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Counseling Adolescents with Chronic Physical Chronic Conditions

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CERTIFICATE OF APPROVAL

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CAPSTONE PROJECT

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Counseling Adolescents with Physical Chronic Conditions

This is to certify that the Capstone Project of

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Abstract

The following paper will address the counseling considerations of children and adolescents who have physical chronic conditions. Mental health counselors must be aware of specific needs for this population including co-occurring mental health disorders, impacts of primary identifiers, and suggestions for implementing a biopsychosocial approach to counseling, which includes both cognitive behavioral and existential interventions.

Keywords: *adolescents, chronic illness, depression, anxiety, eating disorders, suicide, substance abuse, self-medicating, cognitive behavioral therapy, motivational interviewing.*

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Counseling Children and Adolescents with Chronic Illnesses

Our current society began to change overnight to value the status of health. In the United States it was assumed that most of the population would qualify as healthy. This assumption can be seen through American's perception that healthcare is an unnecessary addition or a privilege rather than a basic right. With the recent pandemic the status of one's health is now questioned daily before going to work or even entering a grocery store. Those that were once privileged to maintain their healthy status now may empathize with the daily changing reality of those with a chronic illness in the United States.

Chronic illnesses are a prolonged condition which requires ongoing medical treatment lasting from three-months to a lifetime (Chronic Disease in America, 2020). According to the CDC chronic illnesses affect an estimated every six out of ten Americans and is the number one cause of disability (Chronic Disease in America, 2020). Despite the large percentage of Americans affected, implications outside of the medical or physical effects are not known. Even less is known about the implications of disease in children and adolescents. It is estimated that ten to twenty million children are believed to have at least one chronic illness in America (Chronic Disease in America, 2020). The type of disease degrees of severity, prognosis, and impact of functionality can vary; some of the most common chronic conditions for children include, asthma, diabetes, arthritis, cerebral palsy, cancers, or epilepsy.

Children and adolescents that have a chronic condition are of special interest to the mental health community due to the crucial and influential period in which their disease takes place. Adolescents begin to form their identities and personalities which continue into adulthood. Adolescents can be marked by significant stressors due to changes in one's body and social pressure. The addition of a chronic illness leaves this population particularly vulnerable to mental health disorders. The deceptive assumption that children and adolescents are resilient is

harmful to children that need help from their healthcare team. The following is an overview of mental health concerns when working with an adolescent with a chronic illness.

Review of Literature

Recent findings support that children and adolescents that are diagnosed with one or more physical chronic illness are at an increased risk of developing mental health disorders. According to Suryavanshi and Yang's article, "Clinical and Economic Burden of Mental Disorders Among Children with Chronic Physical Conditions, United Sates 2008-2013", it was estimated that 14% of all U.S. children had at least one chronic physical illness (2016). This percentage is projected to increase due to medical advances such as, diagnostic procedures and access to health care. Compared to their healthy counter parts, children with physical conditions were 62% more likely to experience a mental health disorder (Suryavanshi & Yang, 2016). Disturbances in their social development due to frequent doctor appointments, treatments, use of assistive medical devices, or stigmatization have the potential to lead to behavioral disturbances or mental disorders such as, social disorders, anxiety, and depression.

Anxiety and Depression

There are two theories that are used to view the correlation between physical conditions and depressive disorders: the pathophysiologic theory and the cognitive theory. Pathophysiologic theory proposes that the connection of depression and physical conditions is linked through specific biological mechanism involved with certain physical conditions (Stegmann et. al., 2010). Due to the multitude of studies focusing on a single condition's relationship with depression this theory is often explored in literature. Alternately, the cognitive theory hypothesizes that the relationship between depression and physical conditions is linked through the disability associated with a physical condition (Stegmann et. al., 2010). The cognitive theory

