WINTER 2022

INSIGHTS

THE BC ASSOCIATION OF CLINICAL COUNSELLORS' MAGAZINE

BRIDGING THE GAP between chronic illness and mental health

BRAVE SPACES experiential approach to group counselling

ENDINGS AND NEW BEGINNINGS

Retiring gracefully, termination and closure, and why your private practice needs a business plan

CREATIVE INSURANCE SOLUTIONS

to better meet your needs

WE ARE PLEASED TO PROVIDE THE FOLLOWING INSURANCE SUMMARY TO BETTER PROTECT THE MEMBERS OF BCACC

- Policies start at $100 annually.
- Professional Liability (Errors & Omissions) and Commercial General Liability coverage will now start at $3,000,000. On renewal, any active member who currently has $2,000,000 will automatically be increased to $3,000,000 at the reduced cost. $5,000,000 option available with higher limits upon request.
- Employment Practices Wrongful Act Liability $250,000 limit included. Higher limits available upon request.
- DAS Legal Expense Insurance included for members who have purchased Professional Liability. The policy provides unlimited personal legal and tax protection advice. Simply call 1-877-255-4269 and provide your BCACC Legal Expense Insurance policy number GRP0016100. *$500 deductible applies to CRA tax audits ($10,000 max per claim).
- Policy pays the full cost of the legal defence up to the limit of liability selected. (Subject to sub-limits for the following: Abuse & Sexual Misconduct, Disciplinary Action, Penal Defence.)
- No deductible for any claim.
- No exclusion for Libel & Slander.
- Legal Entity coverage now includes up to three professionals on staff.
- Options available for clinics with more than three professionals. The additional cost for legal entities with up to 25 professionals is now $100.
- E-counselling is included in British Columbia and or any unregulated province.
- Security & Privacy Liability is included up to $100,000 per member – subject to a shared limit of $3,000,000 for all insured members.
- Cyber Liability available upon request.
- Employers Bodily Injury Liability Extension $2,000,000.
- Employee Benefits Errors & Omissions Insurance $1,000,000 .
- Commercial Property coverage available.
- Accidental Death & Dismemberment coverage available.
- Retiring members have the benefit of seven years reporting for claims during the time they were insured on the program.
- Coverage available for inactive members.
- Policy provides coverage for those services rendered by an INSURED member while acting within the scope of the INSURED'S duties as a Registered Clinical Counsellor or a Registered Clinical Counsellor-Approved Clinical Supervisor (RCC-ACS).

Founded in 1921, **Mitchell & Abbott** is built on relationships. With the client at the centre of all we do, we take a holistic approach to our service model.

As a Navacord Broker Partner, one of Canada's largest commercial brokers, **Mitchell & Abbott** offers increased sector expertise, expanded product offerings and stronger relationships with insurance companies. This means we're able to deliver a more diverse service offering, greater support, and more creative insurance solutions to better meet our clients' needs.

For any questions, please contact one of our team members at
800-463-5208

DAWN CARSON
dcarson@mitchellabbottgrp.com

DANICA DANCULOVIC
ddanculovic@mitchellabbottgrp.com

JOHN PAUL MITCHELL
jpmitchell@mitchellabbottgrp.com

A COMPLETE PROGRAM SUMMARY IS AVAILABLE ON THE BCACC AND MITCHELL & ABBOTT GROUP WEBSITES.

CONTENTS WINTER 2022

27 Bridging the gap
Understanding the intersection between mental health and chronic illness

FEATURES

8 STARTING A PRIVATE PRACTICE? START WITH A BUSINESS PLAN An interview with Constance Lynn Hummel about a frequently overlooked aspect of a successful business

11 BUILDING BRAVE SPACES An experiential approach to fostering community in group counselling

14 TERMINATION AND CLOSURE Ethical, clinical, and professional considerations for bringing therapeutic relationships to an end

20 BUILDING CONNECTIONS TO OURSELVES AND OTHERS Using Observed and Experiential Integration to help address trauma and facilitate self-knowledge

