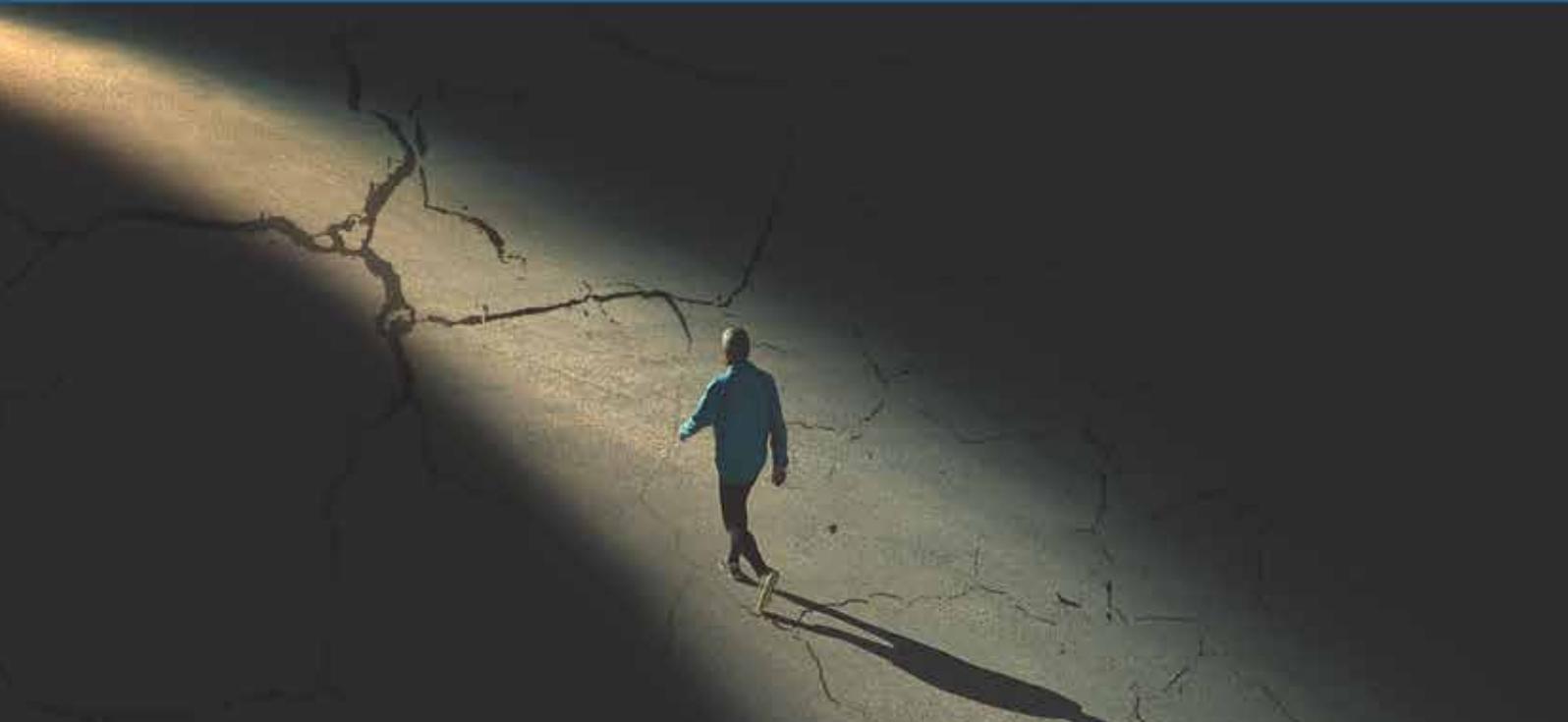


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An American Counseling Association Publication

ct.counseling.org

November 2020 • Volume 63/Number 5



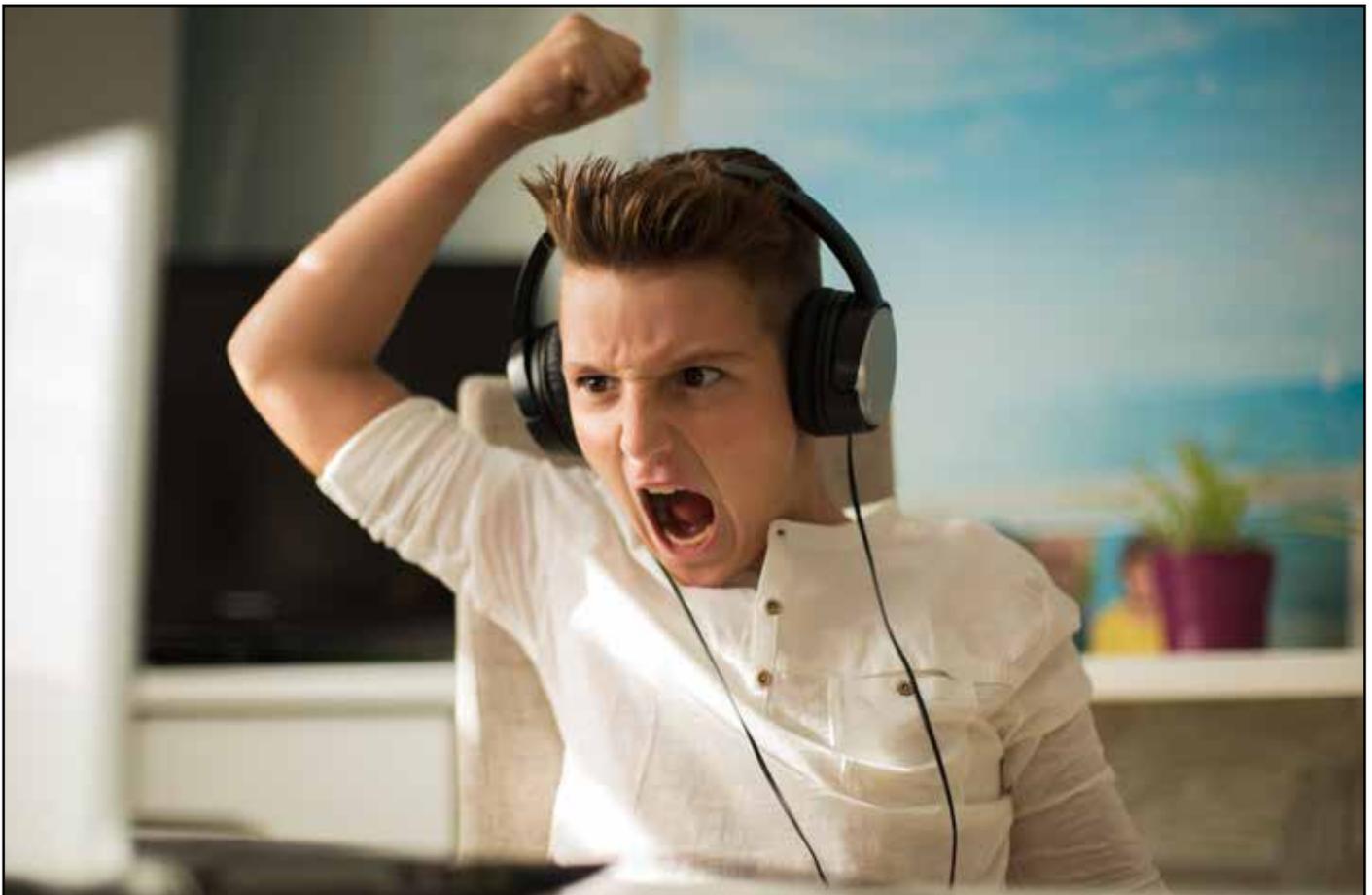
Addiction and the road to recovery

Responding to clients' isolating behaviors during COVID-19

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November 2020

Cover Story

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By Laurie Meyers

The road to recovery is rarely smooth, but counselors can help clients process the pitfalls that led them to addiction and avoid the potholes that can lead to relapse.

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When almost everyone is practicing isolation or experiencing its effects to some degree, how do counselors assess and respond to isolating behaviors among their clients?

40 **Counseling in the trenches**

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Counselors must first understand the military culture to overcome barriers that keep many service members and veterans from receiving the care and support they need.

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Integrating substance abuse and pain management into counseling approaches

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Counselors can create a safe place for clients to speak openly as they try to navigate the complicated landscape of their struggles with substance use and pain management issues.

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DXM: A drug in plain sight

By Emily Weaver, Sharon J. Davis & David Saarnio

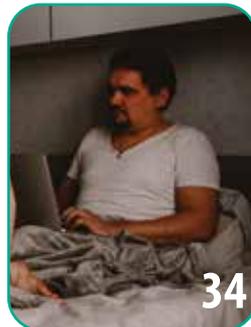
A potentially dangerous drug found in most over-the-counter cough medicines is more popular than opioids among teenagers, largely because it is legal, inexpensive and easy to obtain.

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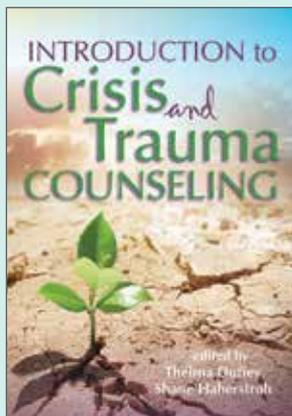
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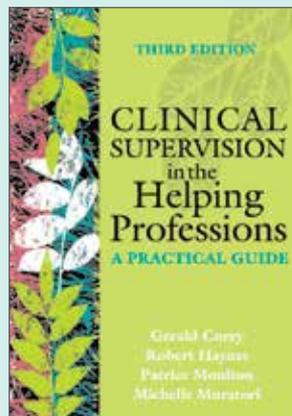
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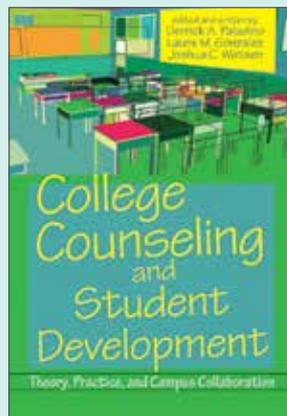
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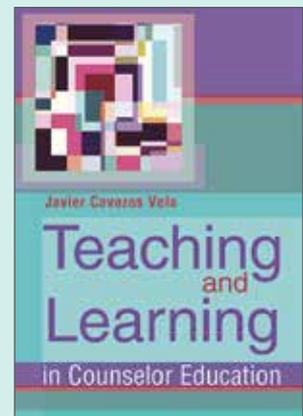
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Sue Pressman

From the President

Counseling Today

Reasons to celebrate: Career development and mentorship

This year, as Thanksgiving approaches, I am especially grateful for my family, friends, American Counseling Association colleagues and the mentors who have supported me on my career journey. As a professional counselor who has also identified as a *career counselor* for almost 40 years, every November is extra special to me. In addition to Thanksgiving, I (and my fellow career counselors) celebrate National Career Development Month.

The intersectionality between career and mental health has never been more significant. National Career Development Month is sponsored by the National Career Development Association (NCDA), which was established in 1913 and is one of ACA's founding divisions, dating back to 1952. While every day is an opportunity for counselors to help clients with career exploration and personal goals, the month of November recognizes the importance of lifelong career development through an annual observance. Collaboration among counselors, teachers, students, families, communities, schools and businesses is a cornerstone throughout the month. Career poetry contests, the development of new posters and infographics, events such as "careerathons," and topical workshops have become the norm during November. It's all very exciting.

This year brings unique challenges and opportunities. For instance, how do counselors implement these activities while simultaneously keeping

spirits high with clients and practicing self-care — all in the midst of the coronavirus pandemic? The answer is not simple, and no magic formula exists. We are finding that virtual gatherings, social media platforms, the sharing of resources, telecounseling, online handshaking, online networking and working from home are among the practical ways that everyone is coping with this "new normal."

Resilience in the face of job loss, financial difficulty, trauma, stress and the other myriad issues that one encounters across a lifetime is a process that involves adapting as we transition to new beginnings. Resiliency is the ability to overcome setbacks and challenges and then grow from the experience. I often demonstrate the concept of resilience with the use of a rubber band. When a new rubber band is stretched, it demonstrates strong resilience by quickly bouncing back to its original shape. A worn rubber band that has no stretch demonstrates a lack of resilience. Metaphorically speaking, it indicates that change is needed. In many ways, that is what we are facing today.

The human spirit is being challenged. On the one hand, we are mourning our losses and the ways of life that once were. On the other hand, we are creating new ways to work, become productive and connect. As a global society going through a pandemic, we have learned to adapt by using technologies to conduct both small and

Continued on page 11

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Richard Yep

CEO's Message

It's a critical time for self-care

The continuing challenges much of the world's population is facing are daunting, consuming and overpowering. Here in the United States, the ongoing battle against the coronavirus, critical discussions around racism, and an unconventional national election can drain one's energy and spirit. Add to that an economy that sees so many people out of work and so many others in a state of food insecurity.

My message to you is that we cannot let all of this overwhelm those who are part of the solution. *You* are part of the solution. The work being done by professional counselors and counselor educators and the education and training that counseling graduate students are receiving are what give me hope for the world that many of us envision: a world of respect, dignity and inclusiveness.

I've said this many times in this column: The counseling profession is so critically important in addressing the challenges that confront clients, students and communities. So, in order to keep going and to help others thrive, I encourage you to continue practicing the basics of self-care. Just as you are passionate about helping others find their way, you must know when it is time to take a break, consult with colleagues or even stop counseling long enough to recharge.

At ACA, we want to help you in your practice, we want to advocate for the profession, and we want to ensure that those who can benefit from your work will seek you out. We can do all of these things, but it will not amount to a "hill of beans" unless we have professional counselors who can practice, teach and supervise. Burn out and we all lose out.

Please take a moment to think about what you do (and what you tell others) about self-care. Search the internet for new ideas. Browse the ACA website for

information. Or just get yourself a big bowl of popcorn and turn on Netflix. Whatever it is that helps you meet the challenges professional counselors face, I encourage you to do that on a regular basis. I also strongly suggest that you schedule your self-care activity in your calendar.

I know that your ACA Governing Council is committed to serving, helping and advocating for you. The actions taken related to licensure portability, reimbursement issues, practice issues in the age of COVID-19, and anti-racism are just four examples of the myriad topics the board has addressed over the past few years. Another important decision the Governing Council has made is that the 2021 ACA Conference will be virtual. While we will miss out on in-person chats and hugs, I like the idea that even more professional counselors will have the chance to gather, learn, network and even socialize with one another. More information can be found at counseling.org.

I would love to have your suggestions about what ACA can do for you. In asking that question and receiving suggestions, I sometimes find that we are already providing that resource or service, but that it has not been well publicized. Other times, suggestions from members have resulted in our exploring and acting on an issue.

If you have time, I would also like to hear what you do to ensure that you are practicing self-care. You can send me a quick email or photo because I truly am interested. When you share that information, I also think it serves as a good reminder to continue that practice.

As always, I look forward to your comments, questions and thoughts. Feel free to call me at 800-347-6647 ext. 231 or to email me at ryep@counseling.org. You can also follow me on Twitter: [@Richyep](https://twitter.com/Richyep).

Be well. ❖

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Counseling Today (ISSN 1078-8719) is the monthly magazine of the American Counseling Association, 6101 Stevenson Ave., Suite 600, Alexandria, VA 22304-3300; Telephone: 703.823.9800; Internet: ct.counseling.org.

Opinions expressed and statements made in this magazine by the article authors or those quoted within articles do not necessarily represent the opinions of the editors or policies of the American Counseling Association.

Subscriptions are available for \$176 (individual rate) or \$204 (institutional rate) for 12 issues.

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Single copies are available for \$15 each by calling ACA in-house fulfillment at 800.298.2276.

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Advocacy Update

Recognizing the importance of professional career counselors

Interview by Guila Todd



Kathy Evans



November is National Career Development Month, so the Government Affairs and Public Policy team chose to highlight an American Counseling Association member who is a professional career counselor. We interviewed current National Career Development Association (NCDA) President Kathy Evans on the role of career counselors, life-work issues and key legislation surrounding the profession.

Evans has been an active member of ACA since 1980. She is professor emerita of counselor education at the University of South Carolina. Before receiving her doctorate from Penn State, Evans held career counseling positions in high schools, community and four-year colleges and universities, and a nonprofit organization. She has been a counselor educator for more than 25 years and has taught the career counseling course for 20 of those years. In addition, she teaches doctoral courses in multicultural counseling/advocacy, supervision and pedagogy. She has also developed a graduate certificate program for career development facilitators.

Evans has published extensively and decided to write *Gaining Cultural Competence in Career Counseling* in 2007 because there were no available texts that helped students understand the synthesis of culture and career. The second edition is due out soon from NCDA. For some of the same reasoning, she also co-authored *Experiential Approach for Developing Multicultural Counseling Competence*

with Mary Fawcett of Winona State University.

Evans has been a leader in counselor education. Her highest national office, until her current position as president of NCDA, was as secretary for Chi Sigma Iota, the international honor society for counselors. She has also held office as president of the Southern Association for Counselor Education and Supervision and, as such, served on the Association for Counselor Education and Supervision (ACES) executive board. Evans also co-chaired the ACES/NCDA Joint Commission for the Preparation of Career Counselors from 2008-2014.

What is a career counselor?

Good question. People have a lot of confusion about career professionals. At NCDA, we have actually designed credentials that outline the education, training and expertise for the various career professionals. As defined by NCDA, career counselors are those who have “trained as counselors, who specialize in the delivery of career counseling services.” They have an advanced degree (master’s or higher) in counselor education, counseling psychology, rehabilitation counseling or a closely related counseling degree and are engaged primarily in a career counseling practice or other career counseling-related services.

What are the education requirements for becoming a career counselor?

Entry level for a career counselor is a master’s degree. There are other career

practitioners who work with people with career concerns, but to be a career counselor, one has to have a master’s degree in counseling.

How do career counselors benefit those in the community?

Career counselors assist people with determining and achieving their work and career goals, help them to choose a life path that will determine their lifestyle, help improve their relationships at work, and help individuals resolve home-work conflicts.

What made you decide to become a career counselor?

I had a career crisis myself. I hated the first job I had after graduation from college and ended up talking to a career counselor at the university where my father worked. I felt inspired after talking with her about what else I could do with my psychology major and applied for graduate school. It so happened that almost half of my graduate curriculum was devoted to career counseling, and I loved it.

How long have you been a career counselor?

I started career counseling 42 years ago.

How can we help promote the career counseling profession?

As [part of] the American Counseling Association, promoting career counseling as a profession within the counseling field is always helpful. It would also be helpful to promote the career counseling specialty by devoting journals, newsletters and social media to the topic of life-work issues. The time is ripe for this with the global pandemic putting so many people out of work.

Are there key pieces of legislation related to career counseling that you would like to see pushed through Congress?

Congressmen Jim Langevin (D-Rhode Island) and Glenn “GT” Thompson (R-Pennsylvania) stand apart as a bipartisan team that champions improving the workforce by supporting and funding programs like Perkins [the Carl D. Perkins Vocational and Technical Education Act, which was reauthorized as the Strengthening Career and Technical Education for the 21st Century (Perkins V) Act in 2018]. They serve as the co-chairs of the Congressional Career and Technical Education Caucus, and last year they introduced the Counseling for Career Choice Act, which makes critical new investments in school counseling to help students make informed career choices. The task of building career counseling frameworks requires targeted, significant funding, and we hope that congressional leaders will recognize this and prioritize passage of the Counseling for Career Choice Act. ❖

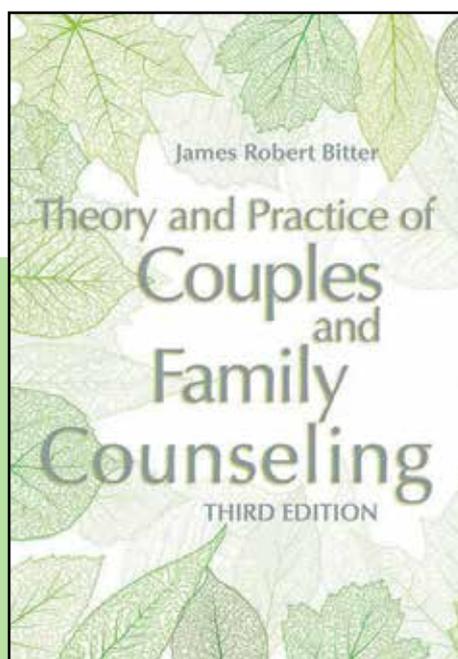
Guila Todd is the government affairs manager at the American Counseling Association. Contact him at gtodd@counseling.org.

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Counselor Career Stories

Helping athletes, coaches and teams grasp the importance of mental health and wellness

Interview by Danielle Irving-Johnson

Shaun Tyrance, a licensed professional counselor who specializes in working with athletes, is in his second season in the NFL as the team clinician for the Kansas City Chiefs, the defending Super Bowl champions. He was just the second full-time team clinician hired by an NFL team.

Tyrance has years of experience helping players and coaches perform at their highest levels, personally and professionally. His experience extends across both professional and collegiate ranks and covers a wide range of sports, including football, basketball, baseball, golf and motor sports. In addition to working with athletes and coaches, Tyrance has consulted with Fortune 500 companies to help them hire the best individuals and get the most out of their employees.

Danielle Irving-Johnson: What led to your interest in the counseling profession with a specific focus on sports psychology?

Shaun Tyrance: I played football in college, and I really struggled on and off the field as a player. I suffered a few significant injuries, and I had a hard time balancing school, athletics and the social scene. I went into counseling because I could have benefited from seeing a therapist during my college football career.

DIJ: Can you share a little about your journey and the steps taken to get to where you are today?

ST: As an undergraduate, I was a four-year letter winner in football at

Davidson College. After graduation, I earned a master's in sports psychology from UNC Greensboro (University of North Carolina Greensboro). After completing my degree, I spent three years as the academic adviser for football at North Carolina State University (NCSU). While I was working in the athletic department, I obtained a master's in counselor education from NCSU.



Shaun Tyrance

I then accepted a role as the director of sports psychology at Chip Ganassi Racing in NASCAR. In this role, I helped the drivers and pit crew members perform at their best on and off the track. After 1.5 years in NASCAR, I decided to get my Ph.D. I spent the next three years earning a doctorate in counseling from UNC Charlotte, and during this time, I also worked in their athletic department as the director of sports psychology.

