INSIGHTS

THE BC ASSOCIATION OF CLINICAL COUNSELLORS' MAGAZINE

SPRING 2023

SOCIAL MEDIA, YOUR WAY
Approaches and Tips

PRIVATE PRACTICE BUSINESS POLICIES

INTERDISCIPLINARY WORKING RELATIONSHIPS

EMBODYING CONNECTION AS A PRACTITIONER

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CONTENTS SPRING 2023

FEATURES

IN EVERY ISSUE

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.

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GETTING CLEAN IN YOUR HEART

Business policies that work for you and your private practice

While Standards of Clinical Practice provide guidance on many aspects of being a counsellor in B.C., private practice RCCs need to make their own decisions about a few areas, for example, complimentary sessions, sliding scale, no shows, and cancellations. A primary reason BCACC doesn't have rules for policies like these is to ensure the counsellor has enough autonomy to allow the therapeutic relationship between the counsellor and client to remain the priority.

As Jennifer Hollinshead, RCC-ACS and founder of Peak Resilience, points out, studies have shown — and most counsellors would agree — that the therapeutic relationship is the biggest predictor for success in therapy, no matter how the client may define success.

"If we're all coming back to the relationship being the most important predictor of therapy working, we also need to have boundaries, and we need to recognize that therapists are 50 per cent of the relationship," she says.

"Every therapist is their own human being in their own location, dealing with their own privileges and barriers. The policies they create need to reflect what is sustainable practice for them and what is also trauma-informed and realistic for clients."

But how do you create your own policies? You start by turning inward, which counsellors are seldom taught to do.

"We are really, really good at turning outward and asking what the client needs and what a situation requires,"

says Carolynn Turner, RCC-ACS and founder and director of Lavender Counselling. "But part of our job is honouring the relationship. Does it feel clean in my heart to provide pro bono counselling or sliding scale or complimentary consultation?"

That turning inward is your responsibility to yourself, your client, and the therapeutic relationship.

"If I don't first listen to myself, and I'm building resentment or a sense of frustration, then I'm going to bring that out in the relationship with the client," she says.

Further, decisions about these policies may require flexibility at different times in our lives.

"When my children were young, I actually couldn't be very flexible in offering last-minute sessions to clients," says Turner, explaining that childcare arrangements meant sticking to her schedule. "Referring clients out to community supports because of this sometimes felt really sad for me."

It was through processing her own sadness and setting the boundary that came from that process — "I wish I could help, but I can't. I have my own family." — that Turner was able to prevent a lack of agency and subsequently a sense of burnout. Doing the work in a way she feels proud of helps to ensure she doesn't become bogged down.

Now that her children are grown, she may occasionally let a client know they can reach out for a last-minute session if something urgent comes up. She also does more pro bono work now than she did when she was new to the profession, and she may sometimes offer a sliding scale.

"To go back to that expression 'clean in my heart,' I feel great about it, because as much as my motivation for helping has always been there, my financial stability has changed, so I have more space to do that," she says.

As BCACC Approved Clinical Supervisors, both Turner and Hollinshead offer their perspectives on policies every private practice RCC needs to consider. Because of the importance of this topic and the space needed to cover it adequately, the beginning appears here in *Insights* magazine, while the full article is featured on the BCACC blog. Learn more about sliding scales, no shows and cancellations, complimentary consultation, refunds, rate increases, vacation time, and communicable disease plans at https://bcacc.ca/blog/ ■

BUILDING RESILIENCE IN CHILDREN

IN TIMES OF DIFFICULTY

CELINE CLUFF, RCC

PSYCHOLOGICAL RESILIENCE represents the ability to cope with a crisis mentally or emotionally or to return to pre-crisis status quickly. Scientific studies on resilience explore the way we execute these coping mechanisms and how we conduct ourselves to survive emotionally — for example, during a pandemic.

According to research from Michael Ungar, founder and director of the Resilience Research Centre at Dalhousie University, and Kristin Hadfield, assistant professor of psychology at Trinity College Dublin, factors that improve a young person's life change depending on whether they live in a stable, safe community or a challenging environment. This means researchers have to pay attention to a child's environment to understand what factors help them build resilience.

Something to keep in mind is the relationship between the child and their primary caretaker(s). A resilient child will have at least one resilient interpersonal relationship with a parent, caretaker, close relative, or even friend. Nurturing these relationships plays a pivotal role in the maturation of a child's psychosocial development. Nurturing our interpersonal relationships is also healthy for our happiness levels. Research from the positive psychology realm continues to point us towards countless mental health benefits of having fulfilling interpersonal relationships. It is the quality, not quantity, of these relationships which brings us the most joy.[1]

The same goes for children. It is important to let children engage with each other on their own terms (interfering only if and when necessary), letting them partake in outdoor and indoor playtime, preferably unsupervised, while letting them act out different scenarios with peers. Allowing children to enjoy each other's company daily is pivotal for developing healthy social skills. It is in these early years in which children's social and emotional repertoires are developed. Extracurricular activities are also valuable; however, they cannot replace the social/interpersonal exchange. It is important to keep in mind the need for both when we strive towards raising resilient kids.

In their research, Ungar and Hadfield place emphasis on people's social ecologies (or preservation thereof) when it comes to their development and level of resilience during times of crisis.[2] Because a stable, safe environment plays a pivotal role in laying the groundwork for this development, stay open-minded about parenting during times of crisis. It is important to have dialogues with children. A brief exchange about your day or how you are feeling will suffice. Keep the message simple. You may be positively surprised to learn how much children give in return if we show them we are vulnerable, too.■

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EXTENDING CARE AND COMPASSION in and beyond our borders

Last May, Dave Hutton took a leave from his position as director of Health Emergency Management BC's Disaster Psychosocial Services Team to go to Ukraine, where he worked for six months as a mental health and psychosocial support specialist for an international non-government organization. During that time, Dave set up a team of mental health professionals and extended support to Ukrainians who have been impacted by the war, many having lost their homes and now living in shelters.

"While there are crises happening all over the world, this was one of those generational conflicts that really captured our attention," says Dave. "It was difficult for me to sit back and watch what was going on. I felt compelled to help and do whatever I could to make a difference. Provincial Health Services Authority was very kind to grant me a leave of absence so I could volunteer my time in Ukraine."


DAVE HUTTON

"It was difficult for me to sit back and watch what was going on. I felt compelled to help and do whatever I could to make a difference."

Despite all his experience working alongside communities impacted by disasters, Dave was particularly struck by the strength, resiliency, and spirit of the Ukrainian people.

"The day the war started, people showed up to support one another, whether that be businesses which overnight closed their doors only to open as community organizations to provide safe spaces for people or just everyday citizens collecting food, clothing, and medication, doing whatever they can to help."

Regardless of how you feel about the conflict, it truly is an all-society effort and the spirit of the Ukrainian people is inspiring. But strength and resilience don't mean people aren't suffering, grieving, and struggling with unmet needs every day, especially now, without power and electricity because of the Russian missile strikes. Canadians can support Ukrainians in Canada and abroad by donating to and supporting trusted organizations and initiatives.*

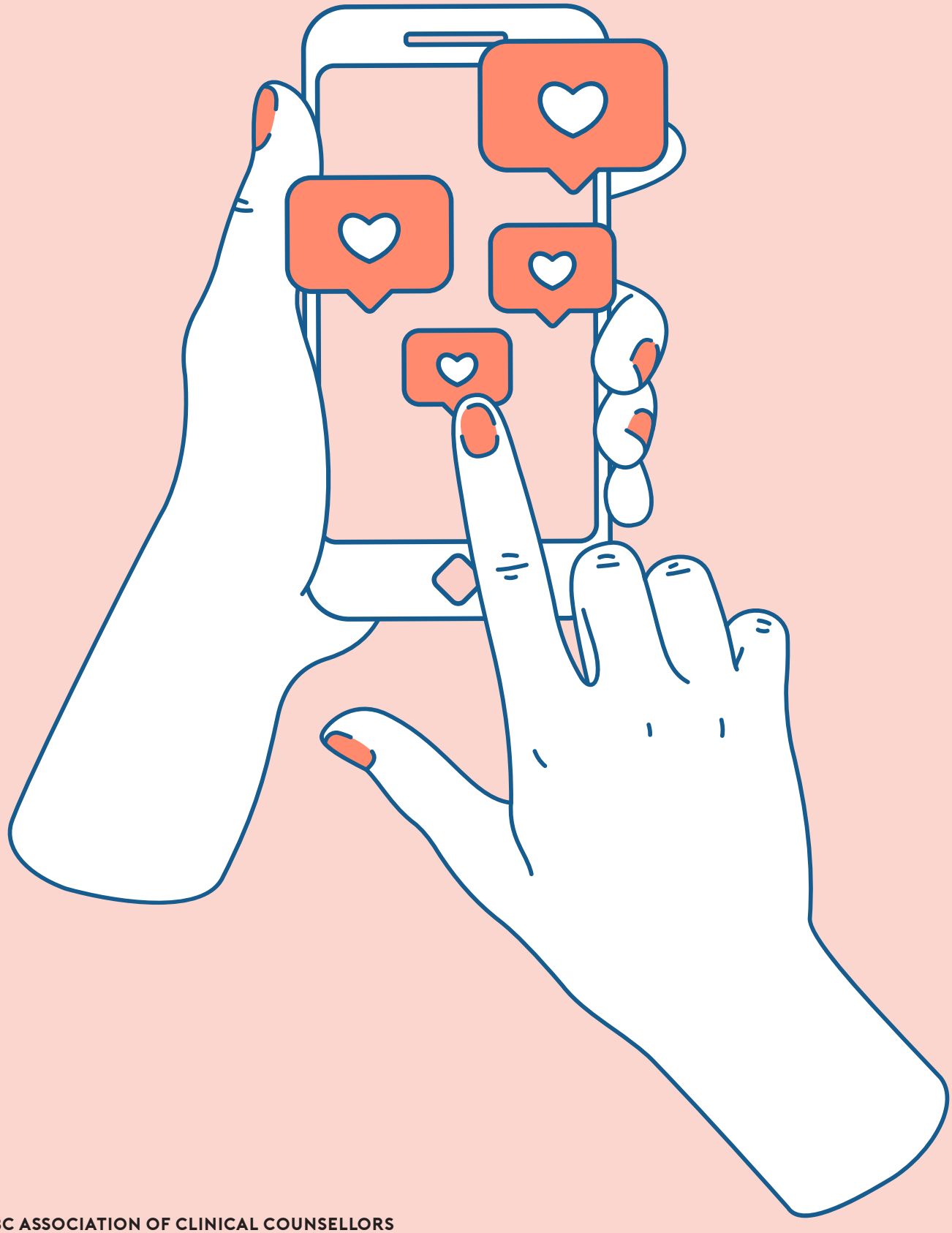
Since returning to Canada, Dave has continued to support volunteers and small organizations in Ukraine. ■

