



THE COUNSELOR

Focus on: Grief + End of Life Issues

President's Message

Happy Spring, ORCA community!

Thank you to everyone who participated in our election for President-Elect and Treasurer. We are delighted to welcome our new President-Elect, Alana Ogilvie, and our new Treasurer-Elect, Laurie Kerridge. [Alana](#) is an LMFT in private practice at Portland Sex Therapy. She also currently serves as ORCA's Membership Chair. During her tenure as Membership Chair, Alana has made some phenomenal updates to our membership database and outreach, which have led to membership growth and retention. I'm excited to see her skills applied to the ORCA Presidency. Welcome Alana! Thank you for your leadership! [Laurie Kerridge](#) is an LPC intern in private practice; she is also a licensed tax accountant with over 25 years of accounting experience specializing and working primarily with small businesses. Welcome Laurie! Alana's and Laurie's respective terms will begin June 1st, 2018, and they will both be sworn in as elected ORCA officials at our July Board meeting.

Of course, with the excitement of welcoming Alana and Laurie comes the ending of the tenures of two esteemed ORCA officials, Raina Hassan, our Past President, and Kara Eads, our current Treasurer. [Raina](#) was chiefly responsible for our rebranding effort that took place in 2016, and her work as President resulted in ORCA receiving the Five-Star Branch and Innovative Practice awards from the American Counseling Association. [Kara](#) has brought an incredible thoroughness and attention to detail to her role as Treasurer that have been instrumental in helping ORCA anticipate and navigate budgetary issues on numerous occasions. Thank you Raina and Kara for your service to ORCA! You have both made incredible contributions that will leave a lasting positive impact on our organization.

I would also like to take this opportunity to introduce you to ORCA's new Communications Chair, [Melissa Chernaik](#), who was appointed to this role at our March Board meeting. Melissa has been involved with ORCA and COPACT for several years, and used to work in politics and public relations, so the skills and experiences she brings in will be highly applicable. Welcome Melissa!

In other news, we are delighted to announce a new benefit for ORCA members stemming from an exciting new partnership between ORCA and [Person Centered Tech](#), a Portland-based company providing mental health professionals with guidance and consultation regarding technology security. Person Centered Tech has agreed to provide ORCA members with quarterly "office hours", for which you can submit your consultation questions to be answered in a webcast that will be available only to ORCA members. You will be able to watch the webcasts live online or any other time on the ORCA website. We are ecstatic about this opportunity for our members, as this benefit will assist you in ensuring that your policies and practices related to technology are HIPAA compliant and in line with the laws and ethics of our profession. The first office hours session will occur later this month, so watch for communications about how to submit your questions and participate in the webcast.

This edition of *The Counselor* has a special focus on grief counseling, and we hope you find the articles here useful for working with bereaving clients. In February, ORCA hosted a professional development event on Death, Dying, and Grief. We were pleased to see so many of you in attendance! Special thanks to [Gianna Russo-Mitma](#), current ORCA President-Elect, and [Tever Nickerson](#) for coordinating an incredible event!

Sincerely,
Joel Lane, PhD LPC NCC
President, Oregon Counseling Association



The Counselor is the quarterly newsletter of the Oregon Counseling Association

Volunteer Staff

Moira Ryan, Editor

For information about advertising or submitting articles, contact editor@or-counseling.org

Membership Info

Information about ORCA membership may be obtained online at www.or-counseling.org

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The Oregon Counseling Association will not knowingly engage in activities that discriminate on the basis of race, gender, color, religion, national origin, sexual orientation, disability, or age.

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Empowering a profession, one counselor at a time.

Whether you're a student, intern, counselor, or mental health ally: If your job is to support the mental health of Oregonians, then we're here to support you.

Join us.



When Death Makes No Sense

by Ronda Gallawa-Foyt, LMHC

When my father died by suicide I was brought to my knees by overwhelming feelings of shock, disbelief, confusion, pain, guilt, anger, and love for him.



The author with her father

If you've lost a loved one to suicide, you share something profound with others who have experienced this life-shattering event. You are forever a member of a group you never wanted to belong to. Membership in this

group means that you will likely struggle with confusion, anger, pain, and frustration at the person who has died – often all at once. Complicating the issue, you will love the person as much as you loved them before the suicide. The deceased is at once the person you loved, the victim of a horrendous death, and the source of your anguish.

Human beings understand and mostly accept that we will lose our parents to old age. Throughout our lives we experience the loss of friends and relatives due to accident and physical illness. We cope with these events and we find support from those around us because these are universal experiences. However, we *don't* know how to cope with the loss of a loved one when the death makes no sense or when it is a kind of loss that rarely occurs in an average person's life—as when we lose a child, when someone we love is murdered, or when we lose someone to suicide.

Most of us don't know how to deal with the complex feelings that arise from these kinds of traumatic losses. Complicating matters, we often feel isolated because the people who care for us and would otherwise be our support

system don't know how to relate to us, and though they want to help, they don't really understand how. Because they don't know what to say or how to help – and because it is painful for them to watch us suffer – too often they want us to *just move on*.

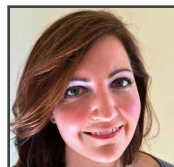
If you've lost someone you loved to suicide, you are not *imagining* how bad the pain is.

There is no way to avoid grieving. There is no way to circumvent the painful journey ahead. It isn't fair and you didn't volunteer for it but you have no choice but to find your way through the darkness.

It's often said that time heals all wounds. I do not believe this. Time can ease pain but we are complex beings and maintain feelings of love, and therefore the pain of loss, all our lives.

But there is hope: my father died twelve years ago and my pain is now manageable. After the first horrible year the anguish began to dissipate and though it has been a difficult path, I have since learned to accept a life without him and to once again embrace happiness. The pain I feel from his loss will never go away but now I can think about my dad without crying. I've come to terms with his death and I'm no longer consumed by pain.

You can find peace too.



Ronda Gallawa-Foyt, LMHC owns [New Direction Counseling](#) in downtown Vancouver. Her specialties include working with people who have lost someone to suicide – both individually and in group. She also enjoys working with couples and individuals who strive to bring joy to their lives and relationships. Her book, *The Weight of Ashes*, will be released winter 2018. [Contact her](#) for more info.

Culture and Grieving "Well"

by Eliza Alvarez McBride, Graduate Student

When I was 12 years old, my family and I flew from America to Southeast Asia to visit my ailing grandfather. To my relief, my grandfather made a recovery, and surprisingly, it was my great-grand uncle who passed away suddenly. After learning of his death, relatives immediately began reciting prayers and weeping openly. I recall how my parents, siblings and I sat there awkwardly, feeling out of place. The only other funeral I had attended at that point was at an American church; the service was subdued, and the following day everyone went back to work. On the other hand, when my great-grand uncle passed away, relatives took time off, made several tables worth of food, and spent days eating and sharing stories. I would remember that time again nearly ten years later, after getting a message that my grandfather had passed away. I read that message alone in my college dorm room, aware that I had work and class early the next day. I had to schedule time to cry. I told a classmate about my grandfather's passing, and her reply was, "You seem to be grieving well." What did that mean?