After completing my degree, I spent the next 10 years working in private practice in Charlotte, North Carolina. In April of 2019, I accepted a position with the Kansas City Chiefs, and I'm entering my second season with the team.

DIJ: Tell us about your role as the team clinician for the Kansas City Chiefs. What does a typical day look like for you?

ST: My primary role is to support our players and coaches and help them manage the daily stressors associated with life in the NFL. Because I work full time for the team, I'm able to meet with players and coaches on a daily basis, and I also attend every practice, team meeting and game.

My role also extends beyond the football field, as I also provide services to our business staff and cheerleaders. Lastly, I am involved in the college draft process, as I meet with our potential draft picks and begin formulating a plan for how we could support them if we bring them into our organization.

DIJ: You currently serve as the team's first in-house clinician. Why do you think it was important for the NFL to mandate that teams have mental health professionals in their facilities on a regular basis?

ST: Some NFL teams have utilized therapists on a contractual basis to support their players, but the players have become more vocal about their needs, and they have begun to discuss the challenges they face during, and after, their time in the league. In the 2019 collective bargaining agreement, the players negotiated that all 32 teams employ a licensed mental health clinician for at least eight to 12 hours per week. Owners, coaches and general managers commit significant resources to the physical development of players, and there is growing recognition that managing one's mental health is at the center of one's overall wellness.

It is also important to note that there is a direct relationship between performance and mental health, as athletes and coaches who are mentally and physically healthy will perform better in their jobs. The Chiefs helped lead the charge on this initiative, as I was the second full-time clinician hired by an NFL team, and since the conclusion of last season, three additional teams have also hired full-time clinicians.

DIJ: In what ways has the COVID-19 pandemic had an impact on you and the Kansas City Chiefs players?

ST: COVID-19 had a big impact on my role this offseason. Due to the pandemic, I was unable to see any of our players and coaches in person prior to the start of training camp. There was a five-month period where I could only meet with people via Zoom, phone or text. It is very tough to establish or build relationships with players through these mediums, but it was the only option that we had.

DIJ: How are the Chiefs and the NFL prioritizing and implementing player safety during the pandemic? Player safety is a main objective for the NFL this season.

ST: The safety measures that our team and the league have implemented are second to none. Our testing protocol, PPE (personal protective equipment) requirements and physical distancing regulations have enabled us to have a successful beginning of the season.

DIJ: The sports seasons will look different due to the ongoing pandemic. Do you envision this having an impact on the mental health of athletes across the nation at the high school, collegiate and professional levels?

ST: Absolutely. Sports are a microcosm of society, and everyone in our country has been impacted by this virus. Athletes have the same stressors as the rest of society, and they have the added pressure and responsibility of competing in their sport. It does not matter what level, all athletes will be forced to train differently this year as a result of COVID-19, and many athletes will have their seasons canceled, postponed or shortened due to the pandemic.

Even though the numbers of NFL players who have contracted COVID-19 is relatively low at the moment, that does not mean these players aren't impacted. Many players that you are watching on Sundays have close family and friends who have been ill or passed away due to the virus.

DIJ: What type of assessments and modalities are administered to assess and assist team players?

ST: During the draft process, prospective players take a battery of personality and aptitude assessments. However, the teams are not allowed to administer assessments to players after they have been drafted to a particular team.

DIJ: You have a unique opportunity. How would you advise a prospective student who is interested in taking a similar path?

ST: There are two things that I think are really important in the field today. First, make sure that you get licensed. The NCAA, NFL and NBA have mandated that their athletes have access to licensed mental health practitioners. The number of full-time therapists working for colleges and professional sports teams has significantly increased in the last five years, and it will continue to do so for the foreseeable future.

My second piece of advice is to get as much experience as you can working with athletes. Working with athletes at any level can be challenging, but once you learn the nuances of the various sports and the expectations associated with athletics, you can create a niche for yourself that is extremely rewarding.

DIJ: The American Counseling Association has more than 50,000 members. Is there anything else that you would like to share about yourself or your work?

ST: Getting started in this industry can be challenging, but the field is growing rapidly. Athletes at all levels need support, and coaches and athletic directors are starting to understand the overall importance of mental health. ❖

Danielle Irving-Johnson is the content project manager at the American Counseling Association. Contact her at dirving@counseling.org.

From the President

Continued from page 5

large gatherings online. We have learned that telework actually works and that telecounseling (“distance” counseling) is not as distant as it once was. We are serving our clients — the world — in new and creative ways. We have also found that traditional programs still offer viable means for learning and to continue lifelong learning.

I am happy to report that in conjunction with National Career Development Month, ACA is launching the ACA Mentorship Program. Collaborating with me on implementation of the program is a team composed of representatives from the ACA Graduate Student Committee, Jan Gay, Reginald “Reggie” W. Holt and Alyx MacTernan; Anaid Shaver, a Virginia Tech counselor education and supervision doctoral intern/assistant; and Danielle Irving-Johnson, the content project manager at ACA.

The ACA Mentorship Program is designed with the intention of building relationships while strengthening and empowering participants. The program provides the opportunity for both graduate students who are currently enrolled in counseling programs and newer professionals to be mentored by accomplished counseling leaders. Mentors guide, support, encourage and empower mentees to further develop and enhance their professional counselor identity. This initiative supports ACA's mission to “promote the professional development of counselors, advocate for the profession, and ensure ethical, culturally inclusive practices that protect those using counseling services.” It also supports ACA's vision that “every person has access to quality professional counseling to thrive.” ❖



Risk Management for Counselors

Coordinating care for substance use without compromising client confidentiality

By Anne Marie “Nancy” Wheeler

Question: I work in private practice as a licensed professional clinical counselor. I have a colleague who often refers clients to me for counseling following their treatment at the federally funded substance use treatment facility where she works. This colleague told me that the federal rules governing confidentiality of substance use disorder treatment records are changing. Can you shed any light on this?

Answer: Your colleague is correct. Regulations have been promulgated, and more are expected in the next year. Even if you are not certified as a substance use disorder counselor, you should be aware of some of these changes and how the exchange of information with your colleague may be affected.

The Substance Abuse and Mental Health Services Administration (SAMHSA), an agency within the U.S. Department of Health and Human Services, published a final rule July 15 governing the confidentiality of substance use disorder patient records. This rule implements changes to what is commonly referred to as “42 CFR Part 2” or simply “Part 2.” The changes became effective Aug. 14. They are designed to improve coordination of care among providers and ensure access to comprehensive care without compromising clients’ confidentiality rights, which have existed for many years under Part 2.

It is important to note that this rule-making *did not* include changes to Part 2 made by Congress in the Coronavirus Aid, Relief, and Economic Security (CARES) Act earlier this year; a separate rule-making process will be forthcoming, with results not expected before late March 2021. This future rule-making is expected to further align Part 2 with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Without knowing all the details of your practice setting or that of your colleague, based on what you have said, I would presume that your colleague’s treatment setting would be considered a “Part 2 program.” Given that you are not holding yourself out as a substance use disorder (SUD) treatment program and do not receive federal funding, I would assume that you are a “non-Part 2 program.” (It would be wise to check with SAMHSA or your local health care attorney to clarify your status.)

Here are some of the changes and clarifications that have come out of the recent final rule:

- ❖ Treatment records created by non-Part 2 providers based on their own patient/client encounters are explicitly not covered by Part 2, unless SUD records previously received from a Part 2 program are incorporated into such records. Segmentation or segregation of any portion of a Part 2 patient record previously received can help ensure that new records created by non-Part 2 providers will not become subject to Part 2.



- ❖ As long as patient/client consent is obtained, a Part 2 program may disclose treatment information orally to a non-Part 2 provider for treatment purposes; when a non-Part 2 recipient records this information, it is no longer protected by Part 2.

- ❖ With patient/client consent, a Part 2 program may disclose treatment information to an entity named by the client/patient without specifying the individual who will receive the information.

- ❖ When a SUD patient/client sends an incidental message to the personal device of a Part 2 program employee, that employee may fulfill the requirement for “sanitizing” the device by deleting the message. In other words, the device itself does not need to be confiscated or destroyed.

- ❖ During a state or federally declared emergency (e.g., a natural disaster) in which a Part 2 program is closed or otherwise unable to secure patient consent, a Part 2 program may disclose certain patient information to medical personnel.

Other aspects of the changes to Part 2 may or may not be applicable to your particular situation. I recommend the following resources to strengthen understanding of the topic:

- ❖ “Health Privacy Rule 42 CFR Part 2 is revised, modernizing care coordination for Americans seeking treatment for substance use disorders” ([tinyurl.com/HHSSUDCareCoordination](https://www.tinyurl.com/HHSSUDCareCoordination))
- ❖ Fact sheet on SAMHSA revised rule for 42 CFR Part 2 ([tinyurl.com/FactSheet42CFR](https://www.tinyurl.com/FactSheet42CFR))
- ❖ American Psychiatric Association resources on understanding the final rule ([tinyurl.com/PsychiatryCFRPart2](https://www.tinyurl.com/PsychiatryCFRPart2)); these resources include a webinar presented by the American Academy of Addiction Psychiatry, the American Psychiatric Association and the American Society of Addiction Medicine in which experts discuss the recent changes.

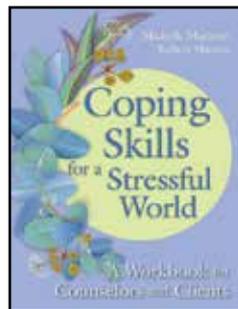
Part 2 programs should begin the process of revising consent forms and patient/client notices. SAMHSA may include a model notice of privacy practices on its website in the future. Both Part 2 programs and non-Part 2 providers should consider the impact of the new regulation on their record-keeping procedures. Finally, all providers should check back in 2021 to see what regulatory changes will be made based on the CARES Act. ❖

Anne Marie “Nancy” Wheeler acted as the American Counseling Association’s risk management consultant for 30 years. She has retired from the practice of law in Washington, D.C., and Maryland but continues to write on issues of mental health risk management. The information presented here is for educational purposes only. For specific legal advice, please consult your own local health care attorney.

NEW!

Coping Skills for a Stressful World: A Workbook for Counselors and Clients

Michelle Muratori and Robert Haynes



“Bravo to Drs. Muratori and Haynes on this timely resource that provides insightful and compassionate narratives on key presenting problems in therapy, combined with actionable exercises and techniques for both counselors and clients as they navigate together through disturbing times in our society. This workbook should be in every counselor’s library and will prove to be one of the well-worn favorites reached for consistently when looking for a way to help a client.”

—Patrice Moulton, PhD

Northwestern State University of Louisiana

This comprehensive counseling tool kit for stress management provides clinicians with hundreds of client exercises and activities. Representing a variety of therapeutic approaches, this workbook offers creative techniques for helping clients handle traditional concerns, including anxiety, depression, anger, and grief in addition to heightened present-day issues, such as natural and human-made disasters, the misuse of social media, political divisiveness, social injustice, and mass shootings and other violence.

Drs. Muratori and Haynes give their personal and professional perspectives on successfully working with clients therapeutically and also invite a number of expert clinicians to share their experiences and exercises they have used that have been effective with clients. The final section of the workbook presents strategies for counselor self-care and client life after counseling.

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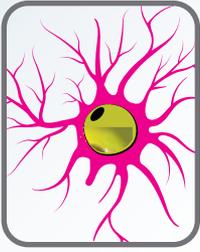


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The biopsychosocial and lifestyle model for case formulation

By Yoon Suh Moh

Previously in this three-part series on an intricate combination of determinants that affect mental health, we have explored lifestyle factors such as diet. We particularly focused on the bidirectional gut-brain connection and microorganisms related to human development and health across the life span. We also explored the modulating role of diet on these neurobiological pathways.

In this article, we will cover the biopsychosocial and lifestyle (BPSL) model of mood disorders for case formulation. This model helps us expand the scope of our case conceptualization by incorporating lifestyle factors such as physical activity, diet, sleep, stress management and mindfulness-based exercises into case formulation that promotes well-being and wellness in individuals, families and communities.

The BPSL model of mood disorders

Gin S. Malhi and colleagues reported in 2015 in the *Australian & New Zealand Journal of Psychiatry* that the BPSL model provides a useful framework for understanding an intricate mixture of determinants that contribute to the onset and persistence of mood disorders and their symptoms.

The model encompasses four domains: biological, psychological, social and lifestyle factors. Lifestyle factors (e.g., physical activity, diet, smoking, sleep) have been recently added to the model because emerging research suggests that they play a significant role in the development and persistence of mood disorders. The BPSL model is helpful for health care professionals

such as counselors in planning clinical management and potential relapse prevention should it be necessary.

The aforementioned authors also noted that case formulation goes beyond diagnostic assessment and diagnosis-based treatment. It also involves how the client's strengths (such as resilience) play a critical role in the process of recovery and promote management of the problem over the long term. Case formulation also draws connections between past experiences and how these relate to the current clinical presentation. The importance of making these connections cannot be emphasized enough, as we explored in previous articles. Early life experiences affect brain and gut development, their intricate communication with each other, and numerous commensal microorganisms and their dialogue with host cells across the life span.

According to Malhi and colleagues, the BPSL model can be used prior to case formulation as a guiding tool for counselors to explore and understand the client's presenting problems. Factors that precipitate or maintain psychiatric symptoms and lead to their expression usually fall into one of the four domains in the model.

The steps traditionally involved in case formulation include examining the *presenting problem* alongside *predisposing*, *precipitating*, *perpetuating* and *protective* factors. Using these steps to conduct case formulation can lead to considering which interventions and strategies are most likely to benefit the client. However, as Malhi and colleagues note, these steps are only a guide, and they may not be relevant or applicable to every client.

More information about the BPSL model is provided in the Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines at tinyurl.com/RANZCPMoodDisorders.

Case formulation

In this section, we provide a case vignette to describe "Abbey." (Note: We are using the pronouns they/them/their for Abbey and Abbey's mother.) Abbey is a 21-year-old cisgender Asian American. Abbey comes to see you for individual counseling through self-referral. Abbey is a junior studying biology at a prestigious university in the greater Philadelphia area. However, they are currently staying at home in Washington, D.C., because their mother's cognitive deficits (including memory decline) and frequent mood swings recently have become more pronounced.

Abbey reports ongoing gastrointestinal (GI) complaints, including frequent bouts of alternating constipation and diarrhea, and sporadic abdominal discomfort for the past month or so. Abbey also notes that they used to suffer from urinary infections growing up. They also voice increased stress associated with the demands of caregiving as they are getting more involved in long-term care for their mother. Even though Abbey deeply loves their mother, they feel "trapped" in the caregiver role and note less emotional support from their sibling living abroad.

As Abbey's stress level increases, they begin to experience frequent agitation, followed by deep sorrow that feels endless at times, excessive fatigue, loss of interest in activities that they used to

enjoy and difficulty maintaining good oral hygiene. Abbey denies a history of mental disorders in their family but discloses that their deceased father struggled with uncontrolled alcohol use.

Abbey usually either skips breakfast or rushes to the local deli for a bacon, egg and cheese bagel because their morning hours are consumed with helping their mother get out of bed and take medications or taking their mother to doctors' appointments. Although Abbey used to eat a variety of vegetables and fruits daily prior to taking on the current role of primary caregiver, their recent lunches and dinners have typically consisted of burgers and fries or pizzas from a local diner. Abbey also discloses that they rarely take time to prepare meals with fresh produce and whole grains. In addition, of late, Abbey has not been drinking much water throughout the day, opting for sweetened sodas instead. Abbey denies drinking alcohol, smoking or using other substances in their lifetime.

Guided by the BPSL model, you can begin to formulate a case with Abbey based on the information provided.

Presenting problem

Abbey's presenting problem seems to be associated with chronic stress caused by the demands of caregiving they are shouldering with limited support and resources. It may also involve the negative consequences of chronic stress, such as frequent agitation followed by deep, persistent sorrow, excessive fatigue, loss of interest in activities and difficulty maintaining good oral hygiene.

Predisposing factors

Early life experiences: Although there is no available information yet regarding biological factors that may have predisposed Abbey to vulnerability for high stress reactivity or responsiveness, these are worth further assessment. Jack P. Shonkoff and colleagues reported in 2012 in the journal *Pediatrics* that early experiences and environmental influences can have considerable impact. In an article in *Frontiers in Behavioral Neuroscience*

in 2009, Elizabeth C. Cottrell and colleagues reported that fetal exposure to maternal stress can influence later stress responsiveness.

Precipitating factors

Abbey discloses the feeling of being "trapped" in the caregiver role without emotional support. In 1990, Leonard I. Pearlin and colleagues introduced the term *role captivity* in *The Gerontologist* to refer to a sense of being an involuntary incumbent of the caregiver role. Having a sense of role captivity is a strong predictor of depressive symptoms in family caregivers.

Furthermore, Abbey appears to be getting involved in prolonged care for their ill mother without receiving sufficient emotional or social support from others. This can become a source of chronic stress and lead to subsequent negative consequences such as depression.

Perpetuating factors

Inflammation: We respond to acute stress via the hypothalamic-pituitary-adrenal axis and autonomic nervous system. Our bodies have negative feedback that can inhibit the fight-or-flight response or sympathetic activation once the immediate or perceived danger disappears. As Emily Deans reported in 2014 in *Psychology Today*, however, under conditions of chronic stress, the feedback tends not to work properly. According to Shonkoff and colleagues, this can lead to symptoms such as anxiety, depression, chronic gut problems, headaches, high blood pressure, etc.

In addition, Deans noted that when we are under stress, our bodies release inflammatory cytokines — little chemical messengers that bring a certain part of our immune system into a state of high alert. While inflammation saves us from pathogens (e.g., viruses), chronic inflammation also leads to chronic diseases such as depression, high blood pressure and autoimmune diseases (e.g., ulcerative colitis, multiple sclerosis). Furthermore, Eiko Fried and colleagues reported in 2019 in *Psychological Medicine* that

specific depressive symptoms such as sleep issues and energy level are associated with increased inflammatory markers in the human body.

Abbey appears to be under chronic stress associated with providing prolonged caregiving without much outside support. Assessing this frequently in practice and helping Abbey with stress management becomes critical. More information about the links between inflammation and certain depressive symptoms is provided in the book *The Inflamed Mind* by Edward Bullmore.

The role of stress in brain-gut dialogue: Alexandra Labanski and colleagues wrote earlier this year in *Psychoneuroendocrinology* that stress induces alterations of the fecal microbiota and manipulation of the gut microbiota. This, in turn, can alter stress responses, underscoring the bidirectional dialogue between the brain and gut. J. Philip Karl and colleagues noted in 2017 in the *American Journal of Physiology-Gastrointestinal and Liver Physiology* that prolonged stress increased intestinal permeability, and this was concomitant with changes in intestinal microbiota composition and metabolism.

Mounting evidence suggests that the gut microbiome plays a pivotal role in educating and regulating our immune response, and this has clinical implications. In particular, the National Institutes of Health Human Microbiome portfolio analysis team reported in 2019 that specific conditions can trigger a normally benign or even beneficial microorganism to overgrow its habitants and become pathogenic. The overgrowth of these normally commensal members is speculated to lead to dysregulation of mucosal immunity and a disruption of gut barrier function. An example of this disturbed state is irritable bowel disease (IBD) and its disease subtypes, Crohn's disease and ulcerative colitis.

The role of dietary inflammation in mental illness: Abbey reports irregular, nutrient-deficient dietary patterns. In addition, Abbey does not drink much water but consumes sweetened sodas instead. In the literature, it has been reported by various researchers that highly processed, poor-quality foods are linked to increased risk for mental disorders. The gut and its resident microbiota are implicated in a pathway for this relationship.

Jacques Amar and colleagues noted in 2011 that high-fat-diet-induced alterations in GI permeability affect mental health. Additionally, Joseph Firth and colleagues wrote in 2019 in *Frontiers in Psychiatry* that given diet's role in modulating inflammatory processes, calorie-dense, nutrient-deficient, processed food intake may contribute to the heightened inflammation observed in severe mental illnesses.

Poor oral hygiene: Abbey is experiencing poor oral hygiene. Katrina Ray reported this year in *Nature Reviews Gastroenterology & Hepatology* that burgeoning evidence supports links between the oral-gut axis, microbiome and immune-mediated mechanisms in GI disturbances (e.g., development of IBD). Specifically, according to Ray, inflammation of the oral mucosa leads to the expansion of bad microorganisms in the oral microbiota. In mice, this process can promote colitis through colonization of the gut, and the induction and migration of bacteria-reactive T cells (a type of immune cell) to the gut.

In summary, oral inflammation can trigger gut inflammation. Although this was documented in rodents, it may also hold true for the mouth-gut dialogue in humans.

Protective factors

Abbey comes for individual counseling by self-referral. Abbey appears to be highly self-aware and willing to seek professional help. This must be acknowledged and validated in counseling because, as Anthony F. Jorm and colleagues reported in 2017 in *World Psychiatry*, in industrialized

countries such as the United States, 36% to 50% of serious cases of mental disorders go untreated. Although Abbey does not appear to suffer from severe psychiatric symptoms yet, it is imperative for counselors to work with Abbey to provide early interventions or preventive interventions.

Clinical management

Considering the association between lifestyle behaviors (such as diet quality and diet patterns) and stress-driven symptoms, as well as gut health, wellness-oriented counselors should take a holistic approach to clinical management. Writing in *International Review of Neurobiology* in 2016, Samantha L. Dawson and colleagues said that an integrative strategy such as lifestyle medicine requires the development of appropriate diagnostic tools that incorporate assessment of health behaviors (e.g., physical activity, diet quality) to identify those who are particularly at risk and to encourage early intervention.

Given Abbey's clinical symptom profile, they would benefit most from an integrative, holistic strategy to clinical management provided by an interdisciplinary team of professionals (i.e., a counselor, a clinical dietitian or nutritional psychiatrist and, potentially, a gastroenterologist). In the following sections, we illustrate a way to conduct a case formulation with Abbey using the BPSL model.

Biological interventions

Abbey may be referred to a psychiatrist for potential psychopharmacological treatment to reduce their stress-induced symptoms. Also, microbiota-based approaches to Abbey's concomitant psychiatric and GI symptoms may be an area for exploration.

Anne K. Thomann and colleagues reported this year in *Alimentary Pharmacology & Therapeutics* that interactions between the gut microbiota and brain may play a role in the pathogenesis of the high comorbidity of psychiatric and GI symptomatology. However, these

authors note that at this time, interventional studies investigating the tridirectional relationship between the gut microbiota, inflammation and behavior are still limited to preclinical work. Furthermore, these authors recommended in 2019 that potential confounding factors (e.g., childhood diet, trauma, home environment, early environmental exposure) that can alter our gut microbiome should be taken into account when formulating the clinical case.

