WINTER 2018

INSIGHTS

THE BC ASSOCIATION OF CLINICAL COUNSELLORS' MAGAZINE

Working with the Families of People with Addictions

Motivational Interviewing

An Attachment-Informed Approach to Grief Counselling

Animal-assisted Interventions

Bringing a four-legged co-therapist into your practice takes more than a love of animals

+ **The Stress of Infertility** and How to Alleviate the Suffering

BCACC Member Health Benefit Plan

Introducing a Health and Dental Benefits plan just for you.

We are pleased to offer our BCACC members a health and dental benefits plan to fit your needs.

Our new plan can be purchased as a standalone health benefits plan, or as a health and dental benefits plan. A basic travel insurance plan and coverage for fractures and breaks are also included in the cost.

In addition, you have the option to add on other components that would cover you in the event of loss of income, critical illness or for more robust travel insurance.

Coverage you can afford and no medical questions on the Basic plan.

We invite you to download the information package from the BCACC website and contact our Plan Representative, Stephanie Ritchie.
You can call her at (778)533-4676 or email her at stephanieritchie@shaw.ca.
Stephanie can answer your questions and assist you with the enrollment process.

BCACC

BC ASSOCIATION OF CLINICAL COUNSELLORS

CONTENTS WINTER 2018

FEATURES

IN EVERY ISSUE

INSIGHTS
THE BC ASSOCIATION OF CLINICAL COUNSELLORS' MAGAZINE

The Insights *team wishes to thank the writers who contributed to this edition of our magazine:*
Mike Mathers, Nadia Stefyn, Elana Sures, Marney Thompson, Tricia Toth

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

#204-780 Tolmie Avenue
Victoria, BC V8X 3W4
Tel: 250-595-4448
Fax: 250-595-2926
Toll Free in Canada: 1-800-909-6303
communications@bc-counsellors.org
bc-counsellors.org

In the spirit of reconciliation, BCACC acknowledges and respects the Indigenous people upon whose traditional territories we work and live throughout the province.

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 Agencies: Getty Images: cover, p. 4-8, 10, 12-20, 22-28, 30, 33-35, 37-38

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

More information about submitting article proposals can be found at bc-counsellors.org/media/insights-magazine or by contacting Marci Zoretich, the BCACC editorial advisor, at communications@bc-counsellors.org.

Printed in Canada by Mitchell Press.

Ideas and opinions expressed within this publication do not necessarily reflect the views of BCACC or Page One Publishing Inc. or its affiliates; no official endorsement should be inferred. *Insights* writers are responsible for the accuracy of the information in their articles and for obtaining permission to use source material, if applicable. The publisher does not assume responsibility for the contents of any advertisement, and any and all representations or warranties made in such advertising are those of the advertiser and not the publisher. No part of this magazine may be reproduced, in all or part, in any form — printed or electronic — without the express written permission of the publisher. The publisher cannot be held responsible for unsolicited manuscripts and photographs.

NEW BCACC MEMBER PORTAL

In October 2018, BCACC launched a newly configured member portal. The new portal has been designed with ease of use in mind and features an "I am looking for..." section with commonly asked questions and member resources.

You will need to set up a password the first time you log in. To log in, visit www.bc-counsellors.org and choose the Member Login button.

CHANGES TO THE WAY WE GATHER IDENTIFYING INFORMATION

BCACC consulted with Ambit Gender Diversity Consulting through 2018 and has changed the way we collect members' gender-identifying information. BCACC uses this information to help us know who our members are. This information is also used by potential clients who are using the Find a Counsellor tool. Firstly, we have made it optional for members to identify at all. If you would rather not identify, you can choose a blank field. Secondly, we have changed from a binary male/female system to the following: Woman, Man, Non-Binary, Trans. We are making moves to create space for our members to identify themselves. We recognize that this list is not complete but hope the additional fields will assist counsellors to portray who they are to potential clients. We also invite you to utilize the "Description of Practice" field to expand your biography.

This information is stored in the "Membership Information" area of the Member Portal. We encourage all members to log into their accounts, look over their information, and make sure it's current and up to date.

Elder Abuse Programs

FAMILY SERVICES OF GREATER VANCOUVER (FSGV) has two elder abuse programs that work in partnership with municipal law enforcement in Vancouver and New Westminster. The Victim Support Worker (VSW) in Vancouver with the Elder Abuse Unit was the very first embedded VSW with the Vancouver Police Department's Domestic Violence Unit 21 years ago. The VPD Domestic Violence and Criminal Harassment Unit has grown in size since then, and it expanded a decade ago to include a specific unit dedicated to responding to elder abuse that pairs one VSW with one VPD detective.

The program serves individuals over 65 who have experienced or are still experiencing any type of abuse, including financial, verbal, emotional, or physical. The VPD receives at least 300 reports of elder abuse a year, but the unit focuses on those cases that are most complex or highest risk. They also consult with community partners about elder abuse issues throughout the city. The collaborative partnership ensures the most effective wraparound services available for each client being supported. Safety is paramount, and supports for the client usually take precedence over criminal justice system outcomes.

An additional element of complexity is that the abuser is usually a family member — sometimes a grown child struggling with mental health and addiction issues — and the focus for many clients is to help their child. By additionally supporting the offending family member through their struggles, the VSW can help the elder experience an increased sense of safety and support.

CALL FOR ABSTRACTS

The BCACC Conference Organizing Committee is inviting members to submit abstracts for presentations at the BCACC Conference **2019 – WIRED TOGETHER: Self, Science, Societies**, which will take place in Richmond from November 1 to 3, 2019. Abstract submissions will be accepted from January 9 to March 6, 2019.

For more details, including submission themes and guidelines, see the inside back cover of this issue of *Insights*.

Family Forward has been recognized by the Supreme Court of B.C., which has asked Jones to train judges on attachment and family dynamics.

FAMILY FORWARD

Parent-child relationships are disrupted for many reasons: divorce, long absences, parental alienation, substance use, mental illness, mental health issues, violence, abuse, or incarcerations. Vancouver-based Alyson Jones and Associates runs a unique family-focused, team-treatment program of therapeutic interventions for attachment disruptions: the Family Forward® Reunification Therapy and Counselling Program.

"In these complex family situations, there are many agendas and many different needs amongst the family system, and this is one of the reasons we approach these cases as a team," says Alyson Jones, clinical director and president. "To be a sole therapist amongst a high-conflict family can cause burnout and a loss of perspective. We are able to assist the family more effectively by utilizing different team members for specific services to the family, while keeping the whole picture in view, and we are then able to better navigate the complicated terrain around these cases. We also provide a high level of support to each other while deepening our skill base and clinical skills through our team approach."

Family Forward has been recognized by the Supreme Court of B.C., which has asked Jones to train judges on attachment and family dynamics.

"The court has been supportive of solutions-focused approaches that assist these families in refocusing on the needs of the children," says Jones. "Both the Provincial Court and Supreme Court have recognized that family issues cannot be solved through court alone: a much bigger perspective is needed. As a team, we have learned to work with the court in exploring solutions and supporting the best interests of the children."

Find more information at www.alysonjones.ca/services/family-forward-reunification-therapy-and-counselling-program/.

Tell us what *YOU* think!

communications@bc-counsellors.org

NEW IN *INSIGHTS*

Do you have comments or feedback about an article in *Insights*? A related experience you want to share? We are developing an online forum for BCACC members to engage about *Insights* topics. The launch is planned for the near future. In the meantime, tell us what you think of articles in *Insights* by sending comments to communications@bc-counsellors.org.

NEW BCACC BENEFITS PACKAGE

Our new BCACC Member Health Benefit Plan is designed to reduce medical, drug, and dental costs for RCCs and their families. A key feature of this new plan under Edge Benefits is its built-in flexibility. Affordable basic coverage is available with no medical questions, with great add-ons including coverage for loss of income, cancer and critical illness, and travel insurance. To learn more, see the inside front cover of this issue of *Insights* or contact our BCACC representative, Stephanie Ritchie, at 778-533-4676 or stephanieritchie@shaw.ca.

PERSUASION IS AN INSIDE JOB

HOW MOTIVATIONAL INTERVIEWING CAN HELP YOU PROFESSIONALLY AND PERSONALLY

BY MIKE MATHERS, RCC

I will stake a claim at being a relatively well-trained therapist on the back of two Master's degrees and a five-year diploma in Existential Analysis. But in terms of clinical work, I believe Motivational Interviewing (MI) has been my most valuable tool. It has also helped my developing skills as a parent, romantic partner, friend, family member, and colleague.

The true beauty of MI is not as a set of technical interventions with a strong evidence base supporting its efficacy, but rather, as a style of communicating that promotes autonomy and guides people towards values-based change. MI is also a wonderful way to experience more ease and deeper connection in your personal relationships — and has much to offer a world in need of ease and connection.

SOME KEY PRINCIPLES

MI is considered the gold standard in treating substance-use disorders, as the creator, Dr. William Miller, developed it in the early 1980s to help problem drinkers more effectively. As a fledgling addiction therapist, I felt fortunate to find out about MI trainings in Vancouver a few years ago. After the two-day advanced training, more was happening for my clients, yet I felt like I was doing less. I was hooked. I noticed growth in the people I supervised once I learned the beauty of "getting out of my own way." I was able to free myself of unrealistic burdens about the need to know and be everything in order to be helpful.

MI IS LIKE GOLD IN OUR PERSONAL RELATIONSHIPS BECAUSE OF A SKILL SO OFTEN RECOMMENDED TO INCREASE INTERPERSONAL EFFECTIVENESS: THE LISTEN AND VALIDATE STRATEGY.

A key principle of MI is creating an environment where the people you are supporting are encouraged to hear themselves talk, in a particular way, and, thus, be guided to make decisions based on their innate wisdom. Although MI is something nearly every therapist initially thinks is easy, it is incredibly challenging to do with a high degree of consistency. Being MI-consistent requires dedication and a commitment to ongoing practice with feedback and coaching. We know it is the basics that work, so I really appreciate that whenever clinical work starts feeling like a slog, I can take it as a reminder to go back to basics.

MI can be thought of as person-centred… PLUS! It recommends a specific set of skills for empathic listening (hardly novel in that regard); however, it also suggests the use of very circumscribed practical tools. More importantly, it is the manner in which the technical is infused with the relational style that makes it so effective. MI represents an attempt to deeply understand the person and is informed by the recognition that

ambivalence to change is normal and an opportunity, versus a source of frustration.

A unique offering of MI is the concept of change talk (one half of the ambivalence: the statements people make in the direction of change) and the importance of listening for it and reinforcing it in order to strengthen the commitment to change. In MI, working through ambivalence about change is seen as a vital part of the process. I remind myself about the nature of change by sharing the following motto with my clients: "We learn what we believe when we say the words out loud." I don't need to be wise all the time — just wise enough to know how to create a climate of dialogue that assists the person in bolstering the commitment to change. It is crucial they hear themselves say why they might even consider changing, before I move to asking them how they are going to do it.

MI specifically recommends we resist "the righting reflex" (which is about the desire to fix), so we can more effectively be of service. Guiding change in this manner requires attention to the nuances of the therapeutic relationship. I appreciate the idea from MI that when "resistance" shows up (in quotes because, in MI, we refer to discord rather than resistance), it is my job as therapist to see it as a function of the relationship. The appearance of "resistance" is the moment for me to reflect on what I might be doing (or not doing) in the context of the therapeutic relationship to contribute to this. This takes into account the robust findings from the outcome literature, which demonstrate that the therapeutic relationship (how therapists are with clients) is more curative than technique (what therapists do to clients).

I DON'T NEED TO BE WISE ALL THE TIME — JUST WISE ENOUGH TO KNOW HOW TO CREATE A CLIMATE OF DIALOGUE THAT ASSISTS THE PERSON IN BOLSTERING THE COMMITMENT TO CHANGE.

USING THE MAGIC PHRASE "TELL ME MORE ABOUT THAT" OR MY REFLECTIVE LISTENING SKILLS CAN BOTH STRENGTHEN THE BOND AND MODEL HEALTHY RELATIONSHIP SKILLS.

THE SPIRIT OF THE APPROACH

MI drew me because it is primarily a way of being with people. This is reflected in the spirit of the approach, which is always paramount to the practice. If there is a conflict between the skills/strategies and the spirit, the spirit of the approach carries the day.

MI is influenced by the work of Carl Rogers, and Miller and Rollnick (2013) have elaborated on these origins by defining the spirit of MI "as a heart set and mindset that falls within four domains: partnership, acceptance, compassion, and evocation."[1] The specific blend between the technical and the relational is what makes MI so effective. The doing (as opposed to being) part of MI is partly comprised of a series of skills and the "acronym OARS+I (open-ended questions, affirmations, reflective listening, summaries, and information exchange) conveys these core skills."[2]

The four processes of MI (engaging, focusing, evoking, and planning) help the therapist track the flow of the conversation as the change process unfolds. Engaging is establishing a safe place within which the client can explore difficult realities and a working relationship. Focusing is coming to understand what matters most to the client and defining an agenda for moving forward. Evoking is calling forth the client's reasons for changing and reaching a commitment to an action. Planning is putting into place the methods by which the client will act on this commitment.[3] Whenever the path gets murky, the basics of MI provide orientation about how we might get back on track.