30 RETIRING GRACEFULLY Tips for reframing retirement as a way to leave behind the overwhelm and start a new journey

IN EVERY ISSUE

4 Plugged In Resources, information, and tools for your practice

7 Good to know News and information from BCACC

34 Member Profile
Dixie Black, RCC

37 Check it out Ideas to motivate and inspire

38 Before you go
5 autistic traits we would all benefit from embodying

INSIGHTS
THE BC ASSOCIATION OF CLINICAL COUNSELLORS' MAGAZINE

The Insights *team wishes to thank the writers who contributed to this edition of our magazine:*
Elysia Bronson, Audrey Cook, Renée Hock, Kerry Schroeder, Britta Regan West, Tricia-Kay Williams

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

109-1034 Johnson Street,
Victoria, BC V8V3N7
Tel: 250-595-4448
Fax: 250-595-2926
Toll Free in Canada: 1-800-909-6303
communications@bcacc.ca
bcacc.ca

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

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

Contributing Agency: Getty Images

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

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

Printed in Canada by Mitchell Press.

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.

ENDINGS AND NEW BEGINNINGS

Whether you are starting a private practice or retiring from one, you'll want to stay on top of administration tasks and standards of practice requirements.

NEW BUSINESS **NUTS AND BOLTS**

Anyone starting a new private practice has a lot to consider. Here are some of the critically important tasks to add to your business "to do" list.

ESTABLISH AN ONLINE PRESENCE OF SOME KIND: You don't necessarily need a website right off the bat — in fact, you should probably wait until you have a very clear picture of your vision and your practice. But you do need to be online somewhere, for example, in online counselling directories, such as BCACC's Find A Counsellor tool.

SET UP A WAY FOR PEOPLE TO CONTACT YOU: Because you may not have a website yet, consider using a dedicated Gmail address. Gmail is favoured over Yahoo and Hotmail, which may not be considered professional.

SET UP A WAY TO ACCEPT PAYMENTS: Designate a separate bank account and

decide how you will accept payments (i.e., cash, cheque, e-transfer). Credit cards are also possible but require set up with your bank. Keep careful track of payments for your tax records and set up a system for computer-produced receipts (such as Squareup.ca or Cliniko.com).

EDUCATE YOURSELF ABOUT GST: In general, once you have made $30,000 within any 12-month period, you have to collect and pay GST and you will need a GST number to do that. Go to www.canada.ca/en/revenue-agency/services/tax/businesses/topics/gst-hst-businesses.html for more information.

GET THE RIGHT INSURANCE: Appropriate insurance coverage for your practice is critically important and legally required. Mitchell and Abbott Insurance Brokers are the official insurers for BCACC and offer information and packages to members.

UNDERSTAND THE LEGAL AND ETHICAL CONSIDERATIONS: This may include registering a business name and getting a business licence, as well as a GST number (see above). You should also consider establishing a relationship with an RCC-ACS (Approved Clinical Supervisor), as well as seeking a supportive counselling community, for example within the BCACC.

DECIDE HOW YOU WANT TO SEE CLIENTS: Do you want to offer services online or in-person or both? If you want office space, avoid locking into a long-term lease until you have your practice running smoothly; consider instead hourly rentals or renting from a colleague or setting up a space in your home. If you choose online, check your computer set up and ensure you are following regulations concerning privacy, insurance, and intake agreements. BCACC has a *Remote Counselling Tools: Decision-Making Guide* (log into the BCACC Member Portal to view) but cannot recommend, endorse, or certify specific platforms.

5 STEPS TO TAKE WHEN YOU ARE RETIRING FROM PRACTICE

Retirement is an emotional time no matter how much planning you do. In the midst of it all, there are some important administration tasks you don't want to overlook.

1 Notify your professional association and insurance providers: Ask your professional association to verify the expected retirement process, and check with your insurance provider about liability coverage once you retire.

2 Tell your clients: Ensure your regular clients have ample notice of your retirement. If you normally have in-person sessions, tell them in person to help facilitate an effective closure to the counselling relationship. Send a letter or email of notification to the last known addresses of any former clients. If you receive clients from referring organizations, provide them with notice as well. *For more information, see "Termination and closure: ethical, clinical, and professional considerations" by Britta Regan West, RCC, on page 14.*

3 Arrange for referrals: Refer current clients to a counsellor or assist in finding a new counsellor. If you are selling or transferring your practice, ensure your clients are aware of the process and assist them with the transfer. Inform new clients at intake of your retirement timeline.

