Central Valley Counselor Association

Serving and Supporting Virginia Counselors in Augusta County, Highland County, Page County, Rockingham County, Shenandoah County, Harrisonburg, Staunton, and Waynesboro since 1962!

January 2012

Letter from the President

Hello everyone,

Believe it or not, it is a new year full of possibilities . . . already! Has the time flown by for anyone else? As current president of Central Valley Counselors Association, I would like to extend a warm welcome to all of those in the helping profession in the Valley. The work we do is rewarding, strenuous, stimulating, and exhausting all at once! As 2012 is upon us and 2011 fades in the distance, it is time to renew and refresh and take a look at how we do things. In this newsletter, you will find lots of opportunities to be involved with CVCA in 2012, including dinner meetings, socials, and workshops. Whether counseling in the community or school systems, I encourage you to check us out, as well as our counseling associations on the state and national levels.

Also in this newsletter, you will find helpful information on topics encountered daily in the counseling profession –abuse and poverty. Please take time to read and reflect on these serious issues in our culture, and the role you play as a helper of those in need. And, as 2012 kicks into full gear, remember to take time for yourself and the greatest gifts of all --the important folks in your life! Happy 2012 from CVCA!

Jodi Myers

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Thursday February 9, 2012 6:00 PM
The Art of Mindfulness in the Counseling Profession
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CVCA Winter Workshop
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Let's Play: The ABC's of Play-based Interventions
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CVCA Going Green

In order to conserve resources and do our part in saving the planet, CVCA is going to start e-mailing the newsletter.

If you would like to continue to receive a paper copy of the newsletter, contact us at CVCA17@gmail.com

Quick Look at Poverty

The government defines someone as being *Poor* "if they have an income less than that deemed as sufficient to purchase basic needs."

Types of Poverty:

- Situational: poverty caused by a sudden crisis or loss and is often temporary
- Generational: occurs in families where at least 2 generations have been born into poverty
- Absolute Poverty: scarcity of such necessities as shelter, running water, and food. This type of poverty is rare in the USA.
- Relative poverty: where a person's or family's income is insufficient to meet society's average standard of living
- Urban Poverty: Poverty in metropolitan areas where the population is at least 50,000 people
- Rural Poverty: Poverty in nonmetropolitan areas with populations below 50,000 people.

By the Numbers (US Census Bureau)

- 46.2 million people or about 15.3% of the U.S. Population had an income below the poverty threshold during 2010
- 861,969 people or 11.1% of Virginia residents are living in poverty

Quick Look at Abuse

Abuse is when a person mistreats or misuses other people, showing no concern for their integrity or innate worth as individuals, and in a manner that degrades their well being.

Types of Abuse:

- Verbal Abuse: when one person uses words and body language to inappropriately criticize another person
- Psychological Abuse: when one person controls information available to another person so as to manipulate that person's sense of reality, what is acceptable and what is not acceptable. Often contains strong emotionally manipulative content.
- Physical Abuse: when one person uses physical pain or threat of physical force to intimidate another person
- Sexual Abuse: any sort of unwanted sexual contact, or when a partner is forced to another level of sexual contact that they did not agree to
- Neglect: when a person fails to provide for the basic needs of one or more dependent victims he or she is responsible for.

Abuse by the Numbers:

- A child abuse report is made every 10 seconds (Child Help)
- About 80% of children that die from abuse are under the age of 4 (Child Help)
- 1 in 4 women will experience domestic violence in her lifetime (NCADV)
- 85% of domestic violence victims are women (NCADV)

Physical and Mental Health Connections for Rural Clients

Life below the poverty line is stressful regardless of where you live; however, it is important to keep in mind that the stressors people face are influenced by their locations. Developing geographically based cultural competencies can help clinicians gain a better understanding of the obstacles their clients face. Most clients living in poverty experience financial difficulties that can include difficulty paying bills, limited access to transportation, unsafe or inadequate housing, and lack of medical care. For clients living in urban centers, unsafe schools and neighborhoods, racial or ethnic discrimination, and the stressors connected with overcrowding such as limited places to play, lack of privacy, and noise and air pollution may be of greater concern. While urban clients may have limited access to resources, they are more likely to have access to public transportation and assistance programs, such as free clinics, day centers, and food banks in closer proximity than their rural counterparts.

Many rural clients appreciate the open spaces and natural beauty of their surroundings; however, they are more likely to struggle with isolation due to lack of transportation or difficult terrain, lack of access to medical care, and levels of underemployment where they cannot afford medical care but make too much to qualify for national programs such as Medicaid. Rural residents are more likely to suffer from co-morbid medical conditions such as obesity, diabetes, and heart disease than suburban residents. They are more likely to smoke and live a sedentary lifestyle, both of which contribute to illness. While these medical conditions certainly exist in urban populations, the strategies rural clients use to deal with these issues may have a serious effect on treatment. Rural residents are more likely to ration medications, limit other expenses such as food, heating, or transportation, rely on family assistance, supplement with alternative medications, or comparison shop due to the limited access to medical care that includes prescription assistance.

It is important for counselors to keep these strategies in mind when they are working with rural clients. It may be necessary to educate clients regarding their medical conditions and to find out how they are complying with medical treatments prescribed by their doctors. Clients who keep the heat too low or skimp on meals to pay for medications may get sick more frequently, experience mood swings, and lack energy for daily tasks.

Physical and Mental Health Connections for Rural Clients cont.

Mood swings could be a result of unstable blood sugar levels, particularly if the client struggles with diabetes. What client's may call "nerve problems" such as dizziness, irritability, and confusion could be symptoms of hypertension if they are rationing their medications. While no one expects counselors to be medical experts, understanding the basics of physical conditions that can affect a client's mental health, and educating clients regarding the importance of compliance with treatment can improve your client's overall wellness, leading to greater progress in counseling.

For some clients, we are the front line of medical care because we see our clients on a regular basis. We are more likely to hear complaints regarding medication side effects, new symptoms, and increases in symptomology that may decrease a client's capacity to engage in the work of counseling. Encouraging a client to see a physician and get medication can make a huge difference. Learn about resources in our area than can help client's gain access to medical care in their area, such as free clinics and community health centers for medical treatment, and programs such as the Shenandoah Valley Compassionate Pharmacy Program, which helps patients get medications from the drug companies through their patient assistance programs. ♦*Lisa Ellison*

A list of free clinics in our area can be found in the Comprehensive Directory of Mental Health Services: http://psyc.jmu.edu/counseling/documents/2010Comprehensive_Directory_of_Mental_Health_Services.pdf. Additional information can be found at 211virginia.org.