MI OUTSIDE OF PRACTICE

On a personal level, the importance of walking the walk (the congruence aspect of MI) was one of the biggest draws for me. A shining example in my own life has been in my journey as a parent. Sometimes correcting behaviour feels like a matter of survival, but if I can resist the "righting reflex" with my kids by taking a few moments for "connection before correction," chances are we are all going to be better off. Not always easy to do when the amygdala is fired up, but if I can remember to seek understanding, affirm strengths, and ask permission before providing information to my kids, chances are I will feel heard and they will feel respected.

Of course, not every parenting moment is the time for an MI conversation, such as when little hands or feet are flying at siblings or parents. "Wow, you have such solid little hands! Tell me more about how you learned to hit so hard" is probably not the most effective response. However, the other 99 per cent of the time, I am required to guide my children: using the magic phrase "tell me more about that" or my reflective listening skills can both strengthen the bond and model healthy relationship skills. I think the reason these skills work so well in therapy, and in parenting, is because, as human beings, we are wired to value autonomy above all else.

Another key takeaway from MI involves using caution around giving unsolicited advice. If I am going to give advice or provide information, I ask for permission before doing so. This attitude communicates respect

for the person's autonomy, and I am increasing the chances the person will take it on. Think of a time you received unsolicited advice — just how helpful was it? Chances are even if helpful, you likely did not appreciate the suggestion in the spirit in which it was intended.

About four years ago, I was on my way back from the UK where I had presented at a conference. My son was only 14 months at the time, and as I was walking up and down the aisle of the plane trying to get him to sleep, just at the moment I thought was going to be a great triumph, an individual called out loudly: "You're doing that wrong!" He was a doctor who knew everything about children (except not to disturb a parent about to taste the victory and sweet relief of a nap). He told me I was holding my son wrong. This unsolicited advice ended up waking my child. I did not give him great feedback about his "planeside" manner, but I took a great lesson from the experience. If he had started by asking permission to give advice plus an affirmation ("I can see you are working hard to put your kid to sleep. May I make a suggestion?") chances are I would have been much more receptive to his message.

MI is like gold in our personal relationships because of a skill so often recommended to increase interpersonal effectiveness: the listen and validate strategy. MI offers the capacity to listen deeper to what is unspoken. The ability to listen to what a person is really trying to say and skillfully convey empathy leads to the experience of validation, which is at the heart of MI's clinical practice.

This is not a plea to wear your therapist hat with everyone in your life — rather to suggest our impulses about how to respond to people we care about when talking about difficult things might not always meet the needs of the situation. Quite often, we want to solve problems when those we care about show up in distress. If I am seeking to be heard and someone moves too quickly to try to take my distress away, it often has the opposite effect of what they intend. By resisting the "righting reflex" and being with someone with an attitude of understanding and compassion, we can build a foundation of trust. Intimacy might emerge from this, which lowers defenses and increases the chances that we can then leverage our concerns.

RESOURCES

I appreciate Cristine Urquhart's teaching style because of how she embodies the spirit of MI in every aspect of how she guides the training. Trainings are ongoing; I encourage you to get on her mailing list. changetalk.ca

MINT – The Motivational Interviewing Network of Trainers. motivationalinterviewing.org

RESPECT FOR AUTONOMY

A central appeal for me in dedicating myself to MI personally and professionally is its respectful nature. As Miller and Rollnick say: "The overall style of MI is one of guiding, which lies between and incorporates elements of directing and following styles."[4] I believe in the importance of meeting people where they are, not so we can stay there, but so I can convince them the relationship we co-create can be a bridge to change.

MI is a way of partnering with people to help them feel heard, and when appropriate (because not every conversation is an MI one), assist them in unlocking their intrinsic motivation towards change. It is an approach that respects the basic human need for autonomy and accounts for the often non-linear and ambivalent nature of people's feelings about change. The MI practitioner acts as a skilled guide and creates an environment where the client is making the case to the therapist for the necessity of change. After all, persuasion truly is an inside job.

Miller's most recent book is called *Listening Well: The Art of Empathic Understanding* and it seems to have been written as a guidebook for the layperson to learn how to effectively apply these skills. I have a feeling I will be suggesting it to many clients in the future, because these types of skills are needed more than ever in today's world. Many challenges we face are inflamed by the absence of empathy on a grand scale. The potential to create understanding between people with diverse values and concerns rests on the ability of skillful guides willing and able to shepherd necessary conversations.

Mike Mathers, MSc, MA, RCC, focuses on treating individual clients and groups for substance-related concerns and is involved with a mental health outpatient clinic in Yaletown as a clinical counsellor for individuals and groups. wellnessevolved.ca, https://about.me/mmathers, https://www.borealwellness.com

REFERENCES

1 Rosengren, D. B. (2018). *Building Motivational Interviewing Skills: A Practitioner Workbook* (2nd edition). Guilford Press.

2 Rosengren, 2018.

3 Rosengren, 2018.

4 Miller, W.R. and Rollnick, S. (2013). *Motivational Interviewing: Helping People Change* (3rd edition). Guilford Press.

ANIMAL-ASSISTED

INTERVENTIONS

Bringing a four-legged friend into your practice as a co-therapist takes more than a love of animals. Here, we talk to two RCCs who are established in the field of animal-assisted therapy.

BY CAROLYN CAMILLERI

CANINE-ASSISTED THERAPY

Counsellor: Michell Bennett, RCC

Michell Bennett's decision to add animal-assisted therapy to her practice goes back to a time she watched a speech and language pathologist use parrots to help children.

"I noticed how the parrots really dissipated barriers to learning and engagement with kids," she says.

Bennett's education combined psychology and education, and she started in counselling working in Vernon as a school-based resource teacher for students with exceptional needs. She had had dogs since childhood, as well as horses, and knew from experience how much animals could teach children and adults.

"Being responsible for another living thing, learning how to care for something else, empathy building, all those really important skills we need to develop as individuals," she says. "I have an affinity for working with kids individually and really believe mental health is an important piece in the school system."

As Bennett explored animal-assisted therapy, she quickly learned it is a fairly new field in Canada compared to other countries. Her search for information pointed her to Alberta-based Dreamcatcher Nature-Assisted Therapy (www.dreamcatcherassociation.com), led by Eileen Bona, a registered psychologist, who has developed training programs for MA-level and BA-level people in the helping professions. After extensive study and training, Bennett brought her screened and trained dog into her work as a high school counsellor and in private practice.

A BRIEF OVERVIEW AND SOME CONSIDERATIONS

So can any counsellor who has a dog (or any other animal) just add animal-assisted therapy as a modality in their practice?

Of course not. Bennett says that misunderstanding is one of the biggest barriers in this field of counselling. Animal-assisted therapy is a really specific scope of work.

"First, you have to be a therapist to do animal-assisted therapy — you can be a clinical therapist, occupational therapist, physical therapist — but you have to be a therapist to do therapy work," she says. "It's goal-oriented and focused on whatever that therapy's agenda and outcomes are focused on."

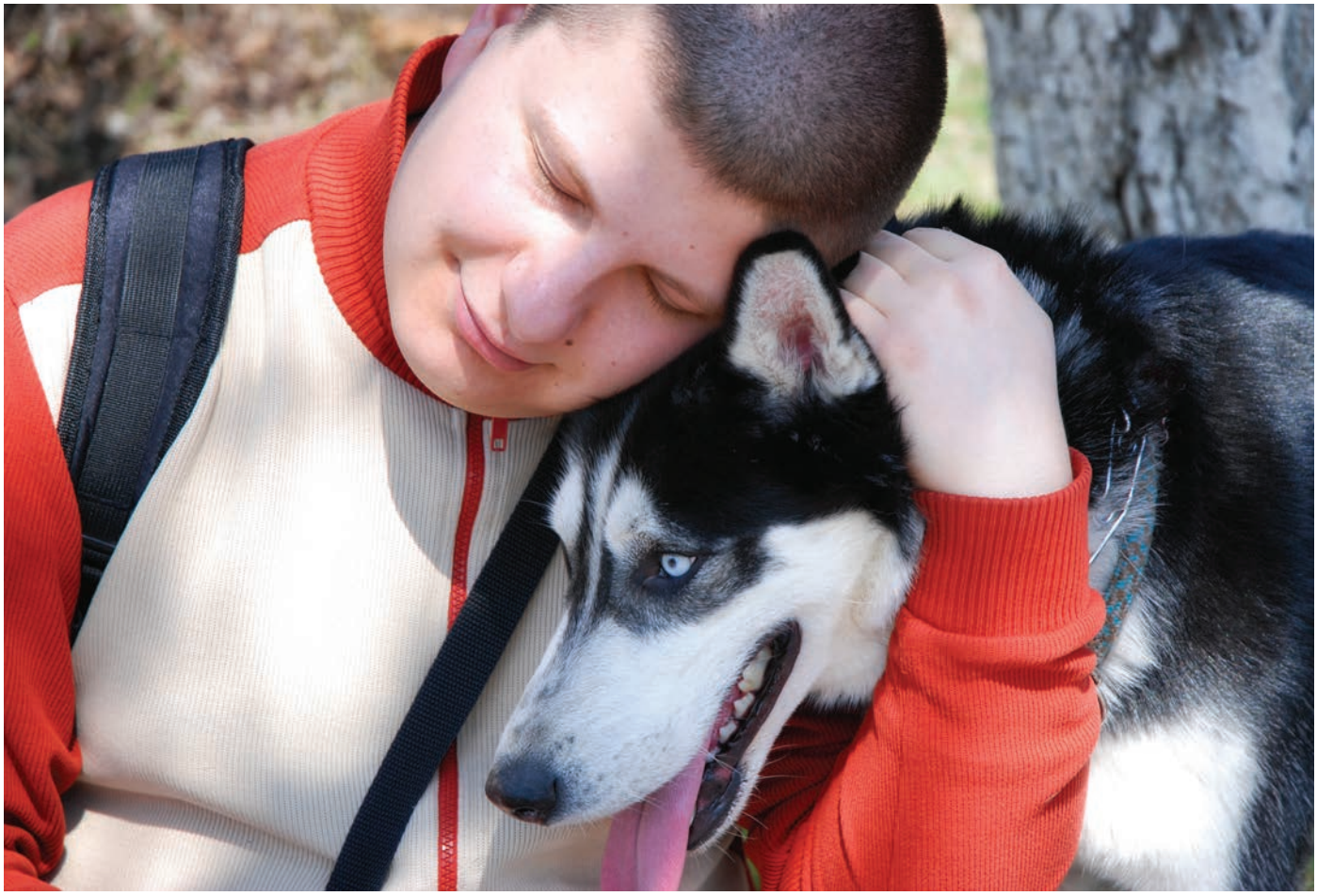
Moreover, animal-assisted intervention is an umbrella term and there are different kinds. For example, animal-assisted activities include animals used for emotional support, for visits to hospitals and nursing homes, to support children in court, and to provide comfort in a crisis. The people handling the animals could be counsellors but could also be trained animal handlers or volunteers using their own animals, as with the St. John's Ambulance Dogs.

"Animals can ease interaction and interpersonal relationships, and they can help create a safe place," says Bennett. "Some people in distress can be calmed by the presence of an animal."

But that is not therapy — there is no goal or evaluation — the animal is simply a benign presence bringing comfort.

"There's a big trend now of individuals saying they need a therapy dog, particularly in schools — 'I need a therapy dog because I'm anxious,'" says Bennett. "They don't need a therapy dog. They're talking about an emotional support animal, and those are different."

Animal-assisted education is another area under the animal-assisted intervention umbrella. "Those are educators trained in handling an animal



Animals can ease interaction and interpersonal relationships, and they can help create a safe place. Some people in distress can be calmed by the presence of an animal.

but also trained in education," says Bennett. "An expert in that field could incorporate an animal — a dog, rabbit, or guinea pig — into their classroom setting to support learning. But even that's just an animal-assisted activity, unless they're being used to work on goals such as literacy or numeracy, some sort of programming to support learning."

Then there is animal-assisted therapy, which is a modality like any other therapeutic modality.

"Animal-assisted therapy is comprised of activities clinicians do with their dogs and clients that are very focused on the goals the client is working on in therapy."

Bennett says animals can be helpful in all sorts of ways in a therapeutic context: empathy building, relationship building, assessing stress levels, identifying anxieties, and biofeedback — learning to read behaviour and paralleling that to human behaviour.