emphasizes universal experiences and stressors such as, finical uncertainty, loss of ability, and lower self-esteem which are not limited to a single diagnosis. The cognitive theory emphasizes the degree of function or restrictions a person experiences, the greater the restriction the greater correlation of depression. Stegmann and associates (2010) aimed to corroborate the cognitive theory by exploring the relationship of seven specific chronic conditions and a 12-month major depressive episode. With each physical condition, the presence of a major depressive episode increased, in the case of four or more physical conditions the likelihood of a major depressive episode increased five time more compared to the control group (Stegmann et. al., 2010). Stegmann and associates' study notes the strongest associations were observed in physical conditions that are linked to greater restrictions and pain such as, arthritis, heart disease, or stomach ulcers (2010). These findings support the cognitive theory that the decrease in function positively increases depressed affect. While these findings may appear to be common knowledge however, this information needs to be applied to the treatment of children and adolescents with a chronic physical condition.

Children are presumed to be resilient even in the face of significant physical conditions resulting in an underdiagnosis and lack of treatment of mental health disorders. Recent data suggests that overall prevalence of depression in US children under the age of thirteen is 2.8% , ages thirteen to eighteen have a prevalence rate of 5.6%, which is then compared to the striking prevalence of depression in children with a long-term physical condition at 40% (Thabrew et. al., 2018). Often co-occurring with depression is anxiety. For children with physical chronic conditions anxiety can be fueled by lack of control of their condition, invasive medical procedures, distressing symptoms, peer rejection, or increase fear of death. Additional risk factors for developing anxiety for children with physical chronic conditions include, young

diagnosis, female gender, and impact of disease (Thabrew et. al., 2018). By highlighting these risk factors parents, mental health providers, and specialty physicians can screen for potential mental health issues. Left untreated, children that experience depression and anxiety can develop poor academics and dysfunction within their personal and social existence. Children with physical chronic conditions as well as depression or anxiety can see negative effects in their physical condition. Depressive symptoms can affect the child's level of motivation to speak about medical concerns or adhere to their treatment plan. Depression also can affect the ability to manage pain and, in some cases, lead to suicide.

Substance Abuse

In addition to increased risk of depression and anxiety, children and adolescents with chronic conditions are at risk of using and abusing substances and alcohol to self-medicate. Nicholas and associates published a study in the American Journal on Addictions which sought to identify the medical demographic of those receiving treatment for co-occurring substance abuse and other mental health disorders which revealed that those in treatment compared to the general population showed a higher prevalence of common chronic conditions such as, hypertension, asthma, arthritis, and smoking (Nicholas et. al., 2012). These results suggest that in conjunction to being at a higher risk of a mental health disorder those with physical chronic conditions are also at an increase risk of substance abuse. The relationship between substance abuse and chronic conditions is circular with each exacerbating the other if either is left untreated. The increase of substance use can mask symptoms of the condition or cause a flare in the condition. On the other hand, decrease in substance use can emphasize the discomfort of the condition resulting in substance use as a form of self-medication. These findings would support a

collaborative-care environment in which the person's treatment plan included progress for not only substance abuse or mental health but also their physical health as well.

While a collaborative-care environment is needed for treatment there is evidence to support further preventative measures. The first is emphasized in the dangers of self-medicating to treat pain or psychological symptoms. The dangers of opioids are well known however, its therapeutic affects are still a valid form of pain management. Addressing only the potential negative affects of the substance without providing alternatives for treating the pain symptoms is ineffective and can lead to abuse. Of those that reported both chronic pain and a prescription for opioids 83% reported that initially the opioids were used to treat the pain (Daniel et al., 2015). The presences of chronic pain not only increased the likelihood of access to substances through prescriptions but also is associated with relapse after detoxification. This emphasizes the circular relationship between treating the substance use and not the pain symptoms.

In efforts to alleviate physical or psychological pain, one of the more recent controversial remedies is marijuana. While the negative effects of alcohol and opioids are generally well marketed to the public including adolescents, marijuana on the other hand is publicly becoming known for its therapeutic use for pain, nausea, muscle spasms, insomnia, and in some states used to treat chronic physical conditions. Adolescents with chronic physical conditions that are looking to self-medicate are uniquely drawn to this substance. Little is known about the non-recreational use of marijuana for adolescents. In the article published by Bottorff and associates "Relief-oriented use of marijuana by teens" sets out to understand the adolescent experience for using marijuana for therapeutic reasons as well as, how that affected social norms. Their study revealed common themes from adolescents who self-medicate including, relief from medication side effects, perceived inadequate medical care, and social acceptance (Bottorff et. al., 2009).

