Hello Everyone,

As the calendar year for 2021 winds down, I wanted to take a moment to say thank you for all that you do to preserve the Counseling field. This year has seen many challenges, not the least of them COVID-19. I have never been prouder to be among a group of professionals than right now.

Many of you have been stretched clinically, emotionally, physically, and spiritually in ways that we never imagined or even wanted. But you have remained steadfast in providing counseling, emergency services, school and college/university support. I hope that you can take some personal time and time with your families during this holiday season.

As we look to next year, there are many uncertainties. What you can continue to rely on is the unwavering support of NVLPC and its volunteer board. We will continue to provide quality training so that you remain abreast of changing trends in the mental health field. Please remember that the board is always looking for volunteers, so if you have an interest, please reach out to us.

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It is important to remain connected to positivity in the counseling field so that we see the possibilities and the promises for those we serve. To that end, good self-care is a must. It is my hope that each of you reading this will incorporate good self-care (positive affirmation, exercise, pets, time spent with loved ones, mediation and prayer) as part of your wind down for 2021 and wind up for 2022.

I look forward to our continued success as a board. I look forward to opportunities to get to know each of you. Have a safe and happy holiday season.

Dr. Faith James and the NVLPC board
The new year has always been a time to reset intentions, refocus our concentration, get reenergized, and create identified (personal and professional) plans for the year. I like to also take the start of the year as a moment to reflect on my choice to enter the helping profession, specifically the mental health counseling profession. This includes remembering the teachings I’ve gained during my counseling graduate program and reflecting on the importance of ethical decision making, promoting good, maintaining safety, doing no harm, theoretical orientations and interventions, diagnostic classification, and identifying the personal signs and symptoms of burnout. The one thing I’d like to see added to this foundation is the opportunity to reflect on our personal reasons for electing this profession. Many would say professional counseling chose them, but it’s our own tenacity and insight that keeps us engaged and hungry to grow and further this area of health. For me, I like to remind myself of the reasons I remain committed to the counseling profession. Here are a few:

**There is always a desire to do good!**
The counseling profession offers many opportunities to support others and assist with cultivating and enhancing hopefulness. As I shared in the previous newsletter, helping others offers a sense of gratitude and compassion for others.

**Counseling education doesn’t stop once you graduate and become licensed.**
Continuing education offers a chance to be creative with assisting clients or residents in counseling to be the most effective and competent counselors for their clients. Finding my niche as a certified eye movement desensitization reprocessing (EMDR) therapist continues to challenge and expand upon my knowledge of how to address and support clients with reprocessing trauma memories. Emotional health development is something I explore, and I seek to enhance this developmental aspect for clients to have a healthier quality of living and interpersonal relationships.

**Equality, Diversity and Inclusivity is learned best when collaborating with others.**
Sharing our thoughts and highlighting intersectionality adds to growing elements of multiculturalism. It also promotes the goodness and strengthens oppressed and marginalized populations to share space with the dominant culture.

**Giving back!**
Coming off the holidays can create a space and mindset for continued giving. There are so many ways to give back within the counseling profession. It can be anything from active involvement in a counseling organization, volunteering to be a guest speaker for local graduate counseling school courses or community agencies, or being a mentor or mentee. All of these support continued connections with others in the counseling world and also restore our intentions to enter the helping profession.

I have shared with you my reflections of being a licensed professional counselor. I’d love to hear your own reflections of choosing this identified career and hopefully connect with you! Please contact me at vicepresidentnvlpc@gmail.com, and I look forward to hearing from you!
Finding a Cause

BY MICHELLE M. MAY, LPC

Too often we are left scratching our heads when trying to find the cause of our clients’ symptoms and suffering. We can’t rely on guesses or often what our clients tell us. So where do we even start to find the true cause of our clients’ complaints?

We Must Look Past Conscious Awareness

In many therapeutic approaches, we focus on the client’s conscious life, such as what feelings and thoughts they are aware of and what they think is going on. If this was enough data to find a true cause of symptoms, we might only need a few sessions to reduce symptoms. As we know too well, this is almost never the case.

