



THE COUNSELOR

Past President's Message

Happy Summer, ORCA members!

This is my final message as ORCA President. Our new President, Gianna Russo-Mitma, was sworn in at our July 7th ORCA Board meeting. It has been an honor to serve as President over the past year. Thank you for entrusting me with this important role.

We are currently in the midst of a major advocacy initiative regarding our country's immigration issue. You may have seen ORCA's recent statement regarding the Trump Administration's zero-tolerance policy (if not, see page 3). As part of the initiative, we are offering ORCA members a chance at a free registration to an upcoming ORCA professional development training. Simply call or write to one of your congressional representatives to share your concerns regarding the zero tolerance policy, and email a screenshot of the message or call log to pastpresident@or-counseling.org to participate in the drawing. We will be giving away one registration for a professional member, and one registration for a student member.

I wanted to take this opportunity to share that, after much deliberation among ORCA leaders, we have decided not to hold our Fall conference this year. This was a difficult decision to make, and ultimately we have decided to focus on individual training sessions this year instead of a conference. While we are excited about the trainings we are planning for the year, we will miss hosting you all at the fall conference. As of now, our plan is to have a fall conference again in 2019. In the meantime, there are multiple exciting conferences taking place in Portland this fall for mental health professionals, including [the national conference for the Association for LGBT Issues in Counseling](#) this September, and [the state conference for the Oregon Association of Marriage and Family Therapists](#) in October.

In other news, we held our first quarterly [Person Centered Tech](#) online office hours session on May 31st. Thanks to everyone who submitted questions, and thanks to Roy Huggins and the rest of the PCT team for sharing your wisdom! Stay tuned for details regarding the next office hours session, to be held later this summer. Don't forget to log in to your member portal on the [ORCA website](#) for a complimentary viewing of PTC's spring "office hours."

Back in May, we also participated in the annual National Alliance on Mental Illness NAMIWalk. Thanks to ORCA Secretary Sofia Jasani for leading the team and motivating so many ORCA members and volunteers to participate! Because of Sofia's efforts, we raised over \$3,000 for NAMI, which ranked us among the top 10 participating teams. Great work, Sofia!

It's been a pleasure.

Sincerely,

Joel Lane, PhD LPC NCC

Past 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

Advertising Policy

ORCA reserves the right to edit all copy and refuse ads that are not consonant with the principles of Title VII of the Civil Rights Act of 1964 (EEO). Publication of an advertisement in *The Counselor* is not an endorsement of the advertiser or of the products or services advertised.

Statement on Anti-Discrimination

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.



Statement by Oregon Counseling Association Regarding the Trump Administration's Zero Tolerance Policy and the Detainment of Immigrant Children

Oregon Counseling Association is shocked and saddened for the thousands of immigrants, including over 2,000 children, who have been detained and separated from their family members as a result of the Trump Administration's Zero Tolerance Policy. Even in this time of extraordinary political divide in our country, the policy and its resulting practices have been widely condemned by individuals and organizations across the political spectrum. While President Trump last week signed an Executive Order formally ending the practice of separating families the border, there is still [no timetable for reuniting separated families](#), and [multiple news outlets are reporting that detained migrants are being offered reunification with their children only if they agree to withdraw their asylum cases and be voluntarily deported](#). Some current and former U.S. government officials believe that [many of the separated families will never be reunited](#).



As counseling professionals, we possess an intimate knowledge through our training and clinical experiences of the harmful consequences of adverse childhood experiences, as well as the trauma that results from forced separation of any duration from parents and caregivers. Separating and detaining children and families indefinitely is a clear catalyst for trauma, and there have been disturbing reports of the treatment children have received while detained, [including being forcibly given psychotropic drugs without patient or parental consent](#) in response to behaviors that counseling professionals can easily identify as trauma responses.

The actions sanctioned by our federal government's policy represent clear risk factors for future mental health and substance abuse challenges. As such, our profession's values, as well as our roles as advocates for positive change, compel all counselors to condemn this inhumane policy in the strongest possible terms. The [American Counseling Association has called on the Trump Administration](#) to immediately and permanently end family

separations and the zero tolerance policy, present a clear plan with a timeline for reuniting detained children with the parents or legal guardians who brought them to the U.S. border, and present a clear plan for providing treatment of the trauma inflicted on all family members impacted by this policy.

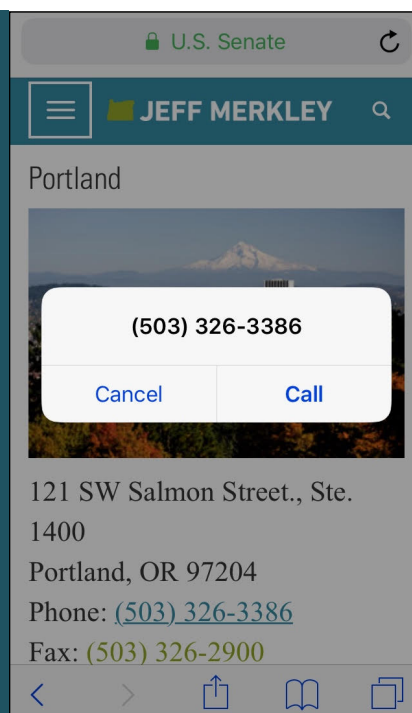
We urge ORCA members and the broader counseling community to take action. Call or write letters to [your congressional representatives](#) urging them to demand that the Trump Administration promptly reunite and provide treatment to the thousands of individuals harmed by the Zero Tolerance Policy. While we recognize that the counseling profession is comprised of both critics and supporters of the current administration, it is also true that our training and knowledge related to human growth and development knows no political ideology. Please join us in standing up in support of detained immigrants and in opposition to government-sanctioned trauma.

Joel A. Lane, PhD LPC NCC
Past President, Oregon Counseling Association

Want a **FREE** CE training? Enjoy supporting your community?