4 Check for loose ends: Ensure a counsellor takes over any outstanding consultations, evaluations, medical / legal reports, or test results.

5 Manage records appropriately: Consult current legal and ethical resources regarding retention and disposal of clinical records.

SO, YOU THINK **YOU HAVE A MARKETING PROBLEM**

People in private practice often believe they will have less trouble getting new clients if their marketing is better. That may be the case sometimes — or there may be an underlying problem. Before you revamp your whole approach to marketing, ask yourself these questions:

1 - What services do I offer?

2 - Who do I offer those services to?

3 - How do I offer those services?

4 - What are the problems I am helping people solve?

5 - How do the services I offer help people solve those problems?

If you don't have really clear answers to all of those questions, you don't have a marketing problem — you have a business plan problem. If you can back up and figure out exactly how you want to answer those questions, marketing becomes quite straightforward, says Constance Lynn Hummel, RCC and owner of The Business of Helping.

"We market directly to the people who have the problems we want to help with. We put the information in places where the people we want already access information. We connect with people our potential clients are already connected to," she says.

Don't even think of it as marketing. Hummel doesn't.

"I like to think of it as letting people know I exist because we're not selling ourselves. We're just saying, 'Hey, this is who I am. This is what I do. If you are looking for what I do, here's how you can access me.'"

LOOKING FOR A BUSINESS COACH?

Business coaches are plentiful; however, there are important differences between traditional business and clinical business. A common example is posting testimonials or offering kickbacks on referrals — RCCs can't do that. Protecting privacy means not every type of communication is allowed. Administration functions like record keeping, informed consent documents, and payment and receipt policies require special handling. You will want to be sure you are getting advice from someone with at least a basic understanding of the counselling profession.

Update on the Pursuit of Regulation of Clinical Counselling: Bill 36

On October 19, 2022, the BC Government introduced Bill 36, titled the *Health Professions and Occupations Act*. The government intends this new legislation to replace the *Health Professions Act*, the legislation that currently governs health regulatory colleges and regulated health professions in the province.

After going through three readings and the committee stage, Bill 36, the *Health Professions and Occupations Act*, received Royal Assent November 24, 2022, and is now law in British Columbia.

While the BC Government has not yet released an implementation schedule and in-force date for the *Act*, BC health regulatory colleges will continue to operate under the *Health Professions Act* until the in-force date for the new legislation is determined.

According to the BC Government new release,* Bill 36 legislation enables:

- A streamlined path to reduce the number of BC health regulatory colleges through amalgamation
- A simplified and streamlined process for regulating new professions
- Creation of an oversight body for health regulatory colleges (funded by the colleges)
- A reformed complaints process that increases accountability and transparency
- A commitment to cultural safety and cultural humility
- Improved information sharing and collaboration between regulatory colleges and with other agencies to enhance public safety and protection
- Creation of an improved governance system where all regulatory college board members are appointed via a competency-based process

The news release also notes that the BC Government "will begin regulating counsellors."

This is an important and foundational step towards the regulation of the profession of clinical counselling.

BCACC is closely studying the new *Health Professions and Occupations Act* and consulting with the Ministry of Health and other BC health regulatory colleges about the legislation. BCACC will communicate with its members/ registrants and other stakeholders as more information about the legislation is confirmed and we learn more about the regulation of clinical counsellors. We invite you to watch your email for our important broadcasts and to log into the BCACC member portal for updates in our "Breaking News" section.

**Patients the focus of new health legislation. https://news.gov.bc.ca/releases/2022HLTH0202-001566*

BCACC MEMBER RENEWALS

BCACC memberships expire on December 31, 2022. BCACC members can renew quickly and easily online by logging into the BCACC Member Portal and looking for the "Membership Renewal" tab at the top of the page.

STARTING A PRIVATE PRACTICE?