References available upon request

What does it mean to live in poverty and to be a student?

Growing up my family and I lived below the poverty line. In elementary school, my dad was a chef who worked for a catering company and Sodexho-Marriot Hotels, while my mom was a server at a steak house. I was embarrassed to answer the question "what do your parents do?" in front of my peers for fear of ridicule, since I went to school with children of doctors, lawyers, and CEOs. We struggled to make ends meet. Although we were never threatened with eviction, my parents were always a month behind on the bills. The dreaded red and brown bills were a common occurrence. If service were terminated, my parents would be expected to pay the full amount due, two months worth, upfront to have the service returned. There were a few close calls, and once our phone was turned off. Clothing was another big struggle. Since my brother and I were still growing, we constantly needed new clothes. My mother became frustrated each new school year with the cost of school supplies and new clothes.

When I was 11, my parents decided they would give our family a second chance, so we moved to Charlotte County, Virginia. We did not own our home in New Jersey, so we did not have the value of a typical house ($600,000) to cover moving expenses. Rather, we left with all of our belongings in one truck and two cars. Before we left, we had several

yard sales because we could only bring the bare minimum. We packed up the dog and any remaining items around the house. Upon arrival, we found out that our new house was 1,000 square feet smaller than the old one. We were forced to have more yard sales to clear "extra" furniture so we could pay for some groceries while my parents looked for jobs. With less space, every room was cramped and cluttered. We were always arguing about the one bathroom that rarely functioned properly. The house was full of noise. There was no such thing as a private conversation.

The beginning of the school year was rough. The well-to-do families were now children of teachers and farmers. Once again, my parents were neither. Although the cost of living was exponentially lower than New Jersey, my parents were still making minimal salaries. We were nearly in the same position as before. This time though, there were more students like me. I did not feel like as much as an outcast as I did in my previous school; however, I found myself wanting to be different from those students. Rather than forming an alliance and seeking comfort from them, I wanted to distance myself and act as though I had more.

My dad was able to transfer to a nearby Marriot location for his job as a chef, but with an hour long commute, and long hours, he decided to look for something else. After two years of searching, my dad found a job as a plant supervisor in a furniture factory. My mother attempted entrepreneurship with several different ideas, but each failed.

Although I should have been grateful that my parents had jobs to put food on the table, I resented them for placing me in the same situation, hundreds of miles away from my friends. I was not "cool," and I did not fit in. I longed to own an article of clothing from *American Eagle* or say that I was going to the beach for a week over the summer. There was one summer that my friend took me to the mall, an hour and a half drive, and my mom gave me $15. I was absolutely stoked when Areopastale was having a sale in the back of the store. The t-shirts were only $5 each. I made them fit, and insisted on only buying the styles that had the brand across the front so everyone would know where I got them from.

When I was promised a new life and nothing seemed to change, I felt like my family was never going to move forward. Outwardly, I worked to fit in, but on the inside I struggled with poor self-esteem, depression, and anxiety. No one in my school ever reached out to ask me how I was adjusting, how my day was going, or why I looked so blue. Fortunately, my parents did not give up. They continued to encourage me to keep striving for a better life. They told me that all I needed were decent grades, strong interests, and determination and things would get better. They were right.

Knowing a child's story, or simply asking questions can make a difference. It is especially important to check in on the quiet kids who might look like they don't need counseling. I wish someone in my school noticed me. Perhaps I would not have had to live through years of depression or struggle with anxiety now. Counselors should know that when a student lives in poverty, it does not simply affect their home situation. It permeates their self-esteem, self-efficacy, education, grades, relationships, and plans for the future. ♦*Vanessa Olson*

Homelessness in the Valley

We live in uncertain economic times. In 2010, 46.9 million people were living in poverty, up from 37.3 million in 2007. Fourteen point five percent of households are currently food insecure. With the rise in poverty comes a rise in homelessness. The latest statistics from the National Alliance to End Homelessness, show that the homeless population increased by approximately 20,000 between 2008 and 2009. It's likely that current numbers are even higher.

There are many factors that lead to a life in transition. Substance abuse and mental health issues can be contributing factors, but there are other issues to consider. A significant number of people living in transition have experienced some form of abuse that directly led to their homelessness. Domestic violence is the leading cause of homelessness among women and children. According to the Center for Urban and Community Studies, childhood risk factors that lead to adult homelessness include lack of care or physical abuse by parents.

In the spring of 2011 the Harrisonburg Community Health Center, in conjunction with JMU and several faith based organizations, started the Suitcase Clinic –a medical mobile unit, which is literally a large suitcase. Inside, nurse practitioners can store and carry around all their diagnostics and medical equipment. These nurse practitioners travel to various shelters and day centers like Our Community Place, and offer medical treatment to residents living in transition in our community. Counseling and Psychological Services (CAPS) at JMU is currently collaborating on a pilot program with the Suit Case Clinic and offering counseling services to some of their patients. I have had the privilege of working on this project, and getting to really learn about the struggles people in our community face on a daily basis.

Our experience at CAPS supports the data regarding causes of homelessness. Abuse and poverty play pivotal roles in the lives of people living in transition. Many were abused as children, lived financially on the edge, and when crises arose, found themselves on the streets. Unfortunately, many of the homeless experience continued abuses as they struggle to survive and regain stability in their lives. It is important to note that we are also seeing that health issues such as chronic severe back pain and complications from medical conditions that limit a person's ability to work that also contribute to homelessness. Even living with a disability can lead to homelessness, if family support is not available.

People living in transition have important tales to tell, if we're willing to listen. Unfortunately, more often than not, as a society we turn a blind eye. They need our care, compassion, and to learn strategies that can support independence. They need us to see them not as statistics or anecdotes, but as real people working to get by. We need to keep in mind that living in transition does not mean living life from hand out to hand out. People living in transition work jobs despite living in shelters, and perform amazing acts of kindness and generosity despite living in cars, shelters, or in the homes of friends. They desire the basic comforts we take for granted – a roof over their heads and a bed to call their own.

