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Cover Story

Do the right thing
By Lynne Shallcross
On the surface, ethical behavior would appear to be a straightforward matter, but as counselors quickly discover, many variables are involved in making the “right” decision. Five members of ACA with expertise in counseling ethics discuss situations that commonly trip up counselors and offer insights on thinking through ethical dilemmas more clearly.

Features

ACAC becomes newest organizational affiliate of ACA
By Lynne Shallcross
The Association for Child and Adolescent Counseling aims to provide a professional home for counselors working with young clients in multiple settings, while also striving to highlight the unique developmental and cultural needs of this population.

‘Don’t touch me’
By Stacy Notaras Murphy
Sensory processing disorders are usually thought of in connection with children with special needs, but by learning how these disorders also present in adults, counselors can be a key cog in helping these clients find more comfortable ways of living.

Reader Viewpoint
To have and to hold
By Mark A. Chidley
A licensed mental health counselor and certified addiction professional examines the possibility that unresolved loss, and traumatic loss in particular, is intimately connected to the development of hoarding behaviors.

Extras

FY 2011 election results
A study released by the Substance Abuse and Mental Health Services Administration in February found that 5.9 percent of U.S. adolescents ages 12 to 14 drank alcohol in the past month. Of those who drank, 44.8 percent — or roughly 317,000 members of that age group — said they either had taken alcohol from their home or had received alcohol from a family member, including 15.7 percent (an estimated 111,000) who said they were provided alcohol by a parent or guardian.

According to SAMHSA Administrator Pamela S. Hyde, individuals who begin drinking alcohol before the age of 15 are six times more likely to develop alcohol problems than those who wait until age 21 or older to drink.
What would you do?

The cover story for this issue focuses on ethics issues in counseling. Contemplating this topic and my development as a professional counselor, I must admit that my thoughts on ethical behavior have evolved over time. That is not to say that I was unethical before, but rather that I once viewed others in a certain way depending on how they handled situations in which I thought the “right” response was a black-and-white decision.

Yes, when I was younger, the answers seemed so obvious to me. But as I grew as a professional and truly started listening to the stories and experiences of my clients and students, I began to realize that life is not always black and white. There is so much color and context to life that we miss if we neglect to take the time to listen to what is going on with those we serve as professional counselors.

What Would You Do? is a TV program from ABC News. Its premise centers on placing people in various staged scenarios without their knowledge and monitoring their responses. As I initially watched some of the various scenes unfold, I said with such conviction, “Oh, I know what I would do. I would confront that injustice” or “I would say something to that person who was mistreating the other individual in the scene.” I truly wanted to believe I would react that way if I witnessed such a scene in real life. As I sat there, however, I began thinking about who I was and how my culture has changed since I was a child.

You may be wondering what this has to do with ethics. Give me just a second and let’s see if I can make it come together, because some of you may possess similar experiences. You see, ethics has several different meanings, including a system of moral principles; the rules of conduct recognized in respect to a particular class of human actions or a particular group, culture, etc.; a branch of philosophy that deals with values relating to human conduct with respect to the rightness and wrongness of certain actions and to the goodness and badness of the motives and ends of such actions.

Growing up back in the day in Alabama, I was a child of the neighborhood, so to speak. What I mean by that is that any adult had permission to correct my behavior if she or he saw me doing something I had no business doing. Not only would I get in trouble with that particular adult, but I knew there would be more to come when I got home. I would walk home from school in shame and in fear of how my grandmother would react to finding out I had misbehaved and that someone in the neighborhood had found it necessary to correct me. This was the culture of that time, and the adults’ response was considered proper.

Nowadays, how many of you would feel comfortable correcting someone else’s child or going up to someone and saying, “Baby, you should not be doing that”? I must admit, it’s not as easy to do now as it was back in the day. Today, we are afraid that we will be chastised in some form or fashion for butting in and not minding our own business. As a result, most people these days just sit on the sidelines, shake their heads and say, “What an awful situation that is” or “The child has no home training.”

Continued on page 8
My base education officer got me on track to achieve my lifelong goal of a bachelor’s degree.

— MSgt. Price E. Martin Jr., U.S. Marine Corps (ret.), Bachelor of Science in Liberal Studies, Excelsior College

Whether you’re advising people who need more education to advance in a job, transition from the military, or start in a whole new career field, Excelsior College is a great piece of advice that can make a tangible difference in someone’s life.

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Forks on the left, knives on the right

When I was young and my mother was making dinner, at some point I would hear her say, “Dinner is almost ready. Would you please set the table?” Many of you reading this probably heard something similar in your homes when you were growing up.

Years later, when my son was playing baseball and he came up to bat, I would occasionally say, “OK, Dylan, table is set.” This is of course referred to having runners on base and his being in a position to move those players forward.

Today, I want to share my thoughts about another table that has been set. In this case, the table is set for you, the members of the American Counseling Association. During the past few years, and under the guidance of the ACA Governing Council, your professional association has slowly but surely been reviewing, rebuilding and restructuring its products and services to make them more valuable and relevant to today’s counseling professionals and graduate students. We have done this in light of changing societal issues that you face as professionals. We also embarked on this multiyear change fully aware that if we didn’t make constant improvements designed with you in mind, ACA would no longer be able to help move the profession forward.

As the association begins celebrating its 60th anniversary, “resting on our laurels” doesn’t do anything to provide you with the products, networking and career services that today’s — and tomorrow’s — professionals will need. Some of you have communicated directly with me about what you want from ACA. Others of you have participated in our surveying and focus groups, imparting wisdom and offering suggestions concerning your ACA membership. Then there are those of you who have sent suggestions to ACA via the Web Idea Bank found on our website at counseling.org/webideabank. Regardless of what form of communication you have used to share your thoughts, I appreciate your time in letting us know. We really do take your suggestions seriously, and we work as a leadership/staff team to determine what we can accomplish to meet your professional needs.

Your suggestions and our ability to tend to your needs can be measured by yet another milestone for the association. In January, ACA surpassed 45,000 members — something we have not seen in many, many years. In addition, voting in the recent ACA election resulted in our largest turnout in more than five years. And the ACA Annual Conference & Exposition in New Orleans, taking place March 23-27, will see us exceed $1 million in conference registrations and welcome more than 4,000 attendees, setting another modern-day record for our organization.

We continue to put more services and products online so you can take care of things from wherever you might live or work. Proof of professional liability insurance, continuing education certificates and many other resources are now available through counseling.org. To make sure we can handle all of this digital traffic, the ACA Governing Council approved a plan we put forward this past year to upgrade our technology infrastructure. We want to continue to deliver information to our most valuable asset — our members. Most of this transition will be completed by June of this year.

What’s next? Well, as I noted above, we have “set the table” with you in mind. But we now need you to come in, explore and then let us know what else we can do to help you meet the professional challenges that you face. We are your professional partner, and we are here to serve. So please contact me with any comments, questions or suggestions that you might have via e-mail at rye@counseling.org or by phone at 800.347.6647 ext. 231.

Thanks and be well.
Advocacy efforts still have a way to go

Like Ms. Dominiquie Boyce (Letters, January 2011), I would like to thank the American Counseling Association and my local chapters for their successful effort to break the code and convince the Department of Veterans Affairs (VA) to hire professional mental health counselors. However, I was terribly disappointed to read that only counselors who have graduated from a CACREP-accredited school need apply.

I, too, knew from the time I started my master’s program that I wanted to work with vets. I am a 24-year veteran who understands the stresses and issues that vets face. I have seen in person how vets struggle with addiction and trauma.

Three years ago when I started my program, there were not many CACREP-accredited schools to choose from in my state that were accessible to me. As a student who also had to work full time, I needed a school that allowed me the flexibility to work during the day. I am in my final internship but find that I am still unwelcome by the VA despite my years of experience and the many intangibles I bring to the workplace.

I think CACREP Standards are admirable. Standardization is the hallmark of the military, so I certainly understand the need for it. It brings credibility and accountability to our profession. Until CACREP accreditation is established in a significant number of schools, however, many counselors who have graduated from rigorous programs will continue to be shut out of serving our nation’s veterans. I hope ACA will also advocate for the best care for veterans and not just care from those fortunate enough to have a CACREP-accredited school available to them.

Anne Golembeski, SMSgt, USAF Retired
Master’s Student
University of Phoenix
Albuquerque, N.M.

Correction: In the February 2011 article “Your witness,” Richard Stride was mistakenly referred to as a psychologist. In addition to being a licensed professional counselor in Colorado and a licensed mental health counselor in Washington, Stride holds the National Certified Psychologist credential but is not a licensed psychologist.

FROM THE PRESIDENT

Continued from page 5

Now I know some of you are saying that you definitely know what you would do in situations such as these, and I applaud your conviction. But many of you are unsure of how you would react. Perhaps you even remember a situation in which you wish you had said something but instead walked away.

As counselors, it is ingrained in us to advocate for those who cannot advocate for themselves. It is our responsibility to be actively engaged in our society.

Granted, as I have matured, my formerly black-and-white mind-set has been altered, especially when it comes to claiming what I would definitely do. I have come away saying, “This is what I hope I would do if the situation ever presented itself.” I firmly believe we cannot know exactly how we would respond until we find ourselves in a given situation.

This, for me, is still a great positive. I review my past behaviors and responses and contemplate the definition of ethical or right behavior. I try daily to move beyond the mandatory ethics of my job and life and toward the aspirational ethics of being a social justice advocate.

What would you do? That is a question you must answer for yourself. My answer is, “I hope I would do the right thing for all involved.” That way, I can walk away with peace. ♦
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Spending compromise, government shutdown or both?

As Counseling Today went to press, it appeared a federal government shutdown might take place for the first time in 15 years unless Congress resolved sharp disagreements over spending levels for the remainder of Fiscal Year 2011, which ends Sept. 30.

On Feb. 19, Republicans in the House of Representatives passed a spending bill (H.R. 1) for the remainder of FY 2011 that would cut domestic nondefense discretionary programs by $61.5 billion compared with current levels, including more than $5 billion in cuts from education programs. These cuts would undermine students’ access to school counselors and other necessary services and supports that help thousands of students to succeed in school and life.

The bill would eliminate all funding for the rest of FY 2011 for the Elementary and Secondary School Counseling Program, Safe and Drug-Free Schools grants, the Leveraging Educational Assistance Partnership (LEAP) program, the federal Supplemental Educational Opportunity Grants and the High School Graduation Initiative (formerly known as the School Dropout Prevention Program), among others. The House spending bill would also cut $100 million from the 21st Century Community Learning Centers program, nearly $25 million from Federal TRIO Programs, nearly $20 million from GEAR UP and more than $100 million from the National Health Services Corps. In addition, H.R. 1 would decrease the maximum Pell Grant award by more than $800; prohibit the use of federal funds to implement the Patient Protection and Affordable Care Act; bar Planned Parenthood health centers from all federal funding supporting provision of birth control, cancer screenings and HIV testing services; and cut more than 40 percent of funding from programs from the Community Service Block Grant program, Community Health Centers program and Workforce Investment Act Title 1 programs.

President Obama has promised to veto H.R. 1 should it reach his desk, while Senate Majority Leader Harry Reid (D-Nev.) has stated that massive cuts focusing exclusively on domestic nondefense spending are a nonstarter in the Senate.

With funding scheduled to run out on March 4, a bill to provide two additional weeks of government funding, until March 18, was being enacted. Passed by the House March 1 on a 335-91 vote, the legislation included $4 billion in spending cuts by scrapping funding for earmarks and eliminating programs that the Obama administration wanted to end. Among the cuts were the $250 million Striving Readers program, the $66 million Even Start program, the $88 million Small Learning Communities Program and the $64 million LEAP program.

The two-week extension may not be sufficient for hammering out an agreement on funding levels for the rest of the fiscal year, and the situation remained volatile. The likelihood of at least a temporary government shutdown remained, and the Obama administration was developing contingency plans for supporting some federal employees, including military, law enforcement, direct-delivery health care workers and federal employees paid with money separate from annual appropriations.

The American Counseling Association continues to believe in the importance of federal investments in education and health care services and is working with its partners in Congress and in allied organizations to maintain important programs that are currently under the knife. For more information, contact Dominic Holt with ACA at 800.347.6647 ext. 242 or dholt@counseling.org.

Sanchez champions school counseling bill

On Feb. 11, Rep. Linda Sanchez (D-Calif.) introduced the Put School Counselors Where They’re Needed Act (H.R. 667) to create a $5 million pilot project to support the hiring of school counselors and help reduce dropout rates in at least 10 troubled, low-income high schools. Sanchez has championed this legislation in previous sessions of Congress as well.

Each grant award would be for a term of four years. The bill encourages grantees to hire one additional school counselor for every 250 students identified as being at risk of not graduating high school in four years. Grantees can also use the funds for school counselors’ professional development, for travel expenses for home visits to students and for other services and materials to support this counseling.

We encourage counselors to ask their representatives to cosponsor H.R. 667 to improve access to school counseling services and to improve students’ success. Studies show that providing access to school counseling services can have a positive impact on student achievement that is roughly comparable to the impact of reducing class sizes.

To identify your lawmakers and to read draft text for sending them a letter or an e-mail, visit capwiz.com/counseling. You can also contact your members of Congress through the U.S. Capitol Switchboard at 202.225.3121.

For more information, or to share your school counseling success stories and challenges, contact Dominic Holt with ACA at 800.347.6647 ext. 242 or dholt@counseling.org.
The 112th Congress has begun, and the American Counseling Association is working with other organizations to lobby for Medicare coverage of counselors and marriage and family therapists. This year, we need to find two new sponsors for the Medicare coverage bills because neither the House nor the Senate sponsor of our bills in the previous Congress is still in office. (Rep. Bart Gordon of Tennessee retired, while Sen. Blanche Lincoln of Arkansas was defeated in the November general election). We want to find a new sponsor in each chamber of Congress so counselors can ask both their representatives and their senators to sign on as co-sponsors. This will lay the groundwork for getting coverage of counselors included in broader Medicare legislation expected to be taken up by Congress this September or October.

It has been proved that members of Congress are more likely to be influenced by individual contacts from constituents than by visits from a lobbyist. The more contacts that offices get from constituents, the more likely they are to take action.

From a policy perspective, covering counselors is a slam dunk:

- **Covering licensed professional counselors under Medicare has enjoyed bipartisan support for years.** The Senate has passed counselor Medicare coverage legislation twice already, in 2003 and again in 2005, when the Senate was under Republican control. The House of Representatives has passed counselor Medicare coverage legislation twice already, in 2007 and 2009, when the chamber was under Democratic control.

- **The five-year cost of covering LPCs and MFTs is only $100 million.** This is a very small price to pay for providing much-needed mental health services.

- **Counselors can address mental health provider shortages in rural areas.** There are more than 120,000 LPCs across the country, and proportionately more counselors work in mental health professional shortage areas than do clinical social workers or psychologists (according to A.R. Ellis, T.R. Konrad, K.C. Thomas and J.P. Morrissy in the 2009 article “County-level estimates of mental health professional supply in the United States” in the journal Psychiatri Service).

- **Establishing Medicare coverage of LPCs and MFTs would not change Medicare’s benefit package (such as by establishing coverage of ‘marriage counseling’).** Instead, it would expand the pool of providers available to provide currently covered services. Only medically necessary outpatient mental health treatment would be covered, pursuant to a diagnosis. Services provided by counselors would be covered under the same rules, requirements and reimbursement rates that apply to care provided by clinical social workers under current law.

To be effective, constituent contacts should be personalized. This means that calls and letters should be in your own words and describe your own thoughts and experiences as a constituent of your legislator. If you have been forced to turn away Medicare beneficiaries, write about that. If you had to stop seeing clients after they became enrolled in Medicare, write about that. If you know you want to be able to work with Medicare beneficiaries when you become an LPC, write about that. If you have a friend or family member who is a Medicare beneficiary and needs outpatient mental health care but can’t find a provider, write about that.

Regardless of whether you send an e-mail, write a letter or make a phone call, include your name and mailing address so the legislator’s office can get back to you. Also keep a copy of your contact so you can follow up with the office later if necessary. All members of Congress can be reached by phone through the U.S. Capitol Switchboard at 202.224.3121 and through ACA’s Internet action center at capwiz.com/counseling.

We also invite you to share your concerns or questions regarding the legislation with ACA Director of Public Policy and Legislation Scott Barstow at 800.347.6647 ext. 234 or sbarstow@counseling.org.

**Whom to contact**
Your senators and representatives

**How to contact them**
U.S. Capitol Switchboard 202.224.3121
senate.gov
house.gov
capwiz.com/counseling

**Suggested message**
“I am calling to ask that any Medicare legislation passed by Congress this year include a provision establishing coverage of medically necessary mental health services provided by licensed professional counselors. This is a bipartisan policy idea that has passed both the House and the Senate twice already. Medicare beneficiaries need better access to outpatient mental health services, especially in rural areas, and professional counselors are as well trained — if not better trained — as some currently covered providers. Please work with the American Counseling Association to establish Medicare coverage of counselors’ services this year. Thank you for your consideration.”

**ACA resource**
Scott Barstow
800.347.6647 ext. 234
sbarstow@counseling.org
Helping other counselors build their practice

I met Anthony Centore when he contacted me about becoming a blogger for the American Counseling Association blog project. He is a working counselor with a truly entrepreneurial spirit. Here is his story.

Rebecca Daniel-Burke: What is your current counseling position?

Anthony Centore: I am a counselor at Thrive Boston Counseling and clinical director of Thriveworks, a company that helps counselors build private practices.

RDB: What led you toward a career in counseling?

AC: I took my first psychology course in high school and knew then that I wanted to work in the field. When it came to choosing a career path, counseling felt like a better fit for me than research.

RDB: When did you know you wanted to be a private practitioner?

AC: Almost every counselor wants to be in private practice! The problem is that it’s difficult to execute. So many great counselors end up working multiple agency jobs with a small practice on the side, if at all. That’s why after building my group private practice, which now has 14 clinicians, I started helping others build their private practices.

RDB: How is it different for you working in a private practice setting as opposed to, say, an agency?

AC: In Massachusetts, changing from a private practice to a “community mental health center” involves an unbelievable amount of bureaucratic regulation, and the practice can lose control of its own destiny. We applied a few years ago to be a center, and after about 40 man-hours of site reviews, we were basically approved. But we decided at the 11th hour, “Thanks, but no thanks,” and we’re really happy with our decision to remain a private practice.

