

INSIGHTS

THE BC ASSOCIATION OF CLINICAL COUNSELLORS' MAGAZINE



**Increasing your
adoption competency**

**Toxic loss and the
sorrow of perpetual
indecision**

**Life after cancer:
Who am I now?**

REACHING OUT

**MODIFYING A SOMATIC THERAPY
AND DELIVERING IT TO FATHERS**

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INSIGHTS

THE BC ASSOCIATION OF CLINICAL COUNSELLORS' MAGAZINE

The Insights team would like to thank the writers and interviewees who contributed to this issue of our magazine:

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BCACC is dedicated to enhancing mental health all across British Columbia. We are committed to providing safe, effective clinical counselling to all and to building the profession through accountable, well-resourced, and supported counsellors.

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In the spirit of reconciliation, BCACC acknowledges and respects the First Nations, Metis, and Inuit Peoples upon whose traditional territories we work and live throughout Canada.

Insights is published on behalf of the BCACC by Page One Publishing 580 Ardersier Road Victoria, BC V8Z 1C7 Tel: 250-595-7243 pageonepublishing.ca



Contributing Agency: Getty Images

Insights is published three times a year. To submit article proposals, contact the editor, Carolyn Camilleri, at ccamilleri@pageonepublishing.ca.

Find more information about submitting article proposals at bcacc.ca/insights-magazine/ or by contacting Marcy McCabe or Elana Ilott, BCACC editorial advisors, at communications@bcacc.ca.

Printed in Canada by Mitchell Press.

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THREADING THE NEEDLE

A chat with Dr. Hillary McBride, RCC, about how to balance distributing information about psychology via media without flattening complexity

These days, information (and misinformation) is widely available through various media channels on every topic imaginable, including mental health. While this abundance of information means people have never before been able to learn so much so easily, it also increases the risk of misunderstanding or misuse. This can put clinical counsellors in a difficult position for a few reasons, starting with the longing to help.

“I have often felt tension in my relationship with doing media work, feeling the longing to share information with my community to improve their mental health and quality of life, and preferring to have more in-person, embodied relational experiences which I believe are more likely to create long-

term change,” says Dr. Hillary McBride, an RCC and Registered Psychologist who has worked with media on numerous occasions. “My theory of change — as connected to embodied relational experiences — impacts my theoretical framework and choices for interventions, but my desire to make health care accessible and destigmatize conversations about mental health makes me want to take risks to change a culture which still has so far to go in the conversation about mental health.”

Responsibility to society is one of the four core ethical principles of the Canadian Psychological Association.

“It is a feature of our work to reflect upon the way society impacts the welfare of an individual and their mental health, as well as exploring the

relationship in the opposite direction,” says McBride. “Historically, counselling has been most accessible to the most privileged, and various social groups have had a more difficult time accessing individual mental health care due to social stigma, financial concerns, or how (mental) health care has been used as an oppressive tool.”

She adds that when clinical counsellors explore the intersection of social and individual health and take seriously the justice orientation to give psychology away and dissolve the divisions in power and hierarchies created by inaccessible health care, they often feel compelled to educate the general public about psychotherapy practice and theory. This can provide more people with access to information

and strategies that can meaningfully and positively impact their mental health and quality of life and decrease stigma and social misunderstanding about mental health. For example, it can help parents learn to promote healthy attachment and emotional regulation or encourage sharing resources for attention regulation or normalize a wide range of neurodivergent presentations.

However, care is needed in how information is provided.

“When this is not done well, the phenomenological nature of diagnosis of psychological disorders is missed for easily communicated bite-sized pieces of information which reduce complexity,” she says, noting that appropriate and person-specific treatment recommendations that suit accurate diagnosis are also missed and distress resulting from inaccurate self-diagnosis can increase.

For example, sharing information about personality disorders may be helpful for flagging issues someone may notice in themselves or witness in their relationships, but this could easily lead to incorrect labelling, resulting

in pathologizing and stigmatizing that person.

“As therapists, we need to thread the needle: find a way to balance the important distribution of information without flattening complexity.”

McBride suggests sharing information in more extended forms and pointing people towards resources where they can seek diagnosis or speak with professionals directly.

“It may also help to share work with citations so consumers of media can read and learn more from direct sources, avoid sensationalizing information for the sake of making it appealing, and create opportunities for more thorough and interactive engagement with content,” she says.

In other words, information that encourages critical thinking, community dialogue, and connection over time — not a single post once from one person.

McBride also reminds us that diagnoses may seem stable and empirical but are influenced — even in their development and creation — by socio-cultural factors, history, and current cultural trends.

“Our categories of information and how we use that for diagnostic purposes is not as neat and tidy as we might think it is, and we need to be careful about how to wield information about it,” she says. “By contrast, tools which promote mental health are much more innocuous, and it is more difficult for them to do harm regardless of how they are used.”

But even seemingly harmless tools need to be distributed with the specificity and appropriateness of who they are for kept in mind. McBride uses deep breathing as an example: while most people benefit from deep mindful breathing, evidence shows it can induce panic states in some people.

“It can be complicated to engage with media and mental health, and it often requires courage, self-reflexivity, and humility,” she says.

But when it is done well, it can make a big difference.

“When more people know more information about mental health and well-being, I believe we can build better societies with more compassionate and skilful communities,” says McBride. ■

NEW SUPPORT FOR FIRST RESPONDERS

The BC Fire Fighter Occupational Awareness Training Program

MATT JOHNSTON, RCC, HAS A DEEP UNDERSTANDING OF THE EXPERIENCES of first responders and the culture of their team-based environment. In 2012, he left his position operating a counselling clinic for children and adolescents in downtown New Westminster and joined the fire service.

Less than three years into his fire service career, Matt’s organization experienced a cluster of fire fighter suicides that was echoed by several losses in other B.C. fire departments. Struck with his own grief, he wanted to do something to help other fire service members. His quest aligned with a new initiative led by then-president of the BC Professional



Fire Fighters Association (BCPFFA) and current Burnaby Mayor, Mike Hurley. In 2016, Matt was appointed to the BCPFFA Mental Wellness Committee.

“Looking back, this was the serendipitous path that I needed to follow to transform my complex feelings of confusion and loss into a meaningful career in the fire service,” says Matt.

The Occupational Awareness Training (OAT) program was established and, for the next three years, Matt and BCPFFA VP Steve Farina travelled throughout B.C., delivering training to health-care providers on how to enhance clinical outcomes with fire fighters and their families.

The OAT program reflects a new style of training that addresses some traditional challenges of previous mental health programs for this population.

“Projecting a trauma-based, disordered lens onto a pridefully stoic audience regarded for maintaining

resiliency is going to be met with poor program outcomes,” say Matt.

He adds that mental health initiatives need to follow a positive psychology approach prior to delving into the worst days of the profession.

“The early stages of the OAT program do not focus on trauma-reduction strategies, but instead, set out to define and normalize the acquisition of a psychological stress injury, while providing fire service personnel with evidence-informed strategies on how to restore optimal performance both on and off the job.”

While the OAT program has been very successful with mental health-care practitioners, the committee decided to expand and go direct to the people it aims to support. Four provincial fire associations were involved in building the OAT program to reflect the needs of all fire personnel in B.C. The result is a customized, modularized, bottom-up program built from the inside out. More than 5,500 personnel registered in the first eight weeks after it launched

in April 2023.

“There are only 12,000 fire fighters in B.C., so there is a demonstrated need by this population to receive relevant mental health training,” says Matt.

Discussions are underway to expand the program in four other provinces.

RCCs who are interested in serving this population or other similarly stoic service audiences may benefit from learning more about the approach taken in the OAT program.

“There is a widespread assumption in the first responder and clinician world that stoic members — typically men — do not reach out for care prior to crisis,” says Matt. “However, a decade of my experience has indicated that many do, only to find that many clinicians are not prepared to work with this audience, thereby, compounding the pain, isolation, and suffering.”

He adds that Canadian males are close to four times more likely to die by suicide than females.

“The rise in popularity of social media influencers regarding men’s mental health has also been a clear indication that a large segment of men has sought direction on mental health and optimal performance through non-traditional and highly unregulated means,” says Matt. “It is my belief that our profession and, in particular, our membership, needs to pivot the way we advertise our services if we want to better serve this demographic.” ■

Learn more about the program at <https://www.firstresponderhealth.org/bcffoat>. The BCPFFA is offering a subsidized training course for BCACC members on November 17 and 18: details and registration are available at <https://www.eventbrite.ca/e/occupational-awareness-training-understanding-fire-culture-tickets-663801587417>.

RE-IMAGINING ENVIRONMENTS

ON NOVEMBER 3 AND 4, 2023,

BCACC is hosting the Counselling in a Changing World conference at the Hyatt Regency Hotel in Vancouver. This year's conference theme is "Re-imagining Our Environments" and places a strong emphasis on understanding the impact of social, cultural, technological, and structural workplace changes on the mental health and well-being of clients and clinical counsellors.

BCACC's conference team has worked hard to bring together a robust lineup of speakers in a conference format designed to allow attendees to choose their own path to learning. We are pleased to welcome Dr. Sue Johnson for a two-hour keynote workshop entitled "Belonging Leads to Becoming: The Alliance in Emotionally Focused Individual Therapy (EFIT)." Dr. Johnson will highlight the importance of building the therapeutic alliance with clients and teach effective ways for counsellors to create a safe haven for clients.

Other conference highlights include these five two-hour workshops:

- Dr. Stefanie Green: Counselling families going through the MAiD process
- Suzanne Iasenza: Integrating couple therapy and sex therapy in an expansive relational world
- Pia Pechtel: Trauma, resilience, and the brain: From neuroscience to clinical practice
- Dr. Lisa Gunderson: Learning to work with IBPOC youth in this current climate: Have your questions answered
- Natasha Files: When there is no rope left: What to do when burnout is high and resources are low

Also featured are 20 concurrent sessions on important topics, such as trauma, interdisciplinary care, AI and technology in counselling, youth, and parenting.



In a keynote workshop, Dr. Sue Johnson will highlight the importance of building the therapeutic alliance with clients and creating a safe haven.

After years of working remotely and in isolation, we warmly invite you to come and learn together with other clinical counsellors and allied health professionals. It promises to be an inspiring opportunity to forge new relationships with your colleagues over two days of fun, learning, and connection. ■

Register at <https://conference.bcacc.ca/>



BCACC CELEBRATES 35 YEARS!

Join us on November 3, 2023, for BCACC's 35th Anniversary Gala at the Hyatt Regency Hotel in Vancouver. This special evening includes networking, dinner, awards, and a look at the evolution of BCACC through 35 years. A special musical guest provides the perfect finish to the evening. Register for the gala on the conference registration page.

