# Counseling Today

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An American Counseling Association Publication

# Law vs. ethics: Rejecting clients on the basis of personal values

**Also inside:**

- **Challenges of counseling in rural areas**
- **New ACA President Catherine B. Roland**
- **Answering the call to work with older adults**

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# Counseling Today

July 2016

## Cover Story



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# Meeting challenges with positivity and hope

Catherine B. Roland

Dear Counseling Colleagues,

This month, I assume the presidency of the American Counseling Association, an organization I have called my professional home for 30 years. The roles I have taken on in my career as a professor, mentor and leader have all been shaped by my identity as a professional counselor. I am filled with pride at our great profession's impact and what so many of you are doing each and every day. We are a dedicated, bright, empathic and wise community of professional counselors, in all venues where counseling takes place.

It is both very exciting and just a bit ominous to serve as the 65th president of ACA. Within that wide berth of feelings, I think humility emerges for me as the element that has always allowed me to practice, teach and mentor in what I hope some would say is an effective manner. My desire is that ACA will work with its divisions, regions and branches to continue our efforts at improving the profession and enhancing the work we do with our clients and students.

I'd like to share with you the general goals for my year as ACA president:

- Focus on inclusion of marginalized populations and advocate for accessibility of counseling services for all those who seek counseling.
- Through an adult development perspective, explore the diversity within each life stage of the LGBTQ population, within the lens of intersectionality.
- Continue the good work of President Thelma Duffey (2015–2016) in support of all members of our counseling profession.
- Focus on mentoring toward leadership within the counseling profession to enhance various aspects of diversity at the state, regional and national levels, thus bringing a voice to all counselors.

In a future column, I will share how we can work together collectively, on various levels, toward the accomplishment of these goals.

We have a particularly challenging year ahead of us, both as ACA and as professional counselors who are dedicated to service and providing exemplary practice to constituents in clinics, schools and private practice in an entirely open and nondiscriminatory manner. A little over a year ago, I never would have dreamed that my first communication to my counseling colleagues would need to include the next sentence: We must continue to defend and protect our *ACA Code of Ethics* so that we remain the shining example of who professional counselors are and how we regard all people and our profession. Challenging, yes. Counselors, are we up for that challenge? You bet we are!

The concepts of my presidency are reflected in these words: *positivity*, *hope*, *action* and *identity*. I ask you to join me in embracing these actions because the challenges to marginalized communities such as the LGBTQ population are real. We remember that marginalization of certain groups has traveled through history for a number of cultures. We must speak and advocate, as we have done in the past, for nondiscriminatory and nonjudgmental counseling practice.

Advocacy, although an interesting concept to ponder, actually begs action. It's a "doing" word. Advocacy requires us to show up, write something, join a group, and be verbal and vocal. There seems no better time to advocate for professional counselors, our constituents and the profession than right now. I want to offer my colleagues encouragement to remain positive, generate hope and stand together, with courage, confidence and an absence of fear to do the work we are here to do.

Our counseling identity and the *ACA Code of Ethics* are vital to the profession. Regardless of any state laws that may be discriminatory in nature and based on hate, we must stand firm in our convictions as professional counselors. No one can do it better, more fully or more skillfully than we can as professional counselors, counseling students, professors, mentors, supervisors and leaders.

I have had a long and rewarding relationship with ACA through various leadership roles. I am certain that, in concert with our excellent and innovative ACA leaders, ACA staff will continue the wonderful and sage support I've known for many years.

Very best,
Catherine
*croland@thechicagoschool.edu* ❖


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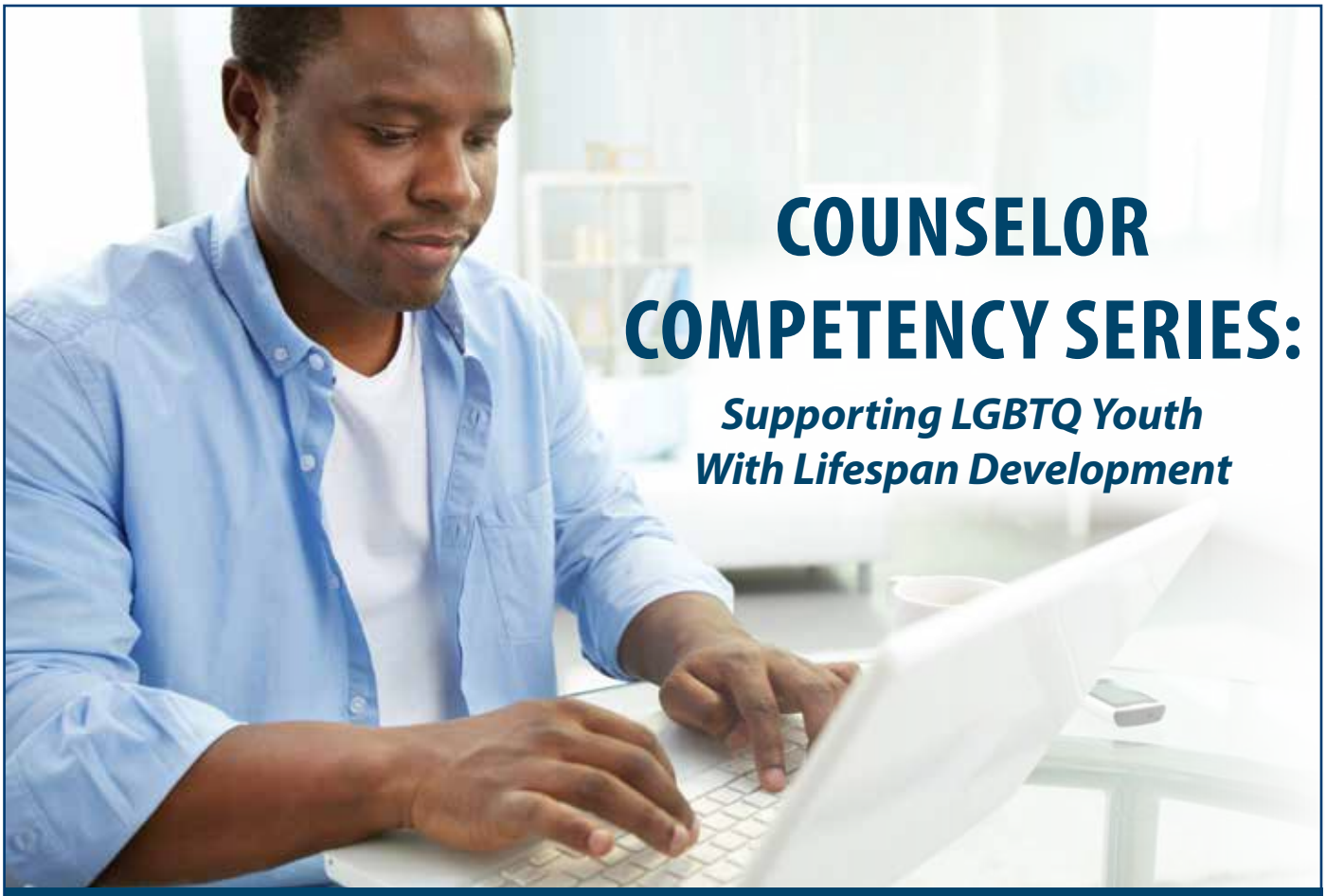

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**This module will be featured as the Free CE of the Month in your July 2016 Member Toollkit email. (Free CE must be completed by the end of July.)**

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Richard Yep

# Advance appreciation all around

Over the past several weeks, a number of men and women completed their years of study and have been awarded graduate degrees. They can now refer to themselves as professional counselors or counselor educators. Some of these highly trained individuals will go on to serve clients and students well beyond the middle of this century. To each of these men and women, congratulations. Know how appreciative we are of the contributions you will make.

Some of you reading this column were instrumental in supporting, educating and guiding these recent grads in your roles as counselor educators and supervisors. That means you have "paid it forward," and your impact on the profession will likely carry on long after you retire. Thanks, both to our recent graduates and to those who brought them to this point.

Each July signals the beginning of ACA's program year. This means welcoming a whole new cadre of individuals who have chosen to volunteer their time, experience and scholarship in service to the profession. Led by our new ACA president, Catherine B. Roland, our new board and committee members will make significant contributions to many areas of counseling. The staff and I express our appreciation in advance for the work they will undertake during the next 12 months.

I also want to thank all of you — our members — for your patience and understanding as the ACA staff worked to identify a new location for our 2017 Conference & Expo, which originally was planned for Nashville, Tennessee. As many of you know, a new law in Tennessee now allows counselors to deny services to anyone based on the provider's strongly held beliefs or values. This is a violation of the *ACA Code of Ethics*. Once the legislation became law in April, the ACA Governing Council made the difficult decision to relocate the ACA Conference & Expo. This is the first time in ACA's history that this type of action has been taken, and it was done only after a great deal of discussion and thought.

We received numerous responses from cities around the United States that wanted to host our conference. By the time the "request for proposal" period had ended, more than 20 cities had expressed great interest. We are pleased to announce that the 2017 ACA Conference & Expo will be held in San Francisco March 16-19, with Pre-conference Learning Institutes taking place March 15-16.

We expect the 2017 ACA Conference & Expo to be one of the best ever, and we strongly encourage you and your colleagues to join us for our 65th anniversary event. The networking opportunities, the speakers, the content sessions, an improved career center and the chance to come together as a community after such a challenging year are things that you won't want to miss.

Last but not least, this is one of those times when I absolutely must give a shoutout to the ACA staff. Each day, these fine individuals come to work to provide for the professional needs of our members, potential members and the public. As we begin each new endeavor — and continue to make enhancements to existing products and services — I am in awe of what has been and is being accomplished. I hope you will join me in my support and acknowledgment of these fine individuals. This past year was one of great accomplishment and challenge. The volunteer leadership was instrumental in providing strategic direction, and the staff's ability to align our work with that direction is something for which I am very appreciative.

As always, I look forward to your comments, questions and thoughts. Feel free to contact me at 800.347.6647 ext. 231 or via email at *ryep@counseling.org*. You can also follow me on Twitter: *@RichYep*.

Be well. ❖


# Counseling Today

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**Mission Statement**

The mission of the American Counseling Association is to enhance the quality of life in society by promoting the development of professional counselors, advancing the counseling profession and using the profession and practice of counseling to promote respect for human dignity and diversity.

# Letters to the Editor

### Dangerous precedent or defining moment?

Recent legislation in Tennessee has received widespread attention in the counseling and legal worlds (see cover story on page 24), and for good reason. I think that House Bill 1840 brings to the surface a long-standing tension not only among counselors, but in the nation and world as well.

I appreciated Richard Yep's message ("A dangerous precedent," CEO's Message, May) that seeks to protect the safety and respect of all from different multicultural backgrounds. I agree that HB 1840 will "violate the fundamental tenets of the counseling profession." At the same time, I feel that the core issue is still not being addressed. I hope my next thoughts do not come across as closed-minded or bigoted, but are considered to be sincere concerns that I hope are addressed.

Richard states in his message that the legislation "is a supposed 'solution' in search of a problem that does not exist." I disagree. From my perspective, there is obviously a "problem." I feel there has been, and continues to be, a tension between conservative religious values and the counseling profession's values. I do not think that saying a problem does not exist is helpful. Messages such as this will likely polarize groups in support of and in opposition to this legislation or, worse, silence groups that are grappling with underlying values conflicts.

I believe many may be comfortable with this polarization and silencing. I personally choose to see this as an opportunity to come together to talk about differences in an environment of respect and civility. Perhaps some believe this cannot happen. I believe that it can and needs to occur. I value seeking to understand the voices of those who support HB 1840 to learn why they feel the way they do. Perhaps there are conservative religious counselors who have felt tension and have chosen to act on it through a legal medium.

Once again, I do not support HB 1840. At the same time, I do not support Richard when he denies that a problem exists on this topic. Religious beliefs and values are at the core of many people in the counseling profession, nation and world. (Obviously, many also do not share these values.) Open dialogue is at the core of the counseling profession. Instead of this being a dangerous scenario, it could turn out to be a defining moment in the identity development of the counseling profession because it gives space for the profession to talk about core conflicts and underlying friction.

*Kirk Thiemann, LPC, NCC*
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### Perspectives on invisible illness

I am writing in praise of "The tangible effects of invisible illness" (Member Insights, May), and I commend you for printing it. Although my own condition isn't totally invisible (I use a wheelchair because of post-polio sequelae), I experience much of what the authors describe. I intermittently see a therapist who is respectful and listens to what I may choose not to say to others.

When a person with a chronic condition comes to counseling after having been through the circuit of doctors, physical therapists, massage therapists, herbalists, pain clinics, chiropractors et al., it seems to be a relief to her or him to have someone who will listen and not try to "fix" things. I try really hard to avoid any implication that there is something my client should have or hasn't done or tried. This implication usually is not true and is insulting. Of course, there is other work in counseling that may be helpful, but I urge counselors to examine closely the person's history and goals for counseling.

I wish the phrase "bound to a wheelchair" hadn't been used in the article because that language is offensive to many folks in the disability community. I recommend *What Psychotherapists Should Know About Disability* by Rhoda Olkin as the best book I have encountered on the subject.

*Judith M. Gibson, M.A., LIMHP*
*Lincoln, Nebraska*
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"The tangible effects of invisible illness" was a well-written article that, unfortunately, only focused on young people. Let's give older people equal time.

A number of older people suffer from invisible illness. On top of that, they also have to deal with retirement and a dwindling number of friends and family. The so-called "golden years" can often be more curse than blessing.

I have a number of invisible illnesses. I have lost 25 pounds as the result of some combination of gastrointestinal problems that no one has been able to identify. People I haven't seen in a while will come up and tell me how good I look, but I feel like I'm starving. I have a series of musculoskeletal problems, including serious scoliosis and kyphosis, which, in conjunction with serving in two branches of the military and 14 years in corrections, has resulted in eight bulged or herniated discs. This causes me pain in my upper, lower and mid back and severely limits lifting and bending, which I find incredibly frustrating. However, I look OK.

The major physical limitations I deal with every day are frustrating for a person who has always been able to take care of himself and do any number of physical activities. Once again, I get told how good I look. Glaucoma has gotten bad enough that I can't see well to drive at night, which prevents me from attending some fraternal organization meetings. People wonder why they haven't seen me in a while but don't seem to think to offer a ride.

After a career in counseling, medicine (doing biofeedback and pain management) and prison mental health, I feel extraneous. I have a wife, a family and grandchildren, but I feel like the world used me and spit me out. Don't write off older people. You will be one some day, and we are not all out in perfect health playing golf.

*Ron Shaver, Ed.D., NCC*

### Holistic healing vs. disease care and profit

I just finished reading "What if it were 10 times more difficult to become a counselor?" (Private Practice Strategies, April) and felt compelled to share my thoughts and feelings.

I agree that the process of becoming a counselor has room for growth. However,

I do not agree that increasing the difficulty of obtaining a degree and licensure will bring about the desired results. Clients are not just "[bouncing] from one counselor to the next"; they are bouncing from one psychologist to the next and one psychiatrist to the next and one doctor to the next ... Before I chose this profession, I was a client experiencing this firsthand.

Increasing the difficulty/workload/length of time/cost of degree programs and licensure does not necessarily produce more competent professionals. It is always a miracle that any student's motivation, compassion, open-mindedness and creativity survive this type of educational environment unscathed.

I entered this profession because I did not want to be on par with doctors or psychiatrists or psychologists, etc. I am in this profession to offer holistic healing and compassion to those who have nearly lost all faith in healing professionals as a result of an industry that has become focused on "disease care" and profit. I agree with L.K. Hill, who stated (1991) that "such terms as *personal empowerment* ... and *positive health* (wellness) may be new to psychology, but they are integral to the very heritage of [the mental health counseling] profession." This is why I strongly oppose looking to psychologists and medical doctors for direction as Anthony Centore suggests.

Nevertheless, it *is* absolutely vital that counselors proactively collaborate to find solutions that address the issue of competence within our field. One simple suggestion I can offer would be for counseling departments to become much more selective when accepting graduate students into their programs.

Lastly, I happen to be an individual whose spiritual and scientific beliefs (quantum physics) align with what was described at the beginning of this article. Perhaps this is an indication of my naiveté, since I am still just a student, but it was highly disappointing to be seemingly ostracized and discredited by a fellow counselor as a result of my beliefs. I am grateful that mindfulness-based stress reduction, mindfulness-based cognitive behavior therapy, yoga therapy and other previously untraditional concepts/therapies were given a chance, and I hope that we can all continue to be open-minded, diverse and experimentative.

*Sera Turgut*
*Clinical Mental Health Graduate Student*
*Marietta, Georgia* ❖

### Letters policy

*Counseling Today* welcomes letters from ACA members; submissions from nonmembers will be published only on rare occasions. Only one letter per person per topic in each 365-day period will be printed. Letters will be published as space permits and are subject to editing for both length and clarity. Please limit letters to 400 words or less. Submissions can be sent via email or regular mail and must include the individual's full name, mailing address or email address and telephone number.

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Email your letters to *ct@counseling.org* or write to *Counseling Today*, Letters to the Editor, 6101 Stevenson Ave., Suite 600, Alexandria, VA 22304.

# A new way to price your counseling sessions

Look online and you might notice a curious way that some counselors price their services. For clients paying cash, sessions are at a premium — say $140 a session. However, the same counselors also accept a number of insurance plans such as Blue Cross, United and Cigna (and even some employee assistance programs), each paying significantly less than the counselor's cash rate.

Insurance is great. I own a company (*credentialing.com*) that helps health care professionals get on insurance panels. Still, there's no denying that accepting insurance is less preferable than cash on the barrel. With insurance, it takes time to get paid, and there's an operational expense to manage and bill claims.

This prompts a question: If cash clients are preferable, why do counselors charge them more? What if counselors charged cash clients *less* than what insurance companies reimbursed?

## Client insurance plans are changing

Consumers are in a strange place right now with health insurance. On the one hand, more people have insurance than ever before (and if they have it, they want to use it). On the other hand, for some, deductibles and copays have increased drastically during the past few years (for example, my own insurance now has a $30 copay and a deductible that I might not meet every year).

What this means is that a growing number of people might not experience much value from their insurance plans. In light of these factors, it's possible that there hasn't been a better time in the past decade than right now to focus on building a caseload with more cash clients.

## Pricing questions and objections

Back to setting prices. There are some common counselor objections to the concept of lowering cash-session rates. Let's identify and address them.

**1) Are you kidding? Other counselors in my area charge $150 a session!** There's no denying that counselors' posted rates are high. In some markets, $130-$150 is typical. However, I know of few counselors working a full caseload at $150 a session. That would work out to more than $215,000 a year. How many counselors do you know earning that much? In reality, those high rates are typically negotiated down, and that's a frustrating way to begin the counseling relationship.

**2) I have some clients paying me $130 a session now. Why would I lower my rates?** If you have a full caseload of clients paying $130 per session, don't lower your rates. In fact, cancel your insurance contracts — you don't need them! It's more common, however, for counselors to have just a few clients paying such sums (and those clients tend to attend sessions infrequently). Plus, to get those few high-dollar clients, counselors have typically turned away dozens of clients who couldn't afford the high rates.

**3) If I keep my rates high, I can see fewer clients and make the same amount of money.** You could, indeed. And that's a choice you'll need to make. It's the proverbial kid selling lemonade for $1,000 a cup — *he just needs to sell one!* See 10 clients a week at $150 per session, and you'll make the same as if you saw 25 clients at $60 per session. But such a high cash rate still doesn't make sense if you're taking insurance too, because a $60 cash client beats a $60 insurance client all day long. As an aside, you got into this profession to have a career helping clients, no?

**4) I need to keep my prices high because my insurance contracts require it.** This is a frequent objection. Some insurance contracts demand that you give the insurance company your very best deal, stating in essence "We'll pay you X dollars per session, or whatever your lowest rate is." I'd like to call b.s. on this. It's none of the insurance company's business how much other people are paying you.

Also, if this is your challenge, here's my question to you: If you have contracts with different insurance companies, they all reimburse different amounts, right? How do you justify that? Should you not accept Cigna because Blue Cross might find out Cigna pays you less? (FYI, they already know.) Still, to make 100 percent certain that you're not violating some contract term, you could get creative and make your cash sessions different in some way from your insurance sessions. That way, there is no apples-to-apples comparison.

## Setting smart rates

How should you price your services? It depends. A better question might be with what rates could you build a full caseload in the next 60 days? Make that your new price. It might be only $40 a session. When your caseload is full and demand is greater than supply (that's you), raise your price by $10. Then keep doing that until there's equilibrium.

Here is where it gets interesting. When your cash rate gets higher than what an employee assistance program or insurance company pays, drop that payer.

When you price your services this way, your reputation in your community will be better and stronger, you will be offering more perceived value to prospective clients, demand will grow higher for your sessions — and your rates will grow in tandem. In essence, this pricing model encourages you to always be getting better at what you do.

What are your thoughts about setting session rates? Shout at me on Twitter: *@thriveworks* or *@anthonycentore*. ❖

Anthony Centore is the founder of Thriveworks, a chain of 26 counseling practices with locations in 10 states. He also serves as the American Counseling Association's private practice consultant and is author of the book *How to Thrive in Counseling Private Practice*. He is a licensed counselor in Massachusetts, Virginia and Georgia.

Letters to the editor: *ct@counseling.org*

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# Identifying strengths and solutions

Jeffrey Guterman is a licensed mental health counselor and a qualified supervisor in Florida who has worked in various clinical settings since 1985. He is the author of more than 125 publications, including the book *Mastering the Art of Solution-Focused Counseling*, published by the American Counseling Association.


Jeffrey Guterman

**Danielle Irving:** You developed a very interesting relationship with the influential Albert Ellis, founder of rational emotive behavior therapy (REBT). Can you describe your relationship with him as his client, supervisee, trainee and, then, colleague?

**Jeffrey Guterman:** My relationship with Albert Ellis was among the most rewarding experiences of my career. I first met Ellis in 1986. At the time, I was working as a mental health counselor in a psychiatric hospital in Fort Lauderdale, Florida. I resonated [with] REBT after obtaining my master's degree in counseling in 1985, and when it came time to take a vacation from my position at the psychiatric hospital, I scheduled three personal therapy sessions with Ellis at his REBT institute in New York City. This allowed me to accomplish several things at once: meet the pioneer of REBT, experience Ellis doing REBT firsthand and work on some of my personal issues.