RDB: Is there one theoretical orientation that you gravitate toward more than others? Why?

AC: Much of what I do is cognitive therapy, with motivational interviewing and existential philosophy. Lately I’ve been using more storytelling in sessions, which is getting good results. These approaches seem to fit with my personality.

RDB: Is there a particular group that responds well to the type of therapy you practice? Is there a particular group that does not?

AC: Thrive is based in Cambridge, Mass., so the practice gets a lot of Harvard and MIT grads, doctors, lawyers, etc. These groups respond well to my counseling approach. I would definitely need to change the delivery if the population was different, but I think the underlying philosophy is adaptable for most client populations.

RDB: As you look back on your career in counseling, what was your favorite position, and why was it your favorite?

AC: I love what I’m doing now. Clinical work, supervising new clinicians and even the business of building a practice is a lot of fun — and a lot of work.

RDB: Was there someone in your life who saw something special in you early on? Who valued you as a unique individual? Who is your hero?

AC: There are many people who have believed in me over the years and whom I’ve been able to learn from. I don’t know if I have a hero, but I have a list of friends, colleagues, mentors, coaches and counselors who would come pretty close.

RDB: What mistakes have you made along your career path? What lessons have you learned from those mistakes?

AC: There’s an adage, “If you want to succeed, double your rate of failure.” I make plenty of mistakes and sometimes need to eat some humble pie. Thankfully, my team is a forgiving bunch. When I really mess up, I’ll quote Gob from Arrested Development and say, “Michael, I’ve made a huge mistake.” Really, I’ve needed to learn that mistakes are OK and that if I’m going to do anything really unique or special, mistakes and failure are going to be in the mix. This, of course, is advice I also give to my clients and staff.

RDB: Is there a saying, a book or a quote that you think about when you need to be inspired regarding your work?

AC: There’s a quote by Erich Fromm that I like. It sounds a bit pessimistic, but I’ve always found it encouraging because it reminds me that everything is a process and we’re always growing. “It requires productive activity to give life to the emotional and intellectual potentialities of man, to give birth to his self. … Development of the self is never completed. Even under the best conditions, only part of man’s potentialities is realized. Man always dies before he is fully born.”

RDB: It is actually more true than pessimistic. I remember my father, dying at 87, saying, “I want to do so many more things — more fishing, more gardening, and I would like your daughter to teach me to kickbox.” He knew he wasn’t complete. He wanted to learn more, do more.

AC: Yes.

RDB: What do you try to think about or remember when the going gets tough?

AC: I try to remember that in any situation, I get to choose how I feel. Even
These 15 new syllabi were contributed by Barbara Jordan, Lead Faculty of the Counselor Training Program at Wisconsin’s College of Menominee Nation:

- Overview of Substance Use Disorder Counseling
- Professional Readiness & Ethics
- Counseling Theories
- Counseling Skills & Practice
- Group Facilitation
- Psychopharmacology
- Introduction to Human Services
- AODA Assessment, Diagnosis, & Treatment Planning
- Treating the Disease of Addiction
- Basic Interviewing Skills
- AODA Reports & Record keeping
- Overview of Mental Health Disorders
- AODA Internship I
- AODA Internship II
- Human Services Internship I

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Email questions or feedback to syllabus@counseling.org

Rebecca Daniel-Burke is the director of professional projects and career services at the American Counseling Association. Contact her at rdanielburke@counseling.org.

Letters to the editor: ct@counseling.org
A little CBT for the unemployed

According to economists, the United States’ Great Recession ended quite some ago. Even so, frustrations remain high for job seekers.

Unfortunately, recent counseling graduates don’t get a pass, as Crista Gambrell discovered after completing her doctorate in counselor education nearly a year ago. After seven months of searching, she finally landed a position with the Recovery Center in Winston-Salem, N.C. In this month’s New Perspectives column, she shares lessons learned from her job hunt, kicking off a three-part career series focused on students’ questions, concerns and experiences as they leave the classroom behind.

Crista Gambrell

Despite knowing the state of the economy, I admit that I did not expect to be out of work for so long. If you are like me, an eager beaver who went straight through in school and collected all of your degrees in record time, then you were likely blindsided by the difficulty of finding employment in this market. After all, you were able to matriculate all the way through school, check things off your list and successfully jump through all the higher education hoops, right?

So, what happens when things don’t wrap up in a nice, neat bow once you have graduated? Oftentimes, the postgrad blues follow. I’d like to offer some practical tips — learned through personal experience — for coping with the emotions of life after grad school. Let’s start by looking at some common thought patterns that lead to the blues.

The pesky shoulds
The “shoulds” are personal, deeply held beliefs that things have to go a certain way. “I have my master’s or Ph.D. I should be able to get a job with no problem.” The trouble here is that when things don’t happen according to your plan, it can leave you feeling confused and discouraged. The reality is that just because you think things should go a certain way doesn’t mean that they will. Because you can’t control everything, try to let yourself off the emotional hook by letting go of the shoulds.

Jumping to conclusions
Something else that can lead to the blues is the idea that you can suddenly read people’s minds. This is common in social situations. For example, you are already feeling sensitive about being unemployed, so you assume others are judging you. “They never understood why I went back to school anyway. I bet they’re secretly thinking, ‘I told you so.’” Without evidence, you just can’t assume that people take satisfaction in your misfortune. As a rule of thumb, don’t jump to conclusions unless you have actual facts to validate your beliefs.

Taking it personally
A third belief pattern, guaranteed to spiral you down into the doldrums, is that it is all about you. I know firsthand the tendency to torture yourself post-interview: “What did I do wrong? Why didn’t they like me? Was it something I said? That’s just not fair.” You are not responsible for everything. Although it is easy to assume that every rejection letter, ignored inquiry and filled position without so much as an invitation to interview says something negative about you, they really don’t. Save your emotional energy and rid yourself of the belief that every twist and turn of the job search journey is all about you.

Stay connected
Let’s face it. Although there shouldn’t be, there is a shame factor in being out of work. It can be particularly embarrassing to have a graduate or even terminal degree and still hold no full-time job prospects. When times get hard, the tendency is to isolate — even for counselors. I often found myself not returning friends’ calls or avoiding social situations because I was too ashamed to have people ask me about my job search.

Even though everything within you wants to run and hide, don’t. As we’ve undoubtedly told countless clients, having healthy connections can breathe life back into you and give you the needed courage to progress. I’m even aware of some compassionate local businesses that are offering free services such as yoga classes to the unemployed. See what’s available in your area. Outlets such as these provide not only emotional support, but also possible connections. You never know when one phone call, e-mail or chance meeting at a yoga class will yield your next opportunity.

Know your triggers
Most of us probably know how feelings change from one moment to the next, but even counselors aren’t always immediately aware of what triggers that shift — at least not without a moment of self-reflection.

I realized that I started to get depressed on Friday afternoons. Why? Well, for everyone else, the weekend meant two days of recreation and leisure. For me, it meant two days of no new postings, e-mails or calls back until Monday. In your case, it might be Monday mornings, when everyone else but you heads off to work. Anxiety can also sneak up in certain social settings because they mean more questions about a stagnant job search. Once you identify emotional triggers, you can be proactive in dealing with them.

As far as responding to people’s questioning, formulate a response or two that you give to everyone. “It’s tough right now, but I’m hanging in there.” Or “I have a number of irons in the fire, so we’ll see what develops.” On the weekends, schedule a self-care activity, such as yoga, which can help you avoid feelings of isolation.

New Perspectives - With Donjanea L. Fletcher

A little CBT for the unemployed
My life, my story

“My life, my story” profiles individuals new to the counseling profession who are proving to be exceptional. To nominate a student or new professional to be featured in this section, e-mail dfletche@westga.edu.

This month, new professional Stephanie Adams is being spotlighted as creator of Beginning Counselor: The Source for Connection (beginningcounselor.webs.com), a social networking and support website for new counseling professionals. Stephanie also cofounded a counselor community group in Texas.

Age: 26

Current residence: Dallas/Fort Worth, Texas

Education: M.A. in counseling from Dallas Baptist University; B.A. in family psychology from Oklahoma Baptist University

Proudest professional accomplishments: Being in a fulfilling career after years of working odd jobs to get through school; becoming a blogger for the American Counseling Association website; cofounding the Counselor and Psychotherapist Network of North Texas group with Diana Pitaru; and starting my website.

Biggest challenge as a new professional: Having faith in myself. Because being a counselor is an important role that requires much learning, it’s easy to feel inadequate, especially when starting out. Supervision in a supportive and empowering environment helped me find my balance.

Words of advice for new professionals and students: Tip No. 1: Take your fate into your own hands because your career is what you make of it. It will require creativity, flexibility and patience. Tip No. 2: I consider this my best advice. Don’t forget that no matter what level of education you have, you have the power to impact others in a unique and necessary way. You are the only one who can do what you do.

For now, just take things day by day and be kind to yourself. Once you survive the moment and navigate this transition, you will be able to share more authentically with future graduates and future clients how you coped thanks to a little CBT for the unemployed.

Donjanea L. Fletcher is a student affairs counselor at the University of West Georgia. If you are a student or new counseling professional who would like to submit a question or an article for this column, e-mail dfletche@westga.edu.

Letters to the editor: ct@counseling.org

April 2011 | Counseling Today | 15
Managed care update 2011

We have revised our list of insurance and managed care companies because of the ever-changing nature of the industry. This past year included many mergers among these companies.

Counselors should note that these changes could offer more opportunities as these companies expand into new areas. This is a good time for counselors to consider applying to become providers. Remember, persistence will pay off when applying to become a provider or even when asking to be considered for an increase in reimbursement rates.

As a service to American Counseling Association members, this column includes the short list of the largest insurance and managed care companies. The full list of nearly 60 companies is available to ACA members at counseling.org/Counselors/PrivatePracticePointers.aspx. That list has direct links to provider relations information on the web as well as details outlining the number of insured lives covered, necessary paperwork and reimbursement rates. We believe this is the most comprehensive information available. Information on the number of covered lives is taken from a study by Harvard University’s John F. Kennedy School of Government Mossavar-Rahmani Center for Business and Government. We compiled information regarding payment and paperwork requirements from insurance and managed care websites as well as surveys of licensed counselors.

Top 11 insurance, managed care and employee assistance providers

<table>
<thead>
<tr>
<th>Company Name</th>
<th>Type</th>
<th>Coverage</th>
<th>Address</th>
<th>Phone Numbers</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Magellan Behavioral Health Services</strong></td>
<td>(national)</td>
<td>24 mln</td>
<td>5565 Sterret Place, Suite #500, Columbia, MD 21044-2611</td>
<td>800.788.4005, magellanprovider.com</td>
<td>$60 with $20 copay, 20 visits per year, preauthorization needed, medium amount of paperwork</td>
</tr>
<tr>
<td><strong>ComPsych Behavioral Health Corp.</strong></td>
<td>(national)</td>
<td>10.9 mln</td>
<td>NBC Tower 24th Floor, 455 N. City Front Plaza Drive, Chicago, IL 60611</td>
<td>800.557.1005, compsys.com/jsp/en_US/core/provider/credentialing.jsp?cid=46</td>
<td>$60 total, $10 copay/EAP $30, $0 copay, extensive paperwork and utilization review</td>
</tr>
<tr>
<td><strong>ValueOptions</strong></td>
<td>(national)</td>
<td>24 mln</td>
<td>P.O. Box 46270, Eden Prairie, MN 55344</td>
<td>800.397.1630, 888.800.8849 ext. 7064, 800.274.7603 (Michigan and New York)</td>
<td>valueoptions.com/providers/Providers.htm $73 initial assessment, $65 total, $55 with a $10 copay, fast payments</td>
</tr>
<tr>
<td><strong>Aetna/Horizon Behavioral Healthcare</strong></td>
<td>(national)</td>
<td>20 mln</td>
<td>UOP Station, P.O. Box 2907, Minneapolis, MN 55402</td>
<td>800.353.1232, aetna.com/provider/credentialing.html</td>
<td>$75 initial session, $65 individual psychotherapy session (will negotiate)</td>
</tr>
<tr>
<td><strong>OptumHealth Behavioral Solutions</strong></td>
<td>(national)</td>
<td>43 mln</td>
<td>6705 Rockledge Drive, Suite #200, Bethesda, MD 20817</td>
<td>800.888.1965, apshealthcare.com/provider_relations_contacts.aspx</td>
<td>$60/$40 insurance, $20 copay, moderate paperwork</td>
</tr>
</tbody>
</table>

**Blue Cross/Blue Shield (various states)**

Covers 98 million lives
Each state has its own Blue Cross/Blue Shield franchise
bcbs.com/bluefinder/
Also affiliated: Empire Blue Cross/Blue Shield (New York); Anthem Blue Cross/Blue Shield/Wellpoint (national)
anthem.com/home-providers.html

**CIGNA (national)**
Covers 9.4 million lives
P.O. Box 46270
Eden Prairie, MN 55344
800.442.2353
888.800.8849 ext. 7064
274.7603 (Michigan and New York)
cigna.com/health/provider/
$50 in network plus $10 copay, extensive paperwork

**Ceridian/Lifeworks (national)**
Covers 7 million lives
800.367.3920
ceridianprovidersolutions.com/Pages/BecomeAProvider.aspx

**Aetna/Horizon Behavioral Healthcare (national)**
Bought Horizon Health
Aetna/Horizon combined covers 20 million lives
UOP Station
P.O. Box 2907
Minneapolis, MN 55402
800.353.1232
aetna.com/provider/credentialing.html

**Wellpoint/Anthem/UniCare (national)**
Covers 13.7 million lives
San Diego, CA
800.728.9493
Call for provider application
wellpointbehavorial.com/pro/pro_index.html

**OptumHealth Behavioral Solutions (national)**
Formerly United Behavioral Health
Covers 43 million lives
ubhonline.com/cred/credIndex.html
optumhealth.com/Solutions/Providers
$80 initial assessment, $65 individual
Q: I have had some difficulty getting included as a provider on managed care and insurance lists. Can you give me some tips on how to approach this issue?

A: The following strategy has been used successfully in responding both to denials by an insurance claim and to refusals to allow a clinician to become a member of a managed care panel. For the most effective response, both the client and the counselor should send a letter.

First, the client sends a letter to the managed care or insurance company explaining why he or she wishes to see a particular licensed counselor. A copy of the letter is sent to the client’s company benefits manager.

Next, the counselor sends an appeal both to the client’s employer benefits manager and to the managed care or insurance company outlining the counselor’s credentials and stating the reason why the client was referred to the counselor. Always have the client sign a release so this letter can be sent.

A more detailed description of this strategy, including examples of how to use these letters in working with managed care, is available at counseling.org/Counselors/PrivatePracticePointers.aspx.

ACA members can e-mail their questions to Robert J. Walsh and Norman C. Dasenbrook at walshgasp@aol.com and access a series of “Private Practice Pointers” on the ACA website at counseling.org.

Letters to the editor: ct@counseling.org
Resource Reviews

**Child-Centered Play Therapy: A Practical Guide to Developing Therapeutic Relationships With Children**


Students and clinicians interested in exploring the play therapy niche need a comprehensive guide that leads them from theory to application. Three self-described “child-centered nerds” — Nancy H. Cochran, William J. Nordling and Jeff L. Cochran — have put together an extensive and thoughtful resource on child-centered play therapy (CCPT) that does just that. Child-Centered Play Therapy provides readers with an understanding of CCPT, from its creation to current methods, with a tone that communicates the authors’ enthusiasm for its effectiveness.

This resource is grounded in theory and research but driven by the vision of application. For each skill and approach introduced, a rationale is outlined for why a therapist would make the clinical decision. Seminal and current research, as well as meta-analyses addressing the effectiveness of the techniques, is included. Each chapter is infused with vignettes and examples that help the material come to life in a clear way for the reader. Attention is also focused on the play therapist as an individual in terms of how CCPT plays a role in professional development.

This text differs from other currently available CCPT textbooks in four ways. First, information is included on how play therapists can introduce and advocate for CCPT with parents, teachers and principals by helping these stakeholders understand and support play therapy. Second, explanations for setting CCPT goals, planning treatment, writing notes and evaluating child progress in session are included with examples. Third, a chapter focuses on the ongoing development of the play therapist after initial education and training is obtained. Fourth, ethical and legal concerns specific to CCPT are highlighted and discussed.

This reference would be useful in master’s- and doctoral-level graduate courses on counseling children or CCPT specifically. It would also be an excellent reference for professional counselors who are new to CCPT and seeking supervision to build CCPT skills. The book is clearly written and inspires the reader throughout to be passionate about this modality.

Reviewed by Michelle Perepiczka, core faculty in mental health counseling at Walden University.

**The New Handbook of Administrative Supervision in Counseling**


The New Handbook of Administrative Supervision in Counseling is a must read for counselors, counselor supervisors and counselor educators. This nicely written text serves as a guide for counselors training to be supervisors or those who would like to enhance their current supervisory relationships. Counselor educators should implement this reading into training for practicum and internship site supervisors.

The handbook is divided into six sections: Defining Administrative Supervision in Counseling; Administrative Supervisors: Promote Client Welfare; Administrative Supervisors: Ensure Their Departments Contribute to the Quality of Their Agencies’ Services and Service Delivery Systems; Administrative Supervisors: Supervise, Lead, Manage and Administer the People Who Report to Them to Help Each Individual Advance Toward Optimum Performance, Productivity and Job Satisfaction; Administrative Supervisors: Design, Maintain and Improve an Effective and Efficient Service Delivery System for Clients; and Administrative Supervisors: Strive Continuously for Excellence in Fulfillment of Their Administrative Supervision Responsibilities.

The first section frames the functions of an administrative supervisor in the counseling field while attending to the roles and responsibilities of counseling supervisees. Author Patricia Henderson defines these functions and roles, which include providing the best possible counseling to clients of diverse backgrounds, working toward goal fulfillment of the counseling facility and attending to policy and procedure. Counseling contexts are discussed in mental health agencies, hospitals, schools, colleges and universities, and other settings. Henderson then clearly presents five responsibilities of a supervisor administrator in the subsequent sections.

When one supervises other counselors, it can be easy to forget that behind all the ins and outs of managing the agency, the primary concern should be for client welfare. Henderson does an excellent job of reminding readers of this priority. She creatively infuses specific ideas for implementing client-focused services and developing a vision for an agency.
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She also discusses ways to be attentive to diverse populations. The importance of upholding relevant professional standards is clearly presented, and the field’s leading professional organizations are referenced. Current trends in the literature highlighting effective ways to implement consequences for noncompliance are included as well.