START WITH A BUSINESS PLAN

An interview with Constance Lynn Hummel, RCC, about the all-important and often-overlooked business plan

BY CAROLYN CAMILLERI

CONSTANCE LYNN HUMMEL, RCC, HAS HER OWN PRIVATE PRACTICE where she manages a roster of clients for psychotherapy, clinical consultation, and leadership coaching. She's also an experienced business strategist, who has bundled her wealth of entrepreneurial know-how with her coaching skills to offer online "Business Bootcamps" especially suited to people launching private practices.

An RCC starting a private practice may have (and should have) many questions — any of which could fill pages. However, there is one aspect of private practice Hummel says often

gets overlooked — the business plan. She likens not having a business plan to trying to build a house without blueprints.

"You can miss some key pieces you don't realize you've missed until you trip over them," she says.

Sometimes people interpret issues they run into as an indication that they aren't cut out for private practice, when the core problem is that they didn't have a business plan.

"People forget that business has a skill set," says Hummel. "People do MBAs so they can be good at business, but therapists often feel they should be able to figure it out on their own."

While it is possible to do it all on your own, getting some basic business skills and support can make all the difference. But the first step, always, is a business plan.

THE EXISTENTIAL CRISIS

Creating a business plan requires careful consideration and brutal honesty about who you are as a therapist and person, who you enjoy working with, and how you enjoy working. And it may be hard to be really honest.

"As therapists, we are often taught to put ourselves in other people's shoes. 'What would my clients want? What would my clients like? How would they want this to work?' And while this is part of the equation, if you build a practice that's only in the service of your clients and functionally doesn't work for your life, it's a recipe for burnout."

Instead, ask yourself these questions: What do I like talking about? What lights me up? What could I spend most of my day discussing with people and not be tired at the end of the day?

The early stage of a business plan is an imagination exercise, where you dig deep to find that big dream, that perfect vision.

"I really encourage people to spend a lot of time in that visualization part because that's also where our mindset stuff is going to come in," she adds.

Those thoughts and beliefs we have about ourselves that work against us: *Who am I to have this perfect life? Who am I to even want this? I could never do this.* If thoughts like this come up, you'll want to find out where they are coming from.

"If we don't believe we are capable or deserving of our big dream, then we're going to find some way to step on it," she says. "Lots of this is internal work to get to the point where we can say, 'Yes, I believe it's possible. I believe I deserve this. I think I am enough.'"

Hummel cautions against mimicking someone else's practice.

"Even if you can functionally replicate another practice, you may end up being miserable because it's not really a reflection of who you are and how you want to work," she says. "Every single business plan for every single therapist is going to be somewhat unique because every therapist is unique, and how you work and who you work with are going to be different."

Creating a business plan requires careful consideration and brutal honesty about who you are as a therapist and person.

THE FRAMEWORK

The next question to ask yourself: How do I like to work?

"People say, 'You have to have evening appointments. You can't have a private practice without evening appointments,'" says Hummel. "But there is no 'have to' for anything with private practice. I know somebody who offers 3:00 a.m. appointments because they're a night owl and they work with shift workers. If your brain turns off at five o'clock, don't offer 7:00 p.m. appointments. You don't have to."

However, if the clients you build your practice around need you on Saturdays, that's a fundamental business plan issue.

"You either need to rethink the clients you want to work with or rethink working on Saturdays."

Another part of the "how do I like to work" question is in-person vs. online therapy. Many counsellors like online work and so do their clients. But it isn't

always the case. You need to be clear on what you want and whether it works for the clients you want to work with. Which leads to the next question: who do you want to work with and what works for them?

"You can specialize in a population, then be a generalist for them. You can specialize in a specific technique, then be a generalist for whoever wants to work in that way. You can specialize in a specific problem and whoever wants to work with it. You can even have a super niche, where you work with a specific population in a specific way solving a specific problem."

While there are many ways you can present yourself, for others to be really clear about what you do, you have to be really clear.

Hummel says sometimes people question whether it's really possible to have the practice they want and still make enough money to live.

"The answer is always 'yes,'" says Hummel. "But it's going to have to look a certain way in order for that to happen. You may have to shift who you work with. You may have to shift when you work or how you work. It's a matter of adapting the business plan to meet the goals. But the answer is always 'yes.'"

IMPLEMENTING THE PLAN

Implementing your business plan means determining whether you have the functional business skills.