Ellis and I developed a close relationship throughout the remainder of his life. I continued to practice REBT throughout the 1980s, and Ellis provided me with training and direct supervision by telephone. Ellis provided the best supervision I ever received. His supervision was oriented to REBT, and his style was direct and supportive.

In 1989, I entered a doctoral program in family therapy which contributed to my shift to a solution-focused counseling approach. This contributed to a significant change in my relationship with Ellis. My 1994 article, "A Social Constructionist Position for Mental Health Counseling" in the *Journal of Mental Health Counseling*, was an impetus for a published debate between Ellis, me and others in the field that culminated in live debates at the American Counseling Association's annual conferences in 1996 and 1999. I was no longer Ellis' client, supervisee or trainee. I was now his colleague debating about critical issues in the field. Although I had moved away from REBT, I continued to be influenced by Ellis' ideas. I consider Albert Ellis to have been my first mentor. When he died in 2007, I lost a close friend.

**DI:** After training under Albert Ellis, what led to your shift from REBT to solution-focused counseling?

**JG:** It was a process. By the late 1980s, I had grown weary of the REBT approach because I found it engendered a great deal of resistance in clients. I began to explore different ways of conceptualizing problems and change. So in 1989, I entered the doctoral program in family therapy at Nova Southeastern University.

Although I obtained a doctorate in family therapy in 1992, I am a licensed mental health counselor and continue to identity myself with the counseling profession. However, my doctorate in family therapy provided me with a family systemic perspective and also introduced me to solution-focused therapy, which led to my developing solution-focused counseling.

**DI:** Could you describe in detail what solution-focused counseling is?

**JG:** Solution-focused counseling is a strength-based approach to counseling. In contrast to traditional problem-focused models, solution-focused counseling emphasizes clients' resources, strengths and effective coping skills to bring about positive change. If these resources — called *exceptions* — are identified and amplified, then problem resolution can be brought about in an effective and efficient manner.

There are several principles that inform solution-focused counseling. First, the model emphasizes a collaborative approach. This means counselors strive to learn and use the unique worldviews of clients in the service of bringing about change. Second, the model holds that a small change is often all that is needed to resolve problems that bring clients to counseling. A small change can result in a snowball effect, which can lead to bigger changes and also resolve bigger problems that clients might face.

Another key principle of solution-focused counseling is its emphasis on diversity, which is a defining feature of the counseling profession. In solution-focused counseling, diversity addresses various domains, including gender, sexual orientation, disability, ethnicity, race, socioeconomic status, age, spirituality, religion and family structure. Solution-focused counseling recognizes the importance of developing self-awareness, acquiring knowledge and

building skills relevant to the diverse worldviews of clients. So it's important for solution-focused counselors to gain an understanding of how the diverse worldviews of clients inform, influence and impact problems and solutions.

Solution-focused counseling also tends to be a brief approach. But the quick results of the model are a byproduct of its perspective rather than an end in itself. Most clients bring to counseling a readiness for change — a window of opportunity — that might be missed if we don't zero in on and amplify these natural, problem-solving mechanisms. It's critical, then, to have an acute and ongoing awareness that each and every counseling session could be the last counseling session.

This is not to say that solution-focused counseling is always brief. It is for this reason that I do not include the term "brief" in the name of the model. It is brief by design, but it does not always work out that way. I set out in each session with the understanding that this might be my last session with this client. Therefore, I always try to be focused. Perhaps it would be more fitting, then, to describe the model as focused by design, rather than brief by design. I have had some long-term cases. Generally, though, my treatment episodes last from three to 10 sessions.

**DI:** In what ways are REBT and solution-focused counseling similar and different?

**JG:** REBT and solution-focused counseling are similar in many ways. For example, each approach tends to be active-directive, emphasizes the present rather than the past and is relatively brief and focused. There are other similarities too numerous to mention.

As for differences between the models, REBT tends to be an educative approach, whereas solution-focused is collaborative. In REBT, the counselor typically teaches clients the principles of the model. In contrast, solution-focused counselors learn the client's worldview as a basis to develop solutions. It could be said that REBT is an outside-in approach, and solution-focused counseling is an inside-out approach. REBT also aims for a large scope of change and engenders resistance as a result. In contrast, solution-focused counseling tends to aim for small changes and seeks to enhance cooperation during the change process.

In our published debate in the *Journal of Mental Health Counseling*, Albert Ellis argued that REBT brings about *elegant* change — i.e., disputing irrational beliefs, thereby helping clients eliminate both present and future disturbances. In this published debate, I countered that elegance is in the eye of the beholder.

As I see it, the change process in solution-focused counseling takes advantage of opportunities that are often missed in REBT. By using the client's, rather than the counselor's, story as the organizing metaphor during the change process, resistance can be avoided and significant change — albeit inelegant from an REBT point of view — can be brought about. So these differences correspond to different ethical imperatives regarding how counselors choose to participate in the change process.

Yet another difference between REBT and solution-focused counseling is the latter's strategic approach to eclecticism. This allows counselors to tailor treatment to account for each unique client, apply a variety of interventions from other treatment models and to do so in ways that enhance the change process of solution-focused counseling.

Although I moved away from REBT, I found that it has utility like other traditional theories of counseling and psychotherapy. So I developed a basis from which to incorporate REBT-like techniques and those from virtually any other model within solution-focused counseling in a manner that retains the integrity of my model. Although REBT is multimodal and eclectic, I'm not sure it is able to incorporate such a wide array of theories and techniques without sacrificing its integrity.

**DI:** What do you consider the most important solution-focused techniques?

**JG:** I consider solution-focused counseling to be more a sensibility than a cookbook of techniques. I offer "homework" and tasks when it fits for the client. But the most important methods in solution-focused counseling are its interventive questions. These take many forms and have many purposes throughout the solution-focused stages, including defining the problem, setting the goal, identifying and amplifying exceptions, reevaluating the problem and goal, and so forth.

For example, when asking questions aimed at identifying exceptions, it is important to ask, "When has there been a time when you coped better with the problem?" rather than, "Has there been a time when you coped better with the problem?" The latter is a yes-or-no question that leaves room for the client to respond negatively. The former carries with it a sense of expectancy that indeed there have been times when the client has coped better with the problem. This type of questioning is interventive because it produces a sudden shift in the client's problem focus.

**DI:** What are some of your current interests?

**JG:** My interests are multidisciplinary. I look to many fields for inspiration, including the arts, philosophy, science and especially technology. The rate of technological growth has increased so much in the past two decades, let alone in the past two centuries. It is exponential. Not only has my use of technology changed, but how I think about technology has changed, and in ways that will never be the same.

**DI:** How do you see technology impacting the counseling profession — and you as a professional?

**JG:** Like the rest of the world, technology has impacted the counseling profession — and me — in ways we are just beginning to understand. Technology is a double-edged sword, so its impact has been both positive and negative.

In the short term, technology has opened the door to many possibilities. A creative confluence has emerged in which counselors are now able to draw from many aspects of cultural life, including social media. This has the potential to create innovative combinations of treatment.

While holding enormous promise, there are risks to the profession. In the long run, as technology develops exponentially in the 21st century, I see humans becoming increasingly augmented by technology. The biggest implication is that the nature of humanity itself may change as post-humans develop. *Post-human* refers to a completely synthetic entity with artificial intelligence. A superintelligent robot, if you will. Some experts in the area of artificial intelligence predict that post-humans could appear in the middle of this century if and when a singularity occurs.

The singularity is a point in time when the rate of technological progress becomes nearly vertical. Smarter computers would design even smarter computers, and a positive feedback loop would ensue. As a result of such technology, people might possess the capability of re-creating their selves in ways that are unimaginable today. Software uploading to the brain, which is already being done for some people with Parkinson's disease, for example, could allow one to experience and manifest alternative personalities. Personality uploading may permit an individual to be anyone he or she wishes to be, presenting new challenges and opportunities for counselors.

**DI:** You've worked in various clinical settings. Which would you describe as your favorite, and why?

**JG:** Any setting that is a context for curiosity, learning and growth. I see counseling, supervision, training and education as a relational process. For example, the client isn't the only one who changes. I include myself in the system to be changed. In effect, I am a participant-observer who both influences and is influenced by the change process.

At present, I work mostly with students and colleagues, providing clinical supervision and training. I also see a small number of clients in private practice. In each of these settings, the people I work with continue to be a great source of inspiration.

**DI:** You have more than 30 years of experience in the profession. What advice would you offer new professionals?

**JG:** Firstly, I suggest both new and experienced professionals value the importance of self-care. As a new professional, I focused too much on advancing in the profession, at great cost to my health. I experienced depression and a lot of stress throughout the past three decades. I am now committed to taking care of myself, and I urge [other] professionals to do the same. There is no stigma to seek counseling or any type of mental health care when in need or if you have any question that there may be a need.

Secondly, be open to new ideas. Powerful institutions such as universities, professional associations and corporations hold so-called "privileged" knowledge and then impose this knowledge in and on our field. Students, counselors and the profession are indoctrinated to prevailing theories and techniques. And the pressure is on to align with particular models in order to advance in academic programs, obtain employment and obtain third-party insurance reimbursement. I invite counselors to question taken-for-granted assumptions about and within our field, to challenge themselves and others, and to think differently.

**DI:** Is there anything I have left out that you want our readers to know about you and your work?

**JG:** There is so much and so little space to share it. At this point, it is probably best to refer readers to my website at *JeffreyGuterman.com* and to my Twitter account, *@JeffreyGuterman*, where they can follow my online activities. ❖

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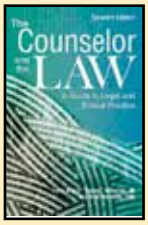


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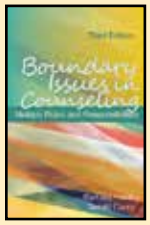


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# Inside telehealth: A personal account of messaging therapy

There's no denying that telehealth is quickly growing in use as a medium for delivering counseling services. (Read my previous article on the ins and outs, ethics and legalities of telehealth at *tameyourpractice.com/telehealth*.) Although most of the focus is on the use of synchronous video, other modalities are growing in popularity too.

Recently, I had the opportunity to interview Tasha Holland-Kornegay, a licensed professional counselor supervisor who has been providing "messaging therapy" to clients through a platform called Talkspace. The service primarily consists of asynchronous messaging via text or web, although some video and audio options are also available. I was especially curious to hear how she was addressing some of the ethical and legal issues raised by this format.

**Rob Reinhardt:** I'm very curious to hear about your experience with messaging therapy but, first, can you tell me a little bit about yourself?

**Tasha Holland-Kornegay:** I am a licensed professional counselor, and I'm also an HIV advocate and have an HIV nonprofit (Partners Against Sexually Transmitted Diseases at *pastd.org/*). I go out into the community and speak to family members and educate individuals. Believe it or not, there's still a lot of misinformation out there about it. So that's another piece of what I do on top of counseling. In private practice (at *ourtreatmentcenter.com/*), I work with individuals anywhere from the age of 3 up to seniors.

**RR:** Very interesting. What is it that led you to messaging therapy? What made you say, "This looks like a great way to provide counseling services. Let's give it a try."

**THK:** I think it was a couple of things. With my passion for HIV [advocacy] and counseling, I have a Facebook page that I use as an educational forum. But a lot of times, once people find out that I'm a counselor, I'll get private messages, and they'll start with, "I just got tested."

I knew that Facebook wasn't a secure way to respond to them, and the messages were coming from all over the country. A lot of times I would make my response very basic and general and refer them to their local health department and HIV counseling and remind them that the Facebook page was more for informational purposes. But I didn't want to turn my back on them; I wanted to help them more.

The second reason was that I recently had a baby, and I was thinking, "Oh my gosh, I don't know how I'm going to continue what I have been doing and still have time home with the baby."

**RR:** What convinced you that messaging therapy would meet the needs of more people and provide you more time at home with family while still practicing ethically and legally?

**THK:** I was a little nervous and skeptical because you don't want to cross state lines and you want to make sure your clients will get everything your face-to-face clients would be getting. I spent a good month researching and processing. I think Talkspace, the company I work with, probably thought, "Is it her again?" because I was asking so many questions. But I wanted to be sure people were getting quality service and help.

So, I did a lot of research on the company and platform before I took the plunge. The company really does things well. They only allow you to have two clients when you first get started, and there are a lot of other things in place that addressed my concerns.

**RR:** It sounds like you got the answers you needed to make you feel confident in moving forward.

**THK:** Yes, and they were very fast to respond, and that was another quality that made me very comfortable with the platform. It was pretty much within the hour that they would respond, and they were very welcoming and informative.

**RR:** What was the process like once you decided to move forward?

**THK:** They signed me up and put me through a vigorous training process. I felt like I was back in school. They send you thorough lessons on how to navigate the platform and then on how to handle the relationship with the client, and there were tests. They want to be sure they are getting quality therapists, so there were case scenarios and "how would you deal with this?" Then you do one-on-one training with someone who tests your knowledge of the system and does mock counseling with you to be sure you're ready.

After that, they set you up with your first two clients, and you have to let those clients know that you're new. After about a month in training, they let you take four more clients, and then you are

transferred out of training and into a mentoring group. My group has about five people in it. It really felt like a full-blown training program to make sure the clients are taken care of.

**RR:** So the people at Talkspace take an active role in setting the clients up with counselors?

**THK:** Yes. In a space in the app, all the clients are listed with age, gender and a general reason why they are seeking services. Then I can go in and say that I'm a good fit for this client because of my background, training and techniques, and I provide details. The employee who's called the "consultation therapist" may even ask you for more details about why you'd be a good fit. Kind of like, what are you going to bring to the table for this client, because we want to make sure you're a good fit. From there, they decide which therapist to assign the client to. Once you're assigned, you connect with the client.

**RR:** Apart from the platform and environment, what has been different about providing messaging counseling from providing counseling services in your office?

**THK:** Because it's unlimited texting and the clients take advantage, some clients will write a lot of journal entries. When I log in, there's a lot to read and catch up on. I'd say 80 percent of my clients are active every day. So it feels like a lot of contact, unlike sessions in my office, where we meet and then go a week between.

I go into the platform five days a week, twice a day, and spend an hour and a half to three hours at a time replying to clients. You really end up forming a relationship with clients because you're interacting with them a lot.

**RR:** If I understand, this process is asynchronous. You aren't actually texting directly back and forth with clients, but rather reading and responding at different times of the day, unless they happen to be on at the same time as you.

**THK:** Exactly, unless they request it. And I've only had that happen once when a client was really antsy about a job interview and wanted to direct-message a couple hours before the interview. They do have a video option now, though I haven't used it yet. People are working all day, and time zones are off, so it's convenient for people to get it out and then wait for a response.

**RR:** Do you find yourself working with clients similar to those in your office?

**THK:** I'm currently dealing with a lot of clients with anxiety and relationship issues and some depression. It's probably 75 percent clients dealing with anxiety. I'm not sure if that's because I'm actively picking those [cases] or because of other reasons.

**RR:** I can see that making sense because people dealing with anxiety may be more likely to use online services.

**THK:** Yes, and I do see that a lot of these clients are experiencing counseling for the first time. They also find it to be really convenient, especially if they work a lot and don't have time to go to a therapy office.

**RR:** In talking about what is different between counseling in your office and online, I thought you might say that working with clients online was briefer because these clients are looking to address a singular issue quickly. Has that been your experience?

**THK:** Actually, much like in the office, people will come in with surface issues and then later open up and reveal other layers — talk about their childhood and the fact that they're actually experiencing anxiety in a lot of situations, for example. I'm finding myself working with clients over a period of time similar to [what I would] in the office.

**RR:** Do you find it challenging to deal with the lack of social and communication cues such as facial expression and tone of voice?

**THK:** The platform really does a great job of addressing this. They include the option to use audio, so if I feel that I'm not hearing a message clearly, I can propose to [the client], "For your next message to me, would you mind using audio?"

I also use a lot of emojis, and some of my clients don't do written journals, they do voice journals. They can also send pictures to show me how they're looking and feeling.

**RR:** So we can't really refer to this as "text therapy" because it's a lot more than that.

**THK:** Yes, it really is. This platform was really thought out. It really answers a lot of the questions and needs in providing services in this environment.

**RR:** Speaking of questions, I know I have a lot of questions about how privacy and confidentiality, HIPAA (Health Insurance Portability and Accountability Act) compliance and other legal and ethical issues are handled. What things have you run into that you think are unique with this platform regarding those topics?

**THK:** The platform covers consent and not moving forward until you have the client's consent. This includes clients consenting to working with you if you're in a different state and that they agree to the license rules and laws of the state where the counselor is licensed. (***Editor's note:*** The American Counseling Association recommends that counselors check with the licensing board in the client's state.)

I was also concerned about privacy. When clients and counselors log in, they are using their own username and password, and there's a significant security and verification process that therapists have to go through.

**RR:** This concept of a client agreeing to abide by the laws of another state is an interesting one. I'm not an attorney, but I have to think the platform had its attorneys vet that policy. I'm not aware of it ever being tested in court though. This makes me wonder what might happen if a complaint is filed — how the courts or a licensure board might rule on it.

**THK:** I've thought about that, and I think we need to start somewhere. I think that it has been well planned and thought out. This is a national site with over 700 therapists. The client sees our full information about our license, and I think the wording in the consent is very tight.

I may well be in a "test group" because there are unanswered questions. We're in a whole new world with technology, and we have to test it out. There are so many people out there who need help and may prefer to meet this way.

**RR:** Back to privacy. Is there any attempt on Talkspace's part to verify the identity of clients? Are they allowed to stay anonymous?

**THK:** Talkspace verifies identity through things like credit card information. The client has the option of being anonymous with their therapist, but all of my clients tell me who they are and where they live. (***Editor's note:*** Standard H.3., Client Verification, of the *ACA Code of Ethics* states: "Counselors who engage in the use of distance counseling, technology and/or social media to interact with clients take steps to verify the client's identity at the beginning and throughout the therapeutic process. Verification can include, but is not limited to, using code words, numbers, graphics or other nondescript identifiers.") You're building a rapport that's remarkable like you'd never think you could do over texting.

**RR:** Because Talkspace does verify the client's identity, does it have safety plans in place for crisis?

**THK:** They do. They warn clients up front that this isn't an appropriate platform for crisis intervention. It states on the website that in crisis, clients should call the 24-hour National Suicide Prevention Lifeline at 1.800.273.8255 or 911.

And we do have a plan to address things as they arise. In addition to providing clients with local resources, we also always have a community and mentors to touch base with about situations to make sure that we and the clients get help if needed.

**RR:** You're in a very interesting position of helping to innovate this new platform.

**THK:** Yes, and in some ways, it's scary. But they have really done their homework with this platform and addressed the things I am most concerned about, so it helps me feel confident about working this way.

I think it's fascinating that therapy and technology are finally merging in this way, and I feel good about it because there are so many people we haven't been able to reach. This [lets] me know that I can help and reach more people and that I have a support system there that a lot of other people don't have.

Please note that I have not personally evaluated the Talkspace service. As Tasha Holland-Kornegay suggests, it is important that counselors fully investigate and evaluate any technology they might consider using to provide services to clients. This includes looking into the ethical implications of such use. Additionally, because state laws regulating telehealth vary widely, it is strongly recommended that you also consult with your state licensure board and a qualified attorney. ❖

Rob Reinhardt, a licensed professional counselor supervisor, is a private practice and business consultant who helps counselors create and maintain efficient, successful private practices. Before becoming a professional counselor, he worked as a software developer and director of information technology. Contact him at *rob@tameyourpractice.com*.

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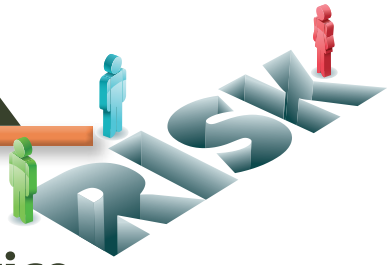


# Settling on the proper form for your practice

**Question:** I am looking to make a switch from agency practice to my own private counseling practice. I am so confused about the different forms that a practice can take. Do you have any suggestions?

**Answer:** I can understand the confusion because the terminology can be complex and the choices are numerous. Let's look at some of the options and the respective pros and cons of operating under the different forms. Keep in mind that state laws may differ regarding the different forms, so it is advisable to consult a health care attorney in your state who handles formation of corporations and other business entities. I would also highly recommend speaking with your accountant because tax consequences of the different practice forms may affect your tax liability.

One possible form of business, and perhaps among the easiest for a counselor starting his or her own private practice, is the *sole proprietorship*. Typically, you would operate under your own name and credentials and use your Social Security number. After obtaining any required operating licenses or permits (in addition to your counseling license), professional liability insurance and premises insurance, you'd be in business. The sole proprietorship is simple and inexpensive to form and operate on an ongoing basis. The disadvantages of operating as a sole proprietor are that your profits are declared on your personal tax return, there is no shield against liability and your personal assets can be reached to satisfy business liabilities or debts.

A *partnership* is a business entity typically composed of two or more individuals or other business entities. Although a partnership is fairly simple to create and maintain, it can pose some tax and liability issues. For example, you may be liable for the acts and omissions of your partner.

A *limited liability partnership* may offer you some insulation from the debts and obligations of the partnership and the independent actions of your partners. You could still incur liability if you supervised partners or employees, however, and you would still be responsible for your own conduct and debts.

*Corporations* are business entities created under state law, and they operate like independent legal "persons" apart from their shareholders and directors. They are owned by one or more stockholders and managed by a board of directors. Corporations may enter into contracts, pay taxes and exist after their shareholders die or sell/transfer their shares to others. Corporation owners or shareholders benefit from limited liability for the corporation's legal obligations. However, maintenance of the corporate form can require annual filings, regular reports and periodic meetings, which can be onerous for some small counseling practices. If you opt for a corporate form of practice, note that various types of corporations exist, and taxation is a key consideration in how to structure a corporation.

In some states, *professional corporations* are available to allow incorporation by similarly licensed professionals. Counselors sometimes operate as *nonprofit corporations* but are advised to seek professional legal and tax advice because corporate registration as a nonprofit entity does not automatically mean contributions are tax deductible.

A *limited liability company (LLC)* is a hybrid version of a corporation and partnership. The main advantage for a counseling practice is limited liability similar to that of a regular corporation. Counselors forming an LLC typically can elect whether the company will be taxed like a partnership (pass through taxation to the individual) or a corporation. Sometimes the LLC is subject to franchise tax.