For counselors to provide clients with the best possible care, counseling agencies must function in effective ways. This text highlights strategies for carrying out a mission, policies and procedures, all while communicating effectively. Henderson makes it a point to discuss the essential role that counselors play in advocating for clients and the importance of carrying out this task on a regular basis. Multiple ideas for success are provided, including ways to implement an advocacy plan.

Henderson makes it clear in her writing that supervisors must be willing to strive for excellence if they are to lead and manage people and administer effectively. Supervisors must also work to establish relationships that are meaningful, and this handbook provides specific ways of pursuing those relationships. The idea of establishing high expectations is helpful in reminding us that it is essential to maintain our counseling skills and avoid becoming complacent in our work.

Related to this issue, Henderson states the necessity of attending to counselor development and supervision, reinforcing the reasons why supervision in counseling is ongoing and imperative. She makes multiple figures available to assist administrative supervisors in creating supervision plans.

In addition to highlighting methods to achieve continued improvement within an agency, this text also provides helpful tips for managing files and necessary documentation. Lists of specifics to keep in employee personnel files and counselor daily time logs are included. Documents such as these make this text even more valuable because it serves as a quick reference manual for the busy professional.

This handbook reminds supervisors that it is essential to be accountable for their own supervisory style. A good leader can facilitate change and growth for professionals in helpful and healthy ways, and this text is a valuable resource in that process.

Reviewed by Carrie Alexander-Albritton, assistant professor at Western Illinois University.

God Is Not One: The Eight Rival Religions That Run the World — and Why Their Differences Matter

As a way to promote effective integration of spirituality into counseling with clients, competencies were developed that suggested counselors should have a sensitivity, understanding and acceptance of diverse belief systems. God Is Not One is a tool that can promote this knowledge, especially given Stephen Prothero’s ability to clearly describe the world’s major religions and how their existence impacts individuals as well as interactions on the social, political and global stages. Although not written specifically for counselors, counselors will no doubt find their previous assumptions challenged in ways that will promote competency in working with diverse populations.

Prothero begins by discussing why he thinks his book is necessary and arguing against the universalism perspective that assumes that every religion’s core is basically the same. This part of the conversation is important for counselors to hear. Although universal core values among religions do exist, it is a disservice to assume that differences do not matter to the clients whom counselors serve.

As Prothero states early on, “The world’s religious rivals do converge when it comes to ethics, but they diverge sharply on doctrine, ritual, mythology, experience and law. These differences may not matter to mystics or philosophers of religion, but they matter to ordinary religious people … differences do not just matter to religious practitioners. They have real effects in the real world.”

After finishing this book, readers will have a clear grasp of those differences and their effects.

In the remaining chapters, Prothero describes eight major world religions: Islam, Christianity, Confucianism, Hinduism, Buddhism, Yoruba, Judaism and Daoism. Although he covers the basic tenets of each belief system, including important concepts and the belief system’s historical and political contexts, he also provides a helpful framework for understanding how the religions are very different in their goals, intents and techniques. For example, within each religion, there is a problem and a solution. With Christianity, the problem is sin and the solution is salvation; with Buddhism, the problem is suffering and the solution is awakening. This might offer readers a new way to conceptualize each religion and help them to recognize the fundamental differences between religions. These types of comparisons could be used as the impetus for reflections or for class discussions on how these different intents might impact an individual’s development.

Prothero also addresses misconceptions, stereotypes and debates that exist among and about each religion. For example, he explains the potentially controversial concept of jihad in Islam and the debate that exists among believers about the meaning and implications of this idea. He does not attempt to brush over these aspects or attempt to provide a scholarly resolution. Instead, the author challenges readers to grasp the complex realities that exist. He recognizes that these complexities also exist for the practitioners of each religion, which can result in internal struggles. “One of the challenges for practitioners of any religion,” Prothero writes, “is wrestling with elements in their tradition that have

Are you interested in reviewing books for Resource Reviews? If so, contact section editor Kelly Duncan at Kelly.Duncan@usd.edu.
been used to justify evil and then bending those elements back toward good.”

Prothero also shares his personal reactions to reading various religious texts. This is an important aspect of his writing because it encourages self-reflection, modeling a way that readers can engage with spiritual ideas not traditionally their own. Counselors can follow his example, asking themselves to be affected by what they read and then reflecting on those reactions. Rather than staying distant by merely being immersed in facts, readers of this book are obliged to grapple with how the different belief systems intersect with their own. Students in a counseling class could dialogue about their reactions and how their personal experiences influenced those reactions.

Prothero has a casual writing style that makes the information easy to digest. As a caveat, however, it is possible that practitioners of a specific religion might disagree with or be insulted by his descriptions. For example, he writes that Buddhism is like a fairy tale. Although not all of his word choices would be considered sensitive, it is further evidence that his personal lens is part of the discussion. Plus, these potential instances of dispute can be embraced as opportunities for readers to engage in important conversations.

Given the value of spirituality and religion in people’s lives, and the common misperceptions about the topic, God Is Not One is an important addition to counselors’ libraries. It is sure to prompt important discussions and a greater understanding of the diverse world in which we live.

Reviewed by Sonya Lorelle, a counseling student at Old Dominion University.

Kelly Duncan is an assistant professor in the University of South Dakota Division of Counseling and Psychology in Education. Contact her at Kelly.Duncan@usd.edu.

Letters to the editor: ct@counseling.org
I have always had a love affair with the cinema.” Sounds like the opening line of a great film, but it’s actually a statement of truth about me as a person and a counselor.

My love affair started early in life when movies were shown only in theaters and when CGI referred to the third, seventh and ninth letters of the alphabet, respectively, rather than to computer-generated imagery. As a young child, movies became my Saturday afternoon sitter. My sister and I would watch old TV serials sponsored by the local chamber of commerce at the movie theater while our parents shopped.

My first venture to a serious film occurred when my father, no longer able to resist all the watercooler conversation, sprung for tickets so the two of us could see 2001: A Space Odyssey in its first run at the cinema. I was hooked. So much so that in my undergraduate studies, I completed a minor in aesthetic English, which for me was a respectable way of saying that I was watching films. There is nothing more satisfying and relaxing for me than to sit in a dark theater, completely immersed in the virtual experience of film. This passion for the celluloid arts has been passed on to both my children and has continued to reward me with some wonderful shared family experiences.

A whole thread of work has evolved around the use of film with clients. It is known by a variety of names, including cinematherapy, movie therapy and reel therapy. As a professional counselor, I have used metaphors from movies to initiate conversation with clients. Sometimes these cinematic metaphors have captured the client’s experience perfectly; a few times, they have missed the mark completely. Once, when working with a father who was trying to resolve conflicts with his adult son, I was inspired to suggest that he see Paul Newman in Nobody’s Fool. The client returned the following week, said he had gone to see the movie and informed me that it was obvious he had not experienced the film in the same way I had.

Regardless, all of us have been moved emotionally by certain films. Transferring that experience into the counseling setting so that it has a clinical impact, however, takes knowledge and skill.

**Understanding cinematherapy**

Perhaps you have never considered how counselors might use movies as part of the counseling process. The following links provide some overview and examples of using movies to work with clients.

- Cinematherapy article from Salon.com: tinyurl.com/45m4hy3
- “Cinematherapy — Reel Help for Real Problems”: tinyurl.com/4jponnc
- Can watching movies improve your mental health?: tinyurl.com/62oa365
- Film therapy article: tinyurl.com/4alrbjg
- TILT Magazine “Reel Culture” column: onlinetherapymagazine.com
- “Movies as Therapy” posting on PsychoBabble blog: tinyurl.com/4brds9
- “Movies and Psychotherapy = Cinematherapy” from Psychology Today: tinyurl.com/4rtnfvn
- How movies stir up emotions: tinyurl.com/4gph8l
- Introduction to cinematherapy by Birgit Wolz on YouTube: tinyurl.com/6aewkzm

**Movie indexes**

Some counselors have collected and organized lists of popular films by mental health topic area and made them available online. Reading through these lists reminds us of how often the nature of human concerns is central to the Hollywood formula. If you are looking for the perfect movie for a client or to serve as an instructional piece for trainees, the following sites will provide plenty of ideas.

- Cinematherapy.com film index: tinyurl.com/24dnvco3
- Brooke J. Cannon’s Psychmovies.com: Psychmovies.com
- Zur Institute’s Therapeutic Themes and Relevant Movies: tinyurl.com/4q3udog
- Christiananswers.net’s Movies for Therapy: tinyurl.com/5rodnene
- Rhonda Mills Sommer Therapy Ideas Movies: tinyurl.com/4dace375
- Fajita’s Blog posting on therapy in TV and movies: tinyurl.com/6yhnmmor
- Serenity Online Therapy’s recommended movies for healing and personal growth: tinyurl.com/5f5fimnn
- Holistic healing movies: tinyurl.com/6j6bwb
- Existential movie recommendations: tinyurl.com/4uxy23g
- Movies that show group counseling: tinyurl.com/4ncmsuw
- Movies that provide therapy and understanding: tinyurl.com/4ax99k
- Films that demonstrate pathologies: tinyurl.com/6a9bxob

**Using movies in counseling**

The ways in which popular movies are used in counseling and counselor training vary from showing short clips to drive home a specific point to viewing a complete film and reflecting on the themes. If the movie is so popular that it has become a universal cultural icon (Star Wars, for example), counselors may be able to reference the metaphor or concept without actually showing the film. The following articles share stories of how movies have been incorporated into the counseling process.

- “Movie Therapy: Do You Believe in the Healing Power of Film?”: tinyurl.com/4se8xfj
“Movie Therapy: Using Movies for Mental Health”: tinyurl.com/32x3d3b
“Reel Therapy”: tinyurl.com/4qqwyyw
“Guidelines for Watching Films: Watching Movies With Conscious Awareness”: tinyurl.com/46nlbfzb

Practitioner sites
A number of counseling professionals have focused their practice and work on enhancing the therapeutic experience through the use of movies. One of the larger resource sites is Birgit Wolz’s Cinematherapy.com. She has extended her thinking to consider the mythological and archetypal themes that emerge from films. Wolz considers the multiple ways that films can be used in counseling to evoke emotion, to prescribe learning and to reach catharsis around an issue.

- Birgit Wolz’s Cinematherapy.com: cinematherapy.com
- Bernie Wooler’s Movie Therapist: themovietherapist.com
- Gary Solomon’s Movie Doctor: cinema-therapy.com
- Cinematherapy.com Professional Directory: tinyurl.com/4nw2vj9

Research and resources
As using cinema for counseling and training became more popular, so did efforts to describe the cinematherapy process and to study its impact in various settings. With more counselors expressing an interest in using this approach, some great research and resources are becoming available. What follows are some training opportunities, individual research articles and a listing from Google Scholar.

- Cinematherapy.com certificate course: tinyurl.com/4suq7af
- Cinematherapy.com bibliography: tinyurl.com/4dlbgg
- Clinical Psychiatry News article on film therapy: tinyurl.com/4qj4cr
- “Movies as Metaphors: A Counseling Intervention”: tinyurl.com/67xuyf
- “Teaching Theories of Couples Counseling: The Use of Popular Movies”: tinyurl.com/5w3x2lp
- “Improving the Empirical Credibility of Cinematherapy”: tinyurl.com/4bmg6t
- Cinematherapy and counseling (Google Scholar): tinyurl.com/4bmng6l

Video film therapy
An interesting twist on the idea that clients or students should watch a commercially produced film to better understand themselves or a counseling construct is for clients or counseling students to create their own movies. Counselors can encourage clients to shoot a video of meaningful portions of their life so they can watch the material together and discuss it in session. Using a method called digital storytelling (which The Digital Psyway spotlighted in December 2009), clients or students can construct a video story of a portion of their lives using historic pictures, symbols and artifacts. In another process similar to Norman Kagan’s Interpersonal Process Recall, some counselors have clients review video from their counseling sessions so they can develop their own ideas about how they appear to others.

- Psychological Perspectives’ explanation of video therapy: tinyurl.com/4rzj3x
- Rodney Karr’s summary of video film therapy: tinyurl.com/4lqmuqn
- Digital Storytelling for Counselor Educators: tinyurl.com/4boeam3

As a counselor educator, I continue to use film as metaphor in my teaching. I find that it helps students become familiar with abstract concepts if they can relate them to popular culture that they already understand. To familiarize my students with online discussion posts, I ask the question, “What is your favorite movie?” I always get an active discussion and plenty of strong opinions.

My favorite movie! Citizen Kane.

You can find these and other links on The Digital Psyway companion site at digitalpsyway.net. Did we miss something? Submit your suggestions to the author at mjenci@kent.edu.

Marty Jenci is an associate professor of counseling and human development services at Kent State University.

Letters to the editor: ct@counseling.org

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Counselor, interrupted (by cancellations)

Learning Curve: Notes From a Novice is a new column that will explore the unique challenges fledgling counselors face during their transition from the Ivory Tower of graduate school to the Real World of clinical practice. Each column will focus on a single topic as viewed through the lens of a postgrad intern in mental health counseling. Students, new professionals, supervisors and seasoned counselors alike are invited to suggest topics, offer comments and share their experiences in future columns. Contact Suze Hirsh by e-mailing her at ct@counseling.org.

All within the same week this past August, I received notification that I had completed my master’s in mental health counseling and had been hired by a local agency for my postgrad internship. I felt like a kid with a kite on a blustery day.

Two months in, the winds shifted. My caseload nose-dived like an errant kite, snarled in a tree and going nowhere. Week after week, my average client face time remained stuck at a measly five or six hours per week, far short of my goal of 12 to 15 hours. Deep inside, a part of me was begging to cut and run.

I snarked to my husband and close friends about the parade of no-shows and last-minute cancelers. Discouraged at work, I became a clock watcher. Following 15 minutes of tick-tocks at the top of each hour, alone with myself in a borrowed office, I’d pick up the phone to check in with the absent client. Take a breath. Dial the number. Stifle a sigh before speaking. “I encourage you to commit to counseling. You deserve a safe place to vent.”

My desperate pleas fell on deaf ears — or, more often than not, were recorded in unanswered voice mails. I had done my part and offered valid reasons for my resistant clients to keep their appointments. To be absolutely honest about my intentions at that point in the internship, though, I was equally concerned about upping my hours.

Later, following a whiny sniffle during yet another sob session with a close friend, I got a reality check. My straight-talking pal reminded me that we all have to “pay our dues” when starting out in a new profession. This friend happens to be an attorney — a counselor of the courts, not of the psyche. Yet, intuitively, she had guided me to a classic therapeutic tool. At her prompting, I practiced what I recently had been trained to preach. Duh! This situation begs for a “reframe.”

Here’s what I came up with: My new field of endeavor, mental health counseling, looms before me with its hand of the psyche. Yet, intuitively, she had guided me to a classic therapeutic tool. At her prompting, I practiced what I recently had been trained to preach. Duh! This situation begs for a “reframe.”

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In fact, I had chosen to work at this agency because (full disclosure) it is only 22 minutes from my home in rush-hour traffic. The other opportunities I had cultivated were 45-minute commutes at best. More than that, I had been drawn to an easy rapport with the agency’s clinical director, who now is my supervisor. Our first conversation felt more like a friendly chat between a mentor and her student than a job interview.

Given that, my anxiety level over consulting on this issue remained rather low — maybe a 3 on a Likert scale, where 10 is tachycardia and 1 is a vegetative state.

“So what’s the protocol here?” I asked. “How many times do I need to call to make sure I fulfill my ethical duty to the client?”

“Well,” Supervisor responded, “how many times have they no-showed or canceled?” I initially heard a tinge of accusation in her tone, then quickly realized I was projecting, likely due to the fact that I felt guilty about wanting to cut loose these recalcitrant clients. Time for another reframe: I had interpreted Supervisor’s question as critical when, in reality, it had been simply direct.

“I waited to bring this up until most of them had three strikes,” I said, “but I feel bad about cutting them off.”

“You’ve called to follow up with the client when this happens, right?” This time I felt like a teen being scolded by her mom. “You did your homework before you started video-chatting, right?”

Reframe: A competent supervisor probes for information to assess the appropriate level of guidance to offer the supervisee. Fortunately, this meant score one for me because I had called to follow up. Multiple times, in fact.

“What kind of reasons are they giving you? Are their cancellations and no-shows consistent?”

“Yes, most every one of them is three in a row. Or some of them have come only once in three weeks. Either they say they have transportation issues, or they’re sick, or maybe they were called into work at the last minute.” These represented my so-called “established clients.” Then there were the others, who had scheduled an initial appointment but had yet to materialize before me.

I shared how one prospective client called to cancel, reporting an earache. “My ear is killing me,” he lamented. “I’m really sorry about this.” This had been his first false start, about two hours before appointment time.

My desperate pleas fell on deaf ears — or, more often than not, were recorded in unanswered voice mails. I had done my part and offered valid reasons for my resistant clients to keep their appointments. To be absolutely honest about my intentions at that point in the internship, though, I was equally concerned about upping my hours.
He was also a no-show for the reschedule but called the next day to apologize profusely. He explained that a case of cold feet had left him frozen in his tracks, unable to get into his car to drive to the appointment.

The third time this would-be client canceled via voice mail, delivered after business hours the night before the appointment. He offered the following excuse: “My friend is moving tomorrow and needs help loading the U-Haul. He helped me move once. I felt like I couldn’t not help him, so I told him I would be there to help with the heavy lifting.”

Peering over the top of her reading glasses, Supervisor indicated she was ready to hand down her ruling. “You’ve done your duty,” she said, glancing down again at the yellow legal pad in her lap and jotting down some notes. “I’ll tell Intake you’re ready for some more new clients.”

When she looked up, Supervisor must have detected residual guilt clouding my expression. Pulling off her glasses and tilting her head sympathetically, she gave a little sigh. “It’s tough. Those are very real issues — not having a way to get here or having to choose between working that day and coming for their session. I get that.”

But sometimes, she explained, those are simply excuses. Clients sign up for the counseling process and then realize they’re not ready to face their stuff. They get overwhelmed. And that’s OK. “When they’re ready — if they’re ever ready — they’ll come back, to you or to somebody else,” Supervisor said. “Don’t take it personally.”

“Besides that, it’s not fair to you that they hold spots when you could be scheduling other clients,” she concluded matter-of-factly. “You’ve got to get your hours.” I learned that, sometimes, Supervisor’s directness isn’t necessarily a bad thing.