Send ORCA a screenshot of you contacting a representative with your thoughts about the shameful and un-American detention of children and asylum-seekers and you could win FREE entry to an upcoming in-person ORCA Professional Development training.

Each screenshot sent to pastpresident@or-counseling.org, Aug. 1st - Oct. 31st 2018 is eligible for this drawing. One ORCA student member and one ORCA professional member will be selected at random to win free entry to an upcoming in-person ORCA-sponsored training. Feel very free to call or email your reps a whole lot because a) they're working for you, and b) each time you send us a screenshot will count as a separate entry.



Upcoming Workshops for Counselors & Therapists

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

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

Friday, September 7, 9 a.m.- 12 p.m. | 3 CEUs

Solution-Focused Supervision

James Gurule, MA, LPC
Satisfies the OBLPCT's 3-hour requirement for licensed and registered supervisors.

Friday, September 21, 9 a.m.- 5 p.m. | 7 CEUs

Understanding Personality for Clinical Professionals: The Enneagram's 9 Points of View

Dale Rhodes, MS, MA

Friday, September 28, 9 a.m.- 3:30 p.m. | 6 CEUs

Law and Ethics Symposium for Mental Health Professionals

Margaret Eichler, PhD, LPC, NCC

Saturdays, October 13 and December 15, 9 a.m.-5:30 p.m. | 30 CEUs

Gambling Counselor Pre-Certification I

Rick Berman, MA, LPC, CADC III, CGAC II;
Mark Douglass, LPC, NCGC-II/BACC, CDAC I

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

Cultural Competency Training

Saturday, September 15, 9 a.m.-4:30 p.m.

Enhancing Reflective Clinical Practice: Recognizing Implicit Bias and Deepening Your Cultural Competence

Michael Kahn, LPC, JD 6 CEUs

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

Talking About Race and Racism: A Developmental and Integrative Approach

Cheryl Forster, PsyD 6.5 CEUs

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

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 7 CEUs

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



Separated at the Border: Kids (and Controversy) Come to Portland

by Moira Ryan, Editor, *The Counselor*

ORCA's values dictate that we support those affected by politics; our values also dictate support for those mental health providers working diligently in the field to care for traumatized children. We continue to bring you articles that educate, enlighten, and empower.

This spring, in a recent escalation of US policy, many asylum seekers began being stopped by Customs Patrol [before](#) crossing a legal point of entry into the States and told to return at a later date. (Asylum claims [must](#) be submitted on US soil.) In April, the Republican administration announced a new "zero tolerance" policy aimed at treating illegal border crossings as crimes (as a migration deterrence strategy). This created the situation we're all familiar with today: children forcibly separated from their parents, adult asylum-seekers held in prisons ([including here in Oregon](#)) or [deported](#), and their children flown across the country and placed in shelters contracted by the Office of Refugee Resettlement (ORR).

On June 20th, KGW published [an article](#) reporting for the first time that Morrison Child & Family Services operates one of those shelters housing at least four children separated from their parents at the border.

Morrison CEO Drew Henrie-McWilliams appears genuine in his warmth for the work Morrison's doing, as seen in [a June 21st video](#) in which he allowed KATU to tour an unnamed Morrison facility. In an [open letter](#) posted June 30th to Morrison's website, Henrie-McWilliams argues against re-traumatizing children:

I feel it is important for us to hear the voices of the youth (aged 13-17), who are currently being served in our ORR programs, about what they have experienced in the past weeks. They want to understand why some, outside of Morrison, "hate them so much" that they would shout and bang on our doors a week ago Wednesday; they want to be able to go outside on outings and appointments without worrying that someone will shout at them or harass the staff helping them; they wanted us to show that their space with us is pleasant and that they feel good about how staff help them; and they too want us to keep working to find family and/or sponsors in our country with whom they can be placed. We ask that those who continue to protest for the reunification of

separated youth remember that all of our youth want to feel safe and want to have their privacy honored.

Exactly how to respect these children's (and their families') right to safety and privacy seems to be at the heart of the matter. And there are many facets to consider. For example, for the last 15 years, the ORR's mission was to assist unaccompanied minors with successfully resettling with their family members already living in the US. As of April's memorandum, however, [all information about a potential sponsor or family member compiled by ORR must now be also given to ICE](#). This obviously raises suspicion in many would-be care-givers who must choose between risking deportation and taking in a child. The stakes are high for teenaged children, who upon turning 18 "age out" of ORR custody and [may be picked up by ICE and deported](#).

When *Portland Mercury* reporter Kelly Kenoyer asked Henrie-McWilliams why Morrison continues to work with ORR, he [replied](#), "I only want our staff to help kids be treated well while they're with us and get them to a family or a sponsor. If at any point we can't make that happen... I wouldn't want to keep doing it."

It's a tricky issue, and an emotional one for many in our roles as professionals as well as democracy participants. When we reached to Multnomah County Commissioner Sharon Meieran, she highlighted the difficult balance between complicity and care this way:

To be honest I have mixed feelings about this issue as a whole [...] I worry about where children would end up if we didn't have trusted providers to care for them, and clearly an established facility and provider is better than a warehouse. But I also worry whether we further entrench these policies and practices by providing links in the chain, even if they're better than the alternative. It's a really tough issue, and one that I think about and struggle with every day.

ORCA's values dictate that we support those affected by politics; our values also dictate support for those mental health providers working diligently in the field to care for traumatized children. We continue to bring you articles that educate, enlighten, and empower.

Not in My Name

by Emma Sohriakoff, LCSW

I am a social worker who worked for two and one half years as a Case Manager and Mental Health Therapist at an ORR immigrant youth detention center run by Morrison Child and Family Services in Portland, Oregon. During my time working in that program, I was witness to many violations of the rights of immigrant children and families by ICE, the Office of Refugee Resettlement (ORR) and the government contractors who run these programs including my former employer.