Now, as a student intern at a domestic violence center, many of the survivors I provide counseling for are processing forms of complicated grief and mention wanting to "grieve well." Some survivors are mourning the loss of a decades-long relationship, feeling conflicted that they could miss an abusive partner who is now incarcerated or cut off. Most survivors are mourning the loss of the future they envisioned and hoped for, and some are mourning past abusive partners who took their own lives shortly after the survivor fled the relationship – in these cases, grief is layered with feelings of guilt and confusion. In all cases, clients understandably feel like they don't have time to grieve or mourn.

As I continue studying and incorporating feminist therapy into my counseling identity, I'm beginning to identify "grieving well" as a reflection of American patriarchal and capitalist culture. This includes deeply ingrained beliefs that we should not outwardly express emotions that may imply weakness (e.g. sadness), out of fear that it may be an affront to masculine qualities that patriarchal society values (e.g.

being "tough"). There seems to be a general fear that openly grieving may negatively affect the capitalist mindset of productivity. There is also a sense of competition, i.e. if we're going to grieve, we should grieve better than everyone else (and within a certain time-frame). This is something that I hope to study further. For now, I validate mourning rituals that may include taking time for camping trips, or simple practices like lighting and blowing out a candle every day to acknowledge that grief is now part of one's everyday life. I share that tears aren't a sign of weakness, and weakness isn't an absence of strength. I ask clients what "grieving well" would look like for them, specifically, if they didn't feel bound by cultural expectations, societal pressures and time-tables.



Eliza Alvarez McBride is a graduate student at Portland State University studying Clinical Mental Health Counseling. Her goal is to provide trauma-informed services to historically underprivileged communities.



CONTINUING ED OPPORTUNITIES

ESTABLISHING HOPE: DEVELOPING A CULTURALLY RESPONSIVE CLINICAL PRACTICE THROUGH AN AFRICANA PARADIGM (meets cultural competency requirement)

FRIDAY, JUNE 1, 2018 4.0 CEUs

THE NEUROBIOLOGY OF TRAUMA

FRIDAY, SEPTEMBER 28, 2018 4.0 CEUs

UPCOMING TOPICS IN 2019:

OPIOIDS AND PAIN MANAGEMENT
EMOTIONALLY FOCUSED THERAPY (EFT) FOR COUPLES

To Register: PacificNWProviders@gmail.com

Learn more: <http://www.pacificnorthwestproviders.com/events>



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&

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Person Centered Tech is now a Partner of ORCA

PCT demystifies the legal and technical topics that are required of counselors by providing education, tools and resources required to help make your business successful. PCT helps ensure digital safety for your clients while obtaining your continuing education credits.

May 31st at 10am–12pm PCT will hold a special “Office Hours” session, a live broadcast Q&A, just for ORCA members.

Members will be able to email PCT their technology security and digital ethics questions and Roy Huggins will answer those specific questions during the session. Join the podcast live or access a recorded session directly from the ORCA website.

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No Platitudes, Please

by Kris Fant, LPC, LMHC

The most well-meaning person may still occasionally find themselves saying “time heals all wounds” or “it was meant to be.” As mental health counselors, we need to hold ourselves to a higher standard. We must recognize the grief that accompanies life, and hold space as clients experience the various dimensions of grief, allowing them to find their way through.

A platitude is a trite statement meant to assuage emotional discomfort. You might be surprised at the number of clients I have heard whose counselors offer platitudes when a client is grief stricken about a significant. “Things will look better tomorrow.” “He’s in a better place.” In our culture, we may be trained to offer these cliches to alleviate another person’s discomfort, but as counselors, we must make space for difficult feelings. People need time and space to enter into the process of grief, and we need to learn to manage our own discomfort so we do not interfere with the client process.

Grieving can be triggered by numerous life events. In my work with people managing persistent pain, I find people wrestling with thoughts like “if only I hadn’t moved that shelf” or “If I could go back, I would have stopped for one more second at the stop sign.” As counselors, we may notice these as thoughts of the past, and challenge people to utilize the skills of mindfulness or CBT to bring their awareness into the present. While this is an important and noble goal, we must not rush too quickly past the grieving. We can help people get into their lived experience of this bargaining. “Where do you feel it in your body when you think about not moving the shelf? What happens to your breath? What do you notice in your hands, shoulders, back?” Often people will talk about loss of time at work or being unable to play with children. These losses must be mourned.

I sometimes meet with people who are incredibly angry. They are angry at their family, their job, their insurance, their doctor, the medical system, and, inevitably, me. An angry person may be grieving a significant loss that they are not yet ready to accept. As counselors, our job is to help people get in touch with their anger, validate the emotion, examine the behaviors, and figure out how to let this emotion move through them. There can be a temptation to focus on the behavior instead of the feeling of anger, because we were not all equipped to deal with anger in the therapy office. There are obvious limits; threats or self harm are clear boundaries. But how validating can it be for a client to yell, shake their fist at the sky, and let out the anger that everyone has been scared to sit with? Slowly, if we can validate and build rapport, we can learn what role the anger serves, and help clients discover skills for recognizing, using, and releasing anger that no longer serves its original purpose.

More than anger, deep sadness and guilt often permeate the life of a person managing persistent pain. When they discuss this with their doctor, the diagnosis is often depression and medication is prescribed. People whisper “the medication doesn’t work.” Too often, it is not a chemical depression but a reexamination of life that is triggering this sadness and guilt.

(Continued on p. 7)

**We are trained to offer cliches,
but we need to learn to
manage our own discomfort
so we do not interfere with our
clients’ process of grief**

(No Platitudes, Please continued from p. 6)

Sometimes medication can help lift spirits enough to re engage people, and sometimes no amount of chemicals can touch the hopelessness. In this situation, we follow our clients down the proverbial rabbit hole. Resisting the temptation to tell them we understand how they feel, that we have had pain too, or that life is about making lemonade out of lemons, we must hold the space for them to cry, to feel deep guilt about the changes that may happen due to this medical condition, and to face the hopeless future. As we stare into the bleak darkness with our clients, the light of connection is born. On their own, they will find their deepest values, and realize that this sadness has served its role. Together we will discover ways clients can pursue a meaningful life, perhaps completely different than the one they had planned, but a life that honors their goals and values.

