one</td>
<td>6</td>
<td>1.25</td>
</tr>
<tr>
<td>A children must be viewed holistically</td>
<td>7</td>
<td>0.25</td>
</tr>
<tr>
<td>Children have their own language and we must speak in it with them</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Children can have mental health issues and get better</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Children are resilient</td>
<td>7</td>
<td>0.25</td>
</tr>
<tr>
<td>Children want to play</td>
<td>6.5</td>
<td>1</td>
</tr>
<tr>
<td>Children are unique and we as therapists can help them get better</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>One must take a nontraditional stance and allow children to express themselves however they feel comfortable</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>One must like children</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Never ask a child to do anything you wouldn’t ask an adult to do</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Always be curious about the child and all the things involved in his/her life</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>It's important to be present and mindful with a child without distractions</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Children are embedded in a community and their families</td>
<td>7</td>
<td>0.25</td>
</tr>
<tr>
<td>It is essential to acknowledge and understand a child’s relationships</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Be warm and open to a child from the beginning</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Have an outside the box attitude</td>
<td>6.5</td>
<td>1</td>
</tr>
<tr>
<td>Children are inherently good</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Child counseling is a separate and distinct process from counseling adults</td>
<td>6.5</td>
<td>2</td>
</tr>
</tbody>
</table>
### Table 7.1 (continued).

<table>
<thead>
<tr>
<th>Knowledge</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Adlerian theory and Adlerian counseling</td>
<td>5</td>
<td>1.25</td>
</tr>
<tr>
<td>Child-centered therapy</td>
<td>7</td>
<td>1.25</td>
</tr>
<tr>
<td>Developmental stage theories (Piaget, Vygotsky, Erikson, etc.)</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Bronfenbrenner's Ecological Systems Theory</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Foundations of play therapy</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Developmental psychology</td>
<td>5.5</td>
<td>2</td>
</tr>
<tr>
<td>Cognitive development</td>
<td>6.5</td>
<td>2</td>
</tr>
<tr>
<td>How to understand developmental or clinical theories and teach them to parents</td>
<td>5</td>
<td>1.25</td>
</tr>
<tr>
<td>Attachment theories</td>
<td>7</td>
<td>1.25</td>
</tr>
<tr>
<td>Laws pertaining to children (i.e. child maltreatment, abuse)</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Parental rights in counseling</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Atypical child development and risk factors</td>
<td>7</td>
<td>.25</td>
</tr>
<tr>
<td>Factors of child resilience</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Ethical standards relating to children</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>The difference between play therapy and freplay</td>
<td>7</td>
<td>1.25</td>
</tr>
<tr>
<td>Child assessment and treatment planning</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>The intersection of child identities</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Family systems and associated theories</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>How to involve families generally in child therapy</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Medical knowledge of child development</td>
<td>5.5</td>
<td>2</td>
</tr>
<tr>
<td>Maternal and paternal mental health knowledge</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Parenting practices and models</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Resources in the community for children</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Evidence based practices for each developmental stage and population</td>
<td>6.5</td>
<td>2</td>
</tr>
<tr>
<td>The DSM-5 sections relating to child diagnoses</td>
<td>7</td>
<td>1.25</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Skills</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Conducting play therapy</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Activity therapy (using structured activities)</td>
<td>6</td>
<td>2.25</td>
</tr>
<tr>
<td>Parent consultation</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Teacher/school/other therapist consultation</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>To be able to join in and meet a child where she is without infantilization</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Respect child autonomy and independence</td>
<td>7</td>
<td>.25</td>
</tr>
<tr>
<td>Using creativity in counseling (i.e. using music, art, media, etc)</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Basic counseling skills</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Ability to tailor basic skills to be appropriate for children</td>
<td>7</td>
<td>0</td>
</tr>
</tbody>
</table>
Table 7.1 (continued).

<table>
<thead>
<tr>
<th>Action</th>
<th>Value 1</th>
<th>Value 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening children</td>
<td>6.5</td>
<td>2</td>
</tr>
<tr>
<td>Assessing children</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Developing comprehensive treatment plans</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Writing behavior plans</td>
<td>5</td>
<td>2.25</td>
</tr>
<tr>
<td>Diagnostic systems and developmental psychopathology</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>How to research literature on child counseling and associated issues</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Allow a variety of mediums for children to be able to express themselves</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Match the developmental needs of a child to a specific intervention</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Educating adults, parents and caregivers on child practices and research</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Reading Individualized Education Plans</td>
<td>5.5</td>
<td>1</td>
</tr>
<tr>
<td>Reading psychoeducational evaluations</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td><strong>Actions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-care</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Seeking supervision</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Continuing education and trainings (professional development)</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Advocating for children's rights and health</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Educating others about child behaviors, the therapeutic process and play</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Collaborating with others involved in child’s life (schools, families, doctors, etc.)</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Making referrals appropriately</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Going to court for children when needed</td>
<td>6</td>
<td>2.25</td>
</tr>
<tr>
<td>Empowering others to take a larger support role in child’s life</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Advocate for the legitimacy of child counseling field</td>
<td>7</td>
<td>0.25</td>
</tr>
</tbody>
</table>

The final question from Round 1 asked participants to list any essential competencies that they felt were not listed in the questionnaire. The six items that participants reported in that item and that were included in the Round 2 questionnaire were: (a) process of calling/reporting with child protective services and the department of health and human services, (b) multicultural and social justice concepts (i.e. understanding the role of adultism, racism, classism, etc.), (c) being able to explore questions/issues that adults think children aren't having (e.g., death, sexuality, other hard topics), (d) flexibility in choosing and implementing interventions, (e) Specific
training for counseling children, preferably play therapy, and (f) specific clinical field work (required hours or practice in practicum and internships) with direct interaction with children.

**Phase 2 Round 2 Results**

In Phase 2 Round 2 of the current study, participants re-rated each item in consideration of group assessments from the previous round to further refine the data for consensus (Linstone & Turoff, 1975; Ziglio, 1996). There were 38 items retained in Round 2 with 6 additional items generated from participants in Round 1 ($N=44$). They were asked to re-rate each item based on the same 7-point Likert-type scale (1 = not relevant… 7 = critically relevant), while considering the group ratings provided from the previous round. The same retention thresholds were used in Round 2 (IQR of $<1$ and median of less than 7).

The link to the Qualtrics survey in Round 2 (Appendix I) was sent to the 32 experts who consented to participate in the study. They were told they had one week to complete the survey (the same timeline from the previous round). See Appendix H for the email that was sent to participants. Twenty-six (81%) responded within the time frame allotted in Round 2. In addition, if participants in this round chose to rate items differently from the median score from Round 1, they were asked to provide justification for doing so. Results were compiled into a descriptive analysis table that includes the median and interquartile range. All comments made by the participants can be found in Appendix J.

Of the 44 items, consensus about essential items (IQR $\leq 1$) and a median of 7 was reached for 15 (34% of all items in this round). Differing from the previous round, items in this round with an IQR of 1 or less indicated true consensus and were not included in the next round. Sixteen items were discarded because they reached consensus without a median of 7. These items included: (a) there is always meaning in a child's behavior, (b) children have their own
language and we must speak in it with them, (c) One must take a nontraditional stance and allow children to express themselves however they feel comfortable, (d) have an “outside the box” attitude, (e) developmental psychology, (f) cognitive development, (g) attachment theories, (h) the intersection of child identities, (i) family systems and associated theories, (j) medical knowledge of child development, (k) maternal and paternal mental health knowledge, (l) parenting practices and models, (m) conducting play therapy, (n) teacher/school/other therapist consultation, (o) diagnostic systems and developmental psychopathology; and, (p) reading individualized education plans. There were 13 items that did not reach consensus and were thus included in the final round of the study. Compared to Round 1 in which six new items were suggested by experts, there were no additional items that were not covered up until that point. So, the 13 items from Round 2 were all that carried over to the third round of the study.

The last items of Round 2 involved participants reading the top 10 ASKAs listed in the brainstorming session and choosing the ones they considered most necessary. This group was calculated differently because it required participants to list all the items they felt were most necessary. If one of the top 10 options was chosen by fewer than half of participants (N ≥14), the item was discarded. No items were chosen by fewer than half of participants this round. See Table 8.1 for a description of the total number of items in Round 2 for each AKSA domain.

**Table 8.1. Distribution of Round 2 Items by Domain.**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Total # of Items</th>
<th>Total # of Items with Consensus and Median of 7 after Round 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitudes</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>Knowledge</td>
<td>18</td>
<td>6</td>
</tr>
<tr>
<td>Skills</td>
<td>12</td>
<td>3</td>
</tr>
<tr>
<td>Actions</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

N=44
Table 9.1 Round 2 – Median and IQR for Attitudes, Knowledge, Skills and Actions

Questionnaire Responses.

<table>
<thead>
<tr>
<th>Attitudes</th>
<th>Median</th>
<th>IQR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Everything needs to be at a child's level in the therapy room</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>There is always meaning in a child's behavior</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>A strengths-based approach is better than a problem centered one</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Children have their own language and we must speak in it with them</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Children want to play</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Children are unique and we as therapists can help them get better</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>One must take a nontraditional stance and allow children to express themselves however they feel comfortable</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Never ask a child to do anything you wouldn’t ask an adult to do</td>
<td>6</td>
<td>2.75</td>
</tr>
<tr>
<td>Always be curious about the child and all the things involved in his/her life</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Have an outside the box attitude</td>
<td>6.5</td>
<td>1</td>
</tr>
<tr>
<td>Children are inherently good</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Child counseling is a separate and distinct process from counseling adults</td>
<td>7</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Median</th>
<th>IQR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adlerian theory and Adlerian counseling</td>
<td>4.5</td>
<td>1.75</td>
</tr>
<tr>
<td>Child-centered therapy</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Bronfenbrenner's Ecological Systems Theory</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Foundations of play therapy</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Developmental psychology</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Cognitive development</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>How to understand developmental or clinical theories and teach them to parents</td>
<td>5.5</td>
<td>2</td>
</tr>
<tr>
<td>Attachment theories</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>The difference between play therapy and freeplay</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>The intersection of child identities</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Family systems and associated theories</td>
<td>6</td>
<td>0.75</td>
</tr>
<tr>
<td>Medical knowledge of child development</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Maternal and paternal mental health knowledge</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Parenting practices and models</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Resources in the community for children</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Evidence based practices for each developmental stage and population</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>The DSM-5 sections relating to child diagnoses</td>
<td>7</td>
<td>1</td>
</tr>
</tbody>
</table>
Table 9.1 (continued).

| *Process of calling/reporting with child protective services and the department of health and human services | 7 | 0 |
| *Multicultural and social justice concepts (i.e. understanding the role of adultism, racism, classism, etc) | 7 | 1 |

Skills

| Conducting play therapy | 6.5 | 1 |
| Activity therapy (using structured activities) | 6 | 2 |
| Teacher/school/other therapist consultation | 6.5 | 1 |
| Screening children | 7 | 1.75 |
| Writing behavior plans | 5 | 2 |
| Diagnostic systems and developmental psychopathology | 6 | 1 |
| Educating adults, parents and caregivers on child practices and research | 6 | 2 |

| Reading Individualized Education Plans | 5.5 | 1 |
| Reading psychoeducational evaluations | 6 | 1.5 |
| *Being able to explore questions/issues that adults think children aren't having (e.g., death, sexuality, other hard topics) | 7 | 1 |
| *Flexibility in choosing and implementing interventions | 7 | 1 |
| *Specific training for counseling children, preferably play therapy | 7 | 1 |

Actions

| Going to court for children when needed | 6 | 2 |
| *Specific clinical field work (required hours or practice in practicum and internships) with direct interaction with children | 7 | 0 |

*Denotes new item for this round, \( N=44 \)

**Phase 2 Round 3 Results**

In the final phase of the current study, participants re-rated each item in consideration of group ratings from the previous round to further refine the data for consensus (Linstone & Turoff, 1975; Ziglio, 1996). Thirteen items were retained for this round with a final task being the ranking of the most important AKSAs. Please see Appendix K for the final email sent to participants instructing them to complete the final questionnaire.

The link to the questionnaire (Appendix L) was sent to the 32 experts who consented to participate in the study. They were told they had 12 days to complete the final survey to account for a holiday period (Independence Day). Twenty-five participants responded for a response rate
of 78%. Additionally, if participants in this round chose to rate items differently from the median score from Round 1, they were asked to provide their justification for their rating. Results were compiled into a descriptive analysis table with the median and interquartile range. All comments made by the participants can be found in Appendix M. One item was changed based on comments made from Round 2. Item number 25 initially read “Never ask a child to do anything you wouldn’t ask an adult to do” but was changed to “Do not expect a child to act the same as an adult in the therapy room”.

Of the 13 items in Round 3, consensus about essential items (IQR \leq 1) and a median of 7 was reached for 1 item which read: do not expect a child to act the same as an adult in the therapy room. Consensus (IQR \leq 1) was reached on the following six items (46% of items this round) but they did not reach the essential item threshold (median of 7) specifically: (a) everything needs to be at the child’s level in the therapy room; (b) a strengths based approach is more appropriate than a problem centered one; (c) Adlerian therapy and Adlerian counseling; (d) Bronfenbrenner's Ecological Systems Theory; (e) how to understand developmental or clinical theories and teach them to parents; and (f) reading psychoeducational evaluations.

There were six items which did not reach consensus at the conclusion of the study, all with an IQR of 2. Four items had a median of 6: (a) activity therapy; (b) screening children; (c) educating adults, parents and caregivers on child practices and research; and (e) going to court when needed. Two items had medians of 5 and represented the lowest rated items of the final questionnaire: (a) writing behavior plans and (b) reading psychoeducational evaluations. See Table 10.1 and Table 10.2 for a breakdown of the results of the final round questionnaire.
Table 10.1 Distribution of Round 3 Items by Domain.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Total # of Items</th>
<th>Total # of Items with Consensus and Median of 7 after Round 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitudes</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Knowledge</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Skills</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Actions</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

N=13

Table 10.2 Round 3 – Median and IQR for Attitudes, Knowledge, Skills and Actions

Questionnaire Responses.

Please indicate on a scale of 1 (not necessary at all) to 7 (very necessary), how necessary you believe each item is for individuals serving in child counseling roles.

<table>
<thead>
<tr>
<th>Attitudes</th>
<th>Median</th>
<th>IQR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Everything needs to be at a child's level in the therapy room</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>A strengths-based approach is better than a problem centered one</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Do not expect a child to act the same as an adult in the therapy room</td>
<td>7</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Median</th>
<th>IQR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adlerian theory and Adlerian counseling</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Bronfenbrenner's Ecological Systems Theory</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>How to understand developmental or clinical theories and teach them to parents</td>
<td>5.5</td>
<td>2</td>
</tr>
<tr>
<td>Evidence based practices for each developmental stage and population</td>
<td>6</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Skills</th>
<th>Median</th>
<th>IQR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity therapy (using structured activities)</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Screening children</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Writing behavior plans</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Educating adults, parents and caregivers on child practices and research</td>
<td>6</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Actions</th>
<th>Median</th>
<th>IQR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reading Individualized Education Plans</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Going to court for children when needed</td>
<td>6</td>
<td>2</td>
</tr>
</tbody>
</table>
Twenty-four participants responded to the item addressing the most essential AKSAs of child counseling. The researcher changed the format from “choose all that apply” to one that required participants to rank order items 1-10, where 1 represented the most essential AKSA. Six different items received a number 1 rating: passion for children (ranked 1st by 45%); knowledge of legal and ethical issues with counseling children (ranked 1st by 17%); authenticity (ranked 1st by 13%); Rogerian core conditions of congruence, empathy, and nonjudgment (ranked 1st by 13%); speaking the language of the child (ranked 1st by 8%); and, multicultural competence with children (ranked 1st by 4%). See Table 11.1 for a breakdown of how each item was ranked with descriptive statistics for each.