Many youth who came to us should have never been in custody. Some youth did come to us after crossing the border alone, but sometimes they came with an adult family member from whom they were separated by ICE. We also received youth who had been living in the US since infancy and were living with their family. Usually after having some type of problem in the community they were removed from their family by local authorities and turned over to ICE who rather than return them home to await their immigration hearing, turned them over to the ORR and placed in a youth detention program.

The law states that they youth are to be kept in the least restrictive environment possible, but that is not happening. ICE is not doing due diligence to contact parents. When I would call a parent informing them that their child had arrived at the youth detention the parents told me that they had not heard from the child and had been terrified.

(Not in My Name continued on p. 5)



Photo by Moira Ryan
(Families Belong Together rally)

(Not in My Name continued from p. 4)

Parents were not even given opportunity to claim their child before they were sent to a youth detention program, which was often out of state, and resulted in the parent having to go through an [arduous process of applications, fingerprinting and background checks to regain custody of their child](#).

While working as a case manager and a therapist, I was involved in the cases of a youth which involved working directly with an ORR Federal Field Supervisor who claimed that because ORR had physical custody of the child that they were the legal parent of the child and the youth had no right to confidentiality from them. They claimed that HIPPA standards did not apply to these programs because they were not treatment centers despite the fact that the youth were receiving medical and mental health treatment while in custody. [Staff were encouraged by the ORR Federal Field Supervisor to gather data on the youth that could be used against them and report it to the ORR](#).

Another example of the ways in which the ORR and youth shelter and detention programs are colluding is in the moving of youth to different programs from state to state. This always resulted in delays in their reunification or legal case and resulted in them being detained longer. Moving from state to state would cause their legal case to be restarted over and over again and such moves could destroy their legal case completely or run down the clock on the time frame for their eligibility which ultimately could result in them being deported.

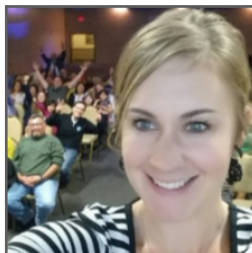
These programs and processes were set up to be a check of the ORR to provide fairness and balance in the decisions that are made about the releases and reunifications of these youth to their families. However, because the money is coming from ORR, they can exert pressure and Morrison was not

willing to push back or stand up for the rights of the youth.

These shelters and detention centers are run by government contractors such as my former employer Morrison Child & Family Services who benefit through high dollar contracts that prop up their budgets. In a recent public statement, Morrison stated that the ORR youth are only 5% of the population that they serve. However, it was told to me by the administration many times that these programs represent over 1/3 of their total budget and do a lot to financially support the other programs that serve youth and families in the community. [Ed's note: Morrison responds [here](#).] They told me this in response to the concerns I brought to their attention about the rights violations by ORR. They clearly told me this as the reason why they would not push back on the unethical and illegal policies of the ORR.

This is the clearest example that I've ever personally witnessed of institutional racism. They were willing to sacrifice the rights of immigrant youth in order to keep their programs open for local youth.

They believe that they are doing something good by feeding and housing the youth and being nice to them but they are benefiting from children being locked up away from their families. They are not willing to push back on the abuses of power by ICE and the ORR. We cannot allow this to continue in our community. Thank you.



Emma Sohriakoff, LCSW is a Mental Health & Chemical Dependency Therapist with experience serving clients in healthcare, non-profit, and hospital settings. She

presented this speech in front of the ICE office in SW Portland during a rally on June 24th.

ORCA: Walking the Walk

If you live in Portland and work in this field, you've probably heard about the annual awareness-raising NAMIWalks event on the Esplanade. Maybe you've walked with your agency, or with friends or family in support of the National Alliance of Mental Illness's educational programs and advocacy work?

ORCA's always been a huge proponent of reducing stigma and advocating for access to healthcare. This spring, ORCA Secretary Sofia Jasani (that's her giving us the peace sign on the far left) got motivated to spearhead an ORCA fundraising page for NAMIWalks NW. [Team ORCA's](#) original goal was to raise \$1,000 to support NAMI's work... but, **thanks to the generous support of donors like you**, we ended up raising over \$3,500! (*I know, right?! WOW!*)

Lesson learned: Sometimes when you stand up for what you believe in, others hear you and want to join in!





Portland AEDP is excited to present:

**Author and Therapist,
Dr. Ron Frederick**

**Neuroplasticity in Action: Rewiring
Internal Working Models of Attachment**

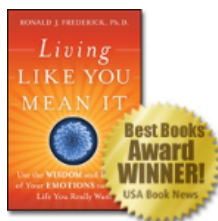
6 CEU'S available (approval in process)

We all have clients who struggle with what seem to be intractable mental models that keep them from making progress despite a deep desire to change. Early lessons about emotion and connection form instructional blueprints that get stored in memory systems outside of our awareness. This workshop will provide concrete skills for using the therapeutic relationship to leverage the brain's neuroplasticity and its innate drive to heal.

Extensively trained by Dr. Diana Fosha, the developer of Accelerated Experiential-Dynamic Psychotherapy (AEDP) Dr. Frederick has been practicing and teaching AEDP for over twenty years and is actively involved in the training and supervision of psychotherapists internationally. Making extensive use of videotaped clinical material, the seminar will demonstrate how AEDP can help you to heal attachment wounds and unlock innate healing tendencies with clients.

Learn More or Register at www.portlandaedp.org

Ronald J. Frederick, PhD, is a licensed psychologist whose career has focused on the transforming power of emotional and relational experience. He is a Founding and Senior Faculty member of the AEDP Institute, co-founder of the [Center for Courageous Living](#) in Beverly Hills, CA, and author of the award-winning book [Living Like You Mean It](#) (Jossey-Bass, 2009).