WORKING WITH INTERPRETERS

Minimizing the challenges of language barriers to make therapeutic outcomes more successful

BY MASITSA L. SHAMALLA, RCC

Another Monday at the office. You're working in an understaffed, overtasked health-care office. A client comes in highly distraught as her children have been apprehended by child protection workers. You try to calm her down. When she starts to explain the situation, you realize her grasp of the English language is too limited for you to communicate effectively or to help her efficiently. You call her social worker and are told she speaks Slovak, a rare language in your city. You then embark on finding a suitable interpreter, acutely aware that your next client will be showing up in less than half an hour. As you dial your local immigration agency for leads, you wonder how much language barriers contributed to your client's current situation.

This scenario has become common in health care and is likely to become more so with increasing migration. Psychology and psychiatry were developed in a Western context, and applicability is limited when it comes to minority populations. Therefore, it is important, if not ethical, for clinicians to be aware of issues facing clients with English as a foreign language, including First Nations communities, and to know how to access help with interpretation.



ISSUES AND SOLUTIONS

Canada is a highly diverse society. According to Statistics Canada, 12.7 per cent of Canadians speak a language other than English or French predominantly at home, and about nine million Canadians have a mother tongue that is neither English nor French.¹ Undeniably, this has a significant impact on every aspect of service delivery, and health care is no exception.

Communication is vital for the delivery of inclusive, culturally competent, safe care. Although interpreter-mediated health care has been shown to improve clinical outcomes and contribute to higher patient satisfaction, studies have found that professional interpreters in health care are underused globally.² There are many reasons for this, some I have experienced and observed:

- ★ lack of knowledge about where and how to access interpreters

- ★ lack of access in remote locations
- ★ lack of knowledge about client background
- ★ lack of confidence in communicating with racial or differing minorities
- ★ lack of training in working with interpreters
- ★ lack of resources (i.e., time and money)
- ★ lack of interest in /awareness of the importance of using interpreters
- ★ poor perceptions of interpreters as professionals

Granted, inviting interpreters into your session is not without its complications. I have experienced various difficulties, including that interpreters and clients tend to be members of a minority group and very often relate outside of session (e.g., breaking Eid fasts

THE FOUR MODELS OF INTERPRETATION³

1. Linguistic: word for word
2. Psychotherapeutic: meaning and feeling is most important
3. Advocate: for the individual or wider cultural group
4. Cultural broker: also interprets relevant cultural and contextual variables

together). If they don't know each other's families, chances are they will before the week is done. Undoubtedly, this can further complicate, as well as compromise, the counselling process.

While this can be avoided by using telephone interpreters, it is not without its faults. Although telephone interpreters tend to be better trained and there are fewer boundary issues, sessions tend to be impersonal, lacking in the vital information garnered through reading body language.

Two typical reactions arise for clinicians considering using interpreters: self-consciousness about having someone observe or judge their work, which could lead to hypervigilance; and frustration that everything takes longer to communicate.⁴ When I started working with interpreters, these two factors didn't affect my sessions as much my sense of a lack of control, detachment from my client, and splitting due to the interpreter and client feeling a camaraderie against the "system" I



TIPS FOR WORKING WITH INTERPRETERS

Before session

* If possible, use an interpreter that speaks the first language (and dialect) that your client speaks. Language contexts predict differences in behaviour and personality.⁵ Meanings may be coded, emotionally processed, and internalized in one language and not directly accessible in another language.

* Match gender, age, and religion whenever you can, and try to use the same interpreter for all sessions, if possible.

* Special care needs to be given when working with First Nations clients. The expectation that interpreters remain neutral and impartial is unrealistic. Interpreters are challenged by a legacy of historical and ongoing power differentials, as well as the drive to express solidarity with their kin, community, and people. Impartiality needs to be balanced against interpreter visibility, which empowers interpreters to carry out their professional duties with agency and confidence, facilitating access and greater engagement with the health-care system.⁶

* Do not use children for interpretation, and only use family members when absolutely necessary.

* Educate yourself about your client's background through research and questioning the client/interpreter. Power differentials in your client's socio-political background may affect their relationship with the clinician and interpreter.

* If possible, meet the interpreter before the session and initiate a therapeutic relationship. Communicate roles, expectations, boundaries, responsibilities, ethics, confidentiality; address transference,

countertransference, vicarious trauma; and explain the therapeutic process.

* Decide if you would like to sit in a triangle so you are equidistant or if the interpreter should sit behind the client.

* Communicate to your client the interpreter's role and background, explain confidentiality and the therapeutic process, as well as your expectations.

During session

* Make eye contact with the client and speak directly to them (not to the interpreter).

* Speak slowly and clearly, being cognizant of your interpreter's education level. Consider how easily your words can be translated. Avoid technical terms and sayings.

* Allow time for the interpreter to communicate what you said and for the client to clarify.

* Use the interpretation time to observe the client and formulate questions and the direction of the session.

* Ensure you remain in charge of the session; this is important to your client. If necessary, interrupt the interpreter to clarify the process.

* Reviewing at the end of session is helpful for all parties.

* Provide supportive health information if possible. A lot of health articles have been translated into different languages and are available free of charge.

* You have a duty of care to debrief with the interpreter after the session. They likely have no knowledge of mental health, no supports without breaking confidentiality, and many times, no self-care strategies.

represented. Fortunately, this changed when I remained consistent with my boundaries and showed respect and unconditional positive regard to my client and interpreter.

Although I am aware that language is not directly interchangeable, I also experienced some frustration when I felt that not everything being said was being translated. However, after appropriately interrupting the interpreter a few times, and with added trust, the interpreter interpreted the client's speech in more detail.

Clients may also be reluctant to have an interpreter in session. Some sense a potential threat from someone who speaks their own language, often for socio-political reasons, or they may fear being judged. Many are anxious about confidentiality as everyone in small communities tends to know each other, or they may feel frustrated if they feel what they are saying is not being relayed accurately. Some clients have reported feeling infantilized, especially if the interpreter is younger than them.⁷

One of my greatest lessons was the assumption that clients are more comfortable with clinicians from their own background. In a group consultation, a client shared that it is "more shameful to share how bad your life is with someone similar to you who is doing much better than you. It makes you feel that it is possible and that you failed."

Other issues include conflict of interest, lack of group confidentiality, cultural considerations (e.g., age, gender, political agendas), vicarious trauma and triggers from their own trauma, professional ethics, and the interpreter not being fluent in both languages.

ENSURING BEST PRACTICE

Counsellors who use interpreters can experience countless benefits, including widening your scope of practice and enriching your practice by appreciating other cultures — their behaviours, health beliefs, and even world religions, because for many clients, culture, religion, and health beliefs are intertwined. It helps you grow by questioning your assumptions and presents an opportunity for learning through additional research. Interpreters interpret the spoken word as well as the social, cultural, and contextual information, which may have significant bearing on psychological issues.⁸

Clearly, serious clinical, moral, ethical, and legal obligations are involved in therapeutic work using interpreters, but it is essential to use interpreters when needed to ensure best practice, access, equity of service, and even

adherence to legislation.⁹ Effective communication is vital for accurate assessment, diagnosis, and treatment. It has been proposed that using interpreters in early mental health interventions is not only best practice, but also cost effective, as the cost of inaccurate diagnosis and referrals may be higher.¹⁰ It also leads to better assessment and improves access and quality of care, which increases client trust and results in a better therapeutic relationship and understanding of the treatment plan.

Clients who are unable to communicate effectively are less satisfied with the client-provider relationship, have a poorer understanding of their diagnosis and treatment, are more likely to be misdiagnosed and/or receive inappropriate care.¹¹

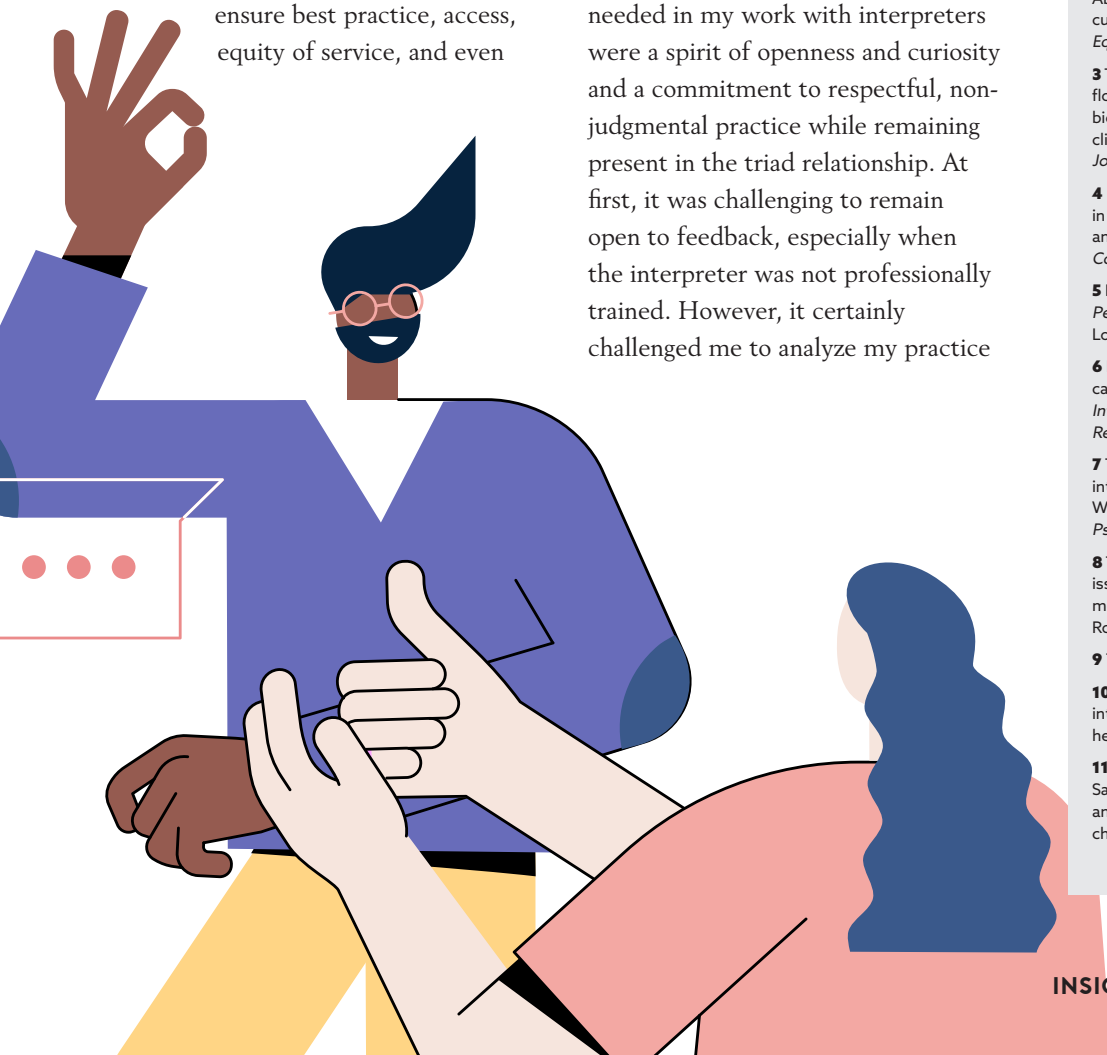
In my experience, the qualities I needed in my work with interpreters were a spirit of openness and curiosity and a commitment to respectful, non-judgmental practice while remaining present in the triad relationship. At first, it was challenging to remain open to feedback, especially when the interpreter was not professionally trained. However, it certainly challenged me to analyze my practice

critically from my viewpoint, as well as that of my client and interpreter. I believe that made me a better clinician and, most importantly, clients received the help they needed in an effective, empowering, and culturally relevant way. ■

Masitsa L. Shamalla, RCC, is a proud Canadian and a native of Kenya, who has lived and worked in Northern B.C. for over five years. In addition to a thriving private practice, she currently serves as a Mental Health and Addictions Clinician on five First Nations Reserves. Shamalla previously spent several years working with immigrants and refugees in the Lower Mainland.