One important point: There really is no counseling practice form that will totally insulate you from your *own* malpractice liability. No matter what form your practice takes, you need professional liability insurance.

Also, as mentioned previously, it is usually worth the cost of hiring a reputable attorney and accountant upfront to make sure that you choose the right form for your practice and personal financial situation and one that is supported by your state laws. If you don't already have an attorney for your practice, you might ask colleagues if they have recommendations. You could cross-check any recommendations through the online attorney directory at *martindale.com*. When you use that site, you can search for law firms or attorneys in your city or state and also pick several areas of practice (e.g., corporate organization, health law and health care corporate law). You might also wish to read Chapter 11 of *The Counselor and the Law: A Guide to Legal and Ethical Practice*, seventh edition, which I co-wrote with Burt Bertram. The book is published by the American Counseling Association.

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The question addressed in this column was developed from a deidentified composite of calls made to the Risk Management Helpline sponsored by ACA. This information is presented solely for educational purposes. For specific legal advice, please consult your own local attorney. ❖

Anne Marie "Nancy" Wheeler, an attorney licensed in Maryland and Washington, D.C., is the risk management consultant for the ACA Ethics Department.

Letters to the editor: *ct@counseling.org*

# The state of the profession

When looking at the current state of the counseling profession, one might be reminded of the beginning of Charles Dickens' *A Tale of Two Cities*: "It was the best of times, it was the worst of times …"

Granted, things are not quite that dire within the profession, but neither are we sailing on calm waters. The counseling profession is strong and growing, but it is also being challenged.

In the United States today, there is more acceptance of mental health care as a whole and, through the efforts of many of you, more recognition of who licensed professional counselors are and what they do. But as we've written before, this recognition comes with notoriety, which creates new challenges. In part because of that notoriety, the counseling profession must recognize the public policy challenges that it faces. We need to come together and focus on the issues at hand if the profession is to continue growing and thriving.

The first of these issues is a question: What does it mean to be a counselor? Most would agree that counselors are professionals who offer mental health care treatment, rehabilitative treatment, treatment of a person's career and so on. Regardless, a qualified professional is delivering a service that helps a client to become a fully healthy and developed person. Counselors are not a group of people practicing a hobby. Years of training are required to become a counselor. And because counselors provide treatment, a professional code of ethics is required to protect both counselors *and* their clients.

That is why the American Counseling Association works so hard to fight religious refusal legislation — because it runs counter to our code of ethics. If counseling is to be regarded as a true profession, then providers cannot chose whom they wish to treat based on personally held beliefs. By saying that counselors *can* choose whom to treat — and whom to refuse service to — a recent law in Tennessee essentially rewrites counselors' professional code of ethics (see cover story on page 24). In other words, a state legislature — a group of noncounselors — is defining what it means to be a counselor.

If the counseling profession is going to survive, counselors cannot stand on the sidelines and let someone else define them. If we are comfortable with that happening, then all of ACA's branches and divisions and all the licensing boards should close their doors and hand over their keys to the states' legislatures.

Another issue demanding our attention is that, in some states, the ability of counselors to diagnose is not clearly articulated. In fact, in certain states, the law could even be interpreted in such a way to mean that counselors are strictly prohibited from diagnosing. Why aren't we concentrating on this issue? Are we complacent in letting these situations stand?

As we look to the states, we also need to tackle another great challenge in the public policy arena: building a framework for license portability. The ACA Government Affairs Department is made up of a group of noncounselors who have been hired to promote and protect the counseling profession. We feel compelled to write that license portability will be achieved only if the counseling profession can reach agreement on what requirements for licensure should look like. That means adhering to the outcomes of projects such as 20/20: A Vision for the Future of Counseling.

Consensus was reached during 20/20 on only two of the three building blocks to counselor license portability: a common licensure title and a common scope of practice, but not common education requirements. Regardless, it is important that we all do what we can to ensure that state licensure boards adopt the common licensure title (licensed professional counselor) and scope of practice so we can begin to build a congruent framework that will lead to portability.

In the end, the profession will survive and thrive only if its professionals stick together. It will crumble if we are divided. But *you* must choose whether we are going to work together or not. The choice is yours alone. Will you come together, or will you simply be a custodian to counseling as it walks the trail to oblivion? ❖

Art Terrazas, Guila Todd and Dillon Harp make up the Government Affairs Department at the American Counseling Association. Contact them at *advocacy@counseling.org*.

Letters to the editor: *ct@counseling.org*

# JCD Learning Test

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## *JCD* Article: ACA307, Identifying and Addressing Grief and Loss Issues in a Person with Aphasia: A Single Case Study

**Learning Objectives:** Reading this article will help you:
1) Understand grief and loss issues experienced by individuals with aphasia.
2) Examine creative approaches to counseling persons with aphasia.

### Continuing Education Examination

1) Impairment of communication as a result of a stroke is called:
   a) Dysfluency
   b) Aphasia
   c) Stuttering
   d) Auditory processing disorder

2) Disenfranchised grief refers to grief that is socially recognized and widely acknowledged by others.
   ____ True ____ False

3) Which of the following is not an example of disenfranchised grief?
   a) Loss of a loved one due to suicide
   b) Loss of identity following the birth of a child
   c) Loss of independence following a marriage
   d) A widower's confusion about finances

4) Although traditional communication may be difficult for clients with aphasia, _____ can be powerful in helping clients convey their emotions.
   a) Narrative therapy
   b) Bibliotherapy
   c) Expressive arts
   d) Cognitive mapping

5) Although it is important that counselors allow clients with aphasia to grieve their multiple losses, it is also significant for counselors to:
   a) Emphasize adaptation
   b) Normalize the client's experience
   c) Recognize the client's personhood
   d) All of the above

❑ I certify that I have completed this test without receiving any help. Signature_____ _____ Date

**Rate the following:**

| | Strongly agree | Agree | No opinion | Disagree | Strongly disagree |
|---|---|---|---|---|---|
| | 5 | 4 | 3 | 2 | 1 |
| _____ I learned something I can apply in my current work | | | | | |
| _____ The information was well presented | | | | | |
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# Making a difference in our profession and communities

This past year, as president of the American Counseling Association, I (Thelma Duffey) established two initiatives related to professional advocacy and anti-bullying and interpersonal violence. I invited Jen Curry to lead the Anti-Bullying and Interpersonal Violence Task Force and Heather Trepal to lead the Professional Advocacy Task Force. These two powerhouses of energy and enthusiasm worked with incredibly dedicated task force members all year, and thousands of counselors across the country participated.

My goal for this year was that we would be "Counselors Coming Together." Through the interview below, we are pleased to share the ways in which ACA members came together as counselors committed to making a difference in our profession and in our communities.

**Thelma Duffey:** Jen, I know the Anti-Bullying and Interpersonal Violence Task Force has been hard at work this year. Can you tell us about that?

**Jen Curry:** Honestly, Thelma, this group was an amazing team from all over the country, passionate about the work counselors do to prevent violence and help clients and communities heal. We completed several projects, and I hope our members will use these resources in the spaces in which they work and live.

**TD:** Please tell us about the projects.

**JC:** The ACA Impact Project, as you know, is about acknowledging positive impact and support. It's been terrific, and we've had universities, counseling organizations and literally thousands of people participate. There was a booth at the ACA Conference, and people were carrying their Impact signs throughout the exhibition hall.

The Illinois and Connecticut counseling associations held Impact Projects, the University of Texas at San Antonio, just to name a few. It's so easy to do, and you can do your project alone or with a group. Students at Louisiana State University had a fun photo booth on campus, and so many people of all ages and walks of life came up to participate.

**TD:** That is exciting to hear. And in addition to those you mentioned, the Idaho Counseling Association, Rollins College, Converse College, Virginia Tech, Northern Illinois University, Chi Sigma Iota at Texas A&M University–Texarkana, Radford University, University of Houston–Clear Lake, Oklahoma State University, the Chicago School of Professional Psychology, Delta State, and Texas State participated. We also had participants at the Time to Thrive Conference, and a number of people independently posted their Impact signs on Facebook or Twitter.

**JC:** And in addition to the counseling world, the ACA Impact Project received some national press, correct?

**TD:** It has. We learned that Rockford, Illinois' WREX.com NBC Channel 13 featured an article titled "New Rockford Social Media Campaign Focuses on Positive Impacts," highlighting the ACA Impact Project, and the *Meridian Press* in Nampa, Idaho, encouraged community members to participate. It's been great to see the Impact Project embraced in this way. In a time when people are hurt through experiences such as cyberbullying, it is gratifying to see technology used to promote the good.

**JC:** This conversation is the opposite of bullying, isn't it? Much like when we started this work in July and looked at defining "anti-bullying" in a new way. We said that based on Dan Olweus' definition, "Bullying is … 1) repeated; 2) deliberate verbal, physical or social abuse and/or exclusion; 3) by someone, or a group of people, with more power than his, her or their target." Anti-bullying, as you and I defined it, is 1) repeated; 2) deliberate verbal or social affirmation, empowerment, support and inclusion; 3) by someone who treats others fairly, with justice, equity and dignity.

**TD:** Indeed. What a wonderful reframe. I know the task force was busy with other projects too. Can you tell us about them?

**JC:** We completed these incredible interpersonal violence modules for counselors to use as primary resources on various forms of violence, including human trafficking, bullying, sexual violence, cyberstalking, dating violence and military domestic violence, to name a few. These modules contain all kinds of video references, PowerPoints created by experts, quick reference guides and more. They will be available to ACA members on the ACA website this summer.

We also created a legislative guide for counselors on anti-bullying legislation and restorative discipline/restorative justice practices for counselors who serve as expert witnesses, client advocates and those who help develop policy in their respective workplaces.

A final project is a survey we hope to launch that will ask counselors what they'd like to know about these topics, which could inform professional development offerings in the future.

**TD:** What an accomplishment! If you could choose a few special people to recognize for their efforts, who would they be and what did they do?

**JC:** Tara Jungersen oversaw the development, identification of experts and editing of the interpersonal violence modules, and Deb Del Vecchio-Scully, Peggy Mayfield, Verna Oliva-Flemming, Hannah Cornelius, Abigail Conley and Karin Jordan were the subcommittee's fantastic members. I headed the legislative module and worked closely with Erin Kern and Christian Chan. Chris Leeth and Abigail Conley worked on the counselor survey. And, of course, you, Allison Pow and Jessica Lloyd-Hazlett spearheaded the Impact Project.

**TD:** This is terrific. I appreciate that the task force brought awareness to the issues of bullying and interpersonal violence and created resources to address them.

Heather, could you give us some highlights from the Professional Advocacy Task Force and some of the areas you are most proud of?

**Heather Trepal:** Advocacy for the profession of counseling is such an important and timely topic. There are so many big and small ways to advocate, and this task force attempted to work on some of them.

Cassandra Storlie and Jennifer Jordan co-chaired the Clarifying the Role of Today's Professional Counselor subcommittee. They developed a contest on this topic as part of April's Counseling Awareness Month. The contest entries ranged from advocacy letters mailed to state counseling boards to tweets sent to TV affiliates voicing their opinions on the misrepresentation of counselors. Many of the entries described personally educating those around them who were unaware of what professional counselors do.

The winning entry was from Peeper McDonald. She addressed the differences between pastoral care and professional counseling. Not only did she address a pastor who was misrepresenting himself, she also created an informational YouTube video. The winner was awarded a free registration to the 2017 ACA Conference.

**TD:** This is just what I hoped would happen. Imagine the clarity we can bring to our profession by addressing misinformation when we see it. What other projects did the task force work on?

**HT:** Stephanie Burns and Daniel Cruikshanks chaired the Counselor Branding subcommittee. Along with Eddie Capparucci, Lotes Nelson and Emerald Templeton, they developed a resource for using social media for marketing and advocacy. This gives counselors ideas and resources for using social media for promotion and advocating for the profession of counseling and clients.

Craig Cashwell and Martin Wesley co-chaired the Counselor Licensure Portability subcommittee. They compiled documents related to the ever-changing landscape of counselor licensure portability. ACA's Professional Standards Committee, co-chaired by Kathy Ybanez-Llorente and Justin Lauka, compiled additional information. We have a link available that could be listed with the resources for this year's work on the ACA website.

**TD:** I appreciate the diversity of ways in which the Professional Advocacy Task Force approached its charge and your examples for counselors interested in supporting the amazing work that the ACA Government Affairs staff does every day on our behalf. If you could choose a few special people to recognize, who would they be and what did they do?

**HT:** Sean Nixon and Denise Magoto co-chaired the Counselor Medicare Reimbursement subcommittee. They do great work with ACA staff liaison and grass-roots organizer Dillon Harp to garner legislator support to cosponsor a bill allowing counselor reimbursement for services rendered to clients using Medicare. In addition, our ACA region chairs connected us with ACA members in key target states and districts to support ACA's Medicare advocacy efforts. As we advocate for professional counselor reimbursement under Medicare, our efforts on the ground are increasingly important.



So, here is the great news. We put out a call, and ACA answered! We are grateful to everyone who aligned with these initiatives and encouraged their members, colleagues and friends to participate. Although this may not be an exhaustive list, our best records indicate that in addition to those already mentioned, the following people and groups also supported one or both initiatives: Rick Balkin and the ACA Research and Knowledge Committee; Bill Green and the Public Policy and Legislation Committee; the University of Omaha; the University of Nebraska; Northwestern University; Elias Zambrano, the directors of guidance and San Antonio school counselors (and those from surrounding areas); and the Arizona, California, North Dakota, Kentucky, Louisiana, South Carolina, Tennessee, Wyoming, Idaho and Connecticut counseling associations.

ACA divisions were also supportive, with a number participating through their newsletters, websites or by creating modules, videos, Impact Projects, Days of Learning and other activities. We'd like to recognize them for their participation: Counselors for Social Justice; the Association for Child and Adolescent Counseling; the Association for Lesbian, Gay, Bisexual and Transgender Issues in Counseling; the Association for Spiritual, Ethical and Religious Values in Counseling; the Association for Multicultural Counseling and Development; the Association for Creativity in Counseling; the American College Counseling Association; the International Association of Addictions and Offender Counselors; the Association for Adult Development and Aging; the Association for Humanistic Counseling; and the Association for Counselor Education and Supervision. Lastly, the North Atlantic, Midwest, Southern and Western Regions offered terrific support.

Be proud, ACA, and thank you, fellow counselors. This past year, volunteer leaders came forth with spirit and generosity and created momentum around advocacy for the profession and social action. As an association, we concluded our year defending our code of ethics and standing firm against discrimination.

We ask that you continue to connect with one another and ACA in advocacy. When you see ACA e-blasts asking you to contact your legislators, or when you receive an email from ACA staff regarding advocacy efforts, please join in. And when you have an opportunity to support anti-bullying and interpersonal violence efforts or express your appreciation to someone, we hope you will. Counselors working together definitely make a difference. ❖

# License to deny services

A new law in Tennessee allows counselors to reject prospective clients on the basis of the provider's personal beliefs and values, setting up a direct conflict with the *ACA Code of Ethics* and marginalizing certain populations

By Laurie Meyers

In April, the Tennessee Legislature passed a bill, which the state's governor then signed into law, allowing counselors to refuse to see any client if counseling that client involves "goals, outcomes or behaviors that conflict with the sincerely held principles of the counselor or therapist."

The law, which is in direct opposition to the *ACA Code of Ethics*, was pushed through despite the concerted efforts of the American Counseling Association, the Tennessee Counseling Association (TCA) and other opponents. Even more alarming is that the legislation could represent only the beginning of efforts to pass similar laws in other states.

In response to the controversial law, the ACA Governing Council made the decision to move the 2017 ACA Conference & Expo out of Nashville and relocate it to San Francisco.

"We agreed it was important to move the conference because the Tennessee governor signed a bill into law that attacked our code of ethics and allowed counselors to refuse services to clients in the Tennessee communities based on their religious and personal beliefs," explains Thelma Duffey, whose term as ACA president ends July 1. "We believed it was important that ACA take a public and powerful stance in opposition to this bill, and relocating provided us with this opportunity. We also believed it was important that we communicate our support to our members who voiced deep concerns about continuing to hold the conference in Tennessee in light of the new law. And, ultimately, we made the move based on our long-held belief of nondiscrimination and our commitment to advocacy for all people."

The intent of Tennessee's law is to allow counselors to discriminate against potential clients who identify as lesbian, gay, bisexual or transgender (LGBT), says ACA CEO Richard Yep. "This [is] a full-frontal attack on specific populations that some very conservative right-wing groups in the United States want to exclude from mental health services that they desperately need," he says. "The new law will permit a counselor to reject an individual simply because of that provider's beliefs and values. ACA and its code of ethics are very clear that counselors do not bring those beliefs and values into a counseling relationship."

In addition to being unethical, the law is harmful to those looking for help, Yep emphasizes. "For someone seeking the services of a mental health provider to be told that because of who they are, a service provider will not work with them sends an incredibly negative message of exclusion, bigotry and discrimination," he says.

### Counseling in the crosshairs

When the Supreme Court ruled in June 2015 that states must recognize the validity of same-sex marriage, it marked a significant step forward in the fight for equal rights for LGBT individuals. At the same time, it also served as a clarion call to those determined to continue discriminatory policies and attitudes.

Currently, there are nearly 200 pieces of proposed anti-LGBT legislation in the United States. Like the Tennessee law, many of these proposed pieces of legislation — and other laws that have already been passed — were born partly in reaction to the Supreme Court's decision, notes Perry Francis, who served as chair of the Ethics Revision Task Force for the 2014 *ACA Code of Ethics*. ACA believes

that conservative politicians and lobbying groups focused on Tennessee and the counseling profession in large part because of a prior legal case, *Ward v. Wilbanks*.

In 2009, a counseling student named Julea Ward was dismissed from the counseling program at Eastern Michigan University (EMU) for refusing to counsel a gay client. Ward then filed suit against EMU in U.S. District Court, asserting that the university's counseling program violated her rights to free speech and freedom of religion. In 2010, a U.S. District Court judge granted summary judgment in favor of EMU.

Ward was represented by the Alliance Defending Freedom (ADF), a nonprofit law firm that Art Terrazas, ACA's director of government affairs, describes as the conservative equivalent of the American Civil Liberties Union. ADF is connected to the Family Research Council, a conservative lobbying organization. These organizations influence the Family Action Council of Tennessee, whose president, David Fowler, is a former Tennessee state senator who was a driving force behind Senate Bill (SB) 1556 and House Bill (HB) 1840. A group of conservative state legislators sponsored the bills, which eventually became the law signed by the governor.

The counseling profession also made an inviting target because the *ACA Code of Ethics* explicitly focuses on protecting clients by not imposing a counselor's viewpoint, explains Lynn Linde, ACA's senior director for the Center for Counseling Practice, Policy and Research. Linde, an ACA past president who also served on the Ethics Revision Task Force, notes that this focus on the client is unique to ACA. Although other organizations' ethics codes implicitly prohibit mental health professionals from imposing their personal beliefs on clients, she says, the *ACA Code of Ethics* is explicit in this prohibition.

The legislation was introduced in the Tennessee Senate in January and passed with very little discussion, according to TCA President Kat Coy. It then moved on to the Tennessee House of Representatives. At that point, TCA rallied its members to contact their legislators to express their opinions on the bill, Coy says.

As the legislation was being debated in the Tennessee House, TCA and ACA worked together to provide expert testimony on the harmful nature of the bill and to educate individual legislators about the counseling profession, its code of ethics and the danger the legislation posed to those seeking mental health services in Tennessee. Although the law states that any counselor who turns away a client because of personal beliefs must give the client a referral, Linde notes that Tennessee has a critical shortage of mental health professionals. That raises questions about whom a counselor can refer to if he or she is the only mental health professional within 150 miles and, more important, where prospective clients are supposed to go to get the help they need, she says.

Linde and others testified about the harm this could do to potential clients. In the process, they also tried to clear up some mistaken beliefs that Tennessee legislators held. For example, Lisa Henderson, who chairs TCA's public policy committee, says one of the first arguments she encountered was that because Tennessee is a sovereign state, it would not be dictated to by the federal government. Henderson had to explain that ACA is a professional organization that is not connected in any way to the federal government.

Linde and others testified that ACA's opposition to the legislation was not about controlling individual counselors but rather concern for the harm that could be done to prospective clients. In addition, the law would be in direct opposition to the *ACA Code of Ethics*, which all member counselors are obliged to follow. Many states — including Tennessee — base their licensure standards of practice all or in part on the ACA ethics code.

## An ethical dilemma

A common claim by those who support the law is that by asking counselors not to impose their beliefs on clients, the *ACA Code of Ethics* is actually demanding that counselors give up certain personal beliefs. That is an incorrect assumption, Linde says.

"Nobody is asking us to give up who we are the moment we walk into a counseling session," she emphasizes. Counselors do not have to change their beliefs, but they must not impose those beliefs on clients, she continues.

"We, as professional counselors, seek to engage our clients in a genuine, thoughtful, caring relationship," says Francis, a professor of counseling and coordinator of the counseling clinic in the College of Education Clinical Suite at EMU. "In order for me to connect to a client, I need to know who I am and what my personal values are so that I can be genuine in the room. At the same time, the profession is saying to counselors that you also enter the room with the values of the counseling profession, which are clearly delineated in the code of ethics."

Francis says a counselor's responsibility is spelled out in the *ACA Code of Ethics* in Standard A.4.b. (Personal Values): "Counselors are aware of — and avoid imposing — their own values, attitudes, beliefs and behaviors. Counselors respect the diversity of clients, trainees and research participants and seek training in areas in which they are at risk of imposing their values onto clients, especially when the counselor's values are inconsistent with the client's goals or are discriminatory in nature."

Many of those who supported Tennessee's "sincerely held principles" legislation asserted that ACA changed its code of ethics regarding counselors' personal values during the 2014 revision in response to *Ward v. Wilbanks*. Francis and Linde say that assertion is false.

"We clarified what has [long] been there," Linde says. From the 1988 version onward, the ethics code has stated that counselors can refer clients only when a client is no longer progressing, when the counselor's services are no longer required because the client has met his or her goals or when counseling no longer serves the client, Linde explains.

Anticipating that some might try to argue that a counselor who holds views diametrically opposed to what the client believes is not "competent" to counsel that client, the 2014 revision of the ethics code clarified the issue of referral, Linde and Francis explain. Standards A.11.a. and A.11.b. were added to further delineate what constitutes competency.

