VACC FALL WORKSHOPS ANNOUNCED

Coming This Fall

Workshops and training (CEU credits available):

- Pharmacology for the LPC: What Therapists Need to Know
- Clinical Supervision
- Ethics Training: Countertransference, Boundaries, and Attraction.
- DSM-5: The Changes that Impact Counselors

Locations Across the state of Virginia:

- The Tidewater area
- Richmond
- Charlottesville
- Northern Virginia/Loudoun County

Locations Across the state of Virginia:

- September 20
- October 4
- October 18

Experienced Speakers:

- Penny Norford, PhD, LPC
- Michael Jeffrey, LPC, LMFT, mitigation specialist
- Lourie W. Reichenberg, LPC, author, *Selecting Effective Treatments, 4th ed.*

Networking and Education Services All in One:

- VACC provides Regional networking meetings and featured speakers on relevant topics across Virginia
- You can sponsor one in your community upon request. We will provide the speakers
- You can sponsor one in your community upon request. We will provide the speakers
- Contact us to arrange a workshop in your area

Watch your mail for details on these exciting workshops coming to a location near you. Or check the VACC website for updates.

VACC Virginia Association of Clinical Counselors
Lourie Reichenberg
6400-R Seven Corners Place
Falls Church, VA. 22044

ISSUE Summer 2013
QUARTERLY NEWSLETTER OF THE VIRGINIA ASSOCIATION OF CLINICAL COUNSELORS

VACC Headlines

Serving the needs of Virginia Clinical Counselors since 1980

IN THIS ISSUE

PRESIDENT'S CORNER

By Michael E. Nahl, LPC, LMFT, CCMHC

The Virginia Association of Clinical Counselors has been serving the needs of Virginia counselors since 1980, shortly after licensure in Virginia was established (1976) and before we were entitled to be reimbursed by third-party payments. VACC has been at the forefront of the maturation of the clinical counseling profession in Virginia and the nation through its extensive advocacy campaign and its legislative efforts.

The reader can review the mission of VACC on our website, along with our bylaws, a history of the organization, and a list of past VACC presidents. We have already won the right to third-party reimbursement, Medicaid coverage, and many other privileges, but there are always challenges yet to be faced.

VACC, by virtue of its status as the state chapter of the American Mental Health Counselors Association, can speak for the clinical counseling profession in Virginia. We do so through advocacy campaigns, occasional legislative efforts, attendance at Board of Counseling meetings, and collaboration with sister organizations such as the Virginia Association of Marriage and Family Therapists.

In addition to the important work mentioned above, VACC presents workshops, fellowships, and liaison with our local chapters and other organizations. We also convey information through our website, email, and newsletter, which will prove particularly important with the advent of changes in state and federal laws pertaining to health care.

In order to accomplish these goals, we do need your membership. The more members we have, the greater the clout we have in our efforts to protect and expand clinical counseling practice in Virginia. So please help us by disseminating our newsletters to your friends and colleagues, along with an invitation to visit our website (www.vacc.org) and join our organization. And do help us with your ideas and talent!

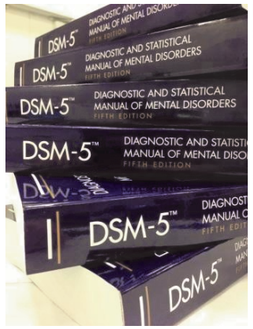
As incoming president, I expect to continue to expand upon the services VACC provides to its membership. The American Mental Health Counselors Association handles issues of national consequence, such as inclusion of LPCs in Medicare, while regional groups provide continuing education, camaraderie, and networking opportunities on a local basis. VACC advocates for the clinical counselor on a state level. To that end, we expect to communicate effectively and quickly any issues that will affect your clinical practice or vocational viability.

Please see the list of upcoming Workshops on ethics, supervision, DSM-5, and psychopharmacology that will be coming to an area near you this Fall.

Let's make this a great year, and let me hear from you!

DSM-5 Questions and Answers: What LPCs Need to Know about the DSM-5 Changes

By Lourie W. Reichenberg, MA, LPC, Co-author, Selecting Effective Treatments



It's been more than 13 years in the making, but now that it's out, the new DSM-5 provides a wide range of changes, both large and small, to the previous edition.

