

**Lessons From Psychotherapy That Inform Counseling Gifted
Students: What We Know and Future Opportunities**

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Introduction

There is a growing interest in the gifted field on the topic of counseling students who are gifted. The student might be a high-ability child or adolescent client who presents with a coexisting psychiatric or mental disorder, or special education disability—termed the “twice exceptional” or 2e student (Pfeiffer & Foley-Nicpon, 2018). Or the client might be a high-ability student just beginning to experience social-emotional difficulties, what the psychiatric field calls clients with “sub-clinical” problems (Pfeiffer, 2013a; Pfeiffer & Burko, 2016). Finally, the client might be a high ability student or group of students in no psychological distress, but who would be excellent candidates for universal, selective, or indicated preventive interventions to support their mental health and well-being (Darling-Hammond, 2015; Pfeiffer & Prado, 2019; Pfeiffer & Reddy, 1998).

This paper provides an overview on what the author has learned in psychotherapeutic work with children and youth that can inform counseling high-ability, gifted students. My hope is that the chapter has application for both preventive and early intervention work, as well as for intensive, psychotherapeutic efforts. The paper includes a discussion on four important principles of evidence-based psychotherapy, including the pre-eminence of a common factors’ perspective. The chapter also briefly discusses progress monitoring and preventive counseling. An actual clinical case is presented to illustrate psychotherapeutic work with a troubled gifted adolescent guided by evidence-based practice.

A Personal Note

Before beginning the paper, it seems prudent to provide the reader with a transparent, “truth in advertising” statement about the author. For much of my career, I was an academic clinician with

primary professional affiliation as a Professor in major Research I Universities—Florida State University and Duke University. My career included working full-time as a clinical psychologist in a large, tertiary care medical center in New Orleans for a number of years and serving as Executive Director of a large gifted center at Duke University, Duke TIP. My thinking and views on counseling and psychotherapy gifted clients (and their parents) is based on a careful reading of the scientific literature, and on my own clinical and research experiences. I have first-hand experience in the real-world of clinical practice, providing a range of mental health services for intellectually gifted students. What follows is a synthesis of my clinical and research experiences and circumspect interpretation of the published scientific papers on counseling the gifted. I have included an actual case example from my own work to highlight what I mean by evidence-based counseling. I hope that readers find the discussion that follows informative.

A Brief History on the Gifted Population

As far back as Confucius in China and Plato in Greece, philosophers wrote about “heavenly” children. Early East Asian and classical European traditions both embraced similar views that giftedness constituted a set of special attributes which we today would view as components of intellectual ability. In the USA, we trace early attention to the gifted to the research conducted by Lewis Terman, whose longitudinal study followed high IQ students (higher than 140). Terman collected data on these students over the course of 50 years and concluded that high IQ kids are healthier, better-adjusted, and higher achievers (Dai, 2018).

Gifted children and youth remain a misunderstood population (Pfeiffer, 2013a). Part of the problem is definitional. The federal definition states that the gifted demonstrate outstanding

ability or potential and require differentiated educational programs, and includes exceptional intellectual, academic, and leadership ability, creativity, and artistic talent (Stephens, 2018). In clinical practice, however, high IQ remains the predominant definitional criterion. Most psychologists and schools use the criterion of an IQ cut score of 120, 125, or 130 (Pfeiffer, 2015; Silverman, 2018).

A second definitional issue that has contributed to misunderstanding is whether we should narrowly define giftedness as persons of high IQ or more broadly define giftedness as any person with exceptional ability or uncommon talent. A third issue is whether we should restrict our conceptualization to those children with already demonstrated high ability or also consider children with outstanding promise—“diamonds in the rough” (Pfeiffer, 2015, 2020).

Most would agree that the child who is reading at age 3, playing competitive chess at age 5, or performing violin in an orchestra at age 10 is gifted. These exemplars reflect children who are developmentally advanced, a hallmark of giftedness. Characteristics commonly associated with giftedness include advanced language and reasoning, interests more aligned with older children and adults, impressive memory, intuitive understanding of concepts, insatiable curiosity, uncanny ability to connect disparate ideas and appreciate relationships, rapid learning, heightened sensitivity of feelings and emotions, perfectionism, and asynchrony across developmental domains (Pfeiffer, 2013a; Sternberg & Kaufman, 2018). However, no gifted child exhibits all of these characteristics and gifted children vary tremendously in core characteristics (Neihart, Pfeiffer, & Cross, 2016a). Giftedness does not always make an early appearance. For every Mozart, who created masterpieces at an early age, there is the Cézanne, whose great art was completed later in life.