Noted for his warmth, humor, and engaging presentation style, Dr. Frederick regularly leads workshops at the Cape Cod Institute, the Kripalu Center, and the Esalen Institute, has provided professional trainings for the Lifespan Learning Institute, CA, Professional Psych Seminars (PPS), and Premier Education Solutions (PESI), and frequently speaks to national, state, and local organizations. He has just completed his second book, *Loving Like You Mean It* (Scheduled for publication in early 2019 by Central Recovery Press).

Intersectionality: LGBTQI Youth & Homelessness

by Kimberlee Harrison, MS, NCC, GC-C, LPC Intern

As the Mental Health Support Specialist (MHSS) at a homeless youth shelter, I see a wide variety of youth from all different walks of life. There are many reasons that youth and young adults end up on the streets, including, but not limited to: abuse or other trauma in the home; parental substance use and abuse; youth substance use and abuse; aging out of foster care; and identifying as lesbian, gay, bisexual, queer/questioning, transgender, or intersex (LGBTQI). It is this last reason that I'm going to address because approximately 40% of homeless youth identify as LGBTQI. According to Durso and Gates (2012), the three main reasons this population ends up homeless are: running away due to rejection by their families (46%), being evicted by their parents because of their identity (43%), and various types of abuse in the home (32%). In fact, youth who identify as LGBTQI have a 120% higher risk of becoming homeless than do their non-LGBTQI peers. While all homeless youth are vulnerable, these youth are at greater risk for victimization and developing mental health problems, such as depression, anxiety, SUDs, and suicidal ideation and attempts.

The message they receive when they are forced to leave home is that they do not matter.

In my capacity as MHSS, I typically work with youth aged 16-24. That age group falls into two of Erikson's Stages of Psychosocial Development: Identity vs. Role Confusion (ages 13-20), and Intimacy vs. Isolation (ages 21-39). These tasks overlap with LGBTQI youth who end up on the streets. While they are trying to

figure out their identity, which includes sexual orientation and gender identity, they are experiencing negative interpersonal interactions from their family/caregivers, which can lead to a crisis of isolation rather than the virtue of intimacy. The message they are receiving when they are forced to leave home is that they do not matter. As we know, this can lead to low self-esteem and a myriad of mental and physical health issues. Couple that with the fact that homeless youth in general may face difficulty getting their basic needs met, and you have a potential recipe for disaster. One of the top issues I hear when meeting with LGBTQI youth at shelter is suicidal ideation. When they have been shunned by family members and caregivers, and their self-esteem is at an all-time low, they often view suicide as the only answer. Having an empathetic ear to hear can help immensely and give them a sense of belonging, unconditional positive regard, and courage to carry on and be their best possible authentic self.

(Continued on p. 11)

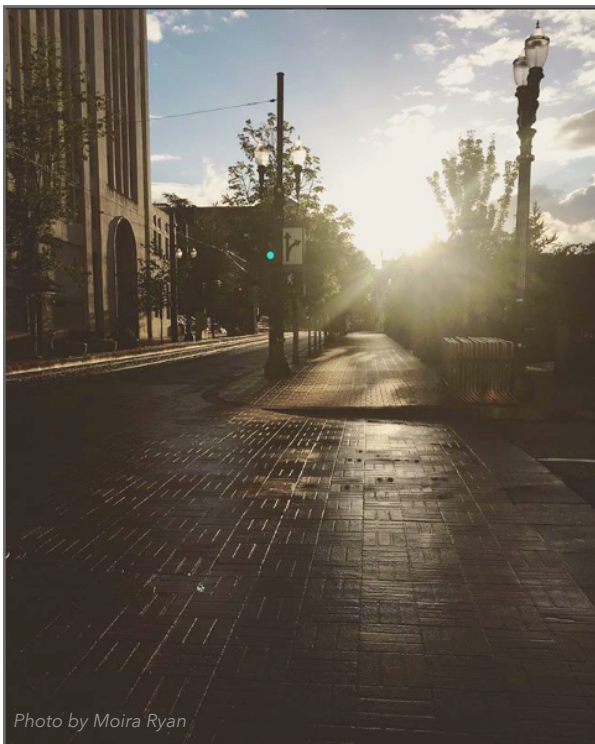


Photo by Moira Ryan

(LGBTQI Youth & Homelessness continued from p. 10)

There is hope, and I don't work alone in a vacuum. I work at Janus Youth Programs, which is under the auspice of the Homeless Youth Continuum (HYC). Three other agencies, as well as Multnomah County, operate in the HYC: [New Avenues for Youth](#), [Outside In](#), and the [Native American Youth and Family Center](#). Together, we provide resources to help youth get their basic needs met (food, shelter, safety, etc.), educational resources, job resources, case management, housing opportunities, and more - if they want that. New Avenues for Youth is also the parent agency of the [Sexual & Gender Minority Resource Center \(SMYRC\)](#), which offers a safe space for LGBTQI youth and allies to meet, hang out, and participate in activities. [Janus Youth Programs](#) operates **Access Center** (503-432-3986), which is the gateway to the HYC. Here, youth can be screened and assigned to a parent agency, so they can have access to services and resources. For younger runaway and/or homeless youth, [Harry's Mother](#) (503-233-8111) is the starting point. Staff at all the HYC agencies are well-versed in the needs of homeless youth, including the unique needs of LGBTQI homeless youth. If you know any youth who might benefit from services, give the Access Center a call.

Durso, L.E., & Gates, G.J. (2012). *Serving our youth: Findings from a national survey of service providers working with lesbian, gay, bisexual, and transgender youth who are homeless or at risk of becoming homeless*. Los Angeles: The Williams Institute with True Colors Fund and The Palette Fund.



Kimberlee Harrison, MS, NCC, GC-C, LPC Intern works as the Mental Health Support Specialist at Janus Youth Programs' homeless youth shelter, and has a [private practice](#). She is the author of [Empowerment through Mythology: A Clinician's Guide to Narrative Group](#)

[Therapy for Survivors of Trauma and Abuse](#), and has an awesome, jargon-free, tip-filled YouTube channel called ["Mental Health Minute with Kim."](#)



**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**

August
Recorded webinar sale all month!
Buy 1, get 1 free!