**Find ways to help here: https://www.canada.ca/en/immigration-refugees-citizenship/services/immigrate-canada/ukraine-measures/help.html*

MAKE A DIFFERENCE AT HOME

Disasters can happen anywhere, anytime, including in our own province. If you are interested in providing psychological first aid in communities impacted by emergencies and disasters, consider applying as a volunteer with the Disaster Psychosocial Services Team. Volunteers must have a level of education, training, and experience equivalent to a BA in a related field, plus a minimum of five of years recent and related experience working in social work, mental health counselling, crisis response, or similar professions.

Find more information at http://www.phsa.ca/our-services/programs-services/health-emergency-management-bc/disaster-psychosocial-program or call Ryan Good, Volunteer Coordinator, at 604-319-0196.



SOCIAL MEDIA, YOUR WAY

Three RCCs discuss their approaches to social media

CAROLYN CAMILLERI

It is hard to imagine not having a social media presence if you're in business. While some people enjoy social media as a business tool, not everyone does — and not everyone manages it in the same way. Some sensible guidelines for clinical counsellors exist, mainly around client confidentiality, but how much or how little you participate in social media is up to you.

FOLLOW THE CODE

Jennifer Hollinshead, RCC and founder of Vancouver-based Peak Resilience, says their practice does its best to use social media to provide helpful information that aligns with the Code of Ethics and supports their client communities.

"The way we use social media is very much just like an extension of our practice, and we're not posting very much, and it's not necessarily a big part of our business," she says, listing Instagram, Facebook, and YouTube, as well as monthly newsletters, as the ways they communicate online. "Our social media policy is relatively sparse compared to a practice moderating online mental health chat spaces, for example."

"Everyone needs to have their own social media policy about what they do and don't do," says Hollinshead, noting that they are very careful not to ask clients for reviews, and they don't accept friend requests.

"If someone posts a review, it wasn't requested by us and we had no control over it, then that's fine, and if it's a positive review, great," she says.

Hollinshead says their social media policy includes not "following" or "liking" posts when they are client related when at all possible.

"It's important to think through what is sustainable over time and ensure your policy reflects what is sustainable for you," she says.

If people identify themselves as clients in their comments, Hollinshead says there is little they can do about it.

SOCIAL TIPS

✦ Be very careful engaging with other pages. "We try our best to filter their content and not just 'like' or 'comment' because they talk about mental health," says Grimm. "We do our best to ensure their values align with ours, too."

✦ Be prepared to direct people to your website or to resources as needed. "We are clear about not being able to have therapeutic conversations using direct messaging," says Grimm. "It's just not an appropriate platform for that. We have free resources on our webpage that we direct people to if they reach out."

✦ Think carefully about your content. "I worry, at times, that what I am saying might trigger someone," says Grimm. "How can I share my message of self-compassion and kindness and that our emotional health is important while offering information that isn't just so generic it is empty? Generic can be helpful because it's accessible, safe, and allows me to connect with the most people. I try to ground myself in values that fit my practice and from that foundation, then create content."

"Clients get to make those decisions, and some people just want to tell everyone," she says.

If people become argumentative about a post, they wouldn't hesitate to shut down comments. That said, social media is not something they have too much of a problem with.

"As long as we are operating within our Standards of Practice and basing our decisions and conduct on an ongoing review of the Code of Ethics, I think we are generally safe," says Hollinshead. "It's if we were to stray from those key documents — that's when our behaviours could become problematic."

MINDFUL MEDIA

Alice Curitz, RCC, is founder and clinical director of Our Landing Place, a collaborative clinic that posts on Facebook and Instagram and also has a rarely used LinkedIn account. She isn't a fan of social media and doesn't have personal accounts, but she does see the usefulness of social media for business: "You do have to be very mindful about how you use it."

Curitz encourages developing a written social media policy, especially if someone else is looking after your accounts.

"Up until recently, it really was just me," she says. "But now that I've very, very happily offloaded all of the social media to my clinic manager and program administrator, we are creating an actual written policy, because it's really important to make sure we're protecting our clients and protecting ourselves and being ethical, and also that we're using social media in meaningful ways."

The policy includes how to respond to comments.

"We don't want to be policing people. We don't want to be silencing people. It's okay to have people disagree," she says.

In fact, disagreement can be healthy.

"I think it's actually really great if someone says, 'I don't agree with this advice,' or 'This has not been my experience of borderline personality disorder.' That's great. We want that engagement from people. We want people to have really healthy conversations about whatever it is that comes up for them."

But not all comments get a response.

"It's okay to not always reply to people if they have a question or post a comment," says Curitz. "I'm not expecting anybody on my team to be glued to our social media 24/7 and replying to everything."

Problematic comments that "border into unsafe territory — hate speech or making others feel unsafe or attacking someone" — are addressed. First, the commenter's account is checked to see if it is spam, promotional, or a bot or troll account — those comments are deleted and blocked. If someone else has responded to the comment, an explanation for why the comment was deleted may be posted. Curitz says, so far, nothing has been so controversial that offering support has been needed, but they are prepared for it.

"We don't have to engage with people when they make us feel unsafe — we can just block and delete. If somebody else has been harmed, we can address that. If we feel harmed, we can get support elsewhere," she says. "We sometimes forget in this age of everything being online that we can walk away. You don't actually have to prolong the interaction if you don't feel safe or if you don't have the capacity for it."

As for reviews, Curitz reinforces that counsellors cannot reply, even to the nice ones.

"If someone leaves a positive review on your Google or Facebook profile, it is really, really lovely, but you can't respond to it and say, 'thanks' because you're acknowledging that that person is a client," she says. "The same thing is true — and I think this is where it becomes a lot scarier for people — if somebody leaves a very negative review, particularly if that information is false

or out of context. We're a queer-centred therapy collective. We are going to get people who just dislike what we do and who we are and are going to do stuff simply because of that, even if we've absolutely not had any interactions with them before."

But you still can't reply.

"We can neither confirm nor deny who our clients are, and it can potentially be harmful to business," says Curitz. "If negative reviews on Google or Facebook deter a few people, I think that's a real shame, but there's not a lot we can do about it. We just have to keep our heads down and keep going in the direction we're going, because we are going to run into this at some point quite likely."

That said, she suspects people are catching on to how unreliable the reviews can be, especially with all the bots, and are not taking them as seriously as before.

"We carry a lot of difficult emotions. We hear a lot of very difficult stories. We genuinely care for our clients, and when they come to us struggling, it can be really hard. We're very good at having boundaries around that — hopefully, we're trained in that, we work on that — but I'm already emotionally done by the end of the day. I have a business to run, I have a family, I have friends, I have a personal life. I have a stack of books I actually want to read. I don't want to invest my time in giving more attention to something that is incorrect."

Ultimately, each counsellor has to decide how they want to use social media.

"Social media can be a really great tool and some people use it a lot. They're on it multiple times a day. They have a social media strategy. It's one way they bring awareness to what they're offering, and that's really great," says Curitz.

"And then there are a lot of us who have social media, but do we have a formal strategy? Do we need one? I don't know."

SOCIAL BUSINESS PLAN

Kelsey Grimm, RCC, is clinical director at Healing Spaces Center, which has its own social media team. Finding the right team was a learning curve.