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INCREASING YOUR ADOPTION COMPETENCY

A guide for clinical counsellors supporting clients in the adoption constellation

BY KAREN PETERS, RCC, AND CONTRIBUTING AUTHORS RENAE REGEHR, RCC, AND BRENDA HUNT, RCC



As an adoptive parent and therapist supporting clients in adoptive constellations, I pay close attention to resources on the topic. Some years ago, I came across a podcast interview with a therapist centred around the question of whether or not more general counselling practitioners could provide competent therapeutic support to adoptive parents, birth parents, and adoptees. The simplified conclusion was, “Yes, to a degree.” This resonated with my own position in the conversation.

As with any area of therapeutic practice, we will come across circumstances, dynamics, or topics outside our scope of understanding to provide the client with what they need. While some of these require a referral to another resource, most fall on a continuum of competency in differing areas of our practice. The “to a degree” ceiling posited in the interview spoke

to the limitations we face clinically in the lack of intimate knowledge that only comes with the lived experience of someone within the adoption constellation. Limitations, however, do not mean those of us without lived experience cannot offer competent support.

Our typical options for growing competencies are ongoing education and supervision. Not only is education pertaining to working with the adoptive population rare, but very few clinical supervisors exist with expertise in these areas, research on counselling adoptive families is minimal, and only a select few therapists offer adoption-specific counselling. This results in limited access to adoption-competent counselling for individuals, couples, and families who often need extensive support at varying stages throughout their journey.

This article serves as one avenue to slide our clinical practice up the

As defined in the Adoptive Families Association of BC's glossary, the adoption constellation “refers to everyone touched by the adoption process: birth parents, adoptee, adoptive parents, adoption professionals, and extended family.”¹



competency scale and point us to resources for ongoing development.

A GOOD PLACE TO BEGIN

There are four common types of adoptions in Canada: public, private domestic, private international, and relative/step child. A public adoption involves adopting a child in the provincial foster care system. Both private domestic and private international adoptions use a licensed private agency. Private domestic placements are typically within Canada, whereas private international placements occur outside of Canada. Lastly, the adoption of a relative or step

child can be public or private depending on the circumstances.²

Generally, the process is similar for both public and private adoptions, whereas adoption of a relative or step child has slight differences in legal procedures. The first step for the adoptive family is to research and choose the best adoption type for their family, then submit the application and paperwork. Next steps require adoptive families to participate in the required educational component. Then the home study takes place and typically involves a licensed social worker coming into the home to better understand the family dynamics and inner workings.

Once the home study is approved, the matching process begins. When a match is made with a child, the adoptive family is offered a proposal package to review with their social worker and determine if the child is the right fit for their family. If the proposed child is a match, placement begins under the thoughtful guidance of the social worker. Public placement is monitored and supported by the social worker for a post-placement period, usually six to 12 months, until the adoption order has been granted. The private adoptions post-placement period is determined by the agency and country the family is adopting from but

typically lasts from one to two years.

The decision to build a family through adoption is extremely personal and can vary amongst prospective adoptive parents. A few (but not the only) reasons someone may choose to adopt include: a yearning to build or expand their family; a deep desire to provide, nurture, and become parents; strong beliefs that there are children already needing permanency; and readiness for parenthood before meeting the right partner. Historically, it was most common for married couples experiencing infertility to choose adoption. However, over the last decade, there has been an increase in both same sex couples and single applicants who choose adoption over biological children.

Clinical counsellors supporting clients with adoptions should become familiar with common adoption-relevant themes.

ATTACHMENT

Attachment and brain development are interconnected. Research demonstrates that early brain development is a combination of genetic unfolding and social experiences that shape the brain's architecture.³ During the first years of a child's life, certain experiences are essential and significantly impact ongoing development. A child that has relationally rich, stimulating, predictable, nurturing, engaging, developmentally appropriate challenges and stress will be able to express their potential and have optimal brain and body growing conditions.

Toxic stress occurs when a child is exposed to intense, frequent hardship, such as physical and emotional abuse, domestic violence, significant attachment disruptions including those at birth, chronic neglect,

war, homelessness, and parental substance abuse or mental illness without adequate adult support to buffer negative impacts. Growing up in an environment of toxic stress can cause prolonged activation of the stress response system, which can disrupt brain growth, organ development, and function, increase risk for immunocompromise, and cause cognitive impairments that persist into adulthood.⁴

During the first few years, a child's brain is highly immature and the primary caregiver plays a crucial role regulating the child's arousal state.⁵ Through the dance of attunement, in

The decision to build a family through adoption is extremely personal and can vary amongst prospective adoptive parents.

which the parent pays close attention and responds to the baby's physiological and emotional cues, a foundation is laid for the child's internal working model (IWM). This model becomes the blueprint through which the child views themselves and all other relationships. The child's repeated experiences are encoded in implicit memory (long-term memory outside of conscious awareness), shaping their expectations and determining whether the child feels an internal sense of security or insecurity in the world.⁶

Thus, a child who has experienced removal from a biological parent, betrayal, multiple placements, parental substance abuse, exposure to domestic

violence, or other significant sources of stress will have their developing sense of self and perception of the world profoundly impacted. It is essential for parents of adoptive or foster children and clinicians to remember that, even if a child is removed from a traumatic environment, their sense of self, ability to relate to others, and physiological systems may carry lifelong echoes.

TRAUMA, GRIEF, AND LOSS

Trauma has a profound impact on the developing brain and body.⁷ Complex trauma, endured by many adopted and foster children, is "exposure to multiple traumatic events — often of an invasive, interpersonal nature." This can result in long-term impacts across various domains, including neurological, physical, social, emotional, relational, behavioural, and cognitive.⁸ Adopted and fostered children carry these impacts into their new relationships with their families, making it challenging for them to form healthy, meaningful relationships with their parents, caregivers, teachers, peers, or other important people in their lives. This means a child may minimize the importance of others or not trust others, as they have learned to rely on themselves or that other people aren't trustworthy.¹¹

Consequently, new parents can be met with resistance, dismissal, or even aggression. This can be extremely confusing and/or demoralising for a parent if they don't understand why their child is constantly rejecting, dismissing, or devaluing their relationship. Not all adoption journeys are like this, but many are and both child and parent spiral into a deep cycle of shame and become further disconnected from one another. If you have a client who exhibits this pattern

of relationship with their child, educate yourself on blocked care and blocked trust¹² because hope is not lost. By developing a thorough understanding of how trauma impacts development and the parenting brain's response to their child, clinical counsellors can provide support and guidance for meaningful progress and positive change in the parent-child relationship.

Trauma impacts all parties within the adoption constellation. Origins Canada provides comprehensive information addressing the trauma associated with birth mothers who have relinquished a child for adoption.¹³ Recognizing and addressing the grief and loss unique to each person is critical for the well-being of all involved.

COMPLICATED DEVELOPMENT AND SPECIAL NEEDS AWARENESS

We know adoptees and their families require higher rates of rehabilitative

supports than the general population. A survey of adopted children with special health-care needs showed that 58 per cent had special needs related to ADHD/ADD, 22 per cent identified as having cognitive-type delays or learning difficulties, 35 per cent reported significant "emotional problems," and 67 per cent of the families received at least one rehabilitative or general service (mostly mental health care) for the child.¹⁴

Dr. Julia Bledsoe MD, also an adoptive parent, shared in a podcast interview with me the development of the adoption medicine field within paediatric care, born out of the obvious need for specialized medical assessment and guidance for those adopted. As part of her work, she helps adoptive families understand and support the developmental impacts of in utero substance exposure among other early experiences that change the course of development.¹⁵

RECOMMENDED RESOURCES FOR CLIENTS

- Adoptive Families Association. <https://www.bcadoption.com>
- Parenting in the Trenches with Karen Peters. <https://www.my.thrive-life.ca/parenting-in-the-trenches>
- Trauma Attuned Parents: Learning to be your child's guide to healing trauma by Heather Toews, RCC. <https://my.thrive-life.ca/traumaattunedparent>
- The Adopted Life with Angela Tucker. <https://www.youtube.com/c/TheAdoptedLife>
- Best Adoption Books for Children. <https://adoption-beyond.org/the-best-adoption-books-for-children/>
- Adoption: What to do while you wait. An online course for those in couple relationships who are preparing to adopt. <https://www.my.thrive-life.ca/adoption-course>
- What White Parents Should Know about Transracial Adoption: An Adoptee's Perspective on Its History, Nuances, and Practices by Melissa Guida-Richards (North Atlantic Books 2021).





RECOMMENDED RESOURCES FOR RCCS

→ Adoption and Foster Care, Karen Peters interview series.

<https://www.youtube.com/playlist?list=PLVZINtqOC60JYYaYSuqoNyQmn9Fj-a3MZ>

→ Birth and Foster Parent Relationship: A Relationship Building Guide.

<https://ctfalliance.sharefile.com/share/viewsfbf4965b0cb04a4cb3aee4a034aa2042>

→ *Building the Bonds of Attachment: Awakening Love in Deeply Traumatized Children* by Daniel Hughes (Rowman & Littlefield Publishers; 3rd edition, 2017).

→ *Children and Complex Trauma: A Roadmap for Healing and Recovery* by Dr. Chuck Geddes (FriesenPress 2022).

→ Meeting Children Where They Are: The Neurosequential Model of Therapeutics.

<https://adoptioncouncil.org/themencode-pdf-viewer-sc/?tncpvfw=ZmlsZT1odHRwczovL2Fkb3B0aW9uY291bmNpbC5vcmcvY29udGVudC91cGxvYWRzLzlwMjEvMDkvQWRvcHRpb24tQWR2b2Nh>

[dGUtTm8uLTE2MC5wZGYmc2V0dGluZ3M9MTEwMDEwMTAxMDAxMDAwMzYsYW5nPWVvLVVT#page=&zoo m=page-height&pagemod e=thumbs](https://www.ikaa.org/2023/02/12/mapping-the-life-course-of-adoption-project/)

→ Mapping the Life Course of Adoption Project.