Prescription drugs can come with a lengthy list of potential side effects. Common side effects an adolescent may stop use over include feeling nauseous, lethargic, foggy, or having a change in appetite or in weight. The adolescent must decide if the benefits or potential benefits outweighs the negative affects of the drugs. If presented with an alternative that not only alleviates symptoms of their condition but also eliminates the need of the drug that is causing negative symptoms, an adolescent would be more likely to use the alternative regardless of the legal status. Unmet health needs are another reason cited by adolescents for seeking self-medicating alternative. Authors highlight the level of distress experienced by adolescents with physical conditions regarding their health care. Feeling that their concerns were unhear or unmet, recognizing insurance policies as barriers to treatments, and adolescents think that they had to take their care into their own hands (Bottorff et. al., 2009). Another perspective brought to light by the article was the desensitization to medical interventions (2009). For a child that has grown up associating consuming a pill or substance to alleviate negative symptoms when they use marijuana to self-medicate, they are less likely to experience the rebellious feeling that their healthy counterparts experience. The emphasis on symptoms relief overshadows adolescent rebellion. Socially marijuana is generally perceived as the “natural” alternative and “safer” than pharmaceutical drugs. The adolescent may have been approached by others in their life inquiring of their attempts of alternative methods about their treatment which results in not only curiosity but perceived as an acceptable route of self-medicating.

While the intended purpose is therapeutic adolescents that chose to self-medicate with marijuana are at risk for health complications, increased risk of developing mental health disorders, and legal sanctions. Two patterns of relief use were identified as intermittent and chronic, the first is associated with an increase in symptoms while the later is defined as daily

marijuana use (Bottorff et. al., 2009). The justification of the use can influence the adolescent's usage as they believe it as a therapeutic need rather than a recreational use. Adolescents with chronic physical conditions may not notify their doctor of the use due to the federal legal status creating the risk of developing health complication. Inhaling the substance is one of the more common modes of delivery which can impact an individual's lungs and heart, especially if they are compromised. Regular marijuana use has been associated with risk factors for mental health disorders such as, psychosis, schizophrenia, and panic attacks (Bottorff et. al., 2009). Marijuana use may provide relief from some mental illnesses such as anxiety or depression however, there is evidence that even light use can worsen depression and increase the risk of suicide (Bottorff et. al., 2009). Adolescents with physical chronic conditions are at an increase for depression and anxiety as well as using marijuana to alleviate pain. Lastly, adolescents using marijuana to self-medicate may be clouded by the perceived benefits and general social acceptance rather than the risk of legal sanctions.

Eating Disorders

Adolescence is a time where bodies undergo a great deal of change through puberty. During this time adolescents attempt to find ways to cope with their changing bodies and achieve peer acceptance. The developmental process of puberty impacts the satisfaction of one's body possibly leading to unhealthy weight loss strategies for both males and females such as, food restricting, excessive exercise, or purging (Smith et. al., 2008). Adolescents with chronic conditions that are dissatisfied with their body or have feelings of isolation could develop eating and body image disorders. Indications of an eating or body image disorder could be camouflaged in this population due to symptoms related to the pre-existing condition resulting in under diagnosis rates (Smith et. al., 2008). In the case of an adolescent with diabetes weight loss is

often a health goal. Dietary regulation, weight management, pressure from doctors, and third parties may be a factor in increasing the risk of developing an eating disorder (Smith et. al., 2008). Weight loss could be perceived as an organic outcome from the disease such as, a side effect from medications, lack of appetite, or disease progression rather than an eating disorder resulting in delayed or underdiagnosing. Adolescents with visible differences from their health peers may perceive weight as something they can control and use to be accepted by their peers or as a tool in attempts to hide their deformities (Smith et. al., 2008). The connection between eating or body image disorders illustrates the need for prevention as well as resources for at risk adolescents. While management of chronic conditions can require a team of providers, parents are integral to implementing the treatment plan. When a disease-specific diet is suggested it is the parents who ensure the child follows the guidelines. Parents that overcontrol or restrict feedings the child's self-regulation over appetite and eating such as internal cue of hunger and self-control may be disrupted (Conviser et. al. 2018). Adolescents with chronic conditions such as, gastrointestinal disorders, celiac, cystic fibrosis, and diabetes increase risk of developing eating disorders due to the therapeutic focus on dietary changes for health outcomes.