With that, I decided to stop chasing my no-shows and cancelers — after a second chance or three, of course. Once again I reframed: When I allow the resistant ones to fall away naturally, I create space for motivated clients who will show up and keep showing up.

Predictably, my last client that day had canceled, so after my heart-to-heart with Supervisor, I ducked out. While zipping along the interstate for the short commute home, I picked up voice mail from the office. I heard a familiar voice. It was earaching/cold-feet-suffering/stuffy-head-fever-so-you-can-rest guy, requesting to reschedule again. Clearly, I had reached a choice point. Should I grant him a fourth chance?

Pulling up to a red light at the end of the exit ramp, I took a moment to stop and consider. This guy had called back (sometimes twice) after each missed appointment to apologize and request a reschedule. Maybe he just needed a compassionate push. Maybe I could make his resistance work for me as a sort of opening to establish rapport.

Before the light turned green, I dialed *67 plus his number. (Supervisor had cautioned me that when calling clients from outside the office, I should take care to block my private number.) He picked up on the second ring. “Thank you for calling back,” he said enthusiastically. Then, remorsefully, “I’m so sorry I had to cancel again. I know I really need to start dealing with my issues.”

I validated, gently confronting him with my hunch that something was holding him back. He seemed relieved that I had asked the question. In the end, he explained that he had tried therapy years before and had a less than positive experience with the process. He had abandoned after “a couple of sessions.”

“Would it make a difference for you if I shared my philosophy about therapy?” I asked.

Long pause. Then tentatively, “Well, maybe.”

“First of all, we would work as a team, going only as fast as the slowest part of you feels safe to go.” (That last bit is a lyric cribbed from the Karen Drucker song, “Be Gentle With Yourself.”)

We talked a little bit more about his presenting issue, and I asked him to think of this first appointment as a one-time-only, zero-obligation meeting, after which he could decide whether he felt we were a “good fit” and whether he wanted to continue. (That strategy had come from a coworker’s comment at my agency’s peer supervision meeting the previous week.)

Apparently, the fourth time is the charm. The client rescheduled, kept the appointment and hasn’t missed since.

Note: These columns use some illustrations from real clients’ lives. However, to protect confidentiality, these illustrations generally are composites or have been fictionalized enough that the original model for the story cannot be traced. In some instances, clients have given signed consent for their cases to be discussed. ☞

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Is grief no longer normal?

The American Psychiatric Association (APA) Mood Disorder Work Group has proposed a controversial revision in the upcoming fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5): elimination of the bereavement exclusion criterion from major depressive episode. The term bereavement refers to the grief reaction associated with the loss of a loved one. The bereavement exclusion requires counselors to differentiate between “normal” grief reactions and a major depressive episode. Consider the following examples:

Client A visits a counselor with complaints of persistently low mood, lack of interest in her normally enjoyable activities, difficulty falling asleep, inability to concentrate and poor appetite. She has not experienced physical health problems. One month ago, her husband passed away.

Client B sees the same counselor and presents with the same symptoms as Client A. Rather than his spouse passing away, however, he lost his job one month ago and his spouse left him.

Both clients have symptoms of major depressive disorder. However, under the current edition of the DSM, only Client B can be diagnosed with major depression. This is because of the bereavement exclusion criterion, which has existed within the major depressive episode criteria since the publication of the DSM-III in 1980.

The aim of the bereavement exclusion is to identify individuals who are experiencing normal grief reactions to a loved one’s death, which often symptomatically resemble a major depressive episode (that is, symptoms of daily depressed mood, trouble sleeping, loss of appetite, loss of interest in activities and trouble concentrating). Standing alone, these symptoms meet five of the nine criteria for a major depressive episode, indicating a diagnosis of major depressive disorder. Within the context of bereavement, however, these symptoms do not warrant a clinical diagnosis.

So when does grief go beyond a normal reaction and become “pathological,” allowing for a depression diagnosis? The bereavement exclusion criterion states that bereaved individuals cannot receive a major depressive episode diagnosis unless their symptoms persist longer than two months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms or psychomotor retardation.

Because Client A has experienced the death of a loved one, she cannot be diagnosed with major depression unless her symptoms are more severe or persist for longer than two months; however, she can be diagnosed with the bereavement V Code — a clinical condition that is not a mental disorder. The bereavement V Code describes grieving individuals as having symptoms characteristic of a major depressive episode (for example, sadness, insomnia, poor appetite and weight loss), while also identifying symptoms that are not characteristic of a normal grief reaction but more indicative of major depressive episode. These include:

- Guilt about things other than the actions the survivor took or did not take at the time of the loved one’s death
- Thoughts of death other than the survivor feeling that he or she would be better off dead or should have died with the deceased
- Morbid preoccupation with worthlessness
- Marked psychomotor retardation
- Prolonged and marked functional impairment
- Hallucinatory experiences other than thinking that he or she hears the voice of, or transiently sees the image of, the deceased person

Reasons for eliminating the exclusion

The DSM-5 Mood Disorder Work Group proposes to eliminate the long-standing bereavement exclusion because, according to the APA’s DSM-5 website, “evidence does not support separation of loss of loved one from other stressors.”

Many behavioral or psychological reactions represent normal responses to common losses and stressors. Studies examining whether depression differs for bereaved and non-bereaved individuals have found, in general, no significant differences in symptomology between the two groups. And yet, bereavement has been singled out as the only stressful life event...
that excludes major depression when it is ruled a normal grief reaction.

Other stressful life events, such as an assault, serious marital problems or a divorce or breakup, can result in normal grief reactions. If a client meets the criteria for a major depressive episode immediately after an assault or a relationship breakup, however, we do not say that he or she is not depressed and consider the reaction normal. Rather, a diagnosis of major depressive disorder is made and appropriate treatment options are recommended. Only in the death of a loved one can a diagnosis of depression be negated.

Advocates of eliminating the bereavement exclusion state that the action is not meant to “medicalize” grief or to suggest that the vast majority of bereaved individuals require professional help. Rather, they believe that eliminating the bereavement exclusion may facilitate accurate diagnosis and appropriate treatment for those persons who need help.

**Reasons for keeping the exclusion**

The reasoning for including the bereavement exclusion in the *DSM-III* (and subsequent editions) came from groundbreaking studies in the 1970s that documented high prevalence of major depressive syndromes occurring during bereavement. Thirty-five percent of widows and widowers met criteria for clinical depression one month after their spouse’s death, and one-third of those remained depressed for at least a year. The depression tended to be relatively mild, without such symptoms as suicidal thoughts, feelings of worthlessness, self-deprecation or psychomotor retardation. Furthermore, in the majority of cases, the symptoms of grief dissipated over time. Only a minority of individuals remained symptomatic over the long term.

These studies provided evidence that bereavement after the loss of a loved one is a natural reaction, not a pathological or diagnosable disorder.

Those in favor of keeping the bereavement exclusion criterion are concerned about the potential for overdiagnosing depression and thus medicalizing normal grief. An inaccurate diagnosis of major depressive disorder can lead to unnecessary treatment (including needless psychiatric drugs), stigmatization and other negative effects.

It is fair to say that no one wants to pathologize grief, which is a normal response to loss. At the same time, clinicians don’t wish to ignore major depressive disorder and deny anyone appropriate and potentially life-saving treatments because of misjudging depressive symptoms as “only” grief. As such, the primary issue for counselors is the ability to accurately construe where normal grief ends and depression begins.
Patrice Hinton Oswalt was flattered upon opening her e-mail and finding an Evite to a client’s long-awaited graduation. Choosing whether to accept or decline the invitation was no simple decision, however.

Oswalt was keenly aware that engaging in contact with a client outside of the counseling office could have ethical consequences. But she also knew the ethically “correct” answer could only be reached by weighing the best interests of her client. So, when the client came in for her next session, Oswalt, a career counselor with a private practice in Birmingham, Ala., opened the discussion by addressing the situation. She asked the woman to think about how it might feel to have her counselor present at the graduation.

The client had been coming to Oswalt for a year and a half. During that period, the client had been working full time while simultaneously earning a bachelor's degree. She had sought out Oswalt mainly for career issues, but the two had also discussed issues surrounding the client’s relationship with her husband. If Oswalt attended the client’s graduation, the likelihood existed that she would meet the woman’s husband and family. Might that lead to questions about the client’s counseling work that the client wouldn’t want to deal with on her graduation day?

“I wanted her to think through it in a 360-degree way, all the way around, not just get caught up in the moment of inviting everyone,” says Oswalt, a member of the American Counseling Association. After reconsidering the situation, the client decided it would be wiser not to have Oswalt attend the graduation.

Having a strong ethical compass is paramount to being a good counselor, says Oswalt, who in addition to running her private practice works two days a week as assistant director of career services at the University of Alabama at Birmingham. “I can’t be unethical and at the same time be an effective counselor,” she says. “The counseling relationship is built on trust — clients trusting that they can be vulnerable and that their counselor will not take advantage of that openness. To earn this trust as counselors, we must be trustworthy, to prove our worth and integrity. These are standards of behavior that tie directly into our professional ethics. Outside of the counseling relationship, our ethical code [the ACA Code of Ethics] provides us with a clearer professional identity, shapes how the public perceives us and offers guidelines for our professional behavior. We have to use our ethical code to increase our ability to analyze issues in ways that will facilitate our ability to move on to ethical action — to make it part of who we are as a professional [and] prepare us to deal with ethical dilemmas before they even arise. Most of us are trained to ‘do things right.’ Ethics help us to ‘do the right thing.’”

Oswalt’s graduation invitation is just one example of the ethical dilemmas that confront counselors on a daily basis. To help counselors anticipate common ethical challenges and learn how best to handle them, Counseling Today invited Oswalt and four other ACA members with expertise in counseling ethics to provide some insights.

Crossing the line

When the 2005 revision of the ACA Code of Ethics acknowledged that multiple relationships (referred to as “nonprofessional interactions or relationships” in the ethics code) are sometimes unavoidable and that they can be acceptable when carried out ethically, Oswalt applauded. “I like that the door opened up a little. It’s a more realistic way of approaching the counseling relationship,” says Oswalt, who presented on “Hot Topics in Counselor Ethics” at the ACA Annual Conference & Exposition in New Orleans in March. In the past, Oswalt says, even if you were the only counselor in town, you might have felt compelled to shut your office doors to someone you knew on a personal level in an effort to avoid any potential boundary issues. This challenge proved particularly formidable to counselors living and working in rural areas, for whom...
Jeffrey Barnett, professor in the Loyola University Maryland Department of Psychology, says the belief used to be that counselors should never carry on multiple relationships because any contact with clients outside of the counseling office would automatically have negative consequences. “But the most recent thinking is that there is a big difference between crossing a boundary and violating a boundary,” says Barnett, who coauthored the Ethics Desk Reference for Counselors, published by ACA, with W. Brad Johnson.

Certain multiple relationships are now ethically acceptable, Barnett says, such as counseling your child’s teacher if no other counselors are available in the area. “Sometimes it’s us or nothing,” he explains. Instead of admonishing any and all multiple relationships, the focus of the 2005 ACA Code of Ethics shifted to determining whether any harm might come to the client if a multiple relationship existed.

Standard A.5.c. of the 2005 ACA Code of Ethics states that “Counselor-client nonprofessional relationships … should be avoided, except when the interaction is potentially beneficial to the client.” Standard A.5.d. goes on to say that “the counselor must document in case records, prior to the interaction (when feasible), the rationale for such an interaction, the potential benefit and anticipated consequences for the client or former client and other individuals significantly involved with the client or former client.” The standard also provides examples of potentially beneficial interactions outside the counseling office, which “include, but are not limited to, attending a formal ceremony (e.g., a wedding/commitment ceremony or graduation); purchasing a service or product provided by a client or former client (excepting unrestricted bartering); hospital visits to an ill family member; mutual membership in a professional association, organization or community.”

One important standard to keep in mind when considering crossing a boundary is the potential for impairment of objectivity, Barnett says. “If it’s a conflict-of-interest situation or if I can’t remain objective, it’s probably not a good idea,” he says. Returning to the example of counseling your child’s teacher, Barnett recommends compartmentalizing the roles — not asking about the teacher’s depression at the parent-teacher conference, and not asking about your child’s homework at a counseling session.

If a counselor ethically chooses to cross a boundary with a client, Barnett says having a good informed consent policy is crucial. “Informed consent clarifies up front the working agreement between the two parties,” he says. “Many clients may not know what their rights are, what appropriate professional behavior includes and what behaviors are not appropriate. Part of [the informed consent] is to educate the client. It is also to clarify our responsibilities and obligations.”

Oswalt adds that it is also wise to reread the ACA Code of Ethics or to use an ethical decision-making model, such as the one designed by Holly Forester-Miller and Thomas Davis, before proceeding.

Some multiple relationships, of course, remain clear ethical violations. Ted Remley, director of the counseling graduate program at Old Dominion University and a former executive director of ACA, served on four licensure boards over a 20-year period. During that time, he saw more than a few counselors stripped of their licenses to practice after having sexual relationships with clients. Although sexual relationships with clients are a clear violation of boundaries, they happen more than people might expect, Remley says.

Gary Goodnough, cochair of the ACA Ethics Committee and professor of counselor education at Plymouth State University, agrees that sexual boundary crossings, whether between a professor and a student or a counselor and a client, are always a hot-button issue in ethics. But he says these boundary violations are rarely the result of counselors being unfamiliar with the ethical guidelines. “I think it has to do with unmet needs that counselors have as human beings that cause them to behave in ways [in which they] meet their needs at the expense of others,” Goodnough says.

Like Goodnough, Remley thinks sexual missteps occur when counselors allow their own needs to invade the counseling space. Although inappropriate relationships can take many other forms, such as a counselor going on vacation with a client or hosting clients in the counselor’s home, Remley points to sexual impropriety as the ultimate problem. Part of the solution, he says, lies in counselor education programs addressing such ethical issues and preparing students to handle them. He adds that practicing counselors need to process their feelings when they are socially or sexually attracted to clients by consulting with peers.

“Because attraction to clients is an uncomfortable topic in our profession, it often is not talked about in preparation programs,” Remley says. “In addition,
counseling practitioners are often reluctant to admit being attracted to clients. Counselors have to create a professional environment where this topic is welcomed and honestly addressed so that future abuses of clients will not occur.”

Goodnough suggests counselor educators bear some responsibility in staying alert for red flags in student behavior. Students are enrolled in counseling programs for at least two years, which is long enough, Goodnough says, for professors to notice students with personality problems or unmet needs that might lead to significant ethical violations down the line. Faculty members should monitor students and assess their attention to ethical and legal issues, he adds. If problems occur, a remediation plan can be set up for the student. If the student is still unable to meet the goals, he or she may be dismissed from the program. “We need to pay attention to our gut as counselor educators, as well as to indicators that we set up for students to meet,” Goodnough says.

Ethical boundaries can be violated not only when dealing with multiple relationships outside the office, Barnett explains, but inside the counseling office as well. Again, it’s an issue of crossing versus violating a boundary. Crossing a boundary, Barnett explains, would be consistent with the client’s treatment plan, culturally welcomed by the client, motivated by the client’s best interests and an action considered professionally acceptable. For instance, with a grieving client, Barnett says he might put his hand on the client’s shoulder or give him a hug to show support. But carrying out that same gesture with a client who has a history of sexual abuse would be very wrong, Barnett says. Whereas a boundary crossing can be clinically acceptable and appropriate, a boundary violation is unwelcome by the client, motivated by the counselor’s personal needs and harmful to the client.

To friend or not to friend

Technology is designed to make things easier and more accessible. But counselors caution that technological advances can also usher in ethical unknowns. Laura Hahn, a private practitioner who offers counseling and consulting services in Atlanta, says the Internet can blur the boundary lines between counselors’ personal and professional lives. Many counselors have professional websites and social media pages while also maintaining a personal presence online. Hahn says it’s important to keep the two identities separate.

Hahn, an ACA member who presented on “Ethics and Technology” at this year’s ACA Annual Conference, points out that counselors have greater control over information they publish themselves, making it easier to keep boundaries intact. But they have less control — and might even be unaware of — information that others publish, such as photos posted by their friends. Hahn says it’s important for counselors to know what’s available about them on the Internet because their clients may be reading things posted not only by the counselor but about the counselor, including information ideally meant to be personal in nature. She advises that counselors regularly conduct a Google search on themselves to monitor what comes up in the results.

Counselors should also take steps to keep personal and professional information separate, Hahn says. “On a social network site like Facebook, use a ‘Page’ to display professional information and use a ‘Profile’ to display personal information. The page allows you to publish information for client use and does not have friends associated with it,” she explains.

The 2005 revision of the ACA Code of Ethics took place prior to social networking’s explosion in popularity and doesn’t address the topic directly, says ACA Manager of Ethics and Professional Standards Erin Martz. That means social networking can quickly become an ethical conundrum for counselors. Martz says sites such as Facebook should be treated as social interactions even though they’re virtual. The deciding factor then should be whether the interaction benefits or harms the client, she says. Martz points counselors toward Standard A.5.d. of the ethics code, which addresses Potentially Beneficial Interactions.

Goodnough agrees that Facebook represents uncharted territory for many counselors. “The ethical downside involves the blurring of personal and professional boundaries that can result when clients and counselors, as well as counselor educators and students, are ‘friends,’” he says. “While counselors typically refrain from [traditional] friendships with their clients, the threshold for online friendships differs in some people’s minds. Additionally, on Facebook, status updates can be reposted to another page, thus allowing friends of friends and, thus, potentially, clients or students, to see personal information and vice versa.”

Hahn simply suggests refraining from “friending” clients on Facebook. “Make it a policy by adding a statement to your informed consent documentation, and inform your clients up front,” she says. Counselors who find clients being overly interested in the counselor’s personal life and conducting intrusive online searches can explore that topic with the client in therapy, she says.

Counselors should be mindful of the content of everything they write, whether in an e-mail, a text message, a Facebook post or any other electronic communication, Hahn says, because the messages can be reposted or forwarded to those not originally intended to be recipients.

Goodnough agrees that counselors should proceed with caution when it comes to technology, especially as it relates to social networking. “There’s a whole new way that individuals and counselors interact with each other,” he says. “It’s not entirely clear what the best way [is to handle those interactions to] ensure that professional standards and ethical guidelines are enforced or that they live in those venues. We have to always recognize that we’re counselors. Even in our private role, people know us as counselors. Caution and being conservative is always called for.”