"Animals can help people see their own personal challenges or circumstances in a different way," she says.

Two different models are used. The diamond model involves four entities: client, counsellor, animal, and animal handler.

"The diamond model is often used in equine therapies for safety reasons and because horses can be very large animals."

The diamond model also allows the counsellor to focus on the nuances of client behaviour, while the animal handler watches the animal.

"It requires a lot of collaboration between the therapist and the handler, because sensitive and confidential information is being passed through therapeutic work," says Bennett, emphasizing that the client

must be comfortable with another adult in the therapeutic space.

Another consideration: how the experience might affect the handler.

"There are lots of ethical considerations in a diamond model," says Bennett.

The triangle model is more commonly used with smaller animals, such as dogs, and has three entities: client, animal, and counsellor-animal handler. Again, Bennett says counsellors need to be really clear about the ethical considerations before moving forward in this dual role.

"The most important standard is around building rapport between the dog and client, so ethically you have to foster that while considering safety for both," she says.

For example, a victim of sexual abuse or trauma might be uncomfortable being touched and because dogs are inclined to touch people, counsellors have to check client comfort. Safety for the dog is another consideration: if the client is triggered, could they hurt the dog? And then there is dog care: dogs need more sleep and breaks than people and can get physically and emotionally tired.

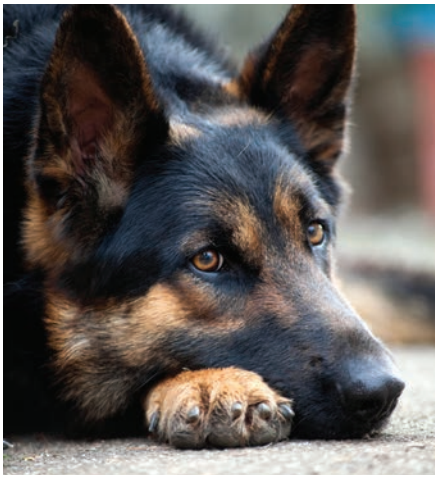
"Animals in therapeutic work can also experience compassion fatigue and burn out," says Bennett. "How many clients has my dog seen today? Are they effective or just kind of present? Are they engaged with this individual? Because just having an animal sit in a therapy session isn't enough to say you're doing animal-assisted therapy."

IS CANINE-ASSISTED THERAPY FOR YOU?

"Canine-assisted therapy is not standardized in Canada, and that's a limitation, because there's no governing body to supervise it," says Bennett, who is a member of the Canadian Counselling and Psychotherapy Association's animal-assisted therapy chapter.

The lack of standardization also means unqualified people may be doing canine-assisted therapy. Moreover, because canine-assisted therapy is somewhat trendy, people may be inclined to take shortcuts.

"I firmly believe in a level of formalized training," says Bennett. "Not to say consultation and collaboration isn't valuable — it is valuable and adds to our greater understanding of our practice — but there needs to be some knowledge gained and content covered that makes it more formal."



Animals in therapeutic work can also experience compassion fatigue and burn out.

Training programs are available mainly internationally and require serious commitment. Bennett encourages interested counsellors to start by reading Aubrey Fine's *Handbook on Animal-Assisted Therapy: Theoretical Foundations and Guidelines for Practice* (Academic Press; 3rd edition, 2010). Another suggestion: Cynthia K. Chandler's *Animal-Assisted Therapy in Counseling* (Routledge; 3rd edition, 2017).

Keep in mind: therapy dogs are specially trained, although, again, it is not standardized.

"Training an animal for therapy is different than training for obedience," says Bennett. "A good, effective therapy animal isn't necessarily the most obedient animal, because they have to read their clients intuitively. They're reading body language. They're sensing stress and distress. That's not something you want to train out with obedience."

And dogs are living beings subject to change. "Your dog's ability or interest in being a therapy animal needs to be assessed on a regular basis, because just like humans, as dogs age, their temperaments change."

Bennett trains her own dogs and consults with trainers and therapists in the field. She says that process helps counsellors better understand their dogs. As a starting point for learning dog handling, she recommends an online course called Dog Emotion and Cognition (www.coursera.org/learn/dog-emotion-and-cognition). She also recommends reading *The Genius of Dogs: How Dogs are Smarter than You Think* by Brian Hare and Vanessa Woods (Oneworld, 2013) and following Turid Rugaas, a Norwegian dog trainer who offers dog handler training internationally.

Final words of advice: check credentials before signing up for a training program.

"Contact them and find out what their process is and who they are, because you want to make sure you're getting your money's worth," says Bennett. "And remember, your pet is going through this process with you."

EQUINE-FACILITATED THERAPY

Counsellor: Deborah Marshall, RCC

Deborah Marshall has a private practice in an office in downtown Nanaimo — but she also works in a farm setting. Generation Farms in Yellow Point offers integrative wellness programs with horses and in nature, as well as professional training. Among her credentials, Marshall is a certified trainer, mentor, and practitioner in the field of equine-facilitated psychotherapy.

While Marshall has been in practice since 1988, horses weren't officially added as co-therapists until 2000. Her motivation to explore the field came from witnessing some impressive results. A handful of times, when her clients were really unstable and at risk, she would invite them to visit the barns to help groom horses and do barn work.

"Sometimes, absolutely magical things happened," says Marshall. "In that environment, and with the horses, something would happen that made a life-changing difference. So I knew there was something, and I knew what horses brought me, but I didn't know how to put it together."

That was about 25 years ago, and seemingly independently, people around the world started to bring horses and people together more formally for healing. Marshall went to the U.S. to participate in a number of trainings, and then combined it with what she knew as an EMDR and somatic practitioner. By 2002, she had purchased a property and started developing her own approach.

"The people in the neurophysiology area, like Dan Siegal and Pat Ogden and Peter Levine and Steven Porges, are very instrumental in what we do," says Marshall. "A spontaneous mindfulness seems to happen around horses. It can be a very strong, spiritual element that emerges quite spontaneously from being in nature and with the horses."

In about 2003-2004, several approaches came together: the neurophysiological-driven approach, which is a somatic body-oriented approach, plus mindfulness-based practices and really, really good relational horsemanship. They all shared similar principles.

The horses will sometimes make better judgments than the human therapists about what to do.

"They were principles like working incrementally, taking your time, being in the present moment, having your feet on the ground, breathing, and tracking your body as a guide to what to do next," says Marshall. "We developed a whole list of core principles we still work with today, and they came from this coming together of quite separate modalities."

HOW IT WORKS

"We work with the horses and most of it is done on the ground," says Marshall.

Horses, due to their size alone, have an immediate influence.

"You can learn about healthy boundaries with horses — they are very clear," says Marshall. "Dogs are predator animals and have different boundary reactions than horses."

Horses also assess people differently than dogs. "People who tend to step over people's boundaries can learn to see the reaction of the horse and how to change their response. This can translate to an increased awareness of the people in their lives."

Alternatively, people who don't stand up for themselves, when they find out they can lead or be comfortable with a 1,500-pound animal, gain confidence in their ability to manage themselves.

"The boundary part is really huge, from children through adults to people in recovery," she says. "To learn to be aware and respectful of another and how to negotiate boundaries so they're healthy, and also to learn how to stand in your boots and believe you can say no and influence this large animal."

And you can't fool a horse.

"People who are in their head or pretending something — such as, pretending they're fine when they're actually afraid — horses are not generally so interested in being with them," she says. "But when the person shifts into awareness, they get this wonderful warm reception. That's therapeutic."

Not all the horses at Generation Farms do therapy.

"The ones that do are a range from miniature horses to large ponies and medium horses and then we've got enormous horses," says Marshall. "People can start small and work up if that's where the comfort is, or they can learn to respect small, because the small horses are very feisty and smart."

And, sometimes, clients are drawn to a horse that feels like a teacher to them, she says.

A spontaneous mindfulness seems to happen around horses. It can be a very strong, spiritual element that emerges quite spontaneously from being in nature and with the horses.

"We have horses that are trauma specialists, and they have the ability to stay right with somebody who is processing trauma or feeling afraid," she says. "The horses will sometimes make better judgments than the human therapists about what to do."

Not all of Marshall's clients come to her specifically for equine-facilitated therapy. "Some come to me because they've heard about my office work, and they stay there. With others, it may just make sense to suggest they come to the horses. And some find out about the work we do at Generation Farms and then get in touch."

Generation Farms' clients come from a variety of sources, including child and youth programs, homeschool programs, addiction programs, and referrals from psychologists. Issues addressed include autism, anxiety, cognitive disorders, and trauma, to name just a few.

"It's a very busy place," says Marshall. "I don't work by myself — we have a team. We have four counsellors. We've got youth workers. We've got barn staff. We all love to work together."

IS EQUINE-FACILITATED THERAPY FOR YOU?

"If a counsellor is a BCACC member and has a Master's degree and all those requirements, they have a good start, because some people want to do this work and don't have that," says Marshall.

Equine-facilitated therapy is like an adjunct to counselling. Generation Farms has been offering training for counsellors since 2006. When the EFW-Can was launched, Marshall was on the ground floor working with people from all over the country.

"I chose to be part of a certification program offered by an association, because it just didn't feel ethical for me to be the one that both trained and certified — I wanted that accountability."

Learning to be a "horse person" is a big learning curve. Marshall says counsellors who are interested but have no horse experience will learn enough horse skills along the way to understand what's happening and to have basic safety, but they would need to partner with an equine professional.

"For counsellors who do have a horse background — there's actually a lot of them — then they can maybe add some new horse skills to their tool kit."

Marshall suggests interested counsellors start with the national association, EFW-Can (www.equinefacilitatedwellness.org).

"We really encourage counsellors to do the longer journey rather than something quick," she says, adding that there is a very strong ethical code with EFW-Can. "There are types of this work where the horse is seen as a tool and is just used to create exciting experiences to talk about, and it doesn't serve the horses — they don't particularly like it. I believe so strongly that it's about partnering with the horse. And if you want them to partner, then you need to have relationships. Horses need to be treated well." ■

HOW CAN THIS BE HAPPENING TO ME

THE STRESS OF INFERTILITY AND HOW TO HELP ALLEVIATE THE SUFFERING

BY ELANA SURES, RCC

"Being pregnant is something that happens to other people."

"I never thought this would happen to me."

"It's a nightmare."

"I had two abortions by the time I was 25 — how could this be?"

If you work, as I do, with a population who is predominantly of childbearing age, you might have heard some version of "I can't believe this is happening to me." With one out of six couples experiencing infertility and one out of four pregnancies ending in miscarriage, the odds are that you, too, are supporting clients through infertility and other reproductive calamities.

Infertility is not just a reproductive crisis — it's an existential crisis. After a prolonged period of trying to conceive, many women wonder if they will ever become a mother. That glaring biological timeline adds a degree of urgency and panic we don't tend to feel with other life goals. Believe me, I know of what I speak in this domain. I spent several years trying to get pregnant with both my children, a phase I am sorry to say I did not greet with equanimity. They were tough years, and I suffered greatly: worried (a lot), loathed social media, and teared up when passing happy mothers in the street. I sought counselling during this difficult period.

Those who have learned to keep their distance and avoid vulnerability tend to fare the worst when coping with infertility.

Some of it was helpful (the therapist who told me I was catastrophising actually did me a huge favour). Another therapist was less helpful ("Have you tried meditating yet?").

There are many dimensions to the struggle of infertility: loss, acceptance, hope, meaning-making. One common denominator in individuals and couples seeking psychological help while experiencing infertility is that they arrive reporting that they are "stressed." In this piece, I will explore the primary ways in which the stress of infertility shows up and how to help alleviate the suffering caused by this stress.

While infertility is stressful for everyone, I reference women more here; this is simply because, in my experience, the vast majority of people presenting for support with this issue are women.

THE RELATIONSHIP BETWEEN INFERTILITY AND STRESS

Women with infertility report higher levels of anxiety and depression, so there's little doubt that infertility causes stress. What is less clear, however, is whether or not stress causes infertility.[1] Predictably, women struggling to conceive will be advised to "just relax!" — followed by an anecdote about someone who got pregnant once she gave up on trying, adopted, etc. (public service announcement: just don't).

That said, research has documented the efficacy of psychological

All client names and circumstances have been changed to protect privacy.

interventions in lowering psychological distress associated with infertility,[2] and some research has even demonstrated increases in pregnancy rates in patients participating in psychotherapy.[3] While this is encouraging, stress is a generic term that needs unpacking. In order to effectively help clients alleviate the suffering caused by stress, we need to step inside each client's world.

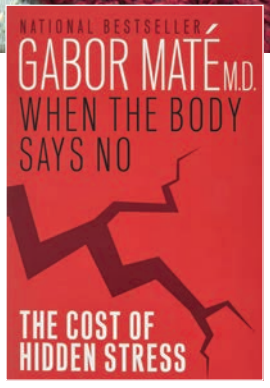
Anecdotally, I find the stress my clients experience while trying to conceive falls generally into the following categories:

1) Overthinking and excessive worrying as a reaction to the inherent uncertainty of their situation.