Suicide

The relationship between chronic illnesses and mental health disorders is established which indicates strong risk factors for suicide. Suicide is the third leading cause of death in the United States for ages 10 to 24 years old and cause for public concern for this population (Greydanus et. al., 2010). There are is not a physical indicator that suicide will take place however, there are factors which make an individual more likely to attempt. The first factor in the equation is age. Suicidal thoughts are reported by 13% of adolescents with 4% attempting to commit suicide (Ferro et. al, 2017). Adolescents must go through one of the biggest transitions in

their lives, puberty. Not only do their bodies transition but they experience many social transitions such as, changing schools and begin to take on more personal responsibility. Adolescents begin to explore and express their identities resulting in either peer acceptance or rejection. The second risk factor is mental health disorders such as, depression, generalized anxiety disorders, and substance use disorders. When screening adolescents who have made a suicide attempt 35-50% indicate depressive symptoms prior to attempt (Greydanus et. al., 2010). Adolescents with a physical chronic condition are more likely to report comorbid mood disorder and substance use disorders compared to their healthy counterparts increasing their odds for suicidal thoughts and attempts (Ferro et. al, 2017). Parents and the health care team should work with adolescents with chronic conditions to bring awareness to the risk and resources for responding to the increase risk. Adolescents with chronic conditions go through an additional transition unique to their health care, switching from pediatric providers to adult care providers. This transition could result in a miss of suicidal indications. New providers may be unfamiliar with the adolescent's disposition, unaware of mental health diagnosis, or additional risk to the adolescent. This transition could result in a lack of care while the adolescent waits to be seen by a new provider therefore, parents of the adolescent must also be aware of the unique risk the chronic condition has on suicide.

Impact of Primary Identifiers

One of the primary goals of adolescences is to find one's identity and acceptance among like peers. To achieve this goal an induvial with a chronic condition may attempt to conceal their illness. In an article by Cook, Salter, and Stadler, *Identity Concealment and Chronic Illness: A Strategic Choice*, the authors explore the benefits of concealing an illness as well as the psychological burden it can have on an individual. When making the choice to conceal their

illness the most influential factor is the degree of the disability. Chronic illnesses that do not have outward physical characteristics are more easily concealed from healthy peers. Conditions that are invisible to an outsider are harder for an adolescent to explain to others therefore, concealing allows for one to maintain personal control over disclosure. Concealing allows for one to avoid being a target of stigma or discrimination. If one's primary identifier is their physical condition they are at risk of discrimination, stereotype threat, microaggressions, and strains on interpersonal relationships or social wellbeing (Cook et. al., 2017). These are legitimate reason for why one might conceal their chronic condition however, it is not done without a cost. Maintaining a persona in public that is different from who someone is privately requires socially tracking who knows what information, regularly searching the environment for signs that concealment is compromised and preparing for the consequences of concealment (Cook et. al.2017). This creates feelings of inauthenticity and decreases the ability to feel belongingness which is the primary goal of adolescences. Concealment of chronic conditions is a strategic choice that does have benefits in the short-term but could have greater affects in adolescents who are beginning to build their own identity.