Of course, the gifted, like their nongifted peers, experience typical developmental and psychosocial challenges. Sometimes, developmental milestones occur quite early, which can create unique problems. Some gifted are vulnerable to emotional problems because of the very characteristics that are the hallmark of giftedness. For example, asynchronous development can generate feelings of being out of sync with their peers (Rinn & Majority, 2018; Wiley, 2016). Some gifted feel uncomfortably different and have difficulty finding a friend; others experience bullying (Peterson, 2016; Pfeiffer, 2003, 2013b). Some gifted view their gift as a burden. Difficulty with affect regulation or negative perfectionism increases their vulnerability to psychological problems (Neumeister, 2016; Rice & Taber, 2018). An appreciable number of gifted experience a mismatch with their educational environment, which can create boredom, inattentiveness, underachievement, and even conduct problems (Plucker & Dilley, 2016; Pfeiffer, 2013a, 2013b; Siegel, 2018).

The gifted are not immune to the social and emotional challenges that all children face. Some gifted underperform to mask their abilities. A number of gifted struggle with depression, suicide ideation, anxiety, social isolation and feelings of alienation, anger management, neurotic perfectionism, and sexual identity issues (Neihart, 2016; Pfeiffer, 2013a; Pfeiffer & Burko, 2016). Finally, some gifted are twice exceptional and have sensory, orthopedic, or communication disabilities or psychiatric disorders coexisting with their giftedness, including ADHD, Asperger's disorder, eating disorders, and mood disorders (Pfeiffer, 2013a; Pfeiffer & Foley-Nicpon, 2018). Experts hypothesize that the majority of twice exceptional gifted/disabled have specific learning disabilities (SLD). There are three types of gifted/SLD. The first type is the gifted with subtle, subclinical learning problems. The second type is diagnosed as learning disabled but rarely identified as gifted. Their learning disability is more pervasive and severe and

moderates their academic success. The third type remains unrecognized as either learning disabled or gifted. Their learning disability masks their gift and their gift obscures their learning disability (Pfeiffer, 2013a).

Most authorities agree that the gifted are those in the upper 3% to 5% compared to their peers in general intelligence, academics, the arts, and leadership. Although some experts argue for a more liberal inclusionary threshold, as high as 10% to 15% (Pfeiffer, 2015, 2020; Worrell & Dixson, 2018). Not surprisingly, there is evidence for a genetic influence (Dai, 2018). The fields of music and mathematics are rich with child prodigies. Evidence also comes from the unfolding of extraordinary accomplishments among kids from impoverished environments (Ackerman & Lakin, 2018). Most authorities agree that the unfolding of extraordinary talent requires a supportive environment and a number of influential, moderating and mediating factors over time (Subotnik, Worrell, & Olszewski-Kubilius, 2016; Tannenbaum, 1983).

Prevalence Considerations

As readers familiar with my writing know, I actually view giftedness as a social construction, not something real like juvenile diabetes, Fragile X Syndrome, or ovarian cancer. Prevalence rates, therefore, are always going to be arbitrary and inexact. The number of gifted students reflects how states and schools define giftedness and what criteria they set. As mentioned above, estimates range from a conservative 3% to as high as 10%-15%. There is no true cut-off between giftedness and non-giftedness, although many would like to believe otherwise (Pfeiffer, 2015).

Research indicates that most intellectually gifted children are socially well adjusted. Contrary to common stereotype, most gifted are popular, make friends, get along with peers, and do not

experience loneliness or depression (Neihart, Pfeiffer, & Cross, 2016b; Pfeiffer & Burko, 2016). Experts estimate that the great majority of the gifted are well adjusted, and perhaps no more than 10-20% experience some of the difficulties noted above. If we assume that roughly 6% of students are classified as gifted, then there are about 3 million gifted students in the United States. This translates into 300,000 to 600,000 gifted students presenting with some type of psychological difficulties at some time in their lives. This is a *not* insignificant number of gifted students in the USA alone warranting mental health attention. Authorities assume that the prevalence of child/adolescent psychiatric problems, such as suicide ideation, gesture, attempts, and successful completions is not markedly different for the gifted and general population (Cross & Andersen, 2016; Mueller & Winsor, 2018; Pfeiffer, 2013b). The gifted engage in suicidal behaviors, just like their nongifted peers (Pfeiffer & Prado, 2019).

In a report by the Institute of Medicine, *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*, it was estimated that each year between 14–20% of children and adolescents experience a mental, emotional, or behavioral disorder (National Academy of Sciences, 2009). This figure is consistent with a recent report by the American Academy of Child and Adolescent Psychiatry (AACAP, 2017). However, it is estimated that 70% of children with a diagnosable mental illness do *not* receive treatment (Centers for Disease Control and Prevention, 2013; Greenberg et al, 2003). It is reasonable to assume that a majority of gifted students with a diagnosable mental illness or emerging psychological problems, likewise, are neither seeking nor receiving mental health services in the schools.

Part of the problem is a shortage of mental health providers in the schools and in the community. For example, within the United States, there is a shortage of child and adolescent psychiatrists.