DSM-5 provides clarification for many diagnostic criteria, and adds helpful specifiers for others. I find it to be easier to use than DSM-IV. Enhancements include:

- codes embedded in the text,
- diagnostic criteria listed under the title of each disorder rather than boxed on a different page (which was so annoying in DSM-IV-TR),
- extensive information on assessment (including assessment of suicidal risk and non-suicidal self-injury),
- more cultural considerations addressed within the text when appropriate,
- and, although it is not required to be used, the alternative model for diagnosing personality disorders is provided.

The publication of DSM-5 also raises a few questions. Following are some of the questions I have been asked most frequently in workshops and discussions with LPCs, residents, and students across the state.

Question: Why did APA eliminate the multiaxial system?

Answer: According to the American Psychiatric Association, the multiaxial system had no research support to back it up. The GAF score in particular was too subjective. Some clinicians also found the system to be cumbersome and many didn't use it anyway. The new uni-axial or non-axial system is intended to be more efficient. Of course, clinicians will still want to conduct a full biopsychosocial assessment to understand the many different variables that impact their clients, but the diagnosis will be written on only one axis. Multiple co-occurring disorders will be listed in order of priority for treatment.

Question: Has Asperger's been eliminated from DSM-5?

Answer. Yes and no. Pervasive developmental disorders and Asperger's disorder are considered to be part of Autism Spectrum Disorders. These disorders will now be identified by course specifiers (e.g., mild, moderate, severe). Under DSM-5, Asperger's is considered to be a mild form of Autism.

Question: Won't the new DSM increase the number of diagnoses and result in an increase in the number of medications produced by pharmaceutical companies?

Answer. Actually, very few new disorders are included in DSM-5. They include:
- hoarding disorder,
- binge eating disorder (BED),
- skin picking disorder,
- disruptive mood dysregulation disorder (DMDD).

DMDD in particular, was intended to reduce the potential of children being prescribed powerful psychotropic medication with long-term side-effects. Recent research shows a reduction in the amount of money pharmaceutical companies are investing in research for new drugs for mental disorders. Also, it is a myth that there will be many new disorders. Most of the disorders found in DSM-IV remain virtually the same in DSM-5.

Question: Isn't the DSM just a money making venture for APA? The American Psychiatric Association is a non-profit organization. Their website notes that the research, development and publication of DMS-5 cost the association 20-25 million dollars, and required the professional association to dip into their reserve funds. Clearly it will be many years before DSM-5 pays for itself. APA notes that the publication of DSM-5 "is an investment in the future of mental health."

Question: Many of the disorders have been moved to new chapters and many of the disorders have been renamed (e.g., hypochondriasis is now "health anxiety disorder"). How do we find the disorders we are looking for?

Answer: Use the Index. Seriously. DSM-5 has an extensive index. The new DSM also includes a chapter that highlights revisions from DSM-IV and DSM-5. While there are a significant number of changes, APA and the DSM-5 task forces managed to maintain just about the same number of diagnoses.

Question: Did the Personality Disorders section undergo substantial changes?

Answer: This is another yes and no answer. The Personality Disorder Work Group proposed a radical change to the personality disorders chapter that would have eliminated all but 6 personality disorders and created a trait-based dimensional system of classification. However, when the APA Board of Trustees met in December 2012, they voted not to adopt the alternative model but to include it in Section III: Conditions for Further Study. As a result, the personality disorders chapter of DSM-5 remains the same as DSM-IV but the alternative model is included for those who would like to incorporate the newer method into their practices.

Question: How can I learn more about the DSM-5 changes?

Answer: VACC will be conducting workshops at various locations across the state in the coming month to address DSM-5 changes, ethics, and topics in psychopharmacology. The workshops will focus on the diagnoses that mental health counselors work with the most (depression, bipolar disorders, anxiety, trauma, and substance abuse). See the related article in this newsletter for dates and locations.

Question: When can we start using DSM-5?

Answer: You can start using the DSM -5 right away. Insurance companies will be updating their information, too, during this initial transition period which is expected to last through the end of the year.

H What?
HPMP and What it Means for You Changes

By Elaine Wescoat, LPC, LSATP

We who work in behavioral healthcare have all had the experience of helping people with all kinds of emotional and psychological issues. Hopefully we are all equally mindful of practicing what we preach. After all, we can't really help people get any farther with their issues than we have with our own.