Identity begins to form in adolescence into young adulthood with continued exploration of self. A young adult with a physical chronic condition attempts to find balance and flexibility between disease management and normal developmental tasks now without parental guidance. Similar to concealment, one may cope with their condition through avoidance or adaptation to their condition rather than integrating the condition as a single part of what makes up their identity. When exploring young adults' identity development, those that fail to establish a strong sense of identity are associated with an increase of disease-related problems and maladaptive coping strategies compared to both those that establish a health sense of self (Luyckx et. al.,

2008). The addition of a physical chronic condition can limit self-exploration compared to healthy counterparts. The lack of exploration can be tied to primary concerns of health management and perceived as fewer opportunities or limitations due to their condition (Luyckx et. al., 2008). The goal of balancing normal development with managing one's condition can be upset by hospital visits during slumber parties, using an adaptive device throughout high school, or the inability to find a campus that provides the needed assistance. Without encouragement and advocacy, an emerging young adult may perceive that their future and identity must be contained to what they think is expected of them.

Impacts of Microaggressions

Those that do not or cannot conceal their chronic conditions are targets for a type of discrimination called microaggressions. Microaggressions are common verbal or behavioral actions which either intentionally or unintentionally convey hostile, negative, or derogatory insults toward persons of marginalized status (Olkin et. al., 2019). These brief interactions can cause significant psychological impacts as they are more likely to occur on throughout one's daily life. Ten common microaggressions for people with disabilities were identified in the article, *The Experiences of Microaggressions against Women with Visible and Invisible Disabilities* (Olkin et. al., 2019).

The first microaggression was termed as, second-class citizenship which occurs when a person with a disability is not allowed to access the same rights as an abled individual (Olkin et. al., 2019). An example of this type of microaggression would occur when reasonable accommodations are viewed as a hassle or unnecessary. Refusal of adding accessible entrances to businesses, charging more for handicapble car services, and public transportation refusal due

to the time it takes to lower the ramp are all examples of microaggressions which elicit the feeling of being less than abled bodied counterparts.

The second type of microaggressions refers to others ignoring other aspects of a person's identity and focusing solely on the disability as one's primary identifier (Olkin et. al., 2019). Assumptions that someone with a disability couldn't also be a full-time employee or a caregiver themselves exemplify the overshadowing of the disability. A person with a disability might be met with shock from others when they identify as married to someone without a disability due to the assumption that they would only be with someone that had a like disability.

Denial of disability experience, perpetrator minimized the effect of the disability for the person with the disability, this is the third microaggression and ranked as one of the most bothersome to endure (Olkin et. al., 2019). The implication by the perpetrator is that the person with the disability is faking it, exaggerating the condition, using their disability for personal gains, or not taking care of themselves causing the condition to be worse than what it could be. This can be especially prevalent for those that have invisible or conditions that at times are more visible than others. A person with an auto-immune disorder could conceal their condition from peers until the condition flares requiring them to use an assisted device, causing visible symptoms such as, limping, or canceling social plans due to the condition. A person in this situation may be perceived as faking it for attention or to get out of prior commitments since the condition is not always seen it is less believed.

The fourth identified microaggression is denial of privacy through overly personal questions (Olkin et. al., 2019). This is seen through the form of unsolicited advice for treatment methods in person or through social media. Humans naturally are curious however, this curiosity can translate into a demand of information such as, asking intrusive comments for why someone

is receiving an accommodation or what their condition is. Privacy can be violated physically by a perpetrator picking up a person with a disabilities belongings without being asked or attempting to physically help the individual move without consent from the person with the disability. Similarly, to the pervious microaggression is the fifth which is helplessness or others assuming a person with a disability needs help (Olkin et. al., 2019). While the intend action or offer is not to harm the individual assuming that they need help most of the time removes a person's autonomy. It is not true that a person with a disability needs more help than an abled bodied individual. Singling a person out based on disability alone is discrimination regardless of intended good will.

The next termed microaggression is the expectation that others should be praised for doing something for an individual with a disability (Olkin et. al., 2019). Previously mentioned an abled bodied individual may think they are doing the right thing by pushing the person in a wheelchair across a door threshold before being asked but could be confused when the individual is upset at the perpetrator. The expected appraisal of doing good by perpetrators could be seen through false advertising for accessibility or exploitation of person with a disability.

