As therapists, we often share our clinical perspective and experience of mental illness, but we rarely hear the perspective of the client. However, it is my goal to help change the angle perceived of mental illness by giving the client a voice to share their perspective of success in counseling. Please take a moment to read the process of success in therapy from the viewpoint of a client. Enjoy!

Annetta Benjamin, LPC, MA, NCC

The Bipolar Illness: Client Perspective “No Excuses”

BY MRS. JODIE HANSOHN, WIFE, MOTHER, AND CLIENT

Hello, I’d like to introduce myself. My Name is Mrs. Jodie Hansohn and I have the Bipolar illness, but it does not have me. I would like to share with you and talk about my past struggles and how I have presently overcome them.

I would first like to thank the NVLPC for giving me the opportunity to share this article and to be recognized. I also would like to thank Ms. Annetta Benjamin, my counselor, and coach, one of the most important people in my life who has helped me to overcome my fears and to reach my goals. Ms. Annetta Benjamin has been there every step of the way. I would not be where I am today without her as my counselor and now to have the opportunity have to have as my life coach.

I would like to begin with sharing that I have presently been in counseling for 11 years to date, and nine of them have been with Ms. Annetta Benjamin. Over the years I have completely dedicated myself to understanding the bipolar illness. Understanding how the bipolar illness works, has helped me accomplish my goals and develop the tools to create a lifetime of happiness.
In order for me to manage the bipolar illness, my counselor taught me that I had to first recognize and focus on understanding what my individual issues were as well as my triggers. Then I was able to communicate those issues in therapy for my counselor to help provide me with coping tools that would help me in the healing process and to assist me to manage the bipolar illness.

In the past, I had layers of misunderstandings, with a lack of knowledge by choice, on how to take care of myself with the illness. I have come to understand that the bipolar illness is its own identity and with its own triggers that you solely can control and take care of for a healthy, happy life.

If you are like me and have struggled to manage your emotions in the past, I know what you are going through and you are not alone. I understand the feeling of being unhappy but not understanding why. I understand the feeling of hurt and the anger that come with the bipolar illness. I understand how important words are to you and you cannot take them back after you say something hurtful. I also understand the consequences of not just name-calling but throwing and breaking things. However, these were choices that I had to take control of so there would not be repercussions that could cause more issues to solve and overcome.

For me, the feeling of hurt that I allowed to be ignited within myself became overwhelming, which then allowed for bad behaviors, choices, and consequences to occur. It is important to understand that each person with the bipolar illness has their own triggers that can push them over the limits.

During my years of counseling with Ms. Annetta Benjamin, she provided the consistent tools that I did not have in my past. Ms. Benjamin provided the tools that helped me recognize when the triggers of hurt and anger ignited inside of me and how not to react to it. It is important to understand that the trigger is just a feeling and only a feeling. The feeling of anger and hurt is in your control and you do not have to react to that force.

During the years of counseling I have followed the two key components to a healthy life with the bipolar illness. The two key components are counseling and medication. Staying dedicated and consistent with cognitive therapy and medication have brought me to a lifetime of happiness. To be stable with the bipolar illness you must have these two in your life. My other necessary tool that I learned in counseling was journaling. I learned to journal my helpers and hurts, which Ms. Benjamin wrote about in her book *5 Helpers 5 Hurts!* This is an imperative tool to manage your thoughts and feelings. I highly recommend that everyone get this book and learn to journal daily!

Overall, to live an emotionally healthy life with the bipolar illness you must make NO EXCUSES. This is my motto for my life. Choose to be accountable for your emotions and behaviors. Be honest with yourself and you can begin to develop a mentally stable life. Thank you again for allowing me to share.

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**Changes to our training events due to COVID-19**

During Fall, 2020, our breakfast trainings and Fall workshops will be held in an online format. We will still offer CEs for attendance at these events.

**FEES FOR VIRTUAL WEBINARS:**
- Student/Resident/Retired members - $20
- Clinical/General - $25
- Non-members - $30

There are no early bird discounts.

In January, we will reevaluate the format for trainings and may add some in-person events. Please stay tuned (via your email and the website) for information on upcoming trainings.