**Table 11.1 Most Essential Attitudes, Knowledge, Skills and Actions After Final Round.**

<table>
<thead>
<tr>
<th>Of the attitudes, knowledge, skills and actions that are identified as necessary, what are the MOST necessary?</th>
<th>#1 Rankings</th>
<th>M</th>
<th>Median</th>
<th>IQR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Passion for children</td>
<td>11(45%)</td>
<td>2.5</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Authenticity</td>
<td>3(13%)</td>
<td>4.2</td>
<td>4</td>
<td>3.5</td>
</tr>
<tr>
<td>Evidenced-based treatments for presenting problems and how these models can be adapted for children</td>
<td>0</td>
<td>7.5</td>
<td>8</td>
<td>4.25</td>
</tr>
<tr>
<td>Advocating for children</td>
<td>0</td>
<td>6.4</td>
<td>7</td>
<td>4.25</td>
</tr>
<tr>
<td>Self-reflection</td>
<td>0</td>
<td>7.1</td>
<td>7.5</td>
<td>3</td>
</tr>
<tr>
<td>Speaking the language of the child</td>
<td>2(8%)</td>
<td>5</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Multicultural competence with children</td>
<td>1(4%)</td>
<td>6.6</td>
<td>6.5</td>
<td>2.25</td>
</tr>
<tr>
<td>Meeting children where they are at with flexibility and creativity</td>
<td>0</td>
<td>5</td>
<td>4.5</td>
<td>3.25</td>
</tr>
<tr>
<td>Rogerian core conditions of congruence, empathy, and nonjudgment</td>
<td>3(13%)</td>
<td>5.2</td>
<td>4</td>
<td>4.25</td>
</tr>
<tr>
<td>Knowledge of legal and ethical issues with counseling children</td>
<td>4(17%)</td>
<td>5.5</td>
<td>6</td>
<td>6.25</td>
</tr>
</tbody>
</table>

1=Most necessary and 10=least necessary, N=24
Conclusion

This chapter provided a summary of the four points of data collection in the current study specifically: the pilot study and three rounds of questionnaire administration to expert participants. The results were presented as they emerged from the iterative questioning process of the classical Delphi method (Linstone & Turoff, 1975; Ziglio, 1996). The overarching research question guiding this study was: what exactly is child counseling? The final list of items generated by the expert participants selected for this study is one way of answering the overarching research questions. Recommendations of how these items can guide training and licensure of child counselors are described in the discussion. The next chapter provides an overview of the results and discussion of the application of them to the field of child counseling, as well as implications, limitations, and future directions for the study.

The pilot study involved a brainstorming session with seven expert participants generating statements about the uniqueness of child counseling. A questionnaire was formed from the pilot about necessary child counseling attitudes, knowledge, skills and actions. The original questionnaire contained 79 items. Seven additional items were created based on suggestions and comments from participants totaling 86 items to be examined by participants via questionnaires. Of those 86 items, consensus agreement was reached on 78 (90.70%) items. One item was changed due to confusion and comments about the wording. No items had a median rating below 5. Total consensus was reached on 58 items with a median rating of 7, resulting in those items being included in the final list of competencies. Although no item emerged as the unanimous most necessary from the final list of 10 most necessary AKSAs, descriptive statistics showed strong evidence to suggest that title could belong to the items about passion for children...
and knowledge of legal and ethical issues with counseling children. Additional investigation into the most necessary attitudes, knowledge, skills and actions of child counseling is needed.
CHAPTER V

DISCUSSION

The purpose of the study is to establish standards and competencies for counseling children using the Delphi process. In this chapter, the researcher examines the findings more broadly and in the context of the professional literature. The researcher then discusses the limitations of the study, its implications for child counselors, and directions for future research.

Overview of the Study

This study is about the question: what is child counseling? Counseling children is different and distinct from counseling adults. Although counseling literature provides a solid base of information defining the features of child counseling with a variety of modalities, interventions and settings, (e.g., Baggerly, Ray & Bratton, 2010; Smith-Adcock & Tucker, 2016; VanFleet, Sywulak & Sniscak, 2011), little has been discussed about the defining features or standards of child counseling itself. The purpose of this study was to elicit information from a panel of experts in the field of child counseling to speak to their understanding of the attitudes, knowledge, skills and actions (AKSAs) involved in child counseling. The resulting AKSAs provide a set of competencies for child counselors to refer and assess their professional skills. Additionally, these competencies provide data from which to justify grounds to establish training requirements for child counselors and implications for creating a separate and distinct license in child counseling.

The brainstorming pilot study round of the study provided 79 total competencies across the four AKSA domains. The researcher employed a constant comparative method to analyze the pilot study to better understand the information developed (Creswell, 2007; Merriam, 1998).
Although each participant’s list of competencies was unique to the individual, the data as a whole achieved saturation after a little over an hour of brainstorming as a group.

The second phase of the study involved recruiting an additional group of experts who were provided a series of questionnaires based on the items generated in the first phase (pilot) study. Saturation of data was achieved after three rounds and consensus was reached on most of the items.

**Summary of Findings**

From the original 79 items, consensus was reached on all by 7 items (9% of original items included). There were 57 items that reached consensus and a median rating of 7 (Table 13.1).

**Table 13.1** Round 3 – Final Results Summary of Items Identified as Very Necessary.

<table>
<thead>
<tr>
<th>Attitudes</th>
<th>Median</th>
<th>IQR</th>
<th>Rounds Required for Consensus</th>
</tr>
</thead>
<tbody>
<tr>
<td>It's important to meet children where they are</td>
<td>7</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Children's issues are relative and it's important to not diminish their concerns</td>
<td>7</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>All behavior is communication</td>
<td>7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Children are more than the products of their behavior</td>
<td>7</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>A child must be viewed holistically</td>
<td>7</td>
<td>.25</td>
<td>1</td>
</tr>
<tr>
<td>Children can have mental health issues and get better</td>
<td>7</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Children are resilient</td>
<td>7</td>
<td>.25</td>
<td>1</td>
</tr>
<tr>
<td>One must like children</td>
<td>7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>It’s important to be present and mindful with a child without distractions</td>
<td>7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Children are embedded in a community and their families</td>
<td>7</td>
<td>.25</td>
<td>1</td>
</tr>
<tr>
<td>It is essential to acknowledge and understand a child’s relationships</td>
<td>7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Be warm and open to a child from the beginning</td>
<td>7</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Do not expect a child to act the same as an adult in the therapy room</td>
<td>7</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Children want to play</td>
<td>7</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
Table 13.1 (continued).

<table>
<thead>
<tr>
<th>Skill / Knowledge Area</th>
<th>7</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children are unique and we as therapists can help them get better</td>
<td>7</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Always be curious about the child and all the things involved in his/her life</td>
<td>7</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Children are inherently good</td>
<td>7</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Child counseling is a separate and distinct process from counseling adults</td>
<td>7</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Knowledge</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developmental stage theories (Piaget, Vygotsky, Erikson, etc.)</td>
<td>7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Laws pertaining to children (i.e. child maltreatment, abuse)</td>
<td>7</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Parental rights in counseling</td>
<td>7</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Atypical child development and risk factors</td>
<td>7</td>
<td>.25</td>
<td>1</td>
</tr>
<tr>
<td>Factors of child resilience</td>
<td>7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Ethical standards relating to children</td>
<td>7</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Child assessment and treatment planning</td>
<td>7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>How to involve families generally in child therapy</td>
<td>7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Process of calling/reporting with child protective services and the department of health and human services</td>
<td>7</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Multicultural and social justice concepts (i.e. understanding the role of adultism, racism, classism, etc)</td>
<td>7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Child-centered therapy</td>
<td>7</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Foundations of play therapy</td>
<td>7</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>The difference between play therapy and freeplay</td>
<td>7</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Resources in the community for children</td>
<td>7</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>The DSM-5 sections relating to child diagnoses</td>
<td>7</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Skills</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent consultation</td>
<td>7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>To be able to join in and meet a child where she is without infantilization</td>
<td>7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Respect child autonomy and independence</td>
<td>7</td>
<td>.25</td>
<td>1</td>
</tr>
<tr>
<td>Using creativity in counseling (i.e. using music, art, media, etc)</td>
<td>7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Basic counseling skills</td>
<td>7</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Ability to tailor basic skills to be appropriate for children</td>
<td>7</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Assessing children</td>
<td>7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Developing comprehensive treatment plans</td>
<td>7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>How to research literature on child counseling and associated issues</td>
<td>7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Allow a variety of mediums for children to be able to express themselves</td>
<td>7</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
Table 13.1 (continued).

<table>
<thead>
<tr>
<th>Action</th>
<th>Score</th>
<th>Frequency</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Match the developmental needs of a child to a specific intervention</td>
<td>7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Being able to explore questions/issues that adults think children aren't having (e.g., death, sexuality, other hard topics)</td>
<td>7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Flexibility in choosing and implementing interventions</td>
<td>7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Specific training for counseling children, preferably play therapy</td>
<td>7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Actions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-care</td>
<td>7</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Seeking supervision</td>
<td>7</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Continuing education and trainings (professional development)</td>
<td>7</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Advocating for children's rights and health</td>
<td>7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Educating others about child behaviors, the therapeutic process and play</td>
<td>7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Collaborating with others involved in child’s life (schools, families, doctors, etc.)</td>
<td>7</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Making referrals appropriately</td>
<td>7</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Empowering others to take a larger support role in child’s life</td>
<td>7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Advocate for the legitimacy of child counseling field</td>
<td>7</td>
<td>0.25</td>
<td>1</td>
</tr>
<tr>
<td>Specific clinical field work (required hours or practice in practicum and internships) with direct interaction with children</td>
<td>7</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

N=57 items

Figure 3.1 depicts the final child counseling competencies generated from the current study. Items were condensed in the interest of brevity for the final model (e.g., “Being able to explore questions/issues that adults think children aren't having (e.g., death, sexuality, other hard topics)” was condensed to be “Explore difficult and existential questions/issues”.)
Figure 3.1. Necessary Attitudes, Knowledge, Skills and Actions.
<table>
<thead>
<tr>
<th>Attitudes</th>
<th>Knowledge</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Meet children where they are</td>
<td>- Developmental stage theories</td>
</tr>
<tr>
<td>- Children's issues are relative</td>
<td>- Laws pertaining to children</td>
</tr>
<tr>
<td>- All behavior is communication</td>
<td>- Parental rights in counseling</td>
</tr>
<tr>
<td>- Children are more than the products of their behavior</td>
<td>- Atypical child development and risk factors</td>
</tr>
<tr>
<td>- A child must be viewed holistically</td>
<td>- Factors of child resilience</td>
</tr>
<tr>
<td>- Children can have mental health issues and get better</td>
<td>- Ethical standards relating to children</td>
</tr>
<tr>
<td>- Children are resilient</td>
<td>- Child assessment and treatment planning</td>
</tr>
<tr>
<td>- One must like children</td>
<td>- How to involve families generally in child therapy</td>
</tr>
<tr>
<td>- Children are embedded in a community</td>
<td>- Resources in the community for children</td>
</tr>
<tr>
<td>- Acknowledging and understanding a child’s relationships is key</td>
<td>- Process of calling/reporting abuse &amp; neglect</td>
</tr>
<tr>
<td>- Do not expect a children to act the same as adults</td>
<td>- Multicultural and social justice concepts</td>
</tr>
<tr>
<td>- Children want to play</td>
<td>- Child-centered therapy</td>
</tr>
<tr>
<td>- Children are unique</td>
<td>- Foundations of play therapy</td>
</tr>
<tr>
<td>- Always be curious about the child</td>
<td>- The difference between play therapy and free play</td>
</tr>
<tr>
<td>- Children are inherently good</td>
<td>- The DSM-5 sections relating to child diagnoses</td>
</tr>
<tr>
<td>- Child counseling is a separate and distinct process from counseling</td>
<td></td>
</tr>
<tr>
<td>adults</td>
<td></td>
</tr>
<tr>
<td>Skills</td>
<td>Actions</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>- Basic counseling skills</td>
<td>- Self-care</td>
</tr>
<tr>
<td>- Tailoring basic skills to be appropriate for children</td>
<td>- Seek supervision</td>
</tr>
<tr>
<td>- Parent consultation</td>
<td>- Continuing education and trainings</td>
</tr>
<tr>
<td>- Joining in and meet a child</td>
<td>- Advocating for children's rights and health</td>
</tr>
<tr>
<td>- Respecting child autonomy and independence</td>
<td>- Educating others about child behaviors, the therapeutic process and play</td>
</tr>
<tr>
<td>- Using creativity in counseling</td>
<td>- Collaborating with others involved in child’s life</td>
</tr>
<tr>
<td>- Assessing children</td>
<td>- Making referrals appropriately</td>
</tr>
<tr>
<td>- Developing comprehensive treatment plans</td>
<td>- Empowering others to take a larger support role in child’s life</td>
</tr>
<tr>
<td>- Researching literature on child counseling</td>
<td>- Advocate for the legitimacy of child counseling field</td>
</tr>
<tr>
<td>- Allowing a variety of mediums for child expression</td>
<td>- Specific clinical field work with direct interaction with children</td>
</tr>
<tr>
<td>- Matching developmental needs of a child to specific intervention</td>
<td>- Be warm and open to a child</td>
</tr>
<tr>
<td>- Flexibility in choosing and implementing interventions</td>
<td>- Be present and mindful with a child</td>
</tr>
<tr>
<td>- Exploring difficult and existential questions/issues</td>
<td></td>
</tr>
<tr>
<td>- Having specific training for counseling children</td>
<td></td>
</tr>
</tbody>
</table>
The final figure depicts the most essential AKSAs (competencies) identified by participants. Although they were ranked in the study questionnaires, data analysis revealed there was several different means by which the researcher could rank the results (e.g., by mean scores, medians, percentage who chose items as number 1, etc.). Therefore, the figure was designed to be nonhierarchical. These items received a 50% or higher rating by participants in Phase 2 of the study. Items that did not reach 50% were not included in this final figure for the most essential competencies of child counseling.

**Figure 4.1.** Most Essential Competencies of Child Counseling.

**Findings by Research Question**

Five research questions were addressed in this study about defining the child counseling profession. Four of these questions addressed attitudes, knowledge, skills and actions of child counseling. The final research question addressed the most necessary competencies overall. Results of this study are discussed in the context of each research question following those
represented in Figures 4 and 5. The findings are presented along with a description of how they apply to established research and literature.

**RQ 1a: What attitudes do counselors identify as necessary for themselves as child counselors?** The expert participants in the study identified 18 different attitudes as very necessary in child counseling (Figure 3). They are: (1) meet children where they are; (2) children's issues are relative; (3) all behavior is communication; (4) children are more than the products of their behavior; (5) a child must be viewed holistically; (6) children can have mental health issues and get better; (7) children are resilient; (8) one must like children; (9) be present and mindful with a child; (10) children are embedded in a community; (11) acknowledging and understanding a child’s relationships is key; (12) be warm and open to a child; (13) do not expect a children to act the same as adults; (14) children want to play; (15) children are unique; (16) always be curious about the child; (17) children are inherently good; and, (18) child counseling is a separate and distinct process from counseling adults.