AIM FOR BALANCE

Social media shouldn't only be a marketing tool. "People are very aware of when they're constantly being sold something," says Curitz. "Use it if you want to share information, and of course, let folks know about groups you're running or workshops. That's fine. But make sure there's some balance."

"I feel very fortunate that the team we now have truly co-creates content with me and has a strong passion for mental health and balance," she says.

For Grimm, social media is her contribution to healing her little corner of the world.

"I try to imagine spreading fairy dust around and supporting others to move towards their own version of healing and balance," she says. "Of course, it is a part of my business plan, but bigger than that, I truly do want to contribute to the healing in our world. There are so many wounded out there amongst us that deserve some fairy dust! I think these are the tenets that guide my behaviour, my business, and my social media presence."

While the majority by far of Grimm's social media interactions are positive, she has learned through experience how to manage negative situations. For example, negative comments on videos, which she takes in stride.

"The trolling world is wild," she says. "We don't encourage or engage with trollers. I believe it is those who carry wounds that wound others, and so in my own way, I just send that person a little fairy dust through the ether and hope they don't cause others harm."

Grimm has had people reaching out over social media for "something a little different from counselling support." Her response is to disengage and direct them to the website.

A hard situation is when people in distress reach out.

"I can see they are in distress but social media is not an appropriate or ethical place for therapy or even a therapeutic conversation," she says. "Resourcing and directing clients to our webpage and crisis lines have been helpful."

But the negatives aside, social media has its rewards — the good comments and messages.

"Seeing that deeper connection others have with our content is truly wonderful," says Grimm. "It means a lot to me because I do spend a lot of thought and time in co-creating content with our team and hashing out ideas, let alone filming. Sometimes you feel like you are pouring so much energy and intention into a vacuum, so knowing it lands for someone truly fills my cup and helps me keep going." ■

INTERDISCIPLIN WORKING RELATIONSHIPS

Embodying connection as a practitioner

SHAUNA PAYNTER, RCC

Working within a multidisciplinary clinic requires a special type of practitioner: a brave, open-minded one who is willing to ride the wave of change. Working within or running a multidisciplinary clinic requires flexible thinking, a strong work ethic, and an ability to collaborate well with others. At the end of the day, our ability to initiate, maintain, and deepen relationships is at the heart of this business journey. Here, I hope to give you a breakdown of how to get started in collaborating with other professionals as well as working within the opportunity once you have established yourself in a competent group.

GETTING STARTED

"No human can survive alone," is a profound statement made almost four decades ago by John Bradshaw in his book *Healing Toxic Shame*.[1] This statement about us as social creatures needing each other to survive also applies to running a business and collaborating with others. Research by Dr. Daniel Siegel on interpersonal neurobiology proves healthy connections and feelings of belonging positively impact physical, mental, and emotional health.[2] We can apply this to our perspective on client healing and our own professional well-being. Along these lines is Dr. Allan Schore's work on therapeutic relationships and how robust, intact relationships are main drivers of well-being.[3] As a humanistic therapist, I deeply align with this concept and have adopted it as a backbone concept for my interdisciplinary clinic.

Two other implicit processes are at play in working well with other professionals. First, know your ongoing professional development is imperative. Second, this unique environment naturally advances your overall effectiveness with clients. Why? Because you are not a lone wolf working in isolation. Accountability drives learning and supports better client outcomes.

Being an accountable member of a dynamic team gives a greater sense of purpose to our daily work. Bernard Shaw stated, "If you teach a man anything, he will never learn."[4] Working within a multidisciplinary team means you will be asked to handle novel cases, and it will be your responsibility to figure out best practices and how to apply them effectively within clinic framework. Learning through doing is an integrative process where you will

be kept on your learning edge, staying sharp and informed. This benefits you (the practitioner), your colleagues, and your clientele. Everyone wins.

As an RCC, I have worked within two completely different multidisciplinary clinics: firstly, a family medical office with medical physicians; and, secondly, an interdisciplinary practice with occupational therapists (OTs), registered massage therapists, and RCCs. The pace and focus of each clinic were completely different. Regardless, I was kept on a unique growth curve where full accountability and novel cases were presented regularly. Your ability to apply techniques within a treatment plan and know why become paramount. Patient outcomes and overall impact for clients are constantly considered.

Working within a team teaches us to keep empirical knowledge close, using it to support positive patient outcomes.

Recall the three pillars of effective RCC practice: therapeutic alliance, approach, and goals.[5] When practitioners all come from this common ground, patient outcomes are positively affected. In *The Bond*, Lynne McTaggart discusses evidence about how healing outcomes improve when we are willing to move beyond the "I" and "you" to "us" which means practitioners and patients working together with specific intentions.[6] The concepts and evidence that McTaggart offers correlate and support the interpersonal neurobiology work of Schore and Siegel.[7,8]

Working from an empirically based modality you know well and believe in is an important part of working within an interdisciplinary clinic. For instance,

I use Acceptance and Commitment Therapy (ACT) and Feedback-Informed Treatment.[9,10] Professionals on your team will appreciate clear articulation and sound evidence as to why you choose particular routes within a treatment plan. Working within a team teaches us to keep empirical knowledge close, using it to support positive patient outcomes. Why use empirically based modalities? The effectiveness of counselling and psychotherapy has been questioned in the past. Various studies now prove it is effective. Our job is to know this research and implement these tools in our work.[11]

How might an RCC break into or create a collaborative interdisciplinary practice or clinic? Here are three ways I have found useful.

Start close to home

The first and most important step is to contact professionals in your community. Start with your own family doctor, any practitioner you have had treatments from, or any law professional who works with family issues. My first contact was with my family doctor. I let him know I was an RCC and was looking to offer his patients a discount for mental health services. I asked permission to drop off information for the other doctors in the clinic along with a poster for the waiting room. The answer was yes.

Keep it simple

Information should be short, concise, and easy to read. Busy professionals do not have time to read long documents about you or your methods. Bullet points are best. A simple, appealing poster for the waiting room is sufficient. Use a QR code on the poster for people to find out more about you and how to redeem their discount.

Do a presentation

My next step was to do presentations to professionals. My first was a 15-minute presentation on mini-ACT interventions to a group of family physicians. The second was to OTs. Short presentations to inform professionals about your methods and how you add value to patients' mental health stability are important. My presentations offered something meaningful as well — an experience.

Dr. Natalie Rogers (Carl Roger's daughter) was my clinical supervisor. She taught us a trick for connecting with others. Do you recall bottom-up processing versus top down? N. Rogers suggested short, impactful bottom-up experiences where taste, smell, touch, sound, or vision are stimulated, stirring and awakening deeper consciousness, which is then integrated into cognitive meaning.[12] Each professional walks away with a meaningful tidbit that has impacted awareness in a unique way. Seeds are planted within the professional's mind and your services are deemed inspirational and valuable. This presentation method led to co-creating my current multi-practitioner clinic.

FOUR ADVANTAGES
TO WORKING WITHIN A MULTIDISCIPLINARY TEAM

1. Superimposed networks
2. Multi-perspective decision making
3. Collaborative strength
4. Respect and learning

WORKING WITHIN THE OPPORTUNITY

Once you establish your value in the professional community, you will find your private practice begins to thrive through people. Your reputation precedes you. Professionals will refer clients requiring mental health support to you, and word of mouth is the best source of client flow.

Superimposition of networks

A client base held by a professional can instantly become your potential contact base. This is a bold statement. If you have brought value to the professional and worked successfully with their referrals, your reputation will continue to build. There is no endpoint to this building. This is what I mean by "superimposition of networks." Each professional has a network of clients and other professionals they work with, and once you make positive contact within your network, it is automatically augmented. Putting up a poster and leaving business cards in another professional's clinic is effective but direct personal contact with them holds more weight.

Challenge: Putting together a succinct, informative seminar that provides impactful learning with a constructive bottom-up experience for attendees. Being brave enough to present to others. Overcome this by creating your lesson plan, and practise presentations with friends, family, or with your supervisor.

Advantage: Your information and reputation have now been registered into the attendee's mind. Your genuine helping intention will remain in the consciousness of the referring professional.

Multi-perspective decision making

Working with other professionals augments our learning. Working alone leaves us in isolation, which is not conducive to anyone's vitality or well-being.[13,14] It takes bravery and effort to reach out and collaborate with others. Dampening down the "I" and ramping up the "We" in today's client-care industry is becoming more and more important. It is through relationships that we heal, learn, and thrive. Being an open-minded, brave professional means being accountable for our treatment plans and application of best practices and staying current with research, mental health trends, and issues. Having the perspectives of all the professionals during case consultations supports cohesive treatment plans and brings practitioner intentions onto the same page, which brings continuity to the client.

The other important point with respect to clients who visit our clinic is that when they arrive, they know everyone. Clients receive a warm

welcome and feel like they belong, which contributes to higher ratings of well-being.[15,16,17]

I have learned so much working with other professionals. Walking into work each day with a beginner's mind, allowing myself to consider and absorb fundamental information from others, is humbling and inspires me to deepen and sustain these professional relationships.