September 28 * 9-12 and/or 1-4
Sexual Health + Well-Being
Karlaina Brooke, PsyD

October 26 * 9-12 and/or 1-4
Ethics of Cultural Self-Awareness
Tanya Prather, PhD

November 16 * 9-12 and/or 1-4
TBA - check our website soon!

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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.

Want to spread the word about an upcoming training or event?

Advertise here with ORCA!

Reach 800+ students, counselors, and mental health allies

\$200.00	Full page, single issue (7 ½" x 10")
\$120.00	Half page, single issue (7 ½" x 5")
\$60.00	Quarter page, single issue (3 ¾" x 5")
\$50.00	1 column x full page, single issue (2 ½" x 7 ½")
\$40.00	1 column x quarter page, single issue (3 ¾" x 2 ½")

ORCA member discounts: 15% off for current members; 25% off for members placing ads in 4 or more issues.

The Counselor is ORCA's quarterly newsletter, and is published February 1, May 1, August 1, and November 1. Copy deadlines for articles and ads are due by the month before publication (i.e. January 1, April 1, July 1, October 1). All advertisements must be of professional interest or use to ORCA members. ORCA reserves the right to reject or cancel any advertisement that conflicts with the purpose, position statements, or ethical standards of ORCA. For more information, [click here](#).

Optimizing the Role of the Mental Health Provider: Letter Writing, Surgery Planning, and Affirmative Assessment for Transgender/Non-Binary Individuals

Friday, November 2, 8:30 a.m.-4:30 p.m.

Lewis & Clark Graduate School of Education and Counseling
Pilar Hernandez-Wolfe, PhD, Stace Parlen, LMFTI, Lindsay Walker LMFTI

This workshop will explore common questions counselors, therapists and mental health providers may have when it comes to assessing the needs of clients seeking trans affirmative medical interventions, including:

What is-and is not-part of the role of the provider; What are the components of a referral letter; and How can we minimize ourself as gatekeepers while supporting our clients?

Through presentation, discussion, experiential activities and small group interaction, we will discuss the ways in which we can use a client-centered, trauma-informed, collaborative, and informed consent approach to the assessment and letter-writing process.

7 CEUs May fulfill the OBLPCT Cultural Competence CE requirement

FAT: A Call for Radical Acceptance

by Haley Tursi Jones, Graduate Student

Sweat lining my brow and heart pounding, I sat waiting for my first counselor. My relationship with food had taken over every aspect of my life. I knew I needed help. Following an acute mental health crisis and subsequent withdraw from university, food became my socially acceptable coping tool to deal with overwhelming self-hatred. Diagnosed and labeled as “obese” at age eight, I was subject to routine maltreatment by so called helping professionals and avoided seeking care for decades. From prescribing weight loss for any presenting concern to chastising my inability to shrink myself, my direct experiences of sizeism left a deep fear and mistrust of medical professionals. Unfortunately, fat individuals are routinely stigmatized and discriminated against in nearly all domains of life, from relationships, education, employment, to health care, all at a large cost to their well-being (Hilbert et al., 2008). Sitting in the counselor's office, I gazed at the slowly ticking clock. After making small talk for the first half of the session, I finally blurted out, “I think I have an eating disorder.” Eyeing me up and down, the counselor scoffed, “I don’t think that’s your issue.”

A war waged directly on my very being, the United States “War on Obesity” launched during my adolescence. Labeled a disease in need of fixing, I grew to loathe my unruly body. Per doctor's orders I began to restrict my food intake at a young age. Subject to countless weight-focused interventions, I quickly fell into the binge-restrict cycle. As a child in a fat body my eating disorder symptomatology was not only discounted, but congratulated.

Sadly, my experience is not uncommon. Villarejo et al. (2003)

found that eating disorder symptomatology is found at significantly higher level in fat individuals and typically overlooked. Full of self-hatred, preoccupied with food, and unable

to lose weight, I viewed *myself* as the problem. With a failure rate of 95%, weight-based interventions are not only unsuccessful for nearly all individuals, but contribute to an increased risk for osteoporosis, increased chronic psychological stress & cortisol production, increased anxiety about weight, eating disorder behaviors, and weight gain (Bacon and Aphramor, 2011; Tylka, 2014).

The origins of eating disorders are complex. For myself, a family history of mental illness and genetic factors loaded the gun, while living in a fatphobic culture pulled the trigger. In a society built upon eurocentric and cisheteropatriarchal standards, I was repeatedly sent the message that my fat, queer body was a problem. As a white individual, the color of my skin spared me the additional body stigmatization that people of color face. Never taught the ineffectiveness and dangers of intentional weight loss efforts, I viewed dieting as a worthy and moral pursuit. Neither doctors nor counselors questioned my motivation and desire to lose weight; rather, I received continuous praise for my commitment and drive. Unfortunately, Fat people who exhibit eating disorder behaviors are routinely overlooked (Miller, 2014). From “lifestyle changes” to medically prescribed restriction, shame-based weight loss interventions infiltrate every aspect of Western culture.

(Continued on p. 14)

**As a child in a fat body,
my eating disorder was
not only discounted, but
congratulated...**

**I came to view dieting as
a worthy and moral pursuit.**

Specify current severity:

The minimum level of severity is based, for adults, on current body mass index (BMI) (see below) or, for children and adolescents, on BMI percentile. The ranges below are derived from World Health Organization categories for thinness in adults [...]