Psychological interventions

Earlier this year in *JAMA Psychiatry*, Grant S. Shields and colleagues wrote that psychosocial interventions (e.g., psychotherapies) are associated with enhanced immune system function, as indexed by decreases in proinflammatory cytokines and increases in immune cell counts over time. Extensive evidence suggests that high levels of stress are associated with unhealthy inflammation in our bodies. In providing a psychological intervention, it is important for counselors to identify, understand and address a variety of interrelating stressors, such as grieving nondeath losses, that arise in the context of caregiving. The relationship between stress and inflammation can be addressed in counseling with Abbey, and counseling may be an effective strategy to approach stress-induced, immune-related symptomatology.

Abbey may benefit from a wide array of therapeutic interventions to address their stress-induced symptoms. For example, Stefan Hofmann and colleagues reported in 2010 in the *Journal of Consulting and Clinical Psychology* that mindfulness-based therapy (MBT) was particularly effective at helping to reduce stress. Jon Kabat-Zinn has defined *mindfulness* as a process that leads to a mental state characterized by nonjudgmental awareness of the present-moment experience while encouraging openness, curiosity and acceptance. Hofmann and colleagues noted that MBT is also effective for reducing symptoms of anxiety and depression across a

relatively wide range of severity, even when these symptoms are associated with medical problems.

MBT may encourage Abbey to relate differently to somatic and visceral sensations and reactions and to have a different experience in managing these symptoms when they occur. Additionally, it is important to maintain a holistic perspective on the role that Abbey's cultural background may play in their treatment.

Social interventions

The World Health Organization reported in 2014 that social interventions can play a strong protective role in recovery from psychiatric symptoms. Abbey might benefit from participating in peer support groups for family caregivers or groups such as the Family-to-Family education program provided by the National Alliance on Mental Illness.

This group modality is an evidence-based intervention known to reduce distress related to caregiving and to

enhance emotion-focused coping. According to Lisa B. Dixon and colleagues in 2011 in *Psychiatric Services*, this intervention is measured by increased acceptance and improved problem-solving.

Lifestyle interventions

In 2014 in the *American Journal of Public Health*, Adrienne O'Neil and colleagues observed a negative relationship between a high-quality diet and mental health disturbances and a positive relationship between unhealthy diets and poorer mental health outcomes in children and adolescents. Similar results have been reported in the literature for adults.

Felice Jacka and colleagues noted in 2015 in the *Journal of Affective Disorders* that, overall, a quality diet that is high in fiber and nutrients has been associated with increased microbial diversity and gut health. Jacka and colleagues also suggested in 2017 in *BMC Medicine* that diets higher in plant-based foods

are associated with a reduced risk for depression.

It may be a good idea, therefore, to refer Abbey to a clinical dietitian or nutritional psychiatrist for comprehensive dietary assessment and consultation to improve and sustain their dietary patterns. As a supplementary strategy to psychotherapy or pharmacotherapy, this will likely improve Abbey's seemingly stress-induced symptoms, including GI symptoms. ❖

Yoon Suh Moh is an assistant professor of community and trauma counseling at Thomas Jefferson University. She is a licensed professional counselor, certified rehabilitation counselor and national certified counselor with professional proficiency in English, Japanese and Korean. Contact her at yoonsuh.moh@jefferson.edu.



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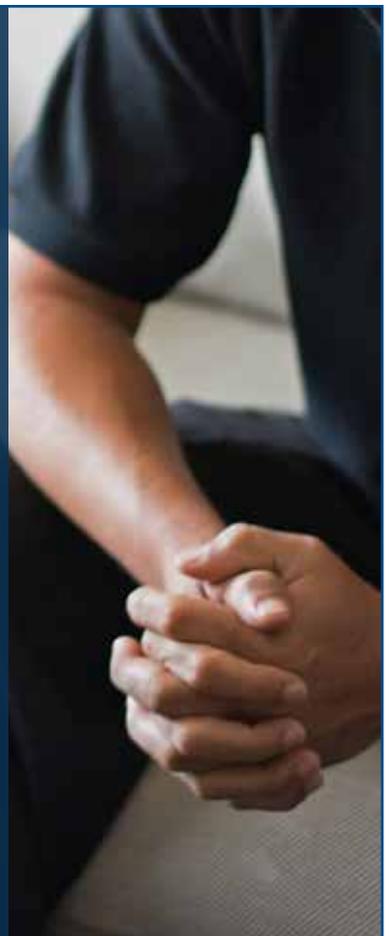
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Why should I send you referrals?

By Deb Legge



I've been in this business a long time (over 27 years), and I know that one of my greatest sources of referrals is other mental health professionals. I'm just one person, and last year I sent more than 300 referrals into my community.

Although I know lots of therapists in my town, I often struggle with making some of these referrals. Traditionally, these are among the tougher referrals for me to make:

- ❖ Individuals who have traumatic brain injuries or other cognitive disabilities
- ❖ Issues faced by military families
- ❖ Support groups (sexual abuse, symptom management, attention-deficit/hyperactivity disorder [ADHD], autism spectrum disorder)
- ❖ Families in need of court evaluations
- ❖ Individuals in need of ADHD and other psychological testing
- ❖ Those with chronic/terminal illness and their support people
- ❖ Those with anger management issues
- ❖ Pretty much any issue when my book is full and I'm still getting calls

I tell you all of this to get across the point that other therapists are *not* your competition. Collaborations with other mental health professionals can be an ongoing source of referrals for everyone involved.

Here are some insights that you might want to know when it comes to me (and others like me) doing business with you (i.e., sending you referrals):

❖ **Don't assume that I'm not interested.** I *need* a solid network of people to refer to. I am super busy, and I need your help.

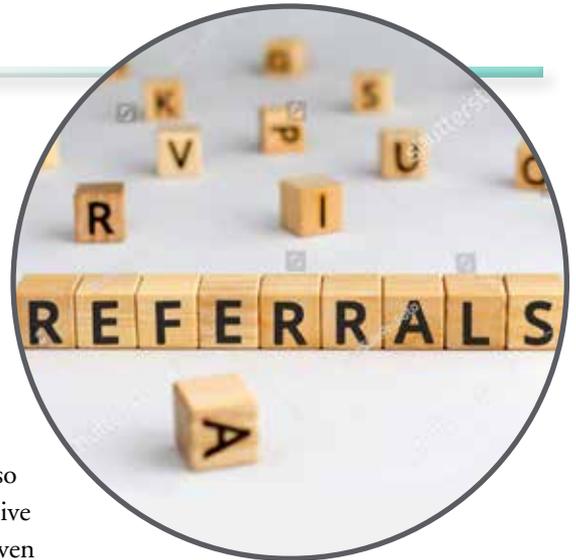
❖ **Don't be bashful or understated.** I want to know who you are, whom you serve, what your specialty is and what types of services you provide.

❖ **Be clear and honest with me.** I need to know how to refer to you in a way that is really easy for me to do business with you. I don't have time for phone tag. I also want to know that you are responsive to every person I send your way (even if it's to refer them on to someone else). I don't drop the ball, and I don't expect you to either.

❖ **Stay in front of me.** I also need to hear from you from time to time so that I remember who you are. I don't have the time, energy or (frankly) the ambition to search for you. You've got to be at the top of my mind or the top of my desk.

❖ **Find ways to show me your value.** I need to know why I can trust you to do good work and take care of the people I send to you because I care deeply about the types of referrals I make. If I'm sharing a client or a family with you, I *need* you to collaborate with me, even if it's just sending me a copy of your notes when it makes sense.

❖ **Work with me here.** I want to know that when I'm really in a jam, you'll do what it takes to help me out. That you'll fit someone in, give me another good referral option or do something for my business and my people. I don't forget those things, and I'll be sure to send you the easy ones too.



❖ **Let's build some reciprocity.** I also want to know that you'll think of me when it comes to referrals. That you'll care enough about me to remember who I am, whom I serve and what type of work I do, and that you'll send me referrals too.

To do these things, we are going to have to communicate. Neither of us has a lot of spare time, so it's going to be a bit of a challenge to get my attention. When it comes to your outreach, be aware that:

❖ I'm going to read the first paragraph of what you send me. By the end of that paragraph, I need to know that you're for me and that it's in my best interest to read on.

❖ Even if I think you're for me, I'm not going to read a full page of anything you send me. I'm one of those people who shudders and closes my eyes when I see pages that are dark with words. Give me some white space so I can breathe!

❖ I want just the facts. Who are you? Whom do you serve? What do you do best? How can I reach you?

❖ I care about you, but just like with any client you may pursue, I'm less interested in what you can do and more interested in what you can do *for me*. You can't guess what I need, but I don't mind answering you when you ask how you could best help me.

❖ I'll hear you if you are clear, confident and concise.

❖ I'll appreciate you and your time if you appreciate my time and care enough to find out how you can help me.

❖ I'll appreciate the fact that you are likely busy too. I don't expect you to dote on me (I don't have time for that either). I'd just like us to be there for each other when needed.

So, what does it take for you to reach out to colleagues and other potential referrers in a way that is clear, concise and confident? From my experience coaching thousands of mental health professionals over the past 27 years, I know that it takes a solid foundation — a foundation you can stand on because you know who you are, what you stand for and where you're going. When you can talk about those things in a way that is clear and compelling, I'll be happy to help you fill your book. ❖

Deb Legge is a licensed mental health counselor, a speaker, a coach and a private practice mentor. Over the past 26 years, she has helped thousands of therapists achieve success with private-pay private practices. She has educated and empowered clinicians nationwide to grow thriving, sustainable practices faster than they thought possible. Contact her, and engage in her free training, at PrivatePayPractice.com.



Bulletin Board

Send Bulletin Board announcements to Jonathan Rollins at jrollins@counseling.org. Announcements are limited to 125 words. **Deadline for the January issue: Nov. 24.**

Coming Events

NCAADA Webinar | Nov. 7

The North Carolina Association for Adult Development and Aging (NCAADA) will be offering a free webinar for all North Carolina Counseling Association (NCCA) members on "Aging Well in Multiple Global and Societal Crises," a topic that meaningfully targets the focus of our division. Our facilitator will be current NCCA President John Nance, who is also the president-elect of the national AADA division of the American Counseling Association. At the completion of the program, participants will be eligible for 1.5 NBCC/CE hours and will receive documentation of attendance. Nonmembers may attend for \$15. To register, go to ncca.wufoo.com/forms/ncaada-webinar-nov-7-2020.

FYI

AHC Emerging Leaders Program

The Association for Humanistic Counseling's Emerging Leaders Program was developed to allow students and new professional leaders to participate in AHC activities, receive regular mentorship, and connect with opportunities that help them grow as leaders. Emerging leaders will be selected to serve for the July 2021-July 2022 term. Master's-level students, doctoral-level students and new professionals are encouraged to apply. More information about the program

and the application process can be found on the AHC website at humanisticcounseling.org. All application materials are due no later than Dec. 1. For questions about the AHC Emerging Leaders Program, contact the program chair, Christina Woloch, at ahcemergingleaders@gmail.com.

Call for proposals for special issue

The Career Development Quarterly seeks manuscripts addressing COVID-19 impacts on career theory, research, practice and advocacy. Full manuscripts will undergo peer review; there is no guarantee of acceptance. All manuscripts must conform to the author guidelines (see mc.manuscriptcentral.com/cdevq). Possible topics: applying career theory to address the pandemic's impact; enhancing career intervention/practice through career development-social justice intersectionality; describing/evaluating career intervention practice/strategies for COVID-19's impacts; engaging in advocacy efforts to end injustice, disparity and discrimination. Proposals should include a title; indicate whether the manuscript is empirical or conceptual; state the manuscript's purpose, study information and outline/structure; be a maximum of three pages, double-spaced, 12-point font with 1-inch margins. Submit to tangmi@ucmail.uc.edu by Nov. 15. Publication anticipated winter 2021. For questions, contact Debra Osborn (dosborn@fsu.edu) or Seth Hayden (haydensc@wfu.edu). ❖



Boundaries of competence and scope of practice

By Michelle E. Wade



Scenario one: A client comes in who has a severe addiction to heroin and wants you to help them “kick the habit.” Your training does not go beyond having a substance abuse class within your master’s program that you completed five years ago. You are fully licensed as a counselor but have not had any continuing education in the past five years regarding substance use. Additionally, you are a private practitioner.

Scenario two: A couple comes in seeking counseling because they are having difficulty communicating with each other regarding their needs and wants within their relationship. It is an ethically nonmonogamous relationship, and one partner has developed feelings for another individual outside of this particular dynamic. The other partner feels betrayed and concerned about the bond. You, as the counselor, have had a marriage and family counseling course but not a course in human sexuality. Your internship was at an agency that worked with couples and families. You have been fully licensed for three years and have worked with couples before, but never one that identified as ethically nonmonogamous.

Scenario three: You are licensed in two states, but one state board does not include diagnosis within the scope of practice in its licensure law. You are working with a client diagnosed with antisocial personality disorder at age 17, but you disagree with the diagnosis. You have been trained to diagnose, and the other state in which you are licensed does allow you to diagnose.

Within the 2014 *ACA Code of Ethics* and licensure laws, counselors are tasked to stay within their boundaries of competency and scope of practice. Specifically, Standard C.2.a. Boundaries of Competence states:

“Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience. Whereas multicultural counseling competency is required across all counseling specialties, counselors gain knowledge, personal awareness, sensitivity, dispositions, and skills pertinent to being a culturally competent counselor in working with a diverse client population.”

Keeping that in mind, one needs to consider the idea of referrals and when they may be appropriate because of a lack of competency in a certain area or because the issue falls outside of one’s scope of practice. One can also consult on the appropriateness of a referral or whether exploring a new specialty area of practice may be the better option. When we consider referring based on competency, we must look at Standard A.11.a. Competence Within Termination and Referral, which states:

“If counselors lack the competence to be of professional assistance to clients, they avoid entering or continuing counseling relationships. Counselors are knowledgeable about culturally and clinically appropriate referral resources and suggest these alternatives. If clients decline the suggested referrals, counselors discontinue the relationship.”

Scenario one

With scenario one, we can argue that a referral may be necessary to a higher level of care because it is outside of the counselor’s boundaries of competency. Additionally, there is a standard of care for withdrawal management that should be upheld and may require constant monitoring. Therefore, the client would be better off in a facility that can meet their needs.

However, let’s change the substance being used by the client from heroin to alcohol or marijuana. Perhaps the option of referral is not as clear cut in those cases because the withdrawal would not necessarily have to be managed. One could argue that the counselor in this scenario does understand addiction due to taking a substance abuse course. One could also argue that the counselor could work on addressing coping strategies with the client more so than the addiction piece. Best practice would be to evaluate what is in the best interest of the client and consult with colleagues. Additionally, best practice would be to seek continuing education related to addiction and substance use. As Standard C.2.f. Continuing Education states:

“Counselors recognize the need for continuing education to acquire and maintain a reasonable level of awareness of current scientific and professional information in their fields of activity. Counselors maintain their competence in the skills they use, are open to new procedures, and remain informed regarding best practices for working with diverse populations.”

Scenario two

Scenario two may bring in the idea of values-based referrals over competency-based referrals. Standard A.11.b. Values Within Termination and Referral states, “Counselors refrain from referring prospective and current clients based solely on the counselor’s personally held values, attitudes, beliefs, and behaviors. Counselors respect the diversity of clients and seek training in areas in which they are at risk of imposing their values onto clients, especially when the counselor’s values are inconsistent with the client’s goals or are discriminatory in nature.”

One could argue that without having taken a human sexuality course, the counselor is lacking competency to work with such a couple. However, as a fully licensed professional who has been trained in working with relationships, the counselor can work with the issue at hand. In fact, the counselor has worked with similar concerns of problem communication and feelings of discontent, betrayal and fear in relationships before. The difference is simply in the type of relationship before the counselor now.

If one were to change the scenario to a couple who is *specifically* looking for sexuality counseling, then the counselor may be practicing outside of their boundaries of competency. The counselor could look into expanding their training to include a new area of specialty that includes sexuality counseling, but this particular couple may need to be referred at the time.

As Standard C.2.b. New Specialty Areas of Practice states, “Counselors practice in specialty areas new to them only after appropriate education, training, and supervised experience. While developing skills in new specialty areas, counselors take steps to ensure the competence of their work and protect others from possible harm.”

Scenario three

Scenario three addresses scope of practice within licensure laws. Not all licensure laws are equal. Therefore, in some states, counselors are not allowed to diagnose or perform assessments. However, as we know, ethics and law are not the same thing. As it relates to ethics, the counselor in this scenario may have a different type of consideration.

While the counselor is trained and capable of diagnosing in the other state in which they are licensed, this particular state requires the counselor to be an advocate instead. Standard A.7.a. Advocacy states, “When appropriate, counselors advocate at individual, group, institutional, and societal levels to address potential barriers and obstacles that inhibit access and/or the growth and development of clients.”

Therefore, in the best interest of the client, the counselor should work with and raise their concerns with those individuals who are diagnosing the client. For instance, antisocial personality disorder does have a historical and social prejudice associated with it (Standard E.5.c.), and if the client is a Black male, the diagnosis

could have a far-reaching impact on him. Additionally, the counselor could advocate for counselors to be able to diagnose within this particular state.

The professional counselor has a terminal degree at the master’s level. Most possess a strong foundational knowledge and level of competency. To aid in that level of competency, licensure laws require postgraduate supervision before allowing an individual to practice without support. However, boundaries of competency need to be strengthened and refreshed through continuing education and by expanding horizons beyond the “typical” that one may have learned in school. For instance, counselors can seek training on working with nontraditional relationships, distance counseling, substance use, psychopharmacology, integrative approaches and more. Finally, counselors should not practice outside their scope of practice, but they can advocate for their scope of practice to accurately reflect their training. ♦

Michelle E. Wade is an assistant professor at the University of New Orleans. She is the senior co-chair of the ACA Ethics Committee.

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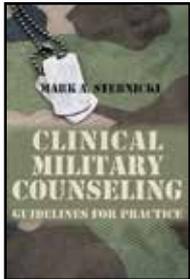


Recent Resources

Newer resources of interest from ACA members

Clinical Military Counseling: Guidelines for Practice

By Mark A. Stebnicki, American Counseling Association

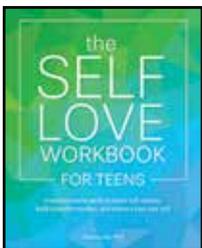


This title provides current research and ethical practice guidelines for the assessment, diagnosis and mental health treatment of active-duty service members, veterans,

and military families in a 21st-century multicultural environment. The author discusses contemporary military culture; the medical and psychosocial aspects of military health, including the neuroscience of military stress and trauma; suicide; chronic illnesses and disability; and blast and traumatic brain injuries. He also offers integrative approaches to healing the mind, body and spirit of service members and veterans dealing with clinical issues, posttraumatic stress disorder, co-occurring mental health conditions, the stresses of the deployment cycle and career transitions.

The Self-Love Workbook for Teens

By Shainna Ali, Ulysses Press



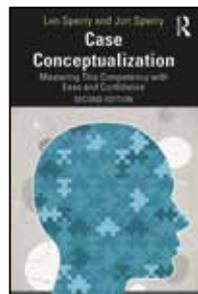
Life can be stressful as a teen, whether from worrying about looks, performance in school, relationships with friends and family,

or societal pressures. It is easy to lose focus and feel like you're not good enough. This interactive resource is aimed at helping teenagers develop a

healthy mindset, overcome self-doubt and cultivate a deep, resilient and lasting sense of self-love. The workbook is full of research-backed exercises, journaling prompts and actionable advice for young adults to work through on their own or to discuss with a trusted adult.

Case Conceptualization: Mastering This Competency With Ease and Confidence, Second Edition

By Len Sperry & Jon Sperry, Routledge

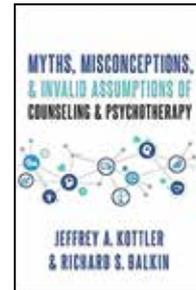


Integrating recent research and developments in the field, this revised second edition introduces an easy-to-master strategy for developing and writing culturally sensitive case

conceptualizations and treatment plans. Concrete guidelines and updated case material are provided for developing conceptualizations for the five most common therapy models: cognitive-behavioral therapy (CBT), psychodynamic, biopsychosocial, Adlerian, and acceptance and commitment therapy. The chapters also include specific exercises and activities for mastering case conceptualization and related competencies and skills. Also new to this edition is a chapter on couple and family case conceptualizations, and an emphasis throughout on trauma.

Myths, Misconceptions & Invalid Assumptions of Counseling & Psychotherapy

By Jeffrey A. Kottler & Richard S. Balkin, Oxford University Press

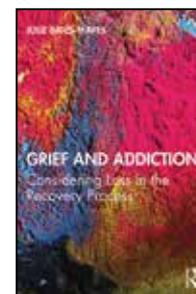


There are certain assumptions about the practice of counseling that are accepted as “truths,” beliefs that are so pervasive that they remain unchallenged by almost all

practitioners of all persuasions and approaches. In this book, the authors cover a wide range of myths, misconceptions and assumptions that have remained unchallenged or that have little research to support their efficacy. Topics covered include the sacrosanct “50-minute hour,” how basic research is conducted and whether the results inform actual practice, why progress made in therapy often doesn't last, what social justice actually means, and what makes someone an effective therapist.

Grief and Addiction: Considering Loss in the Recovery Process

By Julie Bates-Maves, Routledge



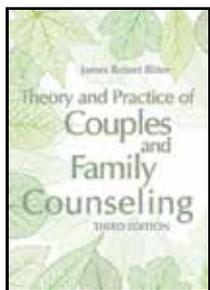
This resource illuminates the role of grief work in addiction counseling, encouraging counselors to be more comprehensive in their treatment

and to increase empathy for what the treatment process is asking of clients. Acknowledging that entering recovery includes a loss of coping skills, and that it requires building a new identity, this book focuses on addiction-specific grief work. The book integrates concepts such as complicated grief,

nonfinite loss, trauma, family grief responses and treatment suggestions in one place — all with a focus on the application to addiction work. It features appendices with information and examples for clinicians.