As counselors we work with people struggling to make meaning in their lives. For some, homelessness is a real possibility. Make sure you have resources on hand for clients who may need them. When working with abused children, keep in mind that abuse, especially when coupled with poverty, can be a risk factor for future homelessness. Build in as many protective factors as possible to help combat this problem. Donate to local organizations that help the homeless. If you have time, volunteer at a local shelter such as the Salvation Army Shelter, at day centers such as Our Community Place, or the HARTS Thermal Shelter that offers people living in transition a place to stay when the temperatures are below freezing so that you can help support the services currently available to people in need. It will also give you an opportunity to meet people in our community who are frequently marginalized, but who possess courage, kindness, and strength. ♦ *Lisa Ellison*

Resources for people living in transition in our area:

HARTS Shelter: http://www.hartsshelter.org/?page_id=2

Salvation Army Shelter: http://www.uss.salvationarmy.org/uss/www_uss_harrisonburg.nsf/vw-sublinks/F5A694431E7713AC852573A200068A5D?openDocument

Our Community Place: http://ourcommunityplace.org/

Homeless Directory in Staunton: http://www.homelessshelterdirectory.org/cgi-bin/id/city.cgi?city=Staunton&state=VA

To find out about services for people living in transition in our location, please call Virginia 211, or go to www.211virginia.org/.

The Healing Caribbean:
My Experience with International Counseling

In the summer of 2010, my fiancé dropped me off at Dulles Airport, with nothing but a couple pairs of clothes, an IPOD, an alarm clock, and *Eat, Pray, Love* packed in my pink suitcase. I made the decision only a couple weeks before, right after I graduated from my Master's program in Counseling, to embark on an international immersion opportunity that would last anywhere from a couple weeks to a few months. For the first time, I would be living on my own in a different country. My destination was the Dominican Republic where I would be volunteering my time to work with at-risk adolescents in a boarding school and engage in missionary projects with the locals.

Needless to say, I wasn't placed in a fancy resort overlooking the deep blue Caribbean waters. Instead, I was taken to the center of the country, up a steep graveled road, to a community at the base of a mountain called Jarabacoa. There, I was taken to a campus nestled on a hill and surrounded by tropical trees and colorful plants. I met about 20 students at this school, all of whom had been sent here by their parents from the United States or Canada. Most of these students were raised in upper-middle class households; however, in many cases, they lacked appropriate boundaries and supervision. This often led to rebellious behavior, promiscuity, and delinquent activities. Parents sent them to this boarding school in the Dominican Republic as an attempt to remove them from their unhealthy environment, as a way to encourage rehabilitation, and in some cases, as a last resort before the children were removed from the homes. The students were very resentful of their parents, many experiencing feelings of resentment and betrayal. Upon arrival to the campus, the students feared a strict structure, not having access to their normal outlets, and being actively supervised by an authority figure.

I was quickly placed as a therapeutic staff member. My goal was to form a relationship with these students that would be supportive, nurturing, open, and understanding to the new and scary situation they found themselves in. There was no Facebook or cable television. You couldn't throw bathroom tissue in the toilets. You couldn't drink water from the kitchen faucet without the fear of getting ill, or have hot showers in the morning. But instead of seeing this only as a punishment, I wanted to help them take something beautiful away from the experience. I wanted this modest lifestyle to be a catalyst for the change that needed to happen within them on a deeper level.

As a counselor with the therapeutic staff, I wanted to help these students learn how to embrace the culture and be completely present to the natural setting around them. I often engaged in one-on-one therapy and small group activities with the students to explore their thoughts and feelings about these new cultural moments. I would also prompt clients during cultural outings to engage in self-reflective dialog with me to process what they were experiencing in the moment. They would often voice a newfound sense of appreciation, respect, and awareness as they fully immersed themselves in the present.

At the end of the day, the students would journal about these topics and have moments of thoughtful meditation. I noticed how gradually many student began appreciating their experiences in the moment, whether it was hiking through the rainforest, swimming under a waterfall, or visiting historical sites. However, what I believe impacted the students the most and what created the most change was the people they met along the way. The Dominican Republic is known for its beautiful beaches and grand resorts that attract tourists from around the world. But deeper into the center of this country is extreme poverty. The students, staff, and I lived and interacted with this population. We saw what it was like for these families to live in this culture. Material possessions, reality TV, designer clothes, and fancy cars were not a priority. But even though they had so little, these families would always invite us into their homes and offer to cook us a warm meal. They were always excited to communicate with us and learn about us. I believe the students were moved by the graciousness and appreciation these families had.

I have been in contact with some of my students since I returned to my home in Virginia, and many of them are grateful for their time in the Dominican Republic. Many are appreciative of the personal growth they see in themselves, especially in the areas of self-esteem and independence. Some of my students have already made a healthy transition into college where they are pursuing degrees directly relating to their experience abroad, such as International Ministries and the Spanish language. Their time spent there had its difficult moments, but they took with them invaluable experiences and memories of relationships that helped them grow as young adults. Many of them also developed a greater appreciation for the life they have with all of its opportunities and resources. Above all things, I believe they began a healing process they will never forget. ♦ Laura Anne Copley, M.A., *Resident in Counseling*

The Intersections of Acquired Brain Injury and Domestic Violence

Meet Carol

Carol found herself in a cycle of violence from the time she was a child. By adulthood, she had already experienced multiple beatings. In the most recent attack, her husband beat her with a 2X4, leaving her with permanent brain damage and a life-long disability. In addition, she suffers from bi-polar disorder and diabetes. We met Carol soon after she was hospitalized for lithium toxicity. We discovered she didn't have enough money for food, lithium, and insulin. She also couldn't keep track of how often she was taking her medications or eating full meals.

Intersections of ABI and DV

Domestic violence does not just leave deep psychological scars; it also leaves physical ones, often in the form of traumatic brain injury (TBI). Both brain injury and domestic violence are recognized public health problems in the US. Up to 35% of women's visits to an emergency department are related to injury from ongoing abuse (Randall, 1990). Furthermore, brain injuries occur in up to 36% of domestic abuse related injuries (Varvaro & Lasko, 1993). Children are also victims of domestic violence and are often left with life-long disabilities due to TBI. Shaken Baby Syndrome (SBS), a form of TBI, is the leading cause of child abuse deaths in the US ("Heads Up: Prevent," 2010). In Virginia, 98 children were hospitalized for injuries related to SBS between 2004 and 2008, and 84% were less than one year of age ("Virginia injury update:," 2010). Research findings indicate an urgent need for early evaluation of victims of domestic violence for potential brain injury and its effects (Corrigan, Wolfe, Mysiw, Jackson & Bogner, 2001).