Mild: BMI ≥ 17 kg/m²

Moderate: BMI 16-16.99 kg/m²

Severe: BMI 15-15.99 kg/m²

Extreme: BMI < 15 kg/m²

(DSM-5)

(FAT continued from p. 13)

My eating disorder behaviors worsened following the session with my first counselor. As an individual in a fat body, I was repeatedly sent the message that I was not only undeserving of help, but not "sick enough" for treatment. Sim, Lebow & Billings (2013) state that obtaining an eating disorder diagnosis is delayed an average of nine months for individuals in fat bodies. In my case, a diagnosis was delayed nearly a decade. Due to the Body Mass Index requirements for Anorexia Nervosa, obtaining this particular diagnosis is highly competitive among individuals suffering from eating disorders. Using my body to communicate my pain, I began to heavily restrict my intake and dramatically increased my exercise regimen to seek help. Contrary to public opinion, individuals in fat bodies can struggle with restrictive eating disorders. According to Lebow, Sim & Kransdorf (2015) One third of teens seeking treatment for anorexia nervosa are in the 85th percentile for weight, reflecting the need for a change in the diagnostic criteria of Anorexia Nervosa. Neither counselors nor medical professionals questioned my relationship with food or my body as I starved myself from "obese" to "overweight".

Stuck in a purgatory of "not sick enough" and failing to meet the BMI requirements for anorexia nervosa, my eating disorder had gone unnoticed for the entirety of my undergraduate degree. Meal planning and working out were my only two priorities. I struggled as my grades began to slip and relationships went by the wayside. My eating disorder

had taken over every aspect of my life.

Overwhelmed, exhausted and defeated, I sought counseling services for the fifth time.

With the guidance of a feminist, [Health at Every Size](#) oriented therapist I began the lifelong journey towards a place of radical self-love. Through ongoing exploration, I learned that the source of my self-hatred stemmed not from my appearance, but societal weight stigma and eurocentric cisheteropatriarchal beauty standards. Gifted with unconditional acceptance of my body at any size and the tools to leave my eating disorder, I slowly began to operate from a place of self-compassion. Fat oppression stole countless experiences and relationships from my life. I spent my childhood hiding from cruel words, public humiliation, and endless body shaming. Hoping to avoid that same fate, I spent my early twenties working to shrink myself. The trauma and oppression faced by my younger self and individuals in fat bodies must end. Dismantling the larger system of fat oppression begins by exploring our own internalized body shame. It is only through the exploration of our own complacency in a system that shames and traumatizes individuals in fat bodies that we can begin to make lasting systemic change.



Haley Tursi Jones (she/they) is a queer, white, currently thin and able-bodied, first generation college student in the Masters of Clinical Mental Health Counseling program at PSU. Haley is passionate about

supporting folx of all identities unlearn diet culture and explore their relationships with food, movement and their body. Her passions include dismantling racial capitalism, integrating the Health at Every Size model into counseling programs across the country, and hiking with her puppy, Sage.

Your ORCA Membership Dues at Work: COPACT's Legislative Advocacy

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 two funding sources: ORCA 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.

COPACT Corner

As part of our ongoing strong advocacy effort in support of parity in reimbursement for mental health professionals, COPACT recently submitted the following letter to Oregon's Department of Consumer & Business Services.

TO: Dennis Powell, Compliance Manager, Financial Regulation Division, OR Dept. of Consumer & Business Services
FROM: Andrea J. Wright Johnston, President, COPACT
DATE: May 15, 2018
SUBJECT: Implementation of Senate Bill 860

Dear Mr. Powell,

Thank you for leading the effort to “examine the parity of reimbursement paid by carriers to mental health providers and physicians,” as directed by [SB 860 \(2017\)](#). Sufficient and affordable access to mental health care in Oregon is a top priority for my organization, which represents mental health providers across the state. ([The Coalition of Professional Associations of Counselors and Therapists \[COPACT\]](#) advocates for the 4500 Licensed Professional Counselors and Licensed Marriage and Family Therapists whose professions are regulated by the Oregon Board of Licensed Professional Counselors and Therapists.)

COPACT supported [Senate Bill 860](#), and we stand ready to provide information and resources to your division to assist in determining how insurer reimbursement practices contribute to a lack of adequate access to mental health treatment in Oregon.

I want to suggest that you consider the following factors, listed here and also outlined in the attached letter COPACT submitted to the legislature when they were considering SB 860.

- a. Look at changes over the last 12 years in reimbursement practices and amounts for the following CPT codes:
 - Current CPT codes:
 - 90791: Psychiatric Diagnosis without medical services
 - 90837: Individual Psychotherapy 53- minutes
 - 90837: Individual Psychotherapy 45 minutes
 - 90832: Individual Psychotherapy 30 minutes
 - 90847: Family Psychotherapy with patient present
 - 90846 Family Psychotherapy without patient present
 - 90853: Group Psychotherapy
 - Codes 2012 and prior: (Other codes same)
 - 90801: Diagnostic Interview Examination
 - 90806: Individual Psychotherapy 50 minutes
 - 90804: Individual Psychotherapy 30 minutes
- b. Look at changes over the last 12 years in each insurer's in-network panel of providers. Has it increased or decreased per 1,000 covered lives?

(Continued on p. 17)

(COPACT Corner continued from p. 16)

c. Look at network adequacy with a specific eye toward behavioral health. Not all providers treat the same patients. Insurers should provide access to a variety of specialized behavioral health providers, including:

- Depression
- Anxiety Disorders
- Post-Traumatic Stress Disorder
- Dissociative Disorders
- Drug and alcohol abuse and addiction
- Eating Disorders
- Gambling Addiction
- Disorders of Children and Adolescents
- Family Therapists
- Major Mental Illness Disorders
- Personality Disorders
- Autism Spectrum Disorders
- Somatization Disorders
- Dementia and Aging related Disorders
- Family Therapists
- Group Therapists
- Providers who have skills working with persons with diversity in language, gender, sexual identity, culture, and age.

b. If possible, look at whether customers of commercial insurers are using their behavioral health benefits at an expected rate. That is to say, are customers with insurance benefits able to access behavioral health within their insurance network? COPACT's members report that many of their patients with commercial insurance are unable to use access adequate in-network treatment, and so they pay out-of-pocket for out-of-network care. They may not even file a claim with their insurance company, so the insurer may not have data showing utilization; however, we recommend comparing utilization rates to an expected or nationally standardized rate to see if there is a lower-than-expected utilization rate in the Oregon population. We also recommend looking at the length of time between initial

contact with an insurer and a client being able to find an available therapist. We believe that can indicate if there is an adequate panel of providers available.