If, as counselors, we recognize and sit with the discomfort of grief, we are also role modeling how our clients can manage when the waves of grief return unexpectedly. Our clients will have learned that fighting means getting stuck, and feeling allows moving forward. And for goodness sake, please don't tell them that "God never gives us more than we can handle." Let their loved ones share cliches, while you lead them on the true path to acceptance.



Kris Fant, LPC, LMHC is a mental health counselor at [Progressive Rehabilitation Associates](http://ProgressiveRehabilitationAssociates.com), working with people who are managing persistent pain or traumatic brain injuries. When she is out of the office, she dual sports her way into the woods on two wheels to reconnect with nature and herself.

Upcoming Workshops for Counselors & Therapists

Center for Community Engagement at Lewis & Clark Graduate School of Education and Counseling

Friday, May 18, 9 a.m.-12 p.m. | 3 CEUs

Supervisee Non-Disclosure James Gurule, MA, LPC

Friday, July 27, 9 a.m.-1:30 p.m. | 4.5 CEUs

Transgender: A Decolonizing Framework for Transitioning in Clinical Practice

Pilar Hernandez-Wolfe, PhD, Stace Parlen, LMFT Intern

Friday, August 24 & November 16, 9 a.m.-5 p.m. | 30 CEUs

Using Dreams in Private Practice and for Personal Development

Pilar Hernandez-Wolfe, PhD

Saturday, October 13, 9 a.m.-4:30 p.m. | 6.5 CEUs

Talking About Race and Racism: A Developmental and Integrative Approach

Cheryl Forster, PsyD

Friday, October 26, 8:30 a.m.- 4 p.m. | 12 CEUs

Listening to the Body: Yoga Calm for Therapists Lynea Gillen, LPC, RYT-200

Friday, November 2, 8:30-4:30 p.m. | 7 CEUs

Optimizing the Role of the Mental Health Provider: Letter Writing, Surgery Planning, and Affirmative Assessment for Transgender/Non-Binary Individuals Pilar Hernandez-Wolfe, PhD, Stace Parlen, LMFTI, Lindsay Walker LMFTI

Portland United Against Hate

A free set of workshops providing attendees with the information, skills and resources necessary to support their actions in resistance to hate and bias.

Wednesday, May 30, 5:30-8 p.m.

Knowledge is Power: Your Legal Rights in a Time of Uncertainty

Aliza Kaplan, JD, Lewis & Clark Law School

Friday, June 8, 1-5 p.m.

Intersections of Hate: Trans Exclusionary Radical Feminism (TERF) and the Far Right

Jenn Burleton, TransActive Gender Center

Saturday, June 16, 10 a.m.-12 p.m.

Managing Compassion Fatigue and Burnout

Evan Dumas, MA, Support Coordinator, ORCA

More at go.lclark.edu/graduate/counselors/workshops



PD&E Update

by Gianna Russo-Mitma, ORCA President Elect

Last month, the Oregon Counseling Association was thrilled to host a great Professional Development & Education (PD&E) event - our first in two years! The turnout was overwhelming: we had about 60 attendees (including some folks who opted to attend via webinar) and we were excited to meet many new members. We're so honored we had the opportunity to learn with you.

We are looking forward to hosting y'all for another clinically focused training in late summer 2018, so keep an eye out for the save the date, and keep in mind that we truly take your evaluations to heart. Hope to see you soon!



Melinda Laus & Dr. Anissa Rogers



ORCA Secretary Sofia Jasani, PD&E volunteer Tever Nickerson, Past President Raina Hassan, President Elect Gianna Russo-Mitma

(Susan B. Zall)



Professional Development & Education presents:

"Death, Dying, & Grief"

Friday, February 23, 2018 @ 8 am - 5 pm or via Webinar
Mark Spencer Hotel, 409 SW 11th Ave, Portland, OR

6 CE's available (Cultural Competency included)

Speakers & Topics:

"Grief Basics & Cultural Components of Death" (3 CE's)

Anissa Rogers, Ph.D., LCSW & Melinda Laus, Ed.S., LMHC

"Working with Children and Teens Experiencing Grief & Loss" (2 CE's)

Jana DeCristofaro, LCSW, The Dougy Center

"Death in the Workplace" (1 CE), **Susan B. Zall, LPC, NCC**

Prices: (in person & webinar)

ORCA Member \$130

Non-Member \$180

Join ORCA now & attend \$155

Students & Interns \$100

Day of/At the door \$200

Limited space available so register now:

www.or-counseling.org/PDE



The Oregon Counseling Association has been approved by NBCC as an Approved Continuing Education Provider, ACEP No. 2038. Programs that do not qualify for NBCC credit are clearly identified. The Oregon Counseling Association is solely responsible for all aspects of the programs.

photos by Gianna Russo-Mitma

Grieving Gendered Selves: The Cycle of Death and Rebirth in the Gender Journey

by Sasha Strong, PhD (cand.), LPC Intern

Finding out who I am as a person is an unfolding journey that has taken me through the uncharted waters of gender, identity, sex, power, and privilege (Bornstein, 2013). During this process, I have felt trapped, stuck, confused, angry, overwhelmed, powerless, ashamed, despairing, and joyful. Similarly, my trans* clients have experienced waves of confusion, disorientation, anger, grief, sadness, loss, and the discovery of something new. These emotions accompany different chapters of the journey of gender, as my clients and I have moved from a received/socialized gender identity into expanding vistas of gender possibility and freedom. As counselors and therapists, we can help people in their journeys of becoming their unique selves, by midwifing people through the process of becoming a new self, recognizing that self, growing into it, giving it up, and grieving the self—then beginning the cycle anew.

Our society recognizes but a few thresholds of grief: the death of a loved one, the end of a career, the loss of a home or property due to theft or disaster. In the clinical setting, we have insight into a few more sources of grief, some linked to changing roles due to circumstances and life transitions: birth and postpartum depression, children growing into adults and leaving the home, mid-life crisis, retirement, or the accomplishment of a major project. These grief processes are often understood as role changes, or adjustments of a person's narrative and self-image to a new situation.

In the case of my ongoing nonbinary/genderqueer gender transition, my experience has been of multiple layers of self that bloom into awareness, ripen, wither, and die, only to reveal something new. Possibly this understanding is influenced by my background in Buddhism, which holds that the self is a fluid phenomenon, characterized by constant change— and thus open to possibility and improvisation. My gender transition, which is revealing itself as a journey without specific goal or endpoint, has involved the coming-into-awareness of a variety of feelings, wishes for gender expression/performance, and associated body states.