To have the other professionals in the clinic rely on you helps clarify your role within the clinic. The role of a mental health professional is sometimes seen as mysterious to others. In an interdisciplinary collaborative clinic, the mystery begins to drop away as clients show improved outcomes in mental stability and better emotional regulation and overall mindset.

Challenge: Knowing your modality so well you can offer meaningful, helpful information in case consultation meetings. Having a multidisciplinary consent form to allow case consultation in the clinic or between professionals is imperative. Talk to your supervisor about how to create this consent form and the details surrounding it. Overcome this by reaching out for help and getting fully informed.

Advantage: You will learn invaluable skills and related knowledge that will serve you for the rest of your career. Your reputation with professionals will precede you as you build relationships within the community.

Collaborative strength

The power of community has a favourable effect on patient outcomes.[18,19] Feelings of belonging and oneness, as discussed by Siegel in his most recent book, *IntraConnected: MWe (Me+We) as the Integration of Self, Identify, and Belonging*, bring home the knowing that connectedness enhances feelings of well-being and overall health.[20] Interdisciplinary teams have an advantage in supporting clients. Each team member gets to know the client and their specific care plan and can congruently support overarching intentions. On top of this, the client feels seen, welcomed, supported, and part of a team effort. I have witnessed clients taking large strides in their process and expressing gratitude for their team. The reward is in the witnessing.

When I am informed by an OT of the challenges a client is facing, I can then address specific issues from the mental health angle. Oftentimes, an OT will ask for specific domains to be supported to bolster what they have already begun to implement. In my case, I am a licensed teacher as well, so I liaise with resource teachers and principals and attend IEP meetings. I must think deeply about what to say, how to say it, who will be reading it, and the impact it will have. Challenges range from knowing how to properly address and word documents to being concise and clear in my role and the client's needs.

Another empirically based argument for collaborative strength has been discovered in working with individuals diagnosed with an eating disorder: treatment team management, including a psychiatrist, dietician, family doctor, as well as family and

individual counselling, are indicated. This method is empirically proven to be more effective than sole practitioner support.[21] And if strength in collaboration is proven, why not apply it to all our clients if possible?

Challenges: Time and scheduling for care plan meetings. Being available for and open to impromptu meetings is important. Another option is scheduling 30 minutes per week for case review and updates. RCCs do not get paid for case planning whereas other professionals do, which means volunteering some of your time. Overcome this by being open and willing to invest some of your time without being paid.

Advantage: Everyone has input and ends up on the same page which further supports the client. The reward is in witnessing enhanced client outcomes.

Respect and Learning

The very first day I started as a high school science teacher, I suddenly knew nothing. I stood at the front of the classroom ready to teach my students how to calculate the number of neutrons and protons inside an atom. I knew how to do this in my head, but when it came to teaching this to 28 16-year-old students, I failed that day. Suddenly, I held new respect for my professors and teachers over the years. That day, I started on chapter one of a new learning journey. This is similar to how I felt starting within this interdisciplinary clinic adventure.

We can go to school and learn a mountain of facts, but can we apply what we learned? This is where working within a multidisciplinary clinic tests us. Other professionals, who may have more and varied experience are not only relying on us but also have a wealth of knowledge to share if we allow ourselves to be open to it.

Having the perspectives of all the professionals during case consultations supports cohesive treatment plans.

Beginner's mind is part of the respect and learning within this environment. The more I learn, the more I realize I do not know. This article started off with the idea that working within a multidisciplinary clinic requires a practitioner who is brave, hardworking, flexible, open minded, and collaborates well with others. Over these last five years, I have been so thankful for the opportunity to work with professionals willing to mentor, teach, and share knowledge. It is a gift to work with others and hold a common goal. This environment has proven to me that interconnectedness as researched by Schore and Siegel really is where our success and well-being resides.[22,23]

Challenges: Stuck thinking can sometimes visit us, so it is important to engage in a daily transpersonal practice: meditation, guided journaling, visualisation, yoga, breathwork, to name a few. Learning to respond rather than react to a co-worker who may be difficult or in a limited mindset. Overcome relationship challenges by resolving to maintain a positive, healthy working relationship with yourself and others.

Advantages: Connectedness, direction, purpose, clear roles and responsibilities along with learning strong boundaries with others. ■

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WHEN THERAPY AND SAFETY COLLIDE

Working with B.C.'s Child Welfare System

CANDICE ALDER, RCC

Anyone who has had a disclosure of child protection concern during a therapy session can recall with sharp accuracy the feeling that occurs when you hear something you may need to report. For some, it is as if a brick has been dropped in your stomach; for others, it is as though a wave has crashed into your chest. It is different for everyone, but the feeling is unforgettable. Ensuring the safety of children is the responsibility of everyone, but it is frequently community professionals who receive the disclosures. It almost never feels good to make the call.

In B.C., the agency responsible for child welfare is the Ministry of Children and Family Development (MCFD). Given the complex intersections of child welfare legislation, policy, and practice, engaging with the system or with child protection workers can bring up feelings of anxiety and negatively effect a therapist's ability to engage in collaborative relationships with child protection workers. Oftentimes, these feelings are based on a fundamental lack of understanding the system. Clearing up confusion not only alleviates concerns but also supports interdisciplinary relationships and allows therapists to better support clients.

DUTY TO REPORT AND SECTION 13

What is duty to report, anyway? Duty to report goes beyond an ethical and moral obligation to be committed to the safety and welfare of children. It is also a legal obligation. Enshrined in B.C.'s *Child, Family and Community Service Act* (CFCSA) under section 14, duty to report necessitates the "prompt" reporting of information that leads any person to have "reason to believe" a child needs protection. The provision's two key components are "prompt" and "reason to believe" and are important to understanding the parameters of your duty to report child protection concerns.

The CFCSA was designed to take the guesswork out of what qualifies as reportable child protection concerns, and what does not,

by using language that directs people to report information as soon after they receive it as possible (i.e., promptly) and to report information that only needs to meet the minimum threshold of concern (i.e., "reason to believe").

The concept of "reason to believe" is a much lower bar than knowing or understanding that a child needs protection. Knowing and understanding often require context, supporting details, and evidence; "reason to believe" is as simple as a disclosure from a client with no further questions asked.

People are generally discouraged from gathering information outside of the disclosure or observation that led to the report, as this is the child protection worker's role. However, sometimes asking a question to support your report is necessary. For instance, maybe you are a play therapist in a session with a three-year-old child. During the session, you notice bruising on the child's face. In this circumstance, it is reasonable to ask the child about the injury. If they give you reason to believe the bruising was caused by a parent, that is a good place to stop and report the information as soon as you can. Alternatively, maybe your client is a parent who lost a loved one last year, and you discover that significant binge alcohol use on weekends is a primary coping mechanism. You are also aware that this client is a single parent to a nine-year-old child and no other adults reside in the home. In this circumstance, it is reasonable that no further questions for the sole purpose of making the report (outside of what is reasonable through the therapeutic process) should be asked and a report to MCFD made as soon as possible.

Counsellors want to believe their clients are open, honest, and transparent in sessions, and it may genuinely seem that way. However, the reality is that when the door to the counselling room closes, the therapeutic conversation exists in isolation and clients often omit or misrepresent aspects of their history, lives, and experience. Of course, clients do this for many valid reasons, some of which may be the root of why they are in therapy. Be mindful that the feeling a client is being completely forthcoming does not translate to that being factually correct. This is particularly salient when we think about timely reporting of child welfare concerns.

For every hour a report is delayed, children and youth persist in their situation without a child protection worker looking into it.

The legislation uses the word "prompt," but therapists can think of this as being closer to "as soon as possible." The reality for child protection workers is that the report may say one thing, but the reality can be and frequently is completely different. Sometimes this means the report is of no concern whatsoever, once all the facts and context are brought together. Other times, a report of what seems like an isolated incident of inappropriate physical discipline, for example, turns out to be ongoing sexual exploitation. There is no way of knowing which report might turn out to be more than what appears on the surface. With that in mind, for every hour a report is delayed, children and youth persist in their situation without a child protection worker looking into it. This is why timely reporting is important.

HOW REPORTING WORKS

So, a client just made a disclosure of a child protection concern, and you know you are obligated to report that information. What next? Before you make the call, some information needs to be ready ahead of time.

First and foremost, gather as much information about the household as you have available. First and last names of parents and children in the home, birthdates if known, residential address of the family, and their telephone number(s). If you do not have all that information, do not let that stop you from reporting — just gather as much as you can before you call.

You will likely be asked if the family is of Indigenous heritage, and it is perfectly fine if you do not know. However, this information informs which regional office receives the report. In an ongoing effort to address and correct historical inequities in service provision, MCFD has designated teams of child protection

workers who work exclusively with Indigenous families. In some areas of B.C., external Indigenous organizations have agreements with MCFD to take over report assessment.

You will also be asked information about yourself, such as your name, phone number, and how you came by the information you are reporting. Under the CFCSA, your identity as the reporter is protected as confidential. However, like the exceptions to confidentiality that exist within therapeutic relationships, section 79 of the CFCSA outlines exceptions to the legal obligation of MCFD to keep all collected information (including your identity as the reporter) confidential.