The next microaggression refers to spread effect or the assumption that the disability effects other capabilities (Olkin et. al., 2019). An example of this microaggression would be the assumption a person with a severe disability would also suffer intellectually. Quite famously, Steven Hawking's is a counter example to this stereotype. Related to the previous microaggression is the eighth microaggression which is termed infantilization, which is when someone treats another person as if they are a child due to their disability (Olkin et. al., 2019). This can be seen when someone kneels down to a person in a wheelchair or through the assumption that an individual with a disability is reliant on others, incapable of be independent.

The next microaggression is patronization through praises for almost anything achieved (Olkin et. al., 2019). Condescending praise for everyday tasks such as, going grocery or being idolized as inspiration for accomplishing normal developmental tasks are examples of patronization.

Desexualization or experiencing devaluation as a romantic prospect is the last identified microaggression (Olkin et. al., 2019). Persons with a disability are assumed to be asexual or that they experience dating difficulties. Those that secure a partner can encounter assumptions from others that their partner is pitying them, their partner is a better person for giving them a chance, or that their partner is a caregiver over a romantic partner.

If the microaggressions associated with their disability identity were not enough to endure, many individuals experience being a member of two or more stigmatized groups. Intersectional invisibility occurs when an individual that is an atypical member due to multiple marginalized identities cannot be accepted fully by either group (Olkin et. al., 2019). Females with disabilities uniquely encounter microaggressions such as, medical professionals assuming their symptoms are psychoemotional rather than physical and assumptions that an individuals' attractiveness negates their condition (Olkin et. al., 2019). The first microaggression can result in females receiving inadequate health care, underdiagnosing, and leads to unnecessary pain or worsening of the condition. The second microaggression experienced by females with disabilities emphasizes the irrational belief that attractive individuals are entailed to better health. This microaggression also perpetuates gender inequalities outside of one's identity as a person with a disability.

Intersectional invisibility can occur for those that identify as a sexual minority and having physical disability. A person that is apart of the LGBTQ+ community and has a disability is at an increase risk of experiencing isolation and a lack of belongingness compared to other

marginalized groups such as race and gender. Unlike those marginalized based on race/ethnicity or genders it is unlikely that a person that experiences both a disability and sexual minority will have other persons in their family or immediate circle that can identify similarly (Conover & Israel, 2018). Homonegative microaggressions can occur when a person seeks out community for their disability but conceals their sexual minority status for fear of rejection. Some disability communities may centralize around ideology of healing through faith or religious beliefs. This can be unwelcoming to a person due to the historic stand religion has with sexual minorities. Ableist microaggressions can occur while one attempts to access the sexual minority community but encounters physical barriers to the community or experiences desexualization due to their disability. Males that are a part of the sexual minority group and disabled community are more vulnerable to rejection of social, sexual, or romantic interactions compared to nondisabled sexual minority men (Conover & Israel, 2018). To counter the negative effects of marginalization and microaggressions social support is cited as a buffer due to the effect of creating beliefs that an individual is loved, valued, and a sense of mutual belongingness (Conover & Israel, 2018). Those that identify with a marginalized group need developing a sense of community especially for those that experience multiple marginalized identities.

Theoretical Approach to Treatment

Those that suffer from physical chronic conditions in childhood are at an increase risk of mental health disorders and discrimination (Schaefer & Kavookjian, 2017). Mental health counselors are positioned to address the effects of discrimination as well as, provide treatment for co-occurring mental disorders. While there are universal experiences that adolescents or children with chronic conditions experience, there are also differences that a counselor should be aware of when choosing theoretical approaches. One theory alone may not be effective in

creating change for the adolescent. Motivational Interviewing and Cognitive Behavioral Theory are two complimentary theories that can be used to elicit positive change for an adolescent with a chronic condition.