- A.11.a. (Competence Within Termination and Referral): "If counselors lack the competence to be of professional assistance to clients, they avoid entering or continuing counseling relationships. Counselors are knowledgeable about culturally and clinically appropriate referral resources and suggest these alternatives. If clients decline the suggested referrals, counselors discontinue the relationship."
- A.11.b. (Values Within Termination and Referral): "Counselors refrain from referring prospective and current clients based solely on the counselor's personally held values, attitudes, beliefs and behaviors. Counselors respect the diversity of clients and seek training in areas in which they are at risk of imposing their values onto clients, especially when the counselor's values are inconsistent with the client's goals or are discriminatory in nature."

In addition, Standard A.4.b. was expanded to include the necessity of obtaining training and multicultural competency, Francis says.

Linde says ACA's official position is that although counselors in Tennessee are now legally able to refer clients on the basis of personal beliefs, that action still goes against the profession's code of ethics. Accordingly, ACA will still sanction any

member who engages in such behavior, Linde emphasizes. This also applies to counselors-in-training at university or college programs.

Linde testified in detail for legislators on the issue of competence. "Counselors can't refer due to client characteristics," she says. "It's on [the counselor] if you come from another country and I don't know anything about you or your culture. I have to educate myself on your culture."

However, if a client comes to a counselor with a problem or issue that the counselor is not qualified to treat based on his or her individual scope of practice, then referral is appropriate. For example, Linde says, a client might present to a counselor for treatment of depression. In the course of therapy, the counselor might realize that the heavy drinking the client is engaging in is due to a chronic substance abuse problem, not just self-medication. Unless the counselor is specially credentialed to provide substance abuse counseling, the counselor would be operating outside of his or her scope of practice to offer those services. In this case, the counselor should instead refer the client to another counselor who is qualified to provide in-depth substance abuse services.

### Values clash

Henderson, a private practitioner in the Nashville area, says that when she met with individual legislators about the "sincerely held principles" bills, it appeared that some of them already had their minds made up. When presented with the ethics testimony, she says, many of these legislators argued that it was impossible for counselors to separate themselves from their beliefs. They also rejected a primary counseling value of putting clients first, Henderson says.

"I kept reminding them that these are complex issues," says Henderson. She points out that even though it takes years to become a professional counselor, the legislators were making decisions about the counseling profession based on a few hours' worth of knowledge gleaned in hearings and meetings.

During efforts to defeat the legislation, Henderson acknowledges that she also encountered some counselors in Tennessee who supported it. The most common reason given was the counselors' religious beliefs, she says. For example, one counselor told Henderson that he could not separate his religious beliefs from his counseling values. So, if a client came to him for treatment of alcoholism and wanted to use harm reduction, the counselor — who believes it is wrong to drink or take drugs — would only agree to treat using complete abstinence. Another counselor said she would not be able to counsel someone committing adultery unless that person pledged to end the adulterous relationship.

Francis says another common explanation or justification for values-based referrals is that a counselor who has a conflict with a client's lifestyle or choices might not provide the best service or even cause harm. "This is a perfectly valid concern and is upheld in the ethics," he says. "We don't want to cause harm. We don't want to put the client in any sort of jeopardy."

However, Francis explains, the flaw in that reasoning is in assuming that the problem resides with the client. Instead, it is the counselor who needs to make adjustments and seek supervision, consult with trusted colleagues or get

additional training to better serve the client.

Ultimately, it is those seeking mental health services who will be harmed by the passage of the legislation. "In rural Tennessee, or anywhere in the state that is listed as a mental health shortage area, there simply are not enough providers," says Catherine B. Roland, who begins serving as ACA president July 1. "So, if a counselor is allowed to pick and choose who they will see simply due to a strongly held belief or value, those most in need of services will have nowhere to turn."

The law is also written very broadly, which leaves it open to individual interpretation, Terrazas notes. "Initially the bill covered religious beliefs, but the wording was changed to 'sincerely held principles,' which could be broadened to include almost anything that a counselor disagrees with," he says.

Duffey agrees. "People seeking mental health services can potentially be affected in any number of adverse ways as a result of this law," she says. "For one, they are now aware that a law exists that protects counselors from working with them if the counselors' beliefs conflict with who they are. That is profound. In a time where so much progress is being made with respect to equality and human rights, this bill may bring a painful resurgence of old feelings of rejection and discrimination and feelings of social exclusion."

**Current and future implications**

Although those who defend the law often cite religious concerns for doing so, TCA leaders say many of their members who are Christian counselors have vowed not to use the law to discriminate.

In fact, other counselors have cited their religious beliefs as a reason *not* to discriminate. "[The Tennessee law] is an affront to the heart of Christianity," says Ryan Thomas Neace, an ACA member and counselor practitioner in St. Louis. "The Scriptures reveal that those whom the religious folks said weren't towing the line — not observing religious rituals or laws, not living up to sexual and moral purity codes by having sex too much or with the wrong people or drinking too much, etc. — those people were often far more hungry for genuine, transformative encounter than the religious folks themselves. This is why Jesus kept their company so much."

Neace, who has been practicing for almost 14 years, cites his experience as an example of how harmful the law is to clients and to the counseling profession's ideals. "By the time many of my LGBTQ+ clients show up at my office, they've already been hounded by unsupportive, and often abusive, friends, family, religious communities and sadly, professionals," he says. "This law makes the sacred space that we offer as counselors less sacred and less spacious."

There are already many barriers that discourage potential clients from reaching a counselor's office, Neace says, and research suggests that LGBT individuals face even more obstacles. In Neace's opinion, the obstacles the Tennessee legislation has erected for LGBT clients "are perhaps more akin to land mines."

Unfortunately, Neace says, some counselors don't seem to comprehend the precedent — and the slippery slope — that this law sets. "In a more long-term sense, it literally opens the door for clients to be denied therapy if they in some way represent an affront to anything counselors sincerely or principally believe," he says. "This actually could, in my case, extend to me as a Christian. Someone could refuse to see me because of my religious beliefs. It's hard to understand that religious folks who back this bill don't see that it ushers in opportunities for the very persecution they hope to avoid."

Keith Myers, a licensed professional counselor and ACA member, wrote an opinion piece for *USA Today* in May in which he highlighted some of the potential consequences of the law that its advocates might not have anticipated. "Imagine that Joe, a veteran who served our country faithfully, comes to counseling at a rural Tennessee practice," Myers wrote. "He talks about his strong opinions concerning the Islamic State terrorist group and ways the military should be intervening. His male counselor happens to be a pacifist. This counselor has strong feelings against any kind of war or any type of military intervention against ISIL. Before the new law, he would have felt obligated to help Joe. Now, he refers Joe to another counselor 25 miles away from where Joe resides. Joe becomes angry and ultimately avoids getting help. The harm has been done."

Henderson has already seen an effect. "After the news broke that the bill had been signed into law, one of my own clients asked if I would continue to see her now that I don't have to," Henderson recounts. "And this is a person who I already have an existing relationship with."

One of Henderson's counseling colleagues shared another story related to the passage of the law. During a client intake, the client asked questions about how the counseling process worked but also asked how long it would be before the counselor might decide not to work with the client any longer. The client wanted to know what he would do if that happened.

Counselors who practice in other states might question why they should be overly concerned about what is happening in Tennessee. "Quite simply, if it can happen in Tennessee, it can happen in any state in the union, making it an issue for all counselors," Roland says. "One only needs to realize that the anti-LGBTQ legislation in so many states continues to grow. Those who believe in an anti-LGBTQ agenda are passionate and are using the legislatures and courts in this country to make their voices heard. ACA stands in support of the counseling profession and the consumers who seek our services — all consumers."

The law could also contribute to misperceptions that go beyond what is happening in Tennessee. "This bill is problematic for counselors who hold religious beliefs and also support our code of ethics," Duffey says. "The discussions around this issue can create misunderstandings and generalizations, with suggestions that faith-based counselors are, in principle, discriminatory. This is, of course, unfair and inaccurate, and runs the risk of creating division where it doesn't exist."

Does the *ACA Code of Ethics* trump discriminatory institutional policies? Read the July issue of the *Journal of Counseling & Development*, featuring three articles in the special Trends section that discuss the ethical issues raised by the practice of accrediting counseling programs at colleges and universities that use statements in their Codes of Conduct that are nonaffirming of LGBT individuals.

Terrazas says there is a danger that similar legislation could be proposed in other states and notes that ACA Government Affairs is maintaining a very watchful eye.

**Seeking solutions**

With the "sincerely held principles" legislation being signed into law in Tennessee, what happens next? ACA and TCA are taking a number of steps.

"We are certainly starting to pick up the pieces of what has transpired over the past several months and focusing on the future," Coy says. "We are aware that there are varying opinions in Tennessee, and we will need to navigate through all of that in the coming months. Our ultimate goal shall remain meeting the needs of our membership and focusing on the needs of our clients."

At July's state leadership institute, TCA plans to focus on educating its members about what happened and encouraging them to in turn educate the public on the issues, Coy says. TCA's annual conference in November will be devoted in part to additional education and training and to deciding what the association's next steps should be.

When she was interviewed near the end of May, Coy said the rest of TCA's plan of action was under development. "We will be sending out a survey to membership asking them what they want," she said. "Our initial ideas will be training in the form of webinars, single-event training opportunities, podcasts, training bulletins and continued membership development."

On the national level, Terrazas says that ACA Government Affairs is encouraging counselors in all states to get to know their legislators. The purpose is not only for counselors to be aware of what bills are being proposed in their states but also to educate legislators about counseling and what counselors do, he says.

The ACA leadership also wants counselors in Tennessee to know that even though the 2017 ACA Conference is being relocated from Nashville, the association is not abandoning the state's practitioners. "ACA stands ready to assist with grassroots advocacy and to provide materials to Tennessee counselors who seek resources that will help the public policy officials understand the deleterious effects of this new law on the citizens of Tennessee," Yep says.

"We will continue to work with our colleagues in Tennessee in hopes that this law can be overturned," Roland says. But she also offers a caution: "We cannot for a moment forget about the other 49 states where efforts like these can arise quickly and without notice."

Despite the potential damage caused by the "sincerely held principles" law in Tennessee, Duffey believes the counseling profession will eventually emerge stronger than ever. "I absolutely believe we will ultimately be stronger as a result of our decision [to relocate the ACA Conference] and the unity we are experiencing through this advocacy," she says. "I have been heartened by the outpouring of support for the Governing Council's decision and by the appreciation of those members who courageously shared their stories and concerns. In fact, people who often vigorously debate other issues have come together on this one — in support, with clarity and with a sense of pride." ❖

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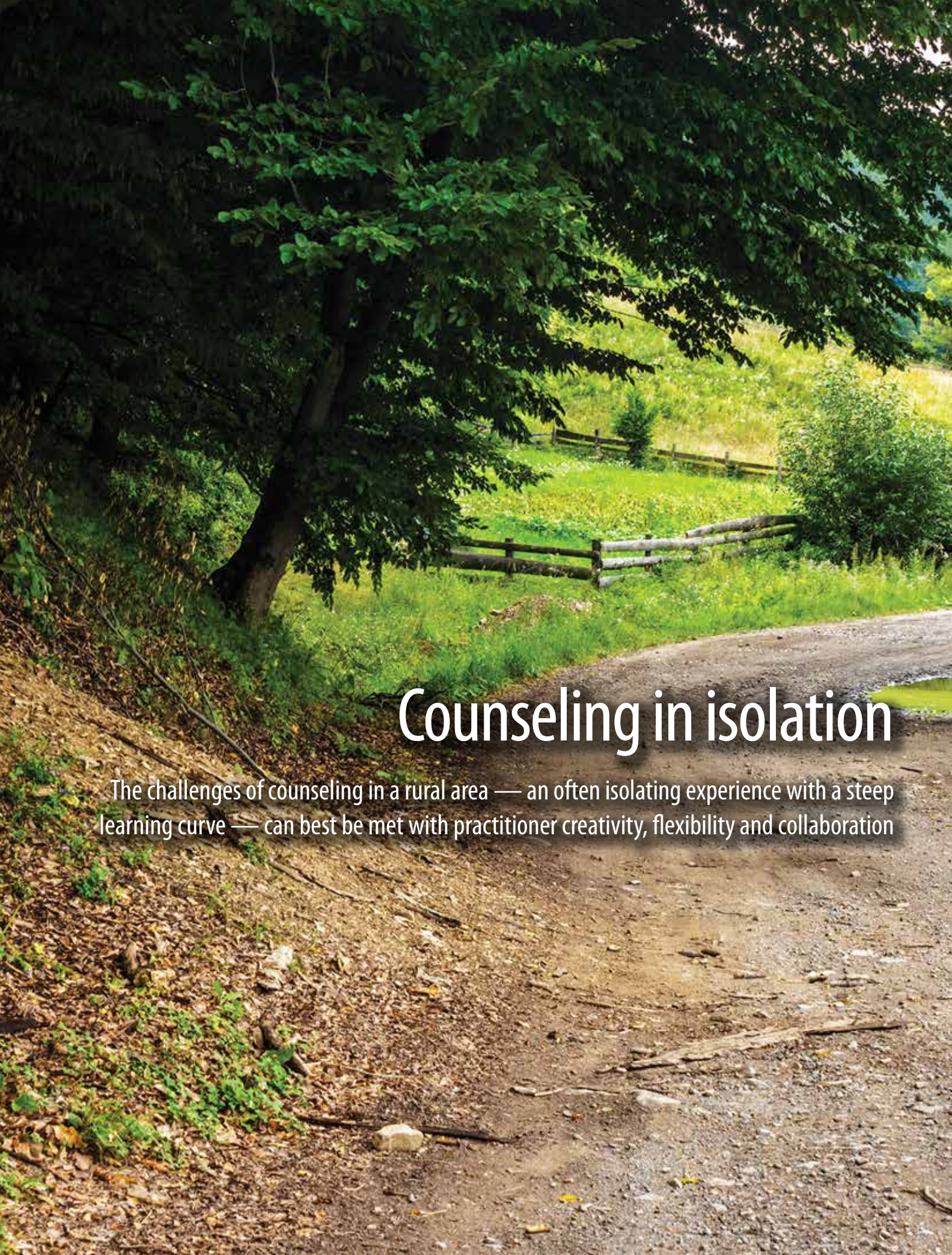

# Counseling in isolation

The challenges of counseling in a rural area — an often isolating experience with a steep learning curve — can best be met with practitioner creativity, flexibility and collaboration

By Bethany Bray

Nebraska native and licensed mental health practitioner Tara Wilson grew up in a town so small that her high school graduating class comprised only 10 people. When her young niece was diagnosed with cancer a few years ago, Wilson's family organized a pancake breakfast and benefit auction to cover the growing medical bills. People traveled from across the county to attend the fundraiser, and the family received cards and words of support from people they didn't even know.

"People bend over backward for you in a rural community," Wilson says. "Whenever a big life event happens … everyone just bands together. We had people from the surrounding communities that I had never even known or heard of or met [who] all came together. The outpouring of support from that was just remarkable. The entire community came together. I think that's very unique to a rural area. I don't know if you'd find that [elsewhere]."

Wilson can attest that working as a professional counselor in a rural area features its fair share of challenges. But the rewards — such as witnessing the impact of an entire county pulling together to support someone in need — make it all worthwhile, she says.

In addition to the "we're in this together" character often in evidence in rural areas, the setting can afford counselors the chance to see young clients grow up, succeed and start families of their own.

"Living in a small town, I see [students] when they come to kindergarten and I see them when they graduate," says Christi Jones, a school counselor and American Counseling Association member in rural Alabama. "I measure my success by the graduation invitations that come [in the mail] or the college students who come back to visit. You know they have overcome a lot of adversity to get there."

### A long and winding road

According to data from the most recent census, 19.3 percent of the U.S. population lived in rural areas in 2010. This reflected a slight decrease from the 2000 census, when 21 percent of the population resided in rural areas. (The U.S. Census Bureau defines "rural" as any population outside of an urban cluster or area with 50,000 residents.)

Counselors working in rural communities can face potential obstacles that practitioners in suburban and urban areas may never know. These challenges can include professional isolation, a culture where "everybody knows everybody" and long hours spent traveling to faraway or widespread professional commitments.

Stacey Meehl begins serving as president of the North Dakota Counseling Association (NDCA), a branch of ACA, in July. Most of the professionals in Meehl's town, from the paramedics to the local parole officer, have her cell phone number on hand, and her phone is apt to ring at any time of day. "I could change [my number] and throw the whole town in a loop," she jokes. "You do it all [as a rural counselor]. … I learned early on in my career not to specialize because you never know what you're going to get walking through the door."

Wilson, an ACA member and assistant professor at Wayne State College in Wayne, Nebraska, agrees. "If you start to specialize, I think everything else [besides what you specialize in] will walk through the door," she says with a chuckle. "[Clients] are going to come at you with anything and everything."

Meehl is a licensed professional clinical counselor who has a private practice in North Dakota and also works at a mental health center just across the border in South Dakota. She currently has clients — individuals, couples and families — ranging in age from 3 to 60-something. In private practice, she covers a four-county area. Last year, she put 15,000 miles on her car driving to meet clients at satellite offices, schools, homes, medical facilities, nursing homes and other locations.

Rural counseling is anything but the neat-and-tidy model in which a

practitioner sees each individual client one hour per week in a single office, Meehl notes. "It's what's expected. It's just part of where you live," she says.

When working in rural areas, a professional counselor or school counselor may be the only mental health practitioner for miles around. Counselors considering moving to rural areas should be aware that the only option available to them may be opening their own private practice because other agencies or clinics in the area may be sparse or nonexistent, Wilson says.

At the same time, Meehl, Wilson and the other counselors interviewed for this article urge practitioners to consider working in rural areas because the needs — and the rewards — are great.

"There's a shortage of [rural] practitioners," says Wilson, who co-presented about the experience of rural mental health counselors at ACA's 2016 Conference & Expo in Montréal. "But it's not an opportunity someone should go into blindly. You need to be aware of the challenges. We'd always welcome more providers though. There's such an opportunity."

Meehl, an ACA member, concurs. "Consider giving your gifts and talents to work in this area," she says. "There is an opportunity — a rewarding opportunity — to work with people. Yes, it is challenging. There is nothing in graduate school that will prepare you for this. But we deal with the same [clinical] issues as anyone in a larger town."

### Blooming where you're planted

The practitioners interviewed for this article agree that working in a rural area has its challenges. But they say those challenges are nothing that can't be lessened or overcome entirely with a little creativity and collaboration. Consider the following insights and words of guidance.

❖ **Prepare for the inevitability of dual relationships.** When you're a counselor practicing in a small town or rural area, Wilson advises, "It's not a question of *whether* you'll see a client at Wal-Mart today; it's *how many* clients you'll see at Wal-Mart."

Or in other real-life scenarios common in rural areas, a client and counselor might find themselves playing in the same softball league, singing together in the church choir or encountering each other regularly because their respective children

are involved in Scouting. The key, Wilson says, is to be prepared, think ahead and talk such scenarios through with clients ahead of time.

Meehl has a conversation with each of her clients — children and adults — at the beginning of the therapy relationship. "I stress that we live in a small town. If you don't want to say anything to me when we pass in the street, I won't be offended," Meehl says.

As the mother of an 11-year-old daughter and a 9-year-old son, Meehl also understands some additional complications that can arise. "In a small town, having kids, they become friends with your clients or their families. You might be sitting next to them at church or at your child's ballgame. You may be fine, but [your clients] might feel uncomfortable," she says.

Wilson has learned the value of asking her clients what *their* preference is ahead of time. In one instance, in trying to prepare ahead of time for any chance encounters, she told a female client that she wouldn't acknowledge her in public unless the client said hello and initiated contact. The client took offense, interpreting this to mean that Wilson was embarrassed to be seen talking with her in public.

Wilson took the client's reaction to heart. "The client felt fine about it, so why not?" she says. "What would have helped there is to approach it with 'How would *you* want this to go?' instead of saying, 'This is what will happen.' Be prepared [for client encounters outside of session], but let the client have a say in it. Ask them 'How do you want to handle [meeting in public]?'"

Early in the therapeutic relationship, it is also helpful to have a discussion with clients about boundaries and what is — and isn't — appropriate to talk about outside of session, Wilson adds.

Family members are also part of the equation, Meehl notes. "My kids learned the word *confidentiality* at a very early age," she says. "They know that when mom gets a phone call and has to go to another room, it's work and they understand. … They learn that boundary."

❖ **Be mindful of appearances.** In a small town or rural area, the stigma of being seen going to therapy can weigh heavily on clients. "Not only does everybody know everybody, but everybody knows everybody's car," Wilson says.

> "There's a shortage of [rural] practitioners. But it's not an opportunity someone should go into blindly."

Counselors should be mindful of this when choosing office space, Wilson advises. When she worked at a rural clinic in the panhandle of Nebraska, the facility shared space with a medical practice. This lessened the stigma for clients because passers-by wouldn't know whether the person was there for a medical appointment or a therapy session, Wilson says.

In addition, if a counselor is aware that two different clients know each other — for instance because they're neighbors or have children at the same school — it might be helpful to avoid scheduling their appointments back to back.

The "everybody knows everybody" rural culture can also affect how clients and potential clients reach out to the counselor, Meehl says, noting that people sometimes call her at home or pull her aside in social or public situations rather than calling her at the office.

"You have to make them feel comfortable. That's the big thing — making them feel like there's nothing that they can't share with you or work with you on," Meehl says. "Everything is case by case. What does [the client] need, and how do I put it together?"

❖ **Carefully consider whether a little self-disclosure can help build trust.** In rural areas, many clients will have spent their entire lives in the same town, growing up around the same neighbors and extended family members. For these clients, it can mean something for a counselor to share a few details about his or her background and family connections, Wilson says.

That might be particularly true when the counselor did not grow up in the immediate area where he or she is now practicing. "Name is huge — what family you belong to, who you're connected to … Be prepared for [these clients'] curiosity of wanting to get to know you," Wilson says. "They're not being nosy or harmful. It's a curiosity to help identify you."

In Wilson's case, she found that offering some limited self-disclosure — what part of town her family lived in, where she grew up — helped her forge relationships with certain clients, especially among the older generations.

Wilson also suggests that counselors practicing in rural areas — and especially those who are new to the area — build connections by getting involved in the community. This can be as simple as participating in an adult sports league or book club. Getting out and mingling in the community is the best way for counselors to get a better understanding of the local culture, while also letting people get to know them, she says.