How Counselors Can Help

If you are working with someone who has a history of domestic violence, please considering the following recommendations:

1. *Ask about brain injury*. There are many tools available to assist counselors in screening for brain injury, such as the HELPS (Picard, Scarisbrick & Paluk, 1991).
2. *Connect with resources*. If a person has experienced a possible brain injury, discuss seeking further assistance and assessment, such as neuropsychological evaluations and brain injury case management.
3. *Be flexible.* Work with the person to develop compensatory strategies to minimize any potential effects of a brain injury, such as short term memory loss. Tailor sessions around the person's needs, such as offering shorter sessions to mitigate fatigue or providing end-of-session summaries to assist in remembering the work you do together.

Reach out to other providers. Crossroads to Brain Injury Recovery, a community-based case management program in the Shenandoah Valley, is great resource for providers seeking to learn more about acquired brain injury, its potential effects, and strategies for working with individuals with ABI. ♦ Elizabeth Lincoln

We all need to be asking survivors of domestic violence about potential brain injuries and be willing to provide services in the context of a person's brain injury. Victims like Carol should not have to wait until multiple hospitalisations gives them the access to services they need in order to live successfully and happily in their communities. To learn more, visit our website at http://www.c2bir.org or contact Elizabeth Lincoln at elizabeth@c2bir.org.

References Available Upon Request

Youth's Needs Not Being Met…Community Response

When I first started in my position with the Office on Youth as the SAW Coalition's Gang Prevention Coordinator, I had very little knowledge of youth gangs. As I went to trainings and began researching gangs, I found that individuals who would submit themselves to the level of physical abuse that many of these gang members endured just to be part of a gang did so for a reason that made perfect sense to them. I wondered what that reason could be.

Diving into my work, I had the opportunity to build relationships with youth and young adults who were identifying themselves as "gang members". They let me into their past and their present. They talked about their earliest recollections as children. I heard about their family lives, their school lives, their "gang" lives. I would be lying if I didn't tell you that I had to pick my jaw up off the floor when I heard some of the stories, about the hardship they endured and the criminal activity they had been involved in. From all of those discussions with those individuals, there was one common theme. These individuals were getting their basic needs met in a very dysfunctional way…a way that was very foreign to me. This is when I thought of Abraham Maslow's Hierarchy of Needs.

Maslow used a pyramid to visualize the building up of needs. As one need is met another presents itself until we reach our full potential, the top of the pyramid. The first set of needs at the bottom of Maslow's pyramid are the *Physiological Needs*-like food, shelter, and clothing. Because of their unstable family lives, these individuals reported that they received food and shelter more consistently from people who were in a "gang" then their own guardians. This was the start of the bond or the hook between the "gang" and the individual.

With that need being met the next level that presented itself was *Safety*. Again, the "gang" offered the individual protection. Sometimes this protection was against the youths own family members who were abusing them…sometimes it was against other youth. It didn't matter what they were offering the protection from; the important thing was that again the gang was there to help the individual reach the next level of Maslow's hierarchy of needs. At this point, the next level of *Love and Belonging* became very easy to achieve because the "gang" had already laid the foundation. The "gang" was now wrapping their arms around this individual, and feeling more and more like a family. The dysfunction continues as the individual progresses up the pyramid to the *Esteem* level. By now the individual is willing to do anything for the gang (family). Getting beat-in shows the new family the individual's level of love and belonging, along with gaining their respect. So the beat-in occurs.

In realizing how this individual gets to this level it becomes necessary for us to understand that asking a now gang member to make a transition to a "normal" functional thought system will take time. We have to undo what has been done. This does not mean we do not hold the individuals accountable for their actions; it just means we have to have an awareness of a possible explanation about how they got to where they are.

The SAW Coalition is a community Coalition whose mission is ***to create and implement intentional strategies to prevent youth from involvement in criminal gang activity, drug use, violence and other risky behavior***. As the SAW Coalition puts in place strategies to prevent identified youth from taking the path to a gang lifestyle and to intervene with the youth who are on this path we have to think about undoing the process and putting protective factors in place that will prevent the process from happening. Some of the strategies we have used are to strengthen neighborhoods and families by providing for their basic needs. We have also used educational presentations to bring awareness of gangs and substance abuse into the community. When people have knowledge they have a tool to do something differently. One strategy the Coalition is using the Comprehensive Gang Model. This is an evidence-based model which has been proven effective in addressing youth gangs. We are in the strategic planning process of this model. The SAW Coalition is looking forward to connecting our community in a way that the community can become the support for our youth – not the "gangs". ♦Diane Kellogg, Office on Youth

Stalking

According to the CDC, 24 people per minute are victims of rape, physical violence, or stalking by an intimate partner in the United States. Stalking is defined as "unwanted and repeated communication, contact, or other conduct that deliberately or recklessly causes people to experience reasonable fear or concern for their safety or the safety of others known to them." The stalking might be indirectly or implicitly threatening to the person. Stalking can persist for months or even years. Women tend to experience stalking more often than men. One in 6 women have experienced stalking during their life compared to 1 in 19 men. In Virginia it is estimated that 11.3% of women experience stalking during their lifetime. About 20% of stalking victims consult doctors about mental or somatic symptoms, but fail to tell the doctor about the stalking.

Stalking turns violent 32% of the time and is sexually violent 12% of the time. While much of the violence committed by stalkers can be minor, stalkers can attack and kill their victims. More serious violence seems to be associated with stalkers who have not had prior criminal convictions and who visit the victim's home. They tend to be unemployed, have had an intimate relationship with the victim, and issued written or verbal threats. Some of the identified risk factors are:

Table 1. Factors in the Guidelines for Stalking Assessment and Management (SAM)

Nature of stalking factors	Perpetrator risk factors	Victim vulnerability factors
N1. Communicates about victim	P1. Angry	V1. Inconsistent behavior toward perpetrator
N2. Communicates with victim	P2. Obsessed	V2. Inconsistent attitude toward perpetrator
N3. Approaches victim	P3. Irrational	V3. Inadequate access to resources
N4. Direct contact with victim	P4. Unrepentant	V4. Unsafe living situation
N5. Intimidates victim	P5. Antisocial lifestyle	V5. Problems caring for dependents
N6. Threatens victim	P6. Intimate relationship problems	V6. Intimate relationship problems
N7. Violent toward victim	P7. Non-intimate relationship problems	V7. Non-intimate relationship problems
N8. Stalking is escalating	P8. Distressed	V8. Distressed
N9. Stalking is persistent	P9. Substance use problems	V9. Substance use problems
N10. Stalking involves supervision violations	P10. Employment and financial problems	V10. Employment and financial problems

Victims of staking should not have contact with the stalker. Contact, which could occur in the form of responding to an email, speaking to the stalker on the phone, or contact through mutual friends, tends to escalate stalking behavior. Informal police warnings are also ineffective; these warnings are often given over the phone and are not attached to a formal warning letter or interview.