Looking to conscious mechanisms and data only goes so far. For most clients, it is essential to understand that unconscious emotions triggered by life’s inevitable events cause unconscious anxiety. This unconscious anxiety causes unconscious defense mechanisms. Knowing this simple, three-step process makes all the difference and can be an anchor to us in session. Simply put, most of our clients’ symptoms are caused by unconscious feelings causing unconscious anxiety, which causes unconscious defenses.

What Are These Three Components?

First, it is important to know that mixed core feelings such as anger, sexual desire, love, care, appreciation, grief, happiness, and guilt begin this unconscious conflict. Hurt, disappointed, and betrayed are all examples of words that clients use as feelings but are actually triggers for the core feelings mentioned above. Teaching this to our clients is vital.

Second, it is critical to understand that anxiety is not thought content or worry. Anxiety is purely a physiological process in the body. There are three types of anxiety. The first is striated (voluntary) muscle tension, such as sighing or fidgeting. The second is smooth (involuntary) muscle anxiety, such as acid reflux, nausea, gastrointestinal issues, and migraine headaches. The third type of anxiety is cognitive perceptual disruption (CPD). Examples include blurry vision, dizziness, or a loss of ability to think. Clients that look relaxed might be over their anxiety threshold and in either smooth muscle anxiety or CPD.

Third, it is important to understand that a defense is anything that blocks the conscious experience of emotion and regulates anxiety. Even anxiety itself can be a defense against feeling as it distracts us from what is underneath.

A Clinical Example: How to Work With This Three-Step Causation Process

Knowing the difference between a feeling, anxiety, and defense is enough to make a huge difference in our clients’ lives because we can help them see in real time what leads to their suffering. Here is an example:

**TH:** Do you notice that when you talk about your wife cheating on you that you get a tension headache?

**CL:** Yeah, I’ve been to doctors. They don’t know what’s going on. I don’t know. It’s just random.

**TH:** From our observations, you seem to get a headache each time someone has hurt you.

**CL:** I never noticed that. I don’t know if that’s true.

Continued on page 4
Finding a Cause continued from page 3

TH: Would you like to gather data to see if there is a pattern to this seemingly random headache? Would you be willing to pay attention to the headache and tell me when the pain goes up and down?

CL: Sure. Why not.

Later in session:

CL: I don’t know why my boss didn’t give me the promotion.

TH: How’s your headache?

CL: It actually hurts a little now.

TH: Tension headaches are a sign of anxiety in the form of tension in those muscles.

CL: That makes sense.

TH: What feelings are coming up toward your boss that are getting you anxious?

CL: Well, I think he knows what he’s doing. I feel like he’s a good guy. It just wasn’t my year.

TH: Well, those are your thoughts. But what are your feelings toward your boss for not giving you the promotion?

CL: Oh, um, man, my head hurts more. I don’t want say anger but I think I feel angry!

TH: Let’s help you feel this anger so you don’t have to tense up around it and get a headache instead.

CL: If that’s possible, that sounds great.

In this vignette, we see that differentiating between feelings, anxiety, and defenses is essential in getting to the cause of a seemingly random headache. What we found through delicate data collection and testing is that this client unconsciously blocked his anger because it made him anxious in the form of striated muscle anxiety, which gave him a headache. He tried to use the defense of rationalize and thought, which kept him tense and in pain. Later in the session, we helped him feel his anger toward the boss he also respected, which released tension and got rid of his headache.

An Empowering Outcome

If we and our clients understand this three-step process, they can start to observe that when they have certain defenses or anxiety, there are unconscious emotions trapped underneath. This is incredibly empowering to our clients because they can act on their own behalf in and out of session, become pattern experts, and achieve lasting relief.

Michelle M. May, LPC, NCC is a faculty member of the Washington School of Psychiatry’s Intensive Short-Term Psychotherapy Program (ISTDP), and specializes in ISTDP in her Arlington private practice.
ADHD, College, and Psychedelics: What Could Go Wrong?