Meehl says that counselors who move into rural areas should consider joining a professional organization such as the Rotary Club. This provides an outlet for these counselors to get ideas, network with other professionals and figure out whom they can call for referrals or support services for their clients.

At the same time, Wilson adds, counselors should keep in mind that word of mouth is a powerful tool in rural areas and small communities. Every client contributes to building the counselor's reputation or could lead to a referral. "[Maintain] a very ethical practice, and keep boundaries with your professional and private life," she says.

❖ **Get creative.** Rural counselors may have to think outside the box to find resources for clients, Meehl says. For example, she might connect a client who is a military veteran with services and support from a local American Legion or Veterans of Foreign Wars post because a Department of Veterans Affairs facility is too far away.

In another example, Meehl says the nearest psychiatrist or other practitioner who can prescribe medication is more than an hour away from her practice. If a client would have trouble making that trip, she sometimes works with the local senior center's bus service to ensure that the client has transportation, even if the client is not a senior citizen.

"You get pretty creative to try and find the services you need," Meehl says. "It just

means you have to know your community very well. It becomes very collaborative. … You just have to get a little more creative in your treatment process."

❖ **Network and collaborate.** In rural areas, counselors must learn to collaborate with professionals of all kinds, from those in social service agencies and law enforcement to schools and other medical professions. In turn, those professionals will routinely call on counselors for support, Meehl says.

With clients' permission, Meehl has collaborated on client issues with domestic violence agencies, child services, local doctors and hospital personnel. On one occasion when a client was having back pain related to stress and anxiety, she even collaborated with the client's chiropractor to set up a treatment plan.

"You learn to work with them all," Meehl says. "The community of professionals becomes very tight-knit."

Collaborating with those outside of the counseling profession is also a good way to learn about issues with which a counselor may be unfamiliar, Meehl adds. "I had several clients come in with eating disorders, and I hadn't done too much with that in [graduate] school. I did any research I could, and I worked with other specialists in the area to figure out a treatment plan, simply because that's a very specialized field. … You call people you may know and ask, 'Where can I get training? How do I work with this?' You learn to count on others to walk through things, or you figure it out on your own," she says.

❖ **Be flexible and navigate the learning curve.** Jean Baird, NDCA president-elect and a school counselor in a very rural part of North Dakota, says much of what she does over the course of a typical workday falls under "other duties as assigned." This may include helping to administer standardized tests, managing Section 504 plans for special education students or, in one instance, picking head lice out of students' hair because her school does not have a nurse.

"We deal with whatever comes along," says Baird, who is one of two school counselors at a high school with 500 students in the northern part of the state. "We are a jack-of-all-trades and do everything."

Baird switched careers to school counseling after working as an elementary school music teacher. At the time she was hired, she was the only counselor at her high school, and she was in the midst of finishing graduate school. Within her first three weeks on the job, a student died by suicide outside of school. Baird also was the first to intervene in another student's suicide attempt in a school bathroom.

Her on-the-job training was "baptism by fire," she says. "It was a steep, steep learning curve — a very eye-opening experience."

Many counselors in rural areas are isolated and may have few, if any, colleagues who do exactly what they do. In those situations, counselors must be disciplined about engaging in as much professional development as they can on their own, Baird says. Fortunately, webinars and other online continuing education opportunities are much more prevalent than they were even a few years ago.

"With every new thing that came up, I would consult with the social worker [in Baird's school district] and read and read and read," says Baird, a member of ACA. "I went to every conference and workshop that I could find. … The more basic information a [counselor] has, the better. You don't know what you're going to need. Prepare for anything and everything."

❖ **Use time spent in the car to your advantage.** Rural counselors often spend many hours behind the wheel commuting and traveling between professional engagements. That time can be spent on the phone returning calls or consulting with colleagues, Wilson says. It can also be a chance to dictate notes into a recorder.

Sometimes, it simply serves as much-needed time alone to decompress or engage in mindfulness or gratitude exercises.

Before Wilson was licensed, she did co-therapy training with another counselor. They rode together and used the 40-minute commute home after sessions to talk through the day's experiences and discuss personal growth and self-care. Those car conversations proved particularly helpful and enhanced the learning experience, Wilson says.

❖ **Stay connected.** Meehl, Baird and Wilson agree that memberships in professional organizations, both at the national and state levels, are a good way for rural practitioners to stay connected to others in the profession. These memberships also open up opportunities to participate in conferences, trainings, workshops, webinars and other learning opportunities.

NDCA offers a monthly meeting via phone conference, which is much easier than meeting in person because its members are so spread out, Baird says.

Jones, an elementary school counselor in rural Alabama, meets periodically with a consortium of school counselors of all grade levels from across her district. The meetings offer not only a chance to share resources and ideas but also serve as an antidote to the isolation that can come with working in a rural area, Jones says.

The other school counselors in the group "know exactly what it's like to walk in your shoes," Jones says. "That support helps. It really is a form of self-care. It's important to have someone you can reach out to and consult with. We all deal with similar issues."

❖ **Make time to be off the clock.** Being the only mental health practitioner in a community can become all-consuming. You are not only constantly in demand but likely will also encounter clients around town when you're not working, Meehl says. Before she scaled back her private practice, Meehl says she could put in a 12-hour day and still get work-related phone calls at night when she was home with her family.

On the flip side, Wilson points out that outdoor activities (her favorite is fishing) are often an easily accessible form of self-care in rural areas.

Meehl urges rural counselors to be deliberate about scheduling time off, whether it's a date night with their spouse, attending their child's sporting event or getting out of town for vacation. Provide clients with a number to call in an emergency, but otherwise, keep your cell phone turned off during personal time, she advises.

"One of the things I had to learn very quickly is to make sure I had time with my family," Meehl says. "My son reminds me when I'm getting crabby. That's my cue [to take a break]," she says. "You have to make sure to take some alone time, time to go out on a date with your husband. If you don't, you will get consumed by [the work]."

### Thinking outside the box

Collaboration is a watchword for rural and small-town counselors that can include everything from partnering with noncounselors in the community to participating in regular communications with mentors or colleagues in other parts of the state.

For Jones, collaboration comes in the form of an innovative program that brings a mental health counselor to her school, which is located in a very rural, high-poverty area, once a week. Jones is the

## Guidance for rural counselors from the *ACA Code of Ethics*

Counselors in rural and small-town settings are often called on to play many roles and deal with multiple relationships with current, former and prospective clients. The more intimate settings common in rural areas present counselors with professional and personal challenges related to competence, effectiveness and self-care. The *ACA Code of Ethics* (*counseling.org/ethics*) provides some guidance to help address issues related to the following:

- Understanding the diverse cultural backgrounds of clients (Section A, introduction)
- Engaging in counseling relationships with friends or family members (Standard A.5.d.)
- Risks and benefits of accepting clients with whom the counselor has had a previous relationship (Standard A.6.a.), extending current counseling relationships beyond conventional parameters (Standard A.6.b.) and entering into nonprofessional relationships with former clients or their family members (Standard A.6.e.)
- Providing counseling services to two or more individuals who have a relationship (Standard A.8.)
- Establishing means of payment for services and accepting gifts (Standards A.10.c., A.10.e., A.10.f.)
- Working within the boundaries of competence (Standard C.2.a.)
- Counselors monitoring their own effectiveness, maintaining self-care and preventing burnout and impairment (Standards C.2.d., C.2.g.)

*— Source: Deborah H. Drew, Mikal Crawford and Cheryl Crabtree's education session, "Multiple Roles in Rural and Small Settings: Personal Impact/Professional Response" at ACA's 2016 Conference & Expo in Montréal*

only counselor in an elementary school of roughly 600 students in prekindergarten through fifth grade. The mental health counselor travels to a different school within the district each day.

The setup allows for intensive, long-term mental health care beyond what Jones can provide to students. The mental health counselor often works with students who have experienced abuse or trauma or who have ongoing issues such as difficulties with a blended family or a parent's military deployment.

In many cases, the program provides treatment for children whose parents wouldn't be able to provide transportation to regular counseling sessions outside of the school building. Jones' school serves three communities, and many of its students are bused long distances to attend. In addition, a large number of parents in the area work two jobs and are already stretched to the limit, she explains.

Prior to the program, students wouldn't always get the extra help they needed, Jones says. "This provides a way for students to get treatment. It's a win-win," says Jones, who has been a school counselor for 14 years. "I'm a school counselor with 600 students in my building. I try very hard to serve them and meet their needs, but that's a lot of students for one school counselor. This [program] has provided extra, long-term support for students' issues. To me, that's an invaluable resource."

The three-year-old program grew out of an idea from the school nurse in Jones' district. After gaining support from the school board, the district set up a contract with the mental health counselor. Costs are covered by students' insurance coverage through Medicaid. Eventually, Jones says, she'd like to see the program expand to accommodate students who aren't under Medicaid. Jones co-presented a poster session about the program at ACA's 2016 Conference & Expo.

A key factor in the program's success is that all the involved providers established clearly defined roles for each participant before the program launched. The school counselors in Jones' district refer students to the mental health counselor whenever a student presents with a mental health concern or other issue that would benefit from intensive, long-term therapy beyond what the school counselors can provide, Jones says. The mental health counselor is also able to meet with students and families year-round.

In return, Jones serves as a bridge between the mental health counselor and the teachers and students within her school, whom she knows very well. She also works with the mental health counselor to introduce families to resources in the community, such as charities that provide school supplies and clothing to those in need or support for families whose power has been cut off.

School counselors who serve students in rural areas often need to step outside of their basic, expected roles, Jones emphasizes. "The most important role of the school counselor is to be an advocate," she says. "I feel like I give my students a voice when they have needs. A counselor cannot be successful if [students'] basic needs aren't met, if they come to school and they're hungry or cold. You have to deal with that first, and then you can sit down and have a counseling session."

Jones is involved in organizing "wraparound" services for students at her school, which she says is a necessity in rural, high-poverty areas. For example, the school keeps a closet of extra clothes available for children who arrive at school with ill-fitting or worn-out clothing or who aren't dressed appropriately for the season's weather. Jones also helps with the school's backpack program, in which a backpack full of snacks and easily prepared foods is sent home with children in need over weekends and school breaks.

"This is the hardest work and the best job I've ever had. When you come to a school and you see all this need, you can't ignore it," Jones says. "This job has changed me in ways that I thought weren't even possible. To see what poverty really is … It's hard work, but when you see students or a family turn a corner, it makes it worth it to come to work every day." ❖

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By Bethany Bray

# Counseling's connector-in-chief

Catherine B. Roland, ACA's 65th president, is known for building connections within the profession and her visionary, relational and intuitive style

*Catherine Roland, surrounded by students from the first counselor Ph.D. cohort at Montclair State University, at a farewell dinner held for her as she was leaving the university in 2013. Roland was instrumental in creating the university's counselor Ph.D. program. The students gave her this photo in a frame inscribed with the words "Thank you for believing in us!"*

When you see Catherine Roland at a professional event, the number of lives she has touched throughout her career soon becomes clear.

"You can go to any American Counseling Association conference, and when [Roland] walks down the hall, people are constantly stopping her, running up to her, hugging her. She's left behind quite a trail of very accomplished people," says Vincent Viglione, clinical assistant professor at Fairleigh Dickinson University in New Jersey. "Without her, I would not be where I am today. And it's not just me. She gives constant, very intentional support, good advice and goodwill through it all. She's very interested in the betterment of the profession."

Roland, chair of the counseling program at the Washington, D.C., campus of the Chicago School of Professional Psychology, becomes the American Counseling Association's 65th president on July 1.

"I think of her as the pied piper of counselor educators. She has a gift for it," says Larry Burlew, a retired counselor educator and licensed professional counselor (LPC) who worked with Roland at the University of New Orleans and Montclair State University. "She draws people in and knows how to connect well with people. She's extremely friendly, very loyal and high energy. She's the glue. She glues people together."

Many of Roland's former students have gone on to educator or leadership roles within the counseling profession. Some now pass on her example of mentorship to students of their own. A case in point: Monica Osburn, a past president of the American College Counseling Association, says she was one of five students from her Ph.D. cohort with Roland at the University of Arkansas who went on to become ACA division presidents.

Richard Balkin, another member of that Ph.D. cohort and a past president of the Association for Assessment and Research in Counseling, says Roland's legacy extends to the students he graduates as a professor at the University of Louisville. "They all know who Catherine Roland is. They see her as part of their lineage," Balkin says. "It really is an ACA family that she has created. … She's very good at making connections. She's very relational in her leadership approach. That's one of the real treats of knowing Catherine and working with her."

Although Roland has held many titles throughout her career, she says her role of mentor is one of the most important to her. "I was mentored well, and I've always thought that was important. You pay it back," Roland says. "It's something that you give to someone, and they give it to other people. … My book of students past is very long, and that is such a gift."

### Career journey

Roland brings a diverse skill set to the ACA presidency. She has worked in private practice; in student affairs as a college dean, residence life director and director of a college counseling center; and as an educator, both in public school classrooms and as a counseling professor.

As a counselor, Roland's areas of focus and expertise include LGBT issues, trauma and aging. She is a past president of the Association for Adult Development and Aging, a division of ACA, and has more than three decades of experience in private practice counseling couples, families and individuals. She has also been employed both at small private colleges and large state universities. A native of Long Island, Roland has worked and studied in eight different U.S. states, plus the District of Columbia.

Roland began her career as a high school English teacher at an inner-city school in Cincinnati, where she became good friends with a co-worker who was a school counselor. Through that friendship, Roland became more interested in the ways that counselors could support students and meet their needs.

"I took a couple of master's classes in counseling, and I knew that was it," Roland says. "When I was in doctorate work, I just fell in love with the clinical piece of [counseling]. I have always dealt with people of all ages. Counseling, in general, fits my personality very well. I really like working with families, couples … and some of the more difficult stuff — trauma, death and dying, and grief."

After earning her master's degree and doctorate from the University of Cincinnati, Roland transitioned from classroom teaching to student affairs, working at universities in Philadelphia, just outside New York City and New Orleans. She spent a decade in full-time private counseling practice in New Orleans before becoming a college professor.

While living in New Orleans, Roland was very involved in providing support services, both as a volunteer and as a professional counselor, to those in the community affected by AIDS. This was in the 1980s, when little was known about the disease and a crushing amount of stigma was attached. People would often lose their jobs because of the diagnosis, Roland says.

"There were no medications. … We didn't know back then. We thought it was a death sentence," she says. "I devoted most of my practice and personal time to HIV/AIDS work, and that's what shaped me. It changed my life, and it changed my practice as well. I started doing a lot of pro bono work. … It was a very difficult time in the city, very tragic."

Roland says she got involved because more and more of her clients were getting sick with HIV/AIDS. As a private practitioner with a background in student affairs, she frequently received referrals to work with young men and college students. When clients couldn't pay, she counseled them pro bono.

"I can't even begin to say how many personal friends I lost, one after the other after the other," she says. "Of course, if you had the [counseling] license and the degree, you wanted to help. … [This experience] is part of who I am. These are the things that shape us. I learned a lot about adversity. It's what you did. It's not something to be congratulated [for]; it's just what had to happen."

Roland was involved in numerous agencies and nonprofits that supported those affected by HIV/AIDS in New Orleans in the 1980s and early 1990s, including serving as chairwoman of New Orleans Women Against AIDS. She also helped cowrite a training manual for HIV/AIDS counseling that is still used in New Orleans today.

Roland spent many hours counseling clients in a clinic that was housed in a New Orleans church basement. The operation was kept very hush-hush because of the stigma that was prevalent at that time surrounding AIDS. Part of the work involved opening a sealed envelope with the client that contained the person's test results. Roland would then counsel the client about the diagnosis, which was most often HIV-positive.

"The indignity those guys must have felt, sitting in a cold room in the basement of a church," Roland recalls. "You [the counselor] are on one side of the table, and the guy comes in, and he's never seen you, you've never seen him. You've got an envelope in your hands which hasn't been opened yet, so I'm also surprised when I see [the test results]. It never occurred to me that that was hard to do. In retrospect, it was horrendous. It was just what you did. Someone had to do that. … I think back, and I'm so happy to have been a part of that, so proud to have been a part of that."

### A mover and a shaker

Many of Roland's former students say that she possesses the ability to see qualities and potential in people that they may not recognize in themselves. She is described as the type of mentor who applies pressure when needed but also gives students enough room to grow and learn on their own.

"There were times with me when [Roland] needed to sit back and let me go, and times when she needed to provide more mentorship or challenge me," says Balkin, an LPC and ACA fellow who is the editor of the *Journal of Counseling & Development*. "I think she struck that balance very well."

"She truly is one of the most intuitive people that I've ever met. As a student, that was kind of scary. You felt like she was peering into your soul," says Balkin with a chuckle. "But that allows her to form deeper connections. … It's not just what you do, but how you get there. That's important to her."

Osburn, director of the counseling center at North Carolina State University, describes her former professor and dissertation chair as a "seed planter."

"She's so unassuming. It's just a series of small, building-block snippets that help turn you into this person you'd never thought you'd be. No one moment defines it. It just solidifies over time," says Osburn, an LPC supervisor. "She is a quiet leader, intentional and thoughtful. She really has a knack for making you feel [that] you are the most capable and worthwhile person, which gives you the confidence to take a leap of faith that you maybe didn't think you were ready for. And she'll always be there to catch you if you fall too."

"She sees things in people that they don't even see themselves," Viglione adds. "She sees their strengths, what they need, and she orchestrates it for them."

In addition to being an intuitive and relational mentor, Roland is a visionary leader who is very driven, according to several people who know her well. "She's extremely kind and giving of herself, her heart and her time," Osburn says. "She is this unassuming, always-smiling person, but don't let that fool you for a second. She is sharp — and fiery if she needs to be."

## Meet Catherine Roland

**Degrees:** Ed.D. in counselor education and M.Ed. in guidance and counseling from the University of Cincinnati; B.A. in English literature and education from Marshall University in Huntington, West Virginia

**Licensure:** Licensed professional counselor, national certified counselor and licensed clinical supervisor

**Has taught or worked at:** The Chicago School of Professional Psychology, Washington, D.C., campus (current position); Georgia Regents University (now Augusta University), Augusta, Georgia; Montclair State University, Montclair, New Jersey; University of Arkansas, Fayetteville, Arkansas; University of New Orleans; Delgado Community College, New Orleans; St. Mary's Dominican College, New Orleans; Manhattanville College, Purchase, New York; Temple University, Philadelphia; and University of Cincinnati (as a graduate assistant)

**What ACA members may not know about her:** She currently works a block and a half from the White House. She's an only child from an Italian American family. She's an animal lover and a self-described "cat lady." She loves to travel (Cape Cod, New Orleans, New York City and the Maine coast are her favorite destinations). She also enjoys being outside and taking walks, photography, needlepoint, knitting and going to plays, musicals and museums. Her taste in music is wide-ranging; her favorite genres are opera, country music and rock 'n' roll.

*— Bethany Bray*

Viglione, an LPC and clinical supervisor who has a private practice in Denville, New Jersey, studied under Roland at Montclair State and later worked with her in private practice, sharing an office. He expects that Roland, as ACA president, "will be a driving force — an absolute driving force. I've never seen her back down from anything or take shortcuts. She's pretty straightforward. She knows what she wants, what she needs, and she pursues it single-mindedly. She's a mover and a shaker, without a doubt."

Viglione and Burlew saw these attributes come out in Roland as she worked to build a doctoral program at Montclair State a few years ago. When Roland joined the faculty at Montclair State, the university's counselor education program offered only a master's degree track. She soon crafted a proposal to introduce a Ph.D. program for counselor education and presented it to the university administration.

A Montclair State dean initially said no to the proposal, Burlew remembers, because the university was considering the creation of several other programs at the time. But that didn't stop Roland. She worked diligently to rework, edit and finalize her proposal, and the school's president bumped it to the head of the queue, according to Burlew.

Montclair State's Ph.D. counseling program, of which Roland was the inaugural director, came to fruition in less than two years. At the time, it was the only counselor Ph.D. program in the tri-state area of New Jersey, New York and Connecticut, Viglione says.

"She hand-picked the professors, designed [the program] and made it happen," Viglione says. "Everything she puts her hands on, she makes it the best possible thing it can be."

Burlew also credits the program's existence and growth to Roland's effort, vision and initiative. "She just kept at it [even] after people said, 'This is never going to happen.' … It was just like a whirlwind. It was like lightning. That's how she works. She does things 200 percent. If it's really important, she'll figure out a way to work through barriers."

*Roland pictured at the White House this past January, when she attended the School Counselor of the Year reception hosted by first lady Michelle Obama.*

### The year ahead

Roland is taking the reins at ACA during what may appear to be a turbulent time. In May, the association announced its decision to move its 2017 annual conference out of Nashville after Tennessee passed a law allowing counselors to deny services to prospective clients based on "sincerely held principles." Denying services based solely on a counselor's personally held values is a violation of the *ACA Code of Ethics* (see cover story on page 24 for more details).

Roland served as president-elect during the past fiscal year under outgoing ACA President Thelma Duffey. As president-elect and a member of the ACA Governing Council, Roland was involved in the discussions and decision to pull the conference out of Nashville. Roland says she is aware of and prepared for the extra demands that will be placed on her and the association in the year ahead.

"I never thought it would be an easy or a simple thing to be president, but this year more than ever, it will be more complicated and intricate," Roland says. "It's going to be a challenge, and I'm up for the challenge. … I think I can approach it with a good heart, ready to learn as much as I can, in addition to what I've learned [already]."

"Catherine is very approachable," Burlew says. "If you feel things should be going in a different direction, you can talk to her and she'll listen. She has an open-door policy. You can walk right up to her as an ACA member, and if she thinks action needs to be taken, she'll take action."

Balkin believes that thanks in part to Roland's previous experience and professional focus on issues affecting the lesbian, gay, bisexual and transgender community, she is the right president at the right time for ACA. "She's very in tune to the issues that are at the forefront of ACA today," he says. "I think she's going to have a very well-timed presidency. … She is a capable person who will, I think, articulate very clearly, compassionately and very empathically the direction that ACA is moving the profession."

While serving as president, Roland says she will have two focuses: life span development of minority populations and bringing ACA's branches, divisions and regions together for mentorship and leadership.