I understand that you have an open inquiry into this matter and cannot respond. COPACT is not seeking to influence the outcome of your study, only to provide information from a provider perspective to help you ask the right questions.

On behalf of [COPACT](#), I thank you for reviewing this letter, and for undertaking this important study to help increase access to behavioral health treatment. We look forward to your report with great anticipation.

Sincerely,

Andrea J. Wright Johnston, LMFT
President, COPACT



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(This fulfills the cultural competency requirement)
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To Register: PacificNWProviders@gmail.com
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We need each other. To care for our clients, our colleagues, our communities, and ourselves - not just in difficult moments but day in and day out - we need each other.



Join us.

The Oregon Counseling Association's mission is to "empower a profession, one counselor at a time." We do this through providing networking and CE events, by advocating for social justice, and by lobbying for the profession. If your job is to support the mental health of Oregonians, then we are here to support you.

Membership benefits:

- Maintaining a **strong lobbying presence** in the capitol on behalf of counselors and therapists. ORCA membership dues directly fund a seasoned lobbyist in Salem who provides ongoing advocacy around improving access to healthcare. This role has also supported bills that outlawed conversion therapy for minors, allowed LPCs and LMFTs to bill insurance companies, and much, much more.
- Being a part of a organization that stands up for **social justice**. Advocating for diversity and human rights is at the heart of what we do.
- Opportunities to **connect** and **network**. Whether IRL during professional development events, Networking Nights, our annual summer picnic - or online via our members-only listserv - ORCA makes building professional relationships easy.
- Opportunities to grow as a leader in the profession, and to make your voice heard on critical issues. ORCA has many mentoring and **leadership opportunities** available to help grad students and new professionals jump-start their careers.
- **Discounted member rates** at our professional development events and conferences, which provide Continuing Education units necessary for licensure and certification.
- Guidance to help you comply with the **ethical standards** of counselors and therapists in Oregon. Expert consultation around ethics, technology and the law are offered free of charge to all ORCA members.

Membership dues:

Professional (LMFT, LPC, etc) / Associate	\$96/year
Registered Intern	\$72/year
Student / Retiree	\$48/year

The Oregon Counseling Association is volunteer-run and membership driven, which means that we depend on our fellow healers joining us as members. [Join us](#). We can't do this without you.



Save the Date!

Professional Development & Education Trauma CE Workshop

Friday, November 9, 2018

Mark Spencer Hotel, Portland, Oregon

**Following the event:
ORCA Annual Awards & happy hour reception**

Topics include:

- Trauma and the brain
- Attachment trauma
- Violence and trauma

More information and registration coming soon!

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.

How to Get Started With Telemental Health Practice

by Roy Huggins, LPC NCC

The OBLPCT recently decided to repeal Division 90 from its chapter of the Oregon Administrative Rules (OARs), which was the Distance Counseling division. The reason for the repeal appears to have been twofold: 1) the ACA Code of Ethics provides quite a few standards for distance counseling practice and 2) there are now extensive resources available on standard of care around distance counseling which were not available when Division 90 was first authored.

So, to help Oregon Counselors get an idea of what those standards of care are and where to find them, I decided to revise this article that was originally published on the Person Centered Tech website. (The original version can be found [here](#).)

A colleague and friend of mine recently told me that he is moving back to his home town and is closing out his practice. Letting go of clients is hard in both directions, and several of his clients have asked if he would be willing to continue via "Skype Therapy." He asked me to help him figure out how to get started with that. Here is my answer, publicly posted in hopes that it will help many more folks.

First, don't use Skype (or Facetime), even though it is often called "Skype Therapy." The most widely accepted name for this style of work is "telemental health," and I will call it that from here forward. Why not use Skype? The reasons are a little more complex than I have space for here, and they are well explained in [this article on how Skype became a no-go](#).

And don't work across state lines unless you're permitted to practice in the state where the client is (and the laws and rules of both states allow that arrangement.) This issue is kinda complex, and requires further reading:

- [Can I Practice "Skype Therapy" Across State Lines?](#)

When practicing telemental health, there are a lot of different authorities whose rules can impact your work. Thus, a prudent approach to starting telemental health practice would have you investigate the rules and guidelines of every body that presides over your practice. It sounds daunting, but it's doable. Here I'll try to lay out where you'll need to inquire for information:

- Insurance companies you're paneled with. Many private insurers are requiring special paneling in order to get reimbursed for telemental health services. Inquire with the companies where you are paneled for details on the process.
 - Note that Medicare and various state Medicaid's will have their own particular rules regarding telehealth in general. [Find CMS' 2018 telehealth guide here](#).
- Your professional liability insurance. Similar to the private insurers, many liability insurance companies are now requiring special riders in order to cover telemental health practice.
- Licensing Board Rules/Laws
- State Law
- State and Local Professional Organization(s) Guidelines or Rules
- Major Professional Organization Guidelines and Ethics Codes
- Federal Law (generally HIPAA)

(Continued on p. 21)

(*Telemental Health continued from p. 20*)

Remember back to being a student and how complex and overbearing the legal-ethical requirements of practice seemed at that time. For many of us, there is a repeat of that process in learning to navigate telemental health standards and laws.

Insurance Companies

Reimbursement policies vary from state-to-state and contract-to-contract. As such, you'll need to look into reimbursement with each insurer. The good news is that reimbursement is getting increasingly common, and many insurers now have a process for getting paneled to provide telemental health services.