<https://www.ikaa.org/2023/02/12/mapping-the-life-course-of-adoption-project/>

→ *"You Should Be Grateful": Stories of Race, Identity, and Transracial Adoption* by Angela Tucker (Beacon Press 2023).

→ *The Primal Wound: Understanding the Adopted Child* by Nancy N. Verrier (Verrier Publishing 2003).

→ *A Child's Journey Through Placement* by Vera I. Fahlberg (Jessica Kingsley Publishers 2012).

→ The Inclusive Family Support Grid.
<https://www.angelatucker.com/blog/the-inclusive-family-support-grid>

→ *Therapy Plays an Important Role in Adoptive Families' Lives*.

<https://nacac.org/resource/therapy-plays-important-adoptive-families-lives/>

IDENTITY AND BELONGING

The adoptee's identity development is highly dynamic and can be impacted by a number of factors, including their age and stage of development when permanency is established and prior attachment relationships and ruptures. Their sense of belonging and connection is shaped not only in the context of family (both adoptive and biological) but also by how they experience the communities in which they are raised. Adoptive families face inappropriate questions on a regular basis, and a host of standard community practices, such as school projects on family lineage, are not adoption friendly. Over time, societal judgments and ignorance about adoption can significantly contribute to the shaken foundation of belonging and worthiness, adding to the trauma experienced by those in the adoption constellation. Those adopted transracially or transethnically have additional layers in the struggle to feel "at home" in their own skin and connected to others and are often vulnerable to the impacts of racism.

Considering the vast range of openness and access to information with their biological family, genetic history, culture, and adoption story, adoptees find themselves on a continuum of sense of self and self-esteem and often grapple with the consideration of searching for information or seeking some degree of reunification. Those with limited access to family history or ethnic heritage may consider learning through DNA and ancestry databases. Adoptees will be at varying degrees of interest and readiness for exploring their own stories of openness or lack thereof in adoption and may seek support as they determine what feels right for them. Awareness of the complexity of

these dynamics can assist therapists in helping clients unpack them and make appropriate shifts.

Transracial adoptee Angela Tucker speaks eloquently in her book, *"You Should Be Grateful": Stories of Race, Identity, and Transracial Adoption* (see resources), about the myth of the fairy-tale adoption and the problematic narrative that poses for adoptees. You can access additional adult adoptee voices on this topic via recorded conversations in my YouTube series (see resources).

It is important to recognize the complex lifelong journey adoptees navigate to answer the fundamental questions "Who am I?" and "Where do I belong?" Questioning our own assumptions and biases about adoption, acknowledging and validating someone's life story as they come to understand it, and recognizing wounds that result from maintaining problematic systems and stigma around adoption can help provide a corrective experience and safer space for deeper healing.

NAVIGATING OPENNESS

The shift in paradigm from adoption secrecy to openness really only began in the 1980s.¹⁶ We have come to understand the value of openness and it is increasingly recognized as a continuum rather than open versus closed. The degree of openness now relates more to what is both possible

and engaged in by deciding members than what the government has dictated families have access to and when.

The Inclusive Family Support Grid (see resources) and its accompanying openness assessment tool are helpful

resources and can assist in supporting families interested in exploring this area.

For those wanting to explore partnering with birth and foster parents, *Birth and Foster Parent Relationship: A Relationship Building Guide* can be helpful (see resources).

For adoptive parents, the foray into openness can feel like an impossible responsibility, bringing them face to face with their own fears and longings, compelled to try their best to discern what is in their child's best interest

and how to go about the journey. It often entails flexing to new seasons of availability, appropriate boundaries, and readiness on all parts. This complicated, emotional exploration often requires therapeutic support.

WHERE TO NOW?

As we grow in our adoption competency, we can look to those within the adoption constellation for their offered wisdom, seek out adoption-informed supervision, and commit to exploring relevant resources. Our hope is that this has sparked inspiration that will lead to increased quality services for those impacted by the complex experience of adoption. ■

"The dominant cultural narrative of adoption as a noble act squelches adoptees' ability to speak openly about our pain. My life is not better because someone adopted me, my life is different. And no lifetime movie can capture how complicated reunion feels."

— Mindy Stern, adult adoptee

Karen Peters, RCC, sees clients in her private practice for a variety of concerns and holds a particular passion for supporting those in the adoption and fostering community. She is also a speaker, host of *Parenting in the Trenches* (podcast), creator of online courses for families, frequent partner with non-profit organizations, and clinical supervisor and consultant.

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- 15 Adoption: Impacts of prenatal substance exposure and adverse in utero experiences, with Dr. Bledsoe. <https://www.youtube.com/watch?v=JaXN6f1mrYA&t=13s>
- 16 History Lessons: Adoptive Family Association of BC. <https://www.bcadoption.com/resources/articles/history-lessons>



TOXIC LOSS AND THE SORROW OF PERPETUAL INDECISION

A contemplative psychotherapist's guide
through disenfranchised grief

BY BENJAMIN WEIDMAN, RCC

All my client wanted was to have her own children and start a family. She had liberated herself from her emotionally abusive long-term partner. She had invested in the healing process, experiencing an immense sense of freedom. With newfound strength and agency, she felt empowered to pursue this journey independently. Having completed the necessary steps to become an adoptive parent, all that remained was for her to say, “Yes, I am ready.” From a therapeutic sense, it seemed we had made it.

One day, her friend made a casual comment about the oppressive weight of having children. This sent my client spiralling into a hot purgatory of indecision, confusion, and rage. She described feeling stuck in life's waiting room and she couldn't get out.

The choice felt impossible to her. Committing to a child or embracing a life of freedom seemed mutually exclusive. The perceived losses associated with each path completely overwhelmed her. Trying to address each option didn't provide any meaningful clarity. This was a moment where disenfranchised grief was being hidden by indecision.

As a contemplative psychotherapist grounded in Buddhist philosophy, I will guide you through a philosophical and practical journey, shedding light on my approach to clients' grief and delving into the significance of understanding disenfranchised grief.

WHEN GRIEF BECOMES TRAUMA

In Western culture, people feel compelled to hide their tears in public settings. There's a societal expectation for grief to adhere to timelines. Our culture fixates on productivity, happiness, and the illusion of permanence — and grief disrupts these ideals. Consequently, we are constantly being told what should or shouldn't cause pain. Grief rituals tend to be transactional, briefly allowing us to lower our emotional guard, perform the necessary actions, and move on. When grief doesn't conform to socially accepted guidelines, it becomes disenfranchised grief. Disenfranchised grief lacks the external and internal permission and support to be fully processed.

When a client undergoes an overwhelming loss, it can become trauma, impeding their capacity to grieve. Surprisingly, the classification of an experience as traumatic often depends on



loss, there is an acute awareness that baked into every decision is the unavoidable experience of loss. Making a choice can become associated with an overwhelming experience of losing connection and existential threat. Even when a simple decision arises, it echoes previous unprocessed losses. In order to avoid the intensity of these previous traumatic losses, ambivalence, indecision, and paralysis are employed. The hope is that we can hedge our bets on the future losses, too.

Tift says, “Loss and limitation are inseparable from choice.” To choose one thing, means we do not get to have something else. It is inherent in our human nature to have conflicting and contradictory desires. For example, the eternal human conflict between safety and growth. In the desire to stay safe, we can feel bored, lifeless, and unsatisfied. Growth and self-actualization require us to face fears and take risks.

Tift, who is rooted in Buddhist philosophy, believes the solution for those who are trapped in the sorrow of perpetual ambivalence is learning how to sit in the “irresolvable middle ground.” Tift says: “I often suggest that they count on having second thoughts or regrets, regardless of their choice: ‘If I stay, I’ll be disturbed. If I move on, I’ll be disturbed.’”¹ There is no escape.

Tift is talking about learning how to contact the immediate experiential truth that there is no way to make a decision without separating from something else.

TRAUMA AND GRIEF

When we help a client with toxic loss, our trauma tools and mindfulness skills come in handy. We first guide the client through the processing and release of the traumatic experience, then we

the individual’s relationships and social support, rather than solely on the event’s severity. The ability to process this trauma can be the unseen gatekeeper of an individual’s ability to access grief. Disenfranchised grief symptoms resemble trauma symptoms, characterized by avoidant behaviours that prevent confronting the stimuli associated with their traumatic experiences and subsequent grief.

THE IRRESOLVABLE MIDDLE GROUND

While searching for ways to assist my client, I had a “holy shit” moment when I revisited Bruce Tift’s book, *Already Free*. As a respected figure among contemplative psychotherapists, Tift explores the concept of “Toxic Loss,” which refers to traumatic losses with lasting and devastating consequences.

For those with a history of toxic

focus on the associated grief of those big losses. Ultimately, we are guiding our client to experience the present moment in a state that's as raw and unfiltered as possible with the support they previously lacked. Slowly, the client can build a foundation of trust in their present moment experience. This way, decisions don't carry a life or death intensity but can be dealt with more skilfully.

It is important to see that grieving is a biological imperative and as natural as daffodils that come up in the spring. It is not pathological. Whenever we experience loss of any kind, our internal and external systems need to undergo a metabolic process physically, emotionally, and energetically. It's important to regard grief as fundamental as digestion.

GRIEF AND A BUDDHIST PERSPECTIVE

A healthy dynamic relationship with our grief is essential to our personal and social well-being. Loss disrupts naivety and sheds unrealistic views. This includes losing the belief in permanence of cherished things. When we lose attachments that define our identities, we're forced to ask ourselves, "Who am I without them?" The experience of loss challenges our illusions and invites a more accurate perception of life.

Disrupted stability offers an opportunity for re-evaluation, reconstruction, and growth. The process of grieving serves as a transformative journey, wherein the

raw experiences of life and loss are converted into valuable nourishment, such as insight and wisdom. This process, inherently spiritual in nature, enables emotional and spiritual growth. It presents us with a pivotal choice either to shut down or to embrace the opportunity for personal

maturation. Loss and grief, despite their challenges, act as benevolent teachers that have the power to guide us towards a more fulfilling existence.

My therapeutic approach to assisting clients in navigating their grief might be different than what conventional psychotherapy has to offer.

From a Buddhist perspective, what causes unnecessary suffering is our resistance to the truth that everything is constantly changing. Reality as we know it is perpetually coming into being, falling apart, and dying. There is nothing we can do about it. I see Buddhism as an ancient psychology that helps us relate to existential grief.

Firstly, it's important to dispel the misconception that Buddhism and meditation aim to achieve a trouble-free state. Instead, the goal is to cultivate the ability to wholeheartedly embrace any experience with kindness and unwavering awareness.

A Buddhist approach to grief doesn't mean things hurt less; in fact, when we sincerely acknowledge the depth of pain that has always been there, it can hurt more. This journey reveals the understanding that intense experiences do not pose a mortal threat; rather,

they are reminders of our existence in human bodies. In this state, we are more likely to give permission to whatever experience is arising, rather than avoid it.