Some stalkers feel a sense of entitlement about the victim. Generally this sense of entitlement is only apparent in the stalking situation and does not carry over to the rest of the stalkers life. In their mind they have a right to the victim's time and attention regardless of the effect upon the victim. Stalkers also appear to show a marked indifference to their victim's feelings, especially the victim's fears and desires. Occasionally the stalker takes pleasure in the victim's fear and distress. Finally stalkers appear to have skills deficits that are causing them to develop stalking behavior.

An intervention that appears to help reduce the stalking behavior is the involvement of mental health professionals.

Stalking cont.

Especially when done in conjunction with legal sanctions, it appears to be the best method for handling the stalking. When treating a stalker the first thing to do is to perform a risk assessment specifically designed to assess stalking behavior, such as the Stalking Assessment Manual (SAM). There is little data or studied about how to treat stalkers, but it appears that stalking is motivated by a wide range of psychiatric issues. Delusional disorders, schizophrenia, bipolar affective disorder, and major depression frequently co-occur with stalking behavior. In many stalking cases the stalker has a diagnosable personality disorder. The three most common personality disorders associated with stalking behavior are borderline, histrionic, and narcissistic personality disorders.

While there is not a lot of data available about how to treat stalking behavior, it appears that a combination of legal sanctions, mental health counseling, and psychopharmacology has had the best success in stalkers with psychological disorders. For stalkers with personality disorders, a lengthy treatment targeted to the personality disorder is required. Effective counseling should help stalkers develop the skills that they currently lack which prompted them to to turn to stalking to get attention or form a relationship. ♦Jorli Swingen

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Client Stalking Behavior: What Counselors Should Know

As a counselor you are in a professional role where you are safe from stalking behaviors, right? Unfortunately this is not true. Mental health professionals are more likely to be stalked than any other professional. In 1996 a study reported that 5% of counseling center staff had been stalked by clients and that 64% experienced some sort of harassing behavior by clients. IN 1998 a second study found that approximately 33% of psychiatrists had been victims of stalking by a client. Stalking can cause counselors to experience high levels of stress, fear, helplessness, and disenchantment.

The clients who are engaging in the stalking behavior are not the ones you might think. Most stalkers do not have a prior history of stalking; however they do appear to have a history of self-harming behavior. They tend to target staff who are directly involved in their care. While both genders can stalk mental health professionals and their staff, it appears that female stalkers are more likely to target professional contacts. Male mental health workers appear to have a greater risk of being stalked over their life time then their female counterparts.

Stalking behavior is complicated. Many people who engage in stalking behavior targeted at mental health professionals suffer from significant psychological disorders. Some of these clients tend to have difficulty forming and maintaining relationships, and might misconstrue the intimacy that develops in as a signal that the counselor would like to have a broader relationship. During termination if a client feels rejected by their counselor, stalking behaviors might develop. Some clients who stalk counselors have also gotten angry or decided that the victim betrayed her in some way. Mental health care professionals who are exposed to antisocial or threatening behavior on a regular basis may have a higher degree of tolerance, leading them to minimize threats . Some counselors may be resistant to reporting the stalking due to feelings of guilt, concern over what their peers might think, or feelings of inadequacy.

It is very important for counselors and staff to be educated about potential stalking behaviors in their clients. Organizations should have a zero tolerance policy concerning threats, and also have a policy and protocol in place about how to respond to inappropriate behavior by clients. Responses must be immediate. Not tolerating inappropriate behavior not only protects the staff and their loved ones, but it also lets clients know the consequences of their behavior. When a client is identified as engaging in inappropriate behavior, all employee that might come into contact with the client need to be informed so they can document and report any concerning behavior. Finally, organization needs to be prepared to follow through on warnings, since failing to do so increases the risk for boundary violations. ♦ Jorli Swingen

CVCA Fall Workshop

Collaborative Care: Working with Clients Who Have Disabilities Across the Lifespan

The CVCA Annual Fall Workshop held on Friday, October 21, 2011 at Blue Ridge Community College was well attended. Led by outstanding presenters, Elaine Almarode,M.Ed, Lisa Ellison, M.A.T., and Faith Patterson, MA/Ed.S , the program covered the following topics: confronting personal biases and perceptions of people with disabilities; increasing knowledge of disability categories and disability laws; developing an understanding of individual roles and methods for collaboration; learning new strategies for working with clients who have disabilities; and increasing knowledge of local, state and national resources for working with clients who have disabilities. Attendees shared their experiences and knowledge and had many questions answered. Everyone was encouraged to "think about capabilities instead of disabilities" for each client they counsel and to give that person time and steps to accomplish something so that he/she will feel capable. It is important that learned helplessness is avoided and clients feel self-sufficient.

Current information on school and community changes and requirements were covered. School systems are moving away from a discrepancy model and to the RTI model, which targets all struggling students regardless of their disability status. The ASCA Model has had a strong influence on this change. Faith Patterson, who works at Woodrow Wilson Rehabilitation Center, discussed the Americans with Disabilities Act (ADA), and offered examples of how Title I deals with employment, Title II deals with public services, Title III deals with public accommodations, Title IV deals with telecommunications (TTY) and Title V grants protection against retaliation by anyone who is advocating for a person with disabilities. It's important for counselors to understand the various facets of this law to ensure that their clients get access to needed services. Currently, funding of resources is a barrier to some clients receiving services as most agencies in Virginia are presently booked to capacity.

Electronic handouts on People First Language, SPED Acronyms, Sensory Strategies and The Ten Commandments of Communicating with People Who Have Disabilities, as well as the powerpoint for the presentation were made available to everyone. All counselors should read and follow the Ten Commandments.