"I think we have a lot of things in common among us as far as ACA's regions, divisions and branches [go]. I want to tap into that. We're more alike than we are different," Roland says. "I believe we have more common ground than we understand, and I want to harness that common ground. From that stems the best kind of leadership and leaders." ❖

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Knowledge Share – By Matthew Fullen

# Have you gone gray?

A great deal has been written about how an aging U.S. population will affect the need for biomedical services, but the story of how older adults can maintain optimal mental health throughout the life span has received far less attention

The United States is going through a rapid demographic shift unlike anything it has ever experienced. Approximately 10,000 Americans are turning 65 every day. Meanwhile, the average life span in the United States has increased to approximately 81 years for women and 76 years for men, with a significant number of people living well beyond those ages.

By 2030, demographers project that 70 million people, or about 20 percent of the U.S. population, will be 65 or older. Industries ranging from health care to technology to real estate have taken note of this emerging trend and are identifying how best to respond to the needs of an older population. Although a great deal has been written about how an aging population will affect the need for biomedical services, the story of how older people maintain optimal mental health throughout the life span has received far less attention.

First, the good news. Research indicates that older adults report the highest levels of life satisfaction when compared with young and middle-aged adults. Older adults are more likely to report a satisfying marriage, and they outperform younger individuals when it comes to remaining calm during times of stress. Subjective well-being is particularly high when older people perceive that they have adequate social support; have a sense of control and mastery, opportunities to derive meaning through paid or unpaid work and a positive perception of their age; and when they participate in spiritual or religious practices. Therefore, for many people, older adulthood can be a very fulfilling phase of life.

On the other hand, a large number of people 65 and older need mental health care but do not have adequate access to it. Approximately 20 percent of adults 65 and older meet the criteria for a mental disorder. Older adults with mental disorders experience higher rates of functional disability than those with a physical illness alone. They also experience poorer overall health outcomes and higher rates of hospitalization. Economically, these factors result in medical costs that are 47 percent to 200 percent higher for older adults with a mental disorder than for other older adults. Furthermore, older Americans are disproportionately likely to die by suicide, with older white males in particular having one of the highest rates of suicide.

## Access to mental health services

Why is there such a discrepancy between the preponderance of older adults who experience increased life satisfaction in old age versus those who are at risk for depression, anxiety and suicide? One factor often cited in the research is older adults' lack of access to mental health care.

In a recent study of older Americans, only 3 percent reported seeing a mental health professional, the smallest percentage of any age group. It is likely that stigma related to aging and mental health is at least partially to blame. For instance, previous cohorts of older adults came of age in an era when mental health services were far more stigmatized. Instead of seeking services from mental health professionals, older people are more likely to share their complaints with primary care providers, family members or friends. It is worth noting, however, that the current generation of individuals turning 65, known as the boomer generation, is likely to be more open to discussions about mental health.

**Matthew Fullen**

Stigma also exists in the form of cultural myths about aging that create barriers to older adults seeking help for mental health concerns. For instance, despite the previously cited research about older adults' high levels of life satisfaction, many people mistakenly believe that depression is a normal feature of growing older. A myth that may

influence clinicians is the notion that certain problems associated with aging — including the increased likelihood of one or more chronic health conditions, the loss of a loved one and existential concerns related to meaning and life purpose — will not be responsive to counseling treatment.

**Practical skills for counseling older adults**

In reality, older adults are excellent candidates for counseling services. They respond to treatment as well as or better than members of other age groups. The counseling profession is particularly well-situated to provide effective services to older adults because of its emphasis on life span development, wellness and attention to diversity. Three practical strategies can promote the work of counselors with this population.

First, it is important for counselors to consider the developmental needs of older adults. Historically, human development theorists, including Sigmund Freud, suggested that development stopped around age 40. Although this seems laughable today, the assumption that most growth and change occurs early in life is still reflected in sayings such as "You can't teach an old dog new tricks."

In fact, in a 2000 study, Paula Danzinger and Elizabeth Welfel found that despite identical symptom profiles, mental health professionals rated older clients as having a more negative prognosis when compared with younger clients. Therefore, when working with older clients, it is imperative for counselors to challenge this myth, first in their own minds, but also potentially with clients who do not believe in their capacity to make changes at this point in their lives. For instance, recent findings in neuroplasticity suggest that humans are capable of making changes to their attitudes and behaviors across the life span. When counselors reflect this viewpoint in session, they provide hope to clients who may have otherwise resigned themselves to a particular problem or mindset.

Next, counselors should consider the use of a wellness perspective when assessing and treating older adults. Although the wellness paradigm is increasing in popularity, its use with older adults has lagged behind, both in research and clinical applications. However, older adults are prime candidates for the use of a wellness approach for multiple reasons.

First, a great deal of research indicates that a broad range of variables influence older adults' longevity and quality of life. These variables include strong mental and emotional health, reciprocal social relationships that are perceived as supportive, participation in preferred spiritual or religious practices that provide meaning and purpose, a belief that one has at least some control over circumstances and a positive perception of aging. A recent example of the multidimensionality of older adults' needs was demonstrated in a 2015 study by Kelley Strout and Elizabeth Howard. The researchers found that emotional wellness was the highest predictor of cognitive health, followed by physical and spiritual wellness as additional significant variables. Therefore, counseling interventions that bolster emotional wellness may influence brain health in later life.

Similarly, there is growing interest in the concept of resilience among older people. Given the wide range of challenges that may accompany older adulthood, some gerontologists suggest that resilience should be used as a primary measure of what it means to age well.

In research supported by the Association for Adult Development and Aging (AADA), a division of the American Counseling Association, Sean Gorby and I recently piloted a program in which older adults participated in a counseling group focused on how participants had demonstrated resilience in various domains over the course of their lives. Group members identified adversities they had experienced, including physical and functional setbacks, emotional distress, changes in social relationships and spiritual and existential hardships. Participants then shared personal stories about resilience, either in their own lives or in the lives of others, and discussed how this could be manifested once again with the current challenges they were facing.

At the conclusion of the group, we found that participants perceived themselves as more resilient. This indicates that counselors may be able to

tap into the reserves of resilience that older clients possess, using discussions of resilience to help these clients restructure their self-concepts around adversity and their ability to bounce back.

Finally, in spite of cultural assumptions to the contrary, older adulthood is an extremely heterogeneous phase of life. Cultural diversity and vast individual differences related to the aging process shape how older adulthood is experienced. For instance, a person's chronological age, by itself, does not communicate a great deal of information about how one perceives life, nor does it directly correlate with overall health and wellness.

Most broad definitions of older adulthood use age 65 and up; however, there have been efforts within gerontological research to subdivide older adulthood into two segments, with the "young-old" representing individuals 65–80, and the "old-old" reflecting those who are older than 80. Although some research supports differing health and life experiences for individuals in these two groups, the division is still limited by the assumption that chronological age is a helpful descriptor. For instance, one's health, holistic wellness and functional status may provide better information about what life is like than simply stating how many years one has lived. For this reason, some have argued for the use of biological or functional age as a more descriptive demographic than chronological age.

How one perceives his or her age can also be a telling indicator for quality of life and longevity. In fact, research by Becca Levy shows that older people with a positive age perception live significantly longer than those older adults who have a negative perception of their age, even after controlling for other health and demographic variables.

The older adult population is also rapidly becoming more diverse. In fact, ethnic minorities, particularly Latino and Asian/Pacific Islander elders, make up the fastest-growing subset of the older adult population. Furthermore, more than 2 million American older adults currently identify as lesbian, gay or bisexual.

In terms of socioeconomic diversity, a wide gap exists between older adults who have accumulated sufficient financial resources and the vast number of older adults who have either experienced poverty throughout their lifetimes or who are now on the edge of poverty because of recent changes to their health, relationships or work status. Therefore, counselors interested in working with older adults should anticipate that their clients will possess a diverse range of backgrounds and perspectives, and differing levels of health, wellness and functional abilities. Some counselors may encounter older adult clients who can afford to pay out of pocket for mental health services, whereas other counselors are likely to interact with older adults whose low income levels qualify them for subsidized housing or health care.

Counselors should recognize that growing older in America is not a monolithic experience. In fact, the diversity of perspectives related to the aging process is one of the most compelling features of working with older adults. Rather than older adults all being alike and resistant to change — as the cultural myth might suggest — older people possess a diversity of backgrounds and life experiences that can make the counseling experience particularly invigorating for client and counselor alike.

### Strategies for including older adults in your practice

Counselors interested in working with older adults should be proactive about seeking opportunities to market their services to these clients. Counselors cannot currently bill Medicare. However, there are other ways to make a difference in the lives of older adults.

For instance, a 2012 report by the Institute of Medicine (now the Health and Medicine Division of the National Academies of Sciences, Engineering and Medicine) found that 47.5 percent of older adults' mental health services were not paid for through Medicare. Non-Medicare payment sources included paying out of pocket (18.3 percent), supplemental private insurance (11.7 percent), Medicaid (11.4 percent) and other state and community programs (6.1 percent). Therefore, in addition to offering services directly to older clients, counselors can also market their services to local agencies on aging, community and neighborhood clinics

with local service grants and capitated health service providers.

For some older people, seeking mental health treatment within a private practice or standalone mental health clinic may be appealing. However, I have found that linking mental health services to older adults' housing, medical care and social services is an excellent strategy for providing integrated care and making mental health services more accessible to older clients. For instance, forming partnerships with primary care providers who view mental health treatment as a necessary and value-added component of integrated treatment can be an effective strategy for connecting with older clients. Counselors accustomed to the use of a wellness paradigm are familiar with the challenges of providing prevention and holistic wellness services to clients in a world of managed care and disjointed services. Therefore, instead of focusing solely on the need for Medicare reimbursement, entrepreneurial counselors may wish to consider how to extend the integrated wellness work that is already being done with younger clients to an older population.

Ongoing education and training are helpful to ensure that your counseling services are well-suited for older clients. Members of the counseling profession should look for continuing education or postgraduate training opportunities that will expand their understanding of the impacts that adult development and aging have on their clients. This could include:

- Attending educational sessions at state or national counseling conferences
- Joining AADA
- Networking with other professionals in the aging sector by getting involved with a local area agency on aging
- Seeking formal education in the form of a certificate program in gerontology at a local university

### Counselor advocacy

Given the rapid growth of the older adult population in the United States, there is a need for more mental health professionals who are both willing and able to work effectively with these clients. Although it is not the only means of access for mental health services, Medicare covers the majority

of these services (52.5 percent) for older adults. Recently, there have been several critiques of the Medicare program for not doing more to address the growing number of older adults who need mental health treatment. According to the 2012 Institute of Medicine report, only 1 percent of the total Medicare budget was spent on mental health services (with a total budget estimated at $505 billion in 2014).

Advocacy for Medicare reimbursement of counselors is vital to expanding the mental health workforce. Two bills were introduced in Congress in 2015 calling for mental health counselors to be included as recognized Medicare providers: the Seniors Mental Health Access Improvement Act of 2015 (S. 1830) and the Mental Health Access Improvement Act of 2015 (H.R. 2759). Both bills have received bipartisan support in the past. However, it is common for legislative efforts to go through many iterations before becoming law.

Due in large part to the advocacy efforts of the counseling profession, there are currently numerous bipartisan co-sponsors for both of these bills. Recently, counselor advocacy efforts resulted in AARP writing a letter that supported passage of congressional bills calling for inclusion of counselors as Medicare providers.

To continue this momentum, it is imperative for all members of the counseling profession to raise awareness of Medicare's lack of attention to mental health and the current restrictions that deny older adults the freedom to choose their mental health providers. Counselors should consider contacting their congressional representatives to provide awareness about the counseling profession and how it is uniquely situated to provide mental health care to older adults that is grounded in wellness, life span development and awareness of the diversity of older adults. Please consider contacting your senators and representative with a brief statement that advocates for S. 1830 and H.R. 2759. Contact information can be found at *congress.gov/members*, where you can sort by state to locate your senators or search by ZIP code to find your representative. (If you are interested in learning more about specific Medicare advocacy strategies, consider reading my April 2016 article in *Adultspan Journal* on this topic.)

Members of the counseling profession must also consider whether the current state of counselor training provides adequate exposure to the possibility of working with older adults. A 2009 study by Thomas Foster, Val Kreider and Jennifer Waugh found that counseling students had a high degree of interest in topics related to older adulthood, including the transition to retirement, helping families navigate the aging of a family member, providing support to caregivers and discussing issues such as dying and grief with clients. However, the authors suggest that counselors and counseling students lack opportunities to follow through with these interests.

At the programmatic level, the Council for Accreditation of Counseling and Related Educational Programs (CACREP) specialization in gerontological counseling was discontinued in 2008 because of a lack of counselor training programs applying for accreditation in this area. Although the lack of Medicare reimbursement for counselors may influence the viability of a gerontology specialization, it is worth asking whether more could be done to promote work with older adults within counselor education programs. For instance, in reviewing the 2016 CACREP Standards, I found zero references to the words *older*, *age* or *ageism*, and only one reference to the word *aging*.

Anecdotally, I have had numerous conversations with counselors and students who express a great deal of interest in focusing more of their work on older adulthood but do not think they have adequate opportunities or knowledge to do so. Therefore, it is important for counselor training programs to assess their students' interest level in working with older adults, identify practicum and internship sites that provide access to these individuals and participate in professional advocacy efforts to expand the role of counselors to meet the mental health needs of older adults. In addition, members of the counseling profession should work with their state counseling associations to coordinate state and local efforts to raise awareness within the community, as well as within the political arena, about the current state of older adults' mental health access and the need for Medicare reform.

## Conclusion

In summary, the "graying" of America is making its mark across a wide range of industries, including mental health. As more attention and public dollars shift toward the national challenge of promoting the health and wellness of an older population, members of the counseling profession will find themselves impacted in myriad ways.

Families will be affected by the growing number of older people living with chronic health conditions. Paid and unpaid caregivers will have greater responsibility for providing support to older adults. Topics such as retirement and lifelong vocation will be reconsidered as individuals work longer to make ends meet and spend their post-retirement years continuing to seek avenues for purpose and meaning.

In spite of the hurdles that remain, members of the counseling profession can support the growing number of older adults by providing mental health services that are developmentally appropriate, grounded in wellness and suited for a diverse range of older individuals. With that in mind, why don't you go gray? ❖

Knowledge Share articles are developed from sessions presented at American Counseling Association conferences.

Matthew Fullen is a licensed professional clinical counselor in Ohio. He has worked with older adults in a variety of contexts since 2005. He currently serves on the board of the Association for Adult Development and Aging and is completing a doctorate in counselor education with a specialization in aging at Ohio State University. Contact him at *fullen.33@osu.edu*.

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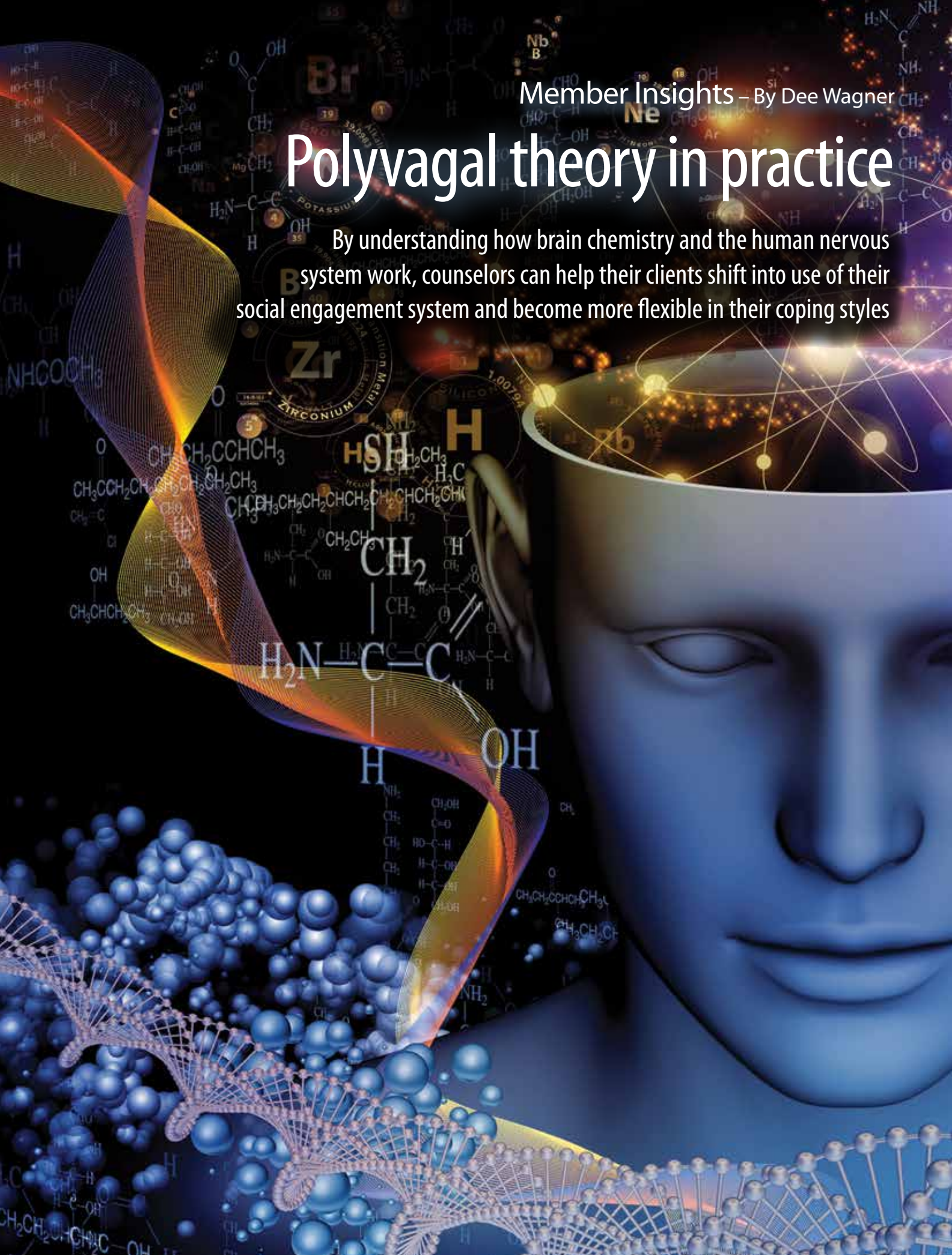
Member Insights – By Dee Wagner

# Polyvagal theory in practice

By understanding how brain chemistry and the human nervous system work, counselors can help their clients shift into use of their social engagement system and become more flexible in their coping styles



Picturing brain chemistry can be something like picturing a hurricane. Although we can imagine bad weather, it is difficult to imagine changing that weather. But Stephen Porges' polyvagal theory gives counselors a useful picture of the nervous system that can guide us in our efforts to help clients.

Porges' polyvagal theory developed out of his experiments with the vagus nerve. The vagus nerve serves the parasympathetic nervous system, which is the calming aspect of our nervous system mechanics. The parasympathetic part of the autonomic nervous system balances the sympathetic active part, but in much more nuanced ways than we understood before polyvagal theory.

**Our three-part nervous system**

Before polyvagal theory, our nervous system was pictured as a two-part antagonistic system, with more activation signaling less calming and more calming signaling less activation. Polyvagal theory identifies a third type of nervous system response that Porges calls the social engagement system, a playful mixture of activation and calming that operates out of unique nerve influence.

The social engagement system helps us navigate relationships. Helping our clients shift into use of their social engagement system allows them to become more flexible in their coping styles.

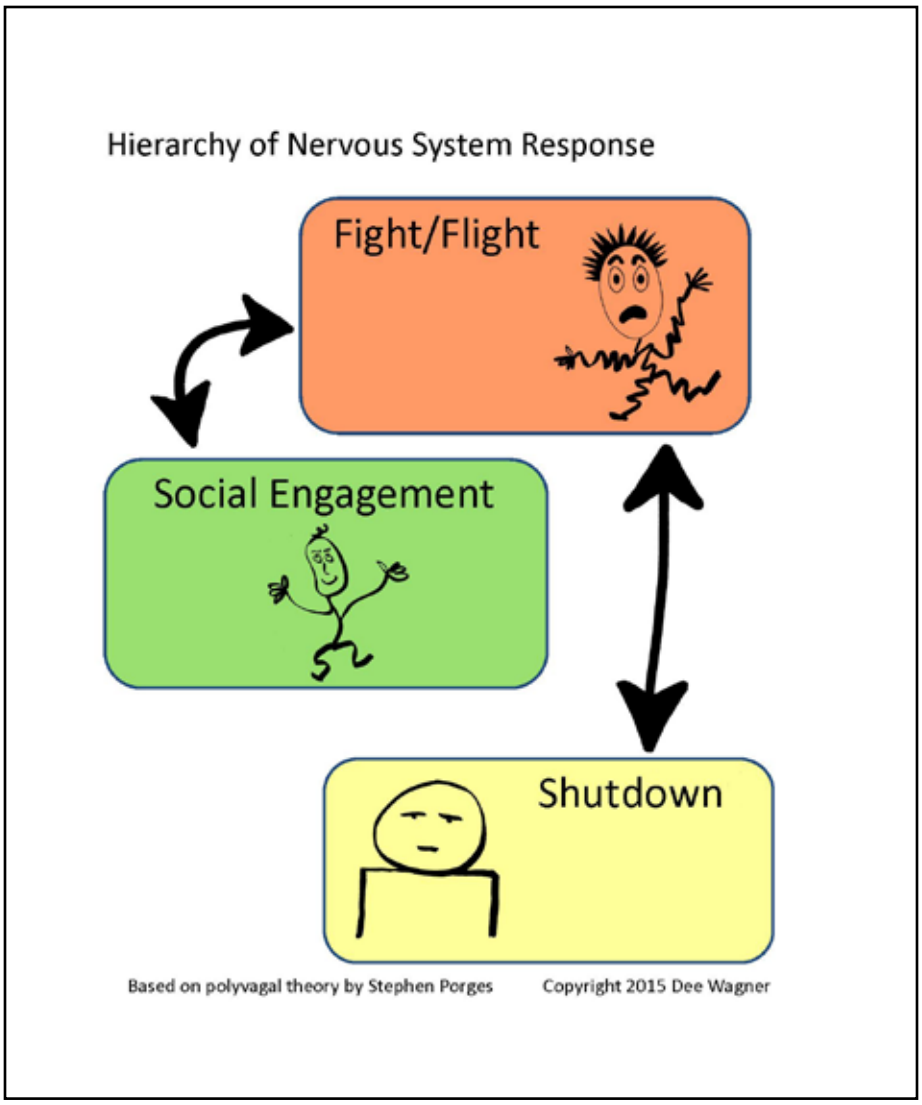
The two other parts of our nervous system function to help us manage life-threatening situations. Most counselors are already familiar with the two defense mechanisms triggered by these two parts of the nervous system: sympathetic fight-or-flight and parasympathetic shutdown, sometimes called freeze-or-faint. Use of our social engagement system, on the other hand, requires a sense of safety.