2) Difficulties dealing with other people in their lives (partners, families, and fertile friends/colleagues).

3) Intense feelings of emptiness, anger, and longing when the trying phase is protracted and unsuccessful.

My own impressions have been corroborated by the work of Dr. Gabor Maté, author of *When the Body Says No: The Cost of Hidden Stress* (2003).[4] According to Maté, the major causes of stress are lack of control, uncertainty, emotional isolation, and the inability to express emotions. I don't endorse a reductionist cause-and-effect relationship between stress and infertility, but I find Dr. Maté's classifications helpful to use as a compass. While it's not necessary to take a top-down approach and impose these categories on clients, having these areas in mind when meeting with clients helps us organize our work together. Rather than being too general, we can then drill down into the crux of the stress and suffering.



According to Maté, the major causes of stress are lack of control, uncertainty, emotional isolation, and the inability to express emotions.

LOCUS OF CONTROL

One of my favourite concepts in modern psychology is that of the locus of control. A person with an internal locus of control believes he or she can influence events and their outcomes, while someone with an external locus of control blames outside forces for everything. Research has suggested infertile patients with a high degree

of internal locus of control experience less anxiety and depression than those with a higher external locus of control.[5] Mahajan et al. found that perceived internal control was correlated with better adjustment to infertility.[6]

Given that infertility is a situation in which sometimes not much can be done to influence the outcome, helping clients experience control over some aspect of their process is essential. When people seek out counselling, they often don't know exactly what they want out of therapy, especially if their locus of control is more external. We can set the tone for locus of control right away by asking a simple question: "What aspect of this problem would you like my help with?" or "What part of this situation is the most upsetting to you?"

A person with an internal locus of control believes he or she can influence events and their outcomes, while someone with an external locus of control blames outside forces for everything.

Casey, like many people experiencing infertility, comes in for her initial appointment with a story to tell. Medical details, marital strife, and misfire after misfire come out in a torrent of words. At the end of it, I say: "Oh, Casey. You have had such a long haul! There is so much grabbing my attention here, I can see why you might be feeling overwhelmed. Can you tell me what part of your current situation you'd like help with right now?"

I can tell Casey hasn't narrowed this down for herself yet, as she takes that question in. She pauses and tears up. "I'm not sure I want to do another IVF procedure. I don't know why, and I don't know if it's just fear or what, but something just isn't sitting right with me." By exploring Casey's conflict about her treatment, we tap into her difficulty trusting her own judgment. We also discussed how she can process some of her doubts with her partner and medical team.

Asking clients to identify which area they would like to explore has two beneficial effects: first, it gives the session focus and relevance. Secondly, it reminds clients that in the midst of so many things they have no control over, there are pockets of agency.

EMOTIONAL RESPONSE TO INFERTILITY

Irvin Yalom (2001) urges therapists to develop "here-and-now rabbit ears" in sessions with our clients.[7] In other words, when a client tells their story, rather than focusing primarily on the content, pay attention to how they tell it and how they relate to you as you engage with them.

Do we hear them resist their pain? ("I'm just trying to be positive!")? Are they amplifying their anxiety ("I'm never going to have children!"), or denying having feelings at all ("I'm fine. This is a first-world problem")? Do you pick up on hints of guilt, grief, or anger? When clients get close to themes that sound important or evoke signs of affect such as tears or anger, I'll ask to slow down and explore their experience in that moment.

When Jenny relayed to me an important consultation she had with a physician at the fertility clinic, I noticed her expression was flat and somewhat matter-of-fact.

JENNY: *"...so, we've got one more round of frozen embryos, and if that doesn't work, we'll then need to decide what to do for the next step. The doctor wants to try a different tactic with us next time."*

ME: *"So you're in a waiting phase right now. What's that like for you?"* [note: I do not ask about the next steps or new strategy. That would bring us out of her present experience and allow both of us to get distracted by speculation and medical details.]

JENNY: (sighs) *"It's okay. I'm used to it by now."* [note: her sigh tells me there may be some feelings beneath her minimizing.]

ME: *"You're saying you're okay, but your sighs hint there may be more..."*

JENNY: (sighs again) *"It's fine. I'm just trying to distract myself. But my husband has been frustrating me."* (clenches jaw, sighs) *"He's so annoying. But it's fine. He's trying. I need to be more patient."*

ME: *"I can see the frustration in your face. I also am noticing that while part of you is having this emotion, the other part of you is trying to dismiss it. If we don't let you brush your feelings away, perhaps we could look at them. What do you think?"*

After a huge sigh, Jenny then proceeds to provide specific examples of feeling disrespected

Women have come to internalize the notion that not only can we have it all, but also that our worthiness is made up of our achievements and impressiveness.

and unappreciated. Words such as "frustrated" eventually turn into "hurt" and then, over time, Jenny explores anger, fear, and sadness. Rather than experiencing an "emotional soup," Jenny is able to identify and feel each emotion and gain some clarity on the needs and actions associated with each feeling.

As we wrap up, I check in with how she's doing. She says, "I feel sad, but lighter somehow." I believe her. Emotions that are put in the vault are very heavy to drag around.

INTOLERANCE OF UNCERTAINTY

Vancouver-based psychologist Melisa Robichaud coined the term "intolerance of uncertainty" as a primary cue for anxiety and precipitators of chronic worry.[8] When I heard Dr. Robichaud speak several years ago, I immediately thought of infertility. My own tolerance for uncertainty hovered around nil during the years in which I was trying to get pregnant. This became a moving target: once I was pregnant, I worried about miscarrying. I assumed all women trying to get pregnant must all be overthinkers like me. As it turns out, not everyone is so allergic to uncertainty. In fact, some are naturally more able to hold a space for not knowing.

Kate Sweeney et al. found that people with a dispositionally high tolerance for uncertainty recalled less anxiety, less rumination, and less use of many uncertainty navigation strategies (such as worrying, reassurance seeking, and — I assume — googling their condition). While not all of us won the genetic lottery for that particular trait, some research suggests that this quality can be developed, particularly through targeted interventions.[9]

In other words, we can enlarge our tolerance for uncertainty. Phew! When it comes to strategies for working on this thorny issue, we are spoiled for choice. Interventions can include (but aren't limited to) Melisa Robichaud's evidence-based Cognitive Behavioural Therapy strategies for intolerance of uncertainty,[10] EMDR protocols that target the negative cognitions and early experiences at the root of the current uncertainties, or the Acceptance and Commitment Therapy strategy of cognitive defusion.

Our (mostly wonderful) neurobiology actually primes us for overthinking and worrying about the future. Intolerance of uncertainty is part of the human condition, but it needn't hijack us.

EMOTIONAL ISOLATION

"Because true belonging only happens when we present our authentic, imperfect selves to the world, our sense of belonging can never be greater than our level of self-acceptance," Brené Brown explains in her work on vulnerability.[11]

It's not unusual for people who have an array of friends and acquaintances to have difficulty feeling emotionally connected to those in their lives. Such vulnerability can feel exposing and anxiety-provoking, despite the now-viral messages about vulnerability and

authenticity. Here's what thickens the sauce: women have come to internalize the notion that not only can we have it all, but also that our worthiness is made up of our achievements and impressiveness. From nursing a baby one-handed while voting in parliament with the other (true story) to rocking a perfectly compact pregnancy bump in those ubiquitous mirror selfies, pregnancy and motherhood has become another hook on which to hang the hashtag #superwoman meme (also see: #supermom). And yet, even Superwoman can be (often is) that one in six. When pregnancy eludes the perfectionists among us, it feels like a personal failure. This impacts self-worth and self-acceptance and can make us long to retreat.

Those who have learned to keep their distance and avoid vulnerability tend to fare the worst when coping with infertility. Mahajan et al. found that women with an "avoidant type of adult attachment style" have poorer adjustment to infertility.[12] As one of my clients once told me when explaining her guardedness: "The last thing I need is for people to feel sorry for me." Sometimes it is good self-care to keep a bit of distance (go ahead and blow off that baby shower if you're feeling too fragile). But those who disconnect from others or pretend that everything is "fine" are likely adding to their stress load. Oversharing isn't the answer either, of course — its indiscriminate nature doesn't help people feel closer to one another.

Even the relationship that is ground zero of fertility experiences — the couple trying to become parents — can become disconnected. An unfortunate byproduct of going through fertility challenges as well as recurrent miscarriage is that this can impact the relationship between the two partners trying to procreate. Research is mixed, however, as to whether marital and sexual satisfaction suffer in couples experiencing infertility as compared to fertile couples.[13] What is clear is that couples with different coping styles can feel frustrated and unsupported by one another, and this can lead to tension and conflict within the relationship and, thereby, increase stress.

It is critical for therapists to identify such struggles with vulnerability and emotional isolation early on and work with clients to develop the self-worth, courage, and trust to be more open and accepting.

Our (mostly wonderful) neurobiology actually primes us for overthinking and worrying about the future. Intolerance of uncertainty is part of the human condition, but it needn't hijack us.

PULLING IT ALL TOGETHER

When it comes to psychotherapy, there are many roads to Rome; working through the struggles experienced in one realm will often tap into overriding patterns affecting many areas in life. As therapists, we get to tap into the most relevant point of pain in our client's experience. This can provide counsellors with a way of organizing our work with clients who are overwhelmed with their current circumstances, yet unsure of how they can be helped. ■

Elana Sures is a Registered Clinical Counsellor in Vancouver. She has a full-time private practice, in which she works with adults and couples. You can find her at www.elanasures.ca

REFERENCES

1 Kristin L. Rooney & Alice D. Domar, PhD. The relationship between stress and infertility. *Dialogues Clin Neurosci.* March 2018, 20(1): 41–47.

2 Kristin L. Rooney & Alice D. Domar, PhD. The relationship between stress and infertility. *Dialogues Clin Neurosci.* March 2018, 20(1): 41–47.

3 Katja Hämmerli, Hansjörg Znoj, Jürgen Barth. The efficacy of psychological interventions for infertile patients: a meta-analysis examining mental health and pregnancy rate. *Human Reproduction Update*, Volume 15, Issue 3, 1 May 2009, Pages 279–295, http://doi.org.10.1093/humupd/dmp002

4 Gabor Maté. *When the Body Says No: The Cost of Hidden Stress*. Vintage Canada: 2003.

5 Reza Omani Samani, Saman Maroufizadeh, Behnaz Navid & Payam Amini (2017). Locus of control, anxiety, and depression in infertile patients. *Psychology, Health & Medicine*, 22:1, 44-50, DOI: 10.1080/13548506.2016.1231923

6 N.N. Mahajan, D.A. Turnbull, M.J. Davies, U.N. Jindal, N.E. Briggs, J.E. Taplin, J.E. Adjustment to infertility: the role of intrapersonal and interpersonal resources/vulnerabilities. *Human Reproduction*, Vol.24, No.4, pp. 906–912, 2009. http://doi.org/10.1093/humrep/den462

7 Irvin Yalom (2001). *The Gift of Therapy: An Open Letter to a New Generation of Therapists and Their Patients*. Harper Collins, 2001.

8 M.J. Dugas & M. Robichaud (2007). *Practical clinical guidebooks. Cognitive-behavioral treatment for generalized anxiety disorder: From science to practice*. New York, NY: Routledge/Taylor & Francis Group.

9 Kate Sweeney, Sara E. Andrews, S. Katherine Nelson, Megan. L. Robbins. Waiting for a baby: Navigating uncertainty in recollections of trying to conceive. *Social Science & Medicine* 141 (2015): 123-132. http://doi.org/10.1016/j.socscimed.2015.07.031

10 M.J. Dugas & M. Robichaud (2007). *Practical clinical guidebooks. Cognitive-behavioral treatment for generalized anxiety disorder: From science to practice*. New York, NY: Routledge/Taylor & Francis Group.

11 Brown, Brené. *Daring Greatly: How the Courage to be Vulnerable Transforms the Way We Live, Love, Parent and Lead*. Penguin Random House, 2015.