The shortage is significant is considered a crisis in the field. The United State Bureau of Health Professions estimates that there are about 8300 child psychiatrists in 2020, only two-thirds of the estimated 12,600 needed. In a study commissioned by the American Academy of Child and Adolescent Psychiatry (2003), it was reported that there was, on average, only one child psychiatrist for every 15,000 children and adolescents under the age of 18 (National Academy of Sciences, 2009). The same shortage of providers exists in the other mental health professions, including clinical and school psychology, social work, marriage and family therapy, and mental health counseling (Pfeiffer, 2015).

Prevalence rates for mental health disorders vary, of course, along racial/ethnic and socioeconomic lines. It is likely that there is a higher prevalence of mental health disorders and higher risk living situations among gifted students of color and gifted students living within less advantaged homes (Centers for Disease Control and Prevention, 2013; Pfeiffer, 2013a). The bottom line is that an indeterminant, but likely substantial number of high-ability children and youth are either at greater risk for, or already presenting with serious mental health concerns, and not receiving counseling or any other mental health services in their schools or in their community. There exists a clear and present need for more mental health services for this special-needs population (Pfeiffer, 2013b).

4 Principles of Evidence-Based Counseling

A provocative and even inconvenient question is whether a unique approach is required in psychotherapeutic work with the gifted. Some who write about counseling the gifted feel that this is a basic maxim, that the gifted warrant a unique therapeutic approach (e.g., Mendaglio & Peterson, 2007). This chapter advocates a slightly different position. The author's position is that the therapist or counselor should follow a psychotherapeutic model of evidence-based clinical

practice. The author defines this approach as *integrating the application of (a) the best available treatment research on the presenting disorder, (b) in conjunction with establishing and maintaining a strong therapeutic relationship with the client [who is gifted], and, finally, (c) clinical expertise* in the context of considerable supervised experience and *a deep understanding working with this unique population*. All three components are synergistic and critical if treatment is to be effective (Norcross & Lambert, 2018; Pfeiffer, 1986; 2013b).

Today, there exists clinically relevant research on almost every type of psychological problem that a therapist or counselor might encounter in work with a gifted child or adolescent. Later in the chapter, I describe a case of successfully treating a gifted adolescent with borderline pathology employing dialectical behavior therapy, guided by an empirically supported intervention (Pfeiffer, 2013a).

The author's position in working therapeutically with gifted children and youth embraces the following four principles. A more detailed explanation of these principles is found in Pfeiffer (2013a), Pfeiffer & Burko (2016), and Pfeiffer & Prado (2018):

- The first principle is that no one theory explains all of what can go awry when a gifted child develops psychological problems, and no one theory can hope to explain all of counseling. However, there are specifiable and helpful counseling theories that help guide the design, implementation, and evaluation of treatment interventions for specific problems exhibited by the gifted (Kendall, 2006; Pfeiffer, 2013b). In the author's experience, the most useful counseling theories are those that explain the *processes of change*. Understanding the processes of change helps gain a focus, specific treatment targets and objectives, and insights into why a given youngster might or might not be responding favorably to the planned intervention. In any clinical work with gifted clients,

it is important to know which therapeutic processes are helping to create the change you are working towards.

- The second principle is that work with the gifted should almost always *address and consider the parents, parenting, and families*. In the author's experience, and this axiom is supported by considerable clinical research, the inclusion of parents in the treatment of children with behavioral, social, or emotional problems increases the likelihood of a favorable therapeutic outcome (Kazdin & Durlain, 2012; Kratochwill & AStoiber, 2002). Of course, the nature and extent of the parent or family involvement will vary by the unique circumstances of each case, the age of the gifted youth, and other relevant considerations. That said, it is clinically imprudent to ignore the gifted child's parents. This does not mean that you always embark upon family therapy as a primary or adjunctive intervention. Rather, it means that you always consider in what ways the parents and family might be contributing to the client's presenting problems -even unwittingly, and also in what ways might the parents and family serve as allies and resources in ameliorating the problem and helping to instill better coping skills, greater resilience, and new psychological strengths (Pfeiffer, 2013a, 2019; Pfeiffer & Tittler, 1983).
- The third principle is that there exists considerable clinically relevant research on almost every type of psychological problem that one might encounter in work with a gifted client. There are published articles in peer-review journals on the incidence, prevalence, expression, associated symptoms, developmental trajectory if left untreated, and response to treatment for almost every developmental and psychiatric disorder that exists. With the advent of the Internet, it is easy for school counselors, school psychologists and private

practitioners to access targeted literature searches. The eMedicine Clinical Knowledge Database is a continually updated evidence-based resource with extensive psychiatric information and specific modules on addictions. eMedicine is a product of WebMD and is available free of charge at <https://emedicine.medscape.com>. Many professional and government organizations have created evidence-based practice websites. For example, the Substance Abuse and Mental Health Services Association (SAMHSA) website at <https://www.samhsa.gov> includes extensive data and reports, including the surgeon general reports. SAMHSA also features the National Registry of Evidence-Based Programs and Practices (NREPP), a database of mental health and substance abuse treatments freely available at www.samhsa.gov.