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**Resources for Members**

NVLPC hosts an [email group/listserv](mailto:) just for members who are current in their paid membership. Request to join our [Yahoo Group here](mailto:). Looking for support, camaraderie, and connection with fellow therapists? Consider joining a [Peer Support Group](mailto:). Sign up [here](mailto:).

*Additional resources* available under For Members on the website.
Is Your Teen Vaping or Using Drugs?

BY ANDREW E. COLSKY, JD, LLM, LPC

WHAT IS VAPING?

Vaping is the act of using an electronic device, or e-cigarette, to inhale vapor infused with nicotine, THC or other chemicals. The user obtains a “buzz” from the nicotine or a “high” from the THC.

E-cigarettes contain a battery, sensor, microprocessor, heater, light and chemical cartridge or tank. The user loads the tank usually with nicotine, THC, or both and inhales the vapor into their lungs.

Vaping is easy to hide because it has low odor and e-cigarettes can be disguised as car keys, inhalers, hoodies, backpacks, magic markers and more. (See photos of devices at www.teenvapingandaddictioncenter.com)

HOW DO I KNOW IF MY TEEN IS USING?

Keep your eyes open for the following tell-tale signs of addiction. By the time you notice the following, the reality is that your teen has probably been using substances for quite some time. Some may start as early as 6th grade while many start in 8th grade, more in 9th grade and by time teens reach 12th grade, there is a greater than 35% chance that they are using substances.

- Changed relationships with family members or friends
- Changes in mood or unusually hostile
- Unusual thirst
- Change to clothing and appearance
- Poor hygiene
- Drop in grades
- Complaints from school/teachers
- Often uses over-the-counter preparations to reduce eye reddening or nasal irritation
- Frequently breaks curfew
- Has cash flow problems
- Drives recklessly, and has car accidents or unexplained dents in the car
- Avoids eye contact
- Locks doors
- Goes out every night
- Makes secretive phone calls
- Makes endless excuses

Continued on page 4
Is Your Teen Vaping or Using Drugs continued from page 3

- Has the “munchies” or sudden appetite
- Exhibits uncharacteristically loud, obnoxious behavior
- Laughs at nothing
- Has become unusually clumsy: stumbling, lacking coordination, poor balance
- Disappears for long periods of time
- Has periods of sleeplessness or high energy, followed by long periods of “catch up” sleep

WHAT DO I DO IF MY TEEN IS USING?

PUNISHMENT DOES NOT WORK

You just caught your teen using drugs. At first you are in shock; you have heard of bad kids abusing drugs, but this is your kid. You’re not a bad parent. You have worked hard to give your child the best home, education and opportunities. It must just be a momentary lapse in your child’s judgment; he just fell in with the wrong crowd.

A typical scenario occurs as follows: You discover that your teen is using drugs. You are furious, yell at him and quickly impose punishment. He yells back, runs to his room and slams the door. You are upset and confused and question where you went wrong. You hope that your punishment has solved the problem. Eventually you discover that your teen is still using drugs. You again become furious, yell louder this time and impose even harsher punishment. Your teen yells back, exclaims that he will not follow your rules and may even become physically violent. You now fear for your own safety and feel at a loss as to how to handle the situation. Arguments, fighting and challenges become commonplace. Assuming your teen has not already become engaged with the legal system, or even if he has, you seek professional help.

Punishment does not work because it is reactive, fear-based, unrelated to the behavior and treats the child as the problem. Consequences, however, are proactive, learning-based, related to the behavior and treat the behavior as the problem. One of the most effective methods I have developed in my practice to address teen substance use is my Teen Action Plan for Success (TAPS). The plan is based on a behavior modification model using consequences, not punishment and is designed to help teens stop using substances by addressing co-occurring disorders, stressors, anxiety and more while avoiding the negative consequences caused by punishment.

If you believe that your teen is using substances it is important to seek professional help before taking action. A proactive, well-planned approach will afford you the best opportunity to address the situation and develop an effective treatment plan.

Andrew E. Colsky, JD, LLM, LPC is a mental health counselor and runs Teen Vaping and Addiction Center at Center for Professional Counseling, PLC in Falls Church, Virginia [www.centerforprofessionalcounseling.com](http://www.centerforprofessionalcounseling.com)

He can be reached at 571-527-8197 or acolsky@centerforprofessionalcounseling.com
Resilience as a Therapist

BY FAITH JAMES, PHD, LPC

According to the APA’s Resilience Initiative, Resilience is the human ability to adapt in the face of tragedy, trauma, adversity, hardship, and ongoing significant life stressors.

On a daily basis, I work to encourage the restructured thinking that harnesses resilience. Dr. Noam Shpancer wrote an article for a recent issue of Psychology Today that touches on this very topic. This lets me know I am in good company. He states that “Resilience is the experience of undergoing adversity without suffering debilitating effects.”

I am regularly reminded of the need for resilience as a therapist and small business owner.

In studying the work of Dr. Arielle Schwartz regarding resilience, I find her to be dedicated to strength-based psychotherapy, which is entrenched in fostering resilience in clients.

When I sat down to write this article, I was thinking of how I as a therapist and business owner am relying on internal resilience to do my job and be in a good headspace at the end of the day. What is interesting about the research related to resilience is the premise that most people are very resilient following trauma. While I know this internally, within my work I find that at times I am re-teaching others to practice some of the tenants of resilience given by Dr. Schwartz: Growth Mindset, Self-Expression, Emotional Intelligence, Choice and Control, Embodiment, and Community Connections.

Over the past month in my work I have focused heavily on having a Growth Mindset and Community Connections. As a therapist I strive to be present in the lives of my clients. We are all working outside of what was “normal” in psychotherapy. I find that I have to be creative, innovative, and forward-thinking to keep my practice thriving. When I hear people say we have been in COVID for 8 months, I can believe it, but at the same time I cannot. I have been so heavily focused on providing good quality care in the face of adversity that I have not really considered the time frame. I believe that growth and wisdom can be gained from this trying time. I work to impart that to clients. My goal is for everyone on my case roster or those working alongside me to feel my energy of growth. Not only is this encouraging, but it gives a road map to internal peace.

I also find myself encouraging people to seek out relationships that are healthy and positive. I believe we should treat our relationships like plants or gardens. We must tend to them and nurture them so they will grow. I work with couples and I have one hard and fast rule related to COVID-19: “Please do not divorce your spouse during a pandemic!” (Of course, there are qualifying statements for abuse). But the moral of the story is, we need each other. Many times, in a crisis we can be reactive, and I want to encourage folks to be proactive. Resilient people stay connected to others and they do not isolate themselves. Some of our clients live alone or have family far away. My goal is to pay close attention to this category because they may be at a higher risk for situational depression. So, I use the tenant of Community Connections as a way to foster resilience in people.

I am not sure what the next month will bring, but I encourage you to visit Dr. Schwartz’s page (https://drarielleschwartz.com/) and read a little about her thought process. For those of you who use strength-based psychotherapy rooted in resilience, thank you for all that you do. While I appreciate that there are many ways to meet clients where they are, I find this approach to be rewarding for the individual both inside and out and it helps me to feel that I am relevant as a therapist.

1 Apa.org
Combat and Stress by the Numbers

BY ALEXIS ARNETTE, MA, LPC

Freshly home from Afghanistan, reintegration into society posed a different set of challenges than my previous deployment. Our country (like many) was grappling with the coronavirus pandemic, Americans were protesting racial injustice and inequality, the Dow dropped to a record low since 1987, and many Americans were unemployed. It was overwhelming. Fortunately, I returned to a supportive community, full-time employment, and stable housing. Unfortunately, many of my fellow brothers-and-sisters-in-arms did not.

I recognize that even without a global pandemic, reintegration poses a unique set of challenges such as community support, family reunification, employment (for retirees, reservists and National Guardsmen), housing, detoxing from the high operational tempo, and healing from physical and psychological injuries. Service members do not necessarily have to experience combat to encounter these stressors.

As the country commemorates Veteran’s Day, as a mental health provider and veteran, I wanted to take time to highlight some common stressors service members and veterans face. Hopefully, the mental health community will continue to sharpen its cultural competency skills for the many facets of the service member and veteran population.

General Dwight Eisenhower (1948) said, “The capacity of soldiers for absorbing punishment and enduring privations is almost inexhaustible so long as they believe they are getting a square deal, their commanders are looking out for them, and their accomplishments are understood and appreciated” (p 315). The sacrifices service members undertake are not always without consequence.

The Army suicide prevention program states veterans are 1.5 times more likely to commit suicide than people who have never served in the military. This might be due to the high operations tempo service members endure. According to the Rand Corporation, there have been a total of 1.4 million combat deployment years to Iraq and Afghanistan from 2001 to 2018. This includes individuals like me with multiple deployments. According to the Watson Institute of International and Public Affairs, veterans are 200 percent more likely to be diagnosed with a disease within 5 years from returning from deployment. The Department of Veteran Affairs website shows that more than 1.5 million of the 5.5 million veterans seen in VA hospitals had a mental health diagnosis in 2016. This represents approximately a 31% increase since 2004.

Although those numbers are daunting, the mental health community can aid in its reduction by continuing to spread awareness to civilians, service members, and veterans. Over the past several weeks I had the privilege of speaking to my fellow brothers-and-sisters-in-arms. The stigma of appearing weak and losing one’s job are two reasons many service members and veterans suffer silently. A young non-commissioned officer stated, “The rest of America sees us as strong; if I go to counseling, they will not believe in their heroes anymore. America needs something to believe in, considering everything happening.”

Many civilians and service members I have encountered often assume every service member who comes home from an overseas tour automatically has PTSD. Combat stress is often confused with PTSD, which can occur after someone goes through a traumatic event like combat yet dissipates after a few weeks or months of being home. While many of the symptoms

Continued on page 7

www.nvlpc.org
are similar between the two conditions, they are different. Educating service members, veterans and the public on the difference will also help in reducing stigma and may allow more members of the military to reach out for necessary help.

Community support also plays a huge role in the reintegration process for service members, whether they are coming home from deployment or retiring from service. If more providers are interested in supporting service members, veterans, and their families, there are plenty of opportunities. 1) Register on Military One Source as a service provider. 2) Credential with TRICARE. 3) Volunteer for the Military Crisis Line at 800-273-8255. 4) Volunteer to speak with a military Chaplin or Master Resilience Team.

Thank you to all the professionals currently providing treatment to service members and veterans. A special thank you to the members of the military community I had the honor of serving and speaking with. In anticipation of Black History month, I will highlight unique challenges facing people of color in uniform.

Resources:


https://www.va.gov/vetdata/

https://www.rand.org/topics/military-veterans.html


**WE ARE HIRING**

Immediate Hiring for VA Licensed Mental Health Practitioners to join our busy group practice with multiple locations. We are a Platinum Provider for insurers which means we provide excellent care and receive great reimbursement. A good fit for our practice is someone who is hardworking, gets along well with others, and brings clinical expertise.

We need all types of providers who can treat a variety of patients (adults, couples, adolescents, children, families). A 2-year minimum commitment and signed contract are required for either a Full or Part-Time Independent Contractor position. We have openings in Old Town & Landmark (Alexandria), Vienna, and Reston. Part-Time contractors can expect to see 32 patients per month or about 8 patients per week. Full-time contractors are required to meet with a minimum 20 patients per week.

Eligible applicants MUST have a VA license in good standing with no malpractice claims. We can assist with developing your CAQH and obtaining your NPI, which are both required for billing insurance. We handle referrals, billing, office space, and administration in addition to providing the EHR; all you have to do is see patients, treatment plan and document progress notes. We are hoping to establish a long-term working relationship. Day, evening, & weekend hours available.

For questions or additional information, please contact our Clinical Director, Dr. Teresa Correia, at 571-969-2367. Interested applicants may email a cover letter and resume to tdcorreia@protonmail.com

https://drgoldberg.org/
FALL WORKSHOP: Anxiety In Person and Online Advanced Assessment and Treatment

NVLPC is proud to host Michelle M. May, LPC, NCC on November 6th, 2020 in webinar format for the Fall 2020 Workshop:

Anxiety In Person and Online:
Advanced Assessment and Treatment

9:00 am-1:30 pm
lunch break from 11am – 11:30am

*Earn 4 contact hours for attending this event*

About the Workshop:

Through the use of videotaped sessions, Michelle M. May, LPC will demonstrate how to spot different types, levels, and symptoms of unconscious anxiety. In addition, she will teach how to regulate and treat this anxiety, leading to lasting change. Michelle will also focus on recognizing and using the therapist’s unconscious anxiety to aid in the therapeutic process. With telementerapy now being so prevalent, Michelle will also discuss how to assess unconscious anxiety in a partially-visible client. This will be a highly interactive workshop.

Confidentiality Notice: Due to the workshop featuring videotaped sessions, all participants will be asked to sign a confidentiality form prior to the workshop. Please see the NVLPC website for additional information.

The following learning objectives will be offered:

- Participants will learn three different types of unconscious anxiety pathways
- Through the use of videotape, participants will learn how to spot and identify these types of anxiety
- Through the use of videotape, participants will begin to learn to regulate and treat these three levels of anxiety and help clients do the same
- Participants will learn how to identify and use their own anxiety to help the client
- Participants will learn how to apply these lessons to teletherapy

About the Presenter:

Michelle M. May, LPC, NCC is a specialist in Intensive Short-Term Dynamic Psychotherapy (ISTDP). She currently is in individual private practice in Arlington, VA, specializing in ISTDP with both individuals and couples. In the past, Michelle has worked in the criminal justice mental health system in Alexandria, VA and at The Renascence Center, LLC, in Arlington, VA.

Michelle M. May, LPC is a faculty member at the Washington School of Psychiatry's ISTDP program in Washington, DC and is also a graduate of the 3-year postgraduate ISTDP training program at the Washington School of Psychiatry. Michelle is a board-approved supervisor with the state of Virginia. Michelle is also certified in Gottman Method Couples Therapy - Level I.

Registration Cost

<table>
<thead>
<tr>
<th>Members</th>
<th>Early (10/27)</th>
<th>Regular</th>
<th>Non-Members</th>
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<th>Regular</th>
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<td>Student/Resident/Retired</td>
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<td>$85</td>
<td><strong>Last day to register for workshop is: 11/4/20</strong></td>
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Register for the Fall Workshop online at https://www.nvlpc.org/events

Membership information is available at NVLPC.org
Amy Hull, Administrative Assistant, PO Box 122 Ashburn, VA 20146
Contact: Workshop@nvlpc.org (703) 400-0751

NVLPC has been approved by NBCC as an Approved Continuing Education Provider, ACEP No. 6130. Programs that do not qualify for NBCC credit are clearly identified. NVLPC is solely responsible for all aspects of the programs.
Play & Expressive Therapy Interventions for Enhancing Emotion Regulation

1.5 Credit Hours

When: Friday, December 4th, 10:00 AM

Where: Online (all events this fall are being held virtually)

Presenter: Christa Butler, LPC, RPT-S

Contact: Ericka Nelson Events@NVLP.org

Registration Information: Online registration is available until: 12/3/2020. Register online at any time. Registration will end at 11:59 pm on 12/3.

***In registering for this event, I agree to allow NVLPC to share my email address with the presenter. This will only be done, as needed, for distribution of presentation-related materials***

Fees for Virtual Webinars:

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<tr>
<th>Student/Resident/Retired members</th>
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<td>$20</td>
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</table>

Refund, Cancellation, and Inclement Weather Policies:

To cancel, please call or email 24 hours in advance or you will be charged for the event. If NVLPC cancels an event, you will be refunded the cost of the event. During inclement weather NVLPC will host the event as scheduled; events will only be cancelled in circumstances when the federal government shuts down due to inclement weather.

About the Event:

In treating youth who have experienced trauma, skills for emotion regulation often becomes one of the primary needs of the treatment plan. This training will help play therapist identify play therapy interventions for enhancing emotion regulation.

Emotion regulation skills that incorporate play are fun, engaging, provide mind-body integration, sensory stimulation, and creative expression. The purpose of this training is to learn how to integrate play therapy interventions when treating emotion dysregulation. Play therapist will learn about how play and expressive therapies can effectively improve emotion regulation. This training will review play therapy interventions that are fun and effective for promoting healthy regulation in children.

Objectives:

1. Enhance knowledge about the signs and symptoms of emotion dysregulation integrated with the use of play therapy assessment skills.
2. Identify at least two play therapy techniques for helping clients expand their affective vocabulary.
3. Identify at least two play therapy interventions for teaching children how to regulate their emotions.
4. Discuss the importance of co-regulation, and how your regulation is a tool for helping clients.

Earn 1.5 Contact Hours for attending this event.

Continued on page 10
Implementing Integrative Models into Clinical Practice

1.5 Credit Hours

When: Friday, December 18th, 10:00 AM

Where: Online (all events this fall are being held virtually)

Presenter: MJ Harford, MA, NCC, RYT, Resident in Counseling

Contact: Ericka Nelson, Events@NVLPC.org

Registration Information: Online registration is available until: 12/17/2020. Register online at any time. Registration will end at 11:59pm on 12/17.

***In registering for this event, I agree to allow NVLPC to share my email address with the presenter. This will only be done, as needed, for distribution of presentation-related materials***

Fees for Virtual Webinars:

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About the Event:
The use of mindbody/integrative approaches within counseling (yoga, meditation, mindfulness, somatic experiencing, etc.) are on the rise, and for good reason! There is a growing body of research to support the effectiveness, and necessity, of bringing the body into the counseling space. This workshop will provide clinical mental health providers with ethical, evidence-based information and resources to increase provider confidence and competence in utilizing these approaches for both virtual and in-person practice. Existing implementation models, a competence and readiness evaluation tool, and how to develop a strong verbal and written informed consent will all be covered. There will be time throughout to explore personal perspectives through guided reflection. Providers who already confident in their mindbody approach and those interested in increasing their mindbody skills will each find meaningful content.

Learning Objectives:
1. Attendees will identify at least 1 implementation model that fits their practice goals and needs.
2. Attendees will assess personal competence and readiness utilizing proposed evaluation tool.
3. Attendees will develop a verbal and written informed consent for a mindbody intervention.

Earn 1.5 Contact Hours for attending this event.

Continued on page 12
# Calendar of Trainings Fall, 2020

<table>
<thead>
<tr>
<th>Date</th>
<th>Meeting Type</th>
<th>Speakers &amp; Credentials</th>
<th>Title of Event</th>
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<tbody>
<tr>
<td>9/25-9/27/2020</td>
<td>Virtual</td>
<td>Sharon Watson, LPC, LMFT, LSATP, NCC, ACS</td>
<td>Supervision Training</td>
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<tr>
<td>10/9/20</td>
<td>Virtual</td>
<td>Annetta Benjamin, LPC, NCC and Mrs. Jodie Hansohn</td>
<td>Coping and Succeeding with Bi-polar: Client Perspective</td>
</tr>
<tr>
<td>10/23/20</td>
<td>Virtual</td>
<td>Andrew Colsky, JD, LLM, LPC</td>
<td>Navigating the Challenges of Teen Vaping and Addiction</td>
</tr>
<tr>
<td>11/6/20</td>
<td>Virtual</td>
<td>Michelle May, LPC, NCC</td>
<td>FALL WORKSHOP: Anxiety In Person and Online: Advanced Assessment and Treatment</td>
</tr>
<tr>
<td>11/20/20</td>
<td>Virtual</td>
<td>Linda G. Ritchie, Ph.D.</td>
<td>Hypnotic Language: Words and Patterns for all Therapists</td>
</tr>
<tr>
<td>12/4/20</td>
<td>Virtual</td>
<td>Christa Butler, LPC, RPT-S, Nationally Certified TF-CBT Therapist</td>
<td>Play &amp; Expressive Therapy Interventions for Enhancing Emotion Regulation</td>
</tr>
<tr>
<td>12/18/20</td>
<td>Virtual</td>
<td>MJ Harford, MA, NCC, RYT, Resident in Counseling</td>
<td>Implementing Integrative Models into Clinical Practice</td>
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<tr>
<td>1/8/21</td>
<td>Virtual</td>
<td>Cyndi Turner, LCSW, LSATP, MAC</td>
<td>Practicing Alcohol Moderation: A Harm Reduction Alternative to the Abstinence-Only Model</td>
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<tr>
<td>1/22/21</td>
<td>West (In Person)*</td>
<td>Joan Monahan, LPC</td>
<td>The Art of Therapy the Value of EMDR</td>
</tr>
<tr>
<td>2/12/21</td>
<td>Virtual</td>
<td>Dr. Lenese N. Stephens, EdD, LPC, LCPC, MAC, MAC, NCC, ACS, BC-TMH</td>
<td>What Are You Hungry For?</td>
</tr>
<tr>
<td>2/26/21</td>
<td>West (In Person)*</td>
<td>Lori Kelly, LPC</td>
<td>Integrating Neuroemotional Technique into the Therapeutic Process</td>
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<tr>
<td>3/12/21</td>
<td>Virtual</td>
<td>MJ Harford, MA, NCC, RYT, Resident in Counseling</td>
<td>Navigating the NCMHC</td>
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<tr>
<td>3/26/21</td>
<td>West (In Person)*</td>
<td>Emily M. Brown, LMFT, Resident in Counseling</td>
<td>Emotionally Focused Therapy</td>
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<td>4/9/21</td>
<td>TBD</td>
<td>TBD</td>
<td>SPRING WORKSHOP: TBD</td>
</tr>
<tr>
<td>4/23/21</td>
<td>West (In Person)*</td>
<td>Megan MacCutcheon, LPC, PMH-C</td>
<td>Understanding and Treating Perinatal Mood &amp; Anxiety Disorders</td>
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<td>5/7/21</td>
<td>Virtual</td>
<td>Terri Pilkerton, MAEd, NCC, Resident in Counseling</td>
<td>Using Mindfulness to Counteract Racial Bias</td>
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<td>5/21/21</td>
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<tr>
<td>6/4-6/6/2021</td>
<td>Virtual</td>
<td>Sharon Watson, LPC, LMFT, LSATP, NCC, ACS</td>
<td>Supervision Training</td>
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</table>

Our Events and Workshop Chairs are working on finalizing details with presenters and venues for some of the events. As the information becomes available, additional information will be provided through future newsletters and the website. Always check the website for the most updated information and registration links.

* A final decision regarding in-person events will be made in January.
The Supervision Corner  Important Notes and Updates

BY SHARON WATSON, LPC, LMFT, LSATP, NCC, ACS – Supervision Chair – supervision@nvlp.org

SURPRISE!!!!

All licensure regulations have been updated as of 10/15/2020!

I briefly reviewed the new LPC regulation and the only changes I saw were: an increase in a returned check fee (from $35 to $50) and on page 7 the addition of “C. Graduates of programs that are not within the United States or Canada shall provide documentation from an acceptable credential evaluation service that provides information that allows the board to determine if the program meets the requirements set forth in this chapter.”

There is a new ONLINE APPLICATION HANDBOOK for LPC/LMFT/LSATP Revised April 2020 that is 204 pages long with step by step instructions on the entire process of licensure application with color replicas of the online application with page by page instructions. Pretty impressive!

There are new LICENSURE PROCESS HANDBOOKS for LPC and for LMFT updated 7/2020 and a CSAC handbook that was updated 2/2020.

The LPC/LMFT application for a residency still requires the name of a worksite and a supervisor, but I was happy to see that the application no longer requires original signatures of the applicant and the supervisor and allows a digital signature of the applicant only. However, I did find the following information which makes this confusing:

On page 159 of the Online Application Handbook it states:

“Step 27 Type your name for the electronic signature and mark that you agree to the above certification. Then select Finish when you are ready to submit your application.”

On page 7 of the LPC Handbook it states:

“NOTE: Original signatures are required on all forms and applications. Copies and digital signatures will not be accepted.”

FYI: I recently submitted a petition to the Board of Counseling which has now closed for comment. However, the reason I mention it is that when I submitted it I used my personal home address since I don’t receive much mail from my business address and I wanted to be sure that if the Board sent me anything I would receive it quickly. What I didn’t realize is that as part of the official process, the ENTIRE petition is published on the Board’s Townhall which included my personal address. I knew in advance the petition would be published, but I didn’t think they would publish my address as part of the petition. I’m sharing this so you’re aware of the process and to use an address you’re comfortable having shared.

IMPORTANT QUESTION & ANSWER:

I recently received this question again so it deserves revisiting: “Can a resident take payment directly from a client under his/her LLC?” The answer is NO.

The regulations state: “10. Residents may not call themselves professional counselors, directly bill for services rendered, or in any way represent themselves as independent, autonomous practitioners or professional counselors.”

A couple of years ago, I suggested to just “not bill” and accept payment, however I had to rescind that suggestion because that is not the intent of the regulation which is: a resident cannot receive payment directly from a client because it demonstrates the

Continued on page 13
appearance that the resident is practicing independently. My next suggestion was that if the payment goes to a “company” i.e., an LLC, that is not the resident’s name, the client wouldn’t know if that LLC was a company with 50 employees or 1 (the resident) and an assumption could not be made that the resident would appear to be practicing independently. Sounds like a plan, right? So, this question was asked in person directly to Jaime Hoyle, the Executive Director of the Board of Counseling, at a training she gave at NVLPC. She said, NO, it cannot go to a resident’s LLC.

Also, to remind everyone of what happened a year ago about this topic, a petition was put to the Board of Counseling asking for residents to be allowed to take payment, since everything they tell and give the client (paperwork) must show they are under supervision and not practicing independently. There were 70 comments in response with an overwhelming majority in favor of allowing residents to directly bill clients for services. But the justifications voiced by many licensed clinicians and residents were not enough to make the case for changing the regulation. The Board responded with: “The Board decided to take no action based on its concern that direct billing by residents is contrary to the reimbursement policy of DMAS and other third party payors, and that it might incentivize residents to engage in independent practice without appropriate supervision.”

So, to summarize: client payments must go to the supervisor or supervisor’s practice and all of the payments (self-pay, insurance, co-pay) from the resident’s clients must pass through the supervisor’s accounts and be given to the resident in their entirety (no split payments are allowed) from which the resident pays for supervision, office rental/use, etc. I understand that the regulation doesn’t explicitly say this and only says not directly bill for services, but this is what that means.

The ideas and suggestions expressed here are my own and not those of NVLPC. If you have any questions about this or any of my previous articles or if you have ideas for future supervision topics, please let me know. I’m happy to research any questions you may have regarding supervision, residency, and the regulations. You can email me at supervision@nvlpc.org.

Attachment, Trauma, and a Bottom-up Approach to Counseling

BY MARY HUNTER

A child longs to be loved and radically accepted for who she truly is. The first place she will have a chance to receive that love is from her primary caregiver. When a primary caregiver is empathic and consistently meets the child’s emotional and physical needs, the child learns that she can trust others and that she is good and worthy to be loved. She is safe to explore her world and try new things, knowing that she is secure in the love of her primary caregiver and, eventually, her own love for herself. This is called a secure attachment.

This was not my experience. My parents both suffer from deep psychological distress. Their struggles impeded their empathy and unconditional love for me. I developed a very anxious attachment because my parents were unable to meet my emotional needs consistently. I was very alone in my thoughts and my emotions. I have worked hard in my own journey to earn a secure attachment as an adult, but I have also discovered the strengths I had developed as a fearful and sensitive young child. I am extremely aware of the emotional states of those around me. I developed deep empathy as a survival strategy to care for my own parents’ needs as a child. I plan to use that empathy to help me coregulate with my clients as they come to me with their unique emotional struggles.

I primarily work with children in my practicum. Many of them have experienced trauma. Dysregulation from...
attachment trauma like mine, and any trauma where a child has felt unsafe and alone, develops in the brain from the bottom up. Trauma is processed by the brain stem at the base of the brain and through the limbic system in the middle part of the brain. The dysregulation from trauma in the limbic system blocks neural pathways to the prefrontal cortex at the top of the brain. Access to the prefrontal cortex is necessary for rational thinking and planning responses. I use a bottom-up, interpersonal neurobiological approach when counseling children. Interpersonal trauma and attachment disruption have been shown to interfere with a child’s ability to emotionally regulate and use their prefrontal cortex (Spinazzola, et al, 2018, p. 632). Emotional regulation starts in the brain stem and limbic regions of the brain. The amygdala in the limbic system, is our safety detector. A counselor must calm the amygdala that has been tripped as a result of ongoing interpersonal traumatic experiences. Connection and interpersonal safety calm the amygdala and the resulting limbic arousal (Dela Hooke, 2019, p. 29), allowing a child to emotionally regulate and access his prefrontal cortex. Interventions must be relational to achieve this goal. I primarily use Child Centered Play Therapy to connect and coregulate with children.

Through my own experiences of childhood interpersonal trauma and my experiences as a parent with an earned secure attachment, I have developed a unique love for helping children and parents thrive. I believe that if we as counselors can change the relationships of parents and children in the next generation, we will also heal children’s brains to allow them to be more empathic, compassionate human beings. And that could change everything.

References: