



THE COUNSELOR

Focus on: Intersectionality

President's Message

Greetings, Oregon counselors!

ORCA leadership has been hard at work preparing for our annual conference, which is quickly approaching! This year's conference theme is [The Constant of Change: Ethical Counseling Embracing Diversity](#). We are delighted to welcome Summer Brown, LMFT, and Dr. David Kaplan as this year's keynote speakers. Ms. Brown is a leader in providing LGBTQI+ mental health treatment, while Dr. Kaplan is the American Counseling Association's Chief Professional Officer and an expert on ACA's code of ethics for counseling professionals. We're very excited to have the opportunity to share their wealth of knowledge with you.

As this is my first newsletter address as ORCA President, I want to take the opportunity to thank you all for electing me to lead this wonderful association over the next year. I would also like to thank Raina Hassan for her incredible leadership as ORCA President, which continues now in her new role as Past President. Under Raina's tenure as ORCA President, she was chiefly responsible for a major rebranding effort that led to ORCA receiving the 2017 Best Innovative Practice Award from the ACA Western Region. I am thankful for Raina's leadership and the mentorship she has provided to me in assuming the role of ORCA President.

In addition to the Innovative Practice award, this summer we received ACA's 5 Star Branch Award. Gianna Russo-Mitma accepted the award for ORCA while attending the ACA Institute for Leadership Training in Washington D.C. While in D.C., Gianna spent a day on Capitol Hill meeting with congressional leaders, advocating for issues important to the counseling profession, including legislation that would authorize counselors to be reimbursed through Medicare.

Recently, we hosted a [networking picnic](#) for ORCA members and their families. It was wonderful having the opportunity to meet some of you there and to introduce you to my wife Megan and newborn son Ari. I would like to thank our Networking Committee Chair, Sue Ujvary, and the rest of the Networking Committee for all of their work in planning such a fun event. Thank you Networking Committee for all that you do to help connect our counseling community!

This edition of *The Counselor* focuses on issues related to intersectionality in the counseling profession. This topic is deeply important to our work, as cultivating awareness of our own identities and values is an ongoing process all counselors can and should engage in to be more responsive to the identities and values of the clients we serve. I am passionate about addressing treatment disparities in mental health services. One of my primary goals as President is for ORCA to provide leadership and, ultimately, positive change for this issue. It is my hope that the articles in this issue of *The Counselor* will help us all think more about the dynamic relationships we have with power and privilege, and the work we can do both internally and externally to better respond to the needs of our clients, ourselves, and our community.

Sincerely,

Joel Lane, Ph.D, LPC, NCC

President, Oregon Counseling Association

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Oregon
COUNSELING
Association

The Counselor is the quarterly
newsletter of the Oregon
Counseling Association

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LETTERS TO THE EDITOR:

The Counselor (like any good counselor) welcomes your feedback and, in the interest of intellectual rigorousness and learning from one another, encourages dissent and debate. If you would like to have your comments or Op-Ed published, please email editor@or-counseling.org with the subject line LETTER TO THE EDITOR. *The Counselor* retains all rights to publish and edit these comments for clarity and space.

CORRECTION:

In our last issue, we erroneously printed Sasha Strong's article and suggested reading as separate pieces. We should have retained the title "Suggested Reading" and placed it immediately after their article.

DEFINITIONS FIRST:

Intersectionality, per the Cambridge English Dictionary:

The way in which different types of discrimination (= unfair treatment because of a person's sex, race, etc.) are linked to and affect each other:

The theory of intersectionality highlights the multiple avenues through which racial and gender oppression are experienced.

The ADDRESSING Framework: Cultural Influences

Age and generational influences

Disability status (developmental disability)

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Sexual orientation

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Gender

from Hayes, P. A. (2013). *Connecting Across Cultures: The Helper's Toolkit*

Making It Visible

by Raina Hassan, LPC, ORCA Past President

When I heard the upcoming issue of the ORCA newsletter was going to focus on intersectionality, I was both excited and frightened. I was excited because I knew I wanted to write about this topic; I was frightened because I'd never done so before and to embark on such a task—publicly—meant I would likely feel vulnerable in this new experience. But, as a therapist, I often encourage my clients to lean toward new experiences with courage and wholeheartedness, and since I try whenever possible to embody these attributes, I decided to volunteer to write about growing up a biracial woman. For clarity, let me explain that my mother is a white American and my father is a Lebanese-born Palestinian who emigrated to this country as a young man in the 1970s and later became a naturalized US citizen.

Prior to writing this article, most of what I'd come to understand about my experiences in the world relating to race and gender I'd seen as separate issues. I've thought quite a lot about how I've been challenged in the world as a woman, and I've thought quite a lot about my challenges as a mixed-race person. But, when I see the two together (which is the brilliant value of intersectionality), it shifts the frame of my experiences in a way that highlights the lived experience of these factors in concert. By the way, if you would like more clarity on what the term intersectionality means, Kimberlé Crenshaw, who created the term, offers an inspiring TED Talk (click [here](#) to view; trigger warning).

I'll illustrate how I experience intersectionality by telling you about some of my experiences.

When I was in junior high, the first Gulf War was happening. We had televisions in the classrooms, and the name Saddam Hussein was frequently mentioned. Because I have had the immense privilege of being born with white skin, most people would only become aware I was mixed race when they would either inquire about my last name or when they would meet my father (or sometimes at the end of summer, after I'd gotten a lot of sun exposure). Prior to the first Gulf War, my name was difficult for most everyone in my small town to pronounce correctly, but suddenly, it became a target in a new way. A few of my classmates began to chide me with questions like, "Hey, is Saddam Hussein your *uncle*?" At other times, a specific racial epithet for Middle Eastern folks was uttered to me—in the guise of a joke, of course.

Sometimes, the racism was not at all disguised with humor. Like the time my family was picketing in front of a movie theater to protest the stereotyped depictions of Arabs in a movie that was showing, and a man in a truck drove by and yelled, "Go back to Saudi Arabia!" (My family is not from Saudi Arabia, by the way, but that's beside the point.) Or the many prank calls we received over the years, ranging from "jokes" to outright threats. And I won't even go into the hours upon hours my family and I have wasted being detained in airports.

So, how did I respond to these experiences? From the jokes to the threats and everything in between, I reacted in pretty much the same way: I got small. I went silent. In therapist speak, I went into a freeze response. Sometimes, as a kid, I would laugh in an attempt to alleviate the discomfort. But as I got older, I learned to go silent and wait it out. What I didn't do was fight back. What I didn't do was stand up for myself and call the behavior out—not even the perennial microaggression many biracial people hear: "What are you?"

Over time and with a lot of effort, I have been able to break out of the freeze response at times. But *always*, I can feel the familiar urge to get small and silent. Perhaps I can attribute my freeze response, at least in part, to nature or temperament.

(Continued on p. 4)

(Making It Visible continued from p. 3)

But when seen through the lens of intersectionality, it becomes pretty clear to me that if I had been male, I would have been much more likely to speak up or fight back, as we know that by and large the fight response is often covertly and overtly encouraged in boys and men. As women, we often learn to keep ourselves safe by being quiet, invisible, non-threatening.

If I *had* fought back, the fallout from these experiences would likely have been much different than it has been for me. Perhaps I would have gotten into physical altercations at school and on the street. This, no doubt, would have negatively impacted my grades and academic standing. Maybe I would have attempted revenge on those I suspected of the prank calls. This may have gotten me in trouble with the law. Certainly, talking back to the TSA would have carried some hefty circumstances. If I had been a biracial man in these circumstances, perhaps the fallout would have been more visible, more external, mirroring my more externalized reactions to the racism. And when seen through the lens of intersectionality, I can see how my entire

life may have played out quite differently. But as a biracial woman, I have glided through the educational system—and many social systems—with ease. But the burden had to get absorbed somewhere, and there has been a fallout. But it has been invisible, internal, somatic.

It occurs to me that by writing about this intersecting experience of race and gender, I have made it visible. And it also occurs to me that writing is a form of fight and protest that I believe is healing. I was telling a friend about my process of writing this article and that it ended up being well over twice the target word count. “You must have had a lot to say,” she noted. Indeed.

Often, I will encourage my clients to write when they are angry or sad, or both. I am grateful to have had the opportunity to practice that suggestion here, in my own life, with all of you. Thank you for participating in it with me.



Raina Hassan, LPC, is the past president of the Oregon Counseling Association. She works in private practice in Portland.

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All Perpetrators, All Victims: Some Reflections on Intersectionality

by Victor Chang, PhD, LPC

Intersectionality allows us to understand our various social identities, which are often associated with both privilege and oppression. Understanding this dynamic is crucial to informing our clinical and social justice work. We can start by acknowledging our own experience.

As a boy, I experienced the privilege that comes from being a straight, cisgender male. Growing up in the 1970s as a son of Korean immigrants, however, I also experienced both overt prejudice and, more frequently, microaggressions. The classic began with "Where are you from?" and continued towards the inevitable insinuation that I couldn't be "from here" or "American." Sometimes, to get along, I would appear to shrug off slights aimed at immigrants who others perceived as "fresh off the boat." I quietly demonstrated that my English was flawless – *I was one of them*. I remember feeling ashamed when clerks "struggled" to understand my mother's non-native English. The pride I felt in passing as an all-American kid with my Little League games, "American" friends and other "non-Korean" interests would be intermittently shattered when someone else treated me as "other" or a "foreigner." It was my privilege alongside my oppressions, arising from my intersecting identities that got me through those difficult times.

In school, I experienced the positive stereotypes associated with being the "the model minority." At the same time, I wondered what part of my success or personality was *me* and what was due to other influences. Was my dislike of math or science, my party animal persona really *me* or just my reaction against the stereotype? In college, I began to grasp my complex

multicultural upbringing and the number it had done on me... and I grew from shame towards self-acceptance. Simultaneously, I began to glimpse how removed my social identities were from the "enlightened liberal" stance I'd assimilated. There's nothing wrong with my stances, except that my critical consciousness was not yet involved. My overlapping identities and my role as a counselor were not yet integrated.

As a mental health counselor on the Navajo reservation in Arizona, I thought I had a good biopsychosocial perspective on the traumas affecting my clients. I thought I understood Navajo culture and the historical effects of oppression on the Navajo. I also was participating in protests against the Black Mesa coal mine on tribal lands. Although the coalition was tribal members and (mostly white) environmentalists... I never connected my clinical work with my protesting. I must have had as clients some families whose lands were impacted. My clinical and social justice efforts could have been integrated and genuinely client-centered as my protesting would have been "work with" and not just "work on behalf of."

With an intersectional lens, I can integrate my multiple social identities, their associated privileges and oppressions, and how they ebb and flow over time and contexts. In college, I wrestled incompletely with the words of Juan Moreno who said "when it comes to oppression, we're all perpetrators and we're all victims," but now I understand more deeply and can act more consciously. Society has changed, even as it remains stagnant. I no longer hide my love of kimchi - now I get to relish Korean food's momentary hipness!



Victor Chang, Ph.D, LPC is an assistant professor of psychology and clinical mental health counseling at Southern Oregon University. His clinical and research interests include: the therapeutic alliance (common factors),

integrative approaches to psychotherapy, and trauma treatment. He can be reached at: changv@sou.edu.

Weight-Inclusive Care

by Hilary Kinavey, LPC

Body shame and dissatisfaction are a common concern in psychotherapy offices. Therapists are in a unique position to name and dispel myths regarding weight and body size with their clients. Unfortunately, many therapists do not feel adequately trained nor do they fully understand the impact of sizism on the lives of their clients.

Those of us who have worked in the disordered eating and body dissatisfaction corner of the mental health world know something that we wish everyone knew: there is no weight loss prescription, weight change suggestion or diet that is psychologically benign. Clinically and culturally, we fail to name and acknowledge the impact of weight stigma on us all. People large and small are often hustling for weight and body change and have their worthiness bound up in the pursuit. All too often, weight change is mistakenly seen as a possible and helpful intervention for clients who live in larger bodies or who feel dissatisfied with the bodies they are in.

It is very true that diets do not work. This is true for fad-diets, plans sold as “lifestyle changes”, and medically prescribed plans. In fact, 95% of diets fail, though often not initially. Typically, dieters regain weight at 2-5 years post diet. This is such a predictable occurrence that we must ask why it is we more commonly blame the individual than the diets or plans themselves? To avoid further harm, it is necessary to consider what could be possible in the lives and wellbeing of our clients if we located weight concern outside of the individual and named it as a cultural concern or mandate? When we critically evaluate the data, what we find is that the evidence that weight is even a risk factor is, at best, incomplete and contradictory. Here are the links to a few research articles critically evaluating weight science and offering data to support a weight-inclusive model of care:

[Weight Science: Evaluating the Evidence for a Paradigm Shift](#)

[The Weight-Inclusive vs. Weight-Normative Approach to Health](#)

The amount of weight bias in the literature (and therefore the medical community) is astounding. Health and mental health care providers must become critical reviewers of the research to provide safe and ethical services. Many studies finding a correlation between weight and health have not controlled for things like SES, weight cycling, fitness, stigma, oppression, trauma, and more. Correlation is different than causation.

Conversations about inclusion and social justice do not commonly include sizism and fatphobia. It is commonplace to believe that a little shame and public humiliation can provide catalyst for change – something we all know to be false about the change process. The truth? Fat people have always existed and will continue to. This is not an abomination or culture gone wrong. But it is an intersection. Fat people are less likely to be believed, trusted, treated (medically) and hired. Add intersections of race, ability, gender expression, and the injustice multiplies.

Consider who told you that people can and should lose weight.

Consider who taught you that people can and should lose weight. Check out the \$60 billion+ industry that thrives on this and then research alternative approaches such as [Health at Every Size®](#) and [Body Trust®](#). Look deeply into this. You will unearth more freedom for yourself perhaps. But do this for equity, truth and justice. Do this for your clients who expect you to collude with the problem of their body. Do this in the name of wellbeing and liberation.



Hilary Kinavey, LPC is the cofounder of [Be Nourished](#), a revolutionary business that helps people heal body dissatisfaction and reclaim body trust. [The Be Nourished Training Institute](#) offers training for helping professionals who want to move towards weight-safe and inclusive care. You may also find

them on [Facebook](#).

It's Intimidating and Important... So Let's Talk About It

by Gianna Russo-Mitma, MS, LMFT, ORCA President-Elect

Diversity and inclusivity have been in continual conversation within the Oregon Counseling Association, even more so since the change in our country within the last year. With our current President Joel Lane's vision for our organization, ORCA's critical goals have focused more on honoring diversity, connecting with more counselors of various backgrounds, and standing up for equity and equality (in small and large ways).

To get this started within ORCA, the organization's newsletter, *The Counselor* (what you are reading right now), asked for articles on diversity, inclusivity, intersectionality, and advocacy. Articles poured in on so many amazing topics from people of all backgrounds - we were thrilled to hear from ORCA members who may have been less vocal in the past! We are so proud of you all for stepping outside of your comfort zone and taking the leap to write for us on such a major topic!

In my honest opinion, it's daunting to write about diversity as a white, cisgender female (as it should be, as I have admittedly faced much less oppression than other folks). While even trying to write this article, I've been nervously thinking, "What if people think I don't grasp what is happening?" Or wondering if people will say, "This white girl has no clue." It's scary to engage in discussions, because truly, I don't fully understand what it's like to be a person of color, or a member of the LGBTQIA community, or part of many marginalized groups; I can only empathize, listen, learn, and be the ally that I am. It is intimidating to engage in discussions like this, but in order to get anything accomplished for this important matter, we have to be uncomfortable, accept that we will make mistakes (then learn from them), pay attention to others' experiences, and validate.

I'm thinking: What if people think I don't grasp what is happening? Or wondering if people will say, This white girl has no clue.

Intersectionality is defined as the "complex way in which multiple forms of discrimination overlap in the experiences of marginalized folks" (Merriam-Webster). We talk about privilege with topics such as race, gender, citizenship status, and sexuality in mind. We easily forget that other privileges exist (i.e. ability, economic status, education, religion, genetics). With fall's edition of *The Counselor* centered on intersectionality, I would like to talk about this topic from my personal experiences. I will preface my article with this: I cannot even fathom what it feels like to be in deeper marginalized groups.

I am a plus size female with asthma. When you read this, you may construct a quick judgment about me or the groups I belong to, you may have your own thoughts on it all, and you may even disagree that these attributes belong to "less privileged" groups. From my unique and individual experience (as these conversations are), I have faced challenges with these qualities, but probably nowhere near the challenges that others have faced for identities such as race, citizenship status, etc.

My first memory of being "different" because I had asthma was in elementary school during a (rare) snow day in Las Vegas. All the kids were allowed to go outside at recess and play it in, except the kids with asthma or other health conditions, who were required to stay in the multipurpose room. This marked the first time that I realized I was different from other kids, because until that point, I wasn't. When P.E. became a required class, I was the kid that had to have a note from their parent that said I couldn't do certain things, and when the teachers forgot your letter from the first day of school, you'd have to mention it to them weekly.

(Continued on p. 9)

(Let's Talk About It continued from p. 8)

Each time we had to run the mile, I was allowed to walk it, but then this created the "us and them" scenario, where I was one of the slow/fat/asthmatic/unhealthy/[enter any negative adjective here] kids. It always felt odd and uncomfortable.

My most recent experience of being told I could not do something due to this health issue was on vacation this summer. After planning for weeks, we decided to sign up for an underwater Caribbean Sea Trek. When we arrived, lo and behold, if you have anything on their medical list (asthma included) you are *NOT* allowed to do this activity. It is an awful feeling to be reduced to a label, told you're not allowed. It is an oddly emotional experience. Aside from emotional stuff like this, having asthma (or any chronic health condition) is a huge nuisance. I have to use a Nebulizer (a really invasive machine with tubes and a mouthpiece), and I am always on the go with my inhalers (home, purse, car, etc).

Considering these turbulent political and societal times (and beyond these times): pause, take a step back, and listen to others' stories. Don't make assumptions. Keep an open mind. Ask questions. Mistakes are how we learn. I would much rather someone ask me questions than assume things about me. And if I, or others, don't feel like answering questions, we won't. Be open to constructive criticism and being educated on topics. Be aware that no one knows everything, including you. I learn things every single day from others, and it's beautiful.

In conjunction with ORCA's movement to honor diversity and create more discussions like this, our conference theme is "[The Constant of Change: Ethical Counseling Embracing Diversity](#)" which starts *THIS WEEK* on November 2-4 in Tigard. [Register here](#).

We can, and we will, make society a better place – it just has to start with a conversation together.



Gianna Russo-Mitma, M.S., LMFT, is ORCA's President Elect. She has a practice in Portland working with teen girls and self esteem, and co-parents after separation and divorce. Gianna also works with foster care youth, doing mental health assessments at DHS. She is also the lead counselor for Clear Transitions PDX and teaches at University of Portland and at Portland State University as an

Adjunct Professor.



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Photo by Gianna Russo-Mitma



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Jenn Burleton and Kit Crosland, TransActive Gender Center

Friday, December 8, 9 a.m.-12:30 p.m. • 3.5 CEUs

Strength-Based Clinical Supervision *James Gurule, MA, LPC*

Friday, December 15, 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*

February 16, 9 a.m.-5 p.m. • 7 CEUs

Application of Dialectical Behavior Therapy when working in Grief and Bereavement *Elyse Beckman, LPC*

Saturday, March 10, 8:30 a.m.-4:30 p.m. • 7 CEUs

Mental Health Assessments and Planning for Transgender-Affirming Surgeries *Kate Kauffman, LPC*

Friday & Saturday, March 16 & 17, 9 a.m.- 4 p.m. • 12 CEUs

Clinical Art Interventions to Explore and Transform Grief and Loss *Maru Serricchio, LMFT, ATR*

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



Between Worlds and Identities

by Neil Panchmatia

Immigration has been very much in the news recently. The United Nations High Commissioner for Refugees estimates that there are currently about 67.8 million forcibly displaced people around the world in need of immediate protection and assistance (UNHCR, 2017). Throughout the world, an unprecedented number of people continue to leave their home countries, either by choice (or degrees of choice) or by becoming forcibly displaced. Individuals and families are uprooted by social, political, and economic trauma – and too often, they are not well served by the current US system of mental health care.

Since the early 1990s Oregon has become home to an influx of migration due to economic and political turmoil. Most Oregon refugees initially resettle in the greater Portland metro area; Portland currently ranks eleventh in US cities that resettle international refugees. According to the Oregon DHS, refugees come here from all over the world, prominently from the former USSR (Russia, Ukraine, and Bosnia), South Asia (Bhutan), Southeast Asia (Vietnam, Cambodia, and Burma), the Horn of Africa (Ethiopia and Somalia), the Middle East (Iraq, Iran, and Syria), and Latin America (Cuba).

Research on displaced individuals has shown that a group's proximity (in terms of outward appearance, language and culture) to the dominant culture of its host country largely determines its ease of acceptance and integration (Colic-Peisker 2005). Refugees who appear as "other" to the dominant racial/cultural group in a historically homogenous state such as Oregon often suffer a more negative experience around their resettlement. Displaced peoples from East Africa or the Middle East, for instance, live on the peripheries of society and are often segregated (physically as well as culturally). On the other hand, refugee groups such as Russians and Ukrainians that settle in Oregon can experience proximity in terms of skin color to the

dominant culture, and have therefore enjoyed a relatively easier integration.

The effects of displacement are well-understood: the trauma resulting from the loss of one's home, loved ones, and community follows individuals and families all the way to one's new life in a host country (Marlowe 2010). Such trauma often exacerbates the problematic expectations that you'll adjust to life in the US as quickly as possible. Most support services here are discontinued within nine months. Refugees are expected to become self-sufficient almost immediately upon arrival by a capitalist system that mythologizes bootstrap-pulling at the expense of general well being (Tyson 2017). Other vital needs such as mental health care are ignored. A preponderance of refugees experience PTSD and similar effects of trauma which go undiagnosed and untreated due to the myriad barriers to accessible care. In Portland, a handful of immigrant and refugee support organizations (e.g., Lutheran Community Services) have stepped up to provide counseling services – yet barriers remain.

In working with forcibly displaced individuals, counselors may be tempted to prioritize one aspect of identity over more immediate concerns. While the experience of displacement is central, and the resulting trauma there is an important locus of concern in treatment planning, this limiting focus misses the mark in understanding the individual holistically. It is necessary to explore and include other salient components of these clients' "hyphenated hybridities" toward creating a successful therapeutic alliance (Asghari-Fard & Hossain 2017).

Research shows that immigrants and refugees maneuvering arrival and adjustment in host cultures do so primarily by constructing and negotiating their identity (Asghari-Fard & Hossain 2017).

(Continued on p. 12)

(Between Worlds and Identities continued from p. 11)

The result is a new, hybrid identity that consists of values, labels and roles that are emphasized differently in different settings. A Somali American would likely identify more as "Muslim" over "Somali" in a mosque setting, more as "Somali" within a community cultural organization, and more as "American" while engaging in civic activities such as voting or running for office. All three intersections of American, Muslim, and Somali are otherwise equally important intersections of identity: they are simply prioritized and performed as the situation demands. Adjustment to life in the US is an ongoing process, one without a finite end, and each individual experiences life between the currents of culture uniquely: constructing and negotiating her/his/their identity independently and collectively with the larger community.

In Portland's Somali community, for instance, identity intersections begin at the individual level and expand out to the societal level. For example, some intersections a Somali-American can have include: being female, black, African, immigrant, Muslim, queer, and differently abled. Identity is uniquely formed and negotiated by each individual. Identity, furthermore, informs the social roles an individual adopts. These social roles are an indication of which aspects of their identity are important to them and to what degree: a Somali woman, for instance, takes on the role of establishing an informal peer-counseling group within the local community in order to support women experiencing domestic violence (which trauma research shows is exacerbated as a result of the displacement experience). She hosts this group within the mosque, which has taken on the role of confronting domestic violence within the broader Muslim community, and so provides her necessary resources. She then may decide to go to graduate school and study counseling, so that she can continue to give back to her community by providing mental health services. She understands that Somali women prefer to work with other women when seeking mental health care. She also understands that needing and

seeking care carries a deeply embedded stigma within her community, and that individuals are hesitant to seek help. She understands that different sub-groups within her community have very different needs: the elders, youth, men, women, queer individuals, people with disabilities and people from different waves of immigration to Portland. She also understands that while she knows her culture and the experiences of her people best, her audience may be reluctant to see her for services because she is "too close to home" in a collectivistic community where reputations and social perceptions matter. Consequently, she decides to partner up with Lutheran Community Services as a "cultural broker" within the Somali community to start up a culturally responsive counseling program.

Take the pressure off the client to educate the counselor.

Mental health professionals should attempt to explore and understand the intersections of identity (or the hyphenated hybridities) of their clients while engaging in cultural humility. A respectful curiosity should be projected within counseling sessions, which creates a safe and brave space for exploration and expression of different intersections of identity. This space should also be designed to take the pressure off of the client to "educate" the counselor. Counselors should enter a session having done their homework and having some basic background information on the cultural and historical background of their clients (a quick Google search, for instance, can reveal so much about Somalia).

Displaying basic contextual knowledge about a client's background in session (not cultural assumptions or stereotypes) can be an encouraging experience for clients and can facilitate a deeper exploration of identities.

(Continued on p. 13)

(Between Worlds and Identities continued from p. 12)

The goal, within therapy, is to fully empower clients who have experienced the trauma of displacement and are maneuvering the additional stressors of culture shock, marginalization and other barriers to successful adjustment to life in the US. By creating and maintaining a therapeutic alliance and space that intentionally accommodates and celebrates all intersections of identity, mental health professionals will be able to cross cultural divides and provide the critical care and support needed. In today's socio-political climate that "others" refugees and migrants and further pushes them to the fringes of society, this deliberate therapeutic intervention of culturally responsive care is nothing short of an act of much-needed social justice activism by helping professionals.

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Neil Panchmatia is a graduate student in counseling at PSU. He is from Kenya and wants to work with immigrant and refugee populations, and is also keen on continuing to work with other marginalized groups in Oregon, including racial/ ethnic and gender/ sexual minorities as well as individuals with disabilities. He can be reached at neilpanchmatia@gmail.com.

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COPACT Corner: SB 860: What Does It Mean?

by Larry Conner, LPC, COPACT Government Relations Chair

In order to explain what SB 860 does, I will have to give some history of the process that eventually got us to its passage this year in the legislature. It is an involved and complex story, so please bear with me, because the details are important.

For over 20 years, there has been a precipitous drop in what health insurers have reimbursed for psychotherapy. For example, up until 2009, a prominent Oregon health insurer, let's call it Insurer A (this particular insurer really does not like it when we mention it by name) reimbursed LCSWs up to \$165 for 90837 (55 minute session). I knew many LCSWs who were serving Insurer A's clients almost exclusively and were making a good living paying their bills, saving for retirement, and getting their children through college.

In 2009, after 15 years of our struggle to get LPCs and LMFTs the right to receive insurance reimbursement for our work, we were able to pass the Practice Act, which achieved that goal. Before the bill was even signed into law, Insurer A reduced its reimbursement rate for Master's level providers by over 50%. They cited an obscure and unintelligible formula they claimed was based on Medicare rates, and which determined what they called "the usual and customary fee." The implication was that the reduced fee was based on what therapists typically charged. Nothing could have been further from the truth. The economic effect of the cut was devastating to providers. I knew a large number of LCSWs who retired or stopped working as therapists because of the impact of the cut.

In 2005 Oregon had passed Parity Law, which defines that health insurers cannot discriminate against mental health. In other words, if they reimburse services for physical health without limitations, they cannot limit services for mental health. Prior to that, insurers often set caps on mental health services, such as \$2000 of coverage every two years. After the passage of Parity Law, insurers had to remove all mental health caps. Without such limitations, overall reimbursements for mental health increased, so insurers started to reduce reimbursement rates sharply.

The Coalition of Oregon Professional Associations for Counseling and Therapy (COPACT) was formed in 2010. COPACT immediately began working alongside a group of independent social workers toward persuading legislators and the Oregon Insurance Commission to reverse these steep cuts in mental health reimbursement. For five years, we tried a number

of approaches and hit one dead end after another. We proposed a bill that would require insurers to publicly explain their reasoning behind their reimbursement rates. We tried another bill that tried to tie mental health reimbursement for psychotherapy to that of psychiatrists. We tried to convince legislators that the deep cuts in mental health reimbursement had put a large number of providers out of business in rural areas, thus putting many Oregonians at risk because of lack of available care. None of these approaches worked.

Several other things happened close together that helped our cause. COPACT, along with the independent social workers group, had been making the case in the legislature that closed panels led to reduced access to care because of the attrition of panel members due to death and retirement. When testifying in Salem in 2015, COPACT cited a study in Massachusetts that suggested Insurer A's national organization had a policy of restricting access to mental health care via closing provider panels indefinitely. A few months later Insurer A unexpectedly opened its panel for the first time to LPCs and LMFTs. But, at the same time, Insurer A effectively cut reimbursement rates for Master's level providers an additional 30% by announcing that, without preauthorization, they would no longer reimburse for 90837 (55-minute session), but only for 90834 (45-minute session).

The preauthorization process to get 90837 covered was nearly always futile. Most insurers seem to follow Insurer A's lead in Oregon. It is now common for health insurers to reimburse only for a 45-minute session, at a reduced rate.

There was no research-based rationale for this reduction. No insurer has tried to prove that a 45-minute session is sufficient for a mental health client. They just changed the policy because they could, even though the 55-minute hour had been the standard for psychotherapy since our field's inception, and that is what our clients expected us to provide. The decision to reimburse only shorter sessions was based merely on insurers limiting mental health reimbursement, without any concern for the welfare of the client. This new insurance gambit gave COPACT an idea.

We began to think about a piece of legislation that would address mental health reimbursement cuts as violations of Parity Law. That eventually became SB 860.

(Continued on p. 16)

(COPACT Corner continued from p. 15)

By 2016, the independent social workers group had ceased to exist and many of its members had joined a new organization of independent multidisciplinary providers. Also by that time COPACT, the National Association of Clinical Social Workers-Oregon Chapter (NASW-OR), and the Oregon Psychological Association (OPA) had formed an informal but strong and active coalition in the legislature to work on mental health issues. We coordinated our work, splitting up tasks while the legislature was in session and in the interim between sessions. The lobbyists from the three organizations, met regularly to coordinate our efforts. By 2016, the new multidisciplinary provider group had hired a lobbyist and we invited them to join the informal mental health coalition. Because COPACT, NASW-OR and OPA were busy with a number of pieces of legislation during the 2017 legislative session, the coalition asked the new group to propose a bill to address reimbursement rates as violations of Parity Law.



Our amazing lobbyist!

With the help of COPACT and the mental health coalition, they wrote an excellent bill, SB 860. They presented it to the legislature with the support of COPACT and all the other members of the mental health coalition. It was a challenging piece of legislation and all of those testifying, including COPACT's lobbyist, Elizabeth Remley, did a great job explaining a complicated issue to legislators, most of whom don't understand mental

health services. SB 860 passed both chambers and was signed into law by Governor Brown. That was a great moment, one that fulfilled 7 years of hard work on this issue.

SB 860 requires the Department of Consumer and Business Services (DCBS), which includes the Insurance Commission, to evaluate mental health reimbursement reductions to see if they violate Parity Law. SB 860 gives Parity Law teeth for the first time. But SB 860 is not a quick fix. No, mental health providers will not get an instant increase in reimbursement rates. But insurers are on notice that their past and present mental health reimbursement reductions will be fully evaluated, and if they are determined to violate Parity Law, the insurer will be disciplined. The exact nature of that discipline is not yet defined. COPACT will be working to ensure that the discipline will be helpful. SB 860 does not just cover reimbursement reductions but also includes 90837-34 shifts, preauthorization, reauthorization, closed or inadequate provider panels and whatever else insurers may come up with to try to limit access to mental health care.

So, the good news is there is now a statute on the books that calls insurers to responsibility concerning mental health reimbursement rates. Another piece of good news is that COPACT has been in dialogue with DCBS about this issue for a

number of years. Because of that dialogue, DCBS has been requiring insurers to give them data about mental health reimbursement rates. So, DCBS already has reams of data about reimbursement changes over time and they may be able get to work on this quickly.

Now for some disappointing news: The Directors of both DCBS and the Insurance Commission have both been transferred to the Oregon Health Authority to help manage the fallout from some major organizational problems there. That means we will have to start over with new administrators. COPACT will not know them and they will not know us. They will not know the process we have been through and the nature of the issue we are dealing with. That will slow down the process. We are all going to have to be patient as the wheels of government turn. I can promise you that COPACT will do whatever is needed to keep this process moving toward true parity.

The passage of SB 860 is a huge accomplishment. SB 860 is what is typically called a "heavy lift" in the legislature. We were successful, thanks to the cooperative work of all the members of the mental health coalition. Many people worked very hard on this for many years. COPACT has made this one of its priorities since its inception in 2010.

For over 15 years, LPCs and LMFTs were excluded from the political process. Thanks to the Practice Act, LPCs and LMFTs are now core providers of mental health services in Oregon, and we are expected to participate in all policy decisions and legislation having to do with mental health. Now that we are fully at the table, COPACT has chosen a path of inclusivity, cooperation, and coordination. That starts with its inclusion of LPCs and LMFTs in the same organization. Beyond that COPACT works to maintain strong working alliances with NASW-OR, OPA and other provider groups. The payoff is in a bill like SB 860. Let's all feel proud of this accomplishment, while COPACT keeps working toward continuing inclusivity and cooperation on behalf of all mental health clients, regardless of the academic degree or license of the person providing the service.

And last, please note that the passage of SB 860, and all of the statutes COPACT has gotten through the legislature, was possible only with our strong lobbying presence in the legislature. Remember you can donate to COPACT directly at www.copactoregon.com/donate to support our lobbying effort. And ALWAYS motivate your colleagues to be ongoing members of ORCA and/or OAMFT. The bulk of the funding for our lobbying effort comes from your membership dues in our two professional organizations.

If you have any questions about SB 860, or any other political or legislative issues, feel free to contact us at president@copactoregon.com.



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.

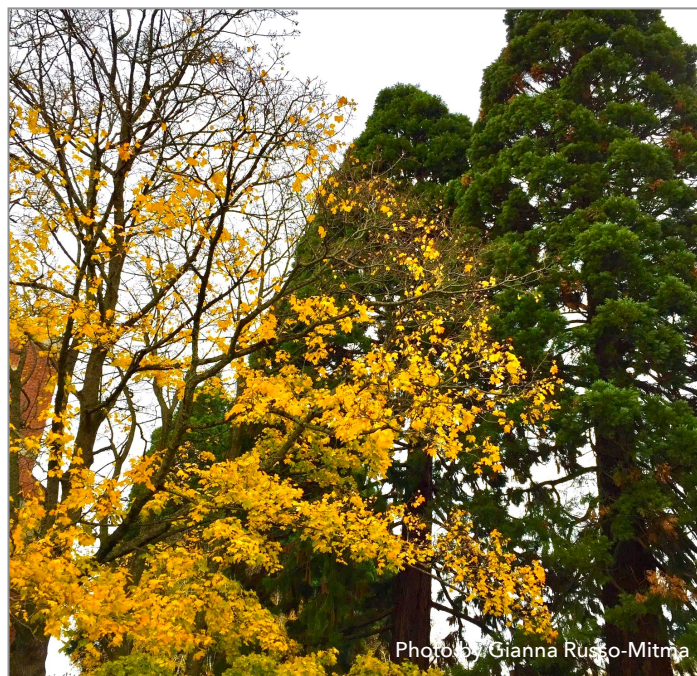
COPACT cannot do this alone. COPACT will continue to protect the interests of LPCs and LMFTs as long as you are able to give your financial support. Please donate at copactoregon.com/donate and maintain your memberships in ORCA and OAMFT. If you are interested in helping out directly, contact us at PublicPolicy@or-counseling.org.

OACES Corner: Changing Campus Climate

by Joel Lane, LPC, Ph.D, ORCA President

Given the focus on intersectionality in this special edition of *The Counselor*, I wanted to devote this OACES Corner to sharing some of my observations working in higher education over the past few years. I work as an Assistant Professor of Counselor Education at Portland State University, and in my four-plus years at PSU, I have witnessed some monumental shifts regarding campus climate and the overall university experience for students. There is a good chance you have heard about some of these shifts as well. There have been a multitude of think pieces in recent years about safe spaces, trigger warnings, and related concepts, with much of the coverage being negative (concerns generally involve free speech, coddling, etc.). I would like to take this opportunity to offer my perspective on why these changes are positive, important, and long overdue.

While there is considerable debate about campus climate trends, there is greater consensus about inequities in higher education on the basis of gender identity, race, sexual orientation, ability, and mental health status. There is a wealth of data demonstrating that some groups have historically enjoyed greater access to higher education, as well as higher retention rates once enrolled. It is my firm belief – and also the consensus among education researchers – that these inequities are self-perpetuating. That is, given that dominant cultures have been overrepresented among college attendees, we should expect this same overrepresentation to exist among those providing education to college students (which is unequivocally the case; for a clear example look no further than the demographics among counselors as a whole versus the demographics of counselor educators). This overrepresentation among educators means that we can also expect an overrepresentation of dominant culture perspectives in higher education curricula, which in turn makes it more likely for students with dominant



cultural identities to thrive in higher education, perpetuating a cycle that makes it disproportionately difficult for individuals with minoritized identities to enjoy the upward mobility that comes from a college education.

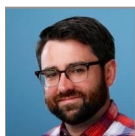
This brings us back to the topic of recent changes in the campus climate, which are being enacted in direct response to these inequalities. Providing safe spaces on campuses, for example, provides individuals with minoritized identities an opportunity to connect with their communities in an environment that is disproportionately comprised of non-minoritized individuals. It also makes it easier for these communities to organize and voice their experiences to the broader campus community. Similarly, despite the overwhelmingly negative public narrative around the issue of offering trigger warnings in class, doing so provides students with trauma histories or mental illnesses greater opportunity to learn and thrive in higher education.

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(OACES Corner continued from p. 18)

These types of provisions are important even in a community like Portland (in fact, perhaps even more so), which prides itself on its openness and acceptance of alternative lifestyles. Many Portlanders would be shocked to know the number of times students have confided in me about being harassed on campus due to their transgender identity, ability status, race, and/or sexual orientation. Sadly, this harassment comes not only from other students, but sometimes from other campus faculty and personnel.

I see this issue as having implications for our counseling practice. Being a counselor has taught me time and again that all clients have different needs and perspectives, and part of what I love about our work is the creativity required of us to be responsive to diverse client perspectives. As an able-bodied, cisgender, heterosexual white man, it is especially important for me to be open to feedback and perspectives from individuals with non-dominant multicultural identities, as without such feedback I am likely limiting my effectiveness as a counselor and as a counselor educator to clients and students who share my identities. I implore all counselors and counselor educators (myself included), regardless of identity status, to strive to better understand how our identities and experiences have shaped our values and worldviews, and to continually learn about the values and worldviews of those who hold identities different from our own.



Joel Lane, Ph.D is an Assistant Professor and Coordinator of Clinical Mental Health Counseling at Portland State University. He provides supervision to registered interns and conducts research related to the mental health implications of emerging adulthood. He lives in Portland with his wife, Megan, son, Ari, and dog, Magglio.



Saturday, February 17, 2018 | Lewis & Clark College, Portland, OR



**An Evidence-Based Sociocultural Approach to Eating Disorders
Prevention in the Age of Neurobiology: 10 Principles for a Bolder Model**

Michael P. Levine, PhD, Emeritus Professor of Psychology, Kenyon College

Participants will examine the prevention of eating disorders from the perspective of a feminist sociocultural theory that extends the Bolder Model of Prevention by Lori Irving and Michael Levine. Topics to include rationale for prevention, relationships between prevention and risk factor research, types of prevention along a spectrum of mental health interventions, and more.



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Jennifer L. Gaudiani, MD, CEDS, FAED, Founder, Medical Director, Gaudiani Clinic

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This conference is co-sponsored by the Columbia River Eating Disorder Network (CREDN), and Lewis & Clark Graduate School of Education and Counseling's Professional Mental Health Counseling-Addictions Program and the Center for Community Engagement.



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2017 ORCA Power + Privilege Essay Award Winners

This year for the first time the Oregon Counseling Association offered graduate students throughout Oregon the opportunity to submit essays in competition for free admission to our 2017 Conference. We received several thoughtful submissions, and today ORCA's Graduate Programs Chair, Meghan Opbroek, is pleased to present our **Power + Privilege Essay Award** co-winners, Eliza McBride and Marjorie Gosling. Feel free to congratulate them when you see them at the conference! And like [ORCA on Facebook](#) to stay up to date on all our events.

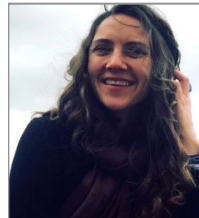


Eliza McBride

Portland State University

"I don't know very much about Filipino culture. Could you summarize it in two to three sentences?" I was given this task by the first mental health counselor I had ever seen. It was junior year of my undergraduate experience, and I had finally worked up the courage to seek therapy at the student counseling clinic. That first session, I tried to explain how family and cultural expectations were further exacerbating the anxiety I felt as a first-generation immigrant student. I shared how the isolating effects of being a racial minority at a university that was over 80% White intensified the depression I experienced, especially during holidays when I stayed on campus because limited finances restricted opportunities to travel home. As I spoke, I noticed the counselor growing more irritated and uncomfortable. The mental health issues I was seeking help for existed within contexts of underprivileged identities related to gender, socioeconomic status, race and ethnicity - topics the counselor may not have been prepared to address. I recall how the counselor focused solely on the diagnostic aspects of anxiety and depression for that first session. It concluded with the counselor sharing various forms of medication I could take with the offer of collaborating with a primary care physician. I left the clinic feeling misunderstood and slightly less hopeful. During the second, and last, therapy session I attended with this particular counselor, I mentioned race and ethnicity again.

(Continued on p. 21)



Marjorie Gosling

Oregon State University

Long gone are the days where a counselor would participate in a session as a blank canvas, writing notes and asking a few well directed questions. As a graduate student in Oregon State University's Masters of Counseling program, I am taught to lean in, to show empathy, to show care. I have been encouraged to develop meaningful and deep rapport with the people who will choose to work with me. It is my opinion that without an understanding of my own relationship to privilege and oppression, true empathy and rapport cannot be achieved.

Personally, learning about my privilege and the ways that that privilege oppresses others has been some of the most transformative work that I have ever done. Before studying Social Justice at Prescott College, I was naïvely blind to privilege, oppression, and the social constructs that continue to feed both. I have never wanted to disconnect with something so much as I did with my White privilege and subsequent White guilt. The chosen blindness to my place and privilege in society was subtle, insidious, and destroyed my ability to connect with the people of color around me. The knowledge and resentment of my privilege grew. I found myself quietly afraid of ethnicity and other cultural differences in the people I interacted with. I allowed myself to become blind to the nuance of others around me and to the oppression that they experienced.

(Continued on p. 21)

(Continued from p. 20)

This led him to ask me to summarize my entire cultural identity in a few sentences. I walked out of that session feeling exhausted, confused and discouraged.

Over the years, as I've slowly processed my first experience seeking therapy, I've realized that it's been a springboard for understanding how crucial it is to be aware of privilege and oppression in therapeutic relationships. I think of this past experience often, especially as I approach the last year of my graduate program to become a mental health counselor. I never want present or future clients to leave a session feeling further marginalized because I was not culturally sensitive or responsive. As a counselor-in-training, I feel that understanding my own relationship with privilege and oppression is vital if I intend to grow as a counselor and better serve the needs of my clients. It is my obligation to be aware of my own implicit biases and prejudices that may negatively affect my work with clients, either in the form of not addressing the client's multicultural identities, or expecting the client to expend limited time and energy towards educating me. It is also my responsibility to stay up-to-date with issues related to social justice so that I can have a working knowledge on how to be a better advocate for my clients. As I've learned from my own personal experiences, a client's mental health issues do not exist in a vacuum – they exist within a spectrum of intersecting identities and backgrounds. It is necessary to acknowledge that a therapeutic relationship already comes with an inherent power imbalance between the therapist and client. It is important to be actively aware of our identities and privileges as counselors and how it affects the power dynamic within the therapeutic relationship. Awareness indubitably leads to growth, both for the counselor and the client.

As I experience the beginning stages of becoming a counselor, I'm often reminded to check in with my privileges and identities. It is not always a comfortable process, but I've learned it is required for growth as an individual and as a professional. I believe that essential to my growth as a counselor is approaching the client and the counseling process with humility – to acknowledge that I am still learning, that I will use the knowledge I have so far, and that I will be open to further discourse that may challenge and ultimately develop my thinking and practice. The field of counseling will continue to improve and evolve depending on our growth as practitioners. Understanding our relationship with privilege and oppression is a fundamental component to making that growth possible.

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I chose to become a part of the problem, looking away from the uncomfortable discrepancies that others around me experienced.

My journey in that place of blindness is as important as the one I took out of it. I am informed by memories of my judgments and bigotry of others. I can see my privilege acting out and participating to oppress. There is much to be said that my hands have never hefted a rock to throw at someone different than myself, or participated in violence. But that my privilege creates a quieting of the outrage I feel when hearing about injustice is as deeply a part of the problem as those acts of hatred. In learning about my privilege and what it has afforded me in my life shapes my empathy, hones my compassion, and makes me a more skilled counselor. I cannot sit a client, both with the privilege and oppression that they have experienced, without diving deeply into my own. I need the knowledge of the ways that racism, homophobia, ableism and more show up in the world and within myself so that I can be truly empathic.

The path to the counseling profession itself is a privilege. I must have a high school diploma, an undergraduate degree, and a master's degree to even become a Licensed Professional Counselor Intern. There are postgraduate tests, continuing education classes, and a position where others will seek out my services. So, again, my privilege shows her head. Here is the nuance of privilege and oppression: it is a never-ending search to see my place in the world and how I affect the people around me.

I have been taught that as a counselor I will be a pillar of the community, but how can that be if a personal study on the inner landscape of privilege and oppression is not conducted? I am within the system and outside of it. I both contribute to the oppression of others, and experience oppression myself. I hold onto long lasting oppressive narratives about people different than myself even as I try to uncover them. But the more I search, deeply, about how my privilege affects the lens in which I see the world, the more effective I become as a counselor and, more importantly, as a human being.

Call for articles

Focus On: Effective Advocacy Approaches

The Counselor, the quarterly newsletter of the Oregon Counseling Association, invites articles to be submitted for consideration for our Winter 2018 issue. This issue will FOCUS ON: EFFECTIVE ADVOCACY APPROACHES as they relate to the helping professions and to communities in Portland and in greater Oregon.

The purpose of Winter's special issue is to share institutional knowledge around counseling folks with particular needs. Let's share what we know and learn from one another's experiences.

For our Winter issue, we welcome personal narrative, annotated resource lists, advice for the helping professions, photographic essays, manifestos, and similar. Here are some questions we know our members would like answered:

- How can I best assess my client's need for a companion animal? If warranted, how can I advocate on my client's behalf with their landlord or workplace?
- Which agencies offer culturally-specific support, and for whom, and how can I help my client access those?
- Help! I have a new client, I've done my Google homework, but I'd love more information about poly families/people seeking "freedom from religion"/advice for dealing with chronic pain, etc.
- A new referral requested that I help them with their goal of medical gender confirmation. What is the fastest way that I can help my client change all their documentation to reflect this change?
- My client is experiencing interpersonal violence - help! What local resources are available, and what basic steps can I take to help my client stay safe?
- Does anyone have a good list of books and articles about interrupting microaggressions in the workplace? How about resources around what it feels like to attend an OA meeting for the first time, a list of places that offer delivery for food boxes, Youtube channels about building DBT skills, or ideas around harm reduction and opioid dependency? Short resources written for a general audience are a plus!

People of color, LGBT folks, people with disabilities, low-income folks, people diagnosed with mental illness, and folks with experience being treated as a case in need of management are particularly encouraged to submit to this issue. To include a range of perspectives, each article will be succinct, with a maximum of 500 words excluding references, figures, artwork, and photography, if you like.

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

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.

Counseling the Person with Legal Blindness

by Deb Marinos, CRC, LPC Intern

Imagine: your first consult with a new referral comes in, and they appear to be blind... but you can tell they're not completely blind. You might feel uncomfortable asking questions or appearing to make assumptions about your new consult. I'm here to help.

First, legal blindness is defined by the Social Security Administration as a state in which vision is "20/200 or worse in the best eye." With correction (usually glasses) a person with legal blindness's vision is fuzzy and labeled Low Vision. They cannot recognize faces or read standard print. You might see a previous diagnosis of Macular Degeneration or Diabetes.

Some folks with slightly better vision can read and recognize faces; however they have great difficulty in moving around safely, finding objects and doorways. For these folks, you might find a previous diagnosis of Retinitis Pigmentosa or Glaucoma.

I've spent several years helping clients with various degrees of sightedness, and as a person dealing with sensory disability myself, I'd like to offer my colleagues some specific tips to help the counseling room be more accessible and help folks feel more connected to you.

Transportation is by far the biggest challenge and frustration, especially for those who used to drive. For this reason, rigid policies about lateness and missed appointments will be problematic to the relationship if not managed compassionately. If folks need at the last minute to cancel their appointment because the bus is running late, a phone session might be something to consider.

First: ask them! Do not assume. Accept clients' stories of their unique sensory disability and its impacts. Each person has a unique experience and may feel discounted if not feel heard. Appearances can be misleading.

Ask what makes them most comfortable in greetings. Do they want you to identify yourself? Can they find your door

through the lobby verbally, or by handshake, or signs? What helps?

Ask, ask, ask! Can they see the clock? Is the lighting hurting their eyes? What are they hearing? (they might be hearing the stress in your voice!). Chuckle when you smile, and make sounds when you are listening or showing compassion. Consider other senses.

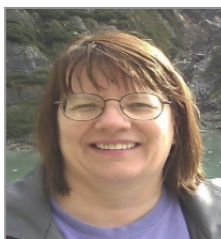
Consider describing the features of your office space. Consider where you place breakable objects - the holidays' sudden onset of new items, often breakable, can be a minefield. What would it feel like to just give specific directions: "At your three o'clock, a small table sits two feet away from you."

Consider: can the client get out to the door out on their own? Will the therapist help - no matter what?