Items 9 and 12 may be more accurately identified as actions and so were moved to the actions category for the final model (Figure 3). Item 3, about behavior being communication, is congruent with literature on behavioral psychology and behavior therapy (Skinner, 1974; Wyatt, Hawkins & Davis, 1986). Items 4, 5, 10 and 11 are a direct contradiction to traditional behavioral models and are more representative of theories such as Ecological Systems Theory (Bronfenbrenner, 1986) or Bandura’s Social Learning Theory (Bandura, 1971). Items 6 and 7 are related to attitudes about child resilience, an idea present in counseling literature more broadly (Smith-Adcock & Tucker, 2016). The remaining items (8, 9 and 12-18) relate strongly to counseling literature on child-centered therapy and Rogerian counseling (Baggerly, Ray &
Bratton, 2010; Cain, 2010; Rogers, 1979; VanFleet, Sywulak & Sniscak, 2011). The two main themes that cover the majority of attitudes expressed in the attitude domain are child-centered and systemic.

**RQ 1b: What knowledge bases and understandings do child counselors identify as necessary?** The expert participants identified 15 different knowledge areas essential for child counseling (Figure 3). They are: (1) developmental stage theories; (2) laws pertaining to children; (3) parental rights in counseling; (4) atypical child development and risk factors; (5) factors of child resilience; (6) ethical standards relating to children; (7) child assessment and treatment planning; (8) how to involve families generally in child therapy; (9) resources in the community for children; (10) process of calling/reporting abuse & neglect; (11) multicultural and social justice concepts; (12) child-centered therapy; (13) foundations of play therapy; (14) the difference between play therapy and free play; and, (15) the DSM-5 sections relating to child diagnoses.

Items 1 and 4 involved stage related theories of child development (Erikson, 1963; Piaget, 1936). Items 2, 3, 6 and 10 address legal and ethical aspects of counseling children (Lawrence & Kurpius, 2000; Remley & Herlihy, 2014; Sileo & Kopala, 1993; Wheeler & Bertram, 2015). Item number 5 is related to factors of child resilience, which is presented more broadly in child counseling textbooks and literature (Masten & Reed, 2002). Items 7 and 15 are related to child assessment and treatment planning (Greenspan & Wieder, 2006; Vernon & Clemente, 2005). Items 8 and 9 acknowledge systems theories (Bowen, 1961; Bronfenbrenner, 1986). Item 11 addresses counseling literature on multiculturalism and social justice (Ratts, Singh, Nassar-McMillan, Butler & McCullough, 2015; Sue, Arredondo & McDavis, 1992). However, very little research has been conducted that highlights the intersection of multicultural
counseling and child counseling. Lastly, items 12-14 relate to counseling literature on child-centered therapy and Rogerian counseling (Baggerly, Ray & Bratton, 2010; Cain, 2010; Rogers, 1979; VanFleet, Sywulak & Sniscak, 2011).

The overall themes of the knowledge domain in child counseling are: (a) stage theories; (b) legal and ethical; (c) resiliency; (d) assessment and treatment planning; (e) systems theories; (f) multiculturalism and social justice; and, (g) child-centered therapy.

RQ 1c: What best practices and skills do child counselors identify as necessary? The expert participants identified 14 essential child counseling skills. These skills are: (1) basic counseling skills; (2) tailoring basic skills to be appropriate for children; (3) parent consultation; (4) joining in and meet a child; (5) respecting child autonomy and independence; (6) using creativity in counseling; (7) assessing children; (8) developing comprehensive treatment plans; (9) researching literature on child counseling; (10) allowing a variety of mediums for child expression; (11) matching developmental needs of a child to specific intervention; (12) flexibility in choosing and implementing interventions; (13) exploring difficult and existential questions/issues; and, (14) having specific training for counseling children.

Items 1 and 2 describe counseling literature addressing basic helping skills (Ivey, Ivey & Zalaquett, 2013) and helping skills with children (Velsor, 2004). Item 3 acknowledges systems theories (Bowen, 1961; Bronfenbrenner, 1986). Item 4 is another item stemming from child-centered therapy concepts (Baggerly, Ray & Bratton, 2010; Cain, 2010; Rogers, 1979; VanFleet, Sywulak & Sniscak, 2011). Items 6 and 10 were not unique items about using creativity in counseling and relate to counseling literature by Gladding (2011) and others (Desmond, Kindsvatter, Stahl & Smith, 2015; Rosen & Atkins, 2014). Items 7 and 8 are related to child assessment and treatment planning (Greenspan & Wieder, 2006; Vernon & Clemente, 2005).
Items 9, 11, 12 and 14 describe research and evidence based clinical interventions and trainings in child counseling. This topic is discussed in a variety of counseling literature, especially in the *Journal of Child and Adolescent Counseling (JCAC)*. Lastly, items 5 and 13 are uniquely about child autonomy and existentialism in child counseling. Scalzo (2018) discusses using existential therapy with children and builds upon the notion in counseling textbooks that children must be allowed to discuss difficult questions about life’s meaning in a counseling domain (Smith-Adcock & Tucker, 2016). Several overall themes appeared in the skills domain of the competency model, including basic helping skills, systems theories and child-centered therapy concepts, but the one with the most items represented was evidence-based practice.

*RQ1d: What actions do counselors identify as necessary for their role as child counselors?* Participants identified 10 actions essential in child counseling. They are: (1) self-care; (2) seeking supervision; (3) continuing education and trainings; (4) advocating for children's rights and health; (5) educating others about child behaviors, the therapeutic process and play; (6) collaborating with others involved in child’s life; (7) making referrals appropriately; (8) empowering others to take a larger support role in child’s life; (9) advocate for the legitimacy of child counseling field; and, (10) specific clinical field work with direct interaction with children.

Item 1 was about self-care and self-reflection and was unanimously chosen as essential by pilot study participants. This notion resonates with literature on the importance of self-care in counseling (Richards, Campenni & Muse-Burke, 2010; Skovholt & Trotter-Mathison, 2014). Item 2 was about the importance of seeking supervision and is often mentioned as essential to child counseling (Velsor, 2014). Items 3 and 10 again point to the use of evidence-based practice in child counseling. Items 4, 7, 8 and 9 relate to advocacy and rights in child counseling (Mellin,
 Items 5 and 6 were about collaborating and connecting with other professionals, a notion highlighted as an important piece of counseling children by some of the more recent literature (Cook-Cotton & Anderson, 2019). The overall themes of the actions domain in this study are self-care, evidence-based practice and advocacy.

RQ2: Of the attitudes, knowledge, skills and actions that are identified as necessary, what are the most necessary? The experts identified the ten most essential competencies in child counseling and they were the following: (1) passion for children; (2) authenticity; (3) advocating for children; (4) evidence-based treatment; (5) knowledge of legal and ethical issues in counseling children; (6) congruence, empathy and nonjudgment; (7) meeting children where they are; (8) multicultural competence with children; (9) speaking the language of the child; and, (10) self-reflection. All of these competencies were highlighted or used directly as items in at least one of the AKSA domains of child counseling, with the exception of the item about evidence-based practice. This item is discussed later.

Competency Themes

The researcher added a layer of analysis to the final competencies and condensed the final competencies using thematic analysis (Braun and Clarke, 2006). Competency items were aggregated and analyzed by research question. They were coded independently and initial codes were created based on the frequency of competencies sharing a common attribute. The codes were then synthesized into themes and subthemes based on their relatability. For example, the items “meet children where they are” and “be warm and open with a child” were categorized as child-centered therapy concepts. See Figure 5.1 for an illustration of all the overall themes of the ASKA domains.
Figure 5.1. AKSA Domain Themes

<table>
<thead>
<tr>
<th>Attitudes</th>
<th>Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systems mindset</td>
<td>Basic helping skills</td>
</tr>
<tr>
<td>Child-centered therapy concepts</td>
<td>Using systems theories</td>
</tr>
<tr>
<td></td>
<td>Child-centered therapy concepts</td>
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<tr>
<td></td>
<td>Creativity</td>
</tr>
<tr>
<td></td>
<td>Assessment and treatment planning</td>
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<tr>
<td></td>
<td>Evidence based practice</td>
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<td></td>
<td>Child autonomy</td>
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</table>

Knowledge

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage theories</td>
<td>Self-care and reflection</td>
</tr>
<tr>
<td>Legal and ethical</td>
<td>Supervision</td>
</tr>
<tr>
<td>Resiliency</td>
<td>Evidence based practice</td>
</tr>
<tr>
<td>Assessment and treatment planning</td>
<td>Advocacy</td>
</tr>
<tr>
<td>Systems theories</td>
<td>Collaboration and connection</td>
</tr>
<tr>
<td>Multiculturalism and social justice</td>
<td></td>
</tr>
<tr>
<td>Child-centered therapy concepts</td>
<td></td>
</tr>
</tbody>
</table>

Items for Which Consensus Was Not Reached

There were 7 items in this study for which consensus was not reached. Two were in the knowledge domain: (1) how to understand developmental or clinical theories and teach them to parents; and, (2) evidence-based practices for each developmental stage and population. The researcher believes that these items did not reach consensus because of their word structure and not their content, because both developmental theories and evidence-based practices are identified as essential competencies elsewhere in the study but in different wording (“matching developmental needs of a child to a specific intervention”). However, given the importance of evidence-based practice in the counseling field, more discussion of this finding is warranted.

The American Psychological Association (2005) and the Society of Clinical Child and Adolescent Psychology (McCauley, 2007) have highlighted the need to improve efforts to design, evaluate and implement evidence-based practice (EBP) in the prevention, assessment, and treatment of child and adolescent mental health (James & Roberts, 2009). A Delphi study in
the *Journal of Clinical Psychology* found that EBP received the greatest consensus by doctoral participants ($N = 45$) regarding the future directions in the field of child and adolescent psychology (James & Roberts, 2009). Given the strong emphasis on EBP in the field of psychology, it was expected that all items related to EBP would be highly ranked. Yet out of over 70 initial items in the study, the item specifically naming EBP did not reach consensus. This could indicate an important overarching result of this study. Namely, child counseling clinicians did not receive training in evidence-based practices and interventions with children and are unsure of how much they are using them in practice. Thus, in this study about essential competencies of their careers, they did not agree that it was essential to use EBP. If evidence-based practice was taught and trained more in a counseling program, then child counselors may be more likely to state that EBP is a core child counseling competency.

There were four items in the skill domain that did not reach consensus: (1) activity therapy, (2) screening children, (3) writing behavior plans and (4) educating adults, parents and caregivers on child practices and research. Activity therapy is a controversial topic in child counseling as it is occasionally confused for structured activities. It involves playing common games (e.g. Jenga) and engaging in therapeutic dialogue. Its purpose is to distract children while they talk in a less formal atmosphere than an individual adult therapy session. However, expert participants did not agree that this was an essential component of child counseling. Instead, they tended to favor more child-centered approaches. The researcher was surprised to note that screening children was not included in the final consensus, as screening and assessment typically are grouped together, and assessment was included in the final model. It is possible that screening children is a vague topic to participants, and they had different understandings of what it involved. The lack of interest in educating adults and parents on research was not surprising
because participants were divided on those who valued research and dissemination of
information and those who felt it was not the child counselor’s job to “teach” materials to adults.
The item about writing behavior plans was also controversial because the participant views on
the role of behaviorism in counseling tended to be divided.

There was one item in the action domain that did not reach consensus, concerning going
to court for children when needed. Counselor involvement in court is a highly charged topic as
many counselors feel pressured in this setting. Additionally, there is little training for counselors
to go to court as professionals for any reason (e.g. expert testimony, custody hearings, explaining
records, etc.). Many counselors avoid going to court unless they are ordered to do so. Thus, it
was expected that this item would involve a wider range of responses as some counselors view
going to court as an essential part of advocacy whereas others tend to avoid it.

Items with Strong Comments

Participants were instructed to submit comments about their choices during the second
and third rounds of the main study. Some comments were intended to clarify a participant’s
rating (i.e. “I believe this is usually true”) whereas others indicated stronger views. These items
will be discussed here.

The item in the attitude domain about “everything needs to be a child’s level in the
therapy room” was discarded because several participants objected to its ambiguity. They stated
“I’m not sure if you mean physical eye line….” and “due to size of rooms etc. at times things are
higher than child’s eye level” and “I enjoy inviting kids to explore things on all levels”. Another
attitude item, “children have their own language and we must speak in it with them” was
considered inapplicable to all children. The item “never ask a child to do anything you wouldn’t
ask an adult to do” was also changed because participants claimed it was too vague. One
participant wrote “this statement is unclear as I’m not sure if you mean in a developmental context or not…seems like there is a statement under this that is convoluted”. So, this item was reworded to “do not expect a child to act the same as an adult in the therapy room”, upon which gained consensus in the next round.

There were several items in the knowledge domain where participants claimed unfamiliarly with the theory/item. One participant wrote of the Bronfenbrenner’s Ecological Systems item; “I don’t even know what that is!”. Others disagreed about a knowledge base, as one participant wrote “not all will use play therapy”. Others wrote about play therapy, one stating “I think play therapy is helpful but not necessary”. Although play therapy methods were mentioned in the knowledge and skill domains, participants eventually agreed that play therapy training and knowledge is nonessential to child counseling. However, items that underpin play therapy were found to be essential, such as knowing the foundations of play therapy, having the ability to play with a children therapeutically and knowing the difference between using play therapy and using free play.

Only a few items produced strong responses in the skills and actions domains. One that prompted comments concerned educating adults and parents about research. One participant commented “it is more important to teach them to be good parents first”. This observation is indicative of a larger trend in which participants tended to disagree on the value of discussing research with parents. Masters-level clinicians who come from practice-oriented graduate programs may not have extensive training in research, so the idea that child counselors must discuss and disseminate ideas from research may not align with their views or backgrounds.

One item that was added after the first round that received a resounding positive response regarded the importance of specific clinical field work with direct interaction with children. One
participant wrote about this, noting “VERY NECESSARY if you are planning to work with children”. This is significant because many graduate programs (CACREP accredited included) do not require any fieldwork with children specifically.

Implications

This research highlights issues related to counseling children that currently exist in the field. Basically, child counselors have been trained to work with all populations in their training programs with no ability to distinguish themselves as specialists in the area of child counseling. Therefore, parents, prospective clients, and other referring professionals do not have a means for vetting the expertise or experience of individuals who claim to specialize in counseling children. This study provides a framework for child counseling competencies that warrant description here. Additionally, what this study shows is that the ASKA’s child counseling experts perceive as necessary for effectively counseling children need attention in two distinct areas: (a) Counselor Training and (b) Licensure/Credentialing requirements.

Child Counseling Competencies

These findings may serve as a framework in the development of child counseling competencies, something that does not currently exist in the field. The foundation of this study lies within the AKSA competencies segment of the Multicultural and Social Justice Counseling Competencies (MSJCC). The following section will highlight the final child counseling competencies developed in this study (Figure 3) and then demonstrate a narrative description of the final child counseling competencies as they align with the MSJCC domains of attitudes, knowledge, skills and actions. The items highlighted in bold are ones the researcher deemed are unique to child counseling and are not necessarily covered in current general counseling training.
programs. These are the items (in bold) that must be incorporated into practicum or internship training procedures or taught in coursework.
Figure 6.1. Necessary Attitudes, Knowledge, Skills and Actions.
<table>
<thead>
<tr>
<th>Attitudes</th>
<th>Knowledge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meet children where they are</td>
<td>Developmental stage theories</td>
</tr>
<tr>
<td>Children's issues are relative</td>
<td>Laws pertaining to children</td>
</tr>
<tr>
<td>All behavior is communication</td>
<td>Parental rights in counseling</td>
</tr>
<tr>
<td>Children are more than the products of their behavior</td>
<td>Atypical child development and risk factors</td>
</tr>
<tr>
<td>A child must be viewed holistically</td>
<td>Factors of child resilience</td>
</tr>
<tr>
<td>Children can have mental health issues and get better</td>
<td>Ethical standards relating to children</td>
</tr>
<tr>
<td>Children are resilient</td>
<td>Child assessment and treatment planning</td>
</tr>
<tr>
<td>One must like children</td>
<td>How to involve families generally in child therapy</td>
</tr>
<tr>
<td>Children are embedded in a community</td>
<td>Resources in the community for children</td>
</tr>
<tr>
<td>Acknowledging and understanding a child’s relationships is key</td>
<td>Process of calling/reporting abuse &amp; neglect</td>
</tr>
<tr>
<td>Do not expect a children to act the same as adults</td>
<td>Multicultural and social justice concepts</td>
</tr>
<tr>
<td>Children want to play</td>
<td>Child-centered therapy</td>
</tr>
<tr>
<td>Children are unique</td>
<td>Foundations of play therapy</td>
</tr>
<tr>
<td>Always be curious about the child</td>
<td>The difference between play therapy and free play</td>
</tr>
<tr>
<td>Children are inherently good</td>
<td>The DSM-5 sections relating to child diagnoses</td>
</tr>
<tr>
<td>Child counseling is a separate and distinct process from counseling adults</td>
<td></td>
</tr>
<tr>
<td>Skills</td>
<td>Actions</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>--------------------------------------------------------------</td>
</tr>
<tr>
<td>Basic counseling skills</td>
<td>Self-care</td>
</tr>
<tr>
<td><strong>Tailoring basic skills to be appropriate for children</strong></td>
<td>Seek supervision</td>
</tr>
<tr>
<td><strong>Parent consultation</strong></td>
<td>Continuing education and trainings</td>
</tr>
<tr>
<td><strong>Joining in and meet a child</strong></td>
<td>Advocating for children's rights and health</td>
</tr>
<tr>
<td>Respecting child autonomy and independence</td>
<td></td>
</tr>
<tr>
<td>Using creativity in counseling</td>
<td></td>
</tr>
<tr>
<td><strong>Assessing children</strong></td>
<td><strong>Educating others about child behaviors, the therapeutic process and play</strong></td>
</tr>
<tr>
<td>Developing comprehensive treatment plans</td>
<td></td>
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<tr>
<td>Researching literature on child counseling</td>
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<tr>
<td>Allowing a variety of mediums for child expression</td>
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<tr>
<td><strong>Matching developmental needs of a child to specific intervention</strong></td>
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<tr>
<td>Flexibility in choosing and implementing interventions</td>
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<tr>
<td>Exploring difficult and existential questions/issues</td>
<td></td>
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<tr>
<td><strong>Having specific training for counseling children</strong></td>
<td><strong>Empowering others to take a larger support role in child’s life</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Advocate for the legitimacy of child counseling field</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Specific clinical field work with direct interaction with children</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Be warm and open to a child</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Be present and mindful with a child</strong></td>
</tr>
</tbody>
</table>
**Child counselor attitudes.** A certain level of self-awareness is necessary to be a child counselor. Working with young children may require a counselor to be comfortable with interactions such as being silly, getting on the ground to play games, speaking through puppets and other play actions. Child counselors are children at heart, and they meet their clients wherever they are. That is, they understand children and are able to connect deeply with their world. Additionally, some people may think they possess traits and skills to work with children but when becoming self-aware, understand that they do not possess the skills they thought they had. For example, a young counselor may think she is ready to work with children but finds that she tends to talk to children as if they are teenagers or older, and they respond to her with confusion or resistance. Developing self-awareness is a lifelong process involving a combination of professional development, introspection, critical analysis, learning, and immersion in a community.

Child counselors are aware of the values and beliefs they hold about children. They are acutely aware of their position on child developmental as well as parenting issues like spanking. This allows child counselors to be cognizant of their biases, perspectives, and limitations in working with children. Child counselors understand the whole child and know that they are resilient, their issues are relative, and their behavior is communicative. They understand and acknowledge that a child’s community and relationships are essential to their development and that children communicate through play. Child counselors are curious, mindful, present and treat child counseling as a separate and distinct process. Child counselors understand that learning about children’s worldviews requires immersion and being connected to a child’s lived experience rather than discounting what they say as fantasy or ignorance.
Child counselors are aware of the strengths and limitations of what they know about children and their development. In addition, child counselors are knowledgeable about relevant resources that will help them become further aware of their attitudes, biases and perspectives regarding children.

Child counselor knowledge. Child counselors are knowledgeable of pertinent theories in addition to how those theories may or may not apply to children. It is inconceivable for a competent child counselor to be unaware of Piaget or Erikson’s foundational concepts regarding a child’s worldview. Additionally, child counselors possess knowledge of relevant research and data related to the experience of different groups of children. This knowledge allows child professionals to understand the issues of the families and communities in which children exist. Child counselors understand the laws, ethics and resources for reporting and assessing for child abuse and neglect. They identify and acknowledge atypical child development and risk factors and know how to engage in comprehensive assessment and treatment planning. They are also proficient in their knowledge of the DSM-5 sections on child-related disorders and diagnoses.

Child counselors recognize that children are part of a family unit and they know how to involve families in counseling. They realize that attachment and systems account for much of a child’s wellbeing. Child counselors are multiculturally competent and know how to incorporate a child’s intersecting identities in counseling. Child counselors know the foundations of play therapy and the basic building blocks of child-centered therapy. Lastly, child counselors possess critical thinking skills allowing them to connect with the thought processes and perspectives of children. Such counselors are able to analyze how a child’s perspective influences his or her lived experience.
Child counseling skills. Child counselors possess critical thinking skills to allow them to connect with the thought processes and perspectives of children. Such counselors are able to analyze how a child’s perspective influences his or her lived experience. Counseling adults is quite different from counseling between a child and an adult. As such, although child counselors employ similar basic skills, they understand the differences in counseling children and can tailor their approach to be developmentally appropriate.

There are significant differences in motivation levels of children compared to adults. Children often do not arrive motivated to change or pursue previously outlined goals as does an adult. Children often experience counseling with a certain degree of hesitation, ignorance or resistance, and child counselors need be keenly aware of this and how it impacts the counseling relationship. Child counselors work through the resistance and discomfort of children to ensure that the child understands the process and feels free to engage with the counselor. These counselors also respect child autonomy and independence and give them space to process difficult questions or situations.

Child counselors possess the communication skills to speak with children in a developmentally appropriate manner. They should be flexible, creative in allowing a variety of mediums for child expression and be able to match an intervention to fit a child’s presenting issues. Child counselors know how to assess a child comprehensively. Lastly, child counselors possess skills outside their relationship with a child in that they know how to consult with parents and develop appropriate treatment plans based on research literature.

Child counselor actions. Child counselors possess a foundation of training experience and clinical field work with direct interaction with children. Their actions are centered on concepts of self-care, collaboration and advocacy. Counseling children is an extremely taxing
and demanding endeavor in which child counselors put the fundamentals of self-care into practice. They seek supervision to inform their practice and input from colleagues as much as they need. They also engage in trainings and continuing education to further their skills to ensure they are staying up to date with the field of child counseling and associated evidence-based practices.

Child counselors collaborate with a variety of sources to support children. They call and meet with school personnel, doctors, family members and others, and educate them about child behaviors, the therapeutic process and play. When appropriate, child counselors know how to make referrals to competent sources. Child counselors advocate and empower. They advocate for children’s rights and health, and for the legitimacy of the child counseling field itself. Child counselors know how to empower others to take a large support role in a child’s life as they understand that children are relational and deserve healthy attachments and relationships. Child counselors seek opportunities to learn about the lived experiences of children and their families. For example, a child counselor who works with boys in the late childhood age range almost certainly has learned about or sought a basic understanding of the massively popular video game *Fortnite* and the perspectives that children have regarding their experience with it.

**Counselor Training**

For the purposes of this study, counselor training centers on the how counselors are taught according to the major governing body of counseling programs, the Council for the Accreditation of Counseling Related Educational Programs (CACREP). CACREP has eight common core curricular areas which all counseling training programs must incorporate into their respective programs (CACREP, 2016). As mentioned earlier in this study, these include: (a) professional counseling orientation and ethical practice; (b) social and cultural diversity; (c)
human growth and development; (d) career development; (e) counseling and helping relationships; (f) group counseling and group work; (g) assessment and testing; and, (h) research and program evaluation. Additionally, CACREP has established six sections of standards by which programs must be aligned in order to be accredited.

Of interest in this study, Section 5, Entry-Level Specialty Areas, provides standards relevant to specific subjects offered by the program (CACREP, 2016). These include addictions; career; clinical mental health; clinical rehabilitation; college counseling and student affairs; marriage, couple, and family; and school counseling. The closest specialty in child counseling is marriage, couple, and family counseling. In fact, the words child or children are only mentioned twice in the entire document of the 2016 CACREP Standards.

School counseling is another specialty area in the 2016 CACREP Standards. This section contains parts that address children such as section G.2.h, “common medications that affect learning, behavior, and mood in children and adolescents” (CACREP, 2016). However, this section is designed to address student needs only in the school setting but does not include counseling children in the context of outpatient settings. The results of this study suggest that child counseling warrants its own entry-level specialty area. Rather than be vaguely included in the school counseling or marriage, couple and family areas, child counseling is a distinct specialty area that should be offered as part of a CACREP program. If there was a child counseling specialty area, graduates of a program with that specialty would be recognized as being trained to be child counselors.

CACREP programs require ten group counseling hours in fieldwork experience. Just as group counseling is recognized as a separate process and warrants a separate set of hours, child counseling requires a separate group of hours as well. In a child counseling specialty area,
students could be required to complete a specified number of hours working directly with children in an age range such as 4-12 years old. They would also be required supervision by accredited professionals who are trained to work with children as well. The competencies identified in this study may form the foundation upon which to base coursework in the specialty area programs, specifically, a set of courses and fieldwork experiences in child counseling would be required to cover each competency deemed essential across all domains of attitudes, knowledge acquisition, skill development and actions.

**Counselor Licensure**

Most mental health subspecialties have a distinct credentialing or licensure process separate from that required to become a licensed professional counselor (LPC). For example, in order to seek treatment for substance use and dependency, it is recommended that individuals seek counseling from licensed clinical addiction specialist counselors, or LCAS. Requirements to obtain an LCAS license vary by state but in North Carolina, for example, specialists are required to complete 4,000 hours (2 years, post-Masters) of experience working with those with substance use disorders, 180 clock hours of substance use disorder specific training, including 6 hours of special topics on addictions, and pass a comprehensive examination centered on addiction and treatment (ncsappb.org).

Other mental health fields have created subspecialties that focus on counseling children. The clinical child and adolescent psychologist is another example of child mental health specialty. This specialty certification ensures the public and the profession that a clinical child psychologist has met the training and experience requirements and has demonstrated them through advanced competencies in a peer reviewed examination. The examination and licensure involve the following core competencies: assessment and intervention, individual and cultural
diversity, interpersonal competency relationships, science base and application, ethical and legal application, and commitment to and involvement in psychology (American Board of Clinical Child and Adolescent Psychology, n.d.). Licensure also includes submission of two recordings of professional work representative of the psychologist’s current practice in addition to an oral examination that involves a critique of ethical case vignettes. All of these core competencies have been established in this present study with the exception of the commitment to the field of psychology and this suggests that it is time for counseling to follow the direction of psychology and establish its own specialty licensure.

The competencies identified in this study could be used to inform the specialty of child counseling licensure in multiple ways. The competencies suggest the importance of specific child counseling fieldwork and education. So, a child counseling licensure (e.g. Licensed Child Counselor Specialist, LCCS) could involve a set of hours of post-master’s work with children in a counseling setting (school, outpatient, inpatient, etc.). The competencies could also inform trainings including a set of hours on special topics in child related issues such as child trauma, bullying, or custody/legal issues with minors. Lastly, these skills can inform items and content on an examination about child counseling.

**Future Research**

There has been little research conducted on what defines child counseling. This research provides a foundation from which to begin to inform child counseling practice, education, training and licensure. The competency model developed in this study was based on the consensus of 37 total expert child counselors and leaders in the field. One of the first steps in future research of these competencies may be to send the final list to many more experts in child
counseling and ask if there are other items they believe should be included or omitted from the list. In this manner, feedback on the final list can be obtained and additional items can be considered for inclusion. Given the financial and procedural constraints in this study, extensive member checks in the pilot study were not conducted but it is recommended that experts be more involved in creating the final list of competencies rather than rely on an individual researcher.

Formal survey development may also be a next step in utilizing the results of this research. Exploratory factor analysis could establish which items can be categorized as attitudes, knowledge, skills, or actions or any additional categories that might be helpful to include. The development of a survey from the items that were identified as very necessary could then be employed in a variety of ways. The survey could provide a tool for individual assessment by allowing individuals to identify areas of strength and growth and assessing their perceptions of competency in each of the items.

The items in the final competency model could also be used to assess what is currently being taught in child counseling-related courses in academic programs. This information could improve counselor training on a class-level in counseling programs. A content analysis of counseling textbooks and course syllabi could illuminate the range of trainings and teachings of child counseling across educational programs.

Researchers may also replicate this study but without the framework of using attitudes, knowledge, skills and action domains. The AKSA domains of the Multicultural and Social Justice Counseling Competencies were used a foundation in this study but future research may offer a more exploratory base and replicate the study without any domains. Rather, researchers may ask the question about defining child counseling more broadly, and research questions can
be about the most essential components of child counseling, rather than the most essential attitudes, knowledge bases, skills and actions. Results may differ by eliminating the AKSA framework and there could be different results.

**Strengths**

There has yet to be established a framework upon which to define the child counseling field, and its overarching research question is thought provoking. Leaders in the field were energized by the ideas presented by this topic which became one of its major strengths as the study progressed. Furthermore, the geographical and career diversity of the participants also contributed to the strengths of this study. The findings could provide considerable applicability because participants were involved from nearly 20 different states across the country. Additionally, all participants were experts in a variety of professional statuses including experience (multiple years with most over 5 years’ experience) authorship and/or supervision (supervising child counselors).

Given the need to first understand which AKSAs are necessary for child counseling and the dearth of research on the topic, the Delphi methodology provided the most appropriate way for evaluating the topics. The researcher was able to combine the results of current counseling research with ideas from child counseling experts in order to evaluate the greatest breadth of AKSAs. The Delphi method has qualitative as well as quantitative components, allowing a more comprehensive understanding of the results. The highly structured Delphi process leaves little room for subjectivity or bias which aided the internal validity of the study’s results.
**Limitations**

This study had clear limitations which warrant discussion. First, it was originally designed to involve an anonymous data collection method for the pilot study. That is, individuals were to participate through text only in the brainstorming focus group, to eliminate any issues of power or influence. Given that some of the participants were high ranking officials in counseling organizations or well-established names in the field, the researcher wished to avoid those individuals influencing the opinions or input of others. However, the researcher felt that authentic and thorough input from participants was most important and communicating via audio and video was expected to yield more content than text alone. Nevertheless, the use of video and audio in the pilot study data collection phase may have created more homogenous input as participants were more likely to want to agree with each other or defer to higher ranking leaders in the field when participating.

There was considerable overlap in identifying items as attitudes, knowledge, skills or actions in the pilot study, which reflected a difficulty in categorizing items. Similar items can be seen in the knowledge and skills domains, such as attitudes of child-centered therapy being in the model as well as the knowledge items about child-centered therapy. A factor analysis may be necessary in order to clearly define how items group together. Additionally, there were only 3 men who participated in the study (10.71% of total sample). It was expected that women would outnumber men, but a higher percentage of men would have yielded more generalizability of the study findings.

It would have also been beneficial to engage in more comprehensive member checking with participants in the pilot study group. After the questionnaire was created from pilot study data, the researcher could have sent the instrument to the pilot study expert participants and
request more input on the items that were generated. However, the researcher attempted to control this limitation’s effect on the study by using the participants exact words from the brainstorming session directly in the items.

Another limitation was related to how the final item was calculated for the list of the top ten child counseling competencies. This list was developed from the pilot study input based on the interview question about the most essential child counseling competencies. As a result, the responses were largely overlapping of items in the domain specific interview questions (i.e. knowledge of legal and ethical issues of counseling children). More importantly though, because of this method, an item about evidence-based practice was not included in the final domain model but was included in the final competencies. Specifically, the knowledge of evidence-based practices for each developmental stage and population achieved a median score of 6 (not the required 7 to be a final competency) but it was nominated as a most essential competency by the focus group, so it was included in the final item.

This discrepancy between the brainstorming pilot study group and the main study group of participants warrants further discussion. It remains unclear why participants in the pilot study felt strongly about evidence-based work with children, but evidence from the main study participants did not agree. It would be more beneficial to base the second research question about the most essential competencies around domain items in the main study. So rather than rank items based on the pilot study interview outcomes, it would have been better for participants to choose from items in the questionnaire and rank their top ten counseling competencies and analyze that data.

Finally, consensus may have been reached for some items simply based on the results presented to the participants during the second and third rounds. There may be a tendency
to change answers to be closer to the consensus regardless of actual opinions. It is the hope that the online method of collecting the questionnaires reduced this level of groupthink. However, the possibility that participants may have changed their responses based on the median and IQR still exists. In addition, there were items that reached consensus in the first round that were included in the second round due to researcher error.

**Conclusion**

The results of this study provide a framework for child counseling competencies. There is a widespread shortage of child counselors and those who fill the gap need to be trained appropriately to work with children. As discussed in the literature review, children are unique and present distinct challenges in addressing their mental health needs. The professional literature supports the idea that child counseling is an exclusive process, separate and distinct from counseling adults. Researchers should strive to generate strategies to address the different mental health needs of children. This study added to the depth of research on this topic from a Delphi methodology foundation.

Continued investment in a set of core counseling competency standards is critical for the future of the field. Thirty-seven experts provided a glance at the range of competencies required for counseling children. Topics such as evidence-based practice and other knowledge bases were not always agreed upon as essential competencies and this suggests that there is a wide variety of training backgrounds and educational understandings of child therapists. More professional discourse about this topic is essential as this study suggests that not all who work with children are trained equally.
REFERENCES


https://doi.org/10.1080/10503307.2016.1208375


http://doi.org/10.1001/archpedi.153.6.629

https://www.loc.gov/item/lcwa00093333/


https://doi.org/10.1377/hlthaff.2014.0944


https://doi.org/10.1046/j.1365-2648.2000.t01-1-01567.x


http://dx.doi.org/10.1002/j.1556-6978.2003.tb01813.x


https://doi.org/10.1097/00004583-200206000-00013


http://dx.doi.org/10.1037/h0035181


https://doi.org/10.1002/14651858.CD009260.pub2.

https://doi.org/10.17744/mehc.32.3.0n31v88304423806


https://doi.org/10.1080/15401383.2014.906874


services in behavioral health care settings. Retrieved from

https://www.socialworkers.org/LinkClick.aspx?fileticket=OilZ7p_EEnE%3D&portalid0

exaggerated?. The Behavior Analyst, 9(1), 101-105.

http://dx.doi.org/10.1007/BF03391933

Why is Children's Mental Health Important? (n.d.). Retrieved December 7, 2018, from


https://pdfs.semanticscholar.org/91f0/6be5a91bc369b1669525cd28519f70d4453f.pdf

Jr. (Ed.), Handbook of infant mental health (pp. 5-21). New York, NY, US: The Guilford
Press.

Ziglio (Eds.), Gazing into the oracle: The Delphi method and its application to social
policy and public health (pp. 3-33). London: Kingsley.
Appendix A

RECRUITMENT EMAIL: PILOT STUDY

Request for Counselor Participants: A Study about Developing Child Counseling

Competencies

Dear Child Counselors and Child Counseling Experts,

I would like to invite potential participants to a study I am conducting as part of my dissertation research at NC State University. As a child counselor, this research is a deep passion of mine. This study is focused on developing a consensus around what constitutes the basic standards (attitudes, knowledge, skills and actions) of counseling children aged 4-12. I am recruiting expert participants who are counselors (school or mental health) or counselor educators who work extensively with children in this age range or teach counselors how to work with this age range. It is my hope that this study can help inform the training of future child counselors and even lead to a separate licensure process for child counseling.

Participants must meet the following criteria:

- Participants must be licensed counselors with at least 2 years of full-time experience.
- Participants must work extensively with children aged 4-12 years OR be a counselor educator who has taught a Masters level course on child counseling subject matter OR be an author of a child counseling book.
- Participants may be outpatient, inpatient or school-based counselors (study is not limited to specific counseling environments).

In this research, there will be an interactive online discussion about the attitudes, knowledge, skills and actions (ASKAs) that the expert-participants feel are essential for child counseling and will only last approximately 45-60 minutes. This session will be audio with video
optional. The results of this discussion will be used to develop a questionnaire about the AKSAs of child counseling and that survey will be disseminated to new participants in a later round in the study.

If you would like to participate, please read and sign electronically the consent form here: https://ncsu.qualtrics.com/jfe/form/SV_0PNDuM8vDDV9G61. In this link you will indicate if you are willing to participate in the online brainstorming session. You will also be given a link to sign up with a Doodle poll for times that work in your schedule to participate in the study.

In appreciation for completing the research, each participant will receive a $15 gift certificate for completing the brainstorming session.

Thank you for considering participating in this exciting research opportunity!

Sincerely,

Cory Clark, LPC-A, NCC, PhD Candidate
Appendix B

PILOT STUDY CONSENT FORM

Phase 1: Developing a Competency System for Counseling Children

North Carolina State University INFORMED CONSENT FORM for RESEARCH
Title of Study: Developing a Competency System for Counseling Children: A Delphi Study.
Principal Investigator: Cory Clark, M.Ed, LPC-A, NCC
Faculty Sponsor: Adria Dunbar, Ph.D.

What are some general things you should know about research studies? You are being asked to take part in a research study. Your participation in this study is voluntary. You have the right to be a part of this study, to choose not to participate or to stop participating at any time without penalty. The purpose of this research study is to gain a better understanding of the clinical competencies of counseling children. You are not guaranteed any personal benefits from being in a study. Research studies also may pose risks to those who participate. In this consent form you will find specific details about the research in which you are being asked to participate. If you do not understand something in this form it is your right to ask the researcher for clarification or more information. A copy of this consent form will be provided to you. If at any time you have questions about your participation, do not hesitate to contact the researcher(s) named above or the NC State IRB office as noted below.

What is the purpose of this study? The purpose of the study is to establish the standards and competencies for counseling children. Counseling children warrants its own subfield and training rather than be considered an elective or an outgrowth of counseling adults. In order to train and teach counselors to work competently with the child population, there needs to be more of an understanding of the attitudes, knowledge, skills and actions for counseling this specific population. In addition, the standards for which counseling programs are set need to be clearer in terms of how child counselors may be trained. Therefore, this study is about building the basic standards for which counselors of children must follow. Am I eligible to be a participant in this study? In order to be a participant in this study you must be an expert in the field of child counseling. An expert in this study constitutes an individual with a full counseling or related field license and at least 2 years of experience in the field of child counseling. You cannot participate in this study if you do not have the necessary qualifications (full licensure) or experience (less than 2 years of practice with primary population of children). What will happen if you take part in the study? If you agree to participate in this study, you will be involved in an interactive online discussion about the attitudes, knowledge, skills and actions (AKSAs) that participants feel are essential for child counseling and will only last approximately 45 minutes. The results of this discussion will be used to develop a questionnaire about the AKSAs that will utilized in a second part to this study. The brainstorming session will be anonymous. To consent for the study, you will electronically sign a consent form through Qualtrics and fill out demographic information. After completing this, you will see a link to complete a Doodle poll. There you will be asked to indicate days and times that you may be able to participate in the online brainstorming session via the online platform Zoom. The link to Zoom is provided in the Doodle Poll. After completing the brainstorming session, you will have option to participate in
the second part of the study which will involve filling out Qualtrics surveys based on the content of the brainstorming session.

Risks and Benefits

There are minimal risks associated with participation in this research. There are no direct benefits to your participation in the research. However, indirect benefits include your contribution to elevating the field of child counseling and enhancing the training and competencies of those in the field.

Confidentiality

The information in the study records will be kept confidential to the full extent allowed by law. Data will be stored securely on an NC State managed computer. Records of the brainstorming session will be recorded through the encrypted online platform Zoom, but the written responses there will be anonymous. No reference will be made in oral or written reports which could link you to the study. Individual data with individually identifiable details removed may be made available to the public as required by some journal and funding agency data sharing policies.

Compensation

In appreciation for completing the research, each participant will receive a $15 gift certificate. What if you are a NCSU employee?

Participation in this study is not a requirement of your employment at NCSU, and your participation or lack thereof, will not affect your job.

What if you have questions about this study? If you have questions at any time about the study itself or the procedures implemented in this study, you may contact the researcher, Cory Clark, at the following:

2617 Needle Pine Dr.
Apex, NC 27539
Coryclark7@gmail.com
(516) 376-0471

What if you have questions about your rights as a research participant? If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this project, you may contact the NC State IRB Office via email at irb-director@ncsu.edu or via phone at 1.919.515.4514. You can also find out more information about research, why you would or would not want to be in research, questions to ask
as a research participant, and more information about your rights by going to this website: http://go.ncsu.edu/research-participant

Consent To Participate

“I have read and understand the above information. I have received a copy of this form. I agree to participate in this study with the understanding that I may choose not to participate or to stop participating at any time without penalty or loss of benefits to which I am otherwise entitled.”

☐ Yes (1)

☐ No (2)

Q8 Please write your first name:

Q9 Please write your email address:

Q2 Please indicate your sex:
Male (1)
Female (2)
Other (please specify) (3) ________________________________________________

Q3 What is your age?

Q4 Which of the following best describes your ethnicity?
Asian American/Pacific Islander (1)
American Indian (2)
African American/Black (3)
White American/Caucasian (4)
Hispanic/Latino/a/x (5)
Multiracial (6)
Other (please specify) (7) ________________________________________________

Q5 Which of the following best describes the role in which you work?
Professional Counselor (1)
Counselor Educator (2)
Author (3)
Other (please specify) (4) ________________________________________________
Q6 How many years of experience do you have counseling children?
2-5 (1)
6-10 (2)
11-15 (3)
16-20 (4)
<20 (5)

Q7 What professional license(s) and/or certifications do you hold?
Appendix C

BRAINSTORMING SESSION PROMPTS

Welcome everyone. I appreciate all of your time and effort with this study as I believe it is an important topic to explore.

I am a child counselor and I have been since I was licensed about 3 years ago. I’ve always been passionate about working with children though and ever since I started counseling, I’ve been struck with how there is no licensure or set training required to work with children specifically. I feel in regards to our counselor training and licensure model, we treat counseling children like an outgrowth of counseling adults and I think there’s major issues with that.

This study is about counseling children and how this process is separate and unique in comparison to counseling adults. You have been selected because you qualify as experts in the field and I am honored to be speaking with each of you.

As you saw in the interview questions, we will start by having each of you talk briefly about your work with counseling children, whether it be in a clinical or teaching or research. After that, we will get into the studies’ research questions which are about the attitudes, knowledge, practices and actions of counseling children. I’d like to spend about 10 minutes on each of those 4 domains.

After this focus group, you will be emailed your gift certificate. Then from there, I will be using this focus group to create a survey for phase 2 of this study. This survey will be about confirming with 25 other experts the things we talk about in here. So if you could help me recruit more experts to be in that phase, that would be awesome and I’ll provide you the info on that later.

Is it ok with everyone if I record this session?

Dissertation Interview Prompts:

- **Question 1**: So let’s get started, how about each of you go around and state your first name and say a little bit about your work counseling children – 5 minutes
- **Question 2**: When you think about your work counseling children, what do you consider the age range of clients you work with? Why? (5 minutes)

The following questions are about the core competencies in counseling children. These competencies are about attitudes and beliefs, knowledge, practices and actions of child counselors. I am going to put these up on the whiteboard for you all to reference. (Explain each)

- **Question 3**: What attitudes and beliefs do you identify as necessary for child counseling? (10 minutes)
- **Question 4**: What knowledge bases and understandings do you identify as necessary for child counseling? (10 minutes)
**Question 5:** What best practices and skills do you identify as necessary for child counseling? (10 minutes)

**Question 6:** What actions do you identify as necessary for your role as a child counselor? (10 minutes)

**Question 7:** Of the attitudes, knowledge, skills and actions that have been mentioned thus far, what stand out to you all as most important and necessary? (5 minutes)

**Question 8:** Is there anything that I didn’t ask that you wish we would have talked about? (5 minutes)
Appendix D

RECRUITMENT EMAIL: MAIN STUDY

1st Request for Counselor Participants: Phase 2 of a Study about Developing Child Counseling Competencies

I would like to invite you to participate in a study I am conducting as part of my dissertation research at NC State University. This study is focused on developing a consensus around what constitutes the basic standards (attitudes, knowledge, skills and actions) of counseling children. It is my hope that your expertise and contributions can help inform the training of future child counselors.

Phase 1 of this study has been completed which involved a focus group about establishing child counseling competencies. In Phase 2 of this study, there will be three surveys over a period of 3-weeks that examine the attitudes, knowledge, skills and actions (ASKAs) that the participants feel are essential for child counseling and the surveys will last approximately 20-25 minutes each. Results of these surveys will be used to pioneer a competency model for counseling children. The first survey will be sent out sometime within the next 2 weeks and then each subsequent survey will be sent out one week later until three total have been disseminated.

Participants must meet the following criteria:

- Participants must be licensed counselors with at least 2 years of full-time experience.
- Participants must work extensively with children aged 4-12 years OR be a counselor educator who has taught a Masters level course on child counseling subject matter OR be an author of a child counseling book.
- Participants may be outpatient, inpatient or school based counselors (study is not limited to specific counseling environments).

If you would like to participate, please read and sign electronically the consent form here and indicate if you are willing to participate in the survey study:

In appreciation for completing the research, each participant will be entered in a random drawing for one of two 50$ gift cards.

Please do not hesitate to email me with any questions or concerns.

Sincerely,

Cory Clark, LPC-A, NCC, PhD Candidate
Appendix E

CONSENT FORM: MAIN STUDY

Phase 2: Developing a Competency System for Counseling Children

North Carolina State University
INFORMED CONSENT FORM FOR RESEARCH

Title of Study: Developing a Competency System for Counseling Children: A Delphi Study
Principal Investigator: Cory Clark, M.Ed, LPC-A, NCC
Faculty Sponsor: Adria Dunbar, Ph.D.

What are some general things you should know about research studies?
You are being asked to take part in a research study. Your participation in this study is voluntary. You have the right to be a part of this study, to choose not to participate or to stop participating at any time without penalty. The purpose of this research study is to gain a better understanding of the clinical competencies of counseling children.

You are not guaranteed any personal benefits from being in a study. Research studies also may pose risks to those who participate. In this consent form you will find specific details about the research in which you are being asked to participate. If you do not understand something in this form it is your right to ask the researcher for clarification or more information. A copy of this consent form will be provided to you. If at any time you have questions about your participation, do not hesitate to contact the researcher(s) named above or the NC State IRB office as noted below.

What is the purpose of this study?
The purpose of the study is to establish the standards for counseling children. Counseling kids warrants its own training rather than be considered an elective or an outgrowth of counseling adults. In order to train and teach counselors to work competently with the child population, there needs to be more of an understanding of the attitudes, knowledge, skills and actions for counseling this specific population. In addition, the standards for which counseling programs are set need to be clearer in terms of how child counselors may be trained. Therefore, this study is about building the basic standards for which counselors of children must follow.

Am I eligible to be a participant in this study?
In order to be a participant in this study you must be an expert in the field of child counseling. An expert in this study constitutes an individual with a full counseling or related field license and at least 2 years of experience in the field of child counseling.

You cannot participate in this study if you do not have the necessary qualifications (full licensure) or experience (less than 2 years of practice with primary population of children).

What will happen if you take part in the study?
If you sign the electronic consent form, you will be asked to participate in three rounds of surveys in the platform Qualtrics over the span of 4 weeks.
In Round 1, you will be sent a questionnaire in Qualtrics via email link. This Round 1 questionnaire will ask you to rate the importance of each item for counseling children and will be available for one week. Items for this questionnaire will be compiled from the information gathered by experts in the field of child counseling. A Likert-scale ranging from 1 (not necessary at all) to 7 (extremely necessary) will be provided for each item.

In round 2, participants who responded to Round 1 will receive an email containing their responses to the Round 1 questionnaire and instructions on how to complete Round 2. This questionnaire will also be available for one week. Participants will be informed that the completion of the questionnaire will indicate their consent to participate in the study. This document will consist of only those items for which consensus was not reached during Round 1. The researcher will ask participants to re-rate each item, given consideration to the measures of central tendency and dispersion provided as well as their previous responses. In the instructions for completion, the author will ask participants to provide their reasoning if they should choose a rating that is different from the median. An open-ended format for statement of reasoning will be included for each item.

In round 3, the final round will follow the same format and procedures as Round 2. Prior to Round 3, the participants who responded to Round 2 will receive an email with their responses to Round 2 and instructions on how to access and complete the questionnaire for Round 3 via the Qualtrics platform. The questionnaire will remain available for one weeks and a follow-up reminder will be sent after three days. During the third and final round, questionnaires will only consist of the items for which consensus was not reached during the second round. All participants will be given the opportunity to re-rate and comment on their rating of these items, regardless of whether or not they had chosen to rate with the average. In this way, both perspectives will be provided in the final discussion of why consensus was not reached for certain items.

Risks and Benefits
There are minimal risks associated with participation in this research. There are no direct benefits to your participation in the research. However, indirect benefits include your contribution to elevating the field of child counseling and enhancing the training and competencies of those in the field.

Confidentiality
The information in the study records will be kept confidential to the full extent allowed by law. Data will be stored securely on an NC State managed computer. Records of the brainstorming session will be recorded through the encrypted online platform Zoom, but the written responses there will be anonymous. No reference will be made in oral or written reports which could link you to the study. Individual data with individually identifiable details removed may be made available to the public as required by some journal and funding agency data sharing policies.
Compensation
In appreciation for completing the research, each participant will be entered in a random drawing for one of two $50 gift cards.

What if you are a NCSU employee?
Participation in this study is not a requirement of your employment at NCSU, and your participation or lack thereof, will not affect your job.

What if you have questions about this study?
If you have questions at any time about the study itself or the procedures implemented in this study, you may contact the researcher, Cory Clark, at the following:

2617 Needle Pine Dr.
Apex, NC 27539
Coryclark7@gmail.com
(516) 376-0471

What if you have questions about your rights as a research participant?
If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this project, you may contact the NC State IRB Office via email at irb-director@ncsu.edu or via phone at 1.919.515.4514. You can also find out more information about research, why you would or would not want to be in research, questions to ask as a research participant, and more information about your rights by going to this website: http://go.ncsu.edu/research-participant

Consent To Participate
“I have read and understand the above information. I have received a copy of this form. I agree to participate in this study with the understanding that I may choose not to participate or to stop participating at any time without penalty or loss of benefits to which I am otherwise entitled.”

〇 Yes (1)
〇 No (2)

Q8 Please write your first name:

Q9 Please write your email address:
Appendix F

MAIN STUDY INSTRUCTIONS EMAIL

Dear Child Counseling Study Participants,

Thank you so much for agreeing to participate in my dissertation study! To kick off the study, I wanted to remind you all of what will be involved in the study and dates for you to mark your calendars.

This study is a Delphi study, which essentially means it is about collecting data from experts in a field about a topic that has not been established yet. In this case, you all are child counseling experts and you are helping me develop a child counseling competency system. It is my hope that this system can help inform the training of future masters level clinicians so that everyone is properly equipped to work as child counselors in the future.

This study will involve three surveys, the first of which is being sent in this email. The second survey will go out in 9 days, and the final survey will go out 9 days after that. The specific dates that the surveys will go out and be due back to me are as follows:

· Round 1 Survey - sent today, June 12th
- Completed by June 19th
  · Round 2 Survey - sent June 21st
- Completed by June 28th
  · Round 3 Survey – sent July 1st
- Completed by July 8th

To begin Round 1, please complete the survey here: https://ncsu.qualtrics.com/jfe/form/SV_3t7t02I7uLJ4d7
*Note: keep in mind the first survey will be longer than the other two surveys since the first includes all items and the second and third only include items that did not reach a consensus score.

This Round 1 questionnaire will ask you to rate the importance of each item for counseling children and will be available for one week. A Likert-scale ranging from 1 (not necessary at all) to 7 (extremely necessary) will be provided for each item. After you complete the survey, a copy of your responses will be sent to you for your reference.

In Round 2, on June 21st, you will receive an email containing your responses to the Round 1 survey and instructions on how to complete Round 2. This survey will also be available for one week. This document will consist of only those items for which consensus was not reached during Round 1. I will ask you to re-rate each item, given consideration to your previous responses. In the instructions for completion, I will ask you to provide your reasoning if you should choose a rating that is different from the median. An open-ended format for statement of reasoning will be included for each item.

In Round 3, on July 1st, the final round will follow the same format and procedures as Round 2. Prior to Round 3, you will receive an email with your responses to Round 2 and instructions on how to access and complete the survey for Round 3 via the Qualtrics platform. The survey will remain available for one week and a follow-up reminder will be sent after three days. During the third and final round, questionnaires will only consist of the items for which consensus was not reached during the second round. You will be given the opportunity to re-rate and comment on your rating of these items, regardless of whether or not you had chosen to rate with the average. In this way, both perspectives will be provided in the final discussion of why consensus was not reached for certain items.
Last but not least, for compensation you will be entered in a random drawing to win one of two 50$ Amazon gift cards!

**Action items:**

- Complete this survey within one week -
  
  [https://ncsu.qualtrics.com/jfe/form/SV_3t7t02I17uLJ4d7](https://ncsu.qualtrics.com/jfe/form/SV_3t7t02I17uLJ4d7)

- Be on the lookout for the next survey on June 21st!

Thank you again for your involvement in this important research!

Best,

Cory Clark, PhD Candidate

NC State University
Child Counseling Questionnaire Round 1

Developing a Competency System for Counseling Children: A Delphi Study
Thank you for your time and support in this important study about child counseling competencies!

This study is focused on developing a consensus around what attitudes, knowledge, skills and actions (AKSAs) are essential in the practice of child counseling. Attitudes are defined as the views and perspectives associated with counseling children. Knowledge is defined as the specific information, facts and models/theories learned through education and subsequent experience in counseling. Skills are defined as the learned or innate abilities and techniques a child counselor holds. Actions are defined as the actions counselors take both in and out of sessions to best support child clients.

You have been chosen for this study because you are an expert in child counseling and it is my hope that your contributions can help inform the training of future child counselors.

In this research, you are asked to participate in 3 rounds of data collection. These three rounds involve answering questionnaires at three separate time points via Qualtrics. These questionnaires will be utilized to reach a consensus about what AKSAs are essential for child counseling. Opportunities for open-ended responses of personal reasoning will be provided in the second and third round so that you will have the opportunity to explain your answers. The questionnaires should take no longer than 15-20 minutes each.

The first section will ask you to provide some of your personal demographics. The second section will address the areas of attitudes, knowledge, skills and actions.

Section 1: Demographic Information

Please answer each question fully, though not all questions in this section are required.

Please write your first name:

Please provide your preferred email address so that the researcher may email you with the results from this round of data gathering, your responses to this round, and an invite to participate in the next round of study.

Please indicate your sex:
Male (1)
Female (2)
Other (please specify) (3) ________________________________________________
Please indicate your age:

Which of the following best describes your ethnicity?
Asian American/Pacific Islander (1)
American Indian (2)
African American/Black (3)
White American/Caucasian (4)
Hispanic/Latino/a/x (5)
Multiracial (6)
Other (please specify) (7) ________________________________________________

Which of the following best describes the role in which you work?
Professional Counselor (1)
Counselor Educator (2)
Author (3)
Other (please specify) (4) ________________________________________________

How many years of experience do you have counseling children?
2-5 (1)
6-10 (2)
11-15 (3)
16-20 (4)
More than 20 years (5)

What professional license(s) and/or certifications do you hold?

Where is the geographical location that you practice child counseling (i.e. Northeast Ohio, rural Pennsylvania, etc.)?

Page Break

D1 Section 2: Child Counseling Competencies

Domain 1: Attitudes as Child Counselors

These items are all about the attitudes a counselor must have in their work as child counselors...please indicate on a scale of 1 (not necessary at all) to 7 (very necessary), how necessary you believe each attitude is for individuals serving in child counseling roles. **An average score of 7 on an item is needed for consensus.**
10 It’s important to meet children where they are
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

11 Children’s issues are relative and it’s important to not diminish their concerns
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

12 Everything needs to be at a child’s level in the therapy room
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

13 There is always meaning in a child’s behavior
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

14 All behavior is communication
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
15 Children are more than the products of their behavior  
1: Not necessary at all (1)  
2 (2)  
3 (3)  
4 (4)  
5 (5)  
6 (6)  
7: Very necessary (7)  

16 A strengths based approach is better than a problem centered one  
1: Not necessary at all (1)  
2 (2)  
3 (3)  
4 (4)  
5 (5)  
6 (6)  
7: Very necessary (7)  

17 A children must be viewed holistically  
1: Not necessary at all (1)  
2 (2)  
3 (3)  
4 (4)  
5 (5)  
6 (6)  
7: Very necessary (7)  

18 Children have their own language and we must speak in it with them  
1: Not necessary at all (1)  
2 (2)  
3 (3)  
4 (4)  
5 (5)  
6 (6)  
7: Very necessary (7)  

19 Children can have mental health issues and get better  
1: Not necessary at all (1)  
2 (2)  
3 (3)  
4 (4)  
5 (5)  
6 (6)  
7: Very necessary (7)
20 Children are resilient
1: Not necessary at all (1)
2  (2)
3  (3)
4  (4)
5  (5)
6  (6)
7: Very necessary (7)

21 Children want to play
1: Not necessary at all (1)
2  (2)
3  (3)
4  (4)
5  (5)
6  (6)
7: Very necessary (7)

22 Children are unique and we as therapists can help them get better
1: Not necessary at all (1)
2  (2)
3  (3)
4  (4)
5  (5)
6  (6)
7: Very necessary (7)

23 One must take a nontraditional stance and allow children to express themselves however they feel comfortable
1: Not necessary at all (1)
2  (2)
3  (3)
4  (4)
5  (5)
6  (6)
7: Very necessary (7)

24 One must like children
1: Not necessary at all (1)
2  (2)
3  (3)
4  (4)
5  (5)
6  (6)
7: Very necessary (7)
25 Never ask a child to do anything you 185e don’t ask an adult to do
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

26 Always be curious about the child and all the things involved in his/her life
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

27 It’s important to be present and mindful with a child without distractions
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

28 Children are embedded in a community and their families
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

29 It is essential to acknowledge and understand a child’s relationships
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
30 Be warm and open to a child from the beginning
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

31 Have an “outside the box” attitude
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

32 Children are inherently good
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

33 Child counseling is a separate and distinct process from counseling adults
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

Page Break

D2 Domain 2: Knowledge Bases of a Child Counselor

These items are about the knowledge and understandings a child counselor must learn in order to be a competent child counselor...please indicate on a scale of 1 (not necessary at all) to 7 (very necessary), how necessary you believe each knowledge and understanding is for individuals serving in child counseling roles. An average score of 7 on an item is needed for consensus.
34 Adlerian theory and Adlerian counseling
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

35 Child-centered therapy
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

36 Developmental stage theories (Piaget, Vygotsky, Erikson, etc.)
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

37 Bronfenbrenner’s Ecological Systems Theory
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

38 Foundations of play therapy
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
39 Developmental psychology
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

40 Cognitive development
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

41 How to understand developmental or clinical theories and teach them to parents
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

42 Attachment theories
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

43 Laws pertaining to children (i.e. child maltreatment, abuse)
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
44 Parental rights in counseling
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

45 Atypical child development and risk factors
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

46 Factors of child resilience
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

47 Ethical standards relating to children
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

48 The difference between play therapy and freeplay
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
49 Child assessment and treatment planning
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

50 The intersection of child identities
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

51 Family systems and associated theories
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

52 How to involve families generally in child therapy
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

53 Medical knowledge of child development
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
54 Maternal and paternal mental health knowledge
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

55 Parenting practices and models
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

56 Resources in the community for children
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

57 Evidence based practices for each developmental stage and population
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

58 The DSM-5 sections relating to child diagnoses
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
D3 Domain 3: Skills a Child Counselor Must Possess

These items are all about the skills a counselor must have in their work as child counselors...please indicate on a scale of 1 (not necessary at all) to 7 (very necessary), how necessary you believe each skill is for individuals serving in child counseling roles. **An average score of 7 on an item is needed for consensus.**

59 Conducting play therapy
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

60 Activity therapy (using structured activities)
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

61 Parent consultation
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

62 Teacher/school/other therapist consultation
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
63 To be able to join in and meet a child where she is without infantilization
1: Not necessary at all (1)
2  (2)
3  (3)
4  (4)
5  (5)
6  (6)
7: Very necessary (7)

64 Respect child autonomy and independence
1: Not necessary at all (1)
2  (2)
3  (3)
4  (4)
5  (5)
6  (6)
7: Very necessary (7)

65 Using creativity in counseling (i.e. using music, art, media, etc)
1: Not necessary at all (1)
2  (2)
3  (3)
4  (4)
5  (5)
6  (6)
7: Very necessary (7)

66 Basic counseling skills
1: Not necessary at all (1)
2  (2)
3  (3)
4  (4)
5  (5)
6  (6)
7: Very necessary (7)

67 Ability to tailor basic skills to be appropriate for children
1: Not necessary at all (1)
2  (2)
3  (3)
4  (4)
5  (5)
6  (6)
7: Very necessary (7)
68 Screening children
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

69 Assessing children
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

70 Developing comprehensive treatment plans
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

71 Writing behavior plans
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

72 Diagnostic systems and developmental psychopathology
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
73 How to research literature on child counseling and associated issues
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

74 Allow a variety of mediums for children to be able to express themselves
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

75 Match the developmental needs of a child to a specific intervention
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

76 Educating adults, parents and caregivers on child practices and research
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

77 Reading Individualized Education Plans
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
78 Reading psychoeducational evaluations
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

D4 Domain 4: Actions a Child Counselor Must Take

These items are all about the actions a counselor must take in their work as child counselors...please indicate on a scale of 1 (not necessary at all) to 7 (very necessary), how necessary you believe each action is for individuals serving in child counseling roles. **An average score of 7 on an item is needed for consensus.**

79 Self-care
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

80 Seeking supervision
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

81 Continuing education and trainings (professional development)
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
82 Advocating for children’s rights and health
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

83 Educating others about child behaviors, the therapeutic process and play
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

84 Collaborating with others involved in child’s life (schools, families, doctors, etc.)
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

85 Making referrals appropriately
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

86 Going to court for children when needed
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
87 Empowering others to take a larger support role in child’s life
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

88 Advocate for the legitimacy of child counseling field
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)

89 Of the attitudes, knowledge, skills and actions that are identified as necessary, what are the
MOST necessary? Please choose all that apply
The Axline principles of play therapy (1)
Passion for children and for learning (2)
Authenticity (3)
Curiosity and willingness to explore (4)
Advocating for children (5)
Self-reflection (6)
Speaking the language of the child (7)
Know how to play (8)
Knowledge of developmentally appropriate interventions (9)
Others (please list) (10) __________________________________________

90 Are there any other competencies of child counseling that you feel were not mentioned?
Please describe any below:

FIN Thank you for your participation! You will be receiving an email with the link to the next round of this questionnaire development soon. Each round the questionnaire will be shorter as items that reached consensus will not be included in subsequent rounds. After three rounds, the study will be complete.
Appendix H

PHASE 2 ROUND 2 EMAIL

Good morning everyone!