For example, an emergent transfeminine identity which has clarified over the last six months, feels graceful, vulnerable, gentle, kind, and open. Although I have had these sorts of feelings before in my life, this mode of being dominates my awareness lately. In the realm of outer gender markers associated with this self-state, I have bought more makeup and have begun studying feminine fashion. These gender performance options swim in my awareness like notes or chord progressions I could play in the spontaneous improvisation of life, an expansion of repertoire rather than a monolithic endpoint to be practiced and mastered. In this way of doing gender, it is much

(Continued on p. 10)



(*Grieving Gendered Selves continued from p. 9*)

more interesting to learn jazz improvisation and mash up genres, rather than practice and perfect a single piano masterpiece with perfect technical skill and zero creativity.

With each reach for greater vocabulary and flexibility in my gender repertoire, I have had to mourn previously conditioned gender moves, many of which (in my case) have been male-socialized impulses to cover up and protect against vulnerability and tenderness. Harsh, barking words, gruff body language, and aggressive urges are the automatic gendered impulses I notice and restrain; then, feeling underneath the aggression, I soften into the tenderness of my open heart. Staying with that gentleness in the moment, the hardness and gruffness dissolve, and a sense of sadness arises. I do this over and over whenever I catch these hardened self-states arising. Practicing these skills of self-compassion and open awareness helps me gain greater neural flexibility (Siegel, 2010) and makes me a therapist who can accommodate my clients in their own vulnerability, tenderness, and growth. This is like a dying of the self, and a momentary grieving of who I have thought myself to be.

In these moments of my internal process, the self that is dying is the self protecting the self that is being born. The struggle between protection and tenderness is my transition between the male socialized self and whatever I am becoming in the world. Understanding this as a transitory process of death and dying, of rebirth and becoming, is a helpful metaphor for me because it frames it as a natural process.

In this way of thinking, we are not meant to be an endless constructive process, an edifice or amassing of ideas and experiences. Rather, like a plant, we grow, flower, bear fruit, give seed, and die, to winter over and then be reborn in the spring (Ferrer, Romero, & Albareda, 2005). This process of death and rebirth is mirrored in many cycles of life, and the gender journey is one of them.

References

- Bornstein, K. (2013). *My new gender workbook: A step-by-step guide to achieving world peace through gender anarchy and sex positivity* (2nd ed). New York, NY: Routledge.
- Ferrer, J. N., Romero, M. T., & Albareda, R. V. (2005). Integral transformative education: A participatory proposal. *Journal of Transformative Education*, 3(4), 306–330. <https://doi.org/10.1177/1541344605279175>
- Siegel, D. J. (2010). *The mindful therapist: A clinician's guide to mindsight and neural integration*. New York, NY: W. W. Norton.



Sasha Strong, M.A., Ph.D. (cand.), LPC Intern (they/them) is a psychotherapist in private practice at [Brilliant Counseling](#) in Portland, OR. Sasha specializes in work with queer and trans* clients, Hakomi mindful embodied therapy, and Buddhism and spiritual integration. They recently began a process group for transwomen and transfeminine folks in cooperation with Brave Space LLC, and they have conducted research and offered training on culturally aware counseling with nonbinary and genderqueer clients. [Email them](#) for more info.

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Behavioral Healthcare Series

pdx.edu/ceed/behavioral-healthcare

Foundations of Motivational Interviewing

With Charles Smith
Fri 5:30–9:30pm Feb 23
Sa 8:30am–4pm Feb 24
10 contact hours

Social Security Disability Law

With Bennett Engleman
Fri 5:30–9:30pm Feb 9
Sa 8:30am–4:30pm Feb 10
10 contact hours

Medication Assisted Treatment

With Nickolas Reguero
Fri 5:30–9:30pm Mar 2
Sa 8:30am–4pm Mar 3
10 contact hours

Clinical Ethics: Best Practices in a Changing World

With Doug Querin
Fri 8:30am–4pm Apr 27
6 contact hours

Advanced Motivational Interviewing

With Charles Smith
Fri 5:30–9:30pm May 18
Sa 8:30am–4pm May 19
10 contact hours

Trauma-Informed Services

Certificate of Completion and Workshops

pdx.edu/ceed/trauma

Integrating Brain Science into Trauma Therapy

With Greg Crosby
Fri–Sa 8:30am–4pm Feb 2 and 3
12 contact hours

Understanding Trauma and Crisis Response

With Ann-Marie Bandfield
Fri 8:30am–4pm Mar 9
6 contact hours

Organizational Resilience: Healing the Trauma and Empowering Your Business

With Patricia Davis Salyer
Fri 8:30am–4pm Mar 16
6 contact hours

Trauma-Informed Services Across the Lifespan

With Dawn Williamson
Fri–Sa 8:30am–4pm Apr 27–28
12 contact hours

Trauma-Integrated Clinical Supervision

With Julie Rosenzweig
Fri 8:30am–4pm May 18
6 contact hours

Integrating Narrative, Strength-Based, and Trauma-Informed Therapy

With Susie Snyder
Fri 8:30am–4pm Jun 8
6 contact hours

Understanding Secondary Trauma Through Brain Science and Joseph Campbell Hero's Adventure

With Greg Crosby
Fri 8:30am–4pm Jun 1
6 contact hours

Photo by Ryan Wilcox, MFT

Clinical Supervision

pdx.edu/ceed/clinical-supervision

Supervision for Social Workers

With Matt Modrcin
Fri 8:30am–4pm Feb 9
6 contact hours

Ethics and Legal Issues in Clinical Supervision

With Douglas Querin
Fri 8:30am–4pm Mar 2
6 contact hours

Clinical Supervision

With Lisa Aasheim
Fri–Sa 8:30am–4pm Apr 13–14
Th–F 8:30am–4pm May 10–11
30 contact hours

Trauma-Integrated Clinical Supervision

With Julie Rosenzweig
Fri 8:30am–4pm May 18
6 contact hours

Kathy Lovrien, LCSW, Mental Health and Addictions program manager
lovrienk@pdx.edu | 503-725-8165

Graduate School of Education
pdx.edu/education



An Invitation to Question: Worldview & Death

by Tamara Webb, LPC, LMHC

As a pet turtle is put to rest in a backyard funeral during the amusing film *Sensitivity Training*, a 6-year-old girl asks if everyone dies. An outspoken family friend responds with a simple, flat "Yes."

"OK," the little girl replies, "I'm just going to try not to think about it."

Her choice is affirmed with a truthful rejoinder: "Yeah, that's actually what most of us do."

Yet, as therapists who inevitably encounter clients struggling with loss and death anxieties, giving serious thought to matters of mortality and grief might be a professional responsibility, not unlike the exploration of our "worldview" often encouraged in cultural diversity trainings.

Because fear of death may arguably constitute the basis for civilization itself, each of us holds ingrained, perhaps unconscious, views about the meaning of death and what constitutes "appropriate" mourning.