YOUR ROLE

Holding space for a client's extreme loss can be challenging. I know what it's like to feel lost for words as a client expresses their grief. To experience a rush of overwhelm and confusion. If our personal losses and experiences are similar to what the client is presenting, we are likely to feel it more acutely. Without a greater awareness, moments of intensity with a client can feel confusing.

If we aren't skilful in this state, the clinician might unconsciously try to control or close down the experience. The clinician might think, "Ah, I'm still too messed up to do this work. I'm a total imposter," so we anxiously look for harbours of safety. In this state, a clinician may prematurely push for closure. This can look like jumping to "silver linings" and making meaning of a client's loss before the client is ready. This can also look like diverting the conversation away from felt experience back into the conceptual realm. For example, getting psychoeducational and blabbing about Kubler Ross and the stages of grief as the client's eyes glaze over (don't worry, I've done it). When we unconsciously pivot away from this intensity, we unwittingly participate in suppressing and disenfranchising the grief. As a result, the client loses an opportunity for accessing their own wisdom and self-discovery.

As a clinician in a session, coming into contact with our own grief is an opportunity for curiosity. I've learned that this experience is not evidence of me faltering as a professional. If I

Our culture fixates on productivity, happiness, and the illusion of permanence — and grief disrupts these ideals.

feel a loss of words, overwhelmed, bewildered, self-doubt, and generally losing a sense of direction, this is typically an accurate experience of the client's reality. It's a signal for me to pay attention to what is going on. The presence of a clinician's grief with the presence of a client's simply means that you are human and you are paying attention.

SHOWING UP AUTHENTICALLY

One of my primary tools as a contemplative psychotherapist is the mechanism of exchange. This means intuitively tuning into what the client is experiencing through the experience in my body and mind. From the Buddhist lens, we are all inextricably energetically, biologically, socially interconnected. If I tune in, I can witness my impulses, physical sensations, images, and thoughts that arise spontaneously to gather essential data about the client's lived experience.

For example, the tone of the client's story and their emotional state might not line up with how I am experiencing the moment. I can skilfully share my experience (not my opinion) with the client to deepen the inquiry. If the client doesn't agree, I don't argue and I ask what feels more true. This allows for the client to feel deeply seen, blind spots can be explored, and the client has a greater opportunity to take ownership for what was previously unconscious. This also relieves me of the burden of holding the unseen.

For some clinicians, this approach may break some rules. We are often instructed to embody a "blank slate" persona. However, this notion inadvertently creates a disconnection

within ourselves, separating our human nature from our role as helping professionals. Despite good intentions, detaching from our subjective experience sends conflicting energetic messages to our clients. In order to truly be present for our clients, we must first show up authentically for ourselves.

Our felt presence as a clinician will prove more valuable than any psychotherapeutic interventions. Exchange allows the clinician to role model a way of energetically, physically, and emotionally relating to the intensity of an "unmanageable loss." The clinician can demonstrate what it's like to get lost in intensity, find awareness,

A clinician's own relationship with personal losses and grief, wordlessly and energetically, becomes a role model for what is possible for a client.

feel what is arising, stabilize, ground, and hold a loving presence for what is arising. Rather than talk about it, we can just do it. This transmits an unconscious energetic message from clinician to client that says, "You don't have to resist; this is all manageable" and "This may be uncomfortable, but it will not kill you."

THEORY IN SESSION

My client's history of toxic loss amplified the intense struggle between choosing freedom and fulfilling her deepest desires. As a clinician who has personally experienced unbearable losses, I empathetically felt this agonizing tension. To begin, I needed

to cultivate a state within myself that could accept and tolerate this experiential intensity.

Through a moment of awareness, I intentionally sent signals to my activated system, acknowledging its importance and validating its presence as a valid part of my experience. This energetic permission extended to my client's system as well. This process expanded my narrow awareness to a more expansive, open state, allowing me to hold space for my client's suffering. Observing her, I witnessed her thoughts oscillating between prioritizing freedom and prioritizing having a child.

Throughout our work together, I've guided this client in tuning into and articulating her immediate physical sensations, detached from the associated narrative. For instance, she would say, "I feel tightness in my chest" rather than "I feel anxiety in my chest." Through skilful assessment and an understanding of my client's capacity to engage with the energy of trauma in her body, informed by approaches like Internal Family Systems, Trauma Resilience Model, and Peter Levine's Somatic Experiencing, I facilitate a process of exploring these sensations as a pathway to personal truth. Furthermore, I hold unwavering confidence in my client's ability to navigate this process.

In the session, I gently and consistently redirected her attention to her physical experience and out of her mind. I guided her to feel and describe the physical state as directly as she can. This is where the irresolvable middle ground exists. Not settling the dispute between choosing this or that but feeling the truth of both



thoughts simultaneously. It wasn't long before she released into deep sobs and described the sensation of intense fear.

After this release, my client intuitively connected to the grief her mother and the women in her ancestral lineage experienced through the self-abandonment that was expected of them in the process of motherhood. Since society aggressively reinforces these roles, this grief was never permitted. She also connected with her own desperation not to return to that previous state of self-abandonment and how deeply sorrowful that state had been for her. The direct experience of existential loss is what she had been avoiding. Paradoxically by giving herself full permission to feel this, she was

then able to move into a more practical evaluation of the impact of each choice without the traumatic charge and baggage of unbearable grief.

My primary objective in writing this article is to point out that a clinician's own relationship with personal losses and grief, wordlessly and energetically, becomes a role model for what is possible for a client. Having an intimate relationship with our personal losses deepens our compassionate presence for our clients. Paradoxically, the more we can create space for our own experience with a client, the less likely we are to make it about managing our own comfort and the more present we can be with a client's experience. They can coexist, and this can be

deeply healing for both clinician and client. This coevolution is necessary and responsible. If we are able to bring awareness and a loving presence, we send a message that the trauma and disenfranchised grief can come out of the shadows — it's safe to feel. ■

In his private practice, Benjamin Weidman, RCC, combines psychotherapeutic expertise with spiritual intuitive wisdom and Buddhist philosophy, facilitating accelerated growth at the client's natural pace for healing. He serves as an ideal mentor for individuals committed to their quest for personal spiritual truth, providing guidance on transformative psychological and spiritual journeys towards living a deeply aligned life. www.benjaminweidman.com or @ben_intuitive_therapist on instagram

REACHING IN RURAL BRITISH CO

Modifying a somatic therapy group for mothers and delivering it to fathers

BY CATHERINE KIMBER, RCC

In 2019, several colleagues and I at the Williams Lake Child Development Centre (CDC), which is located on the traditional territory of the T'xelcenc people, designed and began running a somatic therapy group called Body Based Healing (BBH) for mothers. Since its inception, we have run 12 groups, each presenting opportunities to refine the content, delivery, and group process.

Detailed here are my reflections on delivering this group to fathers for the first time, specifically through the lens of reaching out, an embodied gesture that comprises one of the key BBH building blocks. Reaching out consistently emerged as an unexpected catalyst for emotional interconnectedness and transformation among participants. Pausing to reflect and build on the process of reaching out has informed how we deliver the BBH group in the future.

ORIGIN STORY: EXPERIMENTING WITH REACHING OUT

I was first employed by the CDC in 2018 to work with families, and one of the ways our centre supported parents was through the 10-week BBH closed group. In it, we gave parents the opportunity to study experientially how their procedural tendencies, attachment wounding, and trauma show up in the present moment. The goal is to develop participants'

ability to pause, develop awareness of their present moment experience, and increase their options for how to respond.

BBH is predominately grounded in sensorimotor psychotherapy but also draws on attachment theory, emotionally focused therapy, Ruella Frank's work on developmental movements,¹ interpersonal neurobiology, and non-violent communication. Each group is taught through the active participation of two facilitators.

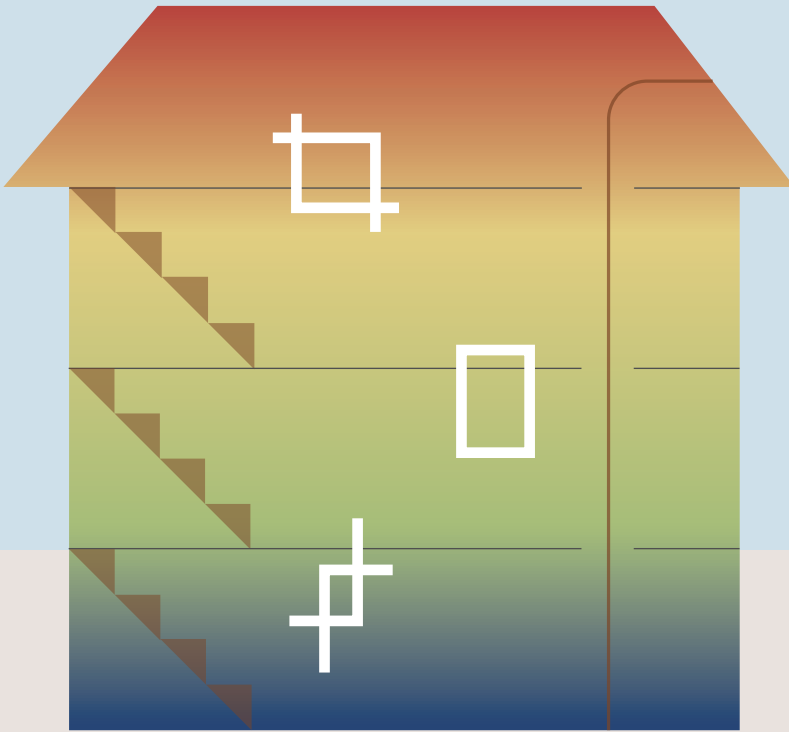
Confidentiality is notoriously difficult to maintain in small, rural communities. In response, participants were asked to refrain from sharing personal stories. While this "no storying" guideline helped participants feel more at ease in the group, it also — and even more crucially, it turned out — promoted experiential, present-focused somatic learning.

Participants share their experience of the somatic experiments (such as embodying dignity,² building a boundary, or making a gesture of reaching out to the group) by reporting on what they notice in their bodies, thoughts, feelings, and how connected they feel to themselves and others. This way of sharing helps participants to stay in their present experience and not get caught up in existing narratives of the past and future. Participants can be with another's nervous system and become aware of how they are responding

OUT LUMBIA



HOUSE OF CAPACITY



→ **Figure 1:** House of Capacity is a fusion of Jane Clapp's Window of Capacity and Dan Siegal's Window of Tolerance, indicating the zone within which one can respond to the demands of life. Each BBH session begins with participants doing a non-verbal check by placing a marker on the House of Capacity.

through somatic experiments. To give a sense of this, in exploring boundaries, each group member drew upon their felt sense of either survival or thriving boundaries to construct a concrete physical representation which could then be used to conduct experiments and explore procedural tendencies. From their self-constructed boundaries, participants were invited to reach out, either as an isolated gesture or to another. People were also invited to try out the boundaries that were constructed by others so they could track how their felt experience subsequently changed.