BY JON L. THOMAS, ED.D, LPC AND DANilo SALLI

The emerging field of Psychedelic Medicine is receiving increasingly positive media coverage as clinical studies continue to report successful therapeutic outcomes. Ketamine, MDMA, and Psilocybin are emerging as highly useful adjuncts to therapy for treating such issues as Post Traumatic Stress Disorder (PTSD), treatment resistant depression, anxiety, and even some addictions. The influx in news of these potential benefits has catalyzed a shift toward positive consideration of what were previously considered recreational or street drugs. What will this mean for college students who have ADHD?

This media nod to the potential benefits of psychedelic medicines might inadvertently provide a green light to action for ADHD college students who find themselves at a confluence of expansive opportunities and freedom afforded by the college experience. This sudden convergence of newfound freedom, high risk-tolerance, impulsivity, and an exceptional drive for post-pandemic stimulation puts ADHD students at higher risk of experimentation, during a life stage when research indicates that underlying mental health issues are most likely to emerge.

A recent study funded by the National Institute on Drug abuse and conducted by the University of Michigan indicated hallucinogen use has increased, reaching record or near-record highs among college age young adults. 9% of responding college students reported using a psychedelic substance at least once the preceding year, the highest rate the survey has reported since 1982.

Beyond cautionary tales, heard experience, and the classic “just say no,” most students have little data to guide their decisions around psychedelic use. The Diagnostic and Statistical Manual of Mental Disorders (DSM-V) references only two rarely occurring symptoms, while other possible psychological consequences such as anxiety, emotional sensitivity, and other varied symptoms that often follow psychedelic experience are not included. Most graduate programs in mental health do not address this subject and continuing education in this area is in its infancy. Information from an internet search may vary in reliability due to the presence of innumerable sources, each containing potentially conflicting material.

So, how do family, educators, physicians, mental health professionals, friends and concerned others help ADHD students at this point of intersecting motivations and lack of information?

There is some basic information that is irrefutable, and a growing list of questions that can be asked in a harm-reduction manner that might lead to safer decisions.

What we know is that at least three of these medications (ketamine, MDMA, Psilocybin) have demonstrated significant mental health benefits, specifically when certain criteria are met. Efficacy of these treatments in clinical studies has been strongest with only certain mental health conditions, in controlled settings, with therapeutic support before, after, and during the psychedelic session.

That said, there is no clinical evidence for beneficial effects of these medicines when used non-medicinally or in uncontrolled environments. In fact, outside of medical and therapeutic use, these substances remain both illegal and potentially physically and mentally dangerous.

But again, ADHD college students are still in a life stage where decisions are based upon a sense

Continued on page 6
of immortality and a good bit of denial where risk is concerned. This risk tolerant perspective might spirt the curious, stimulation-seeking ADHD mind beyond the influence of cautionary data.

Recent conversations with college students from various regions indicate psychedelic experimentation is alive and well. And while most students realize common street drug versions of MDMA, Ketamine, and synthetic Psylocibin are often adulterated (laced with methamphetamine, fentanyl, etc.), responses like, “I bought it from a trusted source,” or “I read up on it on the dark web” or the more sophisticated “I used a ‘test kit’ to assure quality” denote marginal caution.

Students frequently enter the psychedelic experience spontaneously or on a whim, without the careful attention paid to the safety of mind set and setting rigidly adhered to in clinical studies. Thinking they can treat psychedelics like marijuana or other previous drug experiences, they can find themselves caught off guard by the powerful perceptual, cognitive, emotional, consciousness-altering effects.