To discover your worldview of death, consider self-examination or discussion – with colleagues, friends, family – on the following:

Dying

What do you spiritual/philosophical beliefs, and/or your personal experiences, suggest about handling terminal illness and end-of-life decisions? What challenges do you anticipate in discussing these issues with family, friends, clients?

Do you have an Advanced Directive? What are your views on Oregon's Death with Dignity Act?

Death

What do you believe - or suspect - happens at the time of death? Have you ever heard beliefs about death you consider absurd, offensive or ignorant? If so, what informs your views?

What are your earliest memories of death? How do you recall it being explained? Is it OK for children to see a person dying, or observe a corpse? Why or why not?

Grief

What have you learned from your personal experiences of grief?



Photo by Ryan Wilcox, MFT

(Continued on p. 13)

(Worldview & Death continued from p. 12)

Are some demonstrations of grief more “appropriate” based on gender, age, religion or ethnicity? What do you know about grief rituals and practices across cultures?

Is there a hierarchy in grief, where “some losses are more painful than others” (e.g., is it worse to lose a child than to lose a neighbor, friend or pet)? What informs this belief?

What lines do you draw, personally or professionally, to mark the boundary between “appropriate” and “pathological” grieving? On what basis have you come to such a perspective?

What constitutes “successful” grieving? (Hint: Kubler-Ross’s “five stages” emerged from research on terminally ill persons, not those bereaved by death of a loved one...)

Do you have an Advanced Directive?
Is there a hierarchy of grief?
Thoughts on social media condolences?

Mourning

What rituals, if any, are necessary or important to mark the end of someone’s life? How long should a period of mourning last? Are there activities one should avoid, styles or colors of clothing, or hairstyles, one should or should not wear, when in mourning?

Have you ever learned about the death of someone close and significant to you, such as a parent, sibling or dear friend, via social media like Facebook or Instagram? How does this compare to learning the same information via a phone call, text, email, hand-written note? What are your ideas and feelings about using social media to express grief or offer condolences?

.....

Such questions only skim the surface of what we can explore in our understanding of, and cultural beliefs about, death, dying and grief. Consider them a starting point, from which you might ask many more of your own.



Tamara Webb, LPC, LMHC is a psychotherapist and writer in Portland. She can be reached at tamara@fivebodiescounseling.com.





Oregon Career Development Association Presents:

Breaking Into the Tech Sector – With or Without a Technical Background

A Panel Discussion

Thursday, May 10, 2:30-4:30

100 SW Market St, PDX

Come learn from industry experts about the many paths to tech jobs.

Tickets & Details

ocda.ticketleap.com/tech - Space is limited!

Panelists

Annie Thompson, Account Manager/ Software Implementation, CollegeNET

Cathi Row, Manager of Tech Talent Dev. & Change Enablement, Cambia

David Duncan, Tech Sector Job Search Navigator, OED, WorkSource

Sheri Dover, CEO, PDX Code Guild

Happy hour to follow @ [Raven and Rose](#), 5:00 (includes complimentary glass of wine or beer)

Death with Dignity: Clinical Input into Capacity Evaluations

by Harry C. Dudley, PsyD

As a clinician treating a client suffering a terminal illness, it is possible that your client may request from their attending physician a prescription for a lethal dose of medication consistent with the Death With Dignity (DWD) statutes of Oregon, and for those of us practicing on the border, Washington State or California. It is conceivable that the attending physician may have concerns about whether your client is competent or capable of making such a decision, and while you would not be asked to render the ultimate opinion on the matter, which is akin to a forensic opinion, you would no doubt be consulted with concerning your observations and clinical opinion.

The intent of this article is to provide a basic orientation for counselors in Oregon of a few of the relevant statutory factors so that they are better able to consult with other professionals involved in evaluating the client's competence or capacity to proceed with DWD. I will use the term capacity, as it is the term in Oregon, whereas the term competency is used in Washington, but they are synonymous. The Oregon and Washington statutes are very similar, but will underscore those differences as they relate to practice, but the majority of what will be discussed below applies to both states. I will also make reference to aspects of the California statute. Also, please note that I am focusing only on a very small facet of DWD and I encourage you to familiarize yourself with the relevant statutes of your state. Many of us deal with border issues, hence my attention to Washington and California. I have listed below relevant documents that I have drawn upon in the preparation of article.

When a patient requests a lethal prescription from their attending physician, the physician must consider whether the patient is competent, and the majority of the time competency/capacity is not a concern. The attending physician then must also have a consulting physician review the file and examine the patient in order for there to be agreement as to the medical condition, life expectancy (estimated six months or less), and capacity to make an informed decision. If there are concerns about competence on the part of either physician, then there is typically a referral to either a psychiatrist or psychologist. Please note that this type of evaluation is considered to be forensic in nature, and a treating mental health professional should not conduct the assessment, but their observations and clinical opinions would be considered relevant and quite valuable for the mental health consultant.

Capacity requires your client to understand the following factors, which are the same in Oregon and Washington, and are the essential prongs of a capacity evaluation in a DWD case. The patient must have the functional capacity to understand the following:

- 1) His or her medical diagnosis;
- 2) His or her prognosis;
- 3) The potential risks associated with taking the medication to be prescribed;
- 4) The probable result of taking the medication to be prescribed; and
- 5) The feasible alternatives including, but not limited to, comfort care, hospice care, and pain control.

The functional abilities are articulated somewhat differently in California, and require the patient to demonstrate that they can:

- 1) Understand relevant information needed to make a decision;
- 2) Appreciate the situation and the consequences of different options;

(Continued on p. 16)

(Death with Dignity continued from p. 15)

- 3) Reason rationally over different options; and
- 4) Communicate an enduring choice.

An evaluator would need to consider a range of factors of which a treating clinician would likely have some input, these being personality functioning, substance use disorders, existential and religious issues, financial issues, cultural issues, family dynamics, coercion by others, medication and medically induced symptoms, and mental disorders including but not limited to depression, anxiety, dementia, delirium, or other neurocognitive impairments.