Polyvagal theory helps us understand that both branches of the vagus nerve calm the body, but they do so in different ways. Shutdown, or freeze-or-faint, occurs through the dorsal branch of the vagus nerve. This reaction can feel like the fatigued muscles and lightheadedness of a bad flu. When the dorsal vagal nerve shuts down the body, it can move us into immobility or dissociation. In addition to affecting the heart and lungs, the dorsal branch affects body functioning below the diaphragm and is involved in digestive issues.

The ventral branch of the vagal nerve affects body functioning above the diaphragm. This is the branch that serves the social engagement system. The ventral vagal nerve dampens the body's regularly active state. Picture controlling a horse as you ride it back to the stable. You would continue to pull back on and release the reins in nuanced ways to ensure that the horse maintains an appropriate speed. Likewise, the ventral vagal nerve allows activation in a nuanced way, thus offering a different quality than sympathetic activation.

Ventral vagal release into activity takes milliseconds, whereas sympathetic activation takes seconds and involves various chemical reactions that are akin to losing the horse's reins. In addition, once the fight-or-flight chemical reactions have begun, it can take our bodies 10–20 minutes to return to our pre-fight/pre-flight state. Ventral vagal release into activity does not involve these sorts of chemical reactions. Therefore, we can make quicker adjustments between activation and calming, similar to what we can do when we use the reins to control the horse.

If you go to a dog park, you will see certain dogs that are afraid. They exhibit fight-or-flight behaviors. Other dogs will signal a wish to play. This signaling often takes the form that we humans hijacked for the downward-facing-dog pose in yoga. When a dog gives this signal, it cues a level of arousal that can be intense. However, this playful energy has a very different spirit than the intensity of fight-or-flight behaviors. This playful spirit characterizes the social engagement system. When we experience our environment as safe, we operate from our social engagement system.




**Trauma's effect on nervous system response**

If we have unresolved trauma in our past, we may live in a version of perpetual fight-or-flight. We may be able to channel this fight-or-flight anxiety into activities such as cleaning the house, raking the leaves or working out at the gym, but these activities will have a different feel than they would if they were done with social engagement biology (think "Whistle While You Work").

For some trauma survivors, no activity successfully channels their fight-or-flight sensations. As a result, they feel trapped and their bodies shut down. These clients may live in a version of perpetual shutdown.

Peter Levine, a longtime friend and colleague of Porges, has studied the shutdown response through animal observations and bodywork with clients. In *Waking the Tiger: Healing Trauma*, he explains that emerging from shutdown requires a shudder or shake to discharge suspended fight-or-flight energy. In a life-threatening situation, if we have shutdown and an opportunity for active survival presents itself, we can wake ourselves up. As counselors, we might recognize this shift from shutdown to fight-or-flight in a client's move from depression into anxiety.

But how can we help our clients move into their social engagement biology? If clients live in a more dissociative, depressed, shutdown manner, we must help them shift temporarily into fight-or-flight. As clients experience fight-or-flight intensity, we must then help them find a sense of safety. When they can sense that they are safe, they can shift into their social engagement system.

The body-awareness techniques that are part of cognitive behavior therapy (CBT) and dialectical behavior therapy (DBT) can help clients move out of dissociative, shutdown responses by encouraging them to become more embodied. When clients are more present in their bodies and better able to attend to momentary muscular tension, they can wake up from a shutdown response. As clients activate out of shutdown and shift toward fight-or-flight sensations, the thought-restructuring techniques that are also part of CBT and DBT can teach clients to evaluate their safety more accurately. Reflective listening techniques can help clients feel a connection with their counselors. This makes it possible for these clients to feel safe enough to shift into social engagement biology.

**Specific aspects of ventral vagal nerve functioning**

Porges chose the name *social engagement system* because the ventral vagal nerve affects the middle ear, which filters out background noises to make it easier to hear the human voice. It also affects facial muscles and thus the ability to make communicative facial expressions. Finally, it affects the larynx and thus vocal tone and vocal patterning, helping humans create sounds that soothe one another.

Since publishing *The Polyvagal Theory: Neurophysiological Foundations of Emotions, Attachment, Communication and Self-Regulation* in 2011, Porges has studied the use of sound modulation to train middle-ear muscles. Clients with poor social engagement system functioning may have inner ear difficulties that make it hard for them to receive soothing from others' voices. As counselors, we can be conscious of our vocal patterns and facial expressions and curious about the effects those aspects of our communication have on our clients.

Based on his understanding of the effects of the vagus nerve, Porges notes that extending exhales longer than inhales for a period of time activates the parasympathetic nervous system. Porges was a clarinet player in his youth and remembers the effect of the breath patterns required to play that instrument.

As a dance therapist, I am aware that extending exhales helps clients who are stuck in forms of fight-or-flight response to move into a sense of safety. For clients stuck in some form of shutdown, I have found that conscious breath work can stir the fight-or-flight response. When this

occurs, the fight-or-flight energy needs to be discharged through movement for clients to find a sense of safety. For instance, these clients might need to run in place or punch a pillow. The hierarchy of defense system functioning explains these therapeutic techniques.

Respiratory sinus arrhythmia is a good index of ventral vagal functioning. This means we now have methods to study the effectiveness of body therapies and expressive arts therapies.

### Polyvagal theory in my practice

What follows is an example of how I used polyvagal theory with a client who experienced medical trauma during her birth.

The client, whom I have been seeing for some time, described feeling very sleepy and acknowledged having difficulty getting to our session on this day. Her psychiatrist had prescribed her Zoloft as a way of treating anxiety stirred by the birth of her daughter's first child. The client and I had previously normalized her anxiety as a trauma response.

During the years before coming to see me, this client had attempted suicide, which resulted in medical procedures that added to her trauma. Through our work, she has come to understand that the panic attacks she has when in contained situations are also trauma responses. She has lived much of her life in perpetual fight-or-flight response mode.

On this day, she was relieved to be less emotional, but she feared the tiredness that accompanied Zoloft's help in calming her fight-or-flight sensations. I saw this fear of the tiredness as a fear of dorsal vagal shutdown. We discussed the possibility that this tiredness could allow her a new kind of activation. I asked if she would like to do some expressive art that would allow gentle, expressive movement. She shuddered, naming her preference for things that were less subjective.

We talked about the existence of a kind of aliveness that still feels safe. We talked about the possibility of existing in a playful place in which there is no right and wrong, only preference. We acknowledged that since her birth, she and her parents had feared that her health would fail again. This environment in which she had grown up had supported nervous system functioning designed for life-threatening situations. With the Zoloft calming her fight-or-flight activation, I suggested that perhaps she could explore some calmer, more playful kinds of subjective experiences.

"It feels like you are trying to create a different me," she responded. I acknowledged that it might sound as if I were thinking she could be someone she wasn't. But I explained that what I was actually suggesting was the possibility that she could be herself in a different way.

The client told me she had a new book on grandparenting that contained a chapter on play. She said she would consider reading it. At the same time, she said that she might not be able to tolerate the Zoloft and might have to get off of it. Regardless, the idea of this different, more playful way of being has been introduced to her and, for a moment or two, experienced.

### Getting the picture

As counselors armed with polyvagal theory, we can picture defense mechanism hierarchy. We can recognize shifts from fight-or-flight to shutdown when clients feel trapped. We can also recognize the movement from shutdown into fight-or-flight that offers a possible shift into social engagement biology if and when the client can gain a sense of safety.

Before polyvagal theory, most counselors could probably recognize fight-or-flight and shutdown behaviors. They could probably sense a difference between defense responses designed for life-threatening situations and responses that characterize what Porges calls the social engagement system. Polyvagal theory deepens that awareness with the knowledge that playful arousal and restorative surrender have a unique nervous system influence.

Most counselors appreciate brain science but may find it difficult to picture how to use the information. Thanks to polyvagal theory's clarification of the role of the ventral branch of the vagus nerve, we now have a map to guide us. ❖

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Member Insights – By Gregory K. Moffatt

# Recognizing and managing deception in the therapeutic relationship

Certain clients have motivations for not being completely truthful with their counselors, and when this deception is left unchecked, it can have negative consequences for everyone involved

I had been working with "Alex," an 8-year-old boy diagnosed with attention-deficit/hyperactivity disorder, for longer than six months. His hyperactivity had become a major problem at school, and much of our clinical focus had been on managing behavior in the school environment. Each week, Mrs. T, his mother, who drove almost three hours to bring Alex to see me, confirmed that his behavior was improving. Then, one cold December afternoon, she appeared for our appointment without Alex.

"I'm sorry," she said, "but I haven't been honest with you. Alex's behaviors haven't improved at home or at school. I've lied about it all along, and I don't know why. We are withdrawing from therapy, but I wanted to tell you to your face."

Mrs. T was embarrassed. She apologized profusely, thanked me and then left. I never saw her or Alex again.

I was devastated. I had been in the field for more than 20 years and had never had anyone be so overtly dishonest with me. Mrs. T had paid me a lot of money and invested a substantial amount of time driving Alex to and from therapy. I couldn't understand why she hadn't simply told me the truth all along.

From this experience, I learned the valuable lesson that I can't always take a client at his or her word. But how can we know when clients are not being truthful? What clients are most likely to deceive? How can we identify and manage deception? The answers aren't simple ones.

## Problems with research

Before I address the questions at hand, some caveats about the research on deception are necessary. The research on indicators of lying is so full of conflicting ideas that little sense can be made of it all. Even some of the best studies have serious problems.

For example, some studies have argued that agents from the former U.S. Customs Service are no better at detecting lies than the average person. But many of these laboratory studies have subjects lie about little things such as "I have the ace of spades in my pocket" when in fact they don't. These are called "low-stakes lies." Nobody goes to jail for lying about having a playing card in his or her pocket. But when it comes to high-stakes lies — lies that are meaningful — Customs agents are much better at detecting lies than most of us.

In fact, it is easy for people to lie about little things. Most of us do it regularly in daily life.

"Do you like my sweater?"

"Um, *yeah* …"

These little white lies are meaningless in the big picture of life. But the physiological response to lying about big things ("No, sir, there are no illegal drugs in my bag") is much harder to suppress. These are lies that most of us *don't* tell.

Among the beliefs that have been held in the past are that liars fidget more, don't make eye contact and stutter more frequently. Although sometimes these things are true, sometimes they aren't. These oversimplifications were based on problematic research methodology. Today we know much more about deception. But before we look at what people who tell lies do, let's look at who lies and why they tell the lies they tell.

## Who lies?

All of us lie. We just lie about different things. Unless we are pathological liars, we regularly evaluate the cost or benefit of telling the truth, which often involves determining the likelihood of delaying or avoiding a certain cost or increasing a particular benefit by using deception.

For example, if someone made a meal for you and asked if you liked it, you might lie to protect the person's feelings if you didn't really enjoy it. The cost of the truth — hurt feelings — is much higher than the cost of a little white lie. The cost of a child telling me (a counselor) the truth about his or her abuse is shame, embarrassment and humiliation. The lie often feels much safer to the child.

For that reason, over several decades of experience working with children who have been sexually and physically abused, I have found that almost all children attempt to deceive me at some level in the initial interview. My question of whether anyone has ever touched them in a way that hurt them or made them feel uncomfortable is nearly always met with a "no" response, even when I already know that the child has been sexually or physically abused. They don't trust me enough to tell me that secret yet.

By recognizing those clients who might be motivated to lie because of what the truth might cost them, we can, as counselors, better predict the likelihood that a lie is being told.

### Why it matters

Nearly all of our clients will lie to us at some point. Lying can take several forms. A person can lie by saying something that isn't true (called *falsification*) or by denying something that is true (called *concealment*).

Lies can be blatant. Former President Bill Clinton displayed this form of deception when he told the media, "I did not have a relationship with that woman." But many lies are not so blatant. Clients might *deflect* as a form of lying. Again, in the case of the former president, he drew a lot of attention for his statement, "It depends on what the meaning of the word *is* is." This is a common method a person who is lying might attempt to use to save his or her reputation (cost) by parsing terms. The person rationalizes that his or her response wasn't really a lie by deflecting and answering a different question.

Clients might also lie by *diminishing* their behavior: "Well, I didn't really hit my husband. I lost my balance and my hand might have touched his face."

All these forms of lying might be seen in nearly any counseling context — marriage counseling, alcohol and drug counseling, anger management, working with court-ordered clients and so on. The accuracy of the information we get from our clients matters to us as therapists because we structure our interventions and treatment plans and measure progress based on what our clients tell us. When they deceive us, as Mrs. T did to me, at the very least we waste therapeutic resources. But we might also miss

important pieces of information that are critical to a client's survival. For example, a client who is attempting to manage suicidal ideation might end up succeeding at suicide if we miss the intensity and frequency of the individual's ideation due to deception.

All of us can expect our clients to deceive us at some point. I was taught early in my education that "the problem is never the problem." My professors and clinical supervisors were trying to demonstrate the importance of rapport and trust in a therapeutic relationship. Part of that is expecting that, sometimes, the stated presenting problem isn't really why the client came in. Clients have to learn that they can trust us before they will tell us what they *really* want to talk about.

Therefore, early on in the relationship, I am always listening for hints that there might be more to the story than I am being told. I have found that, oftentimes, my teachers were correct.

## High-risk populations

Several client populations are at particularly high risk for lying, including incarcerated individuals, children in foster care, clients who are addicted, people involved in sexual assaults and clients who are suicidal.

**Prisoners and juvenile detention:** Kenneth Bianchi, also known in the 1970s as the Hillside Strangler, came very close to successfully duping several of the country's most renowned experts on multiple personality disorder (as it was known then) by faking the disorder while supposedly under hypnosis.

These professionals made a critical mistake. They naïvely believed that Bianchi wouldn't — and, more importantly, couldn't — fool them. These experts had extensive experience working with clients who were motivated to tell the truth, but a person accused of serial crime is highly motivated to lie.

Any client or patient familiar with the "system" is at risk for manipulating it. One of the lead psychologists in the Bianchi case later served as a clinical director in a prison. He acknowledged that the experience of working with prisoners confirmed that he had been naïve in the Bianchi case.

Most therapists have the luxury of believing their clients will tell the truth, or at least near truths, much of the time. But when working with those who are incarcerated — either those in the juvenile justice system or adults in the prison system — one must verify all information by a second source because the motivation to lie is so high. We have done this with alcohol and drug treatment patients for years.

"I didn't smoke anything this week."

"OK, I believe you. Please pee in the cup."

"But I haven't smoked anything …"

"Fine. Please pee in the cup."

Clients who are addicted could be telling the truth, but the information must be verified. Manipulating people for one's own gain is inherent in the prison system, where inmates have very little power and must always look out for themselves. Nobody trusts anybody. Inside the prison block or juvenile hall, deception is an everyday part of life, giving people motive to lie and providing ample opportunity to practice. In other words, telling the truth doesn't outweigh the benefits of the lie — more privileges, freedom or exoneration.

**Accusations of sexual abuse:** Generally, young children do not falsely accuse others of sexual or physical abuse. They have too much to lose. As noted earlier, the opposite is far more likely. I've seen hundreds of children who have been physically or sexually abused by caregivers, and most of these children still want to go home. They want the abuse to stop, but they don't want to be elsewhere, even if it means returning to the homes of their abusers. Therefore, they are not motivated to make up abuse allegations but rather motivated to lie that it *did not* occur (concealment).

The exception to this general rule involves teenagers who know how to manipulate their parents or guardians with threats of intervention by child protective services and children who have been exposed to the "system" (see the preceding section on prisoners and juvenile detention.) Sadly, I've seen several cases in which adolescent children in foster care accused a foster parent of sexual misconduct or abuse simply to exact revenge on the foster parent for a perceived grievance. These teens knew how to work the system.

Sometimes, parents also have a motivation to lie about abuse. I have worked with dozens of parents who were divorcing. In some of these cases, one of the spouses has either accused the estranged spouse of abuse or proposed a "concern" about potential abuse simply to improve his or her own position in the custody hearing. People know that the mere accusation of abuse can have an effect on a judge's decision for custody. In these cases, the benefit of the lie may outweigh the benefit of the truth.

**Rape allegations:** Unfortunately, I have been in the position several times of having to evaluate the truthfulness of a victim and her alleged rapist. This is a very sensitive process because a mistake in either direction has tragic consequences. If I wrongly suppose an accused rapist is telling the truth, I have provided data that might let him avoid charges. Even more serious, I have contributed to one of a victim's greatest fears — that she won't be believed. On the other hand, if I errantly believe an accuser, an innocent man may go to prison and be labeled a sexual offender for the rest of his life.

Generally, the accuser is least motivated to lie, but both parties can possess motives to lie. The accused, obviously, is motivated to lie to avoid prosecution. But in *false* allegations of rape, the accuser is motivated also. In two of my cases, it was discovered that the accusers had engaged in consensual sex and then, fearing pregnancy or disease, realized their indiscretion would eventually come to light. A false accusation of rape provided the accusers with the benefit of being "victims" rather than facing the cost to their reputations of promiscuous sexual liaisons. Please note, however, that the data is quite clear. Most victims of rape never even call the police. Therefore, the accused is far more likely than the accuser to lie.

**Suicide risk:** Perhaps the most common instance in which clinicians will encounter deception is with suicidal risk assessment. Early in my career, I was working with a 19-year-old woman who was exhibiting suicidal tendencies. We had been working together for several weeks, and our rapport was strong. In one session, she verbally consented to a safety contract, agreeing to contact me before the next session if she felt suicidal. She left my office, and within two hours, I received a call from her mother

saying that my client had taken an overdose of medication.

Fortunately, she survived, but there was no doubt that I had missed something and that my client had lied to me. It was my responsibility to take into account all risk factors, and I had failed. Part of my suicide risk assessment now involves evaluating what stressors a client might have after leaving my office, even if I believe the client is telling me the truth. Clients have to convince me that they are not simply saying what they think I want to hear.

### Detecting lies

So, how can we detect lying? This is a process with many variables, but here are some of the basics.

1) The first issue is for the counselor to ask himself or herself if the client has a motive to lie. Is the cost of the truth potentially higher than the cost of the lie? If so, be on guard. How much trust has been built in the therapeutic relationship? When little trust has been established (such as early in the relationship), this increases the cost of the truth to our clients.

2) When telling a lie, people often provide unnecessary detail, and their stories are often presented verbatim over several tellings. When someone is simply describing an event, the gist of the event is what matters, and sometimes small details vary because they are comparably unimportant. Someone who is lying, however, feels the need to "prove" that his or her story is genuine by providing minute, memorized detail that doesn't change much from one telling to another.

3) The story of a person who is lying won't match the known facts. In a complicated story, cross-referencing facts can often lead to an untruthful person's downfall because there are simply too many details to keep in working memory while the lie is being constructed. Lying requires an immense amount of mental energy.

4) People who are lying may not look you in the eye, but they may be just as likely to stare if they are trying to concentrate on being believable. Staring is an example of a "countermeasure." As described in a 2014 article for *FBI Law Enforcement Bulletin* by Brian D. Fitch, these are behaviors construed in an attempt to prevent the hearer from

recognizing the lie. The person may believe that "people who lie don't look you in the eye," so he or she attempts to counterbalance that by staring. When telling the truth, a client is more natural in either situation, looking off into space at times and making occasional eye contact in the same way.

5) When people lie, they often ramble on and on. When I'm interrogating a suspect in a legal situation, I sit quietly and let the person talk. The person telling the truth will tell the story and then wait for instructions or a response from me. Uncomfortable with silence, the person telling a lie will continue to talk, adding flowery language and detail to the story.

6) People who are telling lies are more physically stiff, use fewer hand motions, are more negative and use fewer first-person pronouns, according to a 1997 article by Mark Frank and Paul Ekman in the *Journal of Personality and Social Psychology*.

7) People who are telling lies often exhibit microexpressions. As described in a 2011 *FBI Law Enforcement Bulletin* article by David Matsumoto, Hyi Sung Hwang, Lisa Skinner and Mark Frank, these are behaviors that communicate a feeling such as contempt or disgust. Microexpressions that communicate an emotion inconsistent with the words being spoken are important clues. For example, a client who should be feeling relief at the telling of a story but is instead exhibiting contempt should be considered potentially untruthful.

## Four steps to managing deception

The first step in managing deception with clients is recognizing that deception has occurred. The second step is determining what form the deception has taken (blatant, deflecting, diminishing, falsification or concealment).

Third, the counselor must decide if the deception must be confronted. Early in a therapeutic relationship, I sometimes can tell that I'm not getting the whole story, but my client needs to trust me more deeply before confiding certain secrets. In these cases, I don't confront the deception. Once trust has been established, however, or in cases in which I am confident that confrontation is the proper therapeutic tool, I address the deception head-on.

Finally, the counselor must evaluate the therapeutic relationship and decide why the client didn't trust the counselor with the truth. In the case of Mrs. T, I suspect that her deception was more for her than for me. She wanted so desperately for her son to be "normal" that it was more costly to admit that he wasn't normal than to admit that nothing was working. She trusted me but couldn't face the fact of her disappointment in her son.

## Conclusion

At some point, we have to trust our clients. Mrs. T betrayed my trust in her, and this came at the expense of her son. But looking back, she gave me hints that she wasn't being honest.

Therapy went too easily. She confirmed that things were better each week almost before I asked. Her confirmation that things were going well were inconsistent with some of the behaviors I saw in therapy and in the child's sand trays — so much so that at one point, I consulted with a colleague on these inconsistencies.

But Mrs. T provided multiple energetic and animated stories to prove to me that therapy was working. She was anxious and nervous when I asked about her son's progress at school and often jumped ahead in the conversation at a pause or lull in our discussions. In hindsight, the most notable clue was that she looked me straight in the eye, almost staring at me, each week as she lied to me.