What’s the worst that could happen? Overdoses do occur and recovery might entail a visit to the ER. Sustained hallucinogen-related disorders issues described in the DSM-V are rare and typically of short duration. However underlying mental health conditions like depression, anxiety, and even psychosis can surface under the intensity of the psychedelic experience. And with a little imagination it’s easy to conjure up other frightening possibilities that could occur, depending upon location and activity while under psychedelic influence. (Think: driving on a freeway…walking in high places…)

Beyond these objective concerns, what other subjective damages might occur? The power of psychedelic medicines to effectively reimprint and rework traumas and difficult experience is well documented in the growing body of research. But what gets imprinted when challenging memories and thoughts emerge during a spontaneous trip in an unplanned setting and in a negative emotional state? What could be an opportunity to work through difficult issues in the safe context of therapeutic preparation and safe setting might become an additional and compounded traumatic experience. As with many medicines, anything that can be this therapeutic can be equally harmful when misused.

Well-formed, analytical questions might offer the greatest possibility for effective self-reflection and place a sacred pause before an impulsive drive to action. For example:

- What do you hope to get from this experience?
- What else have you done to achieve this outcome?
- Who else have you talked to about this and what are their thoughts?
- What do you know about Psychedelics?
- Do you have a family history of mental conditions that could potentially react adversely to psychedelics?
- How could you learn more about related safety concerns?
- Are you seeking benefit or recreation?
- Have you considered what is personally at risk for you? What factors might increase this risk? What might go wrong and what would that be like?
- Are you aware that just because you handled a substance well before doesn’t mean you will every time? Every experience is different.
Because these powerful drugs are still in research stages, young people will have trouble accessing reliable clinical data. While more is being discovered daily, the following links can provide access to relevant and current information:

https://michaelpollan.com/psychedelics-risk-today/
https://hopkinspsychedelic.org/
https://doubleblindmag.com/trip-sit-lsd-psilocybin/
https://doubleblindmag.com/lsd-test-kit/
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8055489/

Psychedelic medicines offer the potential for extraordinary breakthroughs in mental health treatment. But these are medicines. When used irresponsibly, recreationally, or outside of intentional settings, harm may result. College students with ADHD may be more likely than neurotypical students to undertake unsafe experimentation. Providing trusted sources of information and well-formed and caring questions might make a safe decision more likely.

Jon L. Thomas, Ed.D, LPC is founder and president of The ADHD College Success Guidance Program in Fairfax, VA and a licensed therapist in private practice.

Danilo Salli is an intern with The ADHD College Success Guidance Program and a Junior psychology student at Virginia Tech in Blacksburg, VA

NVLPC 2021-2022 Calendar

<table>
<thead>
<tr>
<th>Date</th>
<th>Meeting Type</th>
<th>Speakers</th>
<th>Title of Event</th>
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<tbody>
<tr>
<td>9/24/21</td>
<td>Virtual</td>
<td>Erika Neil, LCSW</td>
<td>Havening for Relief and Resilience</td>
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<tr>
<td>10/8/21</td>
<td>Virtual</td>
<td>Dr. Maya Georgieva, LPC</td>
<td>Beyond Words: Bread Therapy for Wellness and Connection</td>
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<tr>
<td>10/22/21</td>
<td>Virtual</td>
<td>Michelle M. May, LPC, NCC</td>
<td>Helping Clients See: Defense Recognition for Lasting Change</td>
</tr>
<tr>
<td>11/12/21</td>
<td>Virtual</td>
<td>Michelle May, LPC, NCC</td>
<td>Fall Workshop: Finding the Cause: A Clinical Exploration Through Video Tape</td>
</tr>
<tr>
<td>12/3/21</td>
<td>Virtual</td>
<td>Kathy Matay, Licensed Resident in Counseling</td>
<td>When Your Client Asks: &quot;Why Don’t My Kids Listen to Me?&quot;</td>
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<tr>
<td>12/17/21</td>
<td>Virtual</td>
<td>Jon Thomas, Ed.D, LPC</td>
<td>Psychedelic Integration Therapy: What You Need to Know</td>
</tr>
<tr>
<td>1/7/22</td>
<td>Virtual</td>
<td>Dr. Amy Fortney Parks, LPC, ACS</td>
<td>Finding Supervision and Being a Super Resident in Counseling!</td>
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<tr>
<td>1/28 - 1/30/22</td>
<td>Virtual</td>
<td>Sharon Watson, LPC, LMFT, LSATP, NCC, ACS</td>
<td>Clinical Supervision Training: 3-day event</td>
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<tr>
<td>2/11/22</td>
<td>Virtual</td>
<td>Andrew Colsky, JD, LLM, LPC, CCATP, CCTP-II</td>
<td>Obsessive Compulsive Disorder (OCD) Diagnosis and Treatment Tips for the General Practitioner</td>
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<td>2/25/21</td>
<td>Virtual</td>
<td>Laura Winkler, LPC, CTTCC</td>
<td>Navigating Change in the Workplace: Strategies &amp; Resources that Best Support Career Changers</td>
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<tr>
<td>4/8/22</td>
<td>Virtual</td>
<td>Dr. Mary Alice Fisher, PhD</td>
<td>Spring Workshop: Providing Continuity of Care - Ethical Resources and Professional Wills</td>
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<tr>
<td>6/10-6/12/2022</td>
<td>TBD</td>
<td>Sharon Watson, LPC, LMFT, LSATP, NCC, ACS</td>
<td>Clinical Supervision Training: 3-day event</td>
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Our team is working to finalize details with presenters for some spring events. As information becomes available, it will be provided through future newsletters and the website. Please refer to the Community Calendar Page of the website for up-to-date details and registration information.
Finding Supervision & Being a Super Resident in Counseling!