When capacity is at issue, you would likely be asked if you have observations relevant to any items noted above, and I will focus on the topics of mental disorder and medication and medically induced symptoms. These are typically the questions I have for treatment providers in any competency/capacity evaluation. While the functional capacities articulated in the statutes may appear very basic, and they are, neurocognitive impairment due to the disease process and/or treatment process can greatly impact your client's capacity, and I can't emphasize enough that capacity is a very fluid thing that changes over time. A client's functioning may change considerably day to day, or even the course of a few hours, and I have encountered both recently in DWD matters as well as over the years in other civil and criminal capacity evaluations. The most common examples of this that I have encountered, and which my physician and attorney colleagues have also described, are clients who are capable or competent in the morning, but whose mental status deteriorates rapidly over the course of the day and by the afternoon or early evening they lack capacity due to delirium. I recently encountered this with a DWD case where my assessment sessions were purposefully scheduled in the morning, and in the end my opinion was that the client was competent. After my report was issued, the consulting physician conducted the physical examination and subsequently communicated to me that the client did not appear to be competent in the late afternoon when he saw the client. As the treating clinician, you would no doubt have an opinion as to the best time to evaluate the client and the degree to which their mental status vacillates over time. Mental status

my also change as a function of the timing medical treatment, such as dialysis or chemotherapy. Again, this is critical information to convey to the attending physician, consulting physician and psychologist. Also, although capacity may be thought of as a binary construct, meaning, they either are or are not capable (this is the case during a legal proceeding), it is also recognized as being on continuum, which is a reality of clinical and forensic practice. For example, a client may have difficulty conveying their understanding of their medical diagnosis due to word finding and memory difficulties, but if asked to describe the disease, can adequately describe the organ systems involved and the relevant pathophysiology in layman's terms. In short, they don't need to have the language capacities of a fourth year medical student, and as the treating clinician, you are probably in the best place to have explored your clients understanding of their condition over time and can comment about what they understand and if there has been a deterioration of their understanding. The evaluator needs to obtain information about the medication being considered and offer inquiry to the client, and again, you as the treating provider may have information as to the client's understanding and the evolution of their thinking about this. The client would need to have some basic understanding of how the medication or medications work. Although this appears obvious, the client also needs to demonstrate understanding of the lethality of the prescription and that the results are irreversible, and neurocognitive impairment or psychosis may impact this capacity..

With respect to the issue of feasible alternatives, as articulated in the statute, by the point in time the client has invoked DWD, they may have given a great deal of consideration to other options available to them, and many options have been tried or are in place, such as hospice care. It is possible that different options have not been discussed in detail or implemented as the diagnosis is very recent and the progress of the disease is quite advanced. It has been my experience doing different types of capacity evaluations in general that some clients may have difficulty articulating their reasoning and the options that they have considered over time. In my experience this may be due to

(Continued on p. 17)

(Death with Dignity continued from p. 16)

a deterioration in their mental status, or, to be blunt, by the time they get to me they are sick and tired of talking about it, particularly if their medical condition involves fatigue and lack of energy. As such, as the treatment provider you may have input as to the evolution of their reasoning over time which would be useful input into the evaluation. The client would still need to articulate their reasoning to the evaluator, but your input would provide essential context.

Perhaps one of the most challenging and controversial areas is assessing and understanding the role of depression with invoking Death with Dignity. While considerable concern has been raised about major depressive disorder (MDD) impacting the ability to make an informed position, there is agreement that MDD in and of itself may not interfere with or render the client incapable of making an informed decision. Concerns have also been raised that the DSM criteria for depressive disorders is not adequate for the terminally ill. The one principle area of disagreement with regards to practice between Oregon and Washington is with Oregon's guidelines recommending the use of a common depression screening measure, the PHQ-9, as a component of assessing capacity. Concerns have raised about the PHQ-9 being appropriate for this population as well as being unable to differentiate MDD from depression due to a medical condition. Regardless, many clinicians appropriately use the PHQ-9 to screen for depression and monitor treatment outcome as it is a sensitive measure well designed for such purposes. If you have PHQ-9 results as part of your clinical treatment of the client, then the evaluator would certainly want to know the results, which would apply to any other measures that you might use. However, it would be very important to put the results in context, as items related to sleep, energy and appetite may reflect the medical condition rather than depression, per se, and the final item, which pertains to suicidal ideation and intent, would warrant further exploration.

I have a strong opinion, which is that the reliance on the PHQ-9 is problematic in these cases. To be sure, psychometric method can be useful in evaluations and clinical practice, and brief measures do offer an advantage over lengthy test batteries in many cases, but in my opinion the PHQ-9, which I do use in my own clinical work, may lead

to a skewed assessment of depression with DWD cases with the potential for over-diagnosing MDD in this population if great weight is put on PHQ-9 scores. Therefore, the treating clinician's observations of depression, medical symptoms, and functional capacity are extremely relevant in Oregon DWD cases and understanding PHQ-9 results.

With regards to the latter issue of suicidality, physicians and psychologists need to differentiate between the aspects of the desire to invoke DWD from other forms of suicidality, which are those that arise with recurrent MDD or other mood disorders, as well as a Cluster B personality disorder. In my experience, such a differentiation is qualitative and this is where your experience with your client is very valuable. The question that the physician or evaluating psychologist would have is how the client's current desire to invoke DWD is different from past suicide attempts, and this is where a careful history of precipitating events and your clients emotions and cognitions and beliefs would be helpful, and it is likely that you, as the treatment provider, would have information that may be less impacted by the bias of the client distorting information, consciously or non-consciously, at the present time to order to obtain the lethal prescription.

To reiterate, the treating clinician is an essential collateral in the those DWD cases where capacity is in question, and it is hoped that this article provided a basic orientation to the issues faced by evaluators and clinicians.

Resources:

Report to the Board of Directors of the American Psychological Association from the APA Working Group on Assisted Suicide and End of Life Decisions, 2000.

The Oregon Death with Dignity Act: A Guidebook for Healthcare Professionals, 2008.

Washington Death with Dignity Initiative 1000 Report Submitted to the Washington State Psychological Association by Judith R Gordon, PhD, On Behalf of the WSPA End-of Life Committee, June 2008.

California's End of Life Option Act: CPA Guidance for Psychologists, 2017.



Harry Dudley, PsyD provides psychotherapy to children, adolescents, and adults. He is a certified Integrative Restoration - iRest Yoga Nidra teacher. Primarily, he focuses on providing forensic and clinical psychological evaluations.

Your ORCA Membership Dues at Work: The History of COPACT

After 15 years of hard legislative work, LPCs and LMFTs were able to get our Practice Act passed into law in 2009. The Practice Act does two things: it gives us the right to receive insurance reimbursement for our work, and it defines that LPCs and LMFTs are legally considered core providers of mental health services in Oregon, joining Psychiatrists, Nurse Practitioners, Psychologists, and LCSWs. Thus LPCs and LMFTs are at the table whenever a major decision is being made concerning mental health services in Oregon.

The Coalition of Oregon Professional Associations for Counseling and Therapy (COPACT) originated in 2010 to be an ongoing lobbying organization to represent both LPCs and LMFTs and to protect the Practice Act.

COPACT has three funding sources: ORCA membership dues, OAMFT membership dues, and direct donations.