The most notable exception to confidentiality is when the immediate safety or well-being of a child is in question. For instance, when reported information suggests a crime may be or has been committed and a child must be located right away to ensure their safety, MCFD often works collaboratively with police. If the reported information is not sufficient to assist police in locating that child, MCFD may deem it necessary to release the reporter's name and contact information to police so further information can be collected. While these situations are rare, they do occur from time to time. Reporters of child protection concerns have the right to withhold their identity, and the child protection report will still be collected. However, reporters of child protection concerns would be wise to weigh the pros and cons of withholding their identity. Even outside emergency situations, it is not uncommon for child protection workers to have additional questions that would support their assessment of the report.

Once you make your report, the information is held up against section 13 of the CFCSA. Section 13 is arguably the most commonly referred to section of the CFCSA, given that it outlines the circumstances under which a child needs protection and under which MCFD becomes involved in families' lives. If the determination is that an assessment of the reported concerns is required, then the report will be sent to the local district office for the geographical area in which the family resides. If the reported information does not meet the legal threshold outlined under section 13, then MCFD does not have grounds to act.

FAMILY LAW ACT

Child protection work is governed primarily by the CFCSA but is also impacted by other related pieces of legislation. The *Family Law Act* (FLA) has particular significance when children have separated parents.

One of the most often misconstrued implications is that if there are child protection concerns with one parent, MCFD can place the child with the other "safe" parent. This is simply not the case because, in doing so, MCFD would be making a decision that ultimately lies with a family court judge. Regardless of relationship status or parenting agreement, both parents have responsibility for the safety and welfare of their children. MCFD's role in the community is to be a social safety net of last resort.

In that light, a parent who is taking no reasonable action to ensure their child's safety, even if it is from the other parent, is a child protection concern in itself. In a situation where 1) both parents are failing to act protectively (either through their action or inaction), and 2) no other less intrusive measure than removal is adequate to ensure safety, then the child(ren) are removed from the care of both parents.

Separated parents seeking to be protective of their children due to concerns with their co-parent should be encouraged to seek legal advice about steps they can take through the family courts, as well as reporting their concerns to MCFD. Legal aid information for FLA can be found at https://family.legalaid.bc.ca/.

WHEN YOU MUST MAKE A REPORT

- Concerns that a child has been or is likely to be physically harmed, sexually abused or exploited by a parent or someone else, and the parent is not able or willing to protect the child or youth.
- Concerns that the child or youth has been or will be physically harmed due to neglect.
- Concerns that the child or youth is being emotionally harmed.
- Concerns that the parent has been or is absent from the home and the child or youth's safety and/or well-being is in danger.
- Concerns that a child or youth has been abandoned, and no adequate care arrangements have been made.
- Concerns that a child or youth is being exposed to domestic violence in their home towards a person who also lives in the home.
- Concerns that a child or youth's development is being or will be seriously impacted by a parent's refusal to consent to treatment for a treatable condition.
- Concerns that a parent is unable or unwilling to care for their child or youth and has not made adequate care arrangements for that child/youth.
- When a child or youth's parent has died, and no adequate care arrangements have been made.

It is a common misconception that if a report is made, MCFD will act upon it. The truth is that child protection work in B.C. is guided and governed by legislation. While there is some level of clinical judgment used to establish risk level, a report either meets section 13 criteria or it does not. Alternatively, it can be equally frustrating to report child protection concerns and have MCFD take no action. Again, this is a case of reported information either meeting the threshold for action by MCFD or not.

Child protection workers understand families are complex, multi-faceted, dynamic, and fluid entities.

THE ASSESSMENT PROCESS

It is important to understand that when MCFD receives a report that meets the legal threshold to be looked into further, parents/guardians are not investigated; rather, child protection reports are assessed. While this may sound like a matter of semantics, it is actually an important distinction that speaks to the lens through which child protection workers do their job.

Investigating families is predicated on the assumption that something is wrong and launches from a punitive mindset. On the other hand, the idea of assessing reports is grounded in the understanding that the reported information may be incomplete or false to varying degrees; this is consistent with efforts to work collaboratively with families and in the least intrusive manner safely possible. Child protection workers understand families are complex, multi-faceted, dynamic, and fluid entities. While a child protection worker's mandate may be first and foremost to ensure children are safe, it is also fundamentally to understand how and why families function as they do and if supports are available to assist the family in being the best version of themselves.

INFORMATION SHARING

Common feedback from community professionals is that MCFD does not share what is believed to be pertinent information about children and families involved with child protection services. This can be perceived as a roadblock for community professionals to support the family or child(ren). While this can be frustrating, the fact is that information MCFD collects does not belong to MCFD — it belongs to the individuals and families that it is about and is, therefore, not MCFD's information to disseminate without consent or just cause. Clinical counsellors understand this well, as the same concept guides our own confidentiality practices.

That said, it is not uncommon for child protection workers to request to speak with clinical counsellors supporting the family. In this case, child protection workers will almost certainly provide a signed "consent to collect information" form or the client will provide verbal consent to their (or their child's) counsellor. While this is an opportunity to ask the child protection worker questions, you may not get any answers. A signed "consent to collect information" form from the child protection worker is not the same as a signed "consent to disclose information" or a signed "consent to collect information" form provided to the worker by you. Counsellors understand well that conversations have two parts, speaking and listening, and if child protection workers only have consent to listen to what you have to say, you can expect a one-sided conversation.

What if a child protection worker asks questions outside the reported information? Perhaps they ask questions about how long you have been working with the client or how you would describe their therapeutic engagement. These questions and similar others are outside the bounds of your report. You would be well advised to say that you have outlined all the information you have regarding the child protection concerns and you will need a consent form signed by the client to answer further questions.

FINDING OUT WHAT HAPPENED WITH YOUR REPORT

As the reporter of child protection concerns, you are able to ascertain the outcome of report. Call MCFD's Provincial Centralized Screening or the relevant district office and identify yourself as a reporter who would like to know the outcome of their report. You will be provided with only basic information, such as whether there was a need for ongoing child protection services or not, as the assessment details are protected by confidentiality provisions in the CFCSA that also protect your identity as the reporter.

If you have reason to believe a child or youth in B.C. has been or may be harmed, please contact MCFD's Provincial Centralized Screening, 24 hours a day, 7 days a week, 365 days a year at 1-800-663-9122. ■

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TALKING ABOUT SUICIDE AS MENTAL PAIN: THE BLACK EXPERIENCE

NICHOLA WATSON, RCC

I am not afraid to have conversations about suicide, nor am I scared to be in the presence of people who are suicidal. It gives me hope when people show up to therapy regardless of where they are in their struggles around suicide. They are indicating that despite deep despair, they want to live and end the pain of suicide.

Awareness and training are the paths it took to be with people and their experiences of suicide pain. I was raised around people who did not speak openly about suicide, and when they did, their narratives disparaged people who engaged in suicidality. For conversations about suicide, the energy was negative and the spaces felt unsafe. I recall comments from people within the Black community, such as "Weak people kill themselves." Other statements included: "Black people have too much to live for" or "Suicide is for white people." "We are a people of strength" or "The Bible says you should not kill; therefore, it is sinful to kill yourself." Thus, my personal and professional goals are to embody positive energy and create safer spaces to discuss, intervene, and prevent suicide. Working in this area provides the opportunity to explore the contexts behind the pain of suicide.

Before training and academic learning, I had interactions with people who were suicidal. I did not pretend to know anything about the topic or their experiences. Instead, I listened without making judgments and asked about practical ways I could help. For example, I was a teenager when I first interacted with a friend in the hospital because of the circumstances in her

life that resulted in suicidal behaviours. I appreciated that experience, because my friend knew she could reach out to me and that I would show up for her. From an early age, I saw suicide as complex and mind-altering.

Consistently, I remind people that talking about suicide won't make them suicidal. I especially like to remind parents of younger children of the latter. If you are uncomfortable discussing or interacting with people who are suicidal, make referrals. If you cannot provide support and be present for a suicidal person, then find others who can.

CONSIDERING PAIN

In general, most people without awareness or knowledge of supporting individuals suffering from suicidality or grieving losses from such deaths cannot grasp the mental pain of suicide. My learning on the latter is ongoing. When asked about suicidal pain, I usually begin conversations with people's understanding of pain. People easily talk about physical injuries or medical pain, such as headaches, stomach pain, broken bones, post-surgery, or observations of people in pain.

Within the conversation, a common trend among Black people is minimizing pain. When responding to inquiries about pain, Black people said, "It is not a big deal," or "I don't have time to think about the pain," and "If I don't work, then who will pay the bills?" I never dismiss these people's realities. They are correct concerning perseverance. It is also true that ignoring pain can result in death, and life will go on without them.

THERE IS RELUCTANCE AMONG BLACK PEOPLE TO SEEK MENTAL HEALTH AND MEDICAL CARE...