Registration is open! Click HERE to register.

When: Friday, January 7, 2022. Presentation runs from 10:00 am to 11:30 am.

Where: Zoom Meeting

Presenter: Dr. Amy Fortney Parks, LPC, ACS

Contact: Janell Johnson, Events@nvlpc.org or Admin, Executiveadmin@nvlpc.org

Registration Information: Online registration is available until 1/6/2022.

Earn 1.5 Contact Hours for attending this event.

Cost:

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<th>Clinical/General</th>
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About the Event: The road to licensure in the Commonwealth of Virginia, and throughout the US, is rigorous, complex and paved with details. We want to support graduate students, future licensure applicants and current Residents in Counseling on their journey towards LPC licensure. This program will cover the areas of where to start with licensure application, the details of supervision, resident terminology, and testing and endorsement information. We will discuss how to find a supervisor, some of the things to look for in quality supervision, and how to build a professional and collaborative supervisory relationship. Participants will leave this session with a roadmap moving forward to get them to licensure in Virginia!

Learning Objectives: As a result of this presentation, each participant will learn:

1. Participants will explore the licensure process in Virginia
2. Participants will understand the expectations for Residents in Counseling in Virginia
3. Participants will discuss aspects of a positive and collaborative supervisor-resident relationship

About the Presenter: Dr. Amy Fortney Parks brings with her over 30 years of experience working with children, adolescents and families as both an educator and psychologist. She is a passionate “BRAIN-ENTHUSIAST” and strives to help everyone she works with understand the brain science of communication, activation and relationships.

Dr. Parks has a Doctorate in Educational Psychology with a specialty in Developmental neuroscience. She is a Child & Adolescent Psychologist as well as the founder and Clinical Director of WISE Mind Solutions LLC and The Wise Family Counseling, Assessment & Education in Virginia.

Dr. Parks serves as a Clinical Supervisor for Virginia LPC Residents, as well as Dominion Psychiatric Hospital. Additionally, she is an adjunct professor at George Washington University & The Chicago School of Professional Psychology. Dr. Parks is a frequently sought-after parent coach and speaker for families and groups around the world! More information about Dr. Parks and how to connect with her directly about your family or group is available on her website, www.thewisefamily.com.

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.