But what happens when a mental health professional is, well, not so healthy? Sure, we get our CEU hours and can mark yes to our intended adherence to the ethics of the profession. Those boxes and blanks are easy to fill in. Are we walking the walk or just talking the talk? When was the last time that you actually read the code of ethics? Have you looked at state laws lately? How often, when you are reviewing that CEU material, do you actually apply the information to yourself? Or do we put up some of those same barriers--denial, minimizing, justifying, rationalizing--that our clients have used and convince ourselves that we are okay?

All health care providers chose their profession for a reason. Most mental health professionals have actually asked and answered the question of their motive for getting into this field. At least, I hope they have. And no matter how much education and experience we might gain things still boil down to a simple fact--we are all human. Every one of us is just as susceptible to all of those symptoms on all of those conditions in the DSM as the next person.

> *"the standards that HPMP enforces are no joke. If a health care professional comes under suspicion of having a mental health or substance use issue that could jeopardize anyone that professional could lose their license"*

Our humanness, to say nothing of our unresolved issues or late onset illnesses is part of the logic behind the Commonwealth of Virginia program called HPMP, which stands for Health Practitioners Monitoring Program. You may have seen information about this entity on the state licensing web page. If you haven't heard of it or didn't look into it you might want to make a point of doing so.

HPMP is charged with the responsibility of ensuring that every person who carries a health care credential issued by the state is working in the defined profession safely. The staff of HPMP is granted specific power to ensure the safety of patients and the public against any health care provider who may have a behavioral health issue that could compromise their professionalism and potentially be dangerous. And the standards that HPMP enforces are no joke. If a health care professional comes under suspicion of having a mental health or substance use issue that could jeopardize anyone that professional could lose their license unless they follow everything that HPMP tells them to do for five years. That's right, 5 years!

I became familiar with the monitoring process when I first came to Virginia in 1998. I had been aware of impaired professionals from my 11 years of experience as a treatment provider in Tennessee. As I continued my career in substance abuse treatment here I had also been approached by Virginia Monitoring Inc., the agency that had been providing monitoring at that time. Because my licenses (Tennessee LPC and LAODAC) and certificates (National Certified Addiction Counselor I) were not recognized in Virginia I didn't start facilitating the monitoring of impaired professionals until 2001 when I acquired my LSATP (Licensed Substance Abuse Treatment Practitioner). I have been providing monitoring ever since. HPMP won the contract with the state in the years that followed.

HPMP requirements are very thorough. During the 5 year term the professional must: sign a contract that says they will stay clean and sober; complete professionally defined treatment; call in every day for possible alcohol/drug screening; only work approved jobs for specified hours after the HPMP case manager has reviewed and staffed the job option; have a work site monitor, and; complete monthly forms verifying all of this and more. People in the monitoring program cannot see doctors or dentists without the HPMP case manager getting a written report. No medicines can be used, prescribed or over the counter, without first being approved by the HPMP staff and guidelines. Monitoring even has the ability to limit vacations.
If you visit the Department of Health Professions web site you can find all of the details related to HPMP. The following description was copied from that site:

"The Department of Health Professions has a contract with Virginia Commonwealth University Health System, Department of Psychiatry, Division of Addiction Psychiatry, to provide confidential services for the health practitioner, who may be impaired by any physical or mental disability, or who suffers from chemical dependency.

Available services include intake, referrals for assessment and/or treatment, monitoring, and alcohol and drug toxicology screens.

Practitioners who meet certain criteria may receive approval for a stay of disciplinary action. This allows the practitioner to focus on recovery efforts. Requests for stayed disciplinary action are reviewed by a designated board liaison, with the final decision being made by the Monitoring Program Committee.

The Health Practitioners' Monitoring Program eligibility requirements are:

practitioner must hold a current, active license, certification, or registration issued by a health regulatory board in Virginia or a multi state licensure privilege or,

an applicant for initial licensure, certification, and registration or for reinstatement is eligible for participation for up to one year from the date of receipt of their application."

This excerpt implies that HPMP will "provide services." Yet the handbook, also accessible on the site, is more detailed in describing a process of monitoring professionals in an effort to protect others. The stipulations of the program may be modified slightly according to each professional's issue and history, but very little slack or compromise is offered from what I have seen from my experience monitoring professionals since 2001.

An impaired professional is defined in the glossary included in the laws as follows:

"Impairment" means a physical or mental disability, including, but not limited to substance abuse, that substan-

(Continued on page 3)

tially alters the ability of a practitioner to practice his profession with safety to his patients and the public.