Boundary work can also involve somatically exploring ideas of worthiness and connection. With each building block, participants were encouraged to stay away from asking “why” and instead focus on being present with what comes up in the moment through curiosity and non-judgment.

REACHING OUT TO FATHERS

As we revised and gained a deeper understanding of the how to present somatic work in a group setting, I gained confidence that while the group was not for everyone, those who integrated the material into their daily life experienced subtle and often significant shifts in their relationships.

Interest in a similar group for fathers grew, in part because of the changes the fathers had witnessed in their female partners. In spite of this, I was uncertain if the content would translate well to a group of men. I wondered if they would commit to the program as the women had, despite the interest they expressed, or if they would attend and decide that what I was offering was too “touchy-feely” and irrelevant to their lives.

without being drawn into the specific details of the traumatic experiences. This approach often allows participants to be more receptive to people to whom their biases would have otherwise closed them off from.

Each of the 10 sessions focuses on a different BBH building block: regulation; grounding and soothing/taming; survival resources (instinctive resources that have helped endure stressful situations or cope in one's family of origin); thriving resources (developing a pause where options can be considered and new ways of responding can come forth); internal boundaries, relational boundaries, reaching out; attachment patterns; and implementing the building blocks

through art to externalize an emotion.³

Each session has the same rhythm to enhance the felt sense of safety, beginning with participants doing a non-verbal check by placing a marker on the House of Capacity (HOC; a fusion of Jane Clapp's Window of Capacity⁴ and Dan Siegal's Window of Tolerance model⁵ (see Figure 1). This is followed by a body scan to foster participants' awareness of their present experience before, in turn, reporting on their “weekly curiosity” (i.e., self-assigned homework individually determined at the end of the previous session).

The building block of the day is introduced by facilitators via discussion and teaching, with most of the session then dedicated to experiential learning



Those who integrated the material into their daily life experienced subtle and often significant shifts in their relationships.

I also wondered how my procedural tendencies would impact how I reached out to and received the men. The group integrates how I approach and understand the world: experiential, open-ended, collaborative, explorative, and grounded in curiosity and compassion. The group can also be unpredictable, as working more in a “bottom-up” approach can unearth the unexpected.

REACHING OUT TOGETHER

Because of my uncertainty in a father’s group, I was more cautious in how I approached emotions and vulnerability. For this initial group, I recruited a male colleague as a co-facilitator who had trained as a sociologist before becoming a counsellor. Our conversations assured me that I could address overwhelming emotions in this group in the same way I had in previous groups: by taking a

few drops of the present experience and breathing in compassion for the self, followed by breathing compassion out for others.⁶ We have traditionally used this technique when participants cry, but it made sense to apply this same tool to reach out to anger with compassion and support. Yet, vehement anger did not arise in the group. Instead, the men began to explore the shame that often arises with the experience of strong unregulated feelings. They moved into spaces of vulnerability.

Through the supportive atmosphere and implementation of the building block tools, participants began to titrate and “tend and befriend” strong emotions, the historical imprint of developmental wounding and trauma. By week two, the men were somatically exploring the shameful, inadequate, and

grieving parts of themselves. Moreover, they allowed others to witness and support their struggle. They quickly began to ask each other questions about their current experience along with thoughtful insights into their experiences of the present moment.

My co-facilitator’s sociological background led to curiosity about how group interconnectedness impacted the clients’ organization of experience. Indeed, the major group refinement we introduced was to be more explicit about connectedness in somatic experimentations and sharing.

Historically, group participants can share what they noticed in their “body, thoughts, and feelings” after

trying the somatic experiments. In this iteration of the group, and from now on, we invite participants to also note how connected they feel to themselves and others. There were a few pivotal moments in the group where embodying the connectedness allowed people to fully access and take in the somatic felt sense of the building block. Previously during the “reaching out” building block, participants would physically reach out to the group from a grounded place while taking in the message of “in this moment, I am enough.” In the men’s group, we made the support more explicit by having the group respond with “I am here with you” to the man who was reaching out. These shifts allowed people to deepen their experience of reaching out from a place of regulation and being received.

For some participants, this was an unfamiliar and healing space to hold. It prompted me to reflect on my biases that women predominantly provide relational connection and comfort. I thought the group would run more like “male islands,” but it was in the men’s group with a male co-facilitator where reaching out was deeply fleshed out. This gave the men permission to reach out in new ways and have their reaching out be witnessed. In turn, some of the men reported that they became more accepting of the feelings that were driving their anger — something that resulted in less anger in general.

MOVING FORWARD WITH REACHING OUT

Exit interviews were conducted with each participant. If the father had a female partner who had also completed the group, we invited them to interview as a dyad so we could explore how they integrated the material into their family life. One couple discussed the difference in how men and women



show up in the group and commented that: “If men committed to the group, they were there to show up and do the work, where, in general, women worry about how the others perceive them in the group, and this can lead to paralysis.”

The men’s group challenged my own reaching out pattern. I thought anger might negatively affect the group and my ability to manage my nervous system. The following is a broad generalization, of course: the “get ‘er done” attitude of Cariboo men allowed all of us, including me, to enter into the work with less restraint. I did not feel I had to caretake group members’ nervous systems as much as I typically do in the mother’s group where there is more of a tendency for the material to activate shut-down responses. As the group progressed, I reached out with spontaneity, humour, and bravery, and

I have taken this approach forward to subsequent groups.

The group gave the fathers and, with them, their families a new shared language to explore their regulation and attachment miscuing and ways to become aware of how their dysregulated survival patterns impact their families. The relational part of being seen, seeing others, feeling connected, and not feeling alone with shame were noted as healing parts of the group. Not having people share their histories lets them see themselves and be seen differently, as though the clutter and weight of their stories have been removed, allowing the essence of their humanity to come into focus. People want to reach out and be reached out to, but many have little experience of this. The attachment building block works explicitly with this dichotomy: the part of us that we want



Embodying the connectedness allowed people to fully access and take in the somatic felt sense of the building block.

deeply seen is often the part of us we want to keep hidden.

A common theme was that the men realized they had largely ignored their emotional world and that this had relational consequences. One father stated, “It was easier being ignorant, but there has been a cost to my family and myself.” Men reported wanting to reach out more, while the women in the relationship welcomed the emotional reaching out but also, at times, struggled to adjust and process their feelings about these new patterns. As one woman observed, “It was like the dam broke open and I was being swept downstream.” Many couples found this challenging at first but were already seeing benefits, including the courage to keep reaching out, showing new parts of themselves, and being open to transformation.

Couples also shared that they now

have a common language to understand how habitually reaching from a place of survival has created patterns of behaviour that obfuscate their needs. Couples said they could now be more aware of these patterns in interactions, allowing them to pause and reach out differently so that their needs could be better seen and tended to. Couples described their homes as calmer and less angry; they do not need to “manage their kids’ behaviour” as much, as they are choosing to work on their regulation and needs, which, in turn, creates more of a felt sense of safety in the whole family.

One of the greatest gifts we can give another is to reach out from a place of connection and regulation. During an exit interview, one of the men shared that he has introduced the HOC tool to promote more regulated communication in his workplace. He added that one of the most impactful moments for him was a somatic experiment where he reached out and let himself take in drops of being enough and not being alone — a feeling he was unfamiliar with. I would suggest that this experience has supported him in risking more to reach out. Embracing the emotional self, with the group’s support, allowed for transformation.

REACHING OUT ANEW

For the last year, we have been doing staff training to make the principles of BBH alive in our organization. We have recently started an “all gender” BBH group and plan to run a BBH group for youth. I don’t know how

men and women will respond to interconnectedness and reaching out, but the confidence and courage I gained in the men’s group have allowed us to put connection more at the forefront of the group process.

Being part of this BBH group for fathers helped me refine my ideal of reaching out from a place of love and being open to unexpected co-creation. I want to reach out from the “wholest” part of me available in the moment and be receptive to what is present in the other. The men’s group both allowed for new avenues of exploration and challenged my assumptions about what men would be like.

In the final group, the men talked about what the group meant to them, and I spoke of how exploring and being together in a vulnerable caring way let me more easily access love in my day-to-day life. Then we ate Saskatoon crisp together, and because it was the last group, we relaxed the “no storying” rule. The men talked about fishing and knives and the slow-pitch league. Gentle reaching out was alive between us all. ■

Catherine Kimber is an RCC living in Williams Lake, B.C.

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LIFE AFTER CANCER: WHO AM I NOW

How RCCs can support people adjusting to life
after a cancer diagnosis and treatment

BY LESLIE WARNER, RCC

Cancer is a common illness throughout B.C. and many RCCs will come into contact with it in both our personal and professional lives. It is very likely that, regardless of your specialization, you will encounter a client experiencing cancer or a caregiver or loved one of someone with cancer. A cancer diagnosis and treatment can affect someone's personal identity in countless ways, and as RCCs, we can provide support in adjusting to a new normal.

PERSON-CENTRED AND TRAUMA-INFORMED APPROACH

When working with people with cancer, a person-centred approach is absolutely essential. No two people have the same diagnosis, treatment, and post-treatment experience, even if they have a similar type and stage of cancer. We need to listen to our clients and understand how their experience has affected them. There is so much potential for distress within the cancer trajectory but also so much potential for client strength and resilience.

A trauma-informed approach is also crucial. Cancer affects people regardless of age, race, ethnicity, religion, socioeconomic background, and gender identity. At baseline, many clients with cancer have had traumatic experiences in their lifetime that can be further triggered by their experience in the medical system. Feeling out of control, experiencing pain, and submitting to uncomfortable medical procedures can trigger past trauma.

Further, a person's intersections of identity may mean they experience marginalization and prejudice and encounter stigma accessing health care. Some people will develop cancer-related post-traumatic stress disorder (PTSD) during the process; studies show that the incidence of PTSD symptoms ranges between 20 and 80 per cent depending on where people are in their cancer journey. For example, populations with recurrent cancer have a higher incidence of PTSD symptoms than those newly diagnosed.¹ Ensuring emotional and physical safety, empowerment, and collaboration is essential for working with this population.



INITIAL DIAGNOSIS

A cancer diagnosis typically comes into a person's life like a hurricane. Daily routines are rocked by challenging symptoms, countless appointments, sleepless nights, fear of the unknown, and memories of loved ones lost to cancer. Some people are forced to retire earlier than expected or leave work mid-career, some are unable to participate in their hobbies, and others see changes in their daily functioning and relationships. They are learning new medical terminology and trying to understand the roles of health-care professionals. In addition, their fight-or-flight response is likely on high alert, making it extremely challenging to use their brain's prefrontal cortex effectively — the area responsible for problem solving, learning, and processing new information.

Then treatment begins. This can be all or any combination of surgery, systemic therapy (immunotherapy or chemotherapy), and radiation. Clients can experience significant changes in the way their bodies look and function and must navigate challenging new and changing symptoms. Despite the incredible potential for distress during treatment,

people with cancer are resilient and brilliant at adapting to difficult and abnormal circumstances.