Information on the effectiveness of alternative treatments is available at this site. The Society of Clinical Child and Adolescent Psychology, Division 53 of the American Psychological Association (APA), supports a web site on Evidence-Based Mental Health Treatment for Children and Adolescents. The Division of School Psychology (16) of the APA sponsored a Task Force on Evidence-Based Interventions in School Psychology. The Task Force produced a 136-page procedural and coding manual in support of promoting and disseminating evidence-based interventions in schools (Kratochwill & Stoiber, 2002). There is easily available clinically relevant research on best practices and evidence-based interventions which should guide counseling. Norcross, Hogan, and Koocher (2008) published a paperback entitled, *Clinician's Guide to Evidence-Based Practices* which describes how to easily search for and locate the best available research on almost any clinical question.

- The fourth and final principle is the recognition that the quality of the therapeutic relationship, often called *the therapeutic alliance*, is essential in all effective counseling and psychotherapy (Bachelor & Horvath, 1999; Bordin, 1979; Falkenbach, Poythress, & Heide, 2003; Gelso & Hayes, 1998; Horvath, Del Re, Flückiger, & Symonds, 2011; Kazdin & Durbin, 2012; Zilcha-Mano, 2017) including counseling the gifted. This may sound like an obvious counseling axiom. But it has remained a cornerstone in our understanding of what makes counseling special and what helps gifted children and adolescents take the risk to change.

It has been my experience as a therapist that it is impossible to encourage, nudge, or inspire a gifted child or adolescent who is struggling with a personally painful, distressing or embarrassing problem to change what they are doing, thinking, or feeling if they do not trust the therapist and do not feel that the therapist is sincerely concerned about their well-being. All clients in counseling, particularly children and adolescents, need to feel that the therapist understands and even feels, to a degree, what they are personally experiencing (Kazdin & Durbin, 2012; Norcross, 2002). In essence, there needs to be a profound, even palpable bond that the practitioner must work to create between herself and the client if counseling is going to be effective. This fourth principle leads directly into a discussion on common factors in counseling.

A Common Factors Perspective on Evidence-Based Counseling

The fourth principle, recognition of the primacy of the therapeutic relationship, speaks to what has come to be termed, “a common factors perspective” on effective counseling and therapy. Dan Siegel (2010) has written a brilliant book on the synthesis of psychotherapy and neuroscience; what it means to do psychotherapy ‘with the brain in mind.’ His compelling ideas in, *The Mindful Therapist*, are scientifically grounded and exquisitely human. His ideas capture

what the author of this chapter often talks about in terms of effective therapeutic work needing to bring ourselves as therapists fully into connection with those for whom we care—how we respond positively to our therapeutic efforts (Pfeiffer, 2013a). In other words, we need to pay attention to what it is about effective therapists and counselors that is critical in helping support the growth of another person—the client. Siegel (2010) talks about *presence, attunement, mindsight, trust, resonance, and mindfulness*—and links these therapeutic elements to the neurology of our brain. The elements that Siegel emphasizes are fully consistent with what I mean by cultivating our healing presence in psychotherapy (Pfeiffer, 1986, 2013a).

My own thinking about what makes psychotherapy work dates back to my early experiences as a psychotherapist and to a paper that I wrote some 35 years ago at the invitation of a medical colleague. The paper sought to make a connection between effective counselling skills—as applied by accomplished psychotherapists, and the “bedside manner” of skilled physicians (Pfeiffer, 1986). This chapter essentially builds upon my journey as a research clinician over the last 35 years, advocating that what makes psychotherapy uniquely effective has relevance and even important applications to counseling gifted kids.

I should begin by defining some terms. First, what do we mean by psychotherapy. Counseling or psychotherapy is a *collaborative enterprise* in which clients and therapists negotiate ways of working together on mutually agreed-upon therapeutic goals to foster *positive, mutually agreed upon outcomes* (American Psychological Association [APA] Presidential Task Force on Evidence-Based Practice, 2006). Psychotherapy is viewed as a prescriptive, creative, and personal—even intimate, way of working with clients to assist them in *modifying, changing, reducing or eliminating factors that interfere with their otherwise effective living and quality of life* (Corsini & Auerbach, 1998). Psychotherapy often is *an intimate and creative process* that

provides what is called “*corrective emotional experiences*,” allowing clients to think, feel and act in ways that they may have avoided in the past. It can also be a means of enhancing a client’s functioning with *the goal of optimizing mental health, subjective well-being, and even existential meaning in life* (Frank & Frank, 1993; Frankl, 1959; London, 1986; Pfeiffer, 2018).