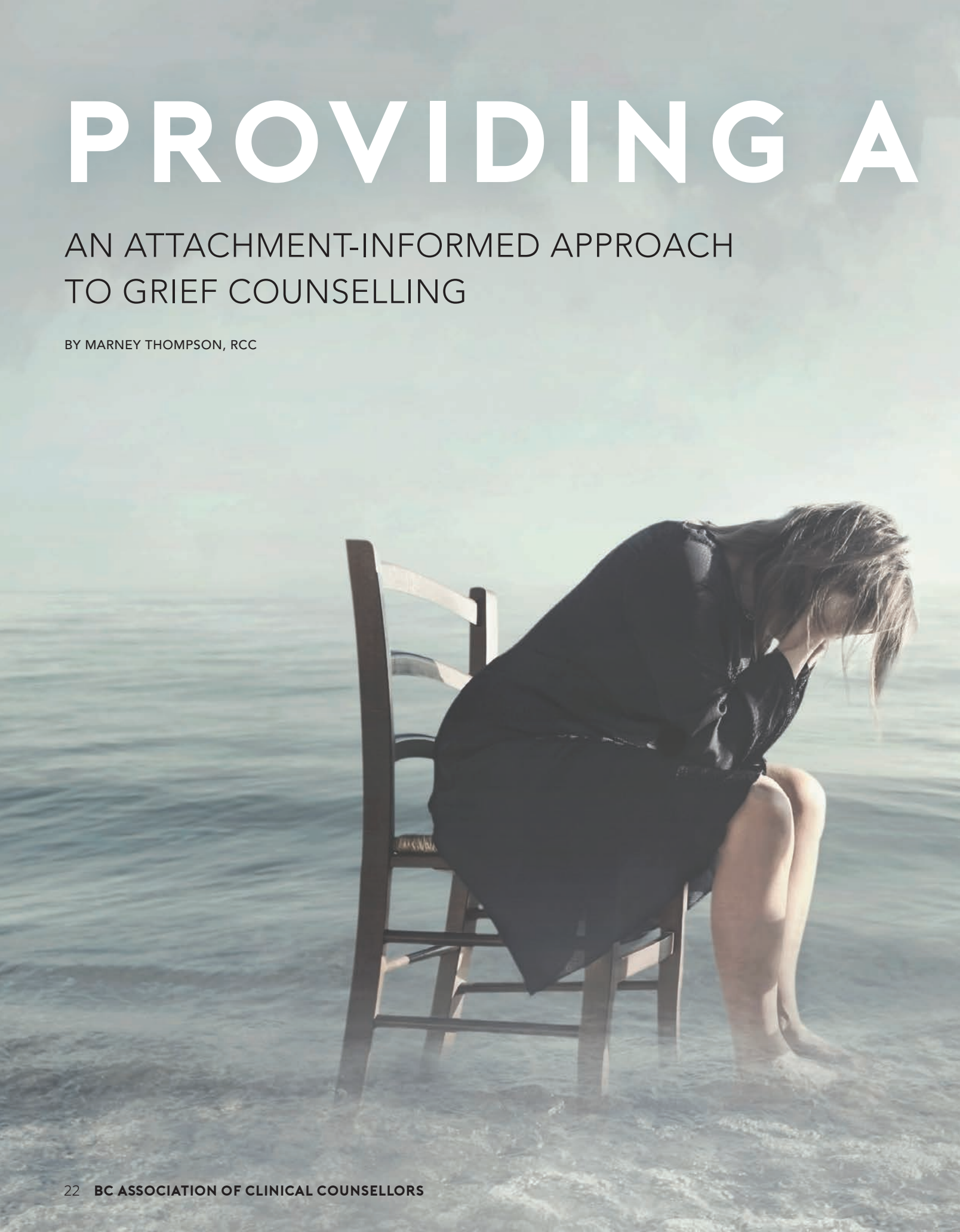
12 N.N. Mahajan, D.A. Turnbull, M.J. Davies, U.N. Jindal, N.E. Briggs, J.E. Taplin, J.E. Adjustment to infertility: the role of intrapersonal and interpersonal resources/vulnerabilities. *Human Reproduction*, Vol.24, No.4, pp. 906–912, 2009. http://doi.org/10.1093/humrep/den462

13 Masoumi Seyedeh Zahra, Garousian Maryam, Khani Somayeh, Oliaei Seyedeh Reyhaneh, Shayan Arezoo. Comparison of Quality of Life, Sexual Satisfaction and Marital Satisfaction between Fertile and Infertile Couples. *Int J Fertil Steril.* 2016; 10(3): 290-296.

PROVIDING A

AN ATTACHMENT-INFORMED APPROACH TO GRIEF COUNSELLING

BY MARNEY THOMPSON, RCC



SAFE HAVEN

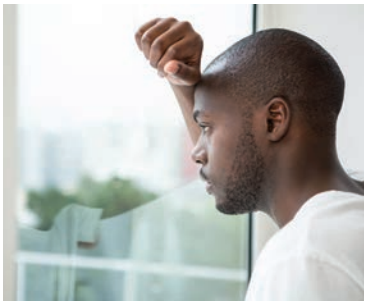
John Bowlby's pioneering work on human attachment is often referenced as a foundation for understanding bereavement.[1] However, empirical research linking his understanding of human attachment to grief counselling has been limited until recently. As our knowledge and understanding about grief and bereavement grow, risk factors and complications in grief are being re-examined through the lens of attachment theory.[2]

BEREAVEMENT AND THE GRIEF PROCESS

Bereavement, which is most often defined as the state of having lost someone to death,[3] can be one of life's most difficult experiences. Grief is our natural and normal response to bereavement and actually helps us learn to live without the person who has died. To varying degrees, grief typically impacts all or most areas of our lives, including our thoughts and feelings, relationships and social activities, daily habits and routines, beliefs and values, and our physical and emotional health.[4] Early in the grieving process, when separation distress is at its peak, we may be:

- preoccupied with thoughts of the deceased person and/or the death,
- yearning and longing intensely for the person who died and searching for ways to feel connected to them,

Bereavement is not about "getting over" a loss but rather about learning how to reconstruct our lives in ways that accommodate it.



Grief typically impacts all or most areas of our lives, including our thoughts and feelings, relationships and social activities, daily habits and routines, beliefs and values, and our physical and emotional health.

- experiencing a variety of persistent and/or overwhelming emotions, and
- inclined to withdraw from our usual interests, social activities, daily routines and habits.

Bereavement, by its nature, disrupts the grieving person's attachment to the person who has died. During early grief (sometimes called acute grief), painful thoughts and feelings serve to help us begin to adapt to life after loss. The distress and disruption we feel in early grief drive us to want to feel better. The yearning and preoccupation we experience compel us to find ways to restore or recreate our connection with the person who died. Since it is difficult to wholly participate in life when we are in deep pain, we instinctively begin to discover ways to ease our suffering, oftentimes without fully realizing it's happening. It may be that, as time passes, we find ourselves more open to reminders of the person who died and capable of reminiscing without so much of the rawness and disruption of early grief. As the turmoil and longing of early grief begin to lighten, we also begin to develop new ways to feel love and find comfort through a continuing bond with the person who died. We begin to understand that, although the person has died, our relationship with them hasn't.

Bereavement is not about "getting over" a loss but rather about learning how to reconstruct our lives in ways

THE ROLE OF ATTACHMENT FIGURES

As human beings, we are hardwired to seek out and form attachments with other people. Over the course of our lifespan, this bio-behavioural drive leads us to form and maintain relationships with parents, friends, romantic partners, children, coaches, teachers, and professional caregivers. This is the essential purpose of the human attachment system, and its most primary function is to keep us alive. It compels us as infants to prefer to be physically close to our caregivers and to become distressed and to protest whenever they are out of reach or sight. In adulthood, the purpose of attachment relationships expands to fulfill not only our need to be comforted and to feel secure but also our need to provide comfort and security to those we are close to.

The attachment system, and the close relationships it motivates us to form, plays a very important role in helping to regulate our psychological and physiological functioning.[5] Our sense of safety in the world, our ability to self-soothe, and our readiness to take risks and explore new things are dependent on the relationships we form. Attachment figures that are reliably available and sensitive to our needs as children promote a sense of security and satisfaction in ourselves, others, the world and our place in it, as well as the confidence to freely explore our environments with curiosity.[6]

However, what happens when our early and later life attachments aren't a source of safety and security? When infants and children grow up with caregivers who aren't reliably able to attend and respond to their needs, their relationships with themselves and others are often negatively impacted. One of the possible consequences is the development of an insecure attachment style that continues into adulthood. Often, this will mean they are less able to navigate the normal stresses and trials of life and may have difficulty trusting and bonding with others.

People with a preoccupied (sometimes referred to as anxious) attachment style tend to have low self-esteem, often process their experiences primarily through their emotions, and need extra reassurance and control in their relationships.

People with a dismissing (also referred to as avoidant) attachment style tend to have an overly positive view of themselves, yet avoid activities that stimulate emotion and vulnerability and may seem aloof and detached or choose not to engage in close relationships.

People with a fearful attachment style tend to be self-critical and depressed, chronically vulnerable, and passive and exploitable in relationships. Any of these disruptions in interpersonal relationships can create additional difficulties and complications for a grieving person.

that accommodate it. A part of us may always miss the person or people we've lost and, as a result, in some ways, we will continue to grieve. It may be helpful to understand that the goal of grieving isn't for it to be over, but rather for our grief to transform from the all-encompassing, sharp, and disabling nature of early grief to an ongoing but much more transient and gentle presence we will learn to carry through the rest of our lives.

Many years ago, J. William Worden, founder of the Association for Death Education and Counselling, proposed the four tasks of mourning as follows:

1} to acknowledge the reality of the loss,

2} to process the pain of grief,

3} to adjust to the world without the deceased, and

4} to form an enduring connection with the deceased, while embarking on a new life.[7]

Margaret Stroebe and Henk Schut, creators of the Dual Process Model of Grief, posit that there are two central features of the grief process: loss orientation and restoration orientation.[8] Loss orientation involves the bereaved person's activities related to the loss, such as crying, mourning, and reminiscing and reflecting on the deceased and the death. Restoration orientation involves activities related to ongoing life, such as revising old and forming new relationships and re-engaging with work and other routines and interests. These authors suggest that what is most essential about these two areas of grief is not that the bereaved person spend equal time and energy in each, but rather that they are able to oscillate between the two as circumstances permit.

Katherine Shear, whose research and clinical work focus on complicated grief, built on these frameworks to describe grief as a natural healing process: one in which the bereaved person confronts the reality and consequences of the loss, learns to manage the resulting thoughts and feelings, re-establishes an enduring bond with the person who died, and

When infants and children grow up with caregivers who aren't reliably able to attend and respond to their needs, their relationships with themselves and others are often negatively impacted.

recovers the possibility of a life with joy, meaning, and purpose.[9] Through this natural healing process, the bereaved person shifts from a state of acute grief immediately following the death, to a state of integrated grief, where the bereaved person is able to live with the loss and engage wholly with life.

AN ATTACHMENT-INFORMED APPROACH TO GRIEF COUNSELLING

Secure attachment relationships provide us with a way to receive and express love and a much-needed safe haven and secure base from which we can confront challenges and explore the world. Thus, the loss of an attachment relationship signals the loss of an important psychological and physiological regulatory mechanism.[10]

The death of an attachment figure, at any point in our lifespan, presents a significant injury to our attachment system and poses a threat to our sense of security and safety, increases our vulnerability, and limits our capacity to engage with new and novel relationships, activities, and interests. Much as an infant separated from a primary caregiver experiences separation distress, when someone we love dies, we also naturally experience stress, disruption, and dysregulation. The degree, intensity, and duration of this distress are important considerations when assessing grief as these responses exist along a wide continuum and may be quite normal in early grief.

In their study of continuing bonds and complicated grief, Nigel P. Field and Charles Filanosky describe how in the initial aftermath of loss, the attachment system doesn't register that the death is irrevocable, and so the bereaved person instinctively engages in behaviour aimed at re-establishing real or even symbolic proximity.[11] This understanding of the attachment system's natural resistance to the permanence of death helps to explain how, often in the early days after the loss, the bereaved person is drawn to the deceased's belongings, or to where they were last together, or even to where the person died. We despair at the separation, are seeking reunion, and are not yet able to comprehend the full reality of the death.

Even into adulthood, the loss of an attachment figure may trigger high separation anxiety and distress, a factor known to be correlated with complicated grief.[12] When working with insecurely attached bereaved people, a counsellor must support and guide them to develop flexibility in their attention to the loss. An anxiously attached person is likely to have difficulty shifting their attention away from the loss. They often spend all or most of their time and energy thinking about the person who died and the death; this prevents them from focusing on restoration-related activities to help recreate a sense of purpose and meaning to their lives. An avoidantly attached person often has difficulty confronting the loss and may focus their time and energy on keeping busy and distracted; this interferes with loss-related activities to help them process painful thoughts and feelings. Failure to attend flexibly to both loss and restoration typically disrupts the grief process and prevents the shift from acute to integrated grief. Counsellors who work with bereaved people must understand the

Our sense of safety in the world, our ability to self-soothe, and our readiness to take risks and explore new things are dependent on the relationships we form.

intermingling and interdependence of attachment styles, the grief response and process, and the inevitable vulnerability elicited by experiences of loss and death. Kosminsky and Jordan define grief therapy as: "… a concentrated form of empathically attuned and skillfully applied social support, in which the therapist helps the client re-regulate after a significant loss by serving as a transitional attachment figure. This includes addressing deficits in affect regulation and mentalizing related to the loss at hand, and early neglect or trauma."[13]

The role of the grief counsellor is to provide a safe haven, where clients can learn to experience and tolerate their feelings of grief, reframe how they think about the loss and their future, and envision a future that includes meaningful relationships and life experiences. Knowledge and consideration of attachment styles can assist grief counsellors as they work to support clients who are navigating this important life transition. ■

Marney Thompson, RCC, trained at Columbia University's Centre for Complicated Grief. She also co-authored an award-winning book, Transitions in Dying and Bereavement: A Psychosocial Guide for Hospice and Palliative Care.