"Practitioner" means any individual regulated by any health regulatory board listed in § 54.1-2503.

The laws also stipulate who must make reports about a potentially unsafe practitioner. The following references were found well summarized and discussed in a presentation link on the DHP site. Access the slide show by typing in the search box "laws on reporting impaired professionals" then go to the link www.dhp.virginia.gov/dhp_guidelines/Jaspen_1441_guidance.ppt#1. The Virginia code that directly applies to all LPC professionals states:

§54.1-2907 (not amended by HB 1441) Every practitioner licensed or certified by a health regulatory board, who treats professionally any other person licensed or certified by a health regulatory board, to report, except as prohibited by federal law, when such health professional is treated for a mental disorder, chemical dependency, or alcoholism unless the treating practitioner determines there is a reasonable probability that the professional being treated is competent to continue practice or would not constitute a danger to himself, his patients, or the public.

Other mandated reporters include administrators of health care organizations and presidents of professional organizations. The professionals who fall under the jurisdiction of the monitoring process include a lengthy list of licenses and certificates. All of these details can be found at the site shown above.

An interesting note about the law related to being a provider and the possibility of reporting a patient who is a clinician. When HPMP first took over the monitoring process the law was not written as quoted above. In fact, I had been told, at an open house hosted by the HPMP staff, that if I was aware of an impaired provider in my care and failed to file a report that my own license could be jeopardized. I had pointed out the potential violation of the federal laws regarding confidentiality but was offered no alternative other than the hope that a law suit would not ensue. I was pleased to see the revision to the law acknowledging our obligations to respect privacy and the laws that protect the necessary rapport of a therapeutic relationship.

While I maintain my mission to help all of my clients deepen their recovery I also have seen first hand how demanding the monitoring process is. I am grateful for the clinical emphasis that my position affords and the opportunity to allow my clients to vent, grieve, and heal in spite of the complications that their issues and consequences have created. Like so many of us, the health care providers that I have been privileged to help have, for the most part, proven to be very dedicated, compassionate, and skilled professionals who freely offered their services to patients but had to learn to reserve some of those resources for themselves. Again, we can only take our clients as far as we ourselves have gone.

After years of offering support and all of the required documentation for the health care providers that I have monitored I can assure you that HPMP means business. At the same time I am free to practice according to my own philosophy and theoretical perspective with comprehensive clinical care as my priority. I remain determined to follow the ethics and laws that govern our profession and have witnessed way too many frightening examples of other so-called professionals who don't appear to respect the same guidelines. Hence, I am offering this article in the hope that others will be more aware of the implications of our role and our responsibilities, including the importance of self-care.

Meet Your Next Favorite Book

by Lourie W. Reichenberg, LPC

Deciding what to read next? You've come to the right place. VACC's Book Corner provides a glimpse into what other LPCs are reading. Here you can gain some insightful recommendations from your colleagues and share some thoughts of your own about these or other books you are reading. Who knows, they might become one of your colleagues' next favorite books!

Daring Greatly: How the Courage to be Vulnerable Transforms the way we Live, Love, Parent, and Lead, by Brene Brown, Ph.D., LMSW (2012)

Reviewed by Penny A. Norford, PhD, LPC, CSAT-S

I had the honor of meeting Brene Brown when she addressed members of the International Institute of Trauma and Addiction Professionals (IITAP) at the annual conference in Scottsdale, Arizona in February of this year. Dr. Brown had just returned from filming her two episodes of Super Soul Sunday with Oprah Winfrey. I encourage you to record those episodes and perhaps share and discuss them with your peers. If you are not able to see these episodes, you can catch her TED talk from 2010, a site that has received well over 5 million hits.

Brene Brown is a Social Work researcher whose research on the topic of shame has benefitted her personally and professionally.

Her books The Gift of Imperfection and Daring Greatly are "must reads" for therapists and no doubt once read, will be referred by therapist to clients.

Daring Greatly reveals the characteristics possessed by people who are most resilient to shame, people she refers to as "wholehearted". Through living (not just thinking) in mindful and vulnerable ways, wholehearted people reduce shame by fully embracing both the gifts and problems associated with being human.