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www.nvlpc.org
NVLPc is proud to host

Sharon Watson, LPC, LMFT, LSATP, NCC, ACS
for the 2021

VIRTUAL CLINICAL SUPERVISION TRAINING

For LPCs, LMFTs, LSATPs & CSACs who plan to supervise residents in Virginia

on January 28th, 29th, & 30th

Friday 9 am–5 pm & Saturday 9 am–5 pm & Sunday 9 am–4 pm

3-Days * 20 CE hours * Including 2 CE hours of Ethics on Day 3

Webinar information: This will be a live, interactive, virtual, visual and audio presentation. Participants will be asked to have a functioning camera and microphone on their laptop or desktop. This will allow the training to mimic the live interactive training format between the presenter and participants and between the participants. It will include experiential content: paper and pencil worksheets, multiple handouts, and many question and answer opportunities. The PowerPoint and handouts will be provided in advance as well as further instructions.

Single or multiple day registration  ◆ NVLPC member discount available

The option of taking 1 or 2 days is an opportunity for those who already have had some supervision training. Content is not defined by the VA Board so you can choose which day(s) will make a well-rounded experience.

Although a supervisor must document 2 years of post-licensure clinical experience before supervising residents, the required clinical supervision training can be taken during those 2 years of practice or even during a residency.

Day 1: CLINICAL SUPERVISION: THEORY AND PRACTICE 7 CE hours
- Training goals  
- Definitions 
- Motivations 
- Models of supervision 
- Role differences: administrative vs clinical 
- Phases in supervision 
- Tasks & Functions 
- Modalities 
- Concepts in the supervisory relationship

Day 2: CLINICAL SUPERVISION: SKILLS AND TECHNIQUES 7 CE hours
- Supervisor characteristics 
- Stages of development 
- Competencies 
- Resident self-monitoring 
- Influences in supervision 
- Supervisor & resident personality traits 
- Stress & burnout 
- Multi-cultural & diversity impact

Day 3: CLINICAL SUPERVISION: COMPLEXITIES OF SUPERVISION 6 CE hours
- Supervision essentials 
- Process: regulations, contracts, documentation, forms, evaluation 
- Ethical & legal practice in supervision 
- Telehealth 
- Reducing vicarious responsibility 
- Supervisory relationship issues

◆

Full 3-day Training: $400 for NVLPC members and $450 for non-members

Individual Days: $150 for NVLPC members and $175 for non-members

NOTE: Advance registration only; Select either 3-days or the specific dates for 1 or 2 days

To register go to the NVLPC Events Page

For question, contact Janell Johnson at events@nvlpc.org
Northern Virginia Licensed Professional Counselors
PO Box 122, Ashburn, VA 20146 www.nvlpc.org ◆ (703)400-0751

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OCD Diagnosis and Treatment Tips for the General Practitioner

Registration is open! Click HERE to register.

When: Friday, February 11, 2022. Presentation runs from 10-11:30 am.

Where: Zoom Meeting

Presenter: Andrew Colsky, JD, LLM, LPC, CATP, CTP-II

Contact: Janell Johnson, Events@nvlp.org or Admin, Executiveadmin@nvlp.org

Registration Information: Online registration is available until 2/10/2022.

Earn 1.5 Contact Hours for attending this event.

Cost:

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About the Event: Do you have an anxiety patient who is not responding to treatment? Have you tried all of your best techniques but the patient remains in a state of heightened anxiety? What is happening? What don't you see? Maybe it's OCD.

Obsessive Compulsive Disorder can be very challenging to diagnose and equally difficult to treat. At times it is as prominent as a pink elephant in the room, yet it can also hide in plain sight. The truth is that OCD simply does not respond well to traditional talk therapy and effective methodologies are not for the faint of heart. OCD treatment can require the therapist to heighten and prolong a patient's anxiety; not an easy thing to do.

In this presentation, we will explore current OCD treatments including Exposure and Response Prevention (ERP) and Inhibitory Learning, using Acceptance and Commitment Therapy (ACT). Each of these methods, as well as OCD medication options will be discussed. This session will be interactive so bring your questions!