The therapeutic alliance is defined by the quality of the client-therapist relationship, their collaborative interaction, and the attachment between the two that develops over the course of counseling (Pfeiffer, 2013b). Research consistently supports the fact that therapeutic alliance, measured by adolescent self-report, is a reliable predictor of treatment outcome for children and adolescents (Florsheim, Shotorbani, Guest-Warnick, Barratt, & Hwang, 2000). In terms of establishing a therapeutic alliance with the gifted client, the two concepts of empathy and unconditional positive regard are as relevant today as when Carl Rogers first wrote about them (Corey, 2005). Establishing and maintaining a therapeutic alliance with the gifted child or adolescent is part of what we consider the *clinical expertise* of the therapist. Clinical expertise includes making wise and prudent clinical decisions, timing interventions well, understanding sociocultural and ethnic nuances, being comfortable with kids and familiar with their world and what interests them, being knowledgeable about developmental psychopathology and normal development—including what is normal for gifted kids, and knowledgeable about psychologically healthy environments. Clinical expertise also includes being kind and considerate, being patient, and respecting that change often is difficult and scary for the client and takes time. Lazarus (1993) wisely advised that therapists tailor their relational approach to the client’s expectations, and in effect, customize counseling so as not to treat every client in the same manner. Lazarus humorously called this elegant, “common factors” therapeutic relationship

accommodation “being an authentic chameleon” (Lazarus, 1993, p. 404). I wholeheartedly agree with this clinical axiom and have found it beneficial in my clinical work with gifted clients.

What follows is an example of applying evidence-based counseling with a gifted adolescent who the author treated in his private practice, first reported in Pfeiffer (2013b). The example illustrates the components of evidence-based practice when working with a gifted adolescent who was referred because of substance abuse, recurring suicidal threats, and pervasive feelings of loneliness, despair, and desolation. This was a very challenging client—why the case was selected for illustrative purposes. Although I use an actual case with a specific set of clinical issues, the point intended is to highlight the value of evidence-based counseling applied to almost any gifted client.

Example of Evidence-based Best Practices:

Counseling a Gifted Adolescent With Borderline Pathology

Borderline personality disorder (BPD) is a serious psychiatric disorder that affects approximately 2% of the adult population (Lenzenweger, Lane, Loranger, & Kessler, 2007; Sharp & Kim, 2015). Persons suffering from BPD display multiple symptoms including intensive efforts to prevent real or imagined abandonment, a pattern of personal relationships characterized by instability and intensity that fluctuates between extremes of idealization and devaluation, impulsivity including high-risk behaviors such as substance abuse, binge eating, high-risk sex, recurring suicidal ideation, gestures or threats, pronounced emotional instability, and inappropriate, impulsive, and/or intensive anger (American Psychiatric Association, 2000). BPD is difficult to diagnose and, some argue, of questionable diagnostic validity in adolescence. This has led many clinicians to describe borderline adolescent symptomatology rather than make a formal diagnosis and use the term “borderline pathology” when referring to adolescents

presenting with BPD symptomatology (Crowell et al., 2008; Pfeiffer, 2015). It is estimated that the prevalence of borderline pathology in adolescents is as high as 3–14% (Crowell et al., 2008). Because of the associated risk of suicide (Anderson, 2002), effective treatment of adolescent borderline pathology is a critical mental health issue. Although there exists no epidemiological data, it is reasonable to assume that the incidence of borderline pathology among gifted adolescents is similar to the reported rates among adolescents in general.

Jon (the client's name has been changed to protect his anonymity) was referred by his parents at the encouragement of his school counselor because of recurring suicidal ideation and behaviors, reported substance abuse, and depression and pervasive feelings of loneliness and despair. He had been seen by a psychiatrist who suspected that Jon was “borderline” BPD—the psychiatrist was diagnostically conservative in respecting the fact that Jon's impulsivity, emotional instability, and existential angst might reflect developmental issues and not an Axis II psychiatric disorder. The initial impression after interviewing Jon and his parents and reviewing his case file was that he qualified for the diagnosis of borderline pathology. Jon was obviously gifted, whichever definition of giftedness one might choose to apply—he had an outstanding academic record at an elite private school, a tested IQ of 135, and combined SAT scores of 1160 taken when in the seventh grade as part of a regional talent search. Also, the previous year, Jon had been the only freshman on his school's debate team. Jon was also a painfully unhappy young man who was engaging in high-risk, unsafe, and potentially self-injurious behaviors. It was apparent that this gifted adolescent desperately needed therapy.

Dialectical Behavior Therapy (DBT; Kliem, Kröger, & Kosfelder, 2010; Miller, Glinski, Woodberry, Mitchell, & Indik, 2002; Neacsiu, Rizvi, & Linehan, 2010) is an empirically validated intervention for adults with BPD. DBT was developed by Linehan to apply cognitive

behavioral treatment (CBT) to borderline personality patients exhibiting suicidal and parasuicidal behaviors (Katz & Cox, 2002; Linehan, 1993). For more information on DBT, the reader is referred to Linehan (1993), Linehan and Dexter-Mazza (2008), and Katz, Fotti, and Postl (2009). DBT is based on a transactional model in which the borderline pathology is viewed as the result of cyclical interactions between an individual's biological predispositions for emotional dysregulation and an invalidating environment (Katz & Cox, 2002). Interestingly, some gifted are described as overly intense and highly overexcited, based on a theory of "overexcitabilities" proposed by the Polish psychiatrist Kasimierz Dabrowski (Kitano, 1990). In fact, some authorities posit that intensity is "an almost universal characteristic of gifted children and adults" (Webb et al., 2005; p. 10). Although I am not convinced that this temperamental characteristic is shared by all or even the majority of intellectually gifted, I have seen gifted youngsters marked by emotional and/or psychomotor over-excitability in my practice.