Hahn suggests that counselors looking to create a web presence for their professional practice should first read Standard A.12. (Technology Applications) of the ACA Code of Ethics to make sure they’ve done their homework before launching a website or networking page. For those counselors already online, Hahn recommends rereading the code to ensure that everything they have online is ethically sound.

Technology also expands accessibility to counseling, whether through videoconferencing services such as Skype,
What are the top three issues you receive calls about, and what advice do you offer to counselors regarding those issues?

- Mandatory reporting. In order to ensure that confidentiality is being appropriately preserved, counselors need to have a working familiarity not only of the *ACA Code of Ethics*, which discusses the ethical obligation to disclose information for danger and legal reasons (Standard B.2.a.), but also the laws that pertain to their state, county, etc. Mandatory reporting regulations can vary significantly, and these differences can impact the obligation to disclose confidential information.

- HIV status. Often, counselors question whether they are permitted to disclose that a client is HIV positive if that client is reporting unsafe sexual activity. Aside from referring to Standard B.2.b. (Contagious, Life-Threatening Diseases) of the *ACA Code of Ethics*, counselors again need to familiarize themselves with the laws in their state regarding this topic. While some states do allow counselors to disclose HIV-positive status to identifiable third parties, the majority of states restrict this capability to medical professionals.

- Access to records. Counselors are sometimes concerned when clients ask for access to records or case notes because they fear that some of the information contained may be misinterpreted or harmful to the client. Standard B.6.d. (Client Access) provides the ethical process for determining how and if to make this information available to clients. If the access is granted, however, the counselor needs to provide the necessary consultation and interpretation for the client to understand the information. Too often, records are turned over without the appropriate amount of support on the part of the counselor.

Why is informed consent so important?

The informed consent process is crucial for multiple reasons. First, it helps the counselor establish rapport with the client and ensures that the client is actively involved in the counseling process. The informed consent document serves to provide information about the roles and responsibilities of both the client and counselor and allows for open discussion regarding critical components of the counseling relationship, such as tentative treatment goals, techniques and approaches that will be utilized, as well as the risks and benefits of services. From a practical standpoint, a proper informed consent can protect both parties in the case of a subsequent dispute involving such matters as fees and payment arrangements.

Two recent court cases have put a spotlight on if and when counselors should refer clients. Can you offer any thoughts on appropriate referrals?

Referral issues are addressed in Standard A.11. (Termination and Referral), and counselors should bear in mind that to preserve client welfare, it is imperative that referrals be the option of last resort — not the first. It is also important to remember that referrals should be based on a lack of competence on the part of the counselor, and competence is always an issue.

Can you share one last bit of advice about the *ACA Code of Ethics*?

The *ACA Code of Ethics* was not intended to function as that old novelty toy, the Magic 8 Ball. It’s important for counselors to consider that although the *ACA Code of Ethics* provides guidance and principles that are germane to multiple aspects of situations commonly encountered by a counselor during his or her professional and/or academic activities, it cannot always provide specific answers to specific occurrences. Adopting an ethical decision-making model and familiarizing oneself with applicable laws and regulations is the best way to ensure that a counselor can appropriately respond to any potential dilemmas.

Have an ethical or professional dilemma? Contact the ACA Ethics and Professional Standards Department at 800.347.6647 ext. 314 or e-mail ethics@counseling.org.
This pocket guide will help counselors interpret and apply the ACA Code of Ethics in order to prevent and resolve ethical dilemmas. In Part I, Drs. Barnett and Johnson provide an easily understood translation of each Standard of the Code, followed by a discussion of common challenges associated with the Standard and a list of recommendations for maintaining ethical, preventive practice in the topical area. Part II contains an ethical decision-making model and specific, practical strategies for responding to frequently faced concerns surrounding culture and diversity, confidentiality, suicidal clients, boundary issues and multiple relationships, competence, supervision, managed care, termination, and responses to subpoenas.

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instant messaging, e-mail or another form of technology. Offering counseling services online connects people with therapy when they might not otherwise be able to head to a counselor’s office, Barnett says.

But if the benefit is that technology expands access to counseling for greater numbers of people, Barnett says the shortcomings can include a lack of visual cues when e-mailing or instant messaging and technological difficulties, especially with videoconferencing, such as when the video freezes or the connection is lost.

“When you’re conducting a counseling session and that happens and the person is grieving or depressed, that’s not good,” Barnett says. “When you’re in the room with them, that can’t and won’t happen. Technology is a convenience, but it can also have drawbacks.”

Barnett suggests creating an electronic communication policy that details the plan for what will happen if the connection is lost. Standard A.12.g.8. of the ACA Code of Ethics supports his point, suggesting counselors should “discuss the possibility of technology failure and alternate methods of service delivery.”

Hahn says two additional ethical gray areas with online counseling include how the nature of the therapeutic relationship might be changed when the counselor and client aren’t sitting face-to-face in the same physical space and limits to confidentiality and privacy when counseling online. She recommends discussing those potential limits in advance with clients. Standard A.12.g.1. of the ACA Code of Ethics says counselors should “address issues related to the difficulty of maintaining the confidentiality of electronically transmitted communications.”

The crisis aspect of counseling is also a concern when a counselor is working with a client from a distance. If the client is in crisis and the counselor isn’t in the same room or even the same state, that can pose a problem, Barnett says. The solution, he says, is to research the area’s resources — crisis hotlines, local hospitals, emergency centers and the like — so the counselor can help the client find local assistance quickly if the need arises. That’s also a point covered under the Technology and Informed
“Frequently, people think of ethics as good and bad, right and wrong. That’s only relevant when [an action is] clearly appropriate or inappropriate. In the middle, the answer is usually, ‘It depends.’”

Consent standard (A.12.g.9.), which states counselors should "Inform clients of emergency procedures, such as calling 911 or a local crisis hotline, when the counselor is not available."

Barnett recommends that counselors offering online counseling of any kind provide thorough informed consent so clients will understand the pros and cons, risks and benefits of the process. Also set out a clear fee structure, he says, including whether e-mail is charged based on the time the counselor spends in responding or by the number of lines.

In addition to having the clinical competence to address a wide variety of topics with online clients, it’s also important to be technologically competent, Barnett says. Before proceeding, he adds, counselors should be sure they have the right technology and know how to use it effectively.

Also important, Barnett says, is that counselors are both licensed and competent to provide the services they are offering online, just as they would be if offering those services in person. Even if counselors are licensed in the state where they are giving the advice, it can be problematic if they aren’t licensed in the state where the client is receiving the services, he says.

That’s true, Martz says. Although regulations can vary from state to state, most states do not allow counselors to provide counseling services — virtual or in person — unless the counselor is licensed in the state where the client is located. Because ethics are tied directly into following the law, Martz says that ethically, counselors offering services to a client in another state need to find out what the laws are and follow them.

### Being prepared

Beyond boundaries and technology, a range of other topics can prove to be ethical sticking points for counselors. For example, Oswalt says, diversity and multiculturalism. “It’s hard to be an expert in all areas of multicultural awareness,” she says. But she adds that it’s the counselor’s responsibility to step outside his or her own worldview when helping clients.

Oswalt says her goal is to be able to sit across from her clients and have a grasp of some of the external issues that might be affecting them. To do that, Oswalt says she takes advantage of training opportunities at state and national conferences where she can expose herself to different cultural competencies. If counselors find themselves lacking the cultural context to understand what might be going on with a client, Oswalt recommends referring.

“Counselors who are ignorant of the social and cultural context of a client risk misdiagnosing and pathologizing something that is very much the norm in the culture of that client,” Oswalt says.

“This could cause great harm to a client, [which goes] against the principles of holding the client’s best interests above all else and avoiding harm. Multicultural awareness also includes communicating in developmentally and culturally sensitive ways and understanding various cultural concepts of confidentiality. Counselors must strive to not only understand the client’s cultural point of view but also to understand how [the counselor’s] own culture has shaped their perceptions of the world.”

To broaden their multicultural competence, Oswalt suggests that counselors participate in individual or group counseling, do volunteer work with populations with which they are unfamiliar, participate in workshops that highlight specific cultural groups or discuss issues in a supervision group.

“The insights and information they gain will better prepare them to understand diverse clients, avoid discrimination and select culturally sensitive and appropriate interventions,” she says.

Barnett suggests another aspect of ethics that counselors should consider: the role of ethical decision making and prevention versus merely cleaning up the mess after a problem occurs. So many situations that counselors face fall in a gray, middle area where the answer to the ethical question isn’t clear, he says. He points to an ethical decision-making model in his book that guides counselors through things to consider and questions to ask when making a decision. “Frequently, people think of ethics as good and bad, right and wrong,” Barnett says. “That’s only relevant when it’s clearly appropriate or inappropriate. In the middle, the answer is usually, ‘It depends.’”

In addition to finding a decision-making model, Barnett says it’s important for counselors to be aware of the major areas where ethical dilemmas might occur, such as confidentiality, competence and multiple relationships, and then take action to prevent difficulties.

Counselors should be cognizant of their own motivations for decision making, use self-awareness to notice when difficulties are first beginning and then respond appropriately, he says.

“Prevention also includes practicing ongoing self-care to ensure our ongoing psychological wellness, maintaining a balance between our personal and professional lives, and regularly practicing what are termed positive career-sustaining behaviors such as regular exercise, getting adequate rest, having a healthy diet, managing stress on an ongoing basis and the like,” Barnett says. “Prevention may also include personal counseling or psychotherapy, the use of consultation when faced with ethical dilemmas and being sure to practice within our areas of competence.”

Yet another important perspective is the idea that ethics are meant to guide you, not your neighbor, Remley says. “In my opinion, the ethical standards are meant to be applied to ourselves. Counselors should be using them to guide their individual behavior, and one of the problems is a lot of people want to impose the ethical standards on others. In a way, that is inappropriate,” he says.

Remley says some counselors get in the habit of using ethical standards to judge...
other people’s behaviors or professional decisions rather than simply saying, “I don’t agree with you.” He offers a hypothetical situation: A counselor is working in a community mental health center, and after talking to a client, the counselor chooses not to have that client admitted to a hospital against his will. One of the counselor’s colleagues might think that it is the wrong decision to make, but instead of saying “I don’t agree with you,” the colleague labels the counselor unethical.

There are times when it might be appropriate to deem someone’s decision unethical, Remley says, but those times are few and far between, because very seldom is a case that clear-cut. People cut others down by calling them unethical because it’s more powerful than just disagreeing, Remley says, but he warns that the approach can have a grave effect on an individual’s reputation.

“Each individual counselor should refrain from labeling the behavior or decision of other people as unethical,” Remley says. “They should be judging their own behavior by this code of ethics and the ethical standards but not constantly applying them to other people. I’ve seen it too often in my career, and we need to talk about it as a profession.”

Do no harm

Striving to be ethical is at the heart of being a good counselor, Goodnough says. “Professional ethics are an extension of our own integrity,” he says. Among Goodnough’s list of recommendations for practicing ethically as a counselor: Be mindful of your actions, be knowledgeable of ethical codes, consult widely on ethical dilemmas, engage in continuing education, be affiliated with a professional association and always be in a supervisory relationship.

Goodnough says the way counselors act can protect clients and support the ideals of the profession — or not. “If we don’t get [ethics] right, we’re not doing our clients or our society any good,” he says. “In fact, we’re causing harm. It deserves the attention of all practicing counselors.”

Among Oswalt’s tips for ethical practice are understanding ethical codes, consulting with colleagues for advice when ethical difficulties arise, keeping up with current literature in the field, knowing how your state laws apply to the profession and taking full advantage of member benefits through ACA, including free ethical consultation.

Oswalt adds that it’s important for counselors-in-training to begin focusing on ethics while still in the classroom. Reflecting on her master’s program at Georgia State University, Oswalt says the topic of ethics was on the table for discussion in many of her classes. Even though she was in “decent shape” in her knowledge of ethics when she graduated, Oswalt says she continued to run into tricky issues. In those instances, she consulted with colleagues. “It’s not if a counselor will face an ethical dilemma, it’s when, so try to get yourself prepared,” she says. “A good foundation doesn’t do it perfectly, but it’s a great springboard.”

One ethical responsibility that counselors must take very seriously is tied directly to the position of power they hold in the counseling relationship, Remley says. “When clients seek counseling services, they are vulnerable. There is very little oversight of the interactions between counselors and clients, and clients could easily be abused in counseling relationships because of the power counselors have. Therefore, it is very important for counselors to practice in an ethical manner that results in their clients being helped and never being harmed or taken advantage of.”

Barnett emphasizes that point as well. “Clients come to counselors in need, seeking assistance for important issues and difficulties. They come to counselors needy, dependent on us and trusting us to only act in ways that are in their best interests. A failure to act ethically in our professional roles can lead to direct harm to clients and can undermine the public’s trust in counselors in particular and in mental health professionals in general. This could result in people who are in need of help not accessing the help they need. The public is trusting us to help them, not to harm them.”

Ethics resources from ACA

For more information and resources from the American Counseling Association, including 10 interviews about the revised ethics code, an online ethics course, a PDF of the 2005 ACA Code of Ethics and a practitioner’s guide to ethical decision making, visit counseling.org/Resources/CodeOfEthics/TP/Home/CT2.aspx.

In addition, the following books can be ordered directly through the ACA online bookstore at counseling.org/publications or by calling 800.422.2648 ext. 222.

- **Ethics Desk Reference for Counselors** (order #72893) by Jeffrey E. Barnett and W. Brad Johnson helps readers interpret and apply the ACA Code of Ethics to prevent and resolve ethical dilemmas ($32.95 for ACA members; $44.95 for nonmembers).

- **The Counselor and the Law: A Guide to Legal and Ethical Practice**, fifth edition (order #72857), by Anne Marie “Nancy” Wheeler and Burt Bertram offers a broad overview of the law and the potential areas of liability that counselors might encounter ($37.95 for ACA members; $49.95 for nonmembers).

- **ACA Ethical Standards Casebook**, sixth edition (order #72839), by Barbara Herlihy and Gerald Corey provides a detailed analysis of the ACA Code of Ethics and a foundation for ethical decision making in counseling practice ($38.95 for ACA members; $60.95 for nonmembers).

- **Boundary Issues in Counseling: Multiple Roles and Responsibilities**, second edition (order #72840), by Barbara Herlihy and Gerald Corey reflects the profession’s most current thinking on nonprofessional and multiple relationships ($36.95 for ACA members; $52.95 for nonmembers).

- **Documentation in Counseling Records: An Overview of Ethical, Legal and Clinical Issues**, third edition (order #72851), by Robert Mitchell offers guidelines on keeping client records that are legally, clinically and fiscally sound ($25.95 for members; $33.95 for nonmembers).
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U.S. General Services Administration
It was a question Randy Astramovich heard over and over: Why doesn’t the American Counseling Association have a division for counselors working with children and adolescents in a multitude of settings? This past spring, Astramovich decided it was time to take action so these counselors could have a true organizational “home.”

Astramovich, along with a few other individuals interested in seeing the idea come to fruition, collected 450 supporting signatures. With approval from the Governing Council, the Association for Child and Adolescent Counseling became ACA’s newest organizational affiliate this past fall. Once ACAC gains 500 ACA members, it can qualify to become an ACA division.

ACA Executive Director Richard Yep says the timing couldn’t be better. “I appreciate all of the work that the founding officers of ACAC did to move the process forward to the Governing Council. The issues that confront professional counselors who work with children and adolescents are at an all-time high, and the work of ACAC could be instrumental to the success of those providers.”

“The movement toward the establishment of ACAC originally grew out of conversations between ACA members who provide counseling services to children and adolescents across a wide variety of settings and who sought venues within ACA for networking, collaboration, research, preparation and training in child and adolescent counseling,” Astramovich wrote in a letter petitioning for ACAC to become an organizational affiliate. He further noted that although ACA’s Annual Conference & Exposition regularly features a grouping of conference presentations on child and adolescent counseling, no place existed within the ACA family for those counselors to collaborate and network outside the conference. Astramovich, now founding president of ACAC and an associate professor of counseling at the University of Nevada, Las Vegas, also pointed out that other organizations for helping professionals, such as the American Psychological Association and the National Association of Social Workers, already offered special divisions for child and adolescent work.

“Many of the child and adolescent counselors and counselor educators found ourselves without a specific network of support in ACA,” echoes Dee Ray, ACAC secretary and associate professor of counseling and director of the Child and Family Resource Clinic at the University of North Texas. “Over the years at conferences and through e-mails, we’ve wondered why there wasn’t a division solely dedicated to working with children and adolescents. We provided informal support for each other, but we wanted to have an organization that provided a formal network and support system for this population.”

Now that ACAC is up and running, Ray says expectations are high. “We hope that ACAC will focus on the training needs of counselors who work with children and adolescents and additionally provide professional support in terms of ideas, resources and encouragement to keep counselors motivated and energized to work with children,” she says.

ACAC will offer a variety of benefits to members, says Astramovich, who also serves as editor of the Journal for International Counselor Education. The organization will promote best practices, as well as research and networking opportunities for professional counselors who work with children and adolescents.
ACAC will also strive to highlight the unique developmental and cultural needs of these clients, advocate for expanded child and adolescent counseling services, promote interdisciplinary collaboration among specialties whose members work with children and adolescents, and offer ACA members a collective voice in this specialty. “Although other [ACA] divisions address children, we felt like there was a need for some unity in the provision of counseling services to children across multiple settings,” Astramovich says.

ACAC’s primary focus will be to promote research and effective counseling services for children and adolescents, Astramovich says. In working with adults, he adds, most counselor practitioners come to understand that many of the issues their clients struggle with are rooted in their childhoods. Professional counseling is based on the idea of optimal human development, Astramovich says, and maximizing counselors’ effectiveness with children and adolescents could prevent or lessen problems for those individuals when they reach adulthood.

ACAC will also work to ensure that counselors in the field have the education and qualifications necessary to be effective, Ray says. “For so long, our field has focused mostly on working with adults and just applying those same skills to children and adolescents. Working with children and adolescents requires a specific skill set, and we will advocate for counselors to become formally trained in those skills. In addition, we will seek to differentiate skill sets needed for children and skill sets needed for adolescents. We will provide a developmental focus to work effectively with children and adolescents.”

**Bridging the disconnect**

ACAC isn’t geared specifically toward school counselors, but because they work closely with children and adolescents, the hope is to get school counselors actively involved in ACAC, Ray says. “However, ACAC will focus on the needs of all counselors who are counseling children and adolescents,” she emphasizes. “Private practitioners, mental health counselors in the schools, agency counselors, counselors in hospitals and school counselors are all part of the network that works with children and adolescents. The counseling part is the most important aspect of our concentration.”