This is what COPACT has done for you since 2010:

2010

- COPACT worked to protect and strengthen the **Practice Act** and to amend any statutes that included social workers but not LPCs and LMFTs
- Passed **HB 3668**, which amended the Practice Act to allow 100 LPCs to hold onto their licenses.

2011

- Passed **HB 2217**, which extended the exemption from punitive damages in malpractice suits to include LMFTs and LPCs.
- Met with the Oregon Insurance Commissioner to address many years of mental health reimbursement rate cuts.
- Stopped a bill that threatened the Practice Act.

2012

- Worked on a failed bill to require insurers to be more transparent about how they determine reimbursement rates.
- Worked on failed independent mental health agencies bill that would increase the availability of internships.

2013

- Hired Maura Roche as COPACT's lobbyist.
- Passed **HB 2768**, which amended the Practice Act to make practice definitions more enforceable and better situated for health care reform. It also amended the LMFT internship section to allow the same amount of internship for LMFTs as LPCs
- Passed **SB 491**, which allowed teens to self-refer to access care from LPCs and LMFTs.
- Worked on **HB 2737**, which allowed independent mental health clinics to more easily bill insurance, which had the effect of increasing the availability of internships. The bill passed.
- Testified in support of a failed bill to require insurers to be more transparent in their determination of reimbursement rates.
- Helped with the merger of the Oregon Mental Health Counselors Association and ORCA to give COPACT a more secure funding base.

2014

- Hired lobbyist Elizabeth Remley following Maura Roche's retirement.
- During the short legislative session, set up an efficient structure to evaluate bills.

2015

- Participated with the Oregon Insurance Commission work group as it created a bill to address how to define insurance network adequacy.
- Evaluated 88 mental health bills during the long legislative session.
- Supported **HB 2307**, which prohibits the use of Conversion Therapy on minors.
- Supported **HB 2796**, which set up licensure process for Music Therapists.
- Helped clarify and support **HB 2023**, which set up policies for hospitals when discharging mental health clients.

- Supported **HB 430**, which prohibits licensure boards from issuing a license to a person with a conviction for sex crimes.
- Supported **HB 2468**, which directs the Oregon Insurance Division to establish specifics for making provider networks more accessible for clients and providers.
- Supported **HB 832**, which allows for full reimbursement of mental health services provided in a primary care setting and opens that treatment setting to LPCs and LMFTs.
- Closely watched **HB 3347**, which makes it easier for courts to commit a mental health patient under the basic personal needs criteria.
- Kept an eye on **SB 901**, which requires insurers to directly reimburse an out-of-network provider who bills the insurer.
- Met with Senator Wyden's staff to lobby for a bill he sponsored in the US Senate to extend Medicare reimbursement rights to LMFTs and LPCs.

2016

- Throughout the year, met with the Insurance Commission work group that was trying to define what makes an adequate provider network.
- During the short session, kept an eye on a number of mental health related bills including **SB 1558**, which protects students' mental health records. This was an attempt to protect the privacy of survivors of sexual assault on college campuses.
- Met with the Insurance Commission to address how reimbursement cuts have a negative effect on access to mental health care for Oregonians.
- Met with the Oregon Health Authority to address increasing caseloads for therapists working in Community Mental Health Programs.

2017

- Evaluated 74 bills that had an impact on mental health services and LPCs and LMFTs.
- Protected the rights of LMFTs and LPCs to use art in their practices and to provide services to sex offenders.
- Supported Art Therapists in their successful effort to obtain state licensure.
- Successfully fought against legislative efforts to define required topics for continuing education training
- Closely watched a failed bill, which would have allowed clients to receive psychiatric medications from qualified and supervised psychologists.
- Helped develop and worked to pass **SB 860**, which creates a structure to evaluate mental health reimbursement reductions as potential violations of parity law. SB 860 may end over 20 years of steady reductions in mental health reimbursement rates in Oregon.
- Kept an eye on revenue raising strategies that would have increased taxes on all mental health related services. That effort died.
- Opposed an insurance company's new policy that would have increased out-of-pocket costs for clients. The company retracted that policy.

COPACT cannot do this alone. COPACT will continue to protect the interests of LPCs and LMFTs as long as you are able to give your financial support. Please donate at copactoregon.com/donate and maintain your membership in ORCA.



Update: Our 2018 Legislative Session

by Andrea J. Wright Johnston, LMFT, COPACT President



The Oregon Legislature just completed the short legislative session that lasted for 5 weeks. The number of bills that can be introduced in a short session is limited, and the time is short, so typically not a lot of huge bills get passed, and things move very quickly.

There were two successful and important bills that COPACT (with help from our lobbyist - who is directly funded by your ORCA membership dues) supported:

HB 4145 closes the “boyfriend” loophole. It now prohibits any domestic partner, who has a stalking order or a history of domestic violence, from possessing firearms. This is an admirable attempt to reduce the number of shooting deaths tied to domestic violence. It passed both chambers very quickly, but with very little Republican support and was one of the first bills Governor Brown signed into law.

HB 4143 directs the Department of Consumer and Business Services to study and report the barriers to assisted treatment for substance use disorders, requires the Oregon Health Authority to establish a pilot program to assess the effectiveness of recovery support mentors in emergency rooms, and requires all prescribing providers to register in the Prescription Drug Monitoring Program. This is an effort to address the opioid crisis. COPACT wrote a letter of support in time for its unanimous passage in both chambers, and its being signed into law by the Governor.

There were also a number of other successful bills COPACT observed closely and were ready to jump in with active support if needed:

HB 4005, a medication price transparency bill. This bill requires prescription drug companies, when raising the price of a drug more than 10% in a year, to report to the Department of Consumer and Business Services their production, research, and marketing costs. Additionally, it requires these companies to report on whether there are equivalent generic drugs on the market, the effectiveness of their drug, the cost of the drug in other countries, and the

reasons for the price increase. COPACT has been hoping for this kind of bill for several years. The pharmaceutical industry put a lot of effort into trying to stop it, but it passed with bipartisan support and was signed into law.

HB 4135 simplified language in Oregon’s Advanced Directives form. It passed both chambers and is waiting the Governor’s signature.

SB 1539 set up funding for a Psychiatric Access Line for adults to be run by OHSU. It is intended to provide psychiatric consultations to health care providers providing care to mentally ill individuals.

And there were a number of interesting bills that failed:

HJR 203 would have referred to voters the option to amend the Oregon constitution to declare health care as a basic right. It passed the House but failed in the Senate.

SB 1531 would have required all law enforcement officers to meet with a mental health professional once every two years. It looks like this one may show up again next year.

HB 4100 would have allowed for equine therapy programs in zones exclusively dedicated to agriculture.