REFERENCES

1 Bowlby, John. The making and breaking of affectional bonds: I. Aetiology and psychopathology in the light of attachment theory. *The British Journal of Psychiatry*, 130, no. 3 (1977): 201-210.

2 Meier, Adrienne M., Drew R. Carr, Joseph M. Currier, and Robert A. Neimeyer. Attachment anxiety and avoidance in coping with bereavement: Two studies. *Journal of Social and Clinical Psychology*, 32, no. 3 (2013): 315-334.

3 People may also experience grief for reasons other than death of a person including chronic illness such as dementia, missing persons, or the death of a pet.

4 Victoria Hospice, M. Thompson, and W. Wainwright. *Transitions in dying and bereavement*, 2nd Ed. Health Professions Press Inc.,2017.

5 Hicks, Angela M., and Lisa M. Diamond. Don't go to bed angry: Attachment, conflict, and affective and physiological reactivity. *Personal Relationships*, 18, no. 2 (2011): 266-284.

6 Mikulincer, Mario, Phillip R. Shaver, Yael Sapir-Lavid, and Neta Avihou-Kanza. What's inside the minds of securely and insecurely attached people? The secure-base script and its associations with attachment-style dimensions. *Journal of Personality and Social Psychology*, 97, no. 4 (2009): 615.

7 Worden, J. William. *Grief counseling and grief therapy: A handbook for the mental health practitioner.* Springer Publishing Company, 2018.

8 Stroebe, Margaret, and Henk Schut. The dual process model of coping with bereavement: A decade on. *OMEGA-Journal of Death and Dying*, 61, no. 4 (2010): 273-289.

9 Shear, Katherine, and Harry Shair. Attachment, loss, and complicated grief. *Developmental Psychobiology: The Journal of the International Society for Developmental Psychobiology*, 47, no. 3 (2005): 253-267.

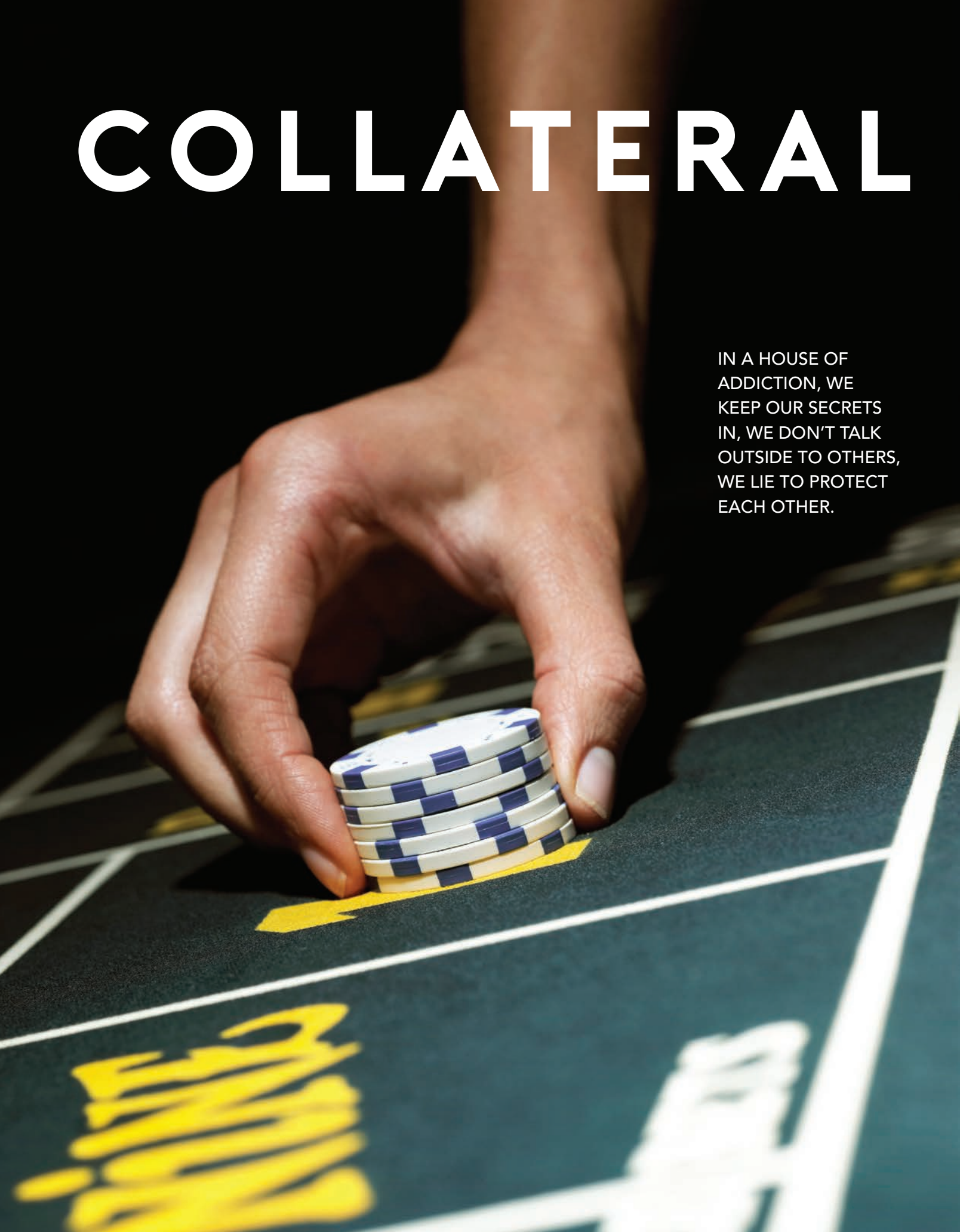
10 Shear, Katherine. *Presentation 1: Introduction – CGT Clinician as Sherpa Guide.* PowerPoint, Center for Complicated Grief, School of Social Work, Columbia University, May 10, 2013.

11 Field, Nigel P., and Charles Filanosky. Continuing bonds, risk factors for complicated grief, and adjustment to bereavement. *Death Studies*, 34, no. 1 (2009): 1-29.

12 Gesi, Camilla, Claudia Carmassi, Katherine M. Shear, Theresa Schwartz, Angela Ghesquiere, Julie Khaler, and Liliana Dell'Osso. Adult separation anxiety disorder in complicated grief: an exploratory study on frequency and correlates. *Comprehensive Psychiatry*, 72 (2017): 6-12.

13 Kosminsky, Phyllis S., and John R. Jordan. *Attachment-informed grief therapy: The clinician's guide to foundations and applications.* Routledge, 2016. p.100.

COLLATERAL



IN A HOUSE OF ADDICTION, WE KEEP OUR SECRETS IN, WE DON'T TALK OUTSIDE TO OTHERS, WE LIE TO PROTECT EACH OTHER.

DAMAGE

Common pitfalls of working with the families of people with addictions

BY CAROLYN CAMILLERI

From her practice based in Surrey and Langley, Kuldip Gill, RCC, helps her clients manage behaviours related to gambling, as well as alcohol and drug addiction. She also works with the family members of people with addictions — oftentimes, people who come desperately seeking guidance and resources to help a loved one. Here, she discusses four of the most common pitfalls of working with people who are trying to help someone else.

MISDIRECTED ATTENTION

For family members of people with addictions, many of the struggles they face relate to trying to find ways to make a difference in the lives of their loved one. They want to help their loved one, and they come seeking ideas for programs and resources — ways to "fix" the addiction. It doesn't work that way.

"The biggest pitfall for a counsellor is to go into that mode with them," says Gill, explaining that, while the family member's efforts may be well intended, they are trying to influence something they can't control. "I use the analogy that before we can help others, we have to help ourselves, and I bring the focus back onto themselves, because that's the where the most power and control is — when they're in your office, you want to focus on them and how they could help themselves."

Family members often feel the crisis is outside of themselves and generally fall into one of two ways of thinking:

1} *"I don't have a problem — they are the problem, so they need to get fixed. I don't even know why I'm here."*

2} *"I'm only here because I want them to change, and then our lives will be better."*

"In both scenarios, we spend a lot of time fleshing out what we can really do in that room, particularly if the other person is not with us," she says, explaining that she draws on some of the principles of AA and AL Anon. "We talk about the addiction as something that's out of their control — something their loved one has to be able reach within their own realm. We talk about feeling powerless and the frustration and desperation that come with it."

It may not be easy for people to shift their thinking, but it is important they do or it may lead them to behave in ways that actually worsen the situation.

"In my practice, I work with a BC Responsible and Problem Gambling Program, so I have a lot of gambling clients who can access our services for free. That means their loved ones can also access our services for free," she says. "There might be financial stress, there might be a relationship breakdown and no trust, and I try to get them to go there first, because if we focus too much on the addicted person and trying to change that behaviour, we are running on a treadmill. We use up a lot of energy, but we're not getting anywhere."

IF WE FOCUS TOO MUCH ON THE ADDICTED PERSON AND TRYING TO CHANGE THAT BEHAVIOUR, WE ARE RUNNING ON A TREADMILL. WE USE UP A LOT OF ENERGY, BUT WE'RE NOT GETTING ANYWHERE.

In order for them to make a difference within their environment, they have to make a difference within themselves.

NOT RECOGNIZING THE INFLUENCE OF CULTURE

A typical behaviour Gill sees is family members trying to control the person with the addiction, whether that means controlling finances or some other area of their life, which often leads to increased stress and conflict. Instead, Gill focuses on setting boundaries, because boundaries give them a way to control their environment to a certain extent.

The first boundaries are around safety. If there is any sort of violence in the house, she says, strong boundaries need to be established. Sometimes people are afraid to call the police, she says, and so it is important for them to understand safety precautions. Because Gill often works with gambling, she also

helps her clients take precautions to stay financially safe.

"I use the words 'protecting our money' because in gambling addictions, for example, the addiction quite often won't stop until the money has run out, and that could put loved ones in risky situations, like losing their life savings," says Gill. "So we talk about setting boundaries to protect that and getting professional legal or financial support or I help the client make decisions regarding that."

"As a counsellor, I hold a standard when it comes to risk issues, and so boundaries regarding safety issues is where I do guide my clients," says Gill.

However, beyond financial and physical safety, she lets her clients decide where they want their boundaries to go — and this is another potential pitfall for counsellors.

"I work from a cultural perspective, so I am completely aware that everyone has their comfort level they're familiar with, and I really hesitate on the 'shoulds and shouldn'ts,'" says Gill. "I ask, 'Within a safe environment, what are you most comfortable with? What keeps you up at night? What's your biggest fear?' And most people will say, 'I don't want to lose my loved one.' And so we have to work out how to create a safe boundary, so they don't feel like they're losing their loved one, but at the same time, they're not getting into an enabling relationship."

Those client-chosen "non-negotiables" may be influenced by culture, which counsellors need to be prepared for and be aware of potential bias. Moreover, Gill notes, sometimes, family members will hide risks out of fear or shame or worry that their loved one will be in more trouble.

"In the earlier parts of counselling sessions with loved ones or in family sessions, I usually start the conversation with what a house of addiction looks like," she says. "In a house of addiction, we keep our secrets in, we don't talk to others, we lie to protect each other."

She contrasts that with what the clients perceive to be a house of recovery, which usually includes healthy communication and no deceit or violence.

SOMETIMES, IT BECOMES APPARENT THAT THE ADDICTIVE BEHAVIOUR IS ROOTED IN A FAMILY DYNAMIC OR FAMILY-RELATED TRAUMA.

"Another analogy I use with clients is that in a house of addiction, even though it's our loved one who's sick — who has the addiction — it's kind of contagious and it makes us all sick. But we might have different symptoms: I might start suffering depression or anxiety because of the addiction," says Gill. "I help people to understand we are all healing and getting better. We are all changing to make the house stronger."

MOVING INTO SECONDARY TREATMENT TOO QUICKLY

Sometimes, it becomes apparent that the addictive behaviour is rooted in a family dynamic or family-related trauma. To manage this, Gill says she uses the idea of primary treatment versus secondary treatment.