"It's important to stay in your zone of genius," says Hummel. "You don't have to be an expert at everything."

The world is full of people who love doing what you might dread — technology, accounting, admin. To do all that yourself, you need a level of confidence in each area or to find people to assist, whether as a contract arrangement, mentoring, or training.

"What therapists can forget is that they also have to do therapy. And if they're doing therapy most of the time, who's running the business?"

Building a good business plan and getting clear on the answers to all the questions may mean checking our belief systems. It may also mean realizing you need to be in a better financial position first or to wait until your children are finished school or to take some courses.

"You can still be building the plan through all that, then hit the ground running when the timing is right," she says.

CHANGING THE PLAN

Hummel emphasizes a key point: it's okay to change your business plan — in fact, flexibility is necessary.

"An issue for many people is they feel like whatever decision they make they are married to for the rest of their career," she says.

They get stuck worrying about making a wrong decision or that they might not want to do the same thing in five or 10 years.

Hummel's response: "Do what makes sense for you for the next year or two. You still want to have a general vision of where you're headed in the next five to 10 years, and you want to make sure whatever you're doing now keeps that vision a possibility. But remember that whatever you are building today, by the time you build it, you are going to be a different person and you may want slightly different things."

Hummel reviews her business plan every year.

"That doesn't mean I rebuild my whole practice every year," she says. "I might make a slight tweak, a little mild pivot, where I just change one thing."

Usually every four years — although that's not a hard rule — Hummel functionally rebuilds her practice.

"Because I am different. What I want to do is different. Who I want to work with is different. How I want to work is different. And in order to do that, I have to go back to make changes to my plan."

The world is full of people who love doing what you might dread — technology, accounting, admin.

For example, maybe working on Saturdays was great when you didn't have kids, but now you have kids. That means revisiting your business plan to adjust how you work and possibly who you work with.

It's important to ask yourself periodically if the plan is still working for you.

"None of this has to be your forever plan," she says. "This is just the map you're using right now to get where you need to go in the immediate future."

In fact, the first year of private practice is a giant experiment.

"If you have no data, you can't really make real decisions. The questions are: 'I think I want to do this. I think I like working in this way.' And then you do it and you figure out, 'Did I like it?' If yes, continue to do it. If no, do something different.'"

And no matter how long you have been in practice, it's never too late to reassess an existing business plan. Creating a unique plan for your practice and building in flexibility put you in the driver's seat and ensure you are running your practice, instead of your practice running you. ■

BUILDING BRAVE SPACES

An experiential approach to fostering community in group counselling

BY RENÉE HOCK, RCC

The rationale for facilitators to take an intentional and experiential approach to building community within group counselling settings is well supported.

In 2013, Brian Arao and Kristi Clemens presented the idea of "brave spaces" with the intention of supporting positive, effective, and respectful dialogue around complex and challenging issues related to diversity and social justice.[1] Farther back, in 1986, William Glasser offered empirical evidence to support the effectiveness of teaching and learning using an experiential approach.[2] Additionally, leaders in the group counselling field have identified cohesion as being central to a group's ability to endure and process conflict in a way that leads to growth and learning for participants.[3,4]

Here are some of the experiential activities and strategies I use during the initial stages of group counselling to foster community and build "brave spaces."

INDIGENOUS WAYS OF KNOWING AND BEING

As a non-Indigenous person, part of my personal journey with reconciliation involves actively seeking to embed the ways of knowing and being of the First Peoples into both my clinical and teaching practices. For example, I always arrange the group in a circle. According to Jalissa Schmidt of Acho Dene Koe First Nations, learning and sharing in a circle is central to the practices of the First Peoples.[5] Further, the circle helps to promote safety and equality, as this structure is non-hierarchical in nature and allows all group members to be visible to one another.

INTERSECTIONAL EXPLORATION OF SOCIO-CULTURAL FACTORS

The next step is to have everyone introduce themselves with the intention of broadening the scope of diversity beyond a First Peoples perspective and towards a more intersectional approach. I begin by inviting participants to share their names, pronouns, and cultural background or heritage. This activity is designed to highlight awareness and insight around how the diverse cultural backgrounds of the group members might influence the overall group experience. This practice offers not only a means for members to introduce themselves, but it also invites deeper reflection and important conversation related to positionality.