Michael Moyer, ACAC trustee and assistant professor at the University of Texas at San Antonio, says when it comes to school counselors and professional counselors working with children and adolescents, partnering is key. “I believe ACAC will emphasize the need for collaboration between school and community counselors,” he says. “School counselors provide valuable services within the school system and the school setting, and community counselors also provide valuable services outside the school walls. Sometimes there is a disconnect between the two, and I feel very strongly that there should be collaboration and support from both sides to best support children and adolescents.”

It’s possible, Astramovich says, that ACAC could also promote a new paradigm in the way services are provided to children and adolescents in schools. Astramovich previously worked in Dallas as a school counselor and found that the ratio of students to school
counselors left counselors juggling too many tasks. “What was clear was that the demands placed on school counselors are enormous,” he says. “There are so many duties school counselors are expected to fulfill that it’s simply impossible for all those duties to be met effectively by one individual.” (ACA recommends a maximum average student-to-counselor ratio of 250:1, but the most recent data released by the U.S. Department of Education’s National Center for Education Statistics show the average ratio in U.S. elementary and secondary schools stands at 457:1; see the March 2011 issue of Counseling Today for more information.)

Astromovich says the future could include creating school-based counseling centers, which might look much like university counseling centers, with a variety of helping professionals, including professional counselors, available to students. If the dynamics trend that way, Astromovich says, school counselors wouldn’t disappear, but their roles would likely change. For example, the roles might be split between an academic counselor who helps students with courses and academic concerns and a mental health counselor who is based in a school counseling center. “Asking one individual to provide all the services that our children need isn’t realistic,” Astromovich says.

A tailored approach

The issues today’s children and adolescents face are wide ranging, Ray says, but perhaps the most common trouble point is society’s lack of understanding of what is developmentally appropriate in terms of mental health, growth and education. “This developmental mismatch between what is expected of children and what is naturally healthy for them is at the root of many children’s behavioral and emotional health problems,” she says.

To see change on the societal level, Ray believes the most important thing counselors can do is be active members of ACA and ACAC and advocate for best practices with children and adolescents. “Clinically, a counselor needs to be educated in working with children and adolescents from a theoretically sound framework,” she says. “Formal education will help counselors develop a belief system from which techniques and skills will emerge. The current trend to just grab any book or article on a technique to use with young people is ethically suspect and fairly ineffective.”

Counselors generally rely on talking in their work with clients, but Ray points out that children and adolescents often communicate in nonverbal ways, making it imperative that counselors cultivate their own nonverbal communication skills. “Because of cognitive differences or emotional issues, children and adolescents typically prefer nonverbal methods of communication to build relationships,” she says. “For example, young children communicate through their play, so we have found play therapy to be the most effective means of developing counseling relationships. Adolescents might prefer a physical activity or expressive arts activity to build their counseling relationships. Counselors need to be trained and supported in these methods to be effective in their counseling.”

Astromovich echoes that sentiment, saying that the use of developmentally appropriate techniques with children and adolescents is key to helping them. For instance, he says, counselors should gain experience using play techniques because substantial research exists showing the effectiveness of these techniques with kids.

Moyer adds that counselors must keep things exciting and moving when working with kids. “I find myself integrating different activities and types of play and not using as much traditional talk therapy,” he says. “Children and adolescents have so many options and activities that involve fast-paced technology that counselors working with that population have to be able to adapt their counseling skills to keep [these clients’] attention and make it meaningful to them.”

Another unique aspect of working with children and adolescents is the potential interaction with their parents or guardians, Moyer says. “Unlike working with adults who can provide their own informed consent, children and adolescents cannot. A legal guardian must provide that consent for them. In addition, parents and guardians have a legal right to know what a counselor is talking to their child about and, I believe, should be involved in the counseling process. On the other hand, as a counselor, I have to balance that sharing of information with the parent or guardian because the child or adolescent is my client, and I have to be able to build a trusting relationship with them. In short, there is a balancing act in building a trusting relationship in which the child or adolescent feels comfortable and confident in talking openly [even as the counselor keeps] the parents informed to an appropriate extent.”

As ACAC gets off the ground, Ray and Moyer offer some general words of wisdom about working with children and adolescents. Quality formal education is absolutely essential, Ray says, as is quality supervision of a counselor’s work by an experienced child counselor supervisor. “Working with children and adolescents is qualitatively different from working with adults,” she says. “Further, working with children is qualitatively different from working with adolescents. One cannot just apply those adult counseling skills to children and expect them to work. Counselors need a new language to be effective.”

Moyer offers the same advice he gives to his counseling students: “Be genuine. Children and adolescents can see right through you when you are being fake, and you will lose them pretty quickly. Be present and listen to their concerns. And [be] nonjudgmental. Children and adolescents — like all populations, I’m sure — are judged constantly on their thoughts and actions. Counselors can do wonderful things just by listening and not judging.”

Interested in getting involved in ACAC? Contact Randy Astramovich at randy.astramovich@unlv.edu for more information.

Lynne Shallcross is a senior writer for Counseling Today. Contact her at lshallcross@counseling.org.

Letters to the editor:
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Sheri Bauman

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Susan* can’t remember not being sensitive to tactile stimuli. Ever since she was a child, she has had aversions to many things, including light touch, the feeling of rain on her skin, being breathed on, tight clothing, and jewelry or hair brushing the back of her neck. “I was never a warm, cuddly person because of my difficulties with touch, and my family gave me endless grief about my short, stiff hugs,” she says. “But in general, on my own, I had coping strategies and just avoided situations that made me uncomfortable.”

It wasn’t until Susan’s young son was diagnosed with a sensory processing disorder (SPD) that she pieced together these bits of her history and began viewing them as parts of a nameable condition. With her son now in occupational therapy and developing a treatment plan, Susan’s knowledge of the SPD spectrum has expanded greatly. Asked what she has learned through personal experience that others cannot discover just by reading a book, she replies, “The problems that are often touted in children don’t go away with adults, and they can have a serious impact on interpersonal relationships and, therefore, happiness.”

By way of definition, individuals with an SPD might have trouble understanding, processing and reacting to information received from their senses. These individuals often feel their senses are unreliable or inconsistent, making basic tasks such as dressing and walking difficult. SPDs can make daily organization challenging, and they can lead to low self-esteem, anxiety and depression. Recent emphasis on diagnosis in childhood has raised the profile of sensory integration issues within parenting communities. SPDs often are recognized in tandem with other diagnoses, particularly attention-deficit/hyperactivity disorder and autism, but some people experience the disorder without a comorbid condition. Although the American Psychological Association does not plan to recognize SPDs as part of the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders, the organization has requested further study on the topic.

It stands to reason that children with SPDs grow into adults with SPDs. But when children are not diagnosed, and do not follow protocols that include occupational therapy, they often reach adulthood without a definition for their struggles. Lacking effective coping strategies, they may find themselves in a counselor’s office facing depression, anxiety, addiction or other complicating conditions. Experts agree that SPDs can present more as a mental health issue, leading to misdiagnoses ranging from generalized anxiety and phobias to obsessive-compulsive disorder and bipolar disorder. Armed with an understanding of how SPDs present in adult populations, counselors can help these clients find more comfortable ways of living.

“I think that most people with SPD will assume their problems psychological and therefore seek either psychotherapy, medication or both,” says Sharon Heller, a developmental psychologist and author. “Few will know that SPD drives their behavior because it is generally considered a dysfunction of special needs children when, in truth, probably as much as 30 percent of functioning adults suffer from it to some degree. The more you learn about SPD, the more you see it all around you, manifested as disorganization, clumsiness, messiness, spaciness, irresponsibility, low motivation, underachievement, distractibility, social awkwardness, inappropriate behavior — the list goes on.”

What it looks like
Heller herself struggles with “sensory defensiveness,” which falls under the SPD umbrella. “I knew my over-reactivity to the world couldn’t be from just stress and anxiety because I had little to no control over it, and I hadn’t always been like that. It came on gradually, following head trauma. But I didn’t know why it was happening or what to do about it, so I built a cave and crawled in. What a sigh of relief when I found out it was an actual
life's slings and arrows, it doesn't cut off
the edge and help you to cope better with
continues. "While this may help take off
your body's 'edges' — and, lacking them,
muscles for body awareness — to feel
less connection to their bodies. You need
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and physical activity has likely caused
is not pleasurable for these individuals
uncoordinated and clumsy, find moving
because they have low muscle tone and,
have great difficulty losing weight
can play out. "Some people with SPD
wont work' — and you get depressed."
"I think there are a lot of adults who
don't have a diagnosis but who have
developed ways of being," Auer says.
He has learned to “disappear” into his
smartphone when he feels overwhelmed
He has learned to “disappear” into his
"Why bother? It won't work’ — and you get depressed.”
Heller gives an example of how this
can play out. “Some people with SPD
have great difficulty losing weight
because they have low muscle tone and, unordered and clumsy, find moving
an effort,” she says, adding that exercise
is not plasurable for these individuals
and physical activity has likely caused
them much embarrassment in the past.
“When they do lose weight, they feel
less connection to their bodies. You need
muscles for body awareness — to feel
your body's 'edges' — and, lacking them,
you need extra weight to feel grounded.”
“[Overweight] and lacking control
over your life, you feel depressed and go
to therapy or take antidepressants,” she
continues. “While this may help take off
the edge and help you to cope better with
life's slings and arrows, it doesn't cut off
to tune out, then I can come back and
interact with someone. It's developing
that communication piece so it's clear for
everyone. That's the same for kids as well.
You want them to recognize what their
coping skills are, but you also want them
to be able to come back and interact in a
social way, to develop the inner resources
or inner pool of energy so they can
function more readily.” Auer and his wife
Michelle, an occupational therapist, have
written a workbook for kids with SPD,
Making Sense of Your Senses.
Kristina Taylor is a developmental
disability specialist and American
Counseling Association member in
Chicago. She became familiar with SPDs
through her work with individuals with
developmental disabilities while she
was pursuing her master's degree. “The
longer I worked with people who had
sensory integration or processing issues,
the more I came to understand aspects
of the disorder and how making small
accommodations can really help,” she
says. “I now work in the developmental
disability field and see these issues in
most of my clients.”
She notes that these issues present in many different ways. “For instance, if the therapy room or their work environment is too light or dark, too hot or cold, if things are not arranged in certain ways, or even if I am wearing my hair a different way that day, it can throw off their ability to engage in what we need to do because it takes more effort to process this input.”

As a result, Taylor says many of her clients have unconsciously developed their own coping strategies for dealing with their individual symptoms. “Many individuals I work with wear headphones or other things over or in their ears while working, riding the bus or being out in public. It helps to decrease the noise input they have to process. I have also seen individuals carry some small item they can squeeze to get needed sensory input when they are having difficulty processing their environment. Wearing certain types of clothing is another coping mechanism. Shutting their eyes when they are overwhelmed with input is common also, or just disengaging from their surroundings until they do not feel as overloaded.”

Cindy is a mental health clinician in California. She struggles with sensory processing issues, such as a sensitivity to artificial light and turbulence and consistently feeling that her body temperature is too warm, but she had not heard of the disorder until two years ago. “I thought I just had strong likes and aversions and adapted my life [and] surroundings to accommodate these things,” she reflects. “It was quite by accident that I stumbled across this disorder through a child I worked with whom had been diagnosed in the early 2000s. I looked it up on the Internet, and suddenly I found myself relating a little too much to some of the things that were mentioned.”

“I believe that unless I was speaking to a mental health professional, I would have no chance of relaying how I experience my world,” Cindy continues. “A general practitioner would probably send me directly to a neurologist for an MRI or make sure I got medicated.”

Today, Cindy never uses the overhead fluorescent lights in her office and often wears noise-canceling headphones when her officemate becomes distracting. She keeps a cooling fan near her desk or tries
to sit near air-conditioning vents. At home, she avoids television, sleeps with a fan on, wears earplugs at night and often has ambient music playing.

On the positive side, Cindy believes her sensitivity has made her a more intuitive counselor for small children. “As my knowledge of SPD has grown, I have been able to make more and more sense of the behaviors I see in the classroom,” she says. “I think it’s probably easier for me to walk into a classroom and notice when the environment is too stimulating, loud, cluttered, boring, etc.”

“We had a child in our program who wouldn’t use the bathroom and would completely melt down every time the class had potty breaks,” she says. “I walked into the bathroom when the class was in there, and the sound was completely overwhelming. Imagine a completely tiled, six-stall bathroom filled with 15 3- to 5-year-olds! No wonder she didn’t want to go in. Sure enough, the teachers found that when they took her on her own, there was no issue. Sometimes, it helps to speak the language.”

In the counseling room

In addition to being diagnosed with Asperger's syndrome, Karen has central auditory processing disorder, which is part of the SPD spectrum and impairs her ability to respond in conversations. She also has difficulties with tactile stimuli, such as cold temperatures and food textures, as well as strong odors. She describes the experience of walking through a department store perfume aisle as “all the keys of a piano being played at the same time.”

Karen’s journey toward understanding herself has included trips to her primary care physician, a speech therapist and an occupational therapist. “I’ve worked with counselors and other providers in psychiatry because from my teens, I’ve been treated for depression, anxiety, etc. I spent a lot of years in therapy and seeing doctors. The therapist was great and helped me think about some of my sensory issues.”

“Counselors need to work with any of their clients to try and address root causes of their suffering,” Karen advises. “It’s not always because of a simple chemical imbalance or because of negative thinking patterns. It’s not the case that the person can articulate what is really going on.”

“SPD is challenging to uncover in a case where someone comes in because they’re ‘feeling bad’ or clinically ‘depressed’ or ‘anxious’ and it’s not clear where the stress is coming from,” she says. “SPD can create other kinds of stress — social, executive functioning, which can lead to job stress, financial difficulties, alienation. It’s not enough to say, ‘Make friends’ when the person is overwhelmed by the sights, sounds or smells of other people in places where people normally spend time with others.”

Karen recommends that counselors “spend time with the person trying to understand their visceral experience of the world. If the setting permits, go out into the world with the person and explore what that is like. It may not just be the depression keeping a person from the grocery store.”

SPD treatment plans often include collaboration with occupational therapists, physical therapists and speech therapists, and Taylor says her experience working with these professionals has been highly positive. “I am not sure if this is typical or if I have just been very lucky, but many times these specialists have been very willing to work together to implement goals and sensory plans. Many work to increase independent living skills and vocational skills and help the clients work on making plans in advance for when they need sensory breaks.

“I have worked with these specialists to develop sensory rooms in homes, schools and workplaces, and to develop sensory diets, including meeting needs for deep pressure, wearing weighted vests, using weighted blankets, taking movement breaks, etc. I have found them all to be a very useful and integral part of a holistic therapy approach and full of great ideas and resources.”

Taylor notes that counselors can play an important role by advocating for SPD clients outside the therapy room as well. “I have written letters to employers to ask for sensory accommodations or to just explain certain behaviors that they often think are odd. I have written letters to state representatives to advocate for increased social services for these individuals, and I have protested at rallies. I also feel that just listening to [these

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April 2011 | Counseling Today | 43
clients’ needs and trying to understand as much as I can is a daily way in which I advocate."

**Taking time to understand**

Roxanne Nichols is an ACA member and senior staff clinician at Boise State University. Despite her training, she admits she was only “minimally familiar” with SPDs as a whole until this past summer. That’s when her daughter, after years of struggle and being diagnosed with bipolar disorder, was referred for neuropsychological testing.

“My daughter has a sensory processing disorder called nonverbal learning disorder,” Nichols says. “As I began to read about it, I recognized almost all of the symptoms in her, whereas [the bipolar diagnosis] kind of fit, but never fully grasped all that she had going on. And bipolar is supposed to be treatable with medication, but that didn’t seem to alter her much, except for the sedation.

“Since her most recent and I believe accurate diagnosis, she has been off medication completely and with great success. We have educated ourselves on how to more effectively communicate with her. I would suggest [to counselors] that if a client presents with symptoms that have you shrugging or the symptoms seem to have atypical patterns, think outside the box and outside the DSM.”

Noting the paradigm shift that comes when a family member is diagnosed with an SPD, Nichols says counselors ought to ask clients questions that might point to the disorder. For example: When did you learn to ride a bike? How do you organize your room? How well do you handle transitions?

Taylor says counselor education programs could do more to educate students on sensory processing issues but adds that many related fields are also lacking knowledge. “I have several counselors and psychologists who are close friends, and since they do not usually work with clients with sensory processing issues, they don’t understand the needs or aspects of the disorder,” she says. “I have discussed aspects of cases, ensuring confidentiality, with them for consultation purposes [and found] out they do not understand why someone would flap their hands, bang their head or need deep pressure to help regulate themselves. I do not think most counseling programs offer enough training on these issues either. I know I never learned about a sensory diet in my [master’s] program.”

Taylor suggests that all individuals can be classified somewhere on the sensory spectrum, which might be a helpful mind-set for counselors to adopt. “Some of us can regulate our sensory processing systems well and do not need many coping mechanisms, while others need more help and support. However,” she says, “we have all had experiences when we were overwhelmed with sensory input. We can take how we felt in these situations and use that to better understand what daily life is like for those with sensory processing disorders.

I think counselors can apply many of the tools and resources used with [the SPD] population to any client.”

Heller laments the lack of SPD information available beyond that which targets children with special needs, so she is writing a new book specifically for adults with SPDs that will be published next year. She notes that many online communities provide support and information on the topic and encourages counselors to spend time educating themselves. “I believe the role of the counselor is to help the client cope with the psychological sequelae that accompany this dysfunction and to give the person guidance and hope, especially because many, if not most, have been crippled by learned helplessness and feel too defeated to take steps to improve their condition,” Heller says.

On the whole, Cindy is optimistic about the counseling profession’s ability to help those with SPDs. “I believe that counseling is moving toward a more holistic view of the person, and not just in the social work way. The systems that support a person are critical, but just as critical is the way a person perceives their experiences and environment — and that is through the senses. Your clients may not even know they have SPD, but as mental health clinicians, we can help them explore the differences between how their senses bring information to them and how that can help or hinder them.”

“Become familiar with SPD and the work that occupational therapists do to assist those who are struggling with SPD,” Cindy advises counselors. “Support your client in becoming their own advocate and in finding coping skills to help them become more successful in their lives.”