The post conference survey of attendees indicated that people learned appropriate ways to communication with people with disabilities, and were encouraged to use the word "accessibility" instead of "handicapped." They learned about "People First" language, were made aware of crisis/evacuation sensitivities, and also about items in our offices that could either be helpful or distracting to our clients. Two areas that people indicated they would like more information included: school counselors working with Special Education Teachers on transition plans, and legal vs. ethical considerations when they seem opposed to each other.

The workshop was very informative and interesting. Attendees wrote that it was an excellent workshop full of helpful information. It was very powerful to hear from Faith, a JMU Counseling Program alumnus and counselor living with a disability, as this is her journey. CVCA would like to extend a special thank you to all the people who made this workshop a real success.

Ten Commandments of Communicating with People Who Have Disabilities

(Diversity World, 2011)

1. Speak directly rather than through a companion or sign language interpreter who may be present.
2. Offer to shake hands when introduced. People with limited hand use or an artificial limb can usually shake hands and offering the left hand is an acceptable greeting.
3. Always identify yourself and others who may be with you when meeting someone with a visual disability. When conversing in a group, remember to identify the person to whom you are speaking. When dining with a friend who has a visual disability, ask if you can describe what is on his or her plate.
4. If you offer assistance, wait until the offer is accepted. Then listen or ask for instructions.
5. Treat adults as adults. Address people with disabilities by their first names only when extending that same familiarity to all others. Never patronize people in wheelchairs by patting them on the head or shoulder.
6. Do not lean against or hang on someone's wheelchair. Bear in mind that people with disabilities treat their chairs as extensions of their bodies. And so do people with guide dogs and help dogs. Never distract a work animal from their job without the owner's permission.
7. Listen attentively when talking with people who have difficulty speaking and wait for them to finish. If necessary, ask short questions that require short answers, or a nod of the head. Never pretend to understand; instead, repeat what you have understood and allow the person to respond.
8. Place yourself at eye level when speaking with someone in a wheelchair or on crutches.
9. Tap a person who has a hearing disability on the shoulder or wave your hand to get his or her attention. Look directly at the person and speak clearly, slowly, and expressively to establish if the person can read your lips. If so, try to face the light source and keep hands, cigarettes and food away from your mouth when speaking. If a person is wearing a hearing aid, don't assume that they have the ability to discriminate your speaking voice. Never shout to a person. Just speak in a normal tone of voice.
10. Relax. Don't be embarrassed if you happen to use common expressions such as "See you later" or "Did you hear about this?" that seems to relate to a person's disability.

CVCA Has Another Award Winning Year at VCA!

Central Valley Counselors Association was honored with three of the five major awards during the annual VCA convention, held in Portsmouth, VA. Board member Pat Lynn won the Humanitarian and Caring Person award, and board member Sandy Hite won the VanHoose Career Service Award. Pat and Sandy have given countless hours of service to their professions, the community, and to CVCA over the years. They certainly deserve these honors!

CVCA won the Large Chapter of the Year award for the second year in a row. The VCA awards committee complimented past president, Katie Baird, and current president, Jodi Myers, on the organization's work –especially the newsletter. While Jorli and I are ecstatic that we were honored for our hard work, we would like to extend a special thank you to all of the CVCA members who contribute to this newsletter. We could not do it without your contributions! We would also like to highlight the work of the board and countless volunteers who work tirelessly to make CVCA the dynamic professional organization that it has come to be. Without their hard work, the events and workshops CVCA hosts would not happen.

State Issues in Counseling

Virginia Proposed Budget Eliminates State Money for Child Advocacy Centers

It is very difficult for abused children to tell their stories one time and very traumatic to have to repeat the story again and again to different agencies. Child Advocacy Centers in Virginia help with this problem by coordinating state services, law enforcement, prosecutors and medical services to avoid subjecting children to repeated inquiries regarding their abuse. They offer a warm and welcoming environment with a one-to-one meeting with a trained forensic interviewer. This safe atmosphere aids in getting the information needed to prosecute the abuser with the least amount of stress for the child. The interview is videotaped and law enforcement, prosecutors, and social services may watch the interview on a television screen in a separate room.

It has been reported that Governor Bob McDonnell has proposed eliminating state money for Child Advocacy Centers and for programs aimed at preventing child abuse. According to a report in the Staunton Newsleader, Dec. 24, 2011, the Director of the Valley Children's Center in Staunton, Sara Christopherson, stated that this elimination would be very detrimental since they receive a little over one-quarter of their funding from the state. "McDonnell's December budget proposal eliminates $846,000 in state money for more than 20 child advocacy centers." In a letter to the editor regarding this article, Linda Varney of Crimora stated "This process costs $340 per child. When each agency has to collect its own information…it costs the state $1640." The Staunton Newsletter article continues by stating "The center estimates doing so (offering these services) saves about $1,300 per case because in the past victims had to go through as many as eight interviews and then agencies had to coordinate what was reported among each other. The center (in Staunton), which helps about 120 children and their families each year, saw reports of abuse or neglect jump 17 percent from fiscal year 2010 to fiscal year 2011." The elimination of this funding is disheartening.

Please be aware of all legislative issues regarding our youth during the Virginia General Assembly, which begins on Wednesday, January 11. It is very important that we are aware of the bills, the budget, and the progress of the Senate and the House and that we let our legislators hear from us regarding all of our concerns. We can make a difference.

ACA in the News

Appeals Court Protects the ACA Code of Ethics and GLBTQ Non-Discrimination

In 2010 Jennifer Keeton, a former school counseling student at Augusta State University (ASU), decided to sue the university for actual and nominal damages regarding the remediation plan required by her program. Keeton claimed that she voiced her Christian beliefs inside and outside the classroom on homosexuality and other biblical teachings and was ordered her to undergo a remediation plan, which would include diversity sensitivity workshops. She refused to participate in the remediation plan, stating that it required her to denounce her religious beliefs, and was expelled from the program.

On Friday, December 15, the US Court of Appeals upheld the Southern District Court of Georgia's decision to deny a preliminary injunction against ASU for expelling Jennifer Keeton, a graduate counseling student who refused to participate in a remediation plan aimed at addressing her views on counseling GLBTQ clients.

As a graduate student, Jennifer Keeton openly stated her views to ASU professors and students that she would not be able to counsel GLTBQ clients because of her religious beliefs and that she supported reparative/conversion therapy. In order to address Keeton's deficits in becoming a multiculturally competent counselor, the ASU counseling program faculty created a remediation plan to help Ms. Keeton become comfortable counseling the GLBTQ population. Rather than comply with the remediation plan, Keeton opted to file a complaint against ASU in federal court, as well as a motion to preliminarily enjoin ASU from enforcing her expulsion.