Learning Objectives: As a result of this presentation, each participant will learn:

1. What is Obsessive Compulsive Disorder (OCD)?
2. How does OCD differ from other anxiety disorders?
3. What are some common types of OCD?
4. What are the current treatment methodologies for OCD?
5. Which Medications are used to treat OCD?

About the Presenter: Andrew E. Colsky, JD, LLM, LPC, CCATP, CCTP-II is owner of Center for Professional Counseling, PLC, a telehealth mental health counseling practice serving clients in Virginia and Florida. Mr. Colsky works primarily with clients experiencing Anxiety, OCD, Trauma and related substance use issues. He is certified in the treatment of Anxiety and Complex trauma, and practices primarily using CBT, ERP and ACT for OCD and EMDR for trauma. Mr. Colsky is a member of the American Bar Association, Anxiety and Depression Association of America, and the International OCD Foundation. He is also a TEAM Certified therapist with the Feel Good Institute. The Center for Professional Counseling is known for successfully treating clients who may not have responded well to traditional talk therapy.

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.

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www.nvlp.org
Navigating Change in the Workplace: Strategies & Resources that Best Support Career Changers

Registration is open! Click HERE to register.

When: Friday, February 25, 2022. Presentation runs from 10-11:30 am.

Where: Zoom Meeting

Presenter: Laura Winkler, LPC, CTTCC

Contact: Janell Johnson, Events@nvlpc.org or Admin, Executiveadmin@nvlpc.org

Registration Information: Online registration is available until 2/24/2022.

Earn 1.5 Contact Hours for attending this event.

Cost:

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About the Event: Disruptive events lead us to reflect on our values and reevaluate our lives and careers. Therefore, it is no surprise that many of our clients are considering a career change. In this interactive presentation you will learn about workforce trends in light of the Coronavirus pandemic, the top reasons professionals are considering a career change, strategies to manage the challenges career changers face, and resources that support them with career decision making, up-skilling, and their job search.

Learning Objectives: As a result of this presentation, each participant will learn:

1. Learn about current workforce trends and their potential impact on career changers
2. Identify and discuss strategies to help clients navigate a career change
3. Share tips and resources that support career changers with their job search

About the Presenter: Laura Winkler is a Licensed Professional Counselor (LPC), a Certified Tough Transitions Career Coach (CTTCC), and an Academy Certified Resume Writer. As the Senior Career Counselor and Manager of the Graduate Counseling Internship Program at George Mason University, she supervises graduate-level counseling interns and provides career counseling for undergraduates, graduate students, and alumni. Laura also provides career and mental health counseling to clients at The Women’s Center and in her private practice.
A recent question in the NVLPC groups.io listserv is being addressed here with permission from the post originator:

“I have a client who is a resident in counseling. She works for a practice that has a 50-50 split. The owner of the practice charges her $175 for individual supervision and $125 for group. Is this ethical? Shouldn’t supervision be included in the 50-50 split she takes?”

- Shafinah Samsudin LPC, CSAC, CSOTP

Some points need to be clarified because this is complicated by several issues.

A few years ago, there was a lengthy NVLPC discussion thread on the topic of “split-fees,” and the consensus was that split-fees are both unethical and illegal in Virginia. Regarding ethical practice, this is the pertinent excerpt from the ACA 2014 Ethics code:

A.10.b. Unacceptable Business Practices

Counselors do not participate in fee splitting, nor do they give or receive commissions, rebates, or any other form of remuneration when referring clients for professional services.

Regarding the issue of legality, this is more of a challenge to clarify since it seems a gray area. The following is a helpful article to read: https://www.psychotherapynotes.com/fee-splitting-private-practice-may-illegal-unethical/

Although this article is specific to California law, the writer encourages clinicians in other states to check their own state law. So, this is what it says in Virginia law:

18.2-502. Medical referral for profit.