Motivational Interviewing emphasizes a collaborative, empathic and autonomy based approach to change (Schaefer & Kavookjian, 2017). This theoretical approach is beneficial to use with adolescents with chronic conditions as it works from where the client is at rather than a directive approach. Core principles of the theory include expressing early empathy, gently addressing discrepancy, rolling with resistance, supporting self-efficacy, and eliciting change talk (Schaefer & Kavookjian, 2017). Motivational Interviewing works to establish an understanding of the disease with the client while developing what goals the client has concerning their overall wellbeing. Through open-ended questions, setting incremental goals, asking permission to give advice, and engaging in change talk the client's autonomy is respected a sense of personal control is maintained (Schaefer & Kavookjian, 2017). When using Motivational Interviewing to increase adherence to medication adolescents with chronic conditions not only improved their medication adherence but saw an improvement in quality of life (Schaefer & Kavookjian, 2017). The improvement of quality of life was due to the belief that they had the control and skills to positively impact their illness outcomes which not only increased life satisfaction and emotional functioning but decreased anxiety and health related worries (Schaefer & Kavookjian, 2017).

Cognitive Behavioral Therapy, CBT, is an evidence-based theory commonly used to treat depression and anxiety. The theory emphasizes the link between thoughts and feelings to a targeted behavior (Thabrew et. al., 2018). The goal of CBT is to recognize and evaluate the thoughts that contribute to a mood or behavior; then implement specific coping skills to improve

or extinguish the undesired outcome (Thabrew et. al., 2018). Adolescents with co-occurring mental disorders and chronic conditions have cognitive distortions about their current self or future self. Common cognitive distortions such as, all or nothing thinking, overgeneralization, mental filter, catastrophizing, or jumping to conclusions can be seen in the following correlating examples: believing that they will never be accepted, since one person rejected them everyone else will do the same, a mild day of symptoms is overshadowed knowing tomorrow could be worse, assuming their disease will only worse, believing that they will never find a partner due to their condition. By recognizing and labeling these thoughts a counselor can provide coping skills to counter or stop the false beliefs. It is imperative to help adolescents adjust to their chronic conditions and develop healthy beliefs that will last into their adulthood.

Both theories are used to elicit positive change for the client. While therapy may target a specific behavior or mood when working with adolescents and children with chronic conditions it is important to work through a biopsychosocial lens. The biopsychosocial model emphasizes the connection between physical health, mental health, and social health. Chronic illnesses not only affect physical health but can decrease the quality of one's mental and social health. Counselors should be open to working collaboratively with the client's health care team to increase the quality of life over all domains. When a mental health counselor uses the biopsychosocial model, they increase the likelihood of improving all aspects of wellbeing and lasting change.

Application to Clinical Mental Health Counselors

Despite the large number of adolescents effected by chronic illnesses mental health professionals may not be seeing this population seeking help due to barriers such as, being uninformed, enduring inaccessible agencies, and lack of awareness in the general population. If a

counselor is only focused on treating symptoms of mental health disorders they may be missing a piece of the client's story.

An adolescent may seek counseling for anxiety, depression, or substance abuse and unless a counselor is familiar with the research that connects childhood chronic conditions to these mental health disorders the client will not see lasting change. Treatment of the whole beginning is imperative for the adolescent to develop a successful identity and healthy coping skills into adulthood. Many chronic conditions do not have cures and will last for a lifetime, distorted thoughts about their condition and expectations for their future self will resurface if a counselor only treats the symptoms rather than the core beliefs.

Mental health counselors are sworn to a code of ethics which promotes nonmaleficence and beneficence. If a counselor is working at an agency that excludes a certain population from receiving treatment it would be viewed as causing harm to those individuals and deemed unethical yet, many counseling agencies are not accessible for those with a disability. Counselors should work to create a space within their agency that is welcoming to all those that are seeking help including all marginalized groups. To have a space that is not physically accessible by all abilities due to inconvenience of the agency is to violate a person with a disabilities' right to equality.

Bringing awareness to the public will allow for those with chronic conditions to seek out counseling by validating the known connections between mental health disorders and the impacts of microaggressions. Counselors can advocate for this population at a local level by providing psychoeducation for specialists to screen for related mental health concerns at hospitals and provide support groups for adolescents with chronic illnesses in the community.