The ACA Code of Ethics featured heavily in the appellate decision. In rebutting Keeton's claim that ASU effectively gave her the ultimatum of "adhering to *the Bible* or to the *ACA Code of Ethics*, "Judge Barkett of the Eleventh Circuit Court explained that the code regulates certain types of speech in the interest of requiring counselors to "separate their personal beliefs from their work".

ACA welcomes the decision of the US Court of Appeals for the Eleventh Circuit, which is available online at http://www.counseling.org/PDFs/ASU_appeals_ruling.pdf

CVCA Dinner Meeting

Thursday February 9, 2012 6:00 PM

Taste of Thai

The Art of Mindfulness in the Counseling Profession

Presented by Renee Staton, Ph.D. and Michele Kielty Briggs, Ph.D.

The intentional practice of mindfulness -- an active process of awareness and attention -- can enhance multiple aspects of our personal and professional lives and enhance our ability to connect with our clients and students. In addition to alleviating stress responses, mindfulness can heighten openness to experience and expand our ability to act with intention. This presentation will offer a brief overview of the tenets of mindfulness as it relates to counseling and provide several exercises and suggestions for developing a mindful approach to counseling.

Please join us for our annual dinner meeting held at the Taste of Thai in Harrisonburg. This event offers CVCA members a chance to socialize in a casual atmosphere while also learning valuable professional information. Dinner will be served family style and guests will have the option of the following meals:

Broccoli Sesame Chicken: Chunks of white meat chicken sautéed in spicy sesame sauce served with steamed broccoli

Pad Talay Stir: Fried combination of seafood in sweet and sour sauce

Pad Thai Tofu: Rice noodles stir-fried with bean sprouts, red tofu, and fried tofu topped with ground peanuts

Combination Fried Rice: Fried rice with shrimp, chicken, and beef



Each meal comes with a spring roll appetizer. The cost is $20.00 per person, and can be paid by cash or check payable to CVCA upon arrival for dinner. This price includes water, soft drinks, or tea. Please bring cash if you would like to purchase alcoholic beverages.

Space is limited, so RSVP to Kelly Brady at kbrady@augusta.k12.va.us no later than February 3rd.

Renee Staton, Ph.D. has been exploring the topic of mindfulness for several years and participated in the Mindfulness in Education Conference in 2011. She is former president of CVCA, VACES, and VCA.

Michele Kielty Briggs is past-president of the Association for Spiritual, Ethical, and Religious Values in Counseling (national and Virginia chapters). She has been trained to use the Mindfulness Based Stress Reduction approach by Jon Kabat-Zinn and has used mindfulness exercises with adults and children.

CVCA Winter Workshop Let's Play: The ABC's of Play-based Interventions

Friday February 24, 2012

Blue Ridge Community College Plecker Workforce Center

8:00 A.M. – 3:00 P.M.

Come join JMU faculty members Anne Stewart, Ph.D., and Debbie Sturm, Ph.D. for a playful day of learning. Researchers argue that play is a critical component of well-being across the lifespan (Brown & Vaughn, 2009). Counselors, psychologists and social workers can help clients by using play-based approaches to resolve emotional and social problems that are interfering with their availability to maintain satisfying relationships, learn, and grow. This presentation will describe the importance of play and play-based techniques in promoting client's mental health, present research evidence supporting the effectiveness of play-based techniques, provide practice in selected play-based techniques, and discuss recommendations for materials to incorporate play-based interventions when working with clients.

Participants will earn 6 contact hours of CEUS. VAPT CEUS are available for an additional charge of $5.00.

The deadline for registration is ***Friday February 17, 2012***.

Registration fees

CVCA/VCA/VAPT members $45, CVCA/VCA/VAPT student members, $35

Nonmembers $65, student nonmembers $55

To register, please go to: http://www.vcacounselors.org/

Anne Stewart is a professor at James Madison and the founder and president of the Virginia Association for Play Therapy (VAPT). She is an educator, trainer, supervisor, and playful practitioner of play therapy.

Debbie Sturm is an Assistant Professor at James Madison University. She has been a Licensed Professional Counselor for the past 7 years specializing in children and families who have experienced abuse, neglect, or violence.

Upcoming Events

Event	Date	Time	Location
Invite, Invest, Inspire,	February 3, 2012	4:30 pm	Blue Ridge Community College; Plecker Workforce
CVCA Dinner Meeting	February 9, 2012	6:00 pm	Taste of Thai, Harrisonburg
The Embodied Self: Deepening Personal Growth of Mind, Body, and Spirituality	February 17, 2012	8:30– 11:00 am	Disciple Center; EMU
CVCA Spring Workshop: Play Therapy	February 24, 2012	8:00– 3:30	Blue Ridge Community College; Plecker Workforce
Introduction to Emotional Freedom Technique (EFT)	February 24, 2012	8:30– 11:00 am	Disciple Center; EMU
In Like a Lion	March 2, 2012	8:30– 11:00 am	Disciple Center; EMU
CVCA Social	March 23, 2012	4:30 pm	Capital Ale House, Harrisonburg
A Seminar in Psychodrama: A Clinical Tool	March 16, 2012	8:30-11:00 am	Disciple Center; EMU
VSCA Convention	March 14-16, 2012	All Day	Marriott City Center New Port News, VA
Living in the New Normal: Helping Children Thrive in Good and Challenging Times	March 22-23, 2012	8am– 4pm	Stonewall Jackson Conference Center; Staunton VA
The Dynamics of Energy	March 23, 2012	8:30– 11:00 am	Disciple Center; EMU
Unraveling Stuck Places in Ethical Decision Making	March 30, 2012	8:30– 11:00 am	Disciple Center; EMU
Using Felt Sensing in therapy and everyday life	April 13,2012	8:30– 11:00 am	Disciple Center; EMU
Invite, Invest, Inspire,	April 19, 2012	4:30 pm	Blue Ridge Community College; Plecker Workforce
AFSP Out of the Darkness Walk, hosted by Chi Sigma Iota	April 22, 2012	12:00– 4:00 pm	Festival Conference & Student Center, Highlands Room; JMU
CVCA Awards Breakfast	April 27, 2012	TBA	Village Inn
CVCA Social	May 18, 2012	4:30 pm	The Clocktower, Staunton