"A primary treatment helps the client or family identify the house of addiction versus the house of recovery and then take steps to modify or change that behaviour, so it's no longer causing harm," she says. "Once we are successful in the changes we want to make, such as abstinence or harm reduction, then we may start looking at the layer underneath the behaviour — what might have been causing some of this behaviour and what we were trying to cover up."

Gill compares it to lifting a carpet — the carpet is the addiction. Once it is removed, the issues underneath are revealed to the counsellor and to the clients. However, she stresses caution when focusing on this secondary level of treatment.

"Because of the stress of uncovering some of that secondary stuff, and if they haven't developed strong coping mechanisms and strong supports, you could pull them back, and that's sometimes the cycle that comes with addiction," says Gill. "Instead, it's really about being able to honour that there's a dynamic or an energy that was influencing the whole house. What we're trying to do is get new, healthier coping mechanisms, because the way we were coping before wasn't helping — it was making it all worse."

Moving too quickly into secondary treatment may be tempting for clients and for counsellors because it can lead to all sorts of conversations.

"Sometimes counsellors think, 'Oh, well, addiction work, isn't it repetitive or all kind of the same?' and with primary treatment, yes, the steps for the counsellor and the client are quite similar — we have to accomplish some things before we can get to secondary treatment," says Gill. "But secondary treatment can be a vast, diverse array

of conversations, and you end up having grief conversations, trust, marriage, family aversion, mental health issues that were perhaps never treated or diagnosed, and we have such rich, long-term conversations — *if* the client is able to continue with the abstinence or the recovery they've started."

But first, there has to be a very strong foothold in primary treatment.

UNDERESTIMATING SUPPORT NEEDED FOR FAMILIES

Part of what Gill does is educate family members on addiction. "Education — and listening with compassion — is such a huge part of it because addiction can cause so much harm, and anger and resentment can be some of the primary feelings, and they come out so easily."

"And I do try to depersonalize it for loved ones, because loved ones fall into that pitfall of, 'He's doing it me, he cheated on me, he stole my money, my kids are going to be in a broken home because of him and his inability to change,'" says Gill. "I try to take away that language to help family members understand that the person with the addiction is not wanting any of this either, and their intention is not to cause this much harm."

With gambling, the intention may be to fix problems: "If I win, I'll solve all the problems."

"I try to help give them some level of education so we can shift some of that resentment and anger, and maybe start to listen with compassion," she says.

Another part of the education is helping people become more aware of resources available to them. While, oftentimes, it is a crisis that brings family members into counselling, Gill says, in many cases, family members don't realize they can access services and get help for themselves, whether their loved one is ready for change or not. People may think they have to wait for loved ones to go into counselling first. A better scenario for family members is to acknowledge needing help and to seek support for themselves.

"Usually the person who has the addiction, they're the ones going into treatment, so they're the ones getting 50 hours, sometimes six to eight weeks or more of intensive treatment, and the family member might get a weekend," says Gill. "What I try to encourage them to understand is that they are all healing, so if their loved one is in treatment, then they should also be 'in treatment.'"

What does that look like?

"Making sure they have their own counsellor who is working with them on their own issues that have been impacted by the addiction," she says. "And I encourage them to go into community programs, such as AL Anon and Narc Anon and peer support groups."

Family members can't listen to their loved ones with compassion, if they don't engage in some compassion for themselves — and that means self-care.

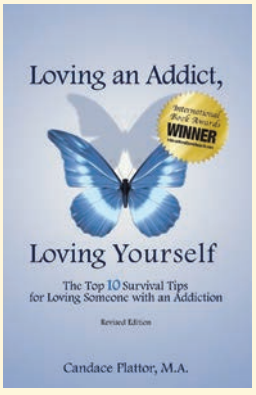
"Whatever that self-care looks like: talking and finally being able to hear everyone's stories, or being able to give ourselves permission to start exercise programs, start meditation, start cooking classes — things that we've always put on the back burner because we were so focused on helping our loved one," says Gill. "All of that stuff is so important, and family members underestimate how that will help the loved one. They almost hold their breath and say, 'Everything's going to be fine, once he comes out of treatment.'"

"But I want to encourage them to say, 'We are going to increase the chances of this being successful, so we are also getting better, while they're getting better.'" ■

RECOMMENDED READING

Parenting an Addicted Child

is an article Ross Laird, RCC, wrote about a parent who attended a public presentation on addictions. Ross's observations of the parent — their behaviour and fears — as well as the story of the family and the child provide a poignant and insightful perspective on the predicament faced by families. Read it at: www.rosslaird.com/addictions/consulting/2017/03/20/parenting-an-addicted-child/



Loving An Addict, Loving Yourself: The Top Ten Survival Tips

by Candace Plattor, RCC (Being at Choice Consultants, 2011). "I usually include this book in one of my initial conversations with all my clients, because I feel like it's a great way for clients to get into the frame of mind of helping themselves first," says Gill.

Kuldip Gill, M.Ed., RCC, is in private practice at Kuldip Counselling and Consulting, where she specializes in addictions and also works with clients in the areas of divorce, parenting, mental health, and workplace issues. She offers services in English and Punjabi. www.kuldipcounselling.com

FLIPPING THE SCRIPT

BEING PROACTIVE ABOUT RACE EQUITY

Dr. Lisa Gunderson, RCC, is an award-winning educator and equity consultant for families and educational and organizational institutions. www.oneloveconsulting.com

For 20 years, Dr. Lisa Gunderson, RCC, has focused on multicultural issues for racialized populations. She received her Ph.D. in clinical psychology from the University of Southern California and, prior to immigrating to Canada seven years ago, she was a tenured professor of psychology and licensed psychologist. Currently, she lives in Victoria, where she works as a counsellor and intern supervisor at ŁÁU, WELNEW Elementary School, an associate program director in the Master of Counselling program at CityU Seattle in Victoria, and an equity consultant in private practice, with a focus on implicit bias and racial education.

When she did her clinical work, she was the only clinician for clients who wanted an "ethnic" counsellor. "Thankfully my university allowed me to work in different communities as opposed to just staying on campus," she says. Her Los Angeles location gave her considerable experience with Latino and African American people; to round out her experience to include Asian Americans and Pacific Islanders, she did a year's residency in Hawaii. Her continued work with minoritized communities led to teaching the psychology of minorities.

"The transracial adoption piece was somewhat accidental," says Gunderson. "When we came to Victoria, I happened to have a friend who was part of an organization that hosted a camp called Harambee in Sorrento for people raising children of African descent — the teens call it 'Black Camp.' A large majority of the parents were transracial adoptive parents."

> A LOT OF PARENTS WORRY ABOUT THE ENVIRONMENT THEY ARE RAISING THEIR CHILDREN IN.

An adoption agency contacted her, which led to a two-part Dear Abby-type series on racial identity, followed by a webinar and workshops for parents, youth, and children — and it kept going from there. So while it has all led to involvement in the transracial adoption community, her focus within it is retaining and supporting racial and ethnic identity.

What led you to counselling and, specifically, to minoritized populations?

I was always curious why people acted a certain way towards other people based on race. When I went into graduate school, I actually wrote that my specialty area was going to be childhood sexual abuse. But in my first year of grad school, I would ask questions like, "What's the information on people of African descent?" and "What about Latinos?" There was just this dearth of literature on people who looked like me.

I joke with my friends who are of minoritized groupings: No matter what program we were in at the time, we all went in with certain ideas of what we wanted to do, but we realized very quickly that nobody's talking about people like us. As the only ones in our program, we realized if we don't do that work, nobody will. My qualifying exam looked at creating a healthy African-American identity, and it was based on this idea of how resilient of a group we were in the United States: considering all the things that had happened to us, we're still around and thriving. My dissertation looked at the validity of the MMPI* and MMPI-A in African-American adolescents.

** Minnesota Multiphasic Personality Inventory*

What do you focus on in your workshops?

Basically, I facilitate this idea of "You're not alone." That's where their strength comes from — realizing they're not alone. There are other people like them. For many of the parents, as soon as they adopted their child, they became a minoritized family and for many of them, they don't know what that means. They get shocked, usually around school age, because before that, they have an infant and they're just loving that infant. It's not until usually school where it kicks in that, "Oh, there is a meaningful racial difference" or "There is an ethnic difference." I'm all about trying to make sure I answer what people are interested in as opposed to what I think they're interested in.

What do the kids want to know?

"If I'm growing up in White space does that mean I'm not really Black? What does it mean to be Black?" My goal is to make sure they feel comfortable looking in the mirror and know when they're 20, 25, if they want to walk into a Sista group — typically, a group of other Black or racialized women — they absolutely should, and they have every right to be there. It's really important for them to feel that connection.

A lot of focus is on how to respond to negative racial incidences and biases in their regular lives. Part of that is a skill set they need to learn. But another piece is, sometimes, they may feel they can't share that with their parents because their parents won't "get it." For example, if they're with a group of friends who are rapping and using the "N" word: how do they deal with that? Kids getting pulled over by cops or followed in stores: how do they deal with that? Part of the answer is there are times when they have to bring in their parents: how do they engage in that conversation?

Then there are the unconscious messages in the media and the bias. Understanding micro-aggressions. We also focus a bit on history and on racial ethnic identity models. Just trying to make sense of what this identity thing means for them and having a safe space for that conversation.

What do the parents want to know?

For parents, school is a big focus. For example, if their kid is dealing with something and they're getting pushback from the principal or teacher.

When do they intervene with their child and when do they leave it alone? When should they try hard not to exercise certain privileges? Part of it for parents is trying to separate their own feelings of upset and anger at systems versus what's happening with their child. Sometimes parents kind of go overboard where they have such a focus on trying to retain the child's ethnic space that they forget their own; especially if they have White siblings in the home, that becomes a really important component. Some parents adopted their children without a really good lens on what that meant. A lot of parents feel they don't have resources, and depending on their circle of friends, their friends may not be helpful. Some parents are trying to build a network and face challenges stepping into a minoritized community. And a lot of parents worry about the environment they are raising their children in.

What's a key message for parents, teachers, counsellors — everyone?

One of the points I really slam home to the parents, and I do this with teachers as well, is getting rid of this idea of being "colour blind" — this idea that, "We're all just humans and I just see students." You can't do that. It is not psychologically sound. That's just a dangerous thing. But this idea of colour equity is more important. It's really important for people to understand what that means. Colour equity is acknowledging our differences, not pathologizing them or asking us to pretend they don't matter, and still treating us fairly and equitably.

What needs to change in how people think and behave?

When people find out I'm from the States, they ask, "Aren't we better here in Canada? Don't you feel better here?" If I don't get that question once a week…. You can't define being Canadian as not being American. You can't compare yourself to a country with such a vastly different history. What you have to ask yourself is what are you doing about the racism here? Because it's here. It's more passive aggressive. And so if it is a little less racist here, does that make the person who's experiencing the racism feel it's little less racist here? When it happens to them, do they say, "Wow, so glad I'm not in the States!"? No.

We have to not be afraid to have conversations around racism, bias, and equity now. We need to reverse that ideology that the only time we need to be proactive is when a crisis occurs. We don't want to wait until a crisis. We have to flip the script.

MY GOAL IS TO MAKE SURE THEY FEEL COMFORTABLE LOOKING IN THE MIRROR AND KNOW WHEN THEY'RE 20, 25, IF THEY WANT TO WALK INTO A SISTA GROUP, THEY ABSOLUTELY SHOULD, AND THEY HAVE EVERY RIGHT TO BE THERE.

Final thoughts?

You know, at the end of the day, I can't help but feel positive about everything and optimistic, despite all these issues that are daunting and maybe sad. It gets exhausting, yes. But when we know and understand our history — especially those of us from a minoritized community, whether it's sexual orientation or persons with disabilities or race or ethnicity — we recognize that all of us have points in time where people tried to destroy us and made up all sorts of stories about us. And yet we're still here. Think about, in my case, the history of being enslaved. There were people who fought for my right to be here, knowing they'd never see that. Even as a woman, to vote — there were women who died for us to do that, knowing they'd never see it. They just had the idea of it. We forget that the seeds were sown for hundreds of years before. We're doing the same thing. We may not see the outcome of it, but you have to know you're doing the right thing. Equity and honouring our differences can never be wrong. ■

BCACC'S NEW INTEGRATED BYLAWS

As of June 29, 2018, BCACC's new integrated bylaws went into effect, setting the course for a more focused pathway for the association and its members.

"We are at the beginning of an implementation process," says Carolyn Fast, BCACC's Executive Director. "Part of that implementation is to develop further the policies and practices that go along with the implementation of the bylaws."

Getting to this implementation stage has taken tremendous time and effort. The revision process began in 2014 and was initiated to ensure continued relevancy and to ensure processes are as efficient as possible. The new bylaws are the accumulated work of member delegations supported by experts in communications, facilitation, and law, as well as a transition team and the many RCCs who participated in reviewing and discussing revisions.