The societal myths surrounding the concept of vulnerability are held as non-negotiable in our culture almost as severely as our society avoid addressing shame. Brene Brown discusses the value in vulnerability as well as revealing what her research on the subject of shame has to offer. In the final chapter, she discusses how to parent for wholeheartedness. I strongly encourage anyone who counsels children or who has children or grandchildren to read Daring Greatly.

Note: As a participant on several listservs, I am frequently given book recommendations on topics relevant to the clinical populations that I treat. If you are able to join such a listserv, I strongly encourage you to do so. If you have book recommendations and or reviews to share in this newsletter, please contact me at pennor4d@aol.com

Member Focus

Cara Marinucci, LPC is a licensed professional counselor in private practice in Charlottesville, Virginia. She has over 23 years experience working with adults, adolescents, families, groups, and organizations to facilitate successful transformation and growth. She has extensive background providing, implementing, and consulting for services across the spectrum of wellness and clinical care including schools, community service boards, intensive outpatient, non-profit and private settings. In her private practice she specializes in anxiety, depression, and addiction as well as creativity and spiritual growth.

In addition to her private practice, Cara is a co-director of the Integrative Music Institute, offering training in The Bonny Method of Guided Imagery and Music, Integrative Therapies, and Mindfulness Meditation. She is a Fellow and Primary Trainer of the Association for Music and Imagery, as well as being a Registered Trainer for the National Acupuncture Detoxification Association. She has presented at many conferences including: Association for Music and Imagery, National Acupuncture Detoxification Association, American Counseling Association, American Music Therapy Association, NASW Virginia, and Virginia Summer Institute for Addiction Studies. Personally, she loves music (saw the Indigo Girls and Joan Baez recently), nature (walking the Rivanna Trail nearby is a favorite), poetry (David Whyte and writing her own), art (visualize Chicago Art Institute) and travel (recently back from Orcas Island and Vancouver, trip before that Mexico).
E-mail address: cara@caramarinuccilpc.com

2013 Linda Heacock Memorial Fellowship Winner Announced

Randall Rhodes, a student at Regent University, is the winner of the Fourth Annual VACC Linda Heacock Memorial Fellowship. Randall's essay on therapeutic style was chosen from among the many entries. The Fellowship Committee would like to thank all of entrants for their submissions. To continue to encourage student involvement, the VACC Board of Directors would like to invite students to participate in VACC's forthcoming workshops, submit articles to the newsletter, or attend the next Board of Directors meeting. Please contact VACC President Michael Nahl at VACCPresident.com for details on how you can get involved in the Virginia Association for Clinical Counselors.

My Therapy Style

By Randall Rhodes

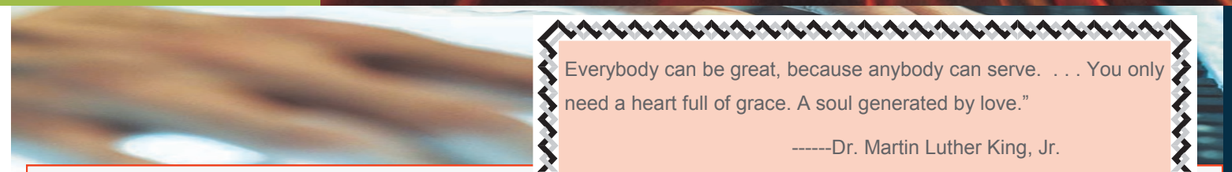
My theoretical approach includes Existential Therapy, Gestalt Therapy, and Rational Emotive Behavior Therapy (REBT). As a brief summary, Existential theory refers to man's desire to find meaning for life. People have an inner drive to find a meaning for existence, influencing an individual's thoughts and actions.

Gestalt therapy is often thought to be a focused subset of Existential therapy, with techniques that help focus the client on thoughts, feelings, and emotions. Gestalt explores major life events in an attempt to find meaning behind the event, rather than its cause. If meaning and understanding can be given to a negative event or experience, the client can gain more understanding in how the event affects life in the present. The goal is to become free from the demands of the past.

The founder of REBT, Albert Ellis, is quoted as saying, "Men are disturbed not by things, but by the views which they take on them." REBT attempts to adjust or "correct" thinking that is leading to suffering or negative behavior. This therapy is commonly summarized as such: A+B = C (activating experiences or events + beliefs = consequence). This therapy is based on the theory that people are not disturbed by the experiences themselves, but rather their beliefs about the experience.