Conclusion

In conclusion, children and adolescents with significant chronic illnesses have a unique set of needs which may not be met by standard clinical mental health providers. The research shows a connection between chronic conditions and mental health disorders. Anxiety and depression increase during adolescences as a result of normal developmental challenges however, the addition of a chronic illness during this period of transition can complicate not only the client's physical health but mental health as well. Isolation can readily occur for adolescents with chronic illnesses as it is a marker of difference that they may not be able to fully conceal. Isolation can increase the severity of symptoms for anxiety and depression therefore the risk of suicide in this population is higher than their healthy counter parts.

Adolescents with chronic conditions attempt to gain control over their condition through self-medicating and concealment. Feeling let down by their health care team may lead an adolescent to experiment with the therapeutic effects of alcohol, opiates, and marijuana. When the substance use is an effort to mask pain or symptoms of the condition, addiction treatment alone will not be effective in terms of relapse prevention. It is developmentally normal to experiment with substances during adolescents however, self-medicating can be dangerous to an adolescent with a pre-existing condition as they are less likely to report the use to their parents or health care team. Self-medicating is one way an adolescent can attempt to control their body and condition. Chronic condition maybe a lifelong diagnosis for some adolescents creating feelings of powerlessness over their bodies. Choosing how to suppress their symptoms helps an adolescent control and conceal their condition. Restrictive eating behaviors or purging is another way adolescent attempt to control their bodies. Eating Disorders in this population are at an increased risk of discovering late or left underdiagnosed due to the perceived benefits of the weight loss or food tracking. Dietary changes can be a part of an adolescent's treatment plan for

their chronic condition and weight loss can positively affect their chronic condition however, teaching restrictive eating practices and rewarding weight loss can set a precedent with the adolescent. Eating disorders during adolescents increase due to low self-esteem and body dissatisfaction. Adolescents with chronic conditions may view weight loss to control how their body appears as they cannot control how the condition effects their physical appearance.

Lastly, adolescents with chronic conditions are at risk of damaging microaggression that can continue into adulthood. Without psychological supports during the critical transition period of adolescences one may develop a false core belief that their condition is their primary identifier. This translates into a false belief system reinforced by microaggressions from the general public. Mental health counselors are uniquely positioned to assist adolescents with chronic conditions to challenge these beliefs, develop a strong identity of self, and better control of their overall wellbeing.

Author's Note

While the research suggestions the need of additional mental health support to this population I can personally attest to the imperative need. As an individual who was diagnosed with a significant chronic illness at the age of nine, I grew up hearing that I was an inspiration to others for living with my disease. I began to feel that I had to conceal my struggle with accepting my chronic illness due to the expectation of others. I could give an example for each of the microaggressions discussed in this paper from being asked by strangers in grocery stores what was wrong with me to missing flights because the travel aid did not think I looked sick enough to receive help. As a woman I have been told that I was too pretty to be sick and asked about my ability to conceive children by loose acquaintances. Despite these events I was able to form a healthy identity and accept my chronic illness as well as mourn for my healthy self. I found

applying Elisabeth Kuber-Ross' five stages of grief, denial, anger, bargaining, depression, and acceptance (1983).

With the diagnosis of a chronic condition at a young age the gravity of the illness may not be realized. Naivety allows for children to deny the existence of the illness however, adolescents brings a greater understanding of the disease and differences between one and their healthy peers. Yet the still developing prefrontal cortex can make impulsive decisions such as, avoiding the medication, concealing the condition, and further isolating to avoid potential rejection. Next is anger about the differences between one and their healthy peers. Adolescents is hard enough without being questioned why you have to use a cane or planning sleepovers with friends around treatments or hospital visits. Anger that those around you were beginning to form their independence while you were tied to the limitations of your condition. Bargaining appears in various forms but for me it was over compliance to treatment plans. I assumed that if I did what the doctors said that my condition might just go away. However, compliance does not promise remissions or cures. Realizing the lack of power and control one has over their own body leads to the fourth stage, depression. When one can let go and stop comparing themselves to the healthy or ideal self, they enter the final stage, acceptance. Mental health counselors can assist this population through their grief to accept themselves as they are. In acknowledging false beliefs about who they could have been or the limits they place on themselves an adolescent with a chronic condition can accept their condition without allowing it to define them.

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