In work with Jon, which lasted over the course of almost 2 years, I employed a DBT approach. I modified the standard protocol since the model was developed for, and empirically validated with, adults, not adolescents. For example, one significant modification was involving Jon's family in the treatment, particularly in the phase where we worked on behavioral skills training. This modification follows the recommendations of DBT experts (Katz et al., 2009; Miller, Rathus, Linehan, Wetzler, & Leigh, 1997). Early in counseling, I took on the role of 'devil's advocate' in challenging Jon's dangerous and life-threatening behaviors (substance abuse, suicidal behaviors) and working to enlist his commitment to the therapeutic process. My experience working with many gifted adolescent clients helped me understand Jon's style of thinking, resistance to confronting his self-defeating behaviors, and world view. Jon did not feel

accepted or liked at his school; he was hypersensitive to teasing and sarcastic comments from peers.

Without the experience of working with many similar adolescents and without the understanding and appreciation for what was unique about Jon as a gifted youngster, a therapist would not have been able to enlist Jon's participation in the treatment. And without Jon's active commitment to therapy—and the establishment of a working therapeutic alliance, even the most powerful therapeutic techniques that DBT has to offer would have proven ineffective (Wampold, 2015). In other words, in work with gifted clients, “common factors” are important and make a difference. After successfully engaging Jon in his treatment—which required about six or seven sessions and considerable patience, much of counseling was skills-based, consistent with the DBT model. My therapeutic posture was as a consultant and adviser to Jon. Many sessions focused on decreasing his substance use and high-risk sex and increasing his repertoire of behavioral skills. Mindfulness, emotional regulation, distress tolerance, and social and interpersonal skills training were introduced, consistent with Linehan and Dexter-Mazza (2008). During skills training, Jon and I frequently enacted and then processed role plays. Jon was often assigned homework tasks. Because Jon held rather rigid, polarizing points of views—not uncommon among bright adolescents with borderline pathology, one therapeutic strategy which was employed was helping him accept a “middle path” and adopting a less harsh, judgmental perspective (Miller et al., 2002). Many sessions were spent working on this particular goal.

Finally, a considerable amount of counseling focused on encouraging Jon to search for positive emotional experiences in his daily life. A therapist's familiarity with gifted adolescents makes this phase of the treatment less challenging. Working with adolescents in general can be tricky (Pfeiffer, 2013a, 2013b; Verhaagen, 2010). Working with gifted adolescents or, for that matter,

any group of children or adolescents who are different in a substantive way from mainstream youngsters is uniquely challenging.

This case illustrates four key points. First, evidence-based practice requires more than simply being aware of the best available clinically relevant research. The second point is that relying on clinically relevant research is critically important in work with any client, including a client who happens to be gifted. It would have been clinically imprudent, and even unethical, to not consider DBT given Jon's presenting constellation of problems (Norcross et al., 2008; Pfeiffer, 2015).

The third point is that evidence-based practice also requires clinical expertise. There is considerable evidence that the therapist's training, skill, and experience promote positive therapeutic outcomes (Norcross et al., 2008). As the chapter has already emphasized, clinical expertise takes time to develop and consists of sound clinical judgment and decision-making, monitoring client progress (or lack thereof), knowing when to nudge or challenge the client and when to back off, and the timing of interventions. Clinical expertise also includes awareness of one's competence and limitations, and willingness to seek consultation and available resources as needed (Norcross, Beutler, & Levant, 2006).

The fourth and final point of this illustrative case is that evidence-based practice appreciates that patient characteristics matter. Competent clinical practice necessitates a deep understanding for the unique characteristics, preferences, culture, and world view of each patient that you are working with. This is as true for the gifted client as it is for the client who is lesbian, gay, bisexual, or transgender (LGBTQ), elderly, from a different culture or racial/ethnic group, or gender than your own. Keen awareness of the cognitive, social, and emotional characteristics, unique concerns, preferences, and challenges facing gifted students is critically important if one hopes to be effective in counseling the gifted student with problems. Zilcha-Mano (2017), a

leading Israeli psychotherapist, reminds us that establishing and maintaining a working therapeutic alliance can be tricky with some clients. She distinguishes between trait-like and state-like components of alliance. Essentially, Zilcha-Mano contends that trait-like components of the alliance include the client's ability to form satisfactory relationships with others, their internal representation of self and others, and their expectations from interpersonal relationships. These trait-like abilities can and often affects the client's capacity to form satisfactory relationships with the therapist, and the client's capacity to benefit from counseling (Zilcha-Mano, 2017). In other words, the therapist's well-intended efforts at establishing trust, conveying unconditional positive regard and warmth, and creating a therapeutic alliance with the client can be limited by the existing traits of the gifted client. Wampold and Budge (2012) offer the sage reminder that no client comes to therapy *tabula rasa*.