Methods for coding telemental health sessions changed in 2018. See [this session of Ask a Biller](#) for some fantastic guidance on navigating those changes.

Licensing Boards

Licensing boards are in no way standardized in their approach to telemental health. Within a single state, every profession may (and often does) have its own particular rules around it. If you're working across state lines, you'll need to know the rules of the relevant board there.

State Law

Some states have nothing in particular to say about telemental health, and some say a lot. Be aware that if your state doesn't have specific laws for telemental health and/or your licensing board has no specific rules, you could be subject to state medical laws regarding telemedicine where they apply.

A great *starting point* for investigating the rules of a particular state is the [Epstein, Becker, Green 50 State Telehealth Survey](#). Don't stop there, however. Follow the links in the survey document to check on what

the current rules are in the state where you wish to work with clients. Also, remember that interpreting law can get complex, and that's one of the many reasons why we have lawyers.

Professional Organizations

I listed state and local professional organizations as people to check with not so much because they may have special rules for you (although they might) but because they can be a good resource for learning how telemental health works in your state and under your board. It doesn't hurt to drop them an email or make a call as part of your process.

National professional organizations are a different issue. Every major professional organization's ethics code requires us to maintain digital confidentiality, and counselors, MFTs, social workers and psychologists all have guidelines for practice in the digital realm.

Part of your due diligence should be to read the telemental health-related guideline and/or ethical standard that is most applicable to you.

- [AAMFT's Code of Ethics, Specifically Standard VI \(2015\)](#)
- [ACA's Code of Ethics, Specifically Section H \(2014\)](#)
- [APA Guidelines for the Practice of Telepsychology \(2013\)](#)
- [NASW & ASWB Standards for Technology and Social Work Practice \(2017\)](#)
- [NBCC Policy Regarding the Provision of Distance Professional Services \(2012\)](#)

We also recommend studying the telemental health guidelines published by the American Telemedicine Association (you'll need an account on their website to view these documents):

(*Concluded on p. 22*)

(*Telemental Health* continued from p. 21)

- [Practice Guidelines for Video-Based Online Mental Health Services](#)
- [Evidence-Based Practice for Telemental Health](#)

Federal Law

Federal laws that directly relate to telemental health will be through specific federal programs or agencies, such as Medicare or the VA.

If you are working within those domains, you will need to get specific information on how they handle guidelines, reimbursement, etc. Once again, [find CMS' 2018 telehealth guide here](#).

The Feds mostly get involved in telemental health practice through the security and privacy rules in HIPAA. Those are a bit complex, of course, and you can learn more about them through Person Centered Tech's many [articles](#) and [CE offerings](#).

Informed Consent

It is clear that informed consent for telemental health treatment requires certain items in addition to those needed for in-person therapy. What is not entirely clear, however, is a specific list of the special informed consent items that are needed.

[ACA's Code of Ethics, Section H](#), includes specific items that are required for informed consent in distance counseling. The American Telemedicine Association's [Practice Guidelines for Video-Based Online Mental Health Services](#) also contains some specific information on what is needed in telemental health informed consent. A number of state laws have requirements for telehealth informed consent, as well.

Getting Training

Not everyone is in agreement on whether or not training is, specifically, an ethical requirement before starting telemental health practice. Some licensing boards do require it, however.

What is universally recognized in professional ethics is that professionals looking to start telemental health

practice need to first ensure that they have the necessary *competence*.

One area of concern among licensing boards is that licensees may not "know what they don't know," and thus may be unaware of whether or not they lack any of the competencies necessary for ethical and professional telemental health practice.

There are a number of sources for getting telemental health training and/or studying up on the competencies.

- [Person Centered Tech's telemental health certification program](#)
- [NBCC's Board Certified Telemental Health credential](#)
- [Telehealth Certification Institute](#)
- [Zur Institute certificate program](#) (developed and presented primarily by Huggins.)

Conclusions

While this article paints a picture of a highly complex landscape of rules and standards, it is not actually as difficult to navigate as it may seem. Remember back to being a student and how complex and overbearing the legal-ethical requirements of practice seemed at that time. For many of us, there is a repeat of that process in learning to navigate telemental health standards and laws. But just like happened after school, practice and assimilation of the standards will cause it all to become second nature. So be sure to get the help you need in order to develop competence in telemental health, but don't hold back from getting started, either!



Roy Huggins, LPC NCC is a counselor in private practice in downtown Portland. He is also the Director of Person Centered Tech, where he performs continuing education, consulting, and general punditry on technology, digital ethics, and security in mental health practice. Find him at www.personcenteredtech.com.

Call for articles

The Counselor, the quarterly newsletter of the Oregon Counseling Association, invites articles to be submitted for consideration for our Fall 2018 issue.

This newsletter seeks to share with our counseling community institutional knowledge, personal narrative, annotated resource lists, advice, photographic essays, manifestos, and the like. We seek to be a safe space in which we all can learn from one another about topics related to social justice and enacting our values as those subjects relate to the helping professions and to our communities in Portland and in greater Oregon.

Submission of articles, etc due for Fall on by October 1, 2018
to editor@or-counseling.org

This newsletter is always available to everyone, and may be found online [here](#). We welcome submissions from members of ORCA as well as non-members. People of color, LGBT folx, people with disabilities, low-income folks, people diagnosed with mental illness, and people with experience being treated as a case in need of management are particularly encouraged to share their voice and their experience. To include a range of perspectives, each article will be succinct-*ish*, with an ideal word count of between 400-1,200 words (not including references, figures, artwork, and photography, if you like).

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.

Thanks for your time!

Moira Ryan, LPC
Editor, The Counselor

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If you're interested in serving ORCA as a volunteer or member of the board, please contact Alana Ogilvie, ORCA President-Elect, at presidenelect@or-counseling.org