I hope you are all keeping well. Thank you for all your great responses to the Round 1 questionnaire. I have analyzed the data and we are ready for Round 2! You can find the new questionnaire here: https://ncsu.qualtrics.com/jfe/form/SV_ac9yFVdmWzLRooZ

In this Round 2, the questionnaire is shorter as 40 items were taken out because you reached consensus on them. This questionnaire shouldn’t take more than 15 minutes. It is slightly different also because you are asked to provide comments on any items you feel strongly about or you feel the median score is not indicative of how you feel about it. Please feel free to comment as much as you want on these items!

This Round 2 questionnaire will be live from today, June 21st through Friday, June 28th (one week). The final Round 3 questionnaire will be sent out July 1st.

Again, thank you so much for your participation and I hope you all have great weekends!

Cory Clark, M.Ed, LPC-A, NCC
Ph.D Student ABD, NC State University

cwclark4@ncsu.edu
Appendix I

PHASE 2 ROUND 2 QUESTIONNAIRE

Child Counseling Questionnaire Round 2

Round 2: Developing a Competency System for Counseling Children: A Delphi Study

Thank you for your time and support in this important study about child counseling competencies! In this round of the study, I’ve only included items for which consensus was not reached last round. Based on the results of Round 1, the median and interquartile range (IQR) are provided to indicate the average of the groups’ ratings of each item. The median is the value separating the higher half from the lower half of all the ratings for that item. The IQR is the middle 50% of a data set. The IQR is often used as a better measure of the range of ratings as it is not affected by outliers. For example, a common IQR is 2, and the middle 50% of this data set is commonly represented with scores of 5 to 7.

When you see the IQR and median, pay attention to how it compares with your chosen ratings this round. If you do not agree with the median, please comment on that. There is a comments option provided for each item so that you can indicate your thoughts on how to refine the item or your reasoning for your rating (i.e. this item should have the word “multicultural” in it, or this item is not as important). The goal by the end of Round 3 is to develop consensus on whether or not to include these items in the final competency model. So far, 40 out of 78 items have reached consensus and those 40 were thus not necessary to include in this round.

You have been chosen for this study because you are an expert in child counseling and it is my hope that your contributions can help inform the training of future child counselors. As a reminder, you are in the second round of questionnaires in this research study.

Opportunities for open-ended responses of personal reasoning will be provided in this round and the third round so that you will have the opportunity to explain your answers. This questionnaire should take no longer than 15 minutes and your completion of it indicates your consent to continue participating in this study.

The first section will ask you to provide some of your personal demographics. The second section will address the areas of attitudes, knowledge, skills and actions.

D1 Section 2: Child Counseling Competencies

Domain 1: Attitudes as Child Counselors

These items are all about the attitudes a counselor must have in their work as child counselors...please indicate on a scale of 1 (not necessary at all) to 7 (very necessary), how necessary you believe each attitude is for individuals serving in child counseling roles. An average score of 7 on an item is needed for consensus.
12 Everything needs to be at a child’s level in the therapy room.
[Median = 6, IQR = 2]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) ________________________________________________

13 There is always meaning in a child’s behavior.
[Median = 6, IQR = 2]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) ________________________________________________

16 A strengths based approach is better than a problem centered one.
[Median = 6, IQR = 1.25]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) ________________________________________________

18 Children have their own language and we must speak in it with them.
[Median = 6, IQR = 2]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) ________________________________________________
21 Children want to play. [Median = 6.5, IQR = 1]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) 

22 Children are unique and we as therapists can help them get better. [Median = 6, IQR = 1]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) 

23 One must take a nontraditional stance and allow children to express themselves however they feel comfortable. [Median = 6, IQR = 2]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) 

25 Never ask a child to do anything you wouldn’t ask an adult to do. [Median = 5, IQR = 2]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) 
26 Always be curious about the child and all the things involved in his/her life. [Median = 6, IQR = 2]
   1: Not necessary at all (1)
   2 (2)
   3 (3)
   4 (4)
   5 (5)
   6 (6)
   7: Very necessary (7)
   Comments: (8) _____________________________________________

31 Have an “outside the box” attitude. [Median = 6.5, IQR = 1]
   1: Not necessary at all (1)
   2 (2)
   3 (3)
   4 (4)
   5 (5)
   6 (6)
   7: Very necessary (7)
   Comments: (8) _____________________________________________

32 Children are inherently good.  
   [Median = 6, IQR = 1]
   1: Not necessary at all (1)
   2 (2)
   3 (3)
   4 (4)
   5 (5)
   6 (6)
   7: Very necessary (7)
   Comments: (8) _____________________________________________

33 Child counseling is a separate and distinct process from counseling adults.  
   [Median = 6.5, IQR = 2]
   1: Not necessary at all (1)
   2 (2)
   3 (3)
   4 (4)
   5 (5)
   6 (6)
   7: Very necessary (7)
   Comments: (8) _____________________________________________
D2 Domain 2: Knowledge Bases of a Child Counselor

These items are about the knowledge and understandings a child counselor must learn in order to be a competent child counselor...please indicate on a scale of 1 (not necessary at all) to 7 (very necessary), how necessary you believe each knowledge and understanding is for individuals serving in child counseling roles. An average score of 7 on an item is needed for consensus.

34 Adlerian theory and Adlerian counseling
[Median = 5, IQR = 1.25]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) ________________________________________________

35 Child-centered therapy
[Median = 7, IQR = 1.25]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) ________________________________________________

37 Bronfenbrenner’s Ecological Systems Theory
[Median = 6, IQR = 3]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) ________________________________________________
38 Foundations of play therapy
[Median = 7, IQR = 2]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) ____________________________________________

39 Developmental psychology
[Median = 5.5, IQR = 2]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) ____________________________________________

40 Cognitive development
[Median = 6.5, IQR = 2]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) ____________________________________________

41 How to understand developmental or clinical theories and teach them to parents
[Median = 5, IQR = 1.25]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) ____________________________________________
42 Attachment theories
[Median = 7, IQR = 1.25]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) ______________________________________

48 The difference between play therapy and freeplay
[Median = 7, IQR = 1.25]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) ______________________________________

50 The intersection of child identities
[Median = 6, IQR = 2]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) ______________________________________

51 Family systems and associated theories
[Median = 6, IQR = 2]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) ______________________________________
53 Medical knowledge of child development
[Median = 5.5, IQR = 2]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) ________________________________________________

54 Maternal and paternal mental health knowledge
[Median = 6, IQR = 2]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) ________________________________________________

55 Parenting practices and models
[Median = 6, IQR = 2]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) ________________________________________________

57 Evidence based practices for each developmental stage and population
[Median = 6.5, IQR = 2]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) ________________________________________________
58 The DSM-5 sections relating to child diagnoses
[Median = 7, IQR = 1.25]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) _____________________________________________________________________________

103 Process of calling/reporting with child protective services and the department of health and human services
[new item, no data on median/IQR yet]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) _____________________________________________________________________________

104 Multicultural and social justice concepts (i.e. understanding the role of adultism, racism, classism, etc)
[new item, no data on media/IQR yet]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) _____________________________________________________________________________

D3 Domain 3: Skills a Child Counselor Must Possess

These items are all about the skills a counselor must have in their work as child counselors...please indicate on a scale of 1 (not necessary at all) to 7 (very necessary), how necessary you believe each skill is for individuals serving in child counseling roles. An average score of 7 on an item is needed for consensus.
59 Conducting play therapy
[Median = 6, IQR = 2]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) ________________________________________________

60 Activity therapy (using structured activities)
[Median = 6, IQR = 2.25]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) ________________________________________________

62 Teacher/school/other therapist consultation
[Median = 6, IQR = 1]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) ________________________________________________

68 Screening children
[Median = 6.5, IQR = 2]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) ________________________________________________
71 Writing behavior plans
[Median = 5, IQR = 2.25]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8)

72 Diagnostic systems and developmental psychopathology
[Median = 6, IQR = 2]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8)

76 Educating adults, parents and caregivers on child practices and research
[Median = 6, IQR = 1]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8)

77 Reading Individualized Education Plans
[Median = 5.5, IQR = 1]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8)
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<th>Median</th>
<th>IQR</th>
<th>1</th>
<th>2</th>
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<th>6</th>
<th>7</th>
<th>Comments</th>
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<td>78</td>
<td>Reading psychoeducational evaluations</td>
<td>6</td>
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<td>100</td>
<td>Being able to explore questions/issues that adults think children aren’t having (e.g., death, sexuality, other hard topics)</td>
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<tr>
<td>101</td>
<td>Flexibility in choosing and implementing interventions</td>
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<td>102</td>
<td>Specific training for counseling children, preferably play therapy</td>
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</tbody>
</table>
Domain 4: Actions a Child Counselor Must Take

These items are all about the actions a counselor must take in their work as child counselors...please indicate on a scale of 1 (not necessary at all) to 7 (very necessary), how necessary you believe each action is for individuals serving in child counseling roles. An average score of 7 on an item is needed for consensus.

86 Going to court for children when needed
[Median = 6, IQR = 2.25]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) ________________________________________________

105 Specific clinical field work (required hours or practice in practicum and internships) with direct interaction with children
[new item, no median/IQR data yet]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) ________________________________________________

89 Of the attitudes, knowledge, skills and actions that are identified as necessary, what are the MOST necessary? Please choose all that apply
Passion for children and for learning (2)
Authenticity (3)
Evidenced-based treatments for presenting problems and how these models can be adapted for children (4)
Advocating for children (5)
Self-reflection (6)
Speaking the language of the child (7)
Multicultural competence with children (9)
Meeting children where they are at with flexibility and creativity (1)
Rogerian core conditions of congruence, empathy, and nonjudgment (11)
Others (please list and rank) (10) ___________________________________________
90 Are there any other competencies of child counseling that you feel were not mentioned? Please describe any below:

FIN Thank you for your participation! You will be receiving an email with the link to the next round of this questionnaire development soon. Each round the questionnaire will be shorter as items that reached consensus will not be included in subsequent rounds. After one more round, the study will be complete!
Appendix J

PHASE 2 ROUND 2 COMMENTS

Item 12: Everything needs to be at a child’s level in the therapy room [Median = 6, IQR = 2]
- development should be accounted for, some materials may not be safe for very young children or those with oral fixation
- I’m not sure if you mean physical eye line level or psychological level
- For me it’s the word everything. Many counselors work with a variety of clients. There should be space that accommodates children but maybe not everything.
- due to size of rooms etc at times things are higher than child’s eye level
- Not necessarily everything because the counselor may be meeting with parents/ guardians as well in the therapy room.
- I enjoy inviting kids to explore things on all levels.

Item 13: There is always meaning in a child’s behavior [Median = 6, IQR = 2]
- I believe usually this is true. But not always.
- I agree with this a majority of the time, but sometime a child may be acting out scene from entertainment, which do not always indicate the child’s reality.

Item 16: A strengths-based approach is better than a problem centered one [Median = 6, IQR = 1.25]
- “better than” is not appropriate phrasing- how is this “better” than a different orientation?
- In many situations
- I believe that focusing on a positive outlook and approach rather then a negative viewpoint helps to build rapport and encourage children to ultimately become better.
- I think this is usually true, but it is also imperative to understand and utilize problem centered approaches, as they are needed often in therapy.
- Parents often focus on the problem, we need to assist with seeing the child’s best qualities.

Item 18: Children have their own language and we must speak in it with them [Median = 6, IQR = 2]
- I don’ think this is true of all children
- We must establish a baseline of their language so we can understand what they mean by what they say.

Item 21: Children want to play [Median = 6.5, IQR = 1]
- some diagnostic features changes the way this is defined for the child, so is this perception from the counselor or the child’s perspective?
- may not want to play yet is their natural ‘language’
Item 22: Children are unique and we as therapists can help them get better [Median = 6, IQR = 1]
- I’m not sure what “get better” means here. Sometimes a child’s stressors and environment does not allow them to “get better”. I believe we can help them cope and value their feelings, but the ceiling is sometimes low for how much children can reasonably
- They have a part in it as well, especially depending on their age

Item 23: One must take a nontraditional stance and allow children to express themselves however they feel comfortable [Median = 6, IQR = 2]
- with some teaching moments if the expression has consequences for them or others
- As long as it’s not detrimental to their development and overall well-being
- setting limits may be necessary however there is freedom of expression in play room
- Within the scope of boundaries set in the therapy room to ensure safety.

Item 25: Never ask a child to do anything you wouldn’t ask an adult to do [Median = 5, IQR = 2]
- ???
- This statement is unclear as I’m not sure if you mean in a developmental context or not. Seems like there is a statement under this statement that is convoluted.
- I would never ask an adult to play with me in the floor of my office, so I think this question can be misconstrued
- Child are much more receptive to engaging in play or “silly” techniques, but I would never ask them to do something that I wouldn’t ask them to do if an adult were in the room with us. If adult clients are willing to try these techniques for their own the

Item 26: Always be curious about the child and all the things involved in his/her life [Median = 6, IQR = 2]
No Comments

Item 31: Have an outside the box attitude [Median = 6.5, IQR = 1]
No Comments

Item 32: Children are inherently good [Median = 6, IQR = 1]
- I’m not sure what “good” means here- lack of behavior problems? Have intrinsic value? Want to grow? Clarity is needed
- Depending on your belief system, this can be true or false. Children are a product of their environment much of the time. This is a judgement statement.

Item 33: Child counseling is a separate and distinct process from counseling adults [Median = 6.5, IQR = 2]
- It’s like a specialty
- Absolutely! Children are NOT little adults
Item 34: Adlerian theory and Adlerian counseling [Median = 5, IQR = 1.25]
  • Your approach will be effective if you develop good rapport, no matter what particular modality you use.
  • Your approach will be effective if you develop good rapport, no matter what particular modality you use.

Item 35: Child-centered therapy [Median = 7, IQR = 1.25]
No Comments

Item 37: Bronfenbrenner’s Ecological Systems Theory [Median = 6, IQR = 3]
  • Children must be understood in their systems
  • I don’t even know what that is!