This approach also provides a foundation for the next part of the activity, which seeks to create awareness and foster understanding around the implicit biases we each might hold given our unique socio-cultural backgrounds. For this activity, I provide each participant with a small translucent square lens that is either blue, yellow, or red. Participants are asked to hold their lens up to one eye, look through it, and communicate what they see. Those holding the blue square see blue, those holding the red square see red, and those holding the yellow square see yellow. These initial observations are used to highlight how folks of different socio-cultural backgrounds see the world.

The circle helps to promote safety and equality, as this structure is non-hierarchical in nature and allows all group members to be visible to one another.

Next, participants are invited to consider — and try to understand — the experience of someone with a different socio-cultural lens from theirs. At first, individuals are quick to just call out the colour of the lens that another group member is holding. This is when I remind them that they are not free of their own socio-cultural lens. To truly experience this in the way it happens in the real world, they would also be looking through their own coloured lens. For example, a person looking through a blue lens and looking at someone with a red lens would not see red but rather purple. Similarly, someone looking through a yellow lens and trying to understand the experience of someone with a blue lens would see green and not blue.

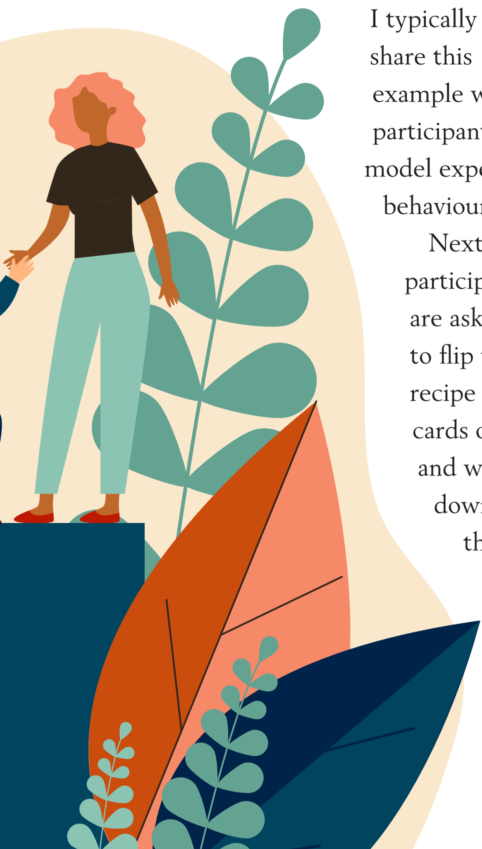
The obvious conclusion from this activity is that we can never fully understand another person's experience without

asking them about it directly. The explicit statement of this intention provides the initial foundation for building community by highlighting the importance of interpersonal communication amongst group members.

REFLECTION AND SHARING OF INDIVIDUAL DIVERSITY

Next, group members are invited to participate in an "inner circle" activity designed to highlight individual factors that might influence their experience in the group setting. Each group member is given a recipe card and a marker. Group members are then invited to take a moment to reflect on and visualize their "best selves."

Following this, members are instructed to write down three distinct characteristics that might be used to describe themselves when they are in that "best selves" state. For example, when I complete this exercise, being fully present, patient, and actively listening are characteristics I feel are consistently part of my best self. As facilitator, I typically share this example with participants to model expected behaviours.



Next, participants are asked to flip their recipe cards over and write down three things they would appreciate receiving from other members to help them to be their best selves throughout the group counselling process.

Finally, group members are invited to share what they have written down with other members then place their card on the floor inside the circle. Once again, I begin by sharing what I have written on both sides of my card and place my card in the circle to model the practice.

As this is the first session, I ask permission from the group to proceed in order around the circle then invite the group member beside me to share next. Group members are always given the option to pass if they do not feel like sharing. As each member shares their card and places it on the floor inside the circle, the recipe cards come together to form a smaller inner circle.

CONSTRUCTION OF COLLECTIVE COMMUNITY AGREEMENTS

Lastly, group members are invited to consider and discuss the purpose and impact of this activity within their group and, in general, within a group counselling setting. Moving