Valley News

Institute for Experiential Therapies Training Series

Eastern Mennonite University

EMU's Institute for Experiential Therapies is offering a variety of training opportunities during the spring 2012 semester including the following:

February 17	The Embodied Self: Deepening Personal Growth of Mind, Body, and Spirituality
February 24	An Introduction to Emotional Freedom Technique (EFT)
March 2	In Like a Lion
March 16	A Seminar in Psychodrama: A Clinical Tool
March 23	The Dynamics of Energy
March 30	Unraveling Stuck Places in Ethical Decision Making
April 13	Using Felt Sensing in Therapy and Everyday Life

All workshops will be held on Fridays from 8:30 AM – 11:00 AM in the Discipleship Center on the EMU Campus. The cost is $60 per workshop, except the Ethics Workshop, which is $40. Please contact Brenda Fairweather at (540) 432-4243 to register. For more information, please send emails inquiries to counseling@emu.edu

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Invite, Invest, Inspire

Pat Lynn and Sandy Hite plan to continue the group opportunity for school counselors "Invite, Invest, Inspire" during the 2010-2011 school year. Meetings will be at 4:30 PM at Blue Ridge Community College's Plecker Workforce Center, Room P124.

GUIDING Tomorrow's Dreams Today

Use the south entrance to BRCC. Parking is on the left, beside the center. This group will meet on the following Thursday Feb. 2, and April 19th. This is an opportunity for school counselors and students in the school counseling field to meet and discuss any situations where they may need assistance and also to share ideas and resources. Everything is confidential - no names of students, teachers, etc. - just an opportunity to get new ideas and helpful suggestions. You are invited to invest a little time and inspire each other by joining Pat and Sandy, have some refreshments and share concerns and current

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Website and Facebook Page

You can now find us on mycvca.org and on Facebook by searching for Central Valley Counselors Association - CVCA. These sites provide professional development opportunities, chapter information, a directory of school counselors, and more!

CVCA

Valley News cont.

2nd Annual AFSP Out of the Darkness Campus Walk

April 22st, 2012

Hosted by Chi Sigma Iota

Chi Sigma Iota is currently in the planning stages for the second annual AFSP Out of the Darkness Campus Walk which will be held on Sunday, April 22st, in Harrisonburg, Virginia. We hope you will plan to attend and will consider volunteering at this very meaningful event that supports many members of our community. Information regarding the walk will be emailed to CVCA members and will be available on the JMU Counseling Program webpages. For more information, please email Lisa Ellison at ellis2la@dukes.jmu.edu, or Grace Jimenez at gkjimenez@gmail.com.

Living in the New Normal: Helping Children Thrive in Good and Challenging Times

March 22 – 23, 2012
8:00 Am – 4:00 both days
Stonewall Jackson Conference Center
24 South Market Street
Staunton, VA 24401

You are invited to the **Living In the New Normal: Helping Children Thrive In Good and Challenging Times Institute**, presented by The Military Child Education Coalition (MCEC)™, a nonprofit organization addressing the educational needs of children in military families. This training is designed for Family Readiness Group leaders, first responders and other concerned adults to gain strategies and practical applications to increase resilience in military-connected children. **There are NO COSTS to participants.** For more information about this institute, please contact Laura Wood at 254-953-1923 or Laura.Wood@MilitaryChild.org. Please visit www.MilitaryChild.org click the Upcoming Trainings to register. Funded by OSD

16th annual Summer Institute in Counseling at James Madison University

"Holistic Healing: The Mind/Body Connection in Change"

Mark your calendars! The 16th annual Summer Institute in Counseling will run from Wednesday, June 13 – Monday, July 2, 2012. It will include thirteen different sessions ranging from manualized treatments such as DBT and Motivational Interviewing to courses for graduate credit such as Human Sexuality and Development to various aspects of mindfulness and alternative therapies such as Egala Equine assisted therapy. The Summer Institute Flyer will be emailed to CVCA members around March 21st. It will also be available on the Counseling Program webpages. Registration will open on Monday April 2nd, 2012. For more information, please email Lisa Ellison at ellis2la@dukes.jmu.edu.

The Neurobiology of Trauma: Implications for Play Therapy Interventions

Presented by
Richard L. Gaskill, Ed.D., RPT-S
Fellow of the Child Trauma Academy
Deputy and Clinical Director of Sumner Mental Health Center, Wellington, Kansas

Friday, January 27, 2012
9:00 am to 4:30 pm
Crowne Plaza Richmond Downtown Hotel
555 East Canal Street
Richmond, VA 23219

You are invited to attend **The Neurobiology of Trauma; Implications for Play Therapy Interventions.** The workshop is co-sponsored by the Virginia Association for Play Therapy and the Institute for Continuing Education. We are pleased to offer this one-day workshop full of learning and fun with accomplished leader and therapist, **Rick Gaskill**. Rick is a Fellow of the Child Trauma Academy and has served as the president of the Kansas Association for Play Therapy. We hope you can join us!
REGISTER ONLINE at http://vapt.cisat.jmu.edu/ winterconference12/index.html

Happy New Year to everyone! We hope you had a relaxing break, and that you are hopeful about all that this year will bring. The beginning of the year is a great time to take stock of the blessing we all have, the strengths we carry with us, and the goals we have for the coming year. We want to thank all of the wonderful contributors to this newsletter for your articles. You are the voice of CVCA and the reason we have such a high quality publication.

Lisa Ellison

Jorli Swingen

Both Jorli and I will graduate this spring, and will be moving out of the CVCA area. We are currently looking for newsletter editors for the 2012 – 2013 year. Working on the newsletter is a great way to network, learn more about the wonderful people in our community, and to ensure that CVCA continues as an award winning professional organization. We will publish one more newsletter for this year in mid-March***. If you are interested in working as an editor, you are more than welcome to shadow us as we prepare this publication.***

We would like to thank the following people who graciously offered their time and experience to make this possible: Elizabeth Lincoln, Vanessa Olson, Lauren Anne Copley, and Sandy Hite.

We are currently accepting articles, book reviews, personal experiences, and questions regarding our next theme: **Working with Military Families**. Please send all submissions to cvca17@gmail.com. As always, you are more than welcome to submit articles outside of the theme. Also, don't forget to send us information regarding trainings that might be of interest to our members.

Have you moved or changed your e-mail address?
If so send us an e-mail at cvca17@gmail.com