Theory and Practice of Couples and Family Counseling, Third Edition

By James Robert Bitter, American Counseling Association

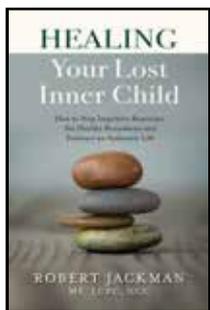


This introduction to couples and family counseling lays the foundation for student skill-building by encouraging the development of personal,

professional and ethical standards of practice. This edition has been expanded to include couples counseling and updated to reflect recent research and current practice. Primary text features include a genogram delineating the history of the field; a comprehensive discussion of 13 widely used theories with real-life examples of quality work for each approach; a single, bicultural couple/family system case for comparison across models; and strategies for the integration and application of the models into clinical practice with diverse clients.

Healing Your Lost Inner Child: How to Stop Impulsive Reactions, Set Healthy Boundaries and Embrace an Authentic Life

By Robert Jackman, Practical Wisdom Press



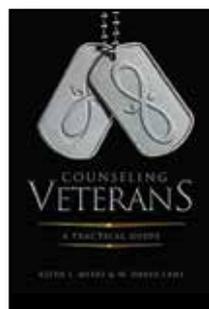
Most people don't realize how much unresolved emotional pain they carry around. These patterns often stem from the attachment trauma of their lost inner child,

which carries a false narrative on repeat since childhood. These hurt emotions resulting from childhood experiences

of abuse, neglect or trauma show up in adulthood. Through stories and exercises, this practical, easy-to-read book and companion workbook encourage the reader to learn how to stop giving in to the wounded inner child and begin living an authentic life. With the HEAL process, discover the original wounding, triggers, family of origin issues, boundaries and, ultimately, healing integration.

Counseling Veterans: A Practical Guide

By Keith J. Myers & W. David Lane, Cognella

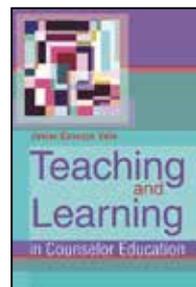


This book equips readers with foundational knowledge of military culture and common issues experienced by service men and women.

This crucial text helps future and practicing counselors compassionately and competently treat individuals who serve or have served in the U.S. armed forces. Each chapter features learning objectives, definitions, research-based literature on the topic, treatment options and programs, a clinical vignette, perspectives from veterans and discussion questions. Designed to help readers build critical competencies, this resource is an ideal text for advanced courses in counseling. It can also serve as an essential guide for practicing counselors.

Teaching and Learning in Counselor Education

By Javier Cavazos Vela, American Counseling Association



This practical guide is one of the first to examine research-based teaching and learning strategies, promote positive and inclusive learning environments, and

provide interactive features that allow readers to demonstrate and apply what they learn. Ideal for courses on teaching and pedagogy, it provides a deep understanding of how learning works in order to improve teaching practices and create strong student learning outcomes. Skill-building chapters explore how to use dynamic lecturing, integrate collaborative team-based principles into teaching, enrich strategies for online learning, develop transparent assessment activities, document teaching effectiveness, practice effective gatekeeping, and engage in the scholarship of teaching and learning.

The Professional Counselor: Challenges and Opportunities

By Shannon Hodges, Routledge



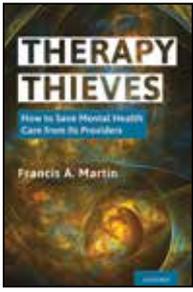
This book weaves a rich narrative for the inner counselor of self-discovery, mindfulness and self-care, emotional intelligence, counselor identity, ethical issues, career maturation, and

future trends in counseling. Readers will be confronted with professional decision points regarding enrollment in the counseling profession, ethical issues, client treatment, accreditation and occupational outlook. The text also posits counseling as an emerging global profession and addresses the ways technology will transform professional practice. Each chapter concludes with a Lessons Learned section in which the author uses his personal and professional experiences to address relevant professional issues in mindfulness-based treatment.

Therapy Thieves: How to Save Mental Health Care From Its Providers

By Francis A. Martin, Oxford University Press

Acting on what started as a hunch, the author has cataloged well over 20,000 distinct approaches to

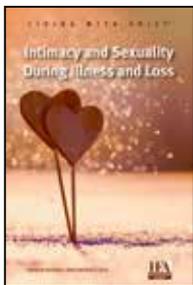


counseling and psychotherapy that are advertised on the webpages of licensed, practicing mental health providers. No doubt some portion of them are harmful, but the sheer volume

of advertised practices and techniques, often with names deceptively similar to actual evidence-based practices, should be cause for concern among all stakeholders in the helping professions — from educators and researchers to policy makers and insurance companies and, especially, consumers. This powerful book advocates for major reforms in several areas of mental health care.

Intimacy and Sexuality During Illness and Loss

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

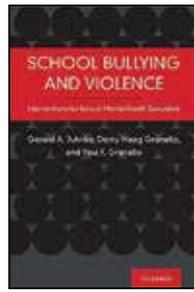


This resource identifies barriers to intimacy and sexuality for terminally ill individuals and the bereaved and the knowledge and skills professionals must have to sensitively

address and suggest interventions to help meet these elemental human needs. Topics addressed include sexuality and intimacy in hospice and palliative care, the assessment of intimacy and sexual needs, intimacy issues with people with dementia, intimacy challenges when a partner dies of suicide, the empowerment of intimacy for LGBTQ individuals at life's end, and intimacy issues for couples following a child's death.

School Bullying and Violence: Interventions for School Mental Health Specialists

By Gerald A. Juhnke, Darcy Haag Granello & Paul F. Granello, Oxford University Press

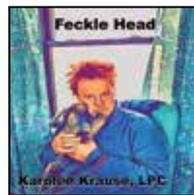


School cyberbullying, bullying and violence have reached epidemic levels. One in 5 school students report being bullied. Youth violence results in more than

475,000 nonfatal injuries per year and is the third-leading cause of death for young people ages 10 to 24. This book provides critically important assessment and intervention information and strategies. Equally important, the authors address assessment and intervention protocols for bullying and violence school perpetrators. Suggested assessments and interventions are both practical and proactive. The authors skillfully utilize mini-case vignettes to demonstrate how to address survivor and perpetrator pressing issues, concerns and needs.

Fackle Head

By Karolee Krause, Independently Published



Fackle Head and his cat Lucky Feister have anger problems. Together, they find picking on and bullying each other fun until, one day, Fackle Head discovers that it feels better to be happy. This is a humorous introduction into the world of anger and bullying for young children, helping them better understand how their actions affect not only themselves but others.

Professional Warrior: The Everyday Summit

By Tim Krause & Karolee Krause, Independently Published

Learn to climb over enormous professional blockages, hike up steep staircases of stress management, conquer employee conflicts, walk across fire pits of angry customers or clients, swim across the sea of diversity, and



crawl through dark cutthroat hallways of competition. This resource focuses on a variety of guided exercises and questions to help you assess how to get your career on solid footing for the

next step in your professional journey. ❖

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Addiction: Paving the way to recovery

The road to recovery is rarely smooth, but counselors can help clients process the pitfalls that led them to addiction and avoid the potholes that can lead to relapse

By Laurie Meyers

When the outside world looked at Julie Bates-Maves' client "James," it saw a 60-something "junkie" who had wasted 20 years of his life shooting up heroin. But in James' community of people who used heroin, he was a respected man — an authority figure who could be trusted.

Throughout his two-decade addiction, James had established himself as a safety expert, recounts Bates-Maves, a member of the American Counseling Association. It might seem incongruous to use the word "safety" when speaking about heroin use, but safer injection practices can save lives. James derived great satisfaction from helping his peers reduce their risk of contracting HIV or hepatitis by teaching them never to share needles and demonstrating how to clean their own. He also taught others how to inject without missing the vein.

James' process of giving up heroin took about a year, but he did well with overcoming the physical addiction, says Bates-Maves, a licensed professional counselor (LPC) whose master's degree is in rehabilitation counseling with a concentration in alcohol and substance abuse counseling. The hard part was when James was alone and feeling lonely. He struggled with feelings of uselessness, and he knew where he could readily find validation. Among other users, all James had to do was offer to lend his expertise. There was always someone willing to take him up on his offer.

"He had not found respect in virtually any other area of his life," Bates-Maves says. That meant that in trying to give up heroin, James would also have to leave behind the solitary piece of his world that made him feel worthwhile.

“

It made her realize that counselors need to have discussions about the search for meaning, about the grief and loss that come with substance abuse, with all clients in recovery.

”

Once Bates-Maves understood that using heroin was tied to James' sense of self, she realized they needed to examine what it was about the behavior and the attached relationships that provided him with a sense of meaning.

“It was a lot of picking each other's brains and saying, ‘Let's try to dissect this,’” she recalls. They set about trying to uncover the *actual* source of the sense of meaning that James derived from using heroin. “Is it truly tied to the syringe and the bleach and the cotton and the heroin?” she asked him. “Or is it that somebody is listening to you because they think you know something that they don't?”

Ultimately, James realized that he didn't actually need the heroin. “I just need someone to look at me and think I'm smart and that I have something to offer,” he told Bates-Maves. So, they worked together to identify another way for James to find a sense of meaning and feel as if he had something to offer others.

Earlier in his life, James had pursued a welding career. For various reasons, he had abandoned that path long ago. But now, he was ready to pick it up again.

With Bates-Maves' help, James got re-enrolled in a tech program for welding. By going back to school, he acquired a skill set that not many people possess, built new relationships and experienced a sense of validation. He was able to say, “Hey, I'm 62, but I don't have to check out of the game, and I don't have to stay stagnant in everything I've done,” Bates-Maves explains. “I can add new things to my life, and by adding more to my life, I can add to other people's lives.”

“So,” she adds, “it became sort of a sense of altruism for him of wanting to give to the world and then to feel good about doing that.”

James had been addicted to heroin for 20 years and recognized that over that time, he had hurt and taken a lot from others, particularly his family. “He had kind of felt like a leech for a long time, and now it was finally time to be able to give that back and repay,” Bates-Maves says.

James was a watershed client for Bates-Maves. His story was the one that changed how she viewed substance abuse counseling. James' narrative hadn't been just informational — it had been existential. It made her realize that counselors need to have those types of discussions — about the search for meaning, about the grief and loss that come with substance abuse — with all clients in recovery.

Bates-Maves and the other counseling professionals interviewed for this article say that when therapists center treatment solely on elimination of the substance and everything associated with it from the person's life — without considering the myriad factors that contribute to use, abuse and the drive to reuse — they are actually hampering clients' recovery.

The need for grief work in substance abuse therapy

“We oversimplify the picture of addiction,” Bates-Maves says. “We do that as a world broadly, and we definitely do that in the counseling profession sometimes. ... We think of it as the erosion of a life — it's only somebody moving backward, it's only someone being stuck. And we get stuck in that narrative.”

Counselors often focus on getting clients “unstuck,” which is certainly not without worth, but it is limited, says Bates-Maves, an associate professor of clinical mental health at the University

of Wisconsin-Stout. “I've worked with many clients who ... loved being stuck [in addiction],” she says. They loved the feeling of being someone else, the ability to lose sight of negative things, the ability to create an optional numbness.

Addiction sets the stage for a lot of destruction in people's lives, but it can also serve as a kind of desperate sustenance for users who see no other way to cope with life, Bates-Maves says. The bald truth is that substance abuse also *adds* things to life, and that's something counselors don't talk about enough, she asserts. Counseling is a profession that focuses on concepts such as identity and a person's sense of meaning, yet counselors often neglect to explore how these concepts tie in to addiction — what clients are actually getting from their substance abuse, what makes it attractive or useful to them, she says.

When presenting on the role that grief and loss play in addiction, Bates-Maves has frequently heard from audience members that the clinics in which they work have told them not to talk about the “good stuff” that substance use brings. She says the usual company line is, “You can't have them celebrate the high or tell those so-called glory war stories. That's encouraging their desire to use.”

“We're so blinded by this fear of people going back to use,” Bates-Maves says. “What if the glory days were the only time people felt powerful, or what if when they're high, it's the only time they don't feel intense [emotional or physical] pain? What if it's the only time they feel confident enough to engage with another human? ... Those are central treatment issues, and they can come out of the quote-unquote ‘positive experiences’ in addiction.”

There's a lot to let go of when you're trying to get to recovery. There's a tremendous amount of loss, and [we've] somehow largely missed that as a field."

Bates-Maves feels so strongly about the necessity of counselors having these conversations with clients as part of the recovery process that she wrote a book, *Grief and Addiction: Considering Loss in the Recovery Process*, which was released at the end of September.

"Addiction ... ravages your life," Bates-Maves says. "Nobody likes that." Even so, she continues, counselors need to encourage clients to think about the things they risk losing when they determine to confront their addiction.

"Even if they're good losses — things you want to go away — it's still a massive change that you're undertaking," she tells clients. "You deserve to feel sad and frustrated and sorrowful ... and relieved."

Even though the changes people go through in recovery need to happen, clients deserve to know that it's OK for them to miss the things they leave behind. "You can miss it forever and still change," Bates-Maves says emphatically.

"When we start to try and shove people forward to recovery without looking at the rearview mirror at all, we're going to miss the things that will chase them down later," she explains.

Bates-Maves believes Kenneth Doka's model of disenfranchised grief perfectly explicates the losses sustained by people struggling with addiction. In the recovery process, these clients typically must abandon coping methods and even relationships that are unhealthy. As such, these things are often deemed "unworthy" of grieving over.

Similarly, many clients in recovery have lost friends to stigmatized deaths such as overdose, suicide, hepatitis and AIDS. Other clients may have chosen abortion or had a miscarriage because of their addiction. Once again, these individuals can be made to feel that they aren't allowed to grieve those losses, Bates-Maves says. In particular, family members — and the courts — tend to convey the message, "You dug your own hole."



But everyone has losses from predicaments that are primarily self-created, Bates-Maves argues. "I have this grief all the time where I'm the one who caused the problem, but I'm still really mad that I have it," she says.

Emotions that are denied usually just fester and show up in other ways, Bates-Maves says. "Just let people" — including those struggling with addiction — "be angry. Let them be sad. Just because we're the creators of our own misery does not mean we don't deserve to be miserable about it," she says.

Counselors can offer clients support as they learn to acknowledge that their current reality — whatever stage of addiction or recovery they're in — is incredibly tricky and comes with myriad, and often confusing, emotions, Bates-Maves says. What counselors *shouldn't* do is tell clients that what they're feeling is wrong or try to "cheerlead" them into a different emotional state, she continues.

People sometimes picture coping as having overcome a difficulty so that it no longer has any emotional effect

on them, Bates-Maves says. "I think it's really important for all of us to remember that's not what coping is. Coping isn't getting over something. ... It's living with something. It's getting through it as you're in it."

"My job as a counselor is not to make the pain go away, because I can't," Bates-Maves continues. "It's not to force the transformation of pain. That's a hope, but sometimes that can take longer than my relationship with [the client]."

So, what is the other side of grief? What is the goal of grief work? Bates-Maves describes it as learning to walk with and carry your pain in a way that doesn't sink you. "You want the pain to be manageable so that you can live life with it there," she says.

Bates-Maves recommends a variety of methods to help clients, including those walking through addiction and recovery, with their grief and pain. One method is containment — the idea of compartmentalizing the pain and building psychological space for it. She says this is particularly useful for pain attached to situations that are unlikely to be resolved anytime soon. Some clients make actual physical boxes, write down their thoughts, feelings or whatever it is that is causing them distress, and lock it up, but the container need not be literal, Bates-Maves explains.

The intent of the exercise is not to lock the person's pain up forever, but rather to put it aside so that the person can carry on with the other parts of their life. This acknowledges the reality that even when people are hurting badly, the demands of living go on. When a client has the time or desire, they can open the container, sit with the pain and feel whatever they feel. Being able to set aside the pain temporarily allows clients to care for their children, drive to work or even just relax by watching TV or listening to music without being confronted by constant intrusive thoughts, Bates-Maves says. Journaling is another way that clients can create a space outside of their own heads for their emotions, she adds.

In contrast, radical acceptance, a method that is the polar opposite of locking one's thoughts away, can be very effective for some clients. "It's this idea that we cannot always change things and we need to accept and acknowledge it and keep moving," Bates-Maves says. With radical acceptance, clients learn that their grief and pain are valid but that they can feel those emotions and still keep moving alongside them.

Bates-Maves has also had clients who experienced intense and disturbing dreams about their grief. She would teach them "directed dreaming." Clients would take five to 15 minutes before going to bed to create detailed mental pictures in their minds of what they wanted to dream about. With practice, people can learn to direct their dreams, Bates-Maves says.

For clients who frequently feel overwhelmed, Bates-Maves recommends belly breathing. She explains that teaching people to breathe more efficiently can reduce panicked breathing, which helps take the body from a state of distress to one of relaxation, or at least closer to it.

She sometimes helps clients transform their pain by learning to reframe how they view their losses. Certain clients realize that they will never feel differently about parts of their past but that they are OK with that. Some clients work through their pain by seeking connection with others. And some clients decide that they need to spend more time with themselves rather than with others, hoping to learn who they are without addiction.

Attachment, trauma and addiction

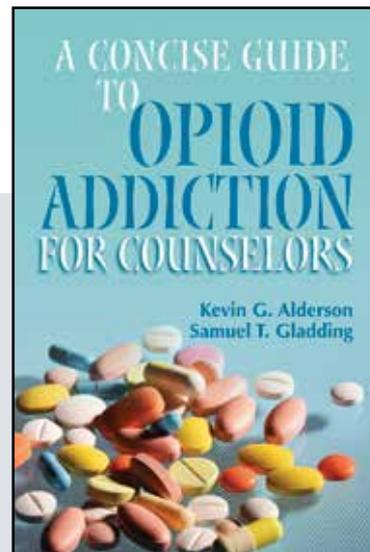
Many people with addiction have been primed to seek solace in substances or processes because of a history of trauma and a lack of healthy attachments, says ACA member Oliver J. Morgan, who has written numerous books on substance abuse and addiction. Caring relationships can help mitigate the effect of trauma in a child's life, whereas a lack of those connections is traumatic in itself. Feeling cared for helps build healthy neural connections

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such as a fully functional stress response and the reward, reinforcement and motivation systems that contribute to emotional coping skills, he explains.

When someone finds it difficult to cope with stressors such as the lasting pain of trauma, dysfunctional relationships, loneliness or the everyday disappointments and frustration of life, they may turn to addictive substances or behaviors, says Morgan, a licensed marriage and family therapist who has been clean and sober for over 30 years but once was addicted to alcohol.

Over time, chronic use and abuse of substances or processes oversensitize areas of the brain related to dopamine so that they are easily triggered, he says. The brain then connects those areas to memory and environmental cues that themselves create desire. In other words, addiction causes the brain to react to cues that a client may not even know exist, Morgan says, creating what neurobiologists call “pulses of craving.”

“The brain organizes reward around memories so that we remember to repeat [the action],” says Morgan, a master addiction counselor. “It’s how we learn and how we fall in love.” A particular song on the radio, specific places or people, or even certain scents can serve as triggers.

That’s why he views all addiction counseling as relapse prevention. “From the beginning, you need to prepare people for the possibility, if not probability, of relapse,” says Morgan, a professor of counseling and human services at the University of Scranton.

He uses psychoeducation to explain the neurobiology underlying addiction and relapse — not just to clients, but to their families if they are willing to listen. Morgan believes this is essential to preventing a common scenario: A client relapses and their family says, “He told me he was going to stop and he didn’t. He lied to me.”

It’s not quite that simple, Morgan says. He explains to families that their loved ones mean it when they say they’re going to stop using, but they’re not anticipating that their brains are going to react to these cues. So, a relapse doesn’t mean that the client

isn't committed to recovery, Morgan says. The support of loved ones helps clients remain dedicated to the recovery process and keep believing that they can achieve it — even if they are momentarily derailed by a relapse.

Morgan, a member of the International Association of Addictions and Offender Counselors, a division of ACA, believes that relationships are the ultimate buffer against addiction. From the start of the recovery process, he helps clients begin forging new relationships with people who are clean and sober. They might develop these connections by finding sponsors or reaching out to strangers at Alcoholics Anonymous (AA), Narcotics Anonymous (NA) or other recovery group meetings and virtual gatherings.

Morgan also gives clients a laminated card with steps to take if they feel the urge to use. This can function as a kind of crisis plan or serve as a reminder to clients that they have tools to help prevent relapse. The first step is to acknowledge their urge but to remind themselves that it is just a feeling, not something that they have to act on.

Next, Morgan wants clients to reach out to someone whom they trust and can talk to. “The best way to deal with stress is to buffer with a relationship,” he says. The person or people clients reach out to could be a sponsor, recovery group members or Morgan himself. This gives clients a way to share the burden by verbalizing their feelings and getting some advice. If none of this works, he tells clients to call him (assuming he wasn't the person they reached out to initially).

Because the urge to use is triggered by external and internal cues that clients may not even be aware of, Morgan urges counselors to walk these clients through their past. He asks clients to think about times when they were using or wanted to use. What was happening in their lives at the time? What were their favorite songs? The broader the exploration of everything in their lives, the more likely it is that potential relapse triggers can be identified.

“Sometimes,” Morgan says, “you have to wait for them to come into

session and say, ‘I really wanted to use’ [to discover their triggers]. That’s why it’s important to let them have access [to you] when it happens [between sessions] so that you can walk them through it. ‘Where were you? What happened? Who was with you?’”

Once the client and counselor have identified triggering situations, they can work together to come up with better ways to handle them. In his own life as someone who was addicted to alcohol, Morgan uses humor. “I make a joke out of it and talk about it widely,” he says.

When Carol Sloan Goodall, a licensed clinical addictions specialist, led group work at a local recovery center, she frequently had clients form smaller circles to identify three external, three internal and three sensory triggers. Group members also had to come up with three ways to cope with each trigger.

“I was often pleasantly surprised to see how many different realistic coping skills they created and excited to see the clients impressed and motivated by these ideas,” says Goodall, a licensed clinical mental health counselor in private practice in Charlotte, North Carolina.

Common external triggers involved people, places and things. Internal triggers usually involved emotions but sometimes also included cravings, chronic pain or illness. Sensory triggers were just that — input from the five senses, such as smells, tastes and sounds.

The coping skills that clients came up with were varied. One client described avoiding temptation by changing their route upon realizing that their drug dealer lived on a particular street. Another client felt like their home was a trigger, so they rearranged the furniture and changed the color of the accessories to make it appear new and different.