Due to advances in screening, diagnosis, and treatment, cancer mortality is decreasing over time. From 1988 to 2021, cancer-related mortality has decreased 37 per cent for males and 22 per cent in females.

The predicted five-year net survival for all cancers combined is 64 per cent, up from 55 per cent in the 1990s and 25 per cent in the 1940s.⁴ More and more people are living their life post-cancer or living while managing cancer as a chronic illness, which means navigating a new normal is a common experience post-treatment.

STATISTICS

Canadian Cancer Statistics estimated that **28,900** British Columbians would be diagnosed with cancer and **11,400** would die of cancer in 2022.² The Canadian Cancer Society states that **two in five** Canadians are expected to develop cancer in their lifetime, and about **one in four** Canadians are expected to die from cancer.³

CANCER REFERRAL RESOURCES

→ **BC Cancer: Patient and Family Counselling Services**
Short-term counselling support and social work services for cancer patients and their families. Services are free (covered by BC Medical Services Plan). Self-referral by contacting regional BC Cancer Centre. Services provided by phone, video conferencing, or in person. Therapeutic groups and education sessions are available.
<http://www.bccancer.bc.ca/our-services/services/supportive-care/patient-family-counselling>

→ **InspireHealth**
Virtual classes, workshops, and programs available for cancer patients. Services are free (non-profit organization). Topics are diet, exercise, stress reduction and finding emotional support.
<https://inspirehealth.ca>

→ **Wellspring Cancer Support**
Virtual classes and programs available for cancer patients. Variety of emotional, practical, physical wellness and education topics, i.e., emotional support groups, information sessions on topics like fatigue and brain fog, seated yoga classes, etc. Services are free (non-profit organization).
<https://wellspring.ca>

NAVIGATING A NEW NORMAL

For those completing treatment as planned, this experience can be long anticipated. They cannot wait to “return to normal” after having their diagnosis and treatment take over many aspects of their lives. It can come as a shock that this time is not always what they imagine.

Many take much longer to recover than they expect. Fatigue can last long after chemotherapy and/or radiation. For some, their cancer and treatment leave them with disabilities they need to accommodate. The “new normal” language originates from this dissonance between what is expected and what actually occurs post-treatment. For some, a flood of emotion comes up as they take stock of what has occurred to their body, mind, and soul during the past months or even years. It is not uncommon for these experiences to spur someone to seek counselling.

As RCCs, we can support our clients by:

- 1 - accounting for the losses they have experienced throughout their cancer journey,
- 2 - evaluating real and perceived barriers to returning to their “normal life,” and
- 3 - supporting our clients to integrate their values into action and determine a meaningful way forward.

Losses can be broad and deep for people with cancer: changes in lifestyle, relationship roles, body appearance, and body ability are just a few. For some, post-treatment life is not what they expected. We can support clients by holding space for these losses and encouraging them to be acknowledged and grieved. Helping clients recognize these changes as a form of loss and educating them on the grief and loss process may be enough intervention for many people with cancer.

For some, these losses have also significantly affected their partners or family members. Often, these topics

are very difficult to discuss between loved ones. RCCs can also provide space and support for a couple or family to acknowledge these losses together and learn tools to communicate more effectively about each person’s experience and emotional needs around these sometimes profound changes.

When our clients are ready, we can

Being able to acknowledge the losses and integrate what they have learned about themselves into how they move forward can be a beautiful process.

begin listening with curiosity and working on questions such as, “Who are you now?” “What has stayed the same?” and “What has changed?” For some clients, having had a life-threatening health concern naturally urges a

reflective process on their values.

Being able to acknowledge the losses and integrate what they have learned about themselves into how they move forward can be a beautiful process. We can then help our clients gain the tools and skills necessary to build on these values through action and create meaningful lives.

FINDING MEANINGFUL WAYS FORWARD

After clients begin identifying and reconnecting with aspects of their past life, they may still struggle with re-integrating hobbies and activities. This may come from changes in their ability or function but can also be related to unhelpful beliefs hindering them from adapting to changes. RCCs can encourage clients to work with their medical team, support groups, and other health-care professionals to manage outstanding symptoms impacting functioning.

For example, an avid knitter may no longer be able to do complicated patterns due to memory and attention

concerns post-chemotherapy (“chemo brain”); but after learning more about chemo brain and how it impacts cognitive functioning, they may find that they can continue knitting when limiting auditory and visual distractions and scheduling knitting for a time of day when they are less fatigued.

Alternatively, a person recovering from breast cancer may find that wearing compression sleeves and having regular massages improves lymphedema symptoms, so they are able to engage in some of the gardening tasks they used to enjoy.

Dr. Pippa Hawley and Gabby Eirew’s book, *Lap of Honour: A no fear guide to living well with dying*, provides inspiring examples of people continuing to live despite managing high symptom burden. In a chapter devoted to travelling with illness, Hawley shares guidance on travelling post-surgery, using prescription medication abroad, and travelling with oxygen based on her experience as a palliative-care physician.⁵

CBT AND MINDFULNESS-BASED COGNITIVE APPROACHES

RCCs can provide cognitive behaviour therapy (CBT) to further evaluate unhelpful thoughts, beliefs, and behaviour patterns. As RCCs, we are familiar with how CBT may assist someone returning to their “old life” when recovering from anxiety or depression. CBT can also be helpful for people with cancer.

For example, those having undergone head and neck cancer treatment may have required surgeries that permanently disfigure their face, drastically changing their appearance and affecting the way they eat and speak. A common concern is body image distress. In fact, one in four people who have experienced head

and neck cancer experience body image distress, which can adversely impact quality of life.⁶ It is helpful to learn to self-monitor feelings, thoughts, and behaviours as well as learn positive coping strategies around body image.⁷ For example, clients may learn to identify their presumption that others are staring at them in the grocery store line up as the unhelpful thinking style of “mind reading” or “catastrophizing,” then take steps to challenge this thinking

style. Connecting with alternative understandings of the experience and learning positive coping techniques could go a long way to help someone with body image distress to feel confident in accessing their community again.

In addition to CBT, mindfulness-based cognitive approaches have been validated in the field of psychosocial oncology. In particular, mindfulness-based stress reduction (MBSR) is a



CANCER SURVIVORSHIP RESOURCES

→ BC Cancer, Northern Health, UNBC, & UBC. (2023, May 22).

Your survivorship care plan. <http://www.bccancer.bc.ca/survivorship-site/Documents/Generic-CP-Electronic-revised-June-2013.pdf>

*Plans available to certain cancer diagnoses or inclusive of all cancers.

→ BC Cancer. (2023, May 22). Coping with cancer.

<http://www.bccancer.bc.ca/health-info/coping-with-cancer>

→ BC Cancer & McGill University.

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→ Canadian Virtual Hospice. (2023, May 22). www.mygrief.ca

→ Palouse Mindfulness. (2023, May 22). Online mindfulness-based stress reduction.

<https://palousemindfulness.com/>



well-accepted support for people with cancer and has been evaluated for its impact on common concerns, such as quality of life, pain, fatigue, anxiety, and depression.⁸

Currently in B.C., Lori Brotto is reviewing the efficacy of group mindfulness-based cognitive therapy for breast cancer patients experiencing sexual distress and changes in sexual

People who experience cancer and its treatment are resilient and can become inspiring models of adaptation and perseverance.

desire that they associate with their treatment. As described in Brotto's

book, *Better Sex Through Mindfulness: Cultivating Desire*, people can learn how to use mindfulness techniques, such as a sensate focus exercise, to tune into their body sensations and tune out cognitive

distractions that may shut down desire.⁹ Brotto et al.'s 2012 work has shown that women with breast cancer

have noted improvements in sexual functioning after learning mindfulness and meditation skills and participating in sex education and therapy.¹⁰

Researchers in the psychosocial oncology field are evaluating and validating the use of CBT and mindfulness-based cognitive approaches for a variety of cancer survivorship concerns.^{11, 12, 13}

In sum, people who experience cancer and its treatment are resilient and can become inspiring models of adaptation and perseverance. RCCs can use a person-centred, trauma-informed approach to provide a safe place for clients to process their losses and rebuild their identity or new normal post-treatment. CBT and mindfulness-based approaches can also be helpful in supporting clients with returning to their activities and hobbies and, ultimately, rebuilding or affirming their identity post-treatment. ■

Leslie Warner, RCC, lives in Prince George, B.C., the unceded territory of the Lheidli T'enneh, where she enjoys gardening, sewing, and spending time with her two children and husband. Leslie has supported people with cancer and their families for the past seven years at BC Cancer-Centre for the North Prince George.

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ADJUSTING TO POST-SERVICE LIFE

The impact of traditional masculinity ideology on veteran mental health and treatment outcome

BY JULIA O'LOUGHLIN, RCC

My dissertation research examined the intersections between traditional masculinity ideology, mental health, and psychotherapeutic treatment outcome among veteran men. This is an important line of inquiry as endorsement of traditional masculinity ideology is common among veteran men and linked to mental health concerns that can negatively impact the transition from military to civilian life. Overall, this work sought to improve our understanding of how, and through which means, traditional masculinity impacts veteran men's mental health and treatment outcome with the aim of identifying approaches to mitigate these difficulties.

A series of three separate studies were conducted with the following goals:

- ◆ 1. to determine the relevance of traditional masculinity ideology to veterans' transition trajectory by examining the relationship between individual masculinity facets and mental health;
- ◆ 2. to assess whether the relationship

between traditional masculinity ideology and veteran mental health extends to psychotherapeutic treatment outcome; and

- ◆ 3. to explore the differential impacts of individual masculinity endorsement versus shared masculinity endorsement between group therapy participants on psychotherapeutic treatment outcome.

Study results indicated that restrictive emotionality (the belief that men should be detached from emotionally charged situations and emotionally inexpressive) was the masculinity facet most predictive of common psychosocial difficulties experienced during military civilian transition, including post-traumatic stress disorder (PTSD), depression, and lack of social support.

We also found that self-reliance (the belief that men shouldn't rely on others) was the masculinity facet most likely to attenuate group therapy treatment outcomes with respect to reductions in PTSD symptomatology and improvements in psychosocial functioning.

Unexpectedly, we found that

endorsement of the toughness facet of masculinity (the belief that men should be willing to take risks) resulted in more improvement in psychosocial functioning over an 18-month post-treatment period.

Finally, results indicated that individual attitudes regarding traditional masculinity ideology have a greater impact on treatment outcome than do the attitudes of others in the group.

Combined, results of the three studies may be used to inform programming aimed at preparing military service members for transition to civilian life and supporting veterans during their transition. The three studies have been published as autonomous manuscripts in the *Journal of Men's Studies, Counselling Psychology Quarterly*, and *Psychology of Men and Masculinities*. ■

Julia O'Loughlin, RCC, completed her PhD in Counselling Psychology under the supervision of Dr. Daniel Cox at the University of British Columbia. Her clinical specializations are in the areas of gender and sexuality.