The focus of my therapeutic approach does not focus on the past, but on the future. Unlike a therapist that primarily uses psychoanalytic theory, I am more interested in the client's future. How can we develop decision-making strategies that are more effective for managing problems? There is value in uncovering past wounds and developmental patterns, but there is a danger of remaining stuck in the past. My therapeutic approach takes the client to the past only briefly, to replace cognitive deficiencies with effective processes and affirming words.

My internship experience causes me to lean towards existential therapies. Most of my counseling occurs in a healthcare setting, and I rarely have time for extended therapy with my clients. I usually have three to four sessions at most. So, it is prudent for me to use an effective and efficient means of therapy. Usually, when I first meet with clients, I try to build rapport and learn a lot of background information: "What brought you into the hospital? Do you have family support?" In the second session, I gather additional information, but the client is typically prepared to open up with emotion. I often ask, "How do you feel about your diagnosis? What will life be like once you are discharged?" When we come across negative thinking, we work together to gain perspective on the problem, including the acceptance of an unfavorable diagnosis. I often find that the demands of family members cause the client needless stress which impairs recovery. We discuss goals for maintaining social supports and dealing with frustrations upon returning home. The type of setting in which I work requires me to be less of an investigator and more "in the moment" with my clients.



> Everybody can be great, because anybody can serve. . . . You only need a heart full of grace. A soul generated by love."
>
> ------Dr. Martin Luther King, Jr.

Service as Self Care

By Michael F. Jeffrey, LPC, LMFT, Mitigation Specialist

I would like to address the concept of service in relationship to being a Licensed Professional Counselor.

Professionals of all kinds are expected to provide some kind of pro bono service to needy clients. This could take many forms from volunteering to supervise at a non-profit training staff to do mental health assessments, to lowering your fees with a client who is going through a hard economic time, to advising a pastor or minister about mental health issues brought to his/her attention.

Another form of service expected by most professions is some type of service to a professional organization. This type of service not only helps the profession to which you are a part of but also puts you in the position of having to comprehend the larger issues affecting the profession as a whole. This could take the form of service on the boards of the Virginia Board of Counseling, the national organization: AMHCA, at the state level on VACC, or locally through chapters in Northern Virginia and Charlottesville. There's no doubt that serving on a board is a big commitment. It usually takes at least a year to figure out the issues, relationships and personalities and how you can contribute. If the idea of serving on a board scares you off then let me seduce you with a reward you probably haven't thought of: self care. Every human being struggles with a range of emotional issues of self-esteem, depression, anger, worry that at any time life can be complicated by death, divorce, illness or economic disaster. Therapists, especially, are expected not to let their personal issues or problems affect their work. We are expected to give 100% all the time. We are essentially paid and expected not to have our personal issues come out in our work. When they do, it often leads to serious problems ranging from ethics violations to malpractice lawsuits.

Serving on the VACC board has been for me a good form of self care. I am surrounded by and responsible to a group of non-judgmental caring people who are mutually supportive and honest. It doesn't get any better than that.

Think of how you can be of service and what it can do for you.

Announcing Linda Heacock Memorial Fellowships for 2013-14

VACC has offered the Linda Heacock Memorial Fellowships for the last three years. The two fellowships, of $1000 each, are designed for graduate students in counseling or those who are in the process of attaining their supervised experience. The Fellowships is named after the late Linda Heacock (wife of one of the VACC Past-Presidents) who was known for her generous and kind spirituality.

We have typically offered these fellowships in the form of an essay contest that is judged by a panel of VACC Board members. Last year, we had seven applicants for the two fellowships, which makes for pretty good odds! However, the year before, we had almost 30 applicants. One has to be a VACC member to be eligible.

Recognizing that not everyone is skilled in writing, we plan to offer a fellowship on a random basis to one nonlicensed VACC member who indicates that they want to participate. The other fellowship will be offered in a competitive essay contest as before. Look for notices about the Fellowship process in this newsletter and on our website (www.vacc.org) in the Fall.

Please share this article with colleagues who provide supervision or who teach in graduate counseling programs. We would like to make more counseling students, residents, and those working towards licensure aware of VACC and the work that we do. This is a great opportunity for them to get involved with the state organization and will provide a substantial benefit to the winners. A list of previous winners can be found on our website, as can membership applications. Please join us in spreading the word!

For more information on the Fellowship, go to vacc.org. or contact VACC President Michael Nahl at president@VACC.org. To join VACC, go to membership@VACC.org