At the same time, Cindy says, counselors should not assume that these clients automatically need, or necessarily want, to function just like everybody else. “Those of us who have SPD and don’t know it don’t even think we’re perceiving things differently than other people. But if we do notice, we just think we’re ‘quirky’ that way, or lazy, or whatever we were called growing up because of the sensory differences we had. Every single person out there has some sort of sensory issue. That’s normal. It’s when the processing of sensory input becomes disruptive to quality of life or success in school or employment that it should become a focus of treatment. Don’t diagnose everyone. And don’t make everyone go to an occupational therapist for treatment. Some of us are very attached to our quirks. … They are part of what others love about us as well.”

For additional quotes and insights into SPDs, read the online version of this article in the *Counseling Today* section of the ACA website at counseling.org.

**Note:** Some names in this article were changed by request.

Stacy Notaras Murphy is a licensed professional counselor practicing in Washington, D.C. To contact her, visit therapygeorgetown.com.

Letters to the editor: ct@counseling.org
The right education can be the start of a more fulfilling career, with an increased salary, real negotiating power, and the pick of the top jobs in your industry. To find out what a Capella degree can do for you, visit Capella.edu.
To have and to hold

Local law enforcement, code enforcement and animal control experts have known about the problems of animal hoarding and object hoarding for a long time. But excepting the sporadic attention given to the issue here and there in the professional literature, the mental health community is relatively new on the scene. As such, it is still investigating and catching up on why people hoard.

Hoarding was initially regarded as an exotic subtype of obsessive-compulsive disorder (OCD). But given that it contains parts of several other Axis I conditions without clearly fitting within any of them, plus has features all its own, there is growing consensus that hoarding might be a distinct disorder.

The psychological study of animal hoarding in particular is a fairly recent development. Gary Patronek initiated this study through his work at Tufts University in 1997, completing a groundbreaking initial data collection from participating animal control agencies nationwide. He used a convenience, non-randomized sample and analyzed submitted inspector reports collected from agencies that cooperated with him. About the same time, the Hoarding of Animals Research Consortium (HARC) formed in Massachusetts. It brought together an interdisciplinary group from psychiatry, social work, veterinary medicine and law enforcement, as well as others dedicated to "exploring the problem of animal hoarding to find more effective and humane solutions for this very problematic and poorly understood behavior." The group collaborated over a 10-year period and eventually published a community intervention manual after a major symposium in 2006. The group’s website (tufts.edu/vet/hoarding/index.html) remains its primary means of communication. Today, HARC’s goals are to eliminate stereotypes, raise awareness and stimulate research among all concerned parties.

The mental health team involved with HARC put forth a working model of the relationships between a broad array of early childhood issues and genetic and environmental factors that produce disordered attachment patterns and/or Axis II traits that further impair relationships. Together, these inadequate attachments and faulty structures of personality form such a massive deficit in resilience that as the person reaches adulthood, he or she is ill equipped to handle life stressors. This situation eventually gives rise to hoarding behaviors. HARC posits that hoarders attempt to repair the self via their relationships with animals, but these individuals are ultimately foiled by some crisis or trauma that causes them to become even more overwhelmed. Their coping deteriorates further, including their ability to care for themselves and the animals (see model at tufts.edu/vet/hoarding/abthoard.htm#A3).

Although this model is good so far as it goes, it only considers animal hoarding, and much more needs to be fleshed out. For instance, what are the intermediary steps in turning away from human attachments and turning toward animals? Does the behavior start to manifest early and, if so, how? What accounts for some hoarders retaining social ties as their collecting worsens? What is the role of trauma or loss in a hoarder’s life?

The loss connection

My opinion is that the roles of unresolved loss in general and traumatic loss in particular need further inspection in connection with hoarding. The mismanagement of a single major loss or clustered losses along life’s way could represent a turning point that makes either object hoarding or animal hoarding go active. This is not to say that loss is omnipresent in all cases, but it is present in enough instances to merit further attention. A recent interview I conducted with Kathleen, a recovering hoarder, speaks to this point.

The woman shared that her first and second husbands died nine years apart, both of natural causes. She had remarried knowing about her second husband’s health problems. Still, she wasn’t prepared when she came in one day to find him dead on the floor. She could tell now, looking back from nine years’ distance, that symptoms of depression had settled in shortly after the second loss. She walked around like a zombie most of the time. She started neglecting routine cleaning and stopped taking out the trash. As things piled up, she just left them there, lacking the energy to deal with them.

During that time frame, her sister also died, and the woman’s hoarding patterns escalated to more serious levels. Friends and neighbors told her she needed to clean up her place, but she turned a deaf ear. By that point, she admitted, well-meaning interventions without any administrative force were easy to turn aside. Still working, she was already good at maintaining a public front while restricting access to her private life. Unchallenged, she discovered the self-medicating effects of buying things for herself. Yard sales, dumpsters and dollar stores became her unholy trinity.

“Thirteen pairs of pajamas make no sense except to someone who is feeling abandoned, empty and in dire need of an emotional boost,” she said. Each purchase or acquisition provided her that much-needed boost. “That’s the way a hoarder thinks,” she explained. “It just generalizes to all sorts of other things.” Recalling all the accumulating piles, she thoughtfully reflected, “I guess when you think you have nothing else, you think at least you have your stuff.”

Normal grief is a hard enough process for a healthy person to navigate. According to George Bonanno in The Other Side of Sadness, grief is an oscillation between loss-centered thinking/feeling (reminiscence, longing for the loved one, reviewing memories) and forward-centered thinking/feeling (planning for a changed life, forming new relationships, moving). Most people oscillate to varying degrees throughout the first year or so, then gradually taper into less intense and less...
frequent oscillations. Bonanno notes this alternation is good because unrelenting loss-centered thinking and feeling would be too much for anyone to bear.

With this in mind, I speculate that some people, perhaps because of the resilience deficits noted earlier or perhaps through the simple misfortune of being hammered by several major losses, go through one loss too many, causing something to go wrong with how losses are processed in the mind. They can neither integrate painful life experiences nor easily oscillate between pain and more pleasant states. All of this happens in a more destabilizing way than occurs with other complicated grief patterns — a way that disrupts multiple areas of functioning such as memory, attention, planning, categorization, judgment and reality testing. They experience a slowing of cognitive processing, which impedes decision making.

As hoarding develops, other changes take place, too. According to Randy O. Frost and Gail Steketee in Stuff: Compulsive Hoarding and the Meaning of Things, hoarders develop an elaborative processing style based on having maximal choices and preserving every imagined opportunity. They reify objects and animals. Reification is the error of regarding an abstraction as a material thing and attributing causal powers to it. Hoarders attribute safety, security, control or any other traits they find comforting or desirable to either inanimate objects or animals. Through repeated avoidance, they escape stress for the moment but reinforce inordinate fears of change and further loss concerning things most of us would consider everyday transactions. Certain other features, such as the aggressive acquiring mentioned previously, take on a life of their own, much like an addiction, particularly process addictions such as spending, gambling and food, some of which often are comorbid with hoarding. In any respect, what we are learning is that hoarders seem to manifest an intolerable existential pain, an abiding sadness, a sense of abandonment and, as their illness manifests into its active phase, a sense of perpetual defeat.

An extreme protest

The mind always has another card to play even in such dire circumstances, so it mounts an equally strong, equally extreme protest against this pain and the threat of future loss. By engaging in behavior that is the opposite of losing — having or hanging onto things — the individual is soothed. If nothing is thrown out, the individual reasons, then nothing will ever be lost again. Or, in the case of animals, especially if one has many of them, the person never has to face a loss leading to aloneness ever again. These inner tactics can be projected onto current relationships and used as a bargaining chip. Hoarders sometimes will resist change until they get an ironclad guarantee from others that they will help or stay with the hoarder, particularly in cases in which the person’s hoarding or other issues have driven relatives away.

One 69-year-old hospice patient had lost two husbands, one through a divorce and the other through death. She was estranged from her only daughter, who lived in a distant state and refused to come see her. The patient was dying of lung cancer that had spread to her chest. She lived alone in her mobile home, a recluse and the other through death. She was lost two husbands, one through a divorce and the other through death. She was estranged from her only daughter, who lived in a distant state and refused to come see her. The patient was dying of lung cancer that had spread to her chest. She lived alone in her mobile home, a recluse and the other through death. She was lost two husbands, one through a divorce and the other through death. She was estranged from her only daughter, who lived in a distant state and refused to come see her. The patient was dying of lung cancer that had spread to her chest. She lived alone in her mobile home, a recluse and the other through death. She was lost two husbands, one through a divorce and the other through death. She was estranged from her only daughter, who lived in a distant state and refused to come see her. The patient was dying of lung cancer that had spread to her chest. She lived alone in her mobile home, a recluse and the other through death. She was lost two husbands, one through a divorce and the other through death. She was estranged from her only daughter, who lived in a distant state and refused to come see her. The patient was dying of lung cancer that had spread to her chest. She lived alone in her mobile home, a recluse and the other through death. She was lost two husbands, one through a divorce and the other through death. She was estranged from her only daughter, who lived in a distant state and refused to come see her. The patient was dying of lung cancer that had spread to her chest. She lived alone in her mobile home, a recluse and the other through death. She was lost two husbands, one through a divorce and the other through death. She was estranged from her only daughter, who lived in a distant state and refused to come see her. The patient was dying of lung cancer that had spread to her chest. She lived alone in her mobile home, a recluse and the other through death.
to collect cats, regardless of her inability to care for them. As with many hoarders, she talked about them as "her life." Her belief that the cats needed her was at least partially a delusion; many of them were neglected to the point of starvation and had learned to forage for themselves. But they gave her life meaning, which she frequently asserted.

I noticed this stayed at the level of an ideal in her mind. Curiously, she spent little time petting, holding or relating to any of the cats. She would dump food in their dish in a rather detached way, and only occasionally would she speak to any individual cat as it passed through the house. It was as if simply having them there was enough. At a deeper level, they were her insurance policy against having to part from anyone dear to her or having to suffer rejection ever again.

She recounted having once fallen to the floor with chest pains and said the cats had organized themselves to revive her, standing on her chest, licking her face, intuiting her needs. She fantasized they would be there like that for her until the end, seeing her off as she passed from this life. She straightforwardly asked her hospice caregivers to bury some of the cats with her, presumably dead or alive. She focused her loyalty and desire to be with these animals far more intensely than she had done with any person she had ever known.

Seen in this light, hoarding is the perfect solution. It is a tactic to have and to hold onto something forever. It is a strategy that effectively erects a buttress against frozen grief and further devastating loss. When someone finally forces the issue and the sheriff or animal control officer takes over, the whole house of cards comes tumbling down.

The presence of delayed frozen grief, possible additional loss (through animal removal, necessary euthanasia or enforced cleanup), intense shame and existential panic all reassert themselves in an abrupt manner. It is a very tricky passage for first responders to manage because brittle hoarders may feel as though they have no remaining resources — that their life is, in effect, over.

**More study needed**

This is a very limited sketch of the possible role of frozen grief in the development of hoarding. This article has not dealt with other dynamics, such as the hypersensitivity to judgment, the distorted projections onto authorities, the continued problems with honesty and compliance, the anger related to thwarted control and the frank sociopathy and exploitive cruelty that can surface across a variety of these cases. These elements are just as important to investigate and illuminate. As the authors of the HARC project stated, we are just at the beginning when it comes to understanding hoarding. A rigorous scientific collection and study of cases is needed to more accurately identify important key variables and the relationships among them that begin to explain the continuum of hoarding phenomena. As the study of key variables proceeds, we may be able to fine-tune the effective and timely interventions currently taking place in some locales, thereby helping more hoarders earlier in their process.

We continue to face some significant obstacles in addressing hoarding, however, including widespread public stigma. At the same time, societal values concerning the sanctity of one’s home and our rights to privacy and self-determination combine to make this population very hard to identify until late in the progression of the illness. This fits the agenda of the hoarder and hoarding families very well because they become extremely adept at hiding their behavior. Typically, cases tend to come to light at their nadir, when the person and his or her lifestyle have deteriorated so severely that they demand attention. Consequently, very little is known about the onset and earlier phases of the disorder or its comorbidity with other disorders.

For every hoarding situation that comes to light, there may be an equal or greater number that go undetected because of uneven reporting procedures from community to community. As multidisciplinary teams such as the one at Tufts multiply across various communities, and specifically as they organize themselves to do research, there is great hope of learning more about, and therefore dealing with, the hoarding disorder more effectively. □

Mark A. Chidley is a licensed mental health counselor and certified addiction professional in Fort Myers, Fla. He serves on the Lee County (Fla.) Task Force on Hoarding and is active in treating those with hoarding behaviors as well as training other professionals in intervention and management of hoarding problems. Contact him at mchidley@gmail.com.

Letters to the editor:
ct@counseling.org
Topics of specific interest for 2012:
- Disaster Mental Health
- Social Media
- Military Members and Their Families

ACA is also seeking advanced programs in all areas.

Timeline:
- Pre-conference Learning Institutes: March 21–22, 2012
- Education Sessions: March 23–25, 2012

April 4, 2011 ............................................. Online proposal site opens
June 8, 2011 .............................. Proposal Submission Deadline (5:00 p.m. ET)
August 11, 2011 .......................... Acceptance/rejection notices emailed
November 2, 2011 ............................. Scheduling notices emailed

Submission Deadline:
June 8, 2011 (5:00 p.m. ET)

Please visit counseling.org/conference for additional information.

Note: The primary presenter must be an ACA member.
All Education Session presenters must be registered for the Conference by January 4, 2012.
FY 2011 Election Results

American Counseling Association  
President-Elect  
Bradley T. Erford

Association for Assessment in Counseling and Education  
President-Elect  
Carl J. Sheperis
Treasurer  
Stephanie A. Crockett

Association for Adult Development and Aging  
President-Elect  
Radha Janis Horton-Parker
Treasurer  
Patricia Goodspeed-Grant
Member-at-Large, Branches  
Carolyn A. Greer

Association for Creativity in Counseling  
President-Elect  
Stella Beatriz Kerl-McClain
Trustee  
Julie Strentzsch

American College Counseling Association  
President-Elect  
Monica Z. Osburn
Treasurer  
David J. Denino
Graduate Student  
Member-at-Large  
Hannah Bayne

Association for Counselors and Educators in Government  
President-Elect  
Andree’ M. Sutton
Board of Directors  
David R. Brinkworth
Angie Walshki
* Winner of third slot being determined at press time

Association for Counselor Education and Supervision  
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Secretary  
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Association for Lesbian, Gay, Bisexual and Transgender Issues in Counseling  
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Vice President for Native American Concerns  
Lisa Grayshield
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Sharon L. Bowles

American Rehabilitation Counseling Association  
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Council for Public Relations & Awareness  
Nykisha Moore

Association for Humanistic Counseling  
(formerly C-AHEAD)  
President-Elect  
Mark B. Scholl

Association for Spiritual, Ethical and Religious Values in Counseling  
President-Elect  
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Southern Region  
Governing Council Representative  
Annette P. Bohannon
AHC announces grant recipient
Submitted by Jeff L. Cochran
Jecoehr11@utk.edu

Each year, the Association for Humanistic Counseling's Make a Difference Grant helps fund the research of a graduate student in counseling whose work embraces a humanistic philosophy and will make a difference in the lives of people in need. The winner of this year's award is Sarah E. Carlson. Carlson points out the tremendous importance of teacher-student relationships and notes that teachers often serve children with emotional and behavioral concerns on a daily basis. Her project, "Effects of a Teacher Consultation Model on Elementary School Classroom Interactions," is a humanistic counselor-led intervention into teacher-student relationships that aims to improve the lives of the many children each teacher will reach. Carlson's project is a multiphase, single-case design research model intended to result in new relational skills for teachers. Interventions include teacher training in basic humanistic play therapy skills, supervised teacher-child play sessions and research team modeling of interpersonal skills in the classroom.

The core of the project is facilitating teacher development in the person-centered constructs of empathy, congruence and unconditional positive regard. A primary goal is to enhance teacher understanding and valuing of each child for her or his unique qualities. Another goal is to demonstrate connection, caring and trust in each child's ability to grow within a classroom that facilitates academic, social and emotional aspects of growth.

We would also like to give a very honorable mention to our second highest-rated application. Deborah Ojiambo's project, "Group Activity Play Therapy: Effects of Behavior Problems of Preadolescent Orphans in Uganda," will measure outcomes of a developmentally responsive intervention based on humanistic principles for children who, especially without intervention, are projected to have very bleak futures.

Our decisions were particularly close this year between the top two applications as well as a second tier of very deserving applications. Being humanists, our reviewers always struggle with the inability to provide funding help to all highly qualified projects. We wish all our applicants the very best and continue to be impressed with the work that humanistic counselors are doing.

ACCA announces new leaders, invites applications
Submitted by Greta A. Davis
davis_greta@yahoo.com

The American College Counseling Association Executive Council is excited to announce the results of the 2011 election. Congratulations to Monica Osburn, president-elect; David Denino, treasurer; and Hannah Bayne, graduate student member-at-large. They will begin their terms on July 1. Participation in ACCA is a tremendous professional opportunity, and we are pleased to have these additional leaders join us in our efforts to provide members with access to timely, relevant resources and continuing education opportunities, while also promoting and advocating for college counseling.

If you are interested in becoming more active in ACCA, please consider running for office on the executive council. We are currently seeking nominations for president-elect, secretary and member-at-large for terms beginning July 1, 2012. For more information, contact Greta Davis at davis_greta@yahoo.com or 972.841.7447.

CCA and AMCD take to the seas for conference
Submitted by Adelaida Santana Pellicier
adelaida.santana@nau.edu

The Association for Multicultural Counseling and Development Executive Council was invited by one of its members, Western Region Representative Rosemarie V. Woodruff, to attend a joint venture between the California Counseling Association and the Western Region of AMCD aboard a Carnival cruise ship in February. A cruise from Long Beach, Calif., to Ensenada, Mexico? How much conferencing can one accomplish on a cruise? Surely this was only designed for fun and frolic! I am happy to report I was wrong. The conference chairs delivered all they promised.

Three keynote speakers delivered thoughtful and inspirational words from their lives, work and research. John Corcoran welcomed attendees with a personal narrative. His delivery was personal, honest, funny and captivating as he told of how he “got over” each step of the education ladder: devising ways of cloaking his illiteracy through the age of 48, including completing a bachelor’s degree, raising a family and teaching high school for nearly two decades.