I understand that stigma, cultural norms, expectations, socialization, and other factors affect Black people's perspectives on pain.[1, 2] Colonizers dismissed Black people's pain;[3] whereas, today such pain is made systematically invisible, and they endure pain unnecessarily.[4] For example, there is reluctance among Black people to seek mental health and medical care because of historical and current systemic racism in health care.[5, 6, 7] An outcome of the latter is increased health disparities among Black people.[8, 9] Health care providers must understand that Black pain and Black lives matter.[10]

CULTURE AND CHURCH

Culturally, conversations about suicide among Black people often shift to the stance of the Black church. Since the Black church can be "the heart of the Black community"[11] that provides relationship building and connections,[12] the research suggests that attendees cannot risk losing those relationships by talking about suicide.[13] While a sense of belonging is present in the Black church, it is inconsistent in supporting people experiencing suicidality.[14, 15]

In the African American community where Christianity is practised, suicide is forbidden, the church does not typically discuss it, and the silence around suicide contributes to community problems.[16] Since isolation increases suicide risk,[17] and since avoidance takes precedence over speaking about suicide in the Black church, attendees can suffer in silence and not participate in church life.[18, 19]

If accessing an institution such as the church results in increased adverse mental health effects, what keeps people from leaving? While I do not frequent the Black church or any religion institution, people's responses to this question remind me of my own answers to it. I was raised in the Black church and love and appreciate the people, the sense of community, and the belonging it provides.

TALKING ABOUT MENTAL PAIN

When talking with people who want to learn about the pain of suicide, I like to use definitions. For example, "What is pain or mental pain?" I use simple content from a Google search, such as "Pain is physical discomfort or injuries to my body." Since I am in the business of trauma-informed practices, I talk about pain as injury to my brain from specific experiences. I give concrete examples of personal traumatic injuries affecting my brain and body from

HERE ARE EXAMPLES OF THE IRRATIONAL THOUGHTS OF SUICIDAL PEOPLE:

- The world will be a better place without me.
- The people I love will be better when I am dead.
- No one understands.
- No one can help.
- Why am I so weak?
- I am such a failure.
- I am trapped with no way out.
- If I am not around, there won't be problems.
- There is no future for me.
- This pain never ends.

incidents such as racial trauma and post-mental and emotional effects from surgical procedures. I discuss the overwhelming negative thoughts I had from historical traumas. Then I invite people to share experiences if they feel safe to do so. We usually discover that physical and mental pain are shared experiences. Our exception of the latter pains to people who are suicidal is that our pain does not make us want to end our lives. Life circumstances have not yet threatened our sense of self to acute suicidal crisis.[20]

Concerning suicide, mental pain is extreme psychological pain.[21] I work with people in different age ranges who have endured violence and other negative experiences that are alarming and detrimental to their health.[22] Suicide is mental pain that overwhelms the brain and body.[23, 24] And suicide behaviours are driven by the contexts of life and the

PEOPLE CAN RELATE TO THEIR PHYSICAL PAIN, WHEREAS MENTAL PAIN IS INVISIBLE YET PRESENT AND EXCRUCIATING.

brain's wiring.[25, 26] Learning about the neurobiology of trauma and suicide behaviour is ongoing.[27, 28]

Because there are practical ways to heal physical injuries, people wish for physical pain instead of the mental pain of suicide. The latter statement does not diminish the physicality of suicidal pain.[29] People can relate to their physical pain, whereas mental pain is invisible yet present and excruciating. According to research, when people think they feel trapped by painful problems and cannot find solutions, their state of mind is triggered uncontrollably.[30]

Suicidal people report that they were not their normal selves anymore

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and were acting in a trance-like state, feeling disconnected from their physical body and feeling no pain. These critical mental states are called dissociation, which disrupts normal self-perception. In such a condition, thinking and acting rationally is practically impossible. People lose faith that this experience of alarm and intense pain will ever subside.[31]

GRIEVING LOSSES

Another area of focus is providing space for grieving suicide losses. Within the Black community and from my experience, there is a vast generational contrast between how people discuss suicide deaths and non-suicide losses. Among older people, there is stigmatizing language associated with people who end their lives by suicide. Younger people are less pathologizing.

Furthermore, in many cases of suicide deaths, there are challenges among families and institutions because of beliefs around suicide deaths. For example, within the Christian framework, there are beliefs that God does not like self-harm or that those who end their lives by suicide go to hell.[32] While the latter beliefs might be protective factors against suicide,[33] there is an erasure of people's struggles with mental pain.

AMONG OLDER PEOPLE, THERE IS STIGMATIZING LANGUAGE ASSOCIATED WITH PEOPLE WHO END THEIR LIVES BY SUICIDE. YOUNGER PEOPLE ARE LESS PATHOLOGIZING.

Other areas within the conversations for grieving suicide losses are decisions about memorializing the deaths and burial practices. Culture and acceptability are critical parts of the discussions.[34] Other presenting issues are spirituality, religion, and social support, which is never guaranteed with losses from suicide deaths.[35]

When working with people who have endured deaths from suicide, my approach is to emphasize conversations about death losses. If people want to centre the conversation on deaths from suicide, that is their choice. We talk about their deceased, their understanding of suicide, what matters to them, any unresolved issues, their pathway to healing, things that are getting in the way of their healing, the full scope of their feelings, attachment issues, and continuing bonds of remembering.[36] And we discuss the circumstances of the death that might result in delayed or complicated grief.[37] In discussing suicide as mental pain, people grieving such deaths are less inclined to blame the deceased. And there is a shift in thinking suicide deaths are about them and their pain. While their grief is real, understanding suicide as mental pain and the contexts of life that affected the deceased helps them with moving forward.

I cannot say that people feel relieved from conversations about suicide as mental pain and grieving such losses. However, the awareness of suicide as mental pain reduces blame, shame, and guilt toward everyone involved, including the deceased. ■

When Nichola Watson, RCC, is not at her private practice, she writes children's books and engages with the group Black Youth Empowerment from Victoria Sexual Assault Centre.

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INDIVIDUAL COLLECTIVE

PLEASURE ACTIVISM FOR COUNSELLORS

DEIRDRE MCLAUGHLIN, RCC

Take a moment. Take a moment and see if you can conjure a memory of a time when you felt really good. What were you doing? Who were you with? How does your body remember this? And: how do you recognize pleasure?

Yes. How do you recognize pleasure? As a noun, it has various descriptors: desire, inclination, sensual gratification. Somatically, pleasure can feel like warmth, unwinding, expansion, calm. Some folks see pleasure as a luxury — a superfluous expenditure if one's cup runneth over. Still others regard it with caution: perhaps it feels sinful, possibly dangerous. Pleasure requires embodiment, and the body can be both a site and source of trauma.

Yet, here's another idea: what if engaging in pleasure were a conscious, revolutionary act? This is the premise of adrienne maree brown's book, *Pleasure Activism: The Politics of Feeling Good*. Whether this concept is new to you or not, I want to share some ideas about how it can be useful, both as an individual and as a counsellor.

BUT FIRST...

There are three tenets of brown's work I'd like to highlight from the outset. First, though the book centres on pleasure, it's actually about oppression and justice. Second, it emerges from the field of somatics: simply put, pleasure activism is an embodied movement. Third, though it welcomes everyone, there is a call to "prioritize the pleasure of those most impacted by oppression."[1]

brown has belonged to activist movements for most of her adult life. However, she began to notice that her activist peers were frequently stretched thin, underresourced, and burnt out. In her words, she grew "tired of the idea that misery and movement felt synonymous."[2] It spawned a question

at the heart of pleasure activism: "What would it take to make the work we do for justice and liberation the most pleasurable experiences we can have with each other?"[3] For brown, transformational change that's grounded in scarcity is destined for limited success. We can accomplish more with abundance.

Before going deeper, I want to name a couple of things. One, I'm a white person writing about a Black woman's work. It's relevant because pleasure activism centres "the experiences of Black women pursuing and related to pleasure."[4] This is who informs her. To make invisible or omit this would be to reproduce what Alta Starr calls "the relentless theft of our time, our labour, and our lives."[5] In writing this, I aim to be as faithful to brown's vision as possible.

Two, when we step into the arena of politics — and pleasure activism does this, even if it's the politics of feeling good — the ground may seem rife with what Gabor Maté calls "rhetorical cannonballs." Otherwise known as triggers, these can be "hurled back and forth by opposing sides in many a debate or confrontation, rarely deepening conversations and often ending them."[6] So let me say this: the premise of this work is pleasure. And justice. And dignity. For all. Should a concept here land like such a cannonball to you, know that we can tap into "an abundance that has enough attention, liberation, and justice for all of us to have plenty."[7] There's enough room for everyone's dignity.

WHO TAUGHT YOU TO FEEL GOOD?

Or maybe the question is: who taught you to fear feeling good? For the body that has known trauma or oppression, the experience of pleasure may have been disrupted or denied. On the other hand, pleasure that's associated with hedonism and excess can similarly be suspect. As brown writes, many of us "are so repressed, our fantasies go to extremes to counterbalance all of that contained longing."[8]

Working in harm reduction for years at a music festival, I saw this: the implicit permission to experiment with sex or substances drives some folks to excesses beyond pleasure. It's not unusual for newcomers to this concept to need to acquaint themselves with genuine pleasure or learn for the first time "what it means to be satisfiable."[9] Still, I love this idea of "contained longing" — that at their core, our yearnings look more like love than like greed.