“One client said he carried a dryer sheet in his pocket and sniffed it when triggered by scents reminding him of drug use,” Goodall recalls. “Another client stated that the perfume cards you spray in department stores served the same purpose.”

Goodall also suggested that when confronted by triggers, clients could distract themselves with sensations such as snapping a rubber band on their wrists or holding an ice cube.

Morgan is a believer that practicing mindfulness can help clients identify and even anticipate triggers. He teaches clients to sit down and find a place on which to focus — a spot on the wall, a beam of sunlight, a candle. Then he instructs them to just “be” in that moment and observe what is happening around them in the here and now, to cultivate awareness and to notice if the urge to use is creeping up. He also finds this mindfulness practice helpful for coping with anxiety and creating a sense of calm by just being in the moment, letting one's thoughts and emotions float by, and then letting them go.

The necessity of reducing in-person meetings during the pandemic has in some ways made it easier for those in recovery to get support. Groups such as AA, NA and other recovery organizations swiftly moved their meetings to digital platforms. People can access virtual meetings or keep in touch with other group members through social media, email or phone. Counselor clinicians have also had to become more comfortable with virtual counseling. Morgan sees this as a positive because he thinks not having to show up in person to access resources is easier for many people who are seeking help with substance abuse. It's less uncomfortable for these clients, Morgan says, because they don't quite have to put themselves out there completely.

Going from prison to the outside world

Julia Thielen, an LPC located in South Dakota, works at an intensive outpatient facility with a particularly challenging substance abuse population: clients living in a post-prison transitional facility after being incarcerated for as long as 10 to 15 years.

These clients are not only working toward recovery, but also coping with trauma and trying to navigate a world that they don't recognize or understand,

Additional resources

To learn more about the topics discussed in this article, take advantage of the following select resources offered by the American Counseling Association:

International Association of Addiction and Offender Counselors (iaacounselors.org)

IAAOC, a division of ACA, is an organization of professional substance abuse/addictions counselors, corrections counselors, students and counselor educators concerned with improving the lives of individuals exhibiting addictive or criminal behaviors.

Counseling Today (ct.counseling.org)

- ❖ “Hidden in plain sight” by Laurie Meyers
- ❖ “Standing in the shadow of addiction” by Lindsey Phillips
- ❖ “Grief, loss and substance use” by Susan Furr & Derrick Johnson
- ❖ “Healing the healers: Counselors recovering from familial addiction” by Suzanne A. Whitehead
- ❖ “Group counseling with clients receiving medication-assisted treatment for substance use disorders,” by Stephanie Maccombs
- ❖ “Informed by trauma” by Laurie Meyers
- ❖ “Suicide, substance abuse and medical trauma” by Bethany Bray

Books (imis.counseling.org/store)

- ❖ *A Concise Guide to Opioid Addiction for Counselors* by Kelvin Alderson & Samuel T. Gladding
- ❖ *A Contemporary Approach to Substance Use Disorders and Addiction Counseling*, second edition, by Ford Brooks & Bill McHenry
- ❖ *Addiction in the Family: What*

Every Counselor Needs to Know by Virginia A. Kelly

- ❖ *Treatment Strategies for Substance and Process Addictions* by Robert L. Smith
- ❖ *Introduction to Crisis and Trauma Counseling* edited by Thelma Duffey & Shane Haberstroh
- ❖ *Coping Skills for a Stressful World: A Workbook for Counselors and Clients* by Michelle Muratori and Robert Haynes

Webinars and article for continuing professional development (aca.digitellinc.com/aca)

- ❖ “Opiate Addiction and Chronic Pain: Overview of Counseling Approaches” with Geri Miller
- ❖ “Opiate Addiction and Chronic Pain: Ethical Practices for Counseling Clients Who Live With Chronic Pain” with Geri Miller
- ❖ “Opiate Addiction and Chronic Pain: Hope, Resilience and Self-Care Strategies for Counselors and Clients” with Geri Miller
- ❖ “Substance Abuse/Disruptive Impulse Control/Conduct Disorder” with Shannon Karl
- ❖ “Developmental Approaches in Treating Addiction” by Ford Brooks & Bill McHenry
- ❖ “Complicated Grief: An Evolving Theoretical Landscape” by Laurie A. Burke, A. Elizabeth Crunk & E.H. Mike Robinson III
- ❖ “Screening, Brief Intervention, and Referral to Treatment (SBIRT) for Substance Misuse” with Amy E. Williams & Kristin Bruns

ACA Mental Health Resources (counseling.org/knowledge-center/mental-health-resources)

- ❖ Substance use disorders and addiction
- ❖ Grief and loss

Thielen notes. They have records, have spent years without employment, are often estranged from their families, have often lost friends to causes such as overdose, and struggle to form a sense of identity. Life has generally moved on without them. The things these clients may have once wanted — steady jobs, families, a house of their own — now feel largely out of reach to them, Thielen says.

Those around these clients often want to sugarcoat their circumstances and make them feel better, but what they really need, Thielen says, is someone to hear them out and help them set realistic goals. “Yes, you are past 30, so having a house before then is not going to happen. But is it possible to achieve that by 40?” she asks them.

For clients who have spent a particularly long time in prison, just getting a job is challenging, Thielen says. They lack a history of employment and have to disclose that they spent time in prison. They need help finding any form of employment just to reestablish a work history so that further down the line, future employers at potentially more attractive jobs might be able to see them as responsible and hard-working, she explains.

In addition to teaching these clients emotional self-regulation skills such as deep breathing, Thielen and her colleagues instruct them in basic life skills. Many of these individuals spent their adolescence and young adulthood in prison, so in essence, they have skipped a developmental stage, she says.

Thielen’s clients regularly talk about the challenges of finding healthy friends and activities. “One of the big things they are lacking is any kind of support or stability in their lives,” she says. Getting these clients involved with AA, NA or another recovery group is one way to help them establish friendships with people who don’t use or who are also in recovery.

Many of Thielen’s clients don’t know what healthy friendships look like, so she spends a significant amount of time helping them identify red flags from their past relationships, such as behaviors that led them toward



While the focus is typically on those who are physically addicted to substances, almost three times as many people are problem users. And it is these individuals whom counselors are most likely to see.



addiction or contributed to them staying addicted. Often, Thielen says, these friends from clients' former lives would call in sick for the client when they were hungover, pay their fines for misbehavior or help them come up with excuses for their probation officer.

Another piece of the puzzle is to help these clients articulate what values they would like potential friends to possess. Often, the easiest way to do this, Thielen says, is to ask them what values and beliefs they would like to instill in their own children and to look for those same characteristics and qualities in others when forming new friendships.

But most of Thielen's clients still have strong ties to the people they previously used with. These aren't "healthy" friendships, but many of these clients have no one else in their lives upon being released from prison. In many cases, their families and any friends they had who weren't fellow users have given up on them long ago. From the perspective of some clients, the people who were their fellow users and have maintained contact have "been there" for them, and the clients want to reciprocate. But spending time with these friends — who may not be interested in stopping their own substance use — is the most common road back to addiction and, often, reincarceration.

Some clients can have the hard conversations and cut ties with the people who are linked to their past substance abuse and prison time, Thielen says. But that's almost an impossible ask until they have formed new relationships. That is why getting them into some type of new community such as a self-help group, addiction recovery group or church group is critical, she says.

Another challenge is that although a transitional facility can offer support and shelter to those who have recently been released, the environment isn't very conducive to learning responsibility, Thielen says. These clients learned to follow a particular set of rules in prison, and now they learn to follow another set of rules in the transitional facility, but they aren't necessarily learning how to set a budget, how to cook a meal or even how to buy groceries for themselves.

Thielen and her colleagues attempt to set clients up with case managers and life skills coaches, but she acknowledges that some individuals are very resistant to this kind of instruction.

Prevention and intervention

Counselors do have opportunities to intervene — before addiction, before prison, before a life goes off the rails. Morgan notes that while the focus is typically on those who are physically addicted to substances, almost three times as many people are problem users. And it is these individuals whom counselors are most likely to see, he says.

Morgan asserts that addiction professionals don't necessarily know how to deal with those individuals who are problematic users but have not reached the threshold for addiction. Recovery centers aren't suitable for these individuals because they aren't physically addicted, he says.

But professional counselors can help clients explore and recognize their problem use through exposure to motivational interviewing and the stages of change, Morgan says. Often, these clients have ended up in the counselor's office because they've had trouble at work, at school, with

their family or other relationships, or elsewhere. They may flatly deny any suggestion of "problem use," but counselors can suggest exploring what is going on in these clients' lives.

"If they're willing, that already puts them into precontemplation," Morgan says. Counselors can take that recognition that something's not quite right and say, "Let's look at what change looks like," he suggests. "Let's stop drinking, drink less or drink less harmfully."

"We have to pay attention to moments of opportunity," he stresses. "Someone gets pulled over for a DUI — that's a moment of opportunity." If someone is overdrinking and prone to accidents around the home, every visit to the emergency room is an opportunity, Morgan continues. Some hospitals are already using motivational interviewing for brief interventions in the ER, and the success rates have been impressive, he says.

The problem is that for too long, the message has been that when people with substance abuse problems are ready, they will seek help, Morgan says. But most of the time, they're not going to come in on their own, he asserts.

"We have to raise the bar," Morgan concludes. ♦

Laurie Meyers is a senior writer for *Counseling Today*. Contact her at lmeyers@counseling.org.



How (not) to isolate during the COVID-19 pandemic

When almost everyone is practicing isolation or experiencing its effects to some degree, how do counselors assess and respond to isolating behaviors among their clients?

By Bethany Bray

The coronavirus pandemic has steeply curtailed social gatherings, travel plans and in-person events for most of 2020. And that has raised something of a perplexing scenario for counselors and other mental health professionals: When almost *everyone* is isolating themselves physically to some extent — and will be for the foreseeable future — how do you identify that a client might be isolating in the “classic” sense, which is typically viewed as a red flag that someone might be struggling with their mental health?

“As I’ve gone through the last six months, my view on what isolation looks like has definitely changed,” says Sean Nixon, a licensed clinical

professional counselor outside of Boise, Idaho, who works with children and families. “I used to think of isolating as a person who is off by themselves, not engaged or interacting with anyone. But now, [for] a lot of people who I’ve worked with in my practice, there’s this forced, constant isolating. Even now that they can leave the house, to walk up and give someone a hug, as you might have done six months ago, is not the norm.”

Nixon, like many clinicians, has needed to shift his thinking about what isolation looks like in clients during the COVID-19 pandemic, and respond differently as well. When screening for isolation and depression, one of the primary indicators counselors look for is



Isolation is now a lot more nuanced. ...
Most relationships right now are facing
a lot of stress [because] we're placing
all the emotional weight on a few places.



a loss of interest or lack of participation in activities that a person once enjoyed. But throughout the pandemic, many clients haven't felt safe playing group sports or participating in activities or hobbies that typically involve others. Plus, many of these activities haven't been available anyway because of widespread cancellations and closures.

"Now, when asking those screener questions, I have to consider the person's situation. ... We have to screen more — are we seeing an increase in depression, an increase in stress because of the pandemic, or are we dealing with both here?" says Nixon, a member of the American Counseling Association who works as a pediatric mental health therapist in an outpatient setting for a medical system.

Nixon says he has also broadened his scope of thinking about isolation to look for it both in individuals and entire family units. Not only are families feeling isolated from friends and outside activities that they used to enjoy, but they are sometimes isolating themselves from each other within the household during this stressful time, he explains. This can range from physical withdrawal, such as shutting themselves in their bedrooms, to spending too much time using digital devices as an avoidance mechanism.

Signs of isolation in families with children often become apparent when youngsters express a constant desire to play with or do one-on-one activities with a caregiver, he says. At the same time, many parents are expressing that they feel overwhelmed or that they feel guilty about needing to spend time sequestered away from their children as they work from home.

"From parents, I'm hearing [in sessions] how they just need a break

and are feeling like their children always want their attention. They're trying to find balance while they still have work commitments and are trying to explain to younger children that 'Mom and Dad aren't just home; we're home and we have work to do.' It's definitely a strain and struggle on parents," says Nixon, who is also a licensed marriage and family counselor.

"A lot of times, the previous concept of isolation was as an individual problem," he continues. "But [as the pandemic worsened] I was working with family units who were limited on where they could go, and I started to see stress and overwhelming emotions that came with being around each other 24 hours a day, seven days a week. As that continued to build, for some families, it helped them grow closer together. For others, it was increasing their dysfunction and tearing them apart faster."

What to listen for

Ryan Holliman is a licensed professional counselor and supervisor (LPC-S) and a counselor educator who counsels adult clients one day per week at a free medical clinic in Dallas. Forging a strong bond with clients and getting to know what is and isn't normal behavior for them is always important for clinicians, but that's even more the case now, he says.

Many of Holliman's clients have personality disorders and struggle with maintaining long-term relationships. During the COVID-19 pandemic, Holliman has found he needs to assess clients more regularly and rigorously for isolation, including asking focused questions about their relationships and the resources they rely on when experiencing stress.

"Isolation is now a lot more nuanced," says Holliman, an ACA member and an assistant professor at Tarleton State University. "You have to listen for different things [such as] if they are being proactive about developing social networks and accessing those networks, or are they letting COVID-19 dictate the terms of their social life? ... Most relationships right now are facing a lot of stress [because] we're placing all the emotional weight on a few places."

Holliman has increased his check-ins with clients about their relationships with friends and family, asking them to rate these relationships on a scale. He asks, "How happy are you with the relationship, and how happy do you think the other person is with the relationship?" The aim of this exercise is to ensure that clients are continuing to grow, not stall, in their relationships during this trying time, he explains.

"With COVID-19, it's easy [for clients] to say 'good enough is good enough' and lapse into complacency. But I tell clients, 'That's not what I want for you.' It would be easy to say, 'It's a crisis, it's a pandemic, and this is as good as it's going to get.' But as counselors, we are called to be dealers in hope," he emphasizes. "Help [clients] move toward hope and [see] that there can be more."

Among the college student population, many individuals are exhibiting typical signs such as having trouble sleeping or feeling overwhelmed that suggest they are struggling and feeling isolated — but exponentially so, says Elizabeth Bambacus, a student engagement and summer studies administrator at Virginia Commonwealth University (VCU). She runs a peer mentoring program for first-generation college students, a



population that is already susceptible to feeling out of place and experiencing self-doubt. Her program pairs freshmen first-generation students with upperclassmen first-generation students for support, guidance and friendship.

Bambacus says many of her students have talked about feeling like their academic programs are much harder this fall. One student recently remarked that she wouldn't be upset if she threw her laptop across the room and it broke. In another conversation, a male student told Bambacus that he hadn't been outdoors in four days.

"We [would] generally have students who pop in [to our office] and say hi and random drop-ins wanting to chat about everything from 'I'm worried about an assignment' to 'I just had a big argument with my dad, and it's impacting my ability to focus.' But there isn't much opportunity for that now," say Bambacus, who has a doctorate in counselor education and supervision. "It's just not the same because everyone is avoiding everyone."

VCU's campus in Richmond is open, but a majority of the school's classes are being held online. While some students are staying on campus, many have chosen to live at home or by themselves in apartments off campus, Bambacus says. Most of the ways that students would typically be personally interacting with others, from staying after class to ask a professor a question to getting involved in student clubs and group events, are off the table this fall.

Another big indicator of isolation among students is avoidance behaviors, such as not engaging with peer mentors and neglecting assignments or otherwise letting their academics slide. Bambacus observes that many students, including those who have a prior history of being responsive, aren't responding to her emails this semester. "College students in general aren't great at this," she says, "but I have noticed an uptick."

Many students this year are also experiencing a resurgence of anxiety and depression that were previously under control, Bambacus adds.

Students with those diagnoses are always at risk for isolating behaviors, but this year, that is acutely so. As they begin to feel disconnected, their anxiety spikes and they get behind in their classwork, leading to a vicious cycle, she notes.

"I see students get overwhelmed, get behind in classes, and that's triggering too — that feeling of doom. 'Oh no. It's happening again.' With all of the anxiety and depressive thoughts, how can anyone do their homework or study for a test? That requires so much mental energy to do that, and the shame in not being able to do that — beating yourself up for not being able to focus for more than 30 seconds at a time — it's just a cycle."

Adapt as needed

In addition to checking in more frequently with clients and listening for the different (and potentially new) ways that isolation is affecting them, Holliman is focusing on self-talk. These past few months have left many clients

prone to a downward spiral of self-critical thinking, he says.

Many of his clients talk about being “stuck in their own thoughts,” he notes. “When you’re at home all the time, that’s a real struggle to fight that.”

That is all the more acute for clients dealing with reduced income or job loss during the recent economic shifts caused by COVID-19, he adds. Feeling trapped financially can lead to increased feelings of isolation, he says, particularly when added to the social isolation and self-doubt that have gone hand in hand with the pandemic.

“Clients may just need to hear, ‘This is not a normal situation, and you’re handling it,’” Holliman says. “Drawing from compassion-focused therapy, I ask [clients], ‘How are you talking to yourself? What’s the tone of voice you use? Do you give yourself credit for managing your mental health during all of this?’ We all need to give ourselves credit.”

Normalization is an important therapeutic tool right now, says Nellie Scanlon, an ACA member and LPC in the counseling center at Slippery Rock University (SRU) in Pennsylvania. Scanlon, a temporary faculty member at SRU, started a support group this fall for students to talk about the loss, isolation and other feelings they have experienced during the pandemic. The group meets weekly via Zoom.

Like Bambacus, Scanlon says she is seeing an uptick in symptoms of depression and anxiety among the college student population she sees. “Many clients are using the phrase ‘It’s fine’ when they really mean they are not fine. I have been encouraging clients to allow themselves to feel what they are feeling and process those feelings in session. So often, we are expected to be OK and move on without acknowledging that our feelings of loss and loneliness are normal responses in times of crisis such as the current pandemic,” says Scanlon, who successfully defended her dissertation and earned her doctorate in counselor education at Duquesne University earlier this fall.

“I also remind clients that they are more resilient than they realize,” she says. “I ask clients to remember a time in the past when they were successful at bouncing back and talk about it. It seems to be personally impactful for them to recall when they have been resilient in the past, and that increases their confidence level to adjust to current life circumstances.”

Of course, there are also some tried-and-true interventions for addressing isolation and loneliness that counselors are no longer finding helpful or appropriate to use during the pandemic. The professionals interviewed for this article agree that counselors should put exposure therapy and similar techniques on the shelf for now. They say it simply isn’t appropriate to encourage clients struggling with depression, social anxiety, obsessive-compulsive disorder or other diagnoses to interact with others in person at this time as a way to stave off isolation.

Bambacus notes that many of the go-to suggestions she would typically give to college students to boost their mental wellness, such as calling a friend to get together, going to a campus event or party, or simply getting out of the house to sit at a coffee shop for an hour, are not advisable at this time. She has been forced to consider other ways that she might help students make connections and avoid isolation. “This is definitely bringing out the creativity in us all right now — along with frustration,” Bambacus says with a chuckle.

“I think this is a real struggle given the current social restrictions in place due to the COVID-19 pandemic,” agrees Scanlon, the chair-elect of ACA’s North Atlantic Region and immediate past president of the Pennsylvania Counseling Association. “I have been encouraging clients to connect with others in a meaningful manner that is effective for them. ... Needless to say, there still appears to be an overwhelming loss of personal connection with others because we are limited due to the pandemic in the how, what, when and where of connecting with others.”

Creative connections

Psychoeducation can be a helpful tool in situations in which clients assume that they can’t be social during the pandemic or even push back against that line of thinking, Holliman says. By making themselves aware of out-of-the-box options, counselors can be ready to offer suggestions. For example, Holliman notes that his local library offers book clubs that meet over Zoom.

“There are a lot of unique ways for us to connect with one another,” Holliman says. “Limited options doesn’t mean no options, and that’s something clients really need to hear. There are ways [to find connection], but you have to be creative. The counselor needs to be a creative co-creator of options.”

For many clients, especially those in recovery, the pandemic actually offers *more* options for attending 12-step meetings and support groups because so many of them are meeting online now, he says.

Holliman found psychoeducation to be a powerful tool recently when working with a woman with bipolar disorder who was estranged from her family and struggling with isolation. She ended up in the hospital due to dosage issues that led to toxicity from one of her medications. In a session following her hospitalization, the client confided in Holliman: “Other than you, those doctors in the hospital were the first people I’ve talked to in a long time.”

Holliman said he knew even prior to this session that relationships were a challenge for the client, but her hospitalization served as a tipping point and an indicator of how acute her isolation had become during the pandemic. During the session, Holliman spent a good deal of time normalizing the client’s experience with bipolar disorder, emphasizing that supports were available and connecting her with resources, including online support groups for individuals with bipolar disorder. Holliman told the client, “You may feel alone, but you don’t have to be alone.”

“She had no idea there were others like her out there,” Holliman says.

“She made the comment, ‘I thought we all just ended up in asylums.’ She didn’t realize [there were supports]. She had just assumed, ‘This is how life goes.’”

Clients with bipolar disorder are at higher risk for isolation because of the rapid mood fluctuations of their disorder and the impact that can have on their close relationships, often causing these clients to become estranged from friends and family members, Holliman notes.

This client has engineered a significant turnaround since her hospitalization, according to Holliman, including rekindling her relationship with her parents. “Things aren’t perfect [in this client’s life], but they are better,” he says.

Bambacus also emphasizes the need for creativity to help clients find ways to avoid isolation during the pandemic. This fall, she started offering online office hours and helped organize a series of faculty talks (also held online) for her first-generation students on nonacademic topics such as impostor syndrome.

At the same time, she is encouraging her upperclassmen mentors to organize events for students in the mentoring program, with a focus on staying connected. If the event is in person, students must hold it outside and limit it to a small number of attendees. Other students are planning virtual events, such as game nights and a live “cooking show” in which students demonstrate how to make their favorite recipes over video chat. Still others are doing low-risk volunteer work, such as writing letters to older adults or doing a trash pickup outdoors.

Bambacus has also been checking in with students more frequently. For those exhibiting withdrawal or avoidance behaviors, she sometimes includes a gentle reminder that she needs to hear back from them.

“I’m watching everyone a little more carefully,” she says. “Especially students who put on a brave face, they often appreciate check-ins. ... I am watching students who are more susceptible to slowing down during the semester and

Related reading

Search for the tag “coronavirus” at CT Online (ct.counseling.org) to find a wealth of articles on various topics related to helping clients during the ongoing COVID-19 pandemic.

struggling and those who have taken breaks [withdrawn from enrollment] previously because of their mental health. Often, the first sign they are struggling is unresponsiveness. I get creative with my emails and give them a deadline, such as ‘I need to know by Friday.’ Once they respond, then I say, ‘Hey, you’re there. Let’s talk!’”

This fall, she has been emphasizing self-care and wellness among her students, including the importance of physical activity, eating and sleeping well, getting outside and turning off the news. She is also pushing the message that it is OK to ask for help when you are struggling. Even something as simple as encouraging students to call their friends and family members instead of texting, so that they actually hear one another’s voices, can foster stronger connection, she says.

“There’s so much healing in knowing that you’re not alone in your feelings of isolation, so create opportunities for clients to see that other people are in the same boat,” Bambacus says. “Maybe that means running more groups and offering those types of services. It can be held outside or virtually. [It’s] just having that space where clients can see that this is not just happening to them and that other people are surviving ‘in spite of’ and offering them some hope and options. Isolation is such a devious thing because it makes you think that you are the only one — you’re not just alone; you’re *the only one* who’s alone — and that’s just not true.”

Families and isolation: A group effort

For families struggling with isolation, Nixon is focusing on ways they can be intentional about prioritizing connection, both within and outside the family unit. With all the stressors families are facing during the pandemic, it is easy to lapse into bad habits, he notes. “When you get resolved to ‘this is how life is going to be,’ you kind of go through the motions,” says Nixon, a board member of the Association for Child and Adolescent Counseling, a division of ACA.

Step one of being intentional often involves creating and maintaining a daily schedule in the household, Nixon advises. He suggests setting times for family members to focus on work or school and times to focus on connecting as a family, including designated times to put away all electronic devices.

Family time should include activities that prompt family members to interact and engage with one another to minimize isolation and boost mental health, Nixon says. This could include everything from getting outside and playing in the yard to coloring or drawing together, playing board games, having an indoor dance party or engaging in a scavenger hunt. (For more ideas, search for the article “Supporting families with engagement strategies during COVID-19” at ct.counseling.org.)

The lack of in-person celebrations during the pandemic, especially surrounding birthdays, has been hard for young clients and families. Nixon has helped clients find new ways to connect with family and friends to mark special occasions, including blowing their celebratory candles out during video chats and organizing walk-by or drive-by “parades” of well-wishers.

Similarly, many of Nixon’s adolescent clients are missing the in-person interactions they would normally have with friends and peers through school and extracurricular activities. Here, intentionality also helps fill the void. Nixon asks adolescent clients to identify what they enjoyed most before the

pandemic. The answers usually involve hanging out with friends, watching movies or playing video games together. One of the ways his clients have adapted is by setting a specific time to watch a movie simultaneously with friends (each in their own home) and then texting or video chatting with one another as they watch.

Nixon also encourages family clients to identify substitutes for things they enjoyed doing together before the pandemic. He uses a whiteboard in sessions to visualize clients' ideas and prompt dialogue.

"I get their perspective and talk about what their preference and focus was before the pandemic. Was it being together at mealtimes? Then be intentional about that now. Or if sports were really important, organized sports may not be an option, but they can play as a family or set time aside to sit down and review tapes from past games and analyze them," says Nixon, a past president of the Idaho Counseling Association. "Identify what was important to [clients] before, and help them realize that it's still important and how to find a new context for it."

Counselors can guide clients to find new rituals by identifying the core reason they enjoyed certain activities before the pandemic. Ask "why do families do what they do, and what meaning do they give to it? Then try and find something else that will give them the same meaning in a different context," Nixon advises.

For one family on Nixon's caseload, family meals were very important, and they found connection by going out to eat in restaurants together. This became more challenging when many restaurants closed their dining rooms throughout the spring and summer.

Nixon helped the family reframe this ritual and brainstorm ways they could re-create the aspects of eating out that they most enjoyed. After breaking it down, the family identified the core features they enjoyed as trying new restaurants and experiencing new cuisines together. The family had a self-imposed rule of never eating at the same restaurant twice in one month or

having the same type of cuisine twice in one week, so they were always looking for new places to try, Nixon says.

"For them, what was meaningful was ... the adventure of trying something new and ordering with the intention of sharing it with someone at the table," he says. "The intention was to be adventurous, to try something new and to share that together."

Once they came to this realization, Nixon suggested the family experience new foods together by learning to cook them at home. Their initial reply? "We don't cook," Nixon recalls.

Undeterred, Nixon suggested the family search the internet for ideas and how-to videos. The family started small, making an appetizer, and found it was easier than they had assumed it would be. From there, the activity blossomed into setting aside one night per week to replicate dishes together that they had previously enjoyed at restaurants.

"They didn't want to mess up and fail, and they didn't want to waste time and money [on specialty ingredients]. But they found that nothing was ever a failure, just as with going out to a restaurant that they didn't like. It was the trying that they enjoyed," Nixon says.

Now, even with restaurants reopening, this family continues with its at-home cooking adventures. They set aside the money they save by eating at home to splurge on an occasional restaurant meal that they previously would have considered a treat.

"The opportunity that this family has taken to take a step outside of their comfort zone has brought them closer together," Nixon says. "They have found that family members have skills that they did not completely see before, and they have found that small changes have always impacted the family. In the past, the small changes were seen negatively, [but] now they see the opportunity and positivity that can come within the family."

Looking ahead

Nixon says he has been contemplating the long-term effects the COVID-19 pandemic might have on mental health, especially with the

increased physical and social isolation that will return for many people during the winter months. As cases of COVID-19 continue to rise in the U.S., combined with the arrival of the traditional flu season, it is possible that states or localities may reimpose some of the stringent lockdown measures, such as school and business closures, that happened back in the spring.

It is possible that counselors might witness an uptick not only of isolating behaviors but also feelings of hopelessness and suicidal ideation among clients, Nixon says. With that in mind, he is increasing his screenings of clients for safety, harm and abuse, plus making sure that he shares resources such as crisis hotline numbers.

"I have been thinking about that a lot lately: how to help families and clients with the potential for an extended stay at home and the long-term aspect with winter coming on," Nixon says. "How can families be intentional [to avoid isolation]? What's important to [a client's] family, and how do you continue to keep that ember burning?"



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Counseling in the trenches

Counselors must first understand the military culture to overcome barriers that keep many service members and veterans from receiving the care and support they need

By Lindsey Phillips

Adrian Marquez, a retired Marine master sergeant and Marine Raider, woke up one morning during his time in the Marine Corps and couldn't remember how to get dressed. He looked down at his pile of clothes and mumbled, "Pants first, then shoes?"

Marquez was also experiencing physical aches throughout his body, including radiating pain in his arms and legs. His left arm would sometimes lose strength and go numb. So, he went to his unit's medical clinic — a team of primary care medical doctors, psychologists, psychiatrists, social workers and physical therapists — and the medical staff told Marquez he was physically healthy compared with peers in his age range across the United

States. They determined it was all in his head. The mental health clinicians made assumptions based on Marquez's extensive combat history and quickly diagnosed him with posttraumatic stress disorder (PTSD), an anxiety disorder and a depressive disorder with severe somatic symptoms.

But the symptoms didn't go away. Marquez later returned to the clinic because of intense pain in the back of his left eye. This time, the clinic performed an MRI and discovered that he had ocular damage, in addition to possible injuries to his brain. Another MRI was scheduled, and it confirmed that Marquez had a traumatic brain injury (TBI) that caused lesions across his brain, including one in his orbital track. The scan also picked up another issue:



There will be a time when you take your uniform off, and you're going to have to live with the person underneath it. If you want to have a normal life, you have to take care of yourself.



Marquez had four compressed disks, two of which had ruptured, so even a moderate impact would lead to paralysis.

Despite his injuries, the Marine Corps insisted that Marquez get ready to deploy again in a few weeks' time. Learning this, his master gunnery sergeant pulled him aside and told him, "There will be a time when you take your uniform off, and you're going to have to live with the person underneath it. If you want to have a normal life, you have to take care of yourself."

The master gunnery sergeant sent Marquez's paperwork to the Wounded Warrior Regiment, which allowed medical staff to fully evaluate him for a month. According to Marquez, the master gunnery sergeant lost his position over that decision, but Marquez took what his "master gunns" said to heart. During the evaluation, Marquez concluded that he needed to take care of his physical and mental health before deploying again. When he told his new master gunnery sergeant that he wanted to have surgery before deploying, the Marine Corps forced him into medical retirement.

The decision shook Marquez to his core. He had given the Marines 17 years of his life, and now he was left to deal with abandonment issues, depression and anxiety — on top of his physical injuries and TBI. When he started mental health therapy, he quickly realized that the clinicians treating him were knowledgeable about mental health issues, but they didn't seem to have much of an understanding about military culture.

Improving military cultural competency

Marquez is now a licensed mental health counselor himself. He created and serves as the director

of programming for the Sheepdog Program, a mental health and substance abuse program for veterans and first responders in Melbourne, Florida.

The fact that he encountered so many mental health clinicians who were not culturally competent about the military is not shocking given that many practitioners lack specific training in that area and don't necessarily consider clients who serve in the military as being part of a distinct culture.

But as Marquez points out, the military does indoctrinate people into a unique culture — one that is fast-paced and possesses its own rules, policies and language. Being in the military changes the way that people think and feel, Marquez emphasizes. He compares this new mentality to being a sheepdog because, he says, service members are trained to stand outside and protect the herd by leaving the herd and staring into the eyes of the wolf. They can't and don't hide from the ugliness of the world. Instead, they are often exposed to a raw violence. And once exposed, they can't unsee it, Marquez says. It is imprinted in their minds and shapes the way they view the world.

Keith Myers, dean of clinical affairs and an associate professor of counseling at Richmond Graduate University, conducted interviews with veterans for his recently published book, *Counseling Veterans: A Practical Guide*, which he co-authored with W. David Lane, a licensed professional counselor (LPC) and professor of counseling at Mercer University. In doing the interviews, Myers says that one topic kept coming up repeatedly: the need for counselors to be culturally competent with this population.

Just like with any other cultural group, counselors have to learn the specific language and customs associated with the military culture, says Taqueena Quintana, an American

Counseling Association member and owner of Transformation Counseling Services, a private practice that works with military-connected populations. The language is also specific between military branches, she points out. For example, calling someone in the Air Force a "soldier" communicates a lack of understanding and can cause offense because they are properly referred to as "airmen," she explains.

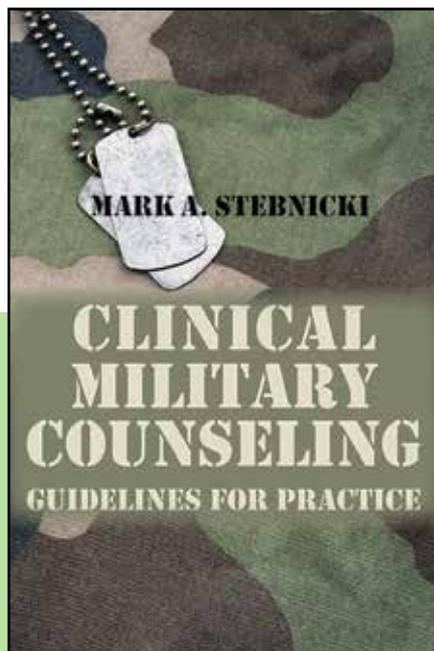
Counselors also need to consider these clients' personal cultural factors — ethnicity, sexual orientation, spirituality, era of service and so on — that further shape their experience both during and after military service.

"Veterans are not cut out from the same material," notes Tanya Workman, an LPC who is the training director for the licensed professional mental health counselor training program at the South Texas Veterans Health Care System's Frank Tejada Outpatient Clinic in San Antonio. "Their overall life experiences, as well as their experiences in the military, will potentially shape their perspective and response to treatment. So, take time to understand the impact that the veterans' time in service has contributed to their current mental health and function."

Workman advises counselors to learn about military culture, the various branches of service, the history of the different eras and the veterans' perceptions of the role they played while in service. Showing interest in the veterans' experiences builds rapport and helps avoid unintentionally creating barriers by assuming to know what that experience was like for them, she continues. For example, if a veteran is struggling with a moral injury, they may find it difficult to respond to a therapist's expectation that they are proud of their time in service, she says. So, Workman recommends counselors

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ask clients, “Why did you join the military? What did your time in service mean to you? What feelings come up regarding your time in the military?”

When she has clients who have retired or finished their time in service, she always asks about their transition from military to civilian life and whether they were ready to retire or separate from the military. Some are ready to be done, she says, but others may feel their time was cut short because of administrative, disciplinary or medical reasons (e.g., not making a designated rank within a specified time period, incurring a medical or mental health condition that prohibits the service member from doing their job). Processing their feelings (such as loss or grief) related to the sudden end of their service can be validating and helps set the tone for future healthy disclosure, she adds.

Myers, an LPC with a private practice serving veterans in Marietta, Georgia, recommends that counselors start by talking to relatives or friends who are veterans and asking them, “What was your experience like? What’s your advice for me as a counselor who wants to work with this population?”

Making counseling relatable

When counselors learn more about clients’ occupations and experiences in the military, they are better able to connect counseling activities and concepts to things that are relatable to the clients, advises Workman, an Army veteran and ACA member who specializes in treating veterans dealing with trauma (including military sexual trauma), substance use disorders and difficulties transitioning from military to civilian settings. For example, she equates the importance of breathing techniques with running and calling cadence or being at a rifle range. All of these activities involve a rhythmic or patterned breathing that some military clients already understand well.

Marquez, owner of the private practice Calm in the Storms, modifies the way he explains mindfulness to his clients. He starts by referring to it as *mindfulness training* rather than

mindfulness meditation. Then he compares mindfulness training to exercise or pistol practice: Clients must repeat the action over and over again for it to work effectively. With meditation, clients are doing a repetitive action — such as focusing on breathing or a certain noise or sensation — to control intrusive thoughts and ground themselves in the present moment, he explains.

Workman, a member of the Military and Government Counseling Association (MGCA), a division of ACA, also uses analogies to explain difficult topics such as hyperarousal, anxiety and avoidance. She often describes hyperarousal as birthday candles setting off smoke detectors and sprinklers to explain how the body's response to the environment is sometimes more than what is needed. The body — like the alarms — is just responding to a perceived danger. This analogy helps clients understand that hyperarousal is a normal bodily response designed to keep them safe. Then, Workman teaches clients how to be aware of this heightened response and how to calm the body so that the response matches the level of danger.

Marquez also refers to solution-focused therapy as *mission-oriented therapy* when working with clients affiliated with the military. He describes the approach as a way of addressing the 5-, 10- and 25-meter targets in clients' lives. He explains that unless the client confronts and takes action on the 5-meter target, it could prevent them from working on their longer-term goals (their 10- and 25-meter targets).

Myers, an ACA member whose clinical specialties include veterans issues, trauma and combat-related PTSD, sometimes makes subtle adjustments to counseling approaches when working with military-connected clients. For example, in couples counseling, Myers often uses John and Julie Gottman's concept of "accepting influence" from your partner, which involves taking your partner's opinion into account and being open to using their input to make decisions together.

With military-affiliated couples, Myers brings in a third partner — the military — because the couple must compromise not only with each other but also with the military. When the military deploys the service member or reassigns the service member to a new post, the couple must readjust their plans and deal with these added stressors together.

It's not all combat-related PTSD

Marquez says he worked with a few therapists who almost did him more harm than good because they assumed that his combat experience was the catalyst for his PTSD. They thought that engaging in military operations and pulling the trigger on his weapon so many times had to be the source of his trauma. They didn't seem to understand or accept that Marquez was comfortable with the actions he took during his military service.

But one therapist was different. He didn't presuppose that Marquez's PTSD was attached to his military service. He set aside his own assumptions and told Marquez, "I can't pretend to understand what you've been through, and I'm not going to. I'm going to ask you questions, hear you talk and connect the dots based on what you say."

In going through that process with the therapist, Marquez finally discovered that the actual source of his PTSD was his experience of escorting his friend's body home to Texas. As the escort, he had to view the body and make sure that the uniform was ready for presentation. Seeing his friend's face — which was almost unrecognizable covered in makeup and saran wrap to preserve the body for the funeral — and confronting the reality of death triggered his PTSD.

Therapists are great at understanding different types of trauma, but some have muddied the water by diagnosing seemingly everything related to the military as PTSD, Marquez adds.

Quintana, an LPC in Washington, D.C., and an assistant professor of counseling at Arkansas State University, agrees that PTSD and TBI are the two mental health issues that people most closely associate with the military.

Although a large number of veterans and service members do indeed contend with these issues, they also deal regularly with depression, anxiety, adjustment disorder, co-occurring disorders, substance use disorders, family discord and marital issues, to name a few, Quintana says. Sometimes people connect the military almost exclusively with war and combat, she says, forgetting or not realizing that chaplains, medical professionals and lawyers also serve in the military.

Combat-related PTSD often makes the news, which is good because it raises awareness about mental health and military-connected clients, but it also leads to the common misconception that the majority of veterans have PTSD, says Myers, an MGCA member who previously served on the association's board of directors. Although PTSD is a common clinical issue, the majority of veterans do not have PTSD. According to the Department of Veterans Affairs, 11% to 30% of veterans have had PTSD over their lifetime.

On the flip side, sometimes clinicians and veterans may assume that certain military service members could not be experiencing PTSD because they have not seen combat in a traditional sense, Workman adds. But trauma is not exclusive to combat occupations, so clinicians should assess all veterans for trauma exposure during service, as well as for trauma that may have occurred elsewhere across the life span, she continues.

For example, she has worked with veterans who served in military intelligence. Their work required them to monitor a computer, and consequently, they were often exposed to the aversive details of violence and war. Even though it would be easy to dismiss their experience as simply sitting in a safe room without the fear of others shooting at them, they still were exposed to combat, just in a different way, Workman says.

Treating co-occurring disorders

Mental health work doesn't always come neatly packaged with only one presenting problem at a time. Issues

often overlap, and Quintana, a deployed resiliency counselor for the Navy, finds that co-occurring disorders are common among military-connected clients.

According to the National Center for PTSD, substance use disorder and PTSD often co-occur with veterans. In the past, mental health and substance use treatment facilities often required clients to be abstinent from substance use before treating them for mental health issues. But this is happening less frequently, and more agencies are taking an integrative approach to care through dual-diagnosis groups, relapse prevention education and comprehensive treatment plans for co-occurring disorders, says Quintana, a member of MGCA and a former school counselor with the Department of Defense Education Activity.

Still, health care professionals too often focus solely on the high intake of substances rather than looking at the big picture or other co-occurring issues, Marquez notes. He says he has known clinics that quickly diagnosed military-connected clients with a substance use disorder and made that the primary treatment plan, or they refused to address trauma at all because they didn't have the time or resources to handle both the substance use disorder and trauma simultaneously. This experience often causes these clients to either leave counseling or to refrain from talking honestly about their substance use out of fear that they will automatically be labeled with a substance use disorder, he says.

When clients come to Marquez with co-occurring issues such as trauma and substance use, he is honest with them. He informs them that their drinking might technically qualify as a substance use disorder, but he also acknowledges that he knows that behavior is considered acceptable in military culture. He doesn't ask them to stop, but he does request that they show him that substance use is not a factor in their presenting issue. Often, they stop using substances without any problems. If they don't, then substance use disorder becomes another part of their treatment plan.



When working with veterans who may have a significant history of alcohol or substance use, Workman advises counselors to be vigilant in looking not just at how much these clients are drinking or using substances but also at their history of trauma, anxiety and other mental health issues. If a person's anxiety is high and not adequately managed, then it isn't shocking to find that they are drinking excessively or having difficulty with irritability, anger, or interpersonal interactions at home or work, she says.

Counselors should also do a thorough evaluation if a military-connected client is referred to them for a behavioral problem because, so often, the problem is not the *problem*, Workman says. "Counselors should ask the veteran, 'When did this behavior start? What makes it worse? What were you thinking and feeling? What else was going on when you were engaging in this behavior? When was it not like this?'"

It is easy to focus only on the negative behavior, but then the underlying mental health issues that contributed to that behavior often go overlooked and untreated, Workman adds.

Likewise, counselors shouldn't focus only on the events that happened during clients' time in the military. Sometimes, past traumas or mental

health issues can go untreated, and military experiences only compound the issue. For example, someone who was previously reprimanded for violence might now be applauded and promoted for similarly violent actions performed during their military service. This person is receiving conflicting moral messages, which may compound the emotional wounds they had before entering service, Marquez says.

Co-occurring disorders can also become an issue when symptoms overlap, Myers points out. TBI and major depression can both involve difficulties with attention, depressed mood and trouble sleeping. And irritability and agitation are both symptoms of TBI and PTSD. This overlap can make it challenging to treat, Myers says. Counselors may get stuck trying to figure out the diagnosis — is it TBI, depression or both? "It's less about deciding what the diagnosis is and more about treating this person holistically," Myers says.

Marquez says that if counselors focus on a client's trauma first and wait to address their grief until later, then when they do get around to focusing on the grief, all of the client's trauma could resurface. That's why Marquez addresses it all at once. In the Sheepdog Program, which offers a partial hospitalization



program and an intensive outpatient program, clients have two to five individual therapy sessions per week, along with other special therapy sessions such as narrative therapy, eye movement desensitization and reprocessing (EMDR), and family therapy that address the specific issues with which they are dealing.

Short-term therapies

Traditional, hourlong counseling sessions aren't always a possibility for military-connected clients, especially those who are active-duty service members, because they are always in motion, Quintana says. Depending on their duties, some service members may have only a short span of time to meet with a mental health professional, such as during lunch breaks, she points out.

For this reason, Quintana continues, solution-focused therapy, which is a future-focused and goal-oriented approach, can be effective for certain issues within military settings (although not for more serious issues such as trauma and suicidality). If a service member presents with a relationship issue, for example, Quintana empowers the client to identify their own solutions. She may say, "Tell me a time when this issue did not exist. What was different then?" This encourages the

client to get away from all-or-nothing thinking and highlight strategies that were helpful previously.

Quintana also believes it is important to build on clients' strengths. For example, if the client says they are good at communication, she would explore with the client how they could use this skill to improve their relationship. After the client sets goals (with Quintana's support), Quintana would continue to follow up with the client to monitor success.

Workman fears some veterans may be burned out by solution-focused therapy because it is used so often with service members while in the military setting. In her work with veterans, she uses prolonged exposure for primary care (PE-PC), a type of abbreviated therapy specially designed for the treatment of trauma. It consists of a minimum of six 30-minute sessions provided at the client's primary care clinic, which tends to be a more convenient and familiar setting for them. This therapy also helps veterans who are not able to dedicate a large portion of their day to counseling and may remove potential barriers to treatment posed by the stigma associated with referral to a mental health clinic, Workman notes.

In these sessions, clinicians teach veterans about common mental health

issues such as PTSD. They learn to recognize distressing symptoms and evaluate the intensity of these symptoms by using the Subjective Units of Distress Scale, a self-assessment tool that measures the subjective intensity of disturbances or distress experienced by an individual. Clients track their distress level using this scale before, during and after writing their trauma narrative. By doing this, Workman finds that clients begin to notice improvements in the way they respond to distressing thoughts and memories and that their distress decreases the more they read their narrative out loud. They also have more control and do not experience the same overwhelming symptoms of trauma-related anxiety, she adds.

Clinicians also teach veterans to safely cope with mood distress by using safe grounding and relaxation techniques, Workman continues. The clients work through a prolonged exposure workbook, recording and processing their personal trauma event in a safe and systematic manner with the therapist's support. The therapist ends each session with a relaxation exercise.

Following this sequence of steps empowers clients to repeat this behavior on their own, she points out. She has found the treatment to be effective, with clients reporting a decrease in severity levels and, more importantly, an improvement in their quality of life.

Marquez finds that virtual reality exposure therapy helps military-connected clients reexperience and remember events connected to emotionally charged memories. Marquez once worked with a client who had dissociative amnesia surrounding an event in which his comrade died in a car. The client felt guilty for not pulling his fellow service member out of the car in time. Marquez positioned the client in front of a black virtual reality screen and asked him to recall the events of that day. At one point, the client described hearing a roar, so Marquez played a few different sounds. When he played a fire sound, the client said, "Yeah, that's the sound."

Marquez then turned on the virtual reality screen, and the client saw a vehicle that was on fire. Seeing this image made the client recall that the car had been on fire, so he couldn't have gone back to save his comrade.

The interactive experience restored the client's lost memories and freed him from the guilt he had felt for years.

Marquez says this therapy helps clients reduce the triggers associated with traditional PTSD responses. It also helps them revisit memories that are often repressed by their military training to react in a rational, nonemotional way. But when they relive the event, they may experience unrecognized emotions associated with it, Marquez points out. So, he uses EMDR to help clients manage the emotional memories that often resurface after virtual reality exposure. "They're allowing themselves to finally feel the emotions that they never let themselves feel because they were just operating in the rational mind, just following their training," he explains.

Creating a pipeline for success

Some military families have confided to Quintana that they don't seek out counseling because they fear they will simply be passed off to someone else or handed a referral list. "Counselors must take time to invest in their clients and ensure they are part of the process," she stresses.

Quintana takes a collaborative approach with military-connected clients. She believes that partnership is key to facilitating change. In addition to meeting clients where they are, Quintana works with them to highlight their past successes, set goals, and identify tools and resources that can help to address their issues.

Quintana provides an example: A military family is experiencing their

second deployment, and the spouse comes to counseling concerned about their child's social, emotional and behavioral responses to the transition. To better understand this family

and their particular needs and strengths, Quintana might explore the family's past experiences and successes. She might ask the spouse, "What helped your child when they previously

navigated challenges related to deployment?" or "Tell me about a time during deployment when this issue was less noticeable. How did you make that happen?" These types of questions help build on what has already worked, highlight the family's strengths and empower the family to identify solutions.

Through this conversation, Quintana learns that during the previous deployment, the school counselor placed the child in a group with other military-connected children dealing with deployment challenges, and the child found bibliotherapy to be helpful in processing their feelings. Rather than handing the parent a list of resources, Quintana would suggest that the family collaborate with their child's new school counselor on bibliotherapy strategies that could be used both at school and at home. She would also work with the spouse to access these services within the school and, if needed, the community. "These relationships are meaningful and foster trust, which is critical when supporting military families," Quintana says.

Myers often seeks to empower his military-connected clients through the use of motivational interviewing. This approach encourages clients to discuss their own reasons and motivations for change. Being able to set their own goals, talk about ways to achieve change and explore their motivations honors their autonomy, Myers says.

Marquez learned the importance of mental wellness the hard way through misdiagnosis and clinicians who were insufficiently trained in the military culture. To correct this issue, he has developed programs and trainings to educate clinicians on working with this population, but he says he would love to see more mental health professionals get involved in creating a pipeline for veterans who want to become counselors and in facilitating peer support specialist groups led by veterans.

Marquez finally found a clinician who took the time to listen and help him figure out the root of his PTSD. Mental health professionals can learn from his experience by becoming more culturally competent and reframing their tools so that military-connected clients do not find themselves alone in the trenches.



Action steps for more information:

- ❖ Read Duane France's series of "From Combat to Counseling" columns at CT Online (ct.counseling.org).
- ❖ Purchase *Clinical Military Counseling: Guidelines for Practice* by Mark A. Stebnicki, newly published by ACA (imis.counseling.org/store).
- ❖ Visit the website of the Military and Government Counseling Association (mgcaonline.org).
- ❖ Join the ACA Veterans Interest Network (counseling.org/aca-community/aca-connect/interest-networks).

Lindsey Phillips is a contributing writer to *Counseling Today* and a UX content strategist. Contact her at hello@lindseyphillips.com or through her website at lindseyphillips.com.

Read the companion article "Advice for counselors who want to work with military clients," available exclusively at CT Online (ct.counseling.org).

Q&A

Meet the candidates to become ACA's next president-elect

The three candidates vying to become the American Counseling Association's next president-elect were asked to provide their responses to questions on issues relevant to the association and the counseling profession as a whole. Their answers appear here. (Note: Responses are being published as submitted by the candidates. They have not been edited.)

Additional information about each candidate, including biographical information, qualifications and reasons for seeking office, will be published in the December issue of *Counseling Today*. Online voting for ACA, division and region elections will begin Dec. 1.



CANDIDATE QUESTIONS

How will you advocate for the strengthening of ACA's position and influence to be the voice for the profession and set the direction for the future of the profession?

Judy Daniels: Affirming ACA as the home and voice for professional counselors begins with a president with a clear vision, who truly understands your needs, and the work you do in diverse practice settings. I have taught and worked in the areas of school, mental health, rehabilitation, and career counseling for 30 years. From these experiences, I understand the importance and value of counseling specialty areas and the power of our collective voices.

Since 1952, ACA has worked to unify the voices of professional counselors across practice settings. As president, I

would strengthen ACA by working to unify branches, regions, divisions, and specialty areas and work collaboratively with our sister organizations. I believe in transparency, clear and direct communication, and a passionate vision for the future of the association. With the double pandemic of racism and COVID-19, we are in a pivotal time to shape ACA's future. As a lifetime member, a past division president, an ACA Fellow, and a member of Governing Council for nine years, I have the leadership skills, organizational knowledge, cultural sensitivity, tenacious advocacy skills, and a clear vision to lead ACA, while strengthening its voice and growing its influence.

My plan is guided by a desire to meet your professional needs and strengthen ACA as an organization. As president, I would:

1. Continue the work on counselor compensation, Medicare reimbursement, and advocate for counselors to be recognized and substantially compensated for their essential work.

2. Provide training to empower counselors to develop business competencies and learn financial planning and investment skills.

3. Survey member needs and offer regular and more in depth free trainings with continuing education credits that address current practice needs.

4. Provide in-depth educational trainings by professionals who practice and do research in cutting-edge areas such as neuroscience, racism, COVID-19, relational-cultural theory, trauma, the climate crisis and disaster mental health. Trainings would also address tele-behavioral health and counselor wellness and self-care.

5. Provide on-demand free access to trainings with free CEU's including past convention sessions.

6. Develop weekly news-blast emails providing current information on relevant issues, legislation and public policy, voter voice actions, practice support, and advocacy opportunities.

7. Continue to advocate for portability for professional counselors licensed at the independent practice level to transfer their license.

8. Develop advocacy statements and resources to address timely social justice/human rights issues that impact clients and communities.

By addressing your needs and working together, we can strengthen ACA's position and influence as the voice for the profession and set the direction for its future.

Kimberly Frazier: In order for ACA to strengthen their position and influence for the profession and set the direction for the future of the profession ACA must create more opportunities for outreach for populations that will be key to shaping the future and voice of the profession. The populations I would focus on would be graduate students, new professionals, and clinicians. I would focus on strengthening the connection of these populations within ACA and create opportunities for these populations to engage with ACA in multiple ways. Some examples might be zoom sessions to ask questions of ACA leadership, as well as panels with topics that are important to each of these populations and seeking their input on topics they would like to see covered in the panels. Some of the things I envisioned are asking what issues they would like to see ACA more involved? What role do they see ACA taking to shape the profession? What ways do they suggest ACA get more involved in the areas they are most passionate? Through these outreach events with graduate students, new professionals, and clinicians, ACA leadership can learn the issues, concerns, and questions regarding the profession these groups are most passionate about and help us shape the future direction of the profession.

Elizabeth O'Brien: ACA serves as the premier organization that serves counselors and holds the vision that "every person has access to quality professional counseling to thrive". This position is important as it serves as the

touchstone for professional counselors and charges us to continuously grow our sphere of influence. ACA's position and influence is strengthened when we offer timely, relevant, and challenging information and resources to our members and stakeholders.

Timeliness in delivering position statements and resources is an issue with which we have struggled. Our organization has a tremendous volume of expertise to pull from, but we must be timelier in responding world events. I will advocate to streamline strategic responses to world events by leveraging the expertise of our members and our ACA staff so that we are at the forefront of response.

Relevance for our members is imperative to retain their trust and commitment to our organization. We are counselors first, and within this profession hold specialties and interests that can be served better within the organization. I will advocate to increase resources for specialty groups so that our distinct voices can continue to learn and grow.

Challenging ourselves to reflect, grow and change is inherent to being ethical counselors. Social justice and advocacy are more than ideas, they are the way we serve our communities and make our world a better and safer place for all of us. This year has given me the opportunity to engage in an internal inventory, identify personal shortcomings, and to move towards change. I will advocate that we create systemic pathways within ACA that allow us to hold ourselves and each other accountable to be better.

Under your leadership as ACA president, what strategies would you promote to recruit and retain diverse counselors (e.g., counselors of color, marginalized populations, etc.) within the counseling profession?

Judy Daniels: Now more than ever, strong and sustained leadership is needed to address the complexities

that we face globally, nationally, and as a counseling association. For 30 years I have a track record of promoting social justice action and advocacy, addressing racism, and supporting diversity, equity and inclusion initiatives. If elected the 71st ACA president, I would continue my commitment to address systemic and institutional racism, marginalization and recruit and retain diverse counselors within the counseling profession. I have been involved in addressing these issues through my work on two ACA taskforces and a division committee:

A. Chair of the presidential task force that wrote the ACA statement on Anti-Racism (ACA Anti-Racism Statement June 22, 2020);

B. Member of the ACA Anti-Racism task force which developed an action plan to proactively deal with racism, recruit and retain diverse leaders, and diversify the profession

C. Former co-chair and member of the Association for Humanistic Counseling Committee on Equity, Diversity and Inclusion

My commitment is to:

1. Work with ACA leadership to address issues of equity and inclusion within ACA.

2. Commission a task force to draw on best practices to develop counselor-specific antiracist curriculum, and identify expert contributors representing diverse counselors.

3. Ensure learning spaces to promote antiracism and empower systemic changes.

4. Develop a set of Antiracist Competencies.

5. Create a mentoring and emerging leaders program that recruits and retains diverse leaders.

As ACA president I pledge to continue my effort to promote diversity and inclusion within ACA.

Kimberly Frazier: In order to attract and retain any group, you must have make that group feel they are wanted and valued in the organization. I would create a taskforce composed of the ACA divisions and branches to create a strategic plan for recruiting

and retaining diverse counselors with outlined goals and specific timeframes for each goal. I would also create separate groups composed of graduate students, new professionals, and clinicians that are counselors of color and other marginalized populations to ask specific questions about what areas they feel ACA has neglected and what areas ACA needs to do more of to attract, recruit, and retain them. Once gathering the information from each of the separate groups, I would work with ACA Governing Council to incorporate the suggestions collected from each group.

Elizabeth O'Brien: Promoting diversity within our profession is imperative. It is an explicit value of those of us in the field and is expressed through our alignment to ethical codes, attainment of credentials, and advocacy efforts for the individuals and families we serve. As a counseling center director, I worked to recruit and retain diverse counselors, and I believe that many of the strategies that I used can serve ACA.

First, it is important that ACA have a comprehensive mechanism for measuring member demographics to determine our existing individual diversities. Assessing current representation of diverse counselors is an important first step to determine where we are as an organization and how we need to move forward.

Next, we must be realistic about our commitment to this endeavor. Real, lasting change takes time and happens over years—not in a single presidency. It took me four years as a director to attain a level of diversity that began to meet the needs of the individuals the center served, and even then, there was more work to be done. Commitment means aligning with our strategic plan, promoting buy-in from members, and working across presidencies and governing councils to create change.

A comprehensive plan includes:

1. Addressing barriers, such as leadership opportunities, that preclude individuals from excelling in the profession and our organization;

2. Creating highly relational opportunities that are synergistic with our divisions and branches so opportunities flow not just from ACA at large, but also comingle with our existing leadership pipelines; and
3. Engaging in deliberate succession planning that promotes emerging leaders in the field and trusting them to lead when the time comes.

How can we strengthen ACA, branches and divisions?

Judy Daniels: My vision for strengthening divisions/branches/regions would be to bring together division presidents and branch/region leaders to work on a joint project identified by this group and facilitated by the president. Possible projects could include:

1. A give back to the community initiative in the conference community in 2022 that targets a specific need of that city;
2. A train-the-trainer mentoring and leadership development initiative to support divisions/branches/regions;
3. Provide training on strategic planning with intentional awareness of best practices on diversity and inclusion
4. Counselor self-care training to be replicated on a large scale for divisions/regions/regions.

As president I would solicit regular feedback from branches/divisions aimed at strengthening ACA's relationship and commitment.

Kimberly Frazier: We can strengthen ACA, branches, and divisions by being more intentional about how each entity is interconnected and providing members with information about how each works and builds within each other. ACA can feature different branches and divisions in *Counseling Today* and the website by having spotlight stories on various advocacy initiatives branches and divisions are working on to aid in fostering a continued connection with ACA. ACA can create an advocacy

initiative the organization will work on for the year and have branches and divisions work together with ACA on the featured initiative to foster strength and connectivity between each.

Elizabeth O'Brien: There is a synergy inherent to the relationship between ACA, branches, and divisions; and yet, there are also fault lines that exist amongst these same entities. It reminds me of my work as a family counselor; a tension between wholeness and individuality. While both are needed for systemic evolution, balancing the needs of the whole (ACA) with needs of the individual (divisions/branches) can be challenging. The greatest way that we can strengthen a relationship is to increase communication and trust amongst and between members.

One way to strengthen ACA, branches and divisions is to engage in transparency regarding what each entity can and cannot do for the other. It is important that ACA is able to articulate and communicate services and resources it can offer to branches and divisions, either for no cost or some cost to these entities.

Similarly, branches and divisions have strengths in their ability to connect on a highly relational and grassroots level with their membership. They have highly specialized strategies for leadership development, service delivery for geographical locales, and specialized best practices that align with the groups they serve. It is important that branches and divisions are able to showcase their specialties and that ACA is able to access these strengths to further the overall mission of the organization.

This requires an acknowledgement that all parties are needed, that we can ask for help from each other and receive it, and that working collaboratively strengthens our ability to build an organization that serves our members, stakeholders and the counseling profession. ♦



Knowledge Share

Integrating substance abuse and pain management into counseling approaches

Counselors can create a safe place for clients to speak openly as they try to navigate the complicated landscape of their struggles with substance use and pain management issues

By Geri Miller

In the United States, 2000-2010 was labeled the “decade of pain.” In 2011, the Institute of Medicine’s Committee on Advancing Pain Research, Care and Education stated that the prevalence of chronic pain in our country exceeded the prevalence of diabetes, heart disease and cancer combined.

Unfortunately, this prevalence of pain has continued, and because of that, counselors need to be aware that substance abuse and pain management may be an issue for their clients — even if it is not a “problem” as presented by clients themselves. Clients may be particularly vulnerable to substance

abuse specific to opioids because they (or others in their lives) may view these drugs as the best treatment for pain (i.e., a “quick fix”).

There is a great deal to know about substance abuse and pain management. Because of this, counselors can easily become overwhelmed and hesitate to work with these issues. I am writing this article to help counselors see that they can readily integrate some basic substance abuse and pain management approaches into their current counseling practices and still be practicing within their area of competence.

Because of the prevalence of substance abuse and pain management in the

“ Counselors can be honest about not knowing much about the client’s experience of pain, be open to being educated about the client’s perspective and be willing to discuss the pain experience with the client. ”

United States, it would serve counselors well to always “wear the lenses” of both of these areas as they assess and treat their clients. However, it is probably most important for counselors who are working with clients specifically on either *one* of these two areas (substance abuse or pain management) to also intentionally explore the area *not presented as a problem* so that the potential relationship between the two is examined. For example, when counseling someone who struggles with chronic pain, a counselor would be well advised to also ask about their substance use. The same exploration needs to happen when a client struggles with substance abuse; a counselor should ask about any issues with pain and its management.

While this exploration is important, it is also imperative for counselors to be able to readily fuse these “lenses” into their existing clinical approaches. Five suggestions on the general process of incorporating these two perspectives follow.

First, counselors need to accept the reality that there is a lot to know about substance abuse and pain management and make sure that they work within their area of competence. One method for exploring and addressing these areas with their clients (while still practicing in their area of competence) is to use the “HOW” approach. This acronym encourages counselors to be *honest, open* and *willing* to discuss substance abuse and pain management issues with their clients. For example, a counselor can be honest about not knowing much about the client’s experience of pain, be open

to being educated about the client’s perspective and be willing to discuss the pain experience with the client.

Second, counselors can anchor their approach in the discussion with respect for and genuineness toward the client. This client-centered approach inherently invites the client’s story of their pain (including the ways they try to handle the pain, such as opiates).

Third, counselors can assess and treat the pain using their typical counseling approaches and continue reassessment throughout the treatment process. Counselors should operate as gatherers of information about the pain and, as appropriate, consult with others (e.g., mentors, supervisors, colleagues, medical professionals) concerning appropriate ways to address the pain.

Fourth, counselors need to be aware of countertransference related to their own and their loved ones’ experiences with pain management and substance abuse. An awareness of their countertransference can enhance counselors’ effectiveness in addressing these overlapping areas.

Finally, counselors need to work within the realistic resource limitations that both they and their clients experience. For example, both counselors and their clients have limitations on the amount of time, energy and money they can invest in learning about and addressing the issues of substance abuse and pain management. Maintaining such a realistic perspective can cultivate more humane and practical counseling interventions that will result in less frustration for both the counselor and client.

An overview of chronic pain

In 2011, as stated previously, the Institute of Medicine’s Committee on Advancing Pain Research, Care and Education reported that chronic pain exceeded the combination of diabetes, heart disease and cancer in terms of prevalence in the United States. These historical statistics, in which the current issues of substance abuse and pain management are anchored, underscore the likelihood that many of our counseling clients are experiencing chronic pain but have not mentioned it or its impact on their lives in session. This prevalence should serve as an invitation for counselors to discuss pain and pain management with their clients.

In 2019, Beth Darnall, a pain scientist and director of the Stanford Pain Relief Innovations Lab, summarized the following information on chronic pain in her book *Psychological Treatment for Patients With Chronic Pain*. By definition, *chronic pain* is pain that lasts longer than three months or that extends beyond the expected time it should take to heal. *Breakthrough pain* is an acute version of chronic pain and centers on days or times when the pain is worse.

Although Darnall called chronic pain a “harm alarm” that tells the person to escape the pain to survive, she said the “riddle of chronic pain” is that it is impossible to escape. This knowledge needs to be fused into the perspective of how the pain experience is affecting our counseling clients in a biopsychosocial manner. This biopsychosocial exploration of the relationship between the overlapping areas of substance abuse

and pain management can be facilitated by the core suggestions presented in the following section.

Core suggestions

I offer seven core suggestions that counselors can use as a guide in addressing substance abuse and pain management from a biopsychosocial perspective.

1) Work out of a systems perspective. From this perspective, the counselor looks at the systemic interactions that result separately for addiction and pain, as well as their overlap systemically. This means that the counselor is aware of the internal and external contributing factors for both addiction and pain and that the client may have developed an addiction in response to their pain or vice versa. The addiction may have resulted from prescribed medication following surgery, or the pain may have resulted from an accident that occurred while the client was under the influence of alcohol or drugs.

2) Watch for prescribed and nonprescribed substance use. This suggestion means that the counselor obtains information from the client about any prescribed medication of substances (such as medication-assisted treatment) in response to their pain or substance dependence as well as

the client's nonprescribed usage of opiates and marijuana for pain. Such an inclusive gathering of information provides the counselor with a broader view of the client's treatment responses to managing the pain.

3) Practice "compassionate accountability." This phrase means that the counselor has compassion for the client *and* simultaneously holds the client accountable for their behavior. For example, I can have compassion that my client has an addiction resulting from their use of opiates in response to chronic pain that prevents the client from performing activities of daily living. However, I also need to hold the client accountable for their behavior, such as stealing prescription opiates from a friend's medicine cabinet.

4) Use firm, direct, honest communication. This is complementary to exercising compassionate accountability because this form of communication avoids enabling behaviors related to both pain management and addiction. No matter what, clients are responsible for the choices they make, and counselors need to be clear with clients about what they see.

5) Consider a harm-reduction perspective. This perspective means that the counselor walks the fine line of not enabling the client's substance use while at the same time not requiring the client to suddenly commit themselves to abstinence. Instead, the counselor works within the reality of the client's willingness and ability to change without encouraging the client to remain at the same level of change.

6) Complete assessment and treatment plans for both addiction and pain. This involves the counselor examining both areas in a broad way that includes the client's fear of the pain returning and their psychological withdrawal from pain medication.