Preventive Counseling and the Gifted

Not all gifted students who would benefit from individual or group counseling present with a clinical or even subclinical problem. Most gifted students, in fact, do quite well socially and emotionally, are well-adjusted and effectively navigate the challenges encountered in their homes, schools and neighborhoods (Neihart et al., 2016b). Even so, preventive counseling is cost-effective and shown to be efficacious (Capuzzi & Gross, 2014; Conyne, 2015; Hage et al., 2007; Pfeiffer & Reddy, 1999, 2001). A growing number of gifted programs include a social and emotional learning curriculum implemented by the teacher (Betts, 1986; Betts & Neihart, 1986; Moon, 2002). A few years ago, for example, I collaborated with a University Lab school-wide pilot project, building a social-emotional learning curriculum throughout the school. The program incorporated encouraging mindfulness and character strengths (Niemic, 2014).

Preliminary program evaluation results suggested a reduction in teasing and bullying, and increases in levels of empathy, compassion, gratitude, and subjective well-being.

Preventive groups for gifted students in schools are another powerful intervention. Conducting preventive and support groups for parents of gifted students is another powerful mental health intervention. Groups can be open-ended or closed. Closed groups have a specific start and end date and group members are recruited with the expectation that they will attend all of the scheduled group meetings. They typically are short-term, and meet for 1–6 sessions, depending upon the focus of the group or curriculum adopted. Open-ended groups, on the other hand, can continue over the course of a semester or even a school year with gifted students or parents able to “drop in” whenever they find a topic of interest. The interested reader can find more details on groups in Pfeiffer (2013a). Parents of high ability students have unique concerns and questions, and SENG (Supporting the Emotional Needs of the Gifted; <https://www.sengifted.org>), an international organization dedicated to the emotional concerns of the gifted, developed an excellent guide for facilitators of parental support groups (Webb & DeVries, 1993). Although there is no published research on its efficacy, attendee feedback is uniformly favorable, and anecdotal evidence indicates that these groups are well received by parents.

Bibliotherapy is another viable preventive counseling strategy for gifted students and their parents. There is no shortage of self-help books and guides to parenting gifted children. Prufrock Press (<https://www.prufrock.com>) and Great Potential Press- recently taken over by Gifted Unlimited (<https://www.giftedunlimitedllc.com>) publish the majority of self-help and parenting books in the gifted field. I coedited one such book for Prufrock Press written for parents of young gifted children, *Early Gifts: Recognizing and Nurturing Children's Talents* (Olszewski-Kubilius, Limburg-Weber, & Pfeiffer, 2003). Biographies of famous people and select

Hollywood films can serve as valuable resources of high appeal with the potential to convey important personal lessons and facilitate the character strengths of gifted students in meaningful and lasting ways. The movie *Good Will Hunting* is one example of a film that many adolescent clients find profoundly insightful and love to discuss. There are numerous well-written biographies and books written by famous individuals who gifted kids can relate to. For example, Stephen Hawking's book, *A Brief History of Time* (Hawking, 1988) a popular read and inspirational for twice exceptional gifted students with SLD, ADHD, and physical disabilities. Professor Hawking has Lou Gehrig's disease, but has not let this debilitating condition slow down his brilliant accomplishments.

The Value of Progress Monitoring and Providing Ongoing Feedback

A chapter on counseling and psychotherapy would be remiss if it didn't include even an intentionally brief discussion on the value of measuring change and improvement—or lack thereof, in counseling. Measuring success as a result of counseling the gifted child or adolescent is critically important (Pfeiffer, 1998a). I would even argue that not only is it extremely helpful, but also ethical, for therapists to incorporate a practical and reliable data system for measuring change in treatment (Pfeiffer, 1998b). The chapter emphasizes “practical” because the author recognizes that most child and adolescent therapists, whether they practice in schools, in an agency, or in private, are very busy and do not have the time to implement a complex assessment protocol for their clients. The system needs to be simple and easy to administer, score, and interpret (Pfeiffer, 1998a, 1998b).

In work with children and adolescent clients, self-report and parent and teacher report scales are particularly useful and readily available. Of course, the scales that the therapist or counselor selects to use to measure progress should directly reflect and reliably measure the goals and objectives of the individual treatment plan. No one test or scale will work best for all gifted clients. The therapist will want to remember two points in establishing a system to measure change and success in counseling. First, client progress waxes and wanes, even in the best of circumstances. And not all clients improve, for many reasons (Lambert, 2013). Second, what may seem like improvement, or for that matter, lack-of-progress or even deterioration, may simply reflect the vagaries of the psychometric qualities of the scale, and not any real changes in the status of the client. The therapist needs to be cautious when collecting data on the client to not over-interpret slight and nonsignificant increases or decreases in test scores (Pfeiffer, 2015).