Item 38: Foundations of play therapy [Median = 7, IQR = 2]
  • not all will use play therapy

Item 39: Developmental psychology [Median = 5.5, IQR = 2]
  • otherwise you will not understand the child’s capacity or typical development, milestones, etc.
  • Maybe the word psychology throws it off. Counselors need an understanding if typical development
  • A knowledge of development assists greatly when working with atypical behaviors or issues. For example, a knowledge of children’s physical development is necessary. As a counselor, if I notice atypical physical movements or patterns, I need to alert the

Item 40: Cognitive development [Median = 6.5, IQR = 2]
No Comments

Item 41: How to understand developmental or clinical theories and teach them to parents [Median = 5, IQR = 1.25]
  • Essential component
  • understanding development & theories is a 7 and teaching them to parents is a 1 for me

Item 42: Attachment theories [Median = 7, IQR = 1.25]
  • Attachment has been trending but I’m not sure it’s critical for most child counselors to utilize regularly

Item 48: The difference between play therapy and freeplay [Median = 7, IQR = 1.25]
  • especially if you are providing play in therapy.

Item 50: The intersection of child identities [Median = 6, IQR = 2]
  • I’m not sure what this statement means- “child identities?”
  • Very important. Same as with adults.
  • I’m not sure what this question means
Item 51: Family systems and associated theories [Median = 6, IQR = 2]
No Comments

Item 53: Medical knowledge of child development [Median = 5.5, IQR = 2]
  • ‘medical knowledge’ no, knowledge yes... a 7

Item 54: Maternal and paternal mental health knowledge [Median = 6, IQR = 2]
No Comments

Item 55: Parenting practices and models [Median = 6, IQR = 2]
No Comments

Item 57: Evidence based practices for each developmental stage and population [Median = 6.5, IQR = 2]
  • population?

Item 58: The DSM-5 sections relating to child diagnoses [Median = 7, IQR = 1.25]
No Comments

Item 103: Process of calling/reporting with child protective services and the department of health and human services [new item, no data on median/IQR yet]
  • understand process and how to if needed

Item 104: Multicultural and social justice concepts (i.e. understanding the role of adultism, racism, classism, etc) [new item, no data on median/IQR yet]
No Comments

Item 59: Conducting play therapy [Median = 6, IQR = 2]
  • I think play therapy is helpful but not necessary

Item 60: Activity therapy (using structured activities) [Median = 6, IQR = 2.25]
No Comments

Item 62: Teacher/school/other therapist consultation [Median = 6, IQR = 1]
  • We need to do more of this but we aren’t incentivized to do so

Item 68: Screening children [Median = 6.5, IQR = 2]
No Comments

Item 71: Writing behavior plans [Median = 5, IQR = 2.25]
No Comments

Item 72: Diagnostic systems and developmental psychopathology [Median = 6, IQR = 2]
No Comments
Item 76: Educating adults, parents and caregivers on child practices and research [Median = 6, IQR = 1]
  • It is more important to teach them to be good parents first.

Item 77: Reading Individualized Education Plans [Median = 5.5, IQR = 1]
  • Helpful for advocacy. But should also happen with consultation

Item 78: Reading psychoeducational evaluations [Median = 6, IQR = 2]
No Comments

Item 100: Being able to explore questions/issues that adults think children aren’t having (e.g., death, sexuality, other hard topics) [new item, no median/IQR data yet]
  • unclear of question regarding ‘aren’t having’

Item 101: Flexibility in choosing and implementing interventions [new item, no median/IQR data yet]
No Comments

Item 102: Specific training for counseling children, preferably play therapy [new item, no median/IQR data yet]
  • not all will be play therapists, if you are doing play therapy it IS important
  • Yes, and a necessity for the first two questions as well

Item 86: Going to court for children when needed [Median = 6, IQR = 2.25]
  • We are critical in courtrooms
  • believe some can specialize in and children need more advocates however not an actions that counselors must take (unless subpoena)

Item 105: Specific clinical field work (required hours or practice in practicum and internships) with direct interaction with children [new item, no median/IQR data yet]
  • VERY NECESSARY if you are planning to work with children. If not less so.
  • I think this should be rephrased to identify supervised clinical work and maybe identify the minimum amount of supervised practice hours in child counseling
  • Most programs do not allow work with children, only adolescents
  • YES!
Appendix K

FINAL ROUND EMAIL

Dear Child Counseling Study Participants,

We are ready for the last round! This final questionnaire should only take a couple minutes of your time. Please see the link here for the last questionnaire for this study-
https://ncsu.qualtrics.com/jfe/form/SV_1A08iicxNWD9ZOt

Compared to about 90 items in Round 1, this final round only has 15 items after the demographic questions. Please comment on any items on which you have thoughts or opinions. These last items are the only ones that we have not reached consensus on at this point (having an IQR at or below 1). Please also pay attention to the last item about ranking the ten most important competencies of counseling children. It may be difficult to rank order items that are all essential in some way but your input will be invaluable in creating the final competency model for counseling children.

Today is Tuesday, July 2nd and this final questionnaire will be live a little longer than a week, until Friday, July 12th, to accommodate vacation schedules this week.

After July 12th, I will analyze and send out two 50$ gift cards via Amazon to two randomly chosen participants in this study.

Again, thank you so much for your participation in this important study!

Sincerely,

Cory Clark, M.Ed, LPC-A, NCC
Ph.D Student ABD, NC State University
cwclark4@ncsu.edu
Appendix L

PHASE 2 ROUND 3 QUESTIONNAIRE

Child Counseling Questionnaire Round 3

Round 3: Developing a Competency System for Counseling Children: A Delphi Study

Thank you for your time and support in this important study about child counseling competencies! This is the FINAL round of data collection! This questionnaire is much shorter than the previous two because it only includes items for which consensus was not reached at this point.

Based on the results of Round 2, the median and interquartile range (IQR) are provided to indicate the average of the groups' ratings of each item. The median is the value separating the higher half from the lower half of all the ratings for that item. The IQR is the middle 50% of a data set. The IQR is often used as a better measure of the range of ratings as it is not affected by outliers. For example, a common IQR is 2, and the middle 50% of this data set is commonly represented with scores of 5 to 7.

When you see the IQR and median, pay attention to how it compares with your chosen ratings this round. If you do not agree with the median, please comment on that. There is a comments option provided for each item so that you can indicate your thoughts on how to refine the item or your reasoning for your rating (i.e. this item should have the word "multicultural" in it, or this item is not as important). The goal by the end of this round is to develop consensus on whether or not to include these items in the final competency model.

You have been chosen for this study because you are an expert in child counseling and it is my hope that your contributions can help inform the training of future child counselors.

As a reminder, you are in the third and final round of questionnaires in this research study. Opportunities for open-ended responses of personal reasoning are provided so that you will have the opportunity to explain your answers. This questionnaire should take no longer than 5 minutes and your completion of it indicates your consent to continue participating in this study.

The first section will ask you to provide some of your personal demographics. The second section will address the areas of attitudes, knowledge, skills and actions.

Section 1: Demographic Information

Please answer each question fully, though not all questions in this section are required.

1 Please write your first name:
2 Please provide your preferred email address so that the researcher may email you with your responses to this round, and your email will be used for the random drawing of two Amazon gift cards!

________________________________________________________________

3 Please indicate your sex:
Male (1)
Female (2)
Other (please specify) (3) ____________________________________________

4 Please indicate your age:
________________________________________________________________

5 Which of the following best describes your ethnicity?
Asian American/Pacific Islander (1)
American Indian (2)
African American/Black (3)
White American/Caucasian (4)
Hispanic/Latino/a/x (5)
Multiracial (6)
Other (please specify) (7) ____________________________________________

6 Which of the following best describes the role in which you work?
Professional Counselor (1)
Counselor Educator (2)
Author (3)
Other (please specify) (4) ____________________________________________

7 How many years of experience do you have counseling children?
2-5 (1)
6-10 (2)
11-15 (3)
16-20 (4)
More than 20 years (5)

8 What professional license(s) and/or certifications do you hold?
________________________________________________________________

9 Where is the geographical location that you practice child counseling (i.e. Northeast Ohio, rural Pennsylvania, etc.)?
________________________________________________________________
D1 Section 2: Child Counseling Competencies

Domain 1: Attitudes as Child Counselors

These items are all about the attitudes a counselor must have in their work as child counselors…please indicate on a scale of 1 (not necessary at all) to 7 (very necessary), how necessary you believe each attitude is for individuals serving in child counseling roles. A median score of 7 on an item is needed to be included in the final competency model.

12 Everything needs to be at a child’s level in the therapy room.
[Median = 6, IQR = 2]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) _______________________________________________

16 A strengths-based approach is more appropriate than a problem centered one.
[Median = 6, IQR = 2]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) _______________________________________________

25 Do not expect a child to act the same as an adult in the therapy room.[Median = 6, IQR = 2.75]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) _______________________________________________
D2 Domain 2: Knowledge Bases of a Child Counselor

These items are about the knowledge and understandings a child counselor must learn in order to be a competent child counselor...please indicate on a scale of 1 (not necessary at all) to 7 (very necessary), how necessary you believe each knowledge and understanding is for individuals serving in child counseling roles. A median score of 7 on an item is needed to be included in the final competency model.

34 Adlerian theory and Adlerian counseling
[Median = 4.5, IQR = 1.75]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) ________________________________________________

37 Bronfenbrenner's Ecological Systems Theory
[Median = 6, IQR = 2]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) ________________________________________________

41 How to understand developmental or clinical theories and teach them to parents[Median = 5.5, IQR = 2]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) ________________________________________________
Evidence based practices for each child developmental stage

[Median = 6, IQR = 2]
1: Not necessary at all  (1)
2  (2)
3  (3)
4  (4)
5  (5)
6  (6)
7: Very necessary  (7)
Comments:  (8) ________________________________________________

D3 Domain 3: Skills a Child Counselor Must Possess

These items are all about the skills a counselor must have in their work as child counselors...please indicate on a scale of 1 (not necessary at all) to 7 (very necessary), how necessary you believe each skill is for individuals serving in child counseling roles. A median score of 7 on an item is needed to be included in the final competency model.

Activity therapy (using structured activities)

[Median = 6, IQR = 2]
1: Not necessary at all  (1)
2  (2)
3  (3)
4  (4)
5  (5)
6  (6)
7: Very necessary  (7)
Comments:  (8) ________________________________________________

Screening children

[Median = 7, IQR = 1.75]
1: Not necessary at all  (1)
2  (2)
3  (3)
4  (4)
5  (5)
6  (6)
7: Very necessary  (7)
Comments:  (8) ________________________________________________
71 Writing behavior plans
[Median = 5, IQR = 2]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) _______________________________________________

76 Educating adults, parents and caregivers on child practices and research[Median = 6, IQR = 2]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) _______________________________________________

78 Reading psychoeducational evaluations
[Median = 6, IQR = 1.5]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) _______________________________________________

D4 Domain 4: Actions a Child Counselor Must Take

These items are all about the actions a counselor must take in their work as child counselors...please indicate on a scale of 1 (not necessary at all) to 7 (very necessary), how necessary you believe each action is for individuals serving in child counseling roles.
A median score of 7 on an item is needed to be included in the final competency model.
86 Going to court for children when needed
[Median = 6, IQR = 2]
1: Not necessary at all (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7: Very necessary (7)
Comments: (8) ___________________________________________________________________

89 Of the attitudes, knowledge, skills and actions that are identified as necessary, what are the
MOST necessary? Please rank them from 1 being the most important to ten being the least.
____ Passion for children (2)
____ Authenticity (3)
____ Evidenced-based treatments for presenting problems and how these models can be
adapted for children (4)
____ Advocating for children (5)
____ Self-reflection (6)
____ Speaking the language of the child (7)
____ Multicultural competence with children (9)
____ Meeting children where they are at with flexibility and creativity (1)
____ Rogerian core conditions of congruence, empathy, and nonjudgment (11)
____ Knowledge of legal and ethical issues with counseling children (10)

90 Are there any other competencies of child counseling that you feel were not mentioned?
Please describe any below:

FIN Thank you for your participation! Within two weeks I will be drawing a two random emails
from the sample in this study and they will rewarded with a 50$ gift card!
Appendix M

PHASE 2 ROUND 3 COMMENTS

Item 12: Everything needs to be at a child's level in the therapy room. [Median = 6, IQR = 1]
- Things above eye level are not intended for child. For example, if have stored items high or office has multiple uses.
- Does "at the child's level" mean developmentally or physically at eye level? This is confusing
- If not at child height, at least visible to the child but furniture should be at their height.
- Sometimes this is not practical due to space limitations
- I do not feel this is necessary as I invite children to explore my office without judgment.
- Depends on if you see just kids or some adults

Item 16: A strengths-based approach is more appropriate than a problem centered one. [Median = 6, IQR = 1]
- I believe that we can identify the concern, but then begin to create a plan for what they want wellness to look like in their lives and the life of their child. Reflect on the perceived problem long enough for it to serve as contrast so you can identify what you would rather see and build on strengths to make that picture a reality
- Today's child is introduced to criticism early in life. Mostly having a desire to succeed in play and school. A strengths based approach highlights their ability to problem solve and reinforce the presence of their importance in the world.

Item 25: Do not expect a child to act the same as an adult in the therapy room. [Median = 7, IQR = 0]
- Adults don't even act the same in the therapy room so we certainly should not expect for a child to act the same as an adult in the therapy room
- They are children! Let them be children.

Item 34: Adlerian theory and Adlerian counseling [Median = 5, IQR = 1]
No Comments

Item 37: Bronfenbrenner's Ecological Systems Theory [Median = 6, IQR = 1]
No Comments

Item 41: How to understand developmental or clinical theories and teach them to parents [Median = 6, IQR = 1]
- Many parents misunderstand developmental issues as mental health problems

Item 57: Evidence based practices for each child developmental stage [Median = 6, IQR = 2]
- I believe various theories are beneficial as a foundation but we must be careful to avoid allowing the theory to dictate how we respond to children because times have changed and those theories were created during a different time.
Item 60: Activity therapy (using structured activities) [Median = 6, IQR = 2]
- A suggested age range for the client would be helpful here- my answer would be different if we are only talking about children under 10 than if we are talking about children 18 and under.

Item 68: Screening children [Median = 6, IQR = 2]
- Screening children based on what type of instrument? I am concerned about "screening" what are we looking for? I wonder if instead of "screening" children we would talk with them, hear their worldview and build from there.

Item 71: Writing behavior plans [Median = 5, IQR = 2]
No Comments

Item 76: Educating adults, parents and caregivers on child practices and research [Median = 6, IQR = 2]
- Research changes so frequently, instead of educating parents on what research says, get to know the child and the family and help them to create a plan that works best for their lives and not necessarily what has been generalized from research findings.

Item 78: Reading psychoeducational evaluations [Median = 5, IQR = 1]
- I feel like psychevals are from a deficit approach instead of a strengths based. It seems as though psych evals are looking for evidence to support what is "wrong" with a child instead of using a strengths based evaluation and allowing the focus to be on what is going well...use that energy to continue working toward wellness. Children are not broken and they are not in need of fixing. If we see them as broken then our work with them will be out of pity and not out of the excitement and belief that they are strong and capable of making greater gains!
- clarity needed on what type of evaluation this is- school/educational evaluation?

Item 86: Going to court for children when needed [Median = 6, IQR = 2]
- If the therapist and family feel this is beneficial
- I only agree to court appearances when the child benefits from this service.