7) Watch for behavioral indicators of pain during the session. A significant amount of information can be gathered when the client is actively experiencing pain.

The client's pain experience can be processed in the moment, and the resulting information can assist both the assessment and treatment processes.

Assessment

Counselors can use a simple anchoring assessment prompt to elicit each client's story: "Tell me the story of your pain."

That open-ended prompt has the power to draw out narratives that clients have perhaps not spoken about previously. These clients may be accustomed to closed questions or scaling questions regarding their pain, but they may never have had anyone ask about and then carefully listen to the actual story of their pain.

This motivational interviewing approach can readily draw out information about the impact of community, culture, family and multicultural factors on the individual's self-report. For example, the client may talk about how pain is simply not discussed in their family and culture. As a result, they have learned not to reach out for support to address their pain. The counselor could then help the client develop skills to reach out to others who will be supportive of them as they live with their pain, or the counselor might refer the client to a group that discusses pain management approaches.

Another assessment approach is to have clients keep diaries or logs pertaining to their pain, sleep and nutrition. These logs can assist in obtaining information about pain patterns and contributing factors to pain. Such record-keeping also needs to focus on what the client is doing "right" as well as what they are doing "wrong," in addition to times when the areas of pain, sleep and nutrition are going well for the client. The collection of this information is solution-focused and strength-based. It can become the cornerstone on which healing treatment is built.

The assessment of pain also needs to be considered within the context of addiction. So, although the client has pain, this does not mean that it is

Geri Miller



necessary for them to use substances to cope with that pain. Neither does the existence of pain prevent the client from being confronted about their addiction as a “stand-alone” diagnosis.

Thus, the message is twofold:

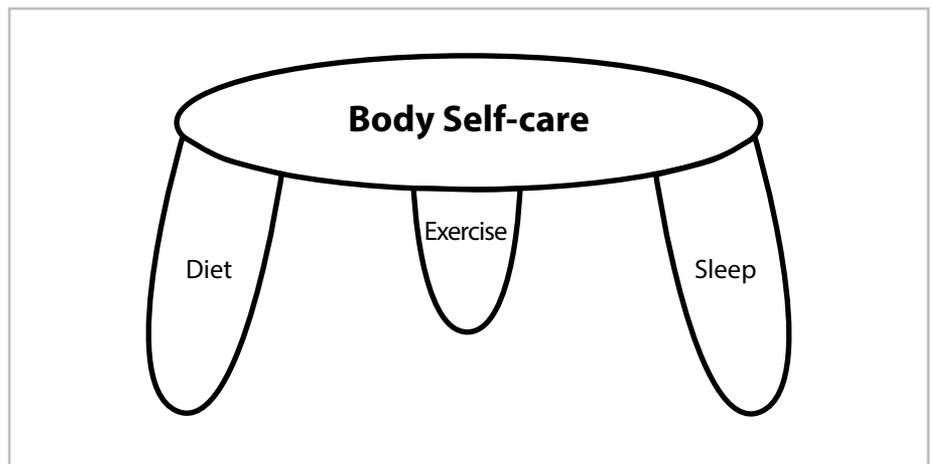
- 1) The client can learn to live with pain without the use of substances.
- 2) The client may need to be confronted solely on their use of substances.

Treatment

Treatment for pain can involve various therapy modalities such as individual, group or family counseling. The counselor and client can choose the modality that seems to best fit the needs of the client, in combination with the resources available related to client income, agency resources and community resources.

Specific therapy approaches can include motivational interviewing, cognitive behavior therapy, acceptance and commitment therapy, and grief counseling (because when dealing with chronic pain, clients frequently have issues of loss). It is within these forms of therapy where clinicians can legitimately practice counseling in their areas of competence by simply anchoring themselves in their treatment approach (e.g., therapy modalities, specific therapy approaches) and adding the lenses of “pain” and “substance abuse” by asking about information in the assessment process that broadly addresses these areas. Such broad assessment can assist the counselor in knowing whether the treatment of pain and substance use can be readily integrated into treatment or whether a more specific assessment and focused treatment of these areas are required.

Treatments that *change the client's relationship with the pain* by focusing on the present (e.g., mindfulness, yoga, biofeedback, acupuncture) are also potential resources. In such cases, clients may remain aware of the pain but work with the knowledge that the intensity of their pain ebbs and flows and learn how to live with that process. They may also find techniques to reduce their pain.



This diagram, developed by Geri Miller for the fifth edition of her book *Learning the Language of Addiction Counseling* (in press with John Wiley & Sons), illustrates how each leg of the stool (diet, exercise, sleep) is needed to keep overall self-care in balance.

Another treatment approach, described by Kirsten Weir in 2017 in *Monitor on Psychology*, encourages the client to practice self-care of the body through diet, exercise and sleep. It uses the metaphor of a stool with three legs. I developed the diagram above for the fifth edition of my book *Learning the Language of Addiction Counseling* (currently in press) to illustrate this metaphor.

The three-pronged stool is precariously balanced, which illustrates that self-care is not a static entity but rather one that needs to fluctuate depending on the client and the context. Each leg of the stool (diet, exercise, sleep) is needed to keep the overall stool (self-care) in balance. In other words, each leg has an impact on the others. For example, the experience of pain may negatively affect a client's sleep, which then inhibits them from exercising and tempts them to eat unhealthy comfort foods. In contrast, a client who gets enough sleep may experience diminished pain, thus encouraging them to exercise and practice healthy eating. Counselors need to remind clients, however, that “pretty good” self-care is good enough; one does not have to practice “perfect” self-care to reap the benefits.

A final treatment approach involves counselors viewing themselves as part of a health management team. Such a team can consist of different health care professionals in which each professional

has an important perspective on the unique aspects of the individual client's pain and pain management. The unique components of the client's pain determine the composition of such a team and the treatment system in which the team exists (e.g., hospital setting, private practice). Whether the team is formally or informally established by the counselor or by the system in which the counselor works, the counselor provides a critical mental health perspective that is needed for a holistic treatment approach.

As part of such a team, counselors familiarize themselves with any prescribed medications that the client is taking for chronic, active disorders. Counselors then play a role in the planned and gradual reduction of medications being taken. Counselors do not need to be experts in pain management or medications to be part of such a team or to be assigned to a formal team. The team approach can be extremely effective in serving the welfare of clients.

The counseling perspective offers important contributions to such teams, including a heightened sensitivity for clients' pain stories and a commitment to advocating for clients. Such a perspective can result in an effective and humane approach to pain management and the use of prescription drugs. Additionally, this perspective can prevent clients from feeling like they are being dehumanized

on a “medical assembly line” during the treatment process.

Conclusions

Clinicians can work effectively with clients by integrating pain management and substance abuse approaches into their already-existing counseling approaches. Awareness of the prevalence of chronic pain and its potential interaction with substance use can assist counselors during the assessment and treatment process.

Chronic pain and substance use frequently overlap, but they are areas that can easily be missed in terms of their impact on clients’ presenting problems. Simply by integrating the lenses of pain management and substance use into their counseling — asking questions and intervening as necessary — clinicians can offer a more holistic approach to their clients.

The development of these lenses can be enhanced through continuing education, ongoing training and staying informed on current research. There are some excellent resources (see below)

that counselors can add to their clinical toolboxes. Counselors who commit to more deeply examining the areas of pain management and substance use can improve their overall treatment effectiveness and, thus, act in the best interests of their clients.

Recommended resources

- ❖ American Chronic Pain Association (ACPA): theacpa.org
- ❖ American Society of Addiction Medicine (ASAM): asam.org
- ❖ Chronic Pain Anonymous: chronicpainanonymous.org
- ❖ Pills Anonymous: pillsanonymous.org
- ❖ Medication Assisted Recovery Anonymous: mara-international.org
- ❖ ACPA resource guide to chronic pain management: tinyurl.com/ACPAREsourceGuide
- ❖ ASAM national practice guideline for the use of medications in the treatment of addiction involving opioid use: tinyurl.com/ASAMPracticeGuideline

- ❖ “CDC guideline for prescribing opioids for chronic pain—United States, 2016”: tinyurl.com/CDCOpioidChronicPain
- ❖ The Pain Toolkit: paintoolkit.org/resources/for-professionals
- ❖ *Pain-Free Living for Drug-Free People: A Guide to Pain Management in Recovery* by Marvin D. Seppala & David P. Martin
- ❖ *Cognitive Therapy for Chronic Pain: A Step-by-Step Guide* by Beverly E. Thorn
- ❖ *The Pain Survival Guide: How to Become Resilient and Reclaim Your Life* by Dennis C. Turk & Frits Winter ❖

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



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PS Form 3526 Statement of Ownership, Management, and Circulation (All Periodicals Publications Except Requester Publications)

1. Publication Title AMERICAN COUNSELING ASSOCIATION/ COUNSELING TODAY		2. Publication Number 847520	3. Filing Date 09/21/2020
4. Issue Frequency MONTHLY		5. Number of Issues Published Annually 12	6. Annual Subscription Price \$ 176.00
7. Complete Mailing Address of Known Office of Publication 6101 STEVENSON AVE SUITE 600 ALEXANDRIA, VA 22304-3580			
8. Complete Mailing Address of Headquarters or General Business Office of Publisher 6101 STEVENSON AVE STE 600 ALEXANDRIA, VA 22304-3580			
9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor Publisher (Name and complete mailing address) Richard Yep 6101 STEVENSON AVE STE 600 ALEXANDRIA, VA 22304-3580 Editor (Name and complete mailing address) Jonathan Rollins 6101 STEVENSON AVE STE 600 ALEXANDRIA, VA 22304-3580 Managing Editor (Name and complete mailing address)			
10. Owner (Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual owner. If the publication is published by a nonprofit organization, give its name and address.) American Counseling Assoc. 6101 STEVENSON AVE STE 600, ALEXANDRIA, VA 22304-3580			
11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box None <input checked="" type="checkbox"/> None Full Name Complete Mailing Address			
12. Tax Status (For completion by nonprofit organizations authorized to mail at nonprofit rates) The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes: <input checked="" type="checkbox"/> Has Not Changed During Preceding 12 Months <input type="checkbox"/> Has Changed During Preceding 12 Months (Publisher must submit explanation of change with this statement)			

PS Form 3526, September 2007 (Page 1) **PRIVACY NOTICE:** See our privacy policy on www.usps.com

13. Publication Title COUNSELING TODAY		14. Issue Date for Circulation Data Below 09/01/2020	
15. Extend and Nature of Circulation		Average No. Copies Each Issue During Preceding 12 Months	No. Copies of Single Issue Published Nearest to Filing Date
a. Total Numbers of Copies (Net press run)		51056	55482
(1) Mailed Outside County Paid Subscriptions Stated on PS Form 3541 (include paid distribution above nominal rate, advertiser's proof copies, and exchange copies)		50397	54945
(2) Mailed In-County Paid Subscriptions Stated on PS Form 3541 (include paid distribution above nominal rate, advertiser's proof copies, and exchange copies)		0	0
(3) Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Paid Distribution Outside USPS		0	0
(4) Paid Distribution by Other Classes of Mail Through the USPS (e.g. First-Class Mail)		0	0
b. Total Paid Distribution (Sum of 15b(1), (2), (3), (4))		50397	54945
(1) Free or Nominal Rate Outside County Copies included on PS Form 3541		0	0
(2) Free or Nominal Rate In-County Copies included on PS Form 3541		0	0
(3) Free or Nominal Rate Copies Mailed at Other Classes Through the USPS (e.g. First-Class Mail)		0	0
(4) Free or Nominal Rate Distribution Outside the Mail (Carriers or other means)		194	100
e. Total Free or Nominal Rate Distribution (Sum of 15e(1), (2), (3), (4))		194	100
f. Total Distribution (Sum of 15e and 15b)		50591	55045
g. Copies not Distributed		603	637
h. Total (Sum of 15f and 15g)		51444	55682
i. Percent Paid ((15c / 15f) times 100)		99.62 %	99.82 %
16. If total circulation includes electronic copies, report that circulation on lines below.			
a. Paid Electronic Copies		0	0
b. Total Paid Print Copies (Line 15c) + Paid Electronic Copies		0	0
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17. Publication of Statement of Ownership <input checked="" type="checkbox"/> If the publication is a general publication, publication of this statement is required. Will be printed in the 11/01/2020 issue of this publication. <input type="checkbox"/> Publication not required.			
18. Signature and Title of Editor, Publisher, Business Manager, or Owner Jonathan Rollins		Title Editor-in-chief	Date 09/21/2020 09:16:11 AM
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Member Insights

DXM: A drug in plain sight

A potentially dangerous drug found in most over-the-counter cough medicines is more popular than opioids among teenagers, largely because it is legal, inexpensive and easy to obtain

By Emily Weaver, Sharon J. Davis & David Saarnio

We are writing this article to raise awareness among parents and counselors about a legal and easily accessible drug that is widely used by adolescents to get high: dextromethorphan (DXM). DXM is an ingredient found in certain medications meant to help us get better, so teens frequently abuse this drug without being aware of the potential consequences and dangers. Given the personal insights and experiences we have with the damaging effects of DXM, we are sharing this story in hopes of reaching a larger population and creating more efficient prevention strategies related to teen drug use.



When co-author Sharon Davis' son was 17, he began abusing over-the-counter (OTC) cough medicine. He had been using marijuana and K2 (synthetic marijuana) for a few

years, but it was Coricidin — a cold medicine marketed as being for people with high blood pressure — that really damaged him.

Sharon's son became a different person. He had always been a moody kid, but his moodiness turned to anger, mania and psychosis. Over a four-month period, his father and mother took him to the emergency room four times. It wasn't until he attempted suicide that they really got him the help he needed and found out the full extent of his addiction.

He had been introduced to Coricidin through some friends. Soon he was using 30 pills at a time. Coricidin use led to cocaine use. Cocaine use led to methamphetamine use. Two years later, he is working on recovery, but his mind and mental health will never be the same.

According to the Partnership for Drug-Free Kids, 50% of American teenagers have misused a drug, and

drug overdose is the fourth-leading cause of death among teens. Parents, counselors and other adults are well aware of the problem of teen drug use, and the nation's opioid epidemic has brought the topic of medication misuse to the forefront of public attention. That attention is long overdue. However, that focus also misleads us because other critical concerns are being overlooked.

For example, our society is largely neglecting to talk about the large-scale problem of adolescent misuse of OTC medicine and its potential as a gateway to other drugs. In fact, OTC cough and cold medicine is one of the most popular drugs that youth use to get high. According to the Monitoring the Future survey funded by the National Institute on Drug Abuse, more teens got high from OTC medicine in 2019 than from prescription opioids.

Why OTC?

OTC cough medication is easy for teens to get. In some places, teens can purchase these medications from their local convenience stores. Furthermore, most stores have these medications out on the shelf where they are easy to steal. Teens can also get them from peers and even from parents. Because they don't necessarily perceive these types of medications as "dangerous," many parents will store them in an unlocked medicine cabinet, unknowingly allowing their teens easy access to them.

The psychoactive drug in OTC cough and cold medicine is DXM, which falls into a class of drugs known as *dissociative hallucinogens*. Other drugs in this category include PCP, ketamine and nitrous oxide. The Food and Drug Administration (FDA) approved DXM as a cough suppressant in 1958. It remains legal to buy and use in the U.S. DXM is a safe drug when used as directed, but when used in 10 times or more the recommended dose, it acts as a powerful dissociative, distorting reality. Currently, 85%-90% of OTC cough medications contain this effective antitussive (cough inhibitor). DXM is a synthetic opioid drug, but it activates different opioid receptors in the brain than prescription opioids do.

Teens typically misuse DXM to feel the euphoric, dreamlike experiences and hallucinations it causes. When individuals use DXM to get high, they experience various levels of inebriation, known as plateaus.

There are four plateaus associated with DXM. The first plateau involves mild intoxication and stimulant-like effects. The second plateau features increased intoxication and mild hallucinations. At the third plateau, the user enters a state of altered consciousness with impaired senses and psychosis. The fourth plateau involves a sense of derealization (in which the world appears unreal) and depersonalization (e.g., detachment from the self).

Users describe the higher plateaus as akin to being in other realms or alternate universes. Commonly, users feel an out-of-body sensation, like being transported to another dimension. They lose their sense of self and time. It is common for users to post videos or blogs about their experiences, including what they felt like and what they saw while high. The slang term *robo-tripping* is how many teens refer to being high on DXM. Slang terms for the drug itself include *triple-C's*, *robo*, *skittles*, *red hots* and *dex*.

Why is DXM problematic?

DXM is a dangerous drug when used outside of therapeutic doses, yet little has been done to curb its misuse among teens. For decades, we have known about the consequences of misusing this drug, including seizures, hyperthermia, tachycardia, psychosis, mania and even death.

The opioid epidemic in this country is a national crisis. It is worthy of public attention and government funding to address. At the same time, DXM misuse among teens is also startling, and yet it is rarely highlighted. This drug is more popular than opioids among young people, and it is legal, inexpensive and easy to get.

It is imperative that prevention efforts and policies address this problem. For example, laws similar to those passed in 2005 that required pharmacies to move the popular methamphetamine-making drug

pseudoephedrine behind the counter could make DXM less readily available. Some states already require purchasers of OTC cough and cold medications containing DXM to present an ID proving they are 18 or older. We believe this should become mandatory nationwide and that sellers of these drugs should be held accountable.

Furthermore, mass awareness campaigns targeting parents, teachers, law enforcement and counselors need to remind adults of the dangers of these drugs, whereas prevention programs for children and teens should increase their focus on the dangers of OTC medications. National campaigns and policy changes are called for, but these alone will not likely be enough to cause real change. True prevention efforts require work on multiple levels — from the policymakers in Washington to counselors and parents in local communities. Each of us has a part to play, and each can make a difference.

Where do teens hear about DXM?

In today's era of prolific internet and social media use, teens have more access to the world than ever before. In past decades, peer pressure to use drugs was a huge concern. It was thought that susceptible teens would be influenced by their peers in the neighborhood and at school. This peer pressure occurred face to face.

Today's teens still confront in-person peer pressure, but they now also face this pressure virtually. Peer influence can come not just from the local teens at school but from millions of teens across the world online. Many teens access the internet and find out about drugs of abuse, including how to get high on OTC cough and cold medications.

A quick search of popular sites such as YouTube can lead teens to videos that either warn of the dangers of DXM or encourage users to experience the high from it. Unfortunately, many websites include dosing recommendations and "tripping" suggestions for having a better experience of getting high.

For example, Reddit, one of the most popular social media sites around the world, has an estimated 430 million active users. Reddit consists of threads that allow its users to post about certain

subjects and topics. These threads are like cybercommunities made up of members who hold similar interests. One of these threads, called “r/DXM,” has more than 31,500 users. This thread allows people a place to describe their DXM highs and the side effects. It also provides advice on how to minimize certain side effects such as nausea.

Other websites and cybercommunities such as Dextroverse.org and the Vaults of Erowid provide teens outlets to post about their DXM highs and get advice from other users on how to use the drug. The site DexCalc.com allows users to enter their weights and get a recommended dose for the “plateau” of high they want to achieve. Although many of these websites claim that their purpose is “harm reduction,” teens typically use these sites for suggestions and advice on the “safest” using pleasures. All of these websites are accessible to teens, and all of them are free to use.

Prevention efforts

Fifteen years ago, the FDA issued warning labels on OTC cough and cold medications aimed at making parents aware of the dangers of medicine abuse by teens. The Stop Medicine Abuse campaign launched nationwide in 2004, but clearly that campaign was not successful. More needs to be done to dissuade youth from abusing OTC drugs.

As counselors, we need to step to the front lines of true preventive efforts. This means that we need to know more about DXM (and other OTC medications), the reasons teens are using it, the ways teens are getting it and the most effective methods to prevent its misuse.

Getting parents involved is a good first step. Parents must know what to look for and how to talk to their teens about OTC drugs. Counselors need to get the message out to parents to be realistic and truthful when educating teens about DXM. Scare tactics do not work for many teens; in fact, they may make teens more curious about experiencing the outcomes for themselves. A better approach for prevention may be for parents, family members and other adults to increase the quality of their connection to and communication with youth.

Research shows that establishing consistent messages against drug misuse and having clear boundaries early on can be among the best prevention efforts for teen drug use. Simple steps, such as hiding medications and taking inventory, can also be effective. Most parents want to trust their teens, but having medications that contain DXM where teens can access them is not wise, and many parents are not aware of the dangers of DXM medications. OTC cough and cold medicine should be as securely stored as opioid prescriptions.

In addition, parents need to know what sites their teens are accessing online. A parallel line of defense involves checking browser histories and having clear rules about what teens can access online. Drug use is a leading cause of death among teens (resulting in more than 5,000 deaths per year according to figures from the National Institute on Drug Abuse). Parents wouldn't want their teens searching for firearms or lethal poisons online, and no parent should want their teen searching for how to get high from DXM. Parents may not be comfortable with this advice. After all, it may feel like snooping, and teens are likely to resist as well. Even so, what teens access online can be one of the biggest telltale signs of drug use.

Establishing rules for computer/internet usage (e.g., allowing a teen to use the internet for two hours a day after completing homework), installing a firewall and setting locks or passwords for downloads can all be safety measures that contribute to prevention or, when needed, intervention. The earlier that parents establish household internet rules, the better. Proactive planning and putting rules in place before children reach their teen years may prove much easier than trying to establish new rules once teens are in late adolescence.

Talking to teens about drug use is often uncomfortable for parents. Many parents do not know where to begin. Some parents are worried that talking about drugs will increase their children's curiosity about using. Other parents simply find the topic embarrassing or awkward. As counselors, we need to help parents develop communication skills with their children and teens, but

especially starting in middle childhood. Counselors can provide parents with resources for where to find information about drugs of abuse, and we can intervene if a teen has already started using. It is almost a certainty that teens talk to other teens about getting high on OTC cough and cold medication. As counselors, we need to encourage parents to talk to their children about choosing not to get high on it.

If Sharon Davis, as both a counselor and parent, had recognized the signs of DXM abuse in her son, he might have gotten help sooner. The message we want parents and counselors to hear is that DXM is one of the most popular drugs for teens, and despite it being legal and easy to get, it is not safe when misused. Sharon was unable to prevent all the damage done to her son, but we hope that her story will help parents of children and teens across the country to protect their own sons and daughters. ♦

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