Who taught brown to feel good was Black women. In particular, she teaches that pleasure is not just each person's birthright; for some, it's also a resistance to — and victory over — oppression. When an external force diminishes the freedom to govern oneself, reclaiming that right is a triumph. brown lists by name several Black women who influence her work. I'm going to discuss one in particular: Audre Lorde.

In her essay "Uses of the Erotic: The Erotic as Power," activist and academic Lorde describes the erotic as an untapped source of power that "becomes a lens through which we scrutinize all aspects of our existence."[10] As a Black woman and a lesbian, she intimately knew the experience of oppression. Within this context, she reclaimed the erotic as a revolutionary act. brown takes Lorde's premise and expands it to encompass other forms of sensual delight. This, she calls pleasure.

Note: you don't need to be a Black woman to find yourself within this work. As brown says, "En masse, we are not satisfied with what we experience and accumulate. As a general state of affairs, we are overworked, undervalued, overwhelmed, burnt out, inauthentic, and suffering unnecessarily."[11] Yet, if we are in touch with our bodies as sources of pleasure, perhaps we become "less willing to accept powerlessness, or those other supplied states of being which are not native to [us], such as resignation, despair, self-effacement, depression, self-denial."[12] Remembering our own power, we can celebrate others in theirs.

SOMATICS FOR SOCIAL CHANGE

The disabled body can be erotic. The queer body can sense safety. The racialized body can know liberation. However, to facilitate others on this journey, we must first feel it in ourselves. So, what is somatics? It comes from the Greek root soma, meaning "the living organism in its wholeness."[13] Certain readers will be acquainted with it as a body-based therapy. Especially helpful in working with trauma, somatic enquiries lean more into what the body is

experiencing than what the mind is thinking. And though some may be familiar with this therapy for individual clients, less may have considered it as a tool for systemic transformation.

Collectively, what we embody can both harm and heal. If we know more about reactivity than we do about accountability, more about scarcity than abundance, that will show up in the soma of our culture. In such climates, there will be more division than solutions. Still, we can unlearn entrenchment in conflict, for example, and deepen our capacity to tolerate the unknown. The more we can "hold our seat" during difficult conversations or uncertain times, the greater our potential to create positive change.

How do we get there? As individuals, we can explore the query: What would I be doing with my time and energy if I made decisions based on a full-bodied yes?[14] As a collective, we can notice what we lean into with pleasure, and ask: Does this space "allow for aliveness, connection, and joy?"[15] Note the curiosity in these questions. When our nervous systems are in fight or flight, there's no room for wonder; our only concern is responding to threat. When we're calm, we can stay open for longer and engage until we find common ground.

THE COUNSELLOR AS PLEASURE ACTIVIST

Perhaps you're asking: How does pleasure activism pertain to me as a clinical counsellor? Valid question. We exist as part of a larger culture, and so do our clients. The structural conditions that create or contribute to trauma do not cease to exist just because clients go to therapy. The idea that we could (or should) return clients to "a pre-trauma Pollyannaish view of the world"[16] is somewhat misguided — and in cases of historic or intergenerational trauma, impossible. (For those unfamiliar, Pollyanna was a fictional character who has become synonymous with a person of "irrepressible optimism and a tendency to find good in everything."[17]) Rather than this, we can support the wisdom that comes from traumatic knowledge, uniting it with "libratory community/collective practices [that are] connected to transformative systemic change."[18] Trauma generally happens in relation to people and systems; it's also healed in relation to the same.

Perhaps pleasure activism captures the imagination of so many because it calls in the expansive power of joy.

Somatically, we take in more, and with greater curiosity and openness, when our nervous systems are relaxed. We can connect with (rather than contract from) others when we're settled. Activism often demands change — and rightly so — by calling out injustice. That makes sense when the oppressing person or group has a great deal of power and little motivation to engage.[19] Yet it can leave activists exhausted and underresourced. Perhaps pleasure activism captures the imagination of so many because it calls in the expansive power of joy. Maybe we intuit that when we remember our own goodness and dignity, "we can generate justice and liberation, growing a healing abundance where we have been socialized to believe only scarcity exists."[20] ■

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BRINGING THE BODY INTO PRACTICE

Somatic Attachment Psychotherapy

LISA MORTIMORE, PHD, RCC

The heart of Somatic Attachment Psychotherapy (SAP) and SAP trainings is the reparation of early attachment injuries through a framework that weaves together attachment theory and application to clinical practice, trauma research and practice application, affect and autonomic nervous system (ANS) regulation, somatic psychotherapeutic principles and practices, and relational/interpersonal psychoanalytic psychotherapy.

SAP therapists are oriented to the reparation and regulation of the neurophysiological body and wounded psyche by facilitating shifts in affect management strategies, attachment patterning, re-organization of the body and psyche, and in supporting the maturation and development of complex right brain functioning.

Broadly, SAP is an embodied, relational orientation to psychotherapy that considers attachment and affect regulation as foundational for healing trauma, with the goal of integration and re-organization of the Internal Working Models (IWM) and neurophysiological regulation capacity. The therapeutic relationship is paramount in offering dyadic regulation, completing absent or distorted affective communication cycles, and working psychodynamically with relational material.

WHAT CLIENT CONCERNS IS SAP ESPECIALLY EFFECTIVE FOR?

This orientation leans into clinical application of multiple theories and principles, giving it wide application to diverse practice populations, with SAP students and graduates creatively applying it across diverse settings and populations, including: private practice, clinical mental health, addictions, sexualized abuse and violence work with adults and children, work with neurodiverse folks, the 2SLGBTQQIA+ community, Indigenous communities, school and university counselling centres, cancer care, and group work, to name a few.

HOW DOES IT WORK?

This orientation responds to clients wishing to heal injuries of the psyche and bodyself that inhibit how they imagine and live their lives. With a focus on disrupting and processing that which is distorted, dysregulated, or disavowed, SAP orientation seeks

to facilitate emerging, expanding, and flexible ways of relating to self, others, and the world.

For many folks with relational trauma, their integrative capacities have been significantly impacted by their early relational experiences (insecure attachment), about 42 per cent of the non-clinical population.[1] This inhibits clinical work, as the psyche unconsciously thwarts affective processing of trauma, both relational and incident. SAP orientation works to build integrative capacities over time by working with the distorted and fragmented IWM of insecure attachment; facilitating increased affect and ANS regulation; and attending to and bringing into awareness the recapitulation of early unconscious relational patterns that continue to reinforce (mal)adaptive relational strategies in current life.

While back and forth dialogue is essential, there is a bias towards working directly with the body and with right hemispheric (RH) processes, seeking to build congruence between the explicit (narrative) and implicit (body) systems. In this way, this work departs from traditional left hemispheric therapy by consistently returning to the bodyself and the RH, where trauma is held and needs to be processed.

WHAT DO YOU LIKE BEST ABOUT SAP?

SAP orientation to clinical practice and psychotherapist training is the culmination of my evolution as a therapist, learner, and educator over the past 19 years and continues to evolve as I deepen my personal and clinical understandings of what it takes to sit with and deeply witness suffering — to traverse the abyss of trauma and return to the living. Essentially, this work seeks to hold, witness, and help metabolize the unbearable within a collaborative, therapeutic relationship. In this process, I have had to reach beyond psychotherapeutic disciplines and find bigger and bigger canvases to practise this art we call psychotherapy. SAP is an orientation where heart and academic rigour meet. I have been offering the two-year Somatic Attachment Psychotherapy training program since 2016; we are currently registering for our ninth cohort.

SAP is a relational psychotherapeutic orientation and not intervention driven. As a clinician, I value the diversity, creativity, and depth of contact it supports in service of reparation of early attachment injuries as they present across the lifespan. I also rely on and appreciate the focus on embodied experience in terms of regulation and tracking my own internal responses. I find this sophisticated information invaluable to clinical practice, and it is essential in terms of preventing vicarious trauma. Because this is so important, we begin the process of embodying this on day one of the SAP two-year training.

WHICH OTHER MODALITIES DOES SAP PAIR WELL WITH?

With such diversity and breadth in the theoretical underpinnings (attachment, relational/interpersonal psychoanalytic psychotherapy, affect and ANS regulation, and body-centred/somatic practice with RH processing), SAP pairs well with numerous modalities. It can often provide a framework to understand what is happening in the body and ANS, the attachment system, and the therapeutic dyad that can deepen the clinician's understanding and increase the traction and effectiveness of clinical work. I see many creative pairings where students apply SAP to art and play therapy, family systems work, couple therapy, narrative therapy, EMDR, and analytic or psychodynamic-oriented work.

ARE THERE ANY CLIENT CONCERNS SAP SHOULD NOT BE USED WITH?