Make it easy to request accommodations ongoing. Make forms accessible by sending by email or recording audio. You might consider getting a "Pen Friend" by RNIB - it's an easy recording tool that lets you record to a sticker that can be played back by person with no sight with headphones. Print forms in larger fonts by request.

Make it ok to clarify as often as needed. Imagine keeping track of your life in your head if you couldn't write notes. Offer to record sessions on their smart phone. Offer a wide marker and 3x5 cards for notes.

Thanks for your interest and concern for all of your clients.



Deb Marinos, MS, CRC, LPC intern has worked with many clients with varying degrees of vision loss for several years. Her practice: Adaptability for Life, LLC provides interactive training for professionals who want to understand how to make their

workplace accessible. www.adaptabilityforlife.com

Veterans Have Their Own Culture

by Rev. Shane Nelson

As a U.S. Army veteran that primarily counsels other veterans in Eugene, most of the clients that sit across from me are like me: Caucasian, cis-gender, heterosexual males. In working with this population, it can be extremely easy to make assumptions and miss the cultural components at play.

A veteran's path toward counseling can be extremely difficult. Each veterans' experience carries its own burdens, traumas, and moral injuries that are specific to their era of military service. Additionally, it is engrained in many veterans that seeking professional mental health counseling can negatively affect the development of their career. For this reason, many active service members and veterans will substitute working with peer support organizations or clergy for traditional counseling. If they do seek out therapy, many veterans believe that they must filter their language and experiences, break out of the moment to translate terminology or explain the expectations of a particular role, or hold back the intensity of what they share with a civilian counselor.

This lack of professional support can lead to isolation and self-medication. Some are from a long line of military families and carry the effects of inter-generational trauma. Many veterans carry a view of themselves as a monster (or use other disparaging self-talk) because of the actions required to survive their experiences. My strongly held belief is that it is almost impossible to provide long-lasting treatment around the burdens, traumas, and moral injuries of military service without encouraging the development of self-compassion and mindfulness skills that can feel weak, feminine, and unimportant to many immersed in veteran culture.

So, the question for me when working with veterans has always been this: How do I provide a space of stability

and safety for my veteran clients? There is no easy answer for this, and what works for me may not work for you. However, this is how I attempt to facilitate an answer to this question: I use appropriate self-disclosure around my military service and my transition experience from the service member to veteran to build alliance. Beyond that, I work with a foundation of internal family systems and narrative therapy techniques. This allows the veteran's story to guide the healing process while explicitly acknowledging the existence of (and working with) the parts that make up an individual. Finally, I incorporate various interventions from other orientations - including cognitive-behavioral therapy, existentialist therapy, mindfulness techniques, and rites of passage techniques - to holistically address the varied concerns that arise when working with a given individual. In short, I let my clients know that I know something about their culture toward creating a safe space, encourage them to think about their experience in a cultural context rather than a vacuum and attempt to meet them where they are.

In closing, it is important to remember that everyone carries a unique cultural experience. Assessment can become an important tool in assisting us helping professionals with not making assumptions. For me, this work is personal. As a white, heterosexual, cis-gendered male, I also want to be seen as an artistic, religious, veteran, and father - it's important to me that these parts of myself are not overlooked. It is deeply important that a veteran's first counselor ask questions about their culture so that the parts of their personal narrative that they find most important do not go overlooked.



Rev. Shane L. Nelson is a ten-year veteran of the US Army infantry, a current student at Northwestern Christian University and a counselor at the Eugene Mission. This February, he will be re-entering the Army as a Chaplain Candidate.

He encourages anyone interested, or who has further questions, to contact him at shnelson@nwcua.edu.

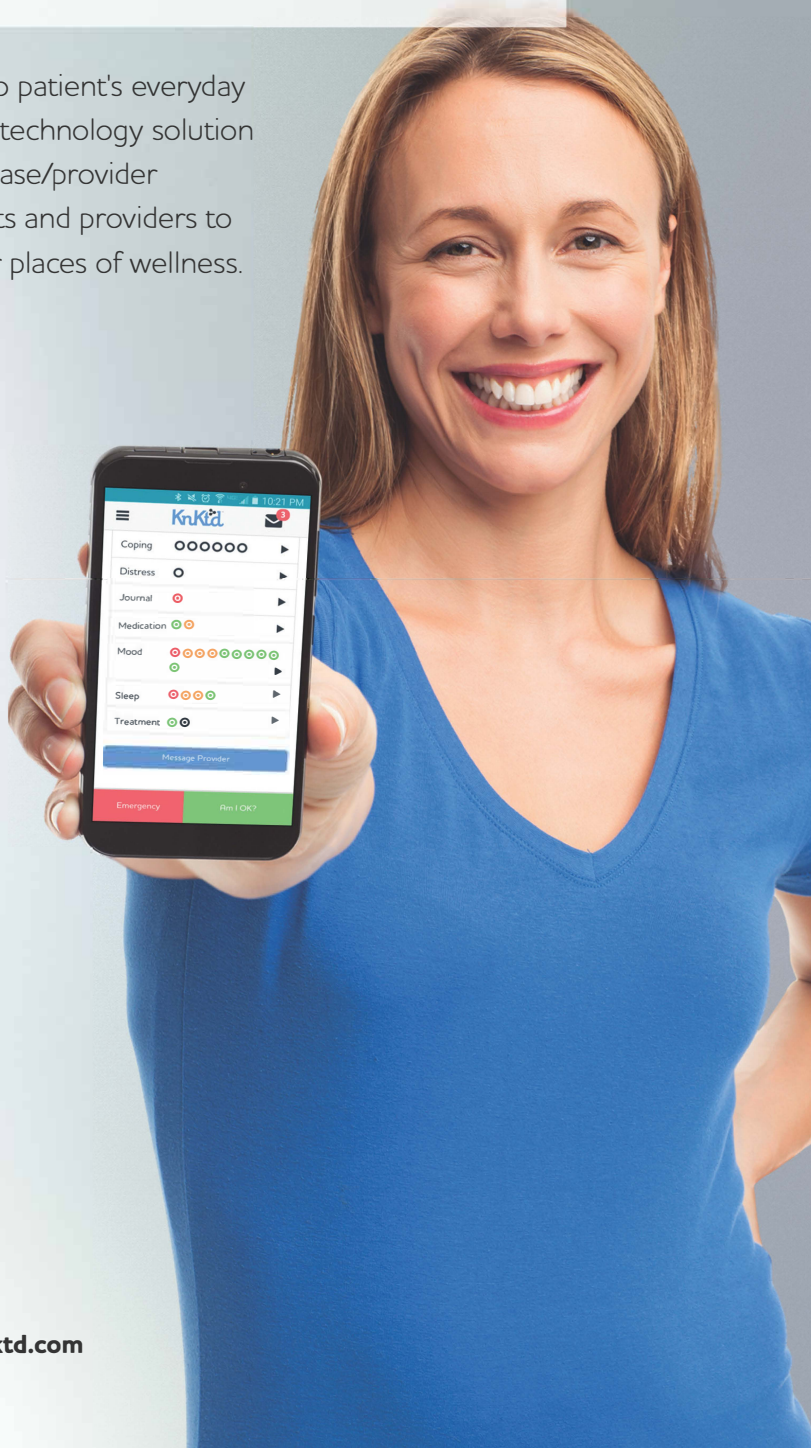
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