I still don't know why Mrs. T was motivated to lie to me, but perhaps the most important lesson I learned from her is that clients will, indeed, deceive me if I'm not careful. In her case, I never even bothered to consider the possibility of deception. It was a mistake I haven't made again. ❖

Gregory K. Moffatt, a licensed professional counselor, runs a private practice in which he specializes in working with children who have experienced physical or sexual abuse. He is also a professor of counseling and human services at Point University in Georgia and serves as a risk assessment and psychological consultant for businesses, schools and law enforcement agencies. Contact him at *Greg.Moffatt@point.edu*.

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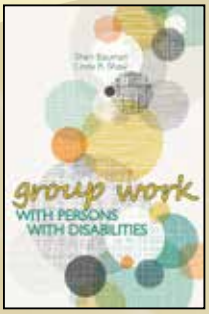
# Newer titles of interest to the counseling community

***Group Work With Persons With Disabilities***
By Sheri Bauman & Linda R. Shaw, American Counseling Association




This one-of-a-kind manual provides direction for leading groups of people with disabilities or groups that have members with disabilities. Viewing disability as a single aspect of a multifaceted person, the authors share their insight and expertise and emphasize practical skill building and training for facilitating task, psychoeducational, counseling, family and psychotherapy groups across various settings. Topics examined include common themes in groups that focus on disability, types of groups, diversity issues, group composition, ethical considerations and training considerations. Among the specific disabilities covered are sensory, psychiatric, cognitive and physical disabilities and chronic medical conditions.

***Moving Beyond Assessment: A Practical Guide for Beginning Helping Professionals***
By Melissa D. Grady & Eileen A. Dombo, Oxford University Press

This text is designed to help beginning professionals, including counselors, navigate the early stages of working with clients in a variety of settings. The authors have trained hundreds of graduate students to learn how to assess, intervene and evaluate their work with clients. In addition to the book's direct practice focus, the authors address issues such as self-care, neurobiology basics, working with multidisciplinary teams, evidence-based practice and supervision. The text has a user-friendly tone, and the authors have included numerous practice vignettes and their own personal and professional experiences to exhibit how the content can be applied to real-life settings.

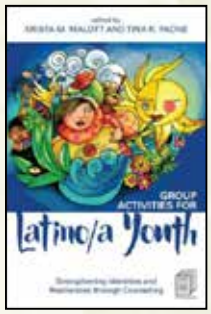
***Grief Is a Journey: Finding Your Path Through Loss***
By Kenneth J. Doka, Atria Books


This groundbreaking book explores a new, compassionate view of grieving. As the author explains, grief is not an illness for us to get over, but an individual and ongoing journey. There is no one-size-fits-all way to cope with loss. And grief does not proceed in distinct stages. Instead, the author replaces our culture's prevailing, often judgmental ideas about grief with a hopeful, inclusive and personalized approach, telling encouraging stories of his clients and others as they work through their losses. The book also explores ways of coping with disenfranchised grief — losses that are not readily recognized or supported by society.

***The Art of the First Session: Making Psychotherapy Count From the Start***
By Robert Taibbi, W.W. Norton & Co.

This book walks readers through all the first-session essentials, including preparing for the first session, action steps for each stage of the session, techniques for changing the emotional climate and "closing the deal" to make sure that clients come back for more. The average client today comes to therapy only five to eight times, and many only come once, so it is increasingly important for therapists to achieve first-session success. In the first 60 minutes, clinicians must build trust, communicate what they have to offer and ensure that clients feel different when they walk out than they did walking in.

***Group Activities for Latino/a Youth: Strengthening Identities and Resiliencies Through Counseling***
Edited by Krista M. Malott & Tina R. Paone, Routledge



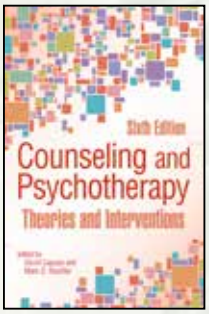

Directly applicable to counseling practice, this book allows helping professionals to select and apply a series of group sessions with topics relevant to today's Latino/a youth. Each session contains detailed directions, suggested discussion questions and additional readings on specific topics. Topic examples include grief, identity development and conflict resolution. Sessions draw on Latino/a cultural norms and strengths to build culturally informed communication and coping skills in an effort to improve educational, social and career outcomes.

***Diagnosis and Treatment of Mental Disorders Across the Lifespan*, Second Edition**
By Stephanie M. Woo & Carolyn Keatinge, Wiley

Designed to serve as a trusted desktop reference on mental disorders seen across the life span for mental health professionals at all levels of experience, this resource expertly covers etiology, clinical presentation, intake and interviewing, diagnosis and treatment

of a wide range of disorders at all developmental stages. Unlike other references, this book takes a life span approach that allows readers to develop the clinical skills necessary to respond to mental health concerns in a patient-centered manner.

***Counseling and Psychotherapy: Theories and Interventions,* Sixth Edition**
Edited by David Capuzzi & Mark D. Stauffer, American Counseling Association




Featuring important theories and trends not covered in other foundational texts, this book is designed to equip the next generation of counselors with the tools they need for understanding the core dimensions of the helping relationship. Topical experts provide contemporary information and insight on a wide range of theories, from psychoanalytic theory to transpersonal theory. Each theory is discussed from the perspective of historical background, human nature, major constructs, applications, the change process, traditional and brief intervention strategies, cross-cultural considerations and limitations. The use of a consistent case study across chapters reinforces the difference between theories.

***Bullying Scars: The Impact on Adult Life and Relationships***
By Ellen Walser deLara, Oxford University Press

Although it's well known that bullying can have a negative impact on a child's mental, emotional and physical health, we rarely discuss how these consequences translate in adulthood. This is the first book of its kind to address the long-range consequences of bullying. The author interviewed more than 800 individuals and discovered that former victims of bullying exhibited a range of emotional and psychological effects as adults, including some positive outcomes that surprised her. Engaging, informative and surprising, this book includes personal stories from former victims of bullying and has important findings for parents, educators, mental health workers and others.

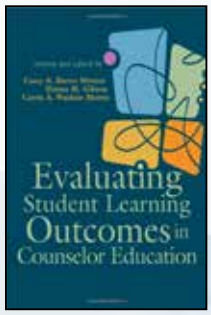
***Accessible Retirement: A Guide for Persons With Disabilities***
By David B. Hershenson, Harvard.com


There are more than 15,000 books about retirement planning on Amazon.com, but this is the first designed to enable persons who retire with a disability or acquire one after retiring to make and implement plans that fulfill their needs and aspirations. Based on rehabilitation counseling principles of mobilizing personal and environmental assets and minimizing the effects of impairments, this book presents a series of exercises (acronym RETIRE) that: *review* one's career and disability history; *explore* current aims, constraints and options; *try* out selected options; *implement* an integrated action plan; *reevaluate* that plan periodically; and *emend* it as needed.

***The STOP Program for Women Who Abuse: Group Leader's Manual***
By David B. Wexler, W.W. Norton & Co.

Long disregarded and downplayed, female domestic violence is rapidly gaining awareness as research proves not only that it exists, but that the frequency of women actually initiating abusive behavior is about equal to men. This resource is the most innovative and comprehensive manual to address domestic violence treatment specifically to female offenders, with a program targeted to engage women in their own healing process. Developed and field-tested for more than 25 years, the program provides a skill-building approach to address the core elements of all intimate partner violence and the aspects that are unique to female offenders.

***Evaluating Student Learning Outcomes in Counselor Education***
By Casey A. Barrio Minton, Donna M. Gibson & Carrie A. Wachter Morris, American Counseling Association




This timely text describes the role of program evaluation in counselor education and provides step-by-step guidance for faculty seeking to develop comprehensive Student Learning Outcome (SLO) evaluation plans to meet accountability expectations. It serves as a blueprint for demystifying the SLO process and making the switch from an input-based measure of productivity that focuses on what counseling programs do, to an outcome-based approach that concentrates on the quality of learning through evidence-based assessment of students' knowledge and skills.

***Loaded: Money, Psychology and How to Get Ahead Without Leaving Your Values Behind***
By Sarah Newcomb, Wiley

Does money represent luxury, security and peace of mind, or stress, inequality, barriers and greed? This book explains how our experiences with money have a psychological basis and can run counter to our core values. Based on years of research, it offers a guide for identifying harmful core beliefs about money and what can be done to overcome those beliefs. Once a clear understanding of an individual's beliefs about money is established, the human-centered approach to budgeting and money management can be put into action. This incorporates several principles from psychology that are missing or misaligned in traditional budgeting methods.

***Love's Fire Works … the Rule-Breaker***
By Andrew Carey, AuthorHouse

This book shares the author's journey through a season of panic attacks and marital difficulties, as well as what he experienced, wrestled with and learned through those struggles. The book


addresses how God or life often breaks our current rules and ways to bring forth higher ways that we have not yet known. Although anyone struggling can benefit from this book, one of its purposes is to reach the Christian population to break open religious boxes and love people more fully. Anyone interested in meaning-of-life issues, counseling or spirituality will be drawn to this thought-provoking work.

***Nutrition Essentials for Mental Health: A Complete Guide to the Food-Mood Connection***

By Leslie Korn, W.W. Norton & Co.

This book provides clinicians with a practical guide to the complex relationship between what we eat and the way we think, feel and interact with the world. Diet is an essential component of a client's clinical profile, and dietary changes can work alongside or even replace medications to alleviate symptoms and support mental wellness. Few therapists, however, have any nutritional training. Covering essential assessment techniques, leading-edge protocols, illuminating clinical vignettes and much more, this book offers clinicians powerful tools to enhance the efficacy of all their methods and support clients' mental health with more effective, integrated treatment.

***Managing Conflict, Finding Meaning: Supporting Families at Life's End***

Edited by Kenneth J. Doka & Amy S. Tucci, Hospice Foundation of America


This book examines the problems of family conflict at the end of life and the struggle to find meaning after a death. It provides instructive guidance using a case study approach. Cases illustrate challenges surrounding dying and grieving as well as opportunities that may arise from crises. Authors include Robert Niemeyer, Katherine Shear, Myra Glajchen and Lori Montross-Thomas. This book is part of the Living With Grief series and is appropriate for clinicians and others working with the dying and bereaved. ❖

**Books that include a cover image were written or edited by a member of the American Counseling Association.**

Book descriptions were provided by the authors or their publishers. Book announcements are for informational purposes only and do not indicate an endorsement by *Counseling Today* or the American Counseling Association. Send information regarding new book releases to Jonathan Rollins at *jrollins@counseling.org*. Descriptions are limited to 100 words or less.

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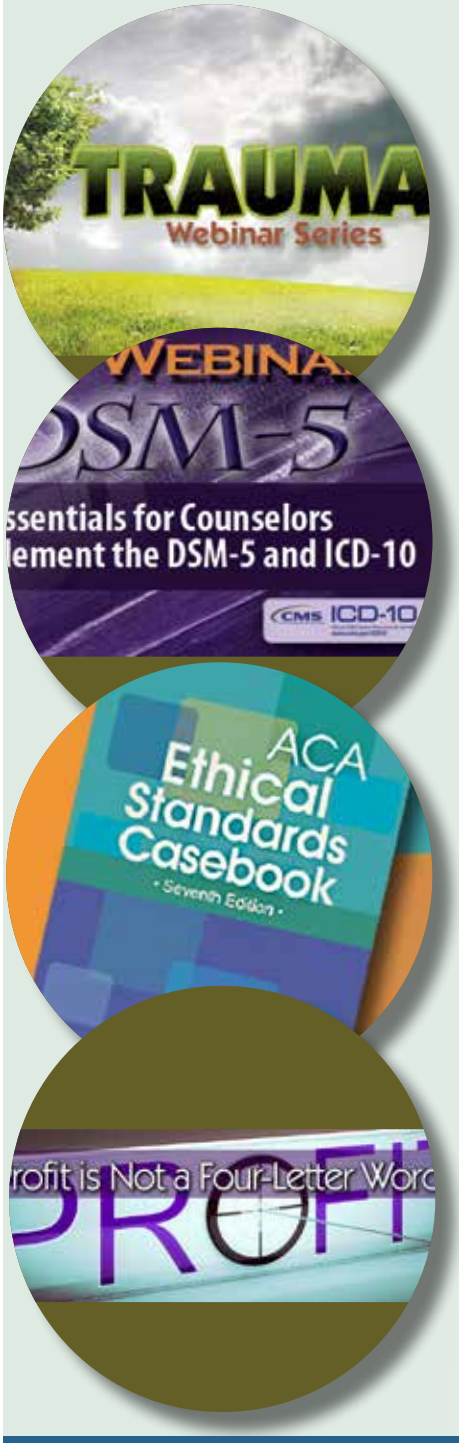


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### Trauma Webinar Series (7CEs)

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### Essentials for Counselors to Implement the *DSM-5* and *ICD-10* (1 CE)

*ICD-10-CM* literacy is an essential part of remaining HIPAA compliant. Learn key diagnostic changes that impact daily practice.

### *ACA Ethical Standards Casebook* and *Boundary Issues in Counseling* (2 CEs)

Co-presenters Barbara Herlihy and Gerald Corey address a range of topics covered in the 2014 *ACA Code of Ethics*, the 7th edition of the *ACA Ethical Standards Casebook* and the 3rd edition of *Boundary Issues in Counseling*.

### Using the *DSM-5* Webinar Series (7 CEs)

Whether you're a practicing counselor or a counselor educator, this series will deliver the information and insights you need. Sessions: General Overview and Addictive Disorders; ASD/Autism/Asperger's; Bipolar Disorders; Anxiety Disorders; Depressive Disorders; Wrap Up and Personality Disorders.

### Profit is Not a Four-Letter Word Webinar Series (7 CEs)

Learn how to combine the ideal and the practical from eight counselors who share their personal strategies on serving clients and making a living.

### The Bootstrapper's Guide to Building a Private Practice from Scratch (1 CE)

There are so many ways to practice your trade. Learn how to build a private practice on a strong foundation.

**Visit *counseling.org/webinars* to explore a complete list of webinar options.**

## COMING EVENTS

**AADA Conference**
**July 14-15**
**New York City**

The Association for Adult Development and Aging is excited to host its annual national conference at the Roosevelt Hotel in Manhattan. Our programs will include education sessions, roundtable sessions and poster sessions. We are excited to continue offering a variety of programs covering diverse issues, best practices and research. CEU clock hours will be available. For additional information, visit *aadaweb.org/conference-events/*. For questions, contact *aadaconference2016@gmail.com*.

**2016 AARC Conference**
**Sept. 9-10**
**Fort Lauderdale, Florida**

The Association for Assessment and Research in Counseling is pleased to announce that its 2016 annual conference will be held in Fort Lauderdale. Enjoy beachfront accommodations at the B Ocean Resort. This year's theme is "Emerging Trends in Counseling Assessment and Research: Practice, Education and Social Change." The association invites members, colleagues, graduate students and other assessment and research specialists to attend the meeting. The conference will provide attendees with critical information regarding innovative practices and techniques, best practices for assessment and evaluation, support for graduate student development and opportunities for networking and collaborating with colleagues. Questions about the conference? Contact conference coordinator, Elizabeth Villares, at *evillare@fau.edu*. Visit *aarc-counseling.org* for more conference details.

**ALGBTIC Conference**
**Sept. 16-17**
**San Antonio**

The Association for Lesbian, Gay, Bisexual and Transgender Issues in Counseling is pleased to announce its second annual conference. The theme of the conference will be "Empowering Through Unity." Registration is now open and will continue until the start of the conference. Please make sure to take advantage of our early bird and membership discounts and get registered today. Visit *algbtic2ndannualconference.eventbrite.com*. Contact Adrienne Erby with questions at *algbticproposals@gmail.com*.

**NARACES 2016 Conference**
**Sept. 22-25**
**Syracuse, New York**

The North Atlantic Region Association for Counselor Education and Supervision 2016 Conference will be held at the DoubleTree by Hilton in Syracuse. The conference theme is "Enriching Our Professional Counselor Identity Through Dynamic Scholarship and Practice." Educators, supervisors, practitioners and graduate students are encouraged to attend. Details for the conference, the call for proposals and conference registration can be found on the NARACES website at *NARACES.org*.

**WCA Annual Conference**
**Oct. 5-8**
**Casper, Wyoming**

The Wyoming Counseling Association will hold its annual conference in conjunction with the Wyoming chapter of the National Association of Social Workers. The theme will be "Creating Connections." The conference will feature several well-respected speakers, including Ric Reamer, Heath Helm and eye movement desensitization and reprocessing expert Jan Schaad. In addition, the inspiring and entertaining Nancy McNenny will present "Superhero Seeks Sanity: Compassion Fatigue and Self-Care." To learn more about the conference, go to our website at *wyomingcounselingassociation.com/annual-conference/*.

**FCA 67th Annual Convention**
**Oct. 14-15**
**Orlando, Florida**

The Florida Counseling Association will host its 67th annual convention at the Florida Hotel and Conference Center. Preconference Learning Institutes will take place Oct. 13, with the conference running Oct. 14-15. Network with colleagues and friends at the luncheons, receptions, annual awards ceremony and our famous "Sunshine Social" after-party. Continuing education credits will be available. Register today at the advance rate to lock in the savings. For more information, visit *flacounseling.org*.

**NCCHC Annual National Conference**
**Oct. 22-26**
**Las Vegas**

The National Commission on Correctional Health Care will celebrate its 40th annual national conference at the Paris Hotel. At the five-day conference — the country's largest gathering of correctional health professionals — clinicians, administrators and others are invited to learn about the latest advancements and best practices in delivering health care behind bars. The conference features eight in-depth preconference seminars and more than 100 concurrent sessions, and offers up to 32 hours of continuing education credit. Topics on the agenda include HIV, mental illness and substance abuse. The American Counseling Association is a supporting organization of NCCHC. For more information, visit *ncchc.org/national-conference*.

**MCA Annual Conference**
**Nov. 3-5**
**Baltimore**

The Maryland Counseling Association will hold its annual conference at the Embassy Suites by Hilton Baltimore at BWI Airport. The theme will be "Multiculturalism and Social Justice at the Crossroads: Creating a Multidimensional Intersectionality Lens," with Courtland Lee serving as the keynote speaker. Attendees may earn as many as 16 NBCC clock hours. For more information, visit *mdcounseling.org/event-2193807*.

**KCA 2016 Conference**
**Nov. 9-11**
**Louisville, Kentucky**

The Kentucky Counseling Association 59th Annual Conference will be held at the Crowne Plaza Airport Hotel. The theme will be "Violence and Tragedy Prevention: Trauma-Informed Approach, Advocacy and Intervention," with Cirecie West-Olatunji, Scarlet Lewis and Kenny Robertson as keynote speakers. Preconference workshops will take place Nov. 9. The conference will provide a wide variety of breakout sessions in an academy approach for counseling professionals in various counseling settings. Proposals can be submitted online until July 15. Registration includes the opening reception, school counselor and LPCC/LPCA luncheons, and closing brunch. For more details and registration information, visit the website at *kyca.org* or call 800.350.4522.

**WACES 2016 Conference**
**Nov. 10-12**
**Vancouver, Canada**

The Western Association for Counselor Education and Supervision is excited to announce its 2016 biennial conference this fall at the Pinnacle Harbourfront Hotel in downtown Vancouver. The conference theme is "Innovation and Collaboration in Counselor Education and Supervision." The conference offers 15 NBCC-approved continuing education credits to attendees. An emerging leaders event will be held on Thursday the 10th. Sessions will be of interest to educators, supervisors, practitioners and graduate students. All attendees are encouraged to apply early for passports or passport cards. Early bird registration for the conference will be available until Sept. 14. A Career Connection will be available for job seekers in the Western region. More information can be found at the WACES website: *waces.org/*.

**PCA Annual Conference**
**Nov. 11-13**
**State College, Pennsylvania**

The 48th Annual Pennsylvania Counseling Association Conference will be held at the Penn Stater Conference Center and Hotel. The conference theme is "Celebrating Creativity and Ingenuity in Counseling." Attendees can take advantage of influential learning opportunities, earn CEs through diverse educational sessions, collaborate with counseling peers, gain career insights and more. To register or obtain more information about the conference, visit us at *pacounseling.org*.

**Law and Ethics in Counseling Conference 2017**
**Feb. 14-17**
**New Orleans**

This annual national refereed professional conference, held at the University of Holy Cross, will bring together counselor educators, counseling graduate students and counseling practitioners to review the latest trends and developments in the areas of law and ethics in counseling. For those who wish to experience a bit of Mardi Gras, the first weekend of parades will roll Feb. 17-19. The deadline for program proposals is Sept. 15. Discounted early bird registration ends Oct. 1. See conference details and the call for program proposals at *uhcno.edu/academics/continuing-studies/events/Law_and_Ethics.html.*

## FYI

**New section in *JMCD***

The *Journal of Multicultural Counseling and Development* has launched its "Hearing Our Elders" section, co-authored by *JMCD* editor Caroline Clauss-Ehlers and associate editor William D. Parham. The purpose of the section is to illuminate the lived experiences of luminaries who have shaped multicultural counseling, to honor their vision and to document their contributions. The section launched in *JMCD*'s January issue with U.S. Rep. John Lewis as the first interviewee. Critical themes captured from the interview include: a) enough is enough; b) resilience; c) stigma; d) access to services (creative approaches); e) prevention and early intervention, with a focus on young people; and f) all people matter. The end of each section article will present a teaser inviting readers to guess the next featured historical hero.

**Call for papers**

VISTAS Online, ACA's dynamic peer-reviewed and peer-created publication with the motto "by counselors and for counselors," is seeking papers for publication in its fall issue (deadline: July 1). VISTAS is designed to provide professional counselors from all settings a place to share knowledge, practices and ideas about any aspect of counseling with other professional counselors. VISTAS welcomes articles based on programs presented at national ACA or ACA division conferences. Additionally, if you have developed a practice or program or have conducted research that has practical implications, we invite you to prepare and submit a VISTAS paper so that you can share your knowledge and resources with others. For more information, contact managing editor Jillian Joncas at *VISTASonline@counseling.org*. Specific submission guidelines can be accessed at *counseling.org/knowledge-center/vistas/vistas-guidelines*. ❖

**Upcoming deadlines for Bulletin Board submissions**

- September issue: July 28
- October issue: Aug. 30
- November issue: Sept. 29

Send Bulletin Board announcements (125 words or less) to Jonathan Rollins at *jrollins@counseling.org*.

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Instructor: **Holly Walrod-Whitehurst, MA**
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Sept. 6, 2016 ..... Online

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July 22 & 23, 2016 - Series B ..... Online
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