Strupp and Hadley (1977), in a now-classic article on psychotherapy, recommend that therapists should use a “tripartite model” to evaluate client improvement. Applied to the gifted client, the therapist would routinely collect outcome data directly from the client (child/adolescent self-report data), from the parent and teacher (rating scales), and finally, from the perspective of the therapist herself. These three independent sources of information provide, Strupp and Hadley persuasively argue, a comprehensive picture of how the client is functioning, and affords more reliable estimates of the positive impact of counseling on the client’s functioning. The tripartite model, elegant in design, unfortunately may stretch the notion of simplicity in everyday counseling practice. The important point here is that it behooves the therapist or counselor to routinely collect outcome data on the gifted client to determine whether, for each client, the planned interventions are helpful or not (Pfeiffer, 1998a). Robertson and Pfeiffer (2016) provide

suggestions on how to measure gifted student improvement within a response-to-intervention (RTI) model in schools.

Concluding Comments

This paper provides a brief review on evidence-based psychotherapy, and its application for working with gifted clients. The author's position is that a scientifically defensible approach to counseling the gifted begins from the perspective of following a model of evidence-based clinical practice. Evidence-based clinical practice consists of the integration of the best available research, with clinical expertise, in the context of understanding the world of the gifted youngster. The importance of the therapeutic alliance and "common factors" is critical to successful outcomes. An actual clinical vignette was provided to illustrate evidence-based practice in working with a troubled gifted adolescent who responded favorably to counseling.

The great majority of information on gifted students at risk for, or presenting with troubling mental health problems, as well as the information the field has on the twice exceptional gifted/disabled is based on case study and anecdotal clinical reports. There are few empirical studies where practitioners can turn. There is not even one prospective, epidemiological study that has examined a large community sample of non-referred gifted to determine the etiology, pathogenesis, course, and incidence for those who develop psychological disorders (Pfeiffer, 2015; Pfeiffer & Foley-Nicpon, 2018). There are also very few well-designed intervention studies that include control groups and carefully prescribed interventions; those studies that exist consist of small clinical samples and almost uniformly lack comparison groups. Research is needed that examines the efficacy of various psychotherapeutic interventions applied to carefully

defined gifted samples for specific problems. Finally, it would be helpful for future research to examine the potential impact and value of alternative prevention and early intervention programs.

Value of a Strength-Based Focus

There has been a growing paradigm shift in psychotherapy, with heightened interest in focusing on the positive aspects of human nature. Historically, clinical psychology and child psychiatry, and allied helping professional fields, emphasized pathology, risk factors, and impediments to human development. More recently, the mental health field has shifted to focusing on assets and strengths of the individual, and assets within the environments in which they live (Bronfenbrenner, 1977; Csikszentmihalyi, 1990; Fredrickson, 2001; Seligman & Csikszentmihalyi, 2000). Theorists now recognize that the impact of counseling increases when therapists focus on identifying and reinforcing traits, skills, competencies, and protective factors that promote mental health and well-being (Pfeiffer, 2013b, 2019; Suldo & Shaffer, 2008). Scholars correctly argue that indicators such as resilience, hope, optimism, and gratitude provide powerful leverage in optimizing human functioning (Luthar, 2006; Park & Peterson, 2008; Sapienza & Masten, 2011). This positive focus can and should be incorporated into counseling, including work with gifted clients (Pfeiffer, 2015, 2017).

The scientific study of optimal human functioning, known as “positive psychology,” has contributed to our understanding of how character strengths and virtues, such as curiosity, love of learning, honesty, enthusiasm, generosity, compassion, and social and emotional intelligence help individuals and communities to thrive and flourish. These very character strengths and

virtues can be woven into counseling to facilitate positive change (Lyons, Huebner, Hills, & Shinkareva, 2012; Pfeiffer, 2015; Seligman & Csikszentmihalyi, 2000; Suldo & Shaffer, 2008).

One example of therapists relying on building resilience and incorporating a strength-based perspective with gifted clients is reported by Renati, Bonfiglio, and Pfeiffer (2017). Another example using coping strategies to achieve positive adaptation within adversity among vulnerable clients is reported by Lee, Cheung, and Kwong (2012).

A resilience-focused, strength-based approach can be tailored to impact any of three levels: the individual gifted child, the family, and the social environment. Overall, the focus should include developing and practicing personal coping skills using training and role plays, including new resources to learn assertiveness, decision-making, relaxation, optimism, and self-control; and enhancing parental and family resources, since the family is the primary social support for the gifted child (Pfeiffer, 2017). These can include teaching positive parent-child communication and interactions skills, effective monitoring of child behavior, and effective discipline, rules, and limit setting; promoting experiences and opportunities for developing supportive friendships, positive teacher interactions, academic success, and emotional well-being within the school environment (Cutuli et al., 2013; Niemiec, 2014; Pfeiffer, 2017).

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