To clearly understand the reasoning behind the new bylaws, you need to look back even farther than 2014. The original bylaws were created in 1988 and modelled from the Social Workers Society.

"The social workers at that time were very similar to BCACC, in that they were not governed by statute, but they were self-regulating," says Glen Grigg, RCC, Chair of FACTBC.

A decade later, in 1998, the bylaws were revised to clarify the two purposes of the BCACC: to serve as a membership and to protect the public.

"In order to protect the public, we were actively advocating — as we are still — for a college of counselling therapists," says Grigg. "Part of that advocacy was to

create, essentially, a process parallel to what a college under the Health Professions Act would look like in order to demonstrate the administrative and practical competence of this profession to function like a regulated profession."

In other words, aspects of the 1998 bylaws were developed so BCACC could be a kind of "shadow college," proving that not only could it run as a college, but also that it should. However, professional colleges must be mandated by the government, and despite BCACC's advocacy efforts, by 2014, there was still no college. Moreover, BCACC's dual purpose — serving the membership and serving the public — had become a double bind of conflicting interests.

In March 2014, FACTBC — Federation of Associations for Counselling Therapy in BC — was established to reduce that conflict and redouble advocacy efforts for the creation of a college as a means of protecting the public.

"That meant that advocacy for the public could be undertaken by BCACC by supporting FACTBC, and it meant that the association was no longer in so much of a double bind," says Grigg. "The creation of FACTBC did not eliminate but it substantially reduced the inherent conflict of interest."

It's a tremendous statement that this group of professionals has agreed to function as a voluntarily self-regulating association, because they want the best for the profession, and they want the best for their clients and the safest practice.

FACTBC serves public interests — specifically, by pointing out to government that without a college, the public is not protected — while BCACC can continue to serve member interests and protect members' clients. The new bylaws support the separation of those interests by moving BCACC away from general protection of the public and reinforcing the contract with the members to uphold a code of ethics and a standard of practice.

"We recognize that BCACC is not a regulator in the same sense as a legislated government-backed college," says Grigg. "Our powers to regulate are limited to the terms of a contract, and our new bylaws reflect that reality and limitation."

In addition to clarifying BCACC's purpose, the new bylaws also streamlined processes, including the process for amending bylaws.

"Often bylaws are created at annual general meetings," says Grigg. "Then, when they become contentious and before the courts, people say, 'Well, that wasn't a very well-attended meeting, and I don't think this is a valid bylaw.'"

Grigg explains that because it is a high-stakes process that can affect a counsellor's professional reputation and access to income, a more robust process for ratifying bylaws was needed, so they wouldn't be so readily subject to being dismissed, should there be any recourse to a civil process.

"Members will find that the bylaws give more power to committees to make policy, and that keeps the bylaws more streamlined, easier to read and interpret, and less cluttered with specifics," says Grigg. "It also makes the association more responsive and flexible when laws change or political context changes."

However, the new process does not make BCACC less accountable, because, like a bylaw, a policy is also a public document.

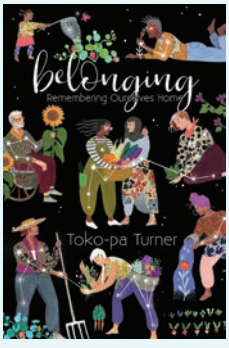
"There's a very explicit and rigorous accountability process — it's not like someone can just decide, 'I'm going to change this rule,'" says Grigg.

Fast says the new bylaws further strengthen member commitment and credibility.

"It's a tremendous statement that this group of professionals has agreed to function as a voluntarily self-regulating association, because they want the best for the profession, and they want the best for their clients and the safest practice," she says. "They voluntarily agree to follow the ethics, principles, and guidelines, and, if there is an inquiry, that member has agreed to be part of a process with their colleagues to reframe those situations, learn from them, and go forward with improved practice."

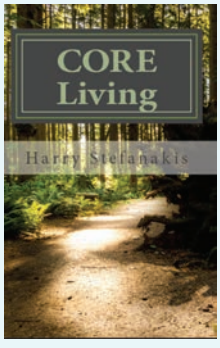
"It is the highest level of voluntary self-management they can do," she says. "Members make a major commitment, and it's to the credit of the association and all the members that they've signed on."

READING LIST FOR YOU AND YOUR CLIENTS



Belonging: Remembering Yourself Home

by Toko-pa Turner (Her Own Room Press, 2017) — Turner explores the origins of estrangement, how that alienation affects the choices we make as individuals and as a culture, and the skills to which we can apprentice ourselves to restore a sense of belonging in our lives.



Core Living: 8 Choices for Living Well

by Harry Stefanakis, Ph.D. (Create Space Independent Publishing) — Using stories, humour, and practical tips, Stefanakis, a Vancouver psychologist, explains why we get lost in life and how to find our way using eight choices to take charge of our lives, as well as strategies to overcome obstacles.

Aging in a healing and thriving community

BY NADIA STEFYN

Often overlooked and under supported, seniors in our society frequently fall through the cracks. Many older adults find themselves isolated for increasingly longer periods, as the loss of loved ones, mobility issues, fewer friends, reduced finances, or language skills begin to erode independence. Having lost those closest to them, seniors often yearn for both physical and emotional intimacy. On top of this, physical limitations can increase dependency on children — not just for getting around, but also for social connection.

A program run by Family Services of Greater Vancouver aims to help change that by supporting seniors in a meaningful way to fulfill social and emotional needs. Vital Connections is a free counselling program offering low-barrier emotional support for seniors dealing with loss, grief, anxiety, loneliness, and isolation among other challenges. The program helps seniors find new ways to continue living a purposeful and fulfilling life — for example, by understanding how to move on after the death of a loved one while still honouring their memory; learning how to develop new friendships to drive intellectual stimulation; and finding activities such as theatre or dance as an outlet for physical expression. The Vital Connections counsellor is also a senior and is, thus, better able to relate to client experiences.

A key factor in the success of the Vital Connections program is its location at Century House, one of Canada's first centres catering to adults aged 50+. It's a hive of activity year round, offering a vast range of free or low-cost social programs and clubs. Seniors can complement counselling sessions with myriad activities to counter isolation. These activities provide mental, emotional, and physical fulfillment and include games, dance and fitness classes, language skills classes, arts, and music. Fluid referrals are made between programs, enhancing effectiveness and creating a web of support under one roof.

One example of a connection-fostering activity at Century House is the Community Kitchens program. Once or twice per month, participants learn to cook a new meal and enjoy it together afterwards. Program manager Pat Steiner says that while the Community Kitchens program teaches valuable life skills, many participants come first and foremost for the social aspect.

Having a place to go each week to meet friends and make new ones has taken the pressure off his family relationships and given him a new sense of purpose.

"Community Kitchens is in an intimate setting, ideal for building connections among seniors whose paths may never cross otherwise," says Steiner. "Even seniors with limited English are able to connect through the universal language of food."

Steiner described one senior whose wife had passed, and he was struggling to fill his long days sitting at home. Like many seniors, he had come to rely on his family for social connection. As supportive as his children were, they were not enough to fill his social needs. He attended Community Kitchens and tapped into a strong and supportive social network. From there, he discovered a number of other programs at Century House, including computer skills classes. Having a place to go each week to meet friends and make new ones has taken the pressure off his family relationships and given him a new sense of purpose.

The interconnected programs at Century House are a great example of communities and organizations working together to facilitate independence and contribute to the quality of life for seniors.

"Many seniors end up becoming surrogates for each other, providing support and friendship," says Steiner. "As a society, we need to do a lot more to support seniors than we do."

Nadia Stefyn is the marketing and communications manager for Family Services of Greater Vancouver. fsgv.ca

COUNSELLING AND CULTURAL DIFFERENCES
During the Holidays

BY TRICIA TOTH

Canada is unique for its multicultural population and the varied backgrounds of its citizens. We are fortunate to live in such an inclusive country, where we have opportunities both personally and professionally to learn openly about each other and gain an appreciation for our diversity. Religious rituals, Indigenous practices, ethnic traditions, and communication methods — these diversities are especially magnified during the holiday season when many customs and beliefs are enriched and celebrated.

In order to maintain supportive and trusting relationships with our clients, as counsellors, we need to be considerate and respectful of cultural differences at all times of practice. It is especially important during the holidays for therapists to be cognizant of their own cultural perspectives and potential biases and be vigilant in recognizing and respecting variations. To establish a relationship that is respectful of cultural and traditional differences, counsellors can adopt several practices.

Research and learn about your client's culture.

It is the counsellor's responsibility to educate themself on how to best meet the needs of their clients. This includes learning about a client's presenting issue and cultural background outside of session time. It shows interest and respect, equips the therapist to address culturally relevant factors, and aides in identifying culturally specific supports and resources.

Use sensitivity when asking your client to describe their cultural practices.

Always ask your client if they are comfortable discussing and sharing this information. Be respectful if they choose not to share. Also, do not assume because a client is of a particular culture, that they share the same traditional practices of the culture as a whole. We are all unique.

Be non-judgmental and have an open mind while learning about the traditions and backgrounds of others.

Be aware of your own cultural values to ensure they do not create a bias or conflict. Be aware of your worldview and recognize that this view is subjective to your own upbringing and life experiences. Consider that you may even want to adopt some of your client's practices as your own family traditions.

Counselling with a multicultural approach is both beneficial to your clients and your practice. It allows you to enhance empathetic skills and gain a diverse awareness and respect for inclusion. When these skills are implemented in practice, we become more self-aware, and our client is better understood.

Tricia Toth, MSW, RCC, RSW, owns and operates Great Life Counselling. She works in the areas of trauma, addiction, and mental health, as well as supports individuals and families work through barriers. She is committed to assisting others to live their greatest life. For further information, go to www.greatlifecounselling.ca.

BCACC CONFERENCE 2019

WIRED TOGETHER: SELF, SCIENCE, SOCIETIES

NOV. 1, 2, 3, 2019 | RICHMOND, BC

This exciting conference brings together clinical counsellors and allied professionals for discussion and exchange of the most cutting-edge knowledge, insights, issues and ideas in the world of counselling therapy.

The BCACC Conference Organizing Committee invites submission of abstracts starting in January 2019.

ABSTRACT SUBMISSION GUIDE

The WIRED TOGETHER: Self, Science, Societies conference will offer a variety of oral presentations ranging from:

- **Parallel workshop sessions** - one and a half hours in length
- **Roundtable participation** – one and a half hours in length
- **Lightning talks** – five to ten minutes

All sessions are designed to be informative and interactive for participants and to promote dynamic discussion. The Organizing Committee encourages established professionals and students alike to engage and participate by presenting at the conference.

ABSTRACT SUBMISSION GUIDELINE REQUIREMENTS

- A presentation theme that most closely describes your oral presentation.
- Your contact name, affiliation/institution name (if applicable) and email address.
- An abstract title.
- The abstract summary content (150 – 250 words).

Individual Presentation Themes

The three main themes of the conference with examples of possible topics are as follows:

Self
- Self-care (the science of self-care)
- Clinical supervision
- Personal growth impacting practice
- Mind/body connection

Science
- Emerging and evidence-based practices with emphasis on neuroscience and brain development
- Somatic Psychotherapy
- Use of technology in counselling practice

Societies
- Informed Indigenous therapy
- Informed trauma therapy
- Gender and sexuality
- Cultural considerations in therapy
- Social justice (poverty, homelessness, disability awareness, racism, addiction)
- Harm reduction

SUBMISSION DEADLINES

The portal to submit an abstract will open on January 9, 2019 at www.bc-counsellors.org.
Deadline for submitting an oral presentation is March 6, 2019, 23:59 PDT

You are welcome to submit more than one abstract; however, presenters will be limited to one presentation at the conference.

WHY SHOULD YOU JOIN THE BCACC?

The BC Association of Clinical Counsellors offers the designation RCC (Registered Clinical Counsellor). This designation is one of the most recognized counselling designations in British Columbia and assists counsellors in demonstrating their professional validity. The RCC designation has become synonymous with professional accountability and adherence to high ethical standards in the counselling profession.

Be Recognized

- Professional recognition as an RCC
- Counsellor regulation and accountability
- Eligibility for further revenue streams (EAPs, WorkSafe, CVAP)
- Association advocacy for the development of the counselling profession
- Inclusion in a province-wide client referral system

Save Money

- Preferential rates on workshops and continuing education opportunities
- Affordable professional insurance packages
- Cost-effective advertising opportunities
- Member rates for hotel reservations and booking software

Grow Community

- Connection to the counselling community
- Ongoing peer support
- Annual networking opportunities
- Access to relevant ethical and legal information

BCACC

BC ASSOCIATION OF CLINICAL COUNSELLORS

CONTACT US FOR MORE INFORMATION **www.bc-counsellors.org** | **250-595-4448**