It was a fairly smooth session for us, as there was not a lot of controversy or conflict around our policy positions.

Once again, we were served extremely well by our lobbyist, Elizabeth Remley, and her assistant, Rachael Wiggins Emory.

In the interim between the sessions, COPACT plans to work on the implementation of **SB 860**, which passed last year and has to do with mental health reimbursement reductions.

And we are starting to generate ideas for legislation ideas. We already have a few, but don’t be shy - if any of you has an idea you wish to share with us, [email us](#).

COPACT members are grateful for the opportunity to serve you. If you have any interest in joining in the effort, please join us at our meetings. Just [email](#) the president of COPACT so we know to expect you.

Editorial



ORCA stands with everyone affected (directly and indirectly) by recurring tragedies of gun violence. Our hearts especially go out to our school counselor colleagues and those of us with kids. Take good care, everybody.

If it's not in your self-care practice yet, we suggest participating actively in this amazing democracy we share: make sure your [voter registration's](#) up to date, practice communicating effectively with folks you don't agree with, put your [reps](#) on speed dial, march as you see fit, and demand action. America's greatness depends on us. And as Churchill admonished us way back when: "The price of greatness is responsibility."

- Moira Ryan, LPC, ORCA Human Rights Chair

England is a cup of tea.
France, a wheel of ripened brie.
Greece, a short, squat olive tree.
America is a gun.

Brazil is football on the sand.
Argentina, Maradona's hand.
Germany, an oompah band.
America is a gun.

Holland is a wooden shoe.
Hungary, a goulash stew.
Australia, a kangaroo.
America is a gun.

Japan is a thermal spring.
Scotland is a highland fling.
Oh, better to be anything
than America as a gun.

Brian Bilston, brianbilston.com

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Scenes from Portland's March for Our Lives



Resource Highlight: SAGE Metro Portland

ORCA improves your Rolodex by highlighting excellent local resources



Photo courtesy SAGE Metro Portland

Previously named “Elder Resource Center (ERA)” and “Gay & Grey,” SAGE Metro Portland was founded in 2001 in collaboration with a coalition of aging service professionals and LGBT older adults.

They work with and for LGBT seniors (60 and better) to create community and social change. They work to ensure the safety and well-being of LGBT older adults living in Multnomah County.

Did you know?

- Roughly 80% of long-term senior care is provided by family members. LGBT older adults are 50% less likely to have relatives they can rely on for help as compared to the general population.
- 73% of LGBT seniors state that discrimination occurs in retirement facilities.

- Police and government agencies can be sources of abuse and mistreatment for transgender older adults, making it difficult to safely report discrimination.

These obstacles, along with others, make it more difficult for LGBT seniors to achieve key components of healthy aging: financial security, quality health care, community support and engagement.

This is where SAGE Metro Portland comes in. Their mission:

- To offer SUPPORT. SAGE Metro Portland offers Options Counseling, case management, and information and referral services to LGBT older adults, offering support in finding and accessing resources, decision making, and aging service system navigation.
- To ADVOCATE. They advocate for all LGBT seniors, locally and nationally. This includes involvement with legislative and community leaders, partnerships with senior housing providers, and connection to the SAGE National network.
- To help with HOUSING. SAGE Metro Portland works directly with senior housing facilities to create lasting change and to advocate for safe, welcoming, and inclusive environments.
- To offer spaces of COMMUNITY BUILDING. They host weekly social groups at local restaurants. We also hold special events including the Gay & Grey Expo (a health and resource fair for LGBT seniors, professionals and allies), Pride events, holiday parties, and guest speakers.
- To EDUCATE the community. Since 2001, SAGE Metro Portland has offered high-quality trainings for students, business leaders and professionals in nursing, social work, naturopathy, gerontology, in-home care services, senior housing, government and non-profit management. Trainings include an expert facilitator and a panel of LGBT seniors who share their life experiences about the joys and challenges of being both LGBT and an aging person in our culture and society.

Call for articles

Focus On: Homelessness

The Counselor, the quarterly newsletter of the Oregon Counseling Association, invites articles to be submitted for consideration for our Summer 2018 issue. This issue will FOCUS ON: HOMELESSNESS as that topic relates to the helping professions and to communities in Portland and in greater Oregon.

The purpose of Summer's special issue is to share institutional knowledge, personal narrative, annotated resource lists, advice for the helping professions, photographic essays, manifestos, and similar around counseling folks impacted by these issues.

Here are some ideas we think our members would like to hear more about:

- My client suddenly reports they're being evicted - what resources can I share with them to prevent this from happening?
- My client says they're homeless, not houseless. Explain?
- What is it *like* to navigate homeless services? Any tips?
- Why does Portland have such a large homeless population, and what can I do to help?
- What's the most helpful service or resource I can offer to my homeless, teen, LGBT clients?
- I'm encountering a lot of clients who receive SSI, and I'm curious how anybody makes life work on that tiny amount of money. I mean, HOW???

Submission of articles, etc due by July 1, 2018
to editor@or-counseling.org

If you're a planner, here are the next topics *The Counselor* will tackle:

- Fall 2018 - Focus on: Our Values at Work
- Winter 2019 - Focus on: Agency Work vs. Private Practice

With the certain knowledge that diverse perspectives make for a more skilled, savvy, and effective environment - and with awareness of the various ways that ORCA is impacted by varied -isms, we're seeking to invite more diverse voices to participate in shaping ORCA's future work. We hope this includes new voices coming on to serve on our Board (if pursuing a career as a licensed professional counselor), or to participate in committee meetings or other events, as well as by shaping the voice of this newsletter.



Upcoming 4th Friday Presentations Sponsored by Oregon MH CE Consortium

APA Approved
Live or via interactive webinar
AM *or* PM for \$100 / 3 CEs
or AM *and* PM for \$150 / 6 CEs

May 25 * 1-4
DSM- V: What's New?
Scot MacLean, MD

June 22 * 9-12 and/or 1-4
TBA - check our website soon!

July 27 * 9-12 and/or 1-4
Substance Abuse + Attachment
Mike Bricker, NCAC-II, CADC-II, LPC

Our best deal yet:
\$350 or \$35/month gets you
2 live in-person or interactive webinar
events,
20% off additional live events,
and *unlimited* CE recordings for 12
months from date of purchase. More than
70 CEs available.

**For more information, to register, or to
inquire about presenting, go to
ormhce.com**

Who We Are: We are a group of
multidisciplinary, licensed + practicing
mental health clinicians bringing you
meaningful CEs by local and regional
experts. We also host a reception and
donate 10% to a regional charity.
Every time.

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If you're interested in serving ORCA as a volunteer or member of the board, please contact Gianna Russo-Mitma, ORCA President-Elect, at presidentelect@or-counseling.org