What's more apt is that the way in which the work looks will differ with different populations, presentations, and clinicians. For example, understanding what is happening in the ANS (client and therapist) and how this impacts what is happening clinically is imperative no matter who we are sitting with. Having said this, the training is oriented to working with clients with relational and incident trauma. More severe presentations of mental health disorders are beyond the scope of the training, and additional specialization would be necessary for people working with these populations.

WHERE CAN WE LEARN MORE?

Upcoming trainings and workshops can be found at www.bringingthebody.ca, where you'll also find links to published articles about SAP, blogs, and a graduate referral list. ■

Lisa Mortimore, PhD, RCC, is a psychotherapist and therapist educator living and working on the unceded territories of the Lekwungen peoples in Victoria. Her Bringing the Body into Practice trainings and workshops are oriented to the reparation and regulation of the wounded psyche and neurophysiological body through Somatic Attachment Psychotherapy. www.bringingthebody.ca

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TRANSFORMING SUPPORTS

A community-based research project to make trauma-related mental health support safer and more accessible for transgender and gender-diverse people.

MATTIE WALKER, RCC

Appropriate mental health care, particularly trauma-related mental health care, for transgender and gender-diverse individuals calls for changes in clinical training and practitioner education.[1,2] Violence against transgender and gender-diverse communities is "a prevalent and significant health and human rights issue."[3] However, when seeking mental health care, many transgender and gender-diverse people report barriers to accessing the care they need and that when they do connect to services, mental health care is often unhelpful or even re-traumatizing.[1,2] Despite a distinct need for practitioners to improve their knowledge and approaches to practice for these communities, there is a lack of literature and research addressing these concerns and a gap in knowledge regarding trauma support for transgender and gender-diverse communities.[1]

Transforming Supports is a community-based research project that seeks to address these gaps and improve mental health services that provide trauma support for transgender and gender-diverse young people. This project is supported by funding from the Vancouver Foundation and the Social Sciences and Humanities Research Council of Canada.

Starting in February 2023, this project engages with participants (ages 19-30) with experience attending, accessing, or wanting to access trauma-related mental health supports in southwestern B.C. This project seeks to explore participants' experiences with these mental health services, understand what safety in trauma-related mental health care means for transgender and gender-diverse communities, and identify goals for improving services and recommendations for future research. Through two participant engagement methods, participants will share their stories, experiences, and perspectives through either interviews or in-person community consultation research events.

Findings from this project will be shared with service providers and community organizations identified by project participants. One of the intended outcomes is specific recommendations for how trauma-related mental health services can begin to be safer and more accessible for transgender and gender-diverse communities.

For more information about the project visit: www.transformingsupports.com.

Mattie Walker, MA, RCC, is a PhD candidate at the University of Victoria and clinical counsellor specializing in working with queer and trans people and trauma.
Co-advisors: *Dr. Nathan Lachowsky and Dr. Aaron Devor*
Program: *Social Dimensions of Health, University of Victoria*

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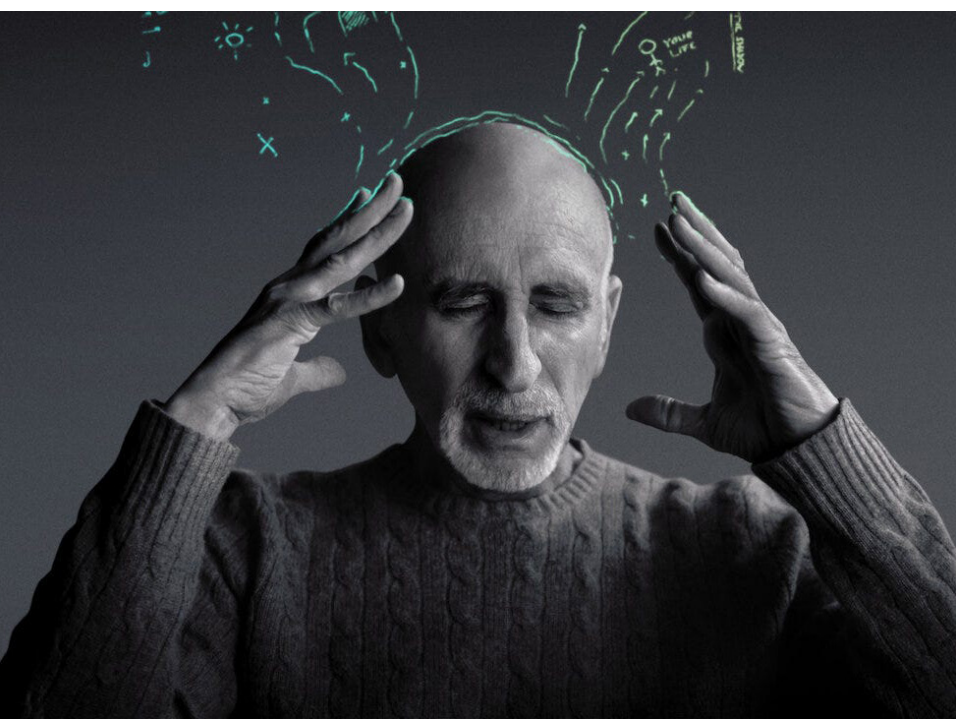

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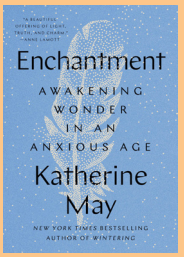
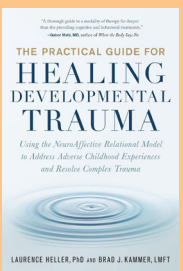


ENCHANTMENT: AWAKENING WONDER IN AN ANXIOUS AGE

by Katherine May

In *Enchantment*, author Katherine May invites the reader to come with her on a journey to reawaken our innate sense of wonder and awe. May asks if there could be a different way to relate to the world, one that would allow us to feel more rested and at ease, even as seismic changes unfold on the planet. Might there be a way for all of us to move through life with curiosity and tenderness, sensitized to the subtle magic all around?



THE PRACTICAL GUIDE FOR HEALING DEVELOPMENTAL TRAUMA Using the NeuroAffective Relational Model to Address Adverse Childhood Experiences and Resolve Complex Trauma

by Laurence Heller, PhD, and Brad J. Kammer, LMFT

The Neuro Affective Relational Model (NARM) is an integrated mind-body framework that focuses on relational, attachment, developmental, cultural, and intergenerational trauma. Inspired by cutting-edge trauma-informed research on attachment, developmental psychology, and interpersonal neurobiology, *The Practical Guide for Healing Developmental Trauma* provides counsellors, psychotherapists, psychologists, social workers, and trauma-sensitive helping professionals with the theoretical background and practical skills they need to help clients transform complex trauma.

A GOOD READ

Community book clubs for connection and collaboration

SHIRLEY GIROUX, RCC

A book club can be an ideal way to bring people together. I ran one with a group of local health, education, and community service professionals for three years. Here are a few notes on starting an interdisciplinary/multidisciplinary book club in your own setting.

1. CONSIDER PURPOSE(S)

In our community, the primary purpose was to provide time and space for people working towards the common goal of community resilience to get to know each other while exploring common ground. You might want to consider reading within a theme; you might find it more fruitful to invite people to share one thing from a book they already own. Consider holding an "unread book club" to encourage members to dig into professional books they already own but have not yet read; maybe someone else has read it and will provide the impetus for others to do the same (or convince them not to).

2. MAKE IT SOCIAL

When our group could meet in person, we met at a pub an hour before they opened to the public and pre-ordered food and non-alcoholic drinks. We also met over Zoom, sometimes as individuals and sometimes in groups. We used a "lit circle" model to decide upon our books: each member had at least two others who were reading the same book to encourage conversation, but the larger group was diverse in the selections. Other than the initial gathering where we decided upon books, the agenda for each gathering was the same: a check-in that included an invitation to comment on something that stuck out from each person's reading.

3. ELEVATE THE COMMON GROUND

Themes and books that fit with a wide range of roles and contexts include:

- Social determinants of health: *The Myth of Normal, A Mind Spread Out on the Ground, The Sum of Us*
- Resilience: *Burnout, The End of Trauma, Change Your World, The Age of Overwhelm*
- Purpose: *Man's Search for Meaning, The Second Mountain, Dare to Lead*

4. MANAGE EXPECTATIONS AND RESPECT PEOPLE'S TIME

Make it clear that set levels of reading, attendance, and sharing are not requirements to participate. Book meetings well in advance but expect fewer attendees than commitments. Although someone might not be able to attend, when people have access to the same information as others who do attend, it can still build community.

5. MAINTAIN A TRAUMA-INFORMED LENS

Encourage people to familiarize themselves with books before selecting them. While *Man's Search for Meaning* is a spectacular work, the setting might be a lot for someone who is not aware of it ahead of time. Asking people to "pitch" books to the group in the first meeting can help facilitate this.

Enjoy the reading and the connections! ■

Shirley Giroux, PhD, RCC, is an experienced teacher who lives on the traditional, unceded territory of the Simpcw and Lheidli T'enneh Peoples in Tête Jaune Cache, B.C. Certified as a Compassionate Systems Leadership Master Practitioner through the Center for Systems Awareness at MIT, Shirley is the school counsellor in Valemount.

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