American Counseling Association President Marcheta Evans dedicated her session to outlining the definition of counseling and its seven principles, all of which must serve as guides in our profession and as members of ACA. Cirecie West-Olatunji, a recent past president of AMCD, closed the conference with a call to go beyond empathizing with our global family members who have been traumatized by tsunamis, earthquakes, hurricanes or floods. She challenged us to act on their behalf whenever feasible.

The organizers must rejoice for a cruise well planned and executed. We cruised through the harsh waves of the Pacific to and from Ensenada, dined, networked, shared our expertise, learned, worked, danced and shopped. This conference was well represented by AMCD Executive Council members. Congratulations to conference and program chairs Sharon Bowles, Rosemarie Woodruff and Emma Borens for three days of professional networking, sharing, learning, inspiration, rejuvenation, discovery and fun.

NECA announces award winner
Submitted by Kay Bravoley
kbravoley@mindspring.com

Congratulations to National Employment Counseling Association member Jennifer Del Corso, recipient of this year’s $1,000 scholarship. An adjunct professor at Old Dominion University, Del
Corso received her doctorate in counseling education supervision in May 2010 from Regent University. She is also the Mentor’s Grant Award recipient from NCDA for research on Mark Savickas’ career story interview. Del Corso has been published in the *Journal of Individual Psychology*, *Journal of Career Assessment*, *Counseling: Italian Journal of Research and Application* and *Career Development Quarterly*. She also has an article under review with the *Journal of Vocational Behavior*.

An accomplished presenter, Del Corso’s areas of expertise include career construction theory, adaptability and narrative career interventions. She holds two master’s degrees, one in community counseling and another in pastoral studies. She has worked for the Department of Juvenile Justice and as a private school elementary/middle school counselor and currently works in private practice. In her spare time, Del Corso teaches step aerobics and runs half-marathons. She is also a mom to two children, ages 7 and 9.

Del Corso’s presentation at the NECA Institute on March 25 in New Orleans highlights the necessity for career counselors to embrace a life design paradigm that emphasizes career adaptability at a time when individuals face unemployment, layoffs, reduced hours and hard family/life/work balance decisions. Career adaptation necessitates active coping styles and problem-focused coping strategies that foster proactive, flexible and positive attitudes, beliefs and competencies.

Fighting despair and anxiety does not mean living on false hope, comforting euphemisms or temporary “feel-good” comments from self-help books. Rather, despair and anxiety can be combated by hope, persistence and commitment to the journey and unfolding story of one’s life. By highlighting six different career-adaptability domains — concern, control, curiosity, confidence, commitment and cooperation — Del Corso’s session assists workforce counselors in understanding how to help individuals use problem-solving strategies and coping behaviors that enable them to construct the next chapter in their lifelong career story.

NECA is extremely pleased to recognize an emerging professional and new member for outstanding contributions to the employment counseling profession.
COMING EVENTS

NCJA Annual Conference
April 1-3
Lincroft, N.J.
Meet your colleagues, receive up to a full year’s worth of CEUs, develop professional knowledge and socialize at this year’s New Jersey Counseling Association Annual Conference, to be held at the Donald Warner Student Life Center at Brookdale Community College. For more information, visit njcounseling.org.

Young Child Expo & Conference
April 7-8
New York City
This conference brings together top leaders to provide the latest information about essential topics in early childhood development. For more information, visit youngchildexpo.com.

ACAM Annual Conference
April 7-9
Jefferson City, Mo.
Join your colleagues for three days of presentations from specialists in various areas of counseling at the American Counseling Association of Missouri Annual Conference. Presentation topics include counseling veterans, forensic outpatients, trauma, ethics and more. Up to 20 CEUs are available. For more information, visit counselingmissouri.org.

MeCA Annual Conference
April 11-12
Rockport, Maine
The Maine Counseling Association invites counselors to its annual conference at the Samoset Resort. In addition to a keynote address from Brandon Baldwin, schools and curriculum coordinator for the Maine Civil Rights Team Project, the two-day schedule includes a variety of poster sessions and education sessions. For more information, visit maineca.org.

SDCA Annual Conference
April 27-30
Sioux Falls, S.D.
The South Dakota Counseling Association Annual Conference will offer sessions on topics including school bullies, terminal illness, private practice, addiction and much more. The conference will be held at the Sheraton/Sioux Falls Convention Center. For more information, visit sdco counseling.org.

CCA Annual Conference
April 28-30
Danbury, Conn.
The Connecticut Counseling Association will host its annual conference at the Westside Campus of Western Connecticut State University. Themed “Counseling Connections 2011: Wellness Across the Lifespan,” the conference will include leadership training, play therapy and specialist training in specific strands. Featured speakers include ACA President Marcheta Evans and Jodi Mullen, editor of Play Therapy Magazine. For more information, visit cccmain.com or contact co-chairs Karla Troesser and Gabriel Lomas at ccaconference@hotmail.com.

MHA Annual Conference
June 9-11
Washington, D.C.
Mental Health America’s Annual Conference, to be held at the Hyatt Regency Washington on Capitol Hill, will provide a unique opportunity for people in the field to connect with others who are committed to promoting improved health outcomes and driving down rates of mental health and substance abuse conditions across the country. For more information or to register, visit nmha.org.

FYI

Call for reviewers
Counseling and Values, the journal of the Association for Spiritual, Ethical and Religious Values in Counseling, is seeking several new Editorial Review Board members. If you would like to be considered for a position on the Editorial Review Board, submit a copy of your curriculum vita and a cover letter describing your experience as a reviewer; your expertise regarding spiritual, ethical and religious values in counseling; your experience with quantitative, qualitative and mixed methods research; and your willingness to join ACA and ASERVIC (if you are not already a member). E-mail materials to Editor-Elect Rick Balkin at richard.balkin@tamucc.edu.

Call for transcripts
Alexander Street Press (ASP) is seeking recordings and/or transcripts of therapy sessions for inclusion in a unique academic research collection, “Counseling and Psychotherapy Transcripts, Client Narratives and Reference Works.” This collection is a fixture at universities around the world, with students and faculty relying on the transcripts to better understand the realities of working with clients. Audio and video recordings will be transcribed and anonymized by ASP in accordance with the American Psychological Association’s ethics guidelines for use and anonymity. ASP will pay $50 for each accepted transcript or recorded session. Submit transcripts or questions to Elizabeth Robey, editor of Counseling and Therapy, at ero bey@alexanderstreet.com or Alexander Street Press, 3212 Duke St., Alexandria, VA 22314. For complete transcript submission guidelines, visit alexanderstreet.com/products/psyc/msguidelines.htm.

Call for submissions
The Wisconsin Counseling Journal is seeking article submissions for its fall 2011 edition, a special issue on professional collaboration between mental health professionals. The journal places emphasis on original, data-based research but will also consider conceptual articles (e.g., position papers, innovative program development, case studies). All manuscripts are subject to a peer-review process involving members of the editorial board. The 2008 edition of the Wisconsin Counseling Journal was awarded “Best Journal, Small Branch” by ACA at the 2009 Annual Conference & Exposition in Charlotte, N.C. For submission guidelines, contact Scott Woitaszewski, guest editor, at scott.woitaszewski@uwrf.edu or visit uwrf.edu/CSP/Wisconsin-Counseling-Journal.cfm.

Call for submissions
Therapeutic Innovations in Light of Technology is a free international magazine for helping professionals. We accept articles about online therapy, online coaching, online self-help, cyberpsychology, cybersex addiction and new interventions related to mental health and technology. The current issue, as well as writers’ guidelines, can be found at onlinetherapymagazine.com or by e-mailing editor@onlinetherapymagazine.com.

Bulletin Board submission guidelines
Items for the Counseling Today Bulletin Board must be submitted via e-mail to sballcross@counseling.org with “Bulletin Board” in the subject line. Limit submissions to 125 words or less. Non-calendar items will be published for a maximum of three consecutive months. The deadline for submissions is the first of the month at 5 p.m. ET for publication in the following month’s issue (for example, the deadline for the May issue is 5 p.m. ET on April 1).

April 2011 | Counseling Today | 53
Do the Right Thing

1. Counselor Patrice Hinton Oswalt applauded which of the following revisions included in the 2005 revision of the ACA Code of Ethics?
   a) Acknowledging that nonprofessional interactions or relationships with clients are sometimes unavoidable.
   b) Establishing boundaries on the use of social media by counselors.
   c) Acknowledging that some counselors fail to interpret tests and other instruments for clients.
   d) Adding sections that address multiculturalism and diversity.

2. Which of the following strategies does ACA Ethics Committee Cochair Gary Goodnough suggest as an initial step in addressing a student behavior issue or problem that may result in an ethical violation?
   a) Dismissal from the program.
   b) Establishment of a remediation plan.
   c) Participation in an ethics seminar.
   d) Requiring personal counseling for the counseling student.

3. Counselor Laura Hahn suggests which of the following social media strategies for counselors?
   a) Keeping personal and professional information separate.
   b) Refraining from "friending" clients.
   c) Including social media policies as a part of informed consent documentation.
   d) All of the above.

4. Which of the following informed consent outcomes does Erin Martz, ACA Manager of Ethical and Professional Standards, cite as important to the counseling process?
   a) It helps the counselor establish rapport with the client and ensures the client is actively involved in the process.
   b) It provides information about the roles and responsibilities of both the client and counselor.
   c) It can protect both parties in the case of a subsequent dispute.
   d) All of the above.

Don't Touch Me

5. Individuals having trouble understanding, processing and reacting to information received through their senses are thought to suffer from:
   a) Sensory stimulus disorder
   b) Sensory defensive disorder
   c) Sensory processing disorder
   d) None of the above

6. Often considered a dysfunction of special needs children, psychologist and author Sharon Heller projects what percentage of functioning adults experience some level of sensory disorder?
   a) Five percent
   b) Fifteen percent
   c) Thirty percent
   d) Fifty percent

ACAC Becomes Newest Organizational Affiliate of ACA

7. According to founding president Randy Astramovich, the Association for Child and Adolescent Counseling is interested in the work of counselors in what settings?
   a) Schools
   b) Private practice
   c) Multiple settings
   d) Mental health and community agencies

Reader Viewpoint: To Have and to Hold

8. When object and animal hoarding first came to the attention of law enforcement, code enforcement and animal control experts, it was thought to be an exotic subtype of what disorder?
   a) Borderline personality disorder
   b) Phobias
   c) Obsessive-compulsive disorder
   d) Panic attacks

New Perspectives

9. The author found the application of what counseling principles to be useful in her personal navigation of the job search process?
   a) Cognitive behavior therapy
   b) Adlerian therapy
   c) Humanistic therapy
   d) Existential therapy

Inside the DSM-5

10. When the bereavement exclusion was inserted in the DSM-III (and subsequent editions), which of the following influenced the inclusion?
    a) Thirty-five percent of widows and widowers met the criteria for clinical depression one month after their spouse's death, and one-third of those remained depressed for at least a year.
    b) Bereavement after the loss of a loved one is a natural reaction, not a pathological or diagnosable disorder.
    c) Symptoms of grief dissipate over time.
    d) All of the above.

I certify that I have completed this test without receiving any help choosing the answers. Signature __________________ Date __________

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Mail: Complete the test and mail (with check or money order made payable to American Counseling Association) to: ACA Accounting Department/CT, American Counseling Association, 5999 Stevenson Ave., Alexandria, VA 22304. Allow 2–3 weeks for processing. Questions? 800-347-6647, x306.

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- Deadlines: Vary per issue. Contact Kathy Maguire at 607.662.4451 or kmaguire@counseling.org for further details.
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Calendrier

Clinical Hypnosis Workshop
12th Annual; April 29 – May 1, Durham, NC. 3 day intensive training approved by American Society for Clinical Hypnosis. Offered by Medical Hypnosis Consultants, co-sponsored by UNC & Duke Integrative Medicine Programs. 20 NBCC CEUs. For information contact Dr Holly Forester-Miller: HFM@WClconsultants.org

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The Department of Veterans Affairs (VA) is one of the largest, most technologically advanced health care systems in the United States. Our employees work at 154 medical centers, 875 ambulatory and community-based outpatient clinics, 136 nursing homes, and many other facilities, such as domiciliaries and readjustment counseling centers. More than a century ago, President Lincoln made a promise to America's servicemen and women, pledges the care and concern of a grateful Nation for the sacrifices they made to preserve freedom. Since 1930, VA's mission has been to keep that promise.

Veterans’ mental health is a top priority at VA. After returning from combat, many veterans struggle to readjust to life at home. Our mental health care providers play a critical role in helping these veterans reclaim their lives by providing cutting-edge care. VA supports this mission by ensuring that our mental health professionals have the most innovative technologies, facilities, and training at their fingertips. When you join VA, you will be a core member of our interdisciplinary care team structure, collaborating with both primary care and other mental health professionals to establish the right course of treatment for patients. VA has health care facilities in all 50 states, the District of Columbia, and Puerto Rico.

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**Desired Qualifications:**
(1) professional counselor licensure or licensure eligibility; (2) demonstrated experience in grant preparation; (3) demonstrated experience working with diverse populations; (4) demonstrated experience in professional service in counseling organizations.

**Responsibilities:**
(1) teach graduate courses in counseling programs (Masters/Doctoral -Counselor Education, Doctoral-Counseling Psychology); (2) conduct research and prepare manuscripts for professional publication; (3) participate in program administration and student clinical practice supervision; (5) prepare grant applications to secure funding for training, research, or service; (6) participate in student research activities including participation in students’ dissertation/thesis committees; (7) participate in professional outreach activities in school and community settings; (8) participate in professional service activities in counseling organizations; and (9) participate on department, college and university committees.

**Qualified applicants should submit:**
(1) a letter of application detailing qualifications for the position and research agenda, (2) a complete vita, (3) official graduate transcripts, (4) examples of research publications (e.g., articles, conference presentations, manuscript drafts etc.), (5) evidence of experience in teaching (e.g., teaching effectiveness reports, faculty peer evaluations, sample syllabi, etc.), and (6) three letters of recommendation to:

Dr. Jamie Carney, Chair, Counselor Education, Department of Special Education, Rehabilitation, and Counseling/School Psychology, 2084 Haley Center, Auburn University, AL 36849-5221

**Application Deadline:**
Screening will begin April 1, 2011 and will continue until a suitable candidate is recommended for appointment. Starting Date: August 2011. The College of Education at Auburn University is committed to the AAUP/Land Grant mission of the university and this mission is carried out through research and outreach programs. The university is located in a college town, a short distance from Tuskegee, Montgomery, Birmingham and Atlanta. http://www.auburn.edu/serc Auburn University is an equal opportunity/affirmative action employer. Women and minorities are encouraged to apply.
anticipated completion by August, 2011). Applicants must have demonstrated the potential to maintain an active program of scholarly research and grant writing related to the substance abuse counseling field. Successful candidates will have demonstrated an ability and commitment to online pedagogy.

To apply for position (210UC2148), please see www.jobsatuc.com. Review of applications will begin February 25, 2011. The position will remain open until filled. Start date for this position is September 1, 2011. For further information, please contact Michael D. Brubaker, Ph.D. at michael.brubaker@uc.edu. The University of Cincinnati is an affirmative action/equal opportunity employer. UC is a smoke-free work environment.

OKLAHOMA

OKLAHOMA CITY UNIVERSITY

Director of Addiction Prevention Studies (Faculty Rank Open)

The School of Liberal Arts and Sciences invites applications and nominations for the position of founding Director of Addiction Prevention Studies at Oklahoma City University. This position will begin in August 2011. We seek a dynamic leader, teacher, and scholar with a demonstrated commitment to the field of addiction prevention studies. The successful candidate will have a background in research on addiction and prevention. A doctorate in the social and/or behavioral sciences or a related field such as public health is required; certification in drug and alcoholism treatment is desirable but is not essential. Both prior clinical work and teaching experience are preferred, but related professional credentials will be considered. This is a full-time 12-month position. The duties will include creating and directing an addiction prevention research center, and seeking external funding to support research and prevention from agencies such as the U.S. Department of Education’s Office of Safe and Drug-Free Schools and other sources. The ultimate goal of the director shall be establishing and developing a regionally recognized Center for Addiction Prevention Studies and program. This position includes a required two course per semester teaching load in an addiction related area. For more details about the position and a description of the University and how to apply, see: http://ocucareers.silkroad.com/. Oklahoma City University is an EOE.

VIRGINIA

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ACA members can download complete issues of Counseling Today from the website.

Visit counseling.org, click on "Publications," then click on "Counseling Today."
A counselor’s story…

8:00 a.m. Get to the office early. Start the coffee. Check voice mail. Leave a brief message for my client Brad. Don’t want his wife over-hearing anything confidential.

9:00 a.m. First client, Mark. Dealing with depression. Lost his job of 15 years. Body language anxious. Admits he is contemplating shooting his ex-boss.

10:00 a.m. Christine has a long-running drug and alcohol problem. Making great progress. Offers to clean my house in return for counseling sessions.

11:00 a.m. Mary gave me a big hug, again. She wants me to testify at her son’s child custody hearing. Let’s me know husband is going to subpoena her records. She invites me to dinner.

12:00 p.m. Grab lunch at desk. Check email. Sign up for CE class on crisis management.

Read an article on lawsuits filed over ‘client confidentiality.’ It is important to know when to protect a client’s privacy and when it’s required by law to report certain behavior.

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LEARN FROM THE EXPERTS

Janis Frankel, Ph.D.

Also known as “Dr. J,” Dr. Frankel has been preparing candidates for licensing exams for 25 years. After completing her undergraduate degree at the University of California, Berkeley, she earned her Ph.D. in Clinical Psychology. Dr. J has many years of experience as a private practitioner, making her full-time consulting work for AATBS as an Educational Consultant a benefit to participants in our programs.

Dear AATBS,

I just wanted to write to you to THANK YOU for helping me pass my NCE exam today! Thank you so much for offering a site that was so easy to navigate and understand. Your questions, method of studying, and way of teaching led me to score significantly higher than I could have imagined.

Please know that if there is anyone else attempting this exam, I will surely refer them to you as this has been the best place for me to study!

I am truly thankful to each of you at AATBS for working as hard as you do to help us older folks excel in our fields when our attempts in the past have failed. Many, many blessings of abundance to all of you. A special thank you to Dr. Frankel who helped me through a few study questions I had. She took time to answer my concerns very quickly and with great support.

THANK YOU SO MUCH!!!!

Sincerely,
Chris Mrazik
(September, 2010)

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