TO EXPERIENCING TRUE FEELINGS

Intensive Short-Term Dynamic Psychotherapy

BY KIM BOIVIN-SONOLET, RCC, AND ROBERT BAL, RCC

Intensive Short-Term Dynamic Psychotherapy (ISTDP) was developed by Dr. Habib Davanloo at McGill University in collaboration with David Malan, whose Triangle of Conflict and Triangle of Person are foundational to ISTDP. Davanloo was concerned about the duration of psychoanalysis, reliance on interpretation, and implied omnipotence. He created a modality rooted in the understanding that early childhood experiences lead to internal dynamics that develop as protective measures against feelings and impulses learned to be intolerable or unacceptable, but later become the cage in which a person finds themselves trapped.

Dr. Ange Cooper states: “ISTDP’s primary goal is to help the patient overcome internal conflicts to

experiencing ALL of their true feelings about the present and past that have been warded off because they are either too frightening or too painful. The technique is intensive in that it aims to help the patient experience these warded-off feelings to the maximum degree possible; it is short term in that it tries to achieve this experience as quickly as possible; it is dynamic because it involves working with unconscious forces and transference feelings.”

WHICH CLIENT CONCERNS IS ISTDP ESPECIALLY EFFECTIVE WITH?

ISTDP is effective for anxiety, depression, and relational difficulties, is supported for clients with C-PTSD/PTSD and treatment-resistant personality disorders, and has a strong evidence base for working

with medically unexplained somatic symptoms.

HOW DOES IT WORK?

ISTDP facilitates change via invitations to experience complex emotions connected to past attachments that underlie issues clients seek help with. It involves building tolerance of unconscious anxiety and identifying/deactivating defenses. We try to not get caught up in thoughts but are more interested in what’s underneath them.

For example, a client says, “I don’t feel good enough.” We invite them to see this as a defense, not a feeling. We don’t try to change or explore the thought; instead, we invite them to get to the bottom of what it is defending against. This is also known as “pressure” in ISTDP. The client shares a specific relational example of when this defensive thought arose and, through

a process tailored to their anxiety tolerance, explores whether thinking this is a pattern when they interact with people who don't meet an attachment need and feelings arise towards that person. "I'm not good enough" may be functioning to defend against such feelings — to cover up that truth.

When anxiety tolerance has increased and defenses have been exhausted enough that truth — those feelings — may show up in the transference, that is welcomed. We express curiosity about the links between those feelings and their original target(s) — the early caregiver(s) — and the bodily experience of grief, rage, guilt, and love the client has been denying themselves.

The process tends to help people become more open and integrated. It's relieving and freeing to get underneath the anxiety and defenses. It can feel like diving for a treasure chest — it's hard work but well worth it.

WHAT DO YOU LIKE BEST ABOUT ISTDP?

KBS: I was initially inspired to explore ISTDP first as a client then professionally. I've been using ISTDP since 2017. I most appreciate the emphasis on us being attachment-based creatures with needs that create feelings in our bodies. When these needs are not met, especially by people important to us, we may unconsciously engage a combination of bodily anxiety and defensive processes to avoid the powerful mix of feelings and impulses that arise. This way of looking at the human condition and symptoms people come into therapy with is foundational to ISTDP. I find it a grounding, humanizing, and compassionate way to work. I've had more moments of deep emotional connection with my clients;

I feel more emotionally open and have seen that transformation happen in clients. I also love that clients can apply Malan's Triangle of Conflict and Triangle of Person to navigate challenges in their life. They don't need to rely on me — it's collaborative and empowering.

RB: I became an RCC specifically to practise ISTDP after a significant experience with it as a client. I view it as inherently compassionate — an active attempt to reach the person inside the person, the one who was long ago locked away. What I most love is the way it centres the unconscious. I am continually awed by how the unconscious moves in therapy — how, in this relational work, there is the unconscious of the client, unconscious of the therapist, then, as attachment develops, an unconscious therapeutic alliance, an active healing force leading the dyad forward. This force can perhaps be understood as the sound of that same music at which spirituality and faith the world over is directed.

ARE THERE OTHER MODALITIES IT PAIRS WELL WITH?

ISTDP is inherently trauma-informed and is a good pairing with any modality used with trauma survivors. It has similarities with aspects of CBT, including views of self and other. The Rogerian ground upon which most good therapy stands is also concomitant. ISTDP and EFT have shared emphasis on attachment, emotions, and negative interactional cycles. AEDP was developed by Diana Fosha, who trained with Davanloo. The relative cost-effectiveness of ISTDP, linked with fewer treatment times, means it has potential value for marginalized folks, for whom many barriers to therapy exist, and connecting it to multicultural and feminist modalities.

ARE THERE ANY ISSUES ISTDP SHOULD NOT BE USED WITH?

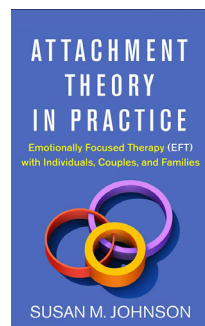
The ISTDP Institute states: "Other treatment options should be considered for patients suffering from organic syndromes, brain injury, active psychosis, active alcohol and/or drug addiction, severe acting out, antisocial personality disorder, life-threatening active health conditions (i.e., active inflammatory bowel disease)... For some disorders, ISTDP might be considered if the patient condition has stabilized (i.e., bipolar disorder, some psychotic conditions) but these would need to be attempted with great care and advanced training."

WHERE CAN WE LEARN MORE?

There are lots of opportunities to learn ISTDP! Core trainings are offered by instructors who trained with Davanloo, such as Dr. Allan Abbass, Dr. John Rathauer, and Dr. Patricia Coughlin. Many of the following generation have become trainers, such as Dr. Joel Town, Dr. Ange Cooper, Jon Frederickson, and Dr. Jonathan Entis. Shorter trainings with specific areas of focus are also offered. Much ISTDP literature is available, such as Davanloo's original texts and Abbass's *Reaching Through Resistance* and Frederickson's *Co-Creating Change*. Finally, it is our heartfelt recommendation that one of the best ways to learn about ISTDP is to experience it first-hand — as a client. ■

Kim Boivin-Sonolet, RCC, of Positive Change Counselling in East Vancouver, gives special thanks to Tamara Skjolden, RCC, and Jessie Langlois, RCC, for their part in her healing and learning process through ISTDP. Robert Bal, RCC, is a psychotherapist and poet living on stolen Musqueam, Squamish and Tsleil-waututh land, trying to do some good in the world.

 **Read**



ATTACHMENT THEORY IN PRACTICE: Emotionally Focused Therapy (EFT) with Individuals, Couples, and Families

By Susan M. Johnson

Dr. Sue Johnson is the developer of Emotionally Focused Couple Therapy and “the most original contributor to couple’s therapy to come along in the last thirty years,” according to Dr. William J. Doherty. In this volume, Johnson now extends her attachment-based approach to individuals and families. And don’t miss your chance to learn from Dr. Johnson in-person. She’ll be presenting a workshop this fall at BCACC’s conference, *Counselling in a Changing World: Re-imagining Our Environments*, in Vancouver on November 3 and 4, 2023!



TELL ME WHAT YOU WANT: A Therapist and Her Clients Explore Our 12 Deepest Desires
By Charlotte Fox Weber

Written with warmth and compassion, full of dramatic, intimate, and moving personal stories and based on careful research as well as firsthand observations, *Tell Me What You Want* by psychotherapist Charlotte Fox Weber guides readers through a moving exploration of the 12 fundamental psychological needs we all share and goes behind the closed doors of therapy to guide us in navigating our deepest longings.

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SORT OF
Streaming now on CBC Gem

A 2022 winner of the prestigious Peabody Award, *Sort Of* is a big-hearted series about Sabi Mehboob, a fluid millennial who is exploring life at the intersection of various identities.

 **Try**

AWAKENING SELF-COMPASSION CARDS
Ann Saffi Biasseti, PhD, LCSW

Awakening Self-Compassion Cards offer a clear, actionable program of self-compassion, mindfulness, and embodiment practices that will resonate with anyone who wants to cultivate more confidence and agency in their life.





Small business and self-employment benefit packages for RCCs

YOUR PARTNER FOR SUCCESS

A message from BCACC Member's Benefits Senior Advisor Stephanie Ritchie:

Did you know that many RCCs who have left employment and are in their own private practice are surprised to find out that they are unable to have same "Employee Benefits" coverage? Their option is to self-insure with "Individual" Health & Dental insurance & Loss of Income Disability coverage.

- Health & Dental plans that do not require any medical exams
- Loss of income Disability/ Business Overhead Expense coverage
- Critical Illness Insurance
- Life Insurance

For RCC's who have two or more employees, ask about the "Premier Upgraded Plan," where health and dental benefit limits actually increase year after year.

COVERAGE PROTECTING YOUR...

MEDICAL COSTS

No medical questions to enrol and available to ALL RCCs!

Affordable and flexible Medical & Dental Coverage for Prescription Drugs/ Vision care/ Dental and much more! These benefits offer the "Second Benefit Discount" when adding Injury Disability for about same monthly cost as just having the health and dental benefits on their own! (certain non-medical criteria)

SELF EMPLOYED & SMALL BUSINESS INCOME

Loss of Income Disability insurance is continuous 24-hour coverage that pays a monthly benefit if one is unable to do their job due to an Injury or illness. Simplified underwriting (Illness Disability) and it includes the Disability Claims Advocacy service.

BUSINESS OVERHEAD

Business Overhead Expense (BOE) coverage reimburses business expenses to help keep your business running when you are unable to work. Designed to reimburse your business for overhead expenses in the event of disability.

For consultations and quotes please contact:

Stephanie A. Ritchie, BCACC's Member's Benefits Senior Advisor
778-533-4676 — stephanieritchie@shaw.ca

Become an RCC!

We are over 6,000 members strong and growing every day. Access unparalleled value and recognition. Join us!

The RCC designation is synonymous with professional accountability, labour mobility, and adherence to high ethical standards in the counselling profession. BCACC supports RCCs in the important work they do with an array of in-house benefits, such as BCACC's Find a Counsellor Tool, Approved Clinical Supervisor Program, Member Advertising Rates, Committees, Events and professional development, EConnect, and #RCCconnect. RCCs also have exclusive cost-savings from BCACC's benefit partners.



With an average of 18,000 visitors per month, BCACC's Find a Counsellor search tool can help you connect to clients and grow your practice with ease and simplicity.

Learn more at bcacc.ca/counsellors



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→ Free membership and 60 free driving minutes

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→ A robust health and dental plan with available add-ons.

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oxygenyogaandfitness.com



→ 10% discount per month with month-to-month contract towards any subscription with a first month free OR 20% discount per month with an annual contract towards any subscription with a first month free.

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→ 20% off virtual trainings and workshops

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