(a) No person, firm, partnership, association or corporation, or agent or employee thereof, shall for profit engage in any business which in whole or in part includes the referral or recommendation of persons to a physician, hospital, health related facility, or dispensary for any form of medical care or treatment of any ailment or physical condition unless the person is advised of the criteria of selection of the physicians, hospitals, health-related facilities or dispensaries considered for the referral or recommendation. The acceptance of

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a fee or charge for any such referral or recommendation shall create a presumption that the business is engaged in such service for profit. A violation of the provisions of this section shall be punishable as a Class 1 misdemeanor.

This brings up several gray areas: 1. Is this law only for physicians or does “health related” include counselors? (If anyone has found any information in VA law regarding counselors and split-fees, please email me!) 2. Does fee-splitting apply to supervisors and residents working in the same practice? 3. Does it matter if the resident in the practice is an employee or a contractor?

The legal issue with fee-splitting is that the portion of the client payment that goes to the supervisor (the referral source) could be considered a “kick-back,” even if the supervisor and the resident work in the same practice. The purpose of the law is to protect the client by ensuring that the referral is in the best interest of the client and not for monetary gain of the referring entity (i.e., supervisor). In a fee split, the supervisor is making the referral to their resident in their own monetary interest because they receive their portion of the split. The issue of split-fees likely only applies to residents who are contractors because employees are typically paid on a per session basis and not a split.

Now, before getting to the issue of whether the supervision charge should be included in the split, let’s tackle the amount being charged by the supervisor.

Supervision pricing is a difficult area and not commonly discussed. Unfortunately, this puts residents at a disadvantage when they have to pay for supervision out of pocket and don’t have any idea what the range is. But because I was recently asked this question about my own fees, I decided to investigate by asking colleagues what they charge. Also, the question of what to charge comes up in my Clinical Supervision Training and I typically ask what the participants paid for their own supervision. I’ve been told everything from $0 to $275 per hour, but those extremes I believe are unusual. The $0 was a supervisor who wanted to support residents of her own ethnicity and the $275 was for supervision of an LMFT, which is more difficult to find. The more typical range I’ve found is between $75 to $175 per hour, with various justifications cited for those fees, as well as creative arrangements. I was told by one clinician that she plans to charge half of her rate while her resident builds their practice and her full rate after 6 months, which I think is innovative. Keep in mind that what a supervisor charges doesn’t always reflect their supervisory skill, so a resident shouldn’t assume that. I encourage residents to “price check” with several supervisors, even if the supervisor doesn’t have openings. So, the $175 is at the high end. I haven’t researched charges for group supervision to the same extent, but $125 seems high, even taking into consideration the supervisor’s vicarious liability (unless the group supervision is longer than one hour).

Now I’ll turn to the question of whether the supervision charge should be included in the supervisor’s “split.” Besides the fact that there should not be a split, the way a resident’s earnings must be handled is that all of the money paid by a client for the resident’s services is to go, in its entirety, to the supervisor or supervisor’s practice. THEN, ALL OF THE MONEY COLLECTED IS TO BE RETURNED IN FULL TO THE RESIDENT if they are a contractor in the supervisor’s practice, as well as when the resident has their own private practice. Out of those earnings the resident pays for supervision, office rental, etc. NO SPLIT FEES!

As an additional point, there are some practices that hire residents as employees and the practice owner provides supervision for free. There are other practices that don’t. For instance, I am aware of a practice owned by an LCSW who provides supervision free for the social work
supervisees, but the residents in counseling are required to pay out of pocket for outside supervision.

Lastly, the ethical question about a resident paying for supervision separately from their earnings: This is ethical because it’s what’s required by the Virginia regulations. However, the question about charging a resident $175/$125 is a question of economics, meaning, should supervisors charge as much as they possibly can based on what the market will bear? It’s likely not an ethical question unless it’s about taking advantage of residents who are likely earning very little, at least initially, and may be burdened with student loans and are required to have supervision and pay out of pocket. That question I’ll leave to you, the reader.

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

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**Notice**

The next issue of the NVLPC Newsletter will be March 2022. The deadline for article submission, committee reports, bulletin board items, membership spotlights and advertising is February 15, 2021. Please send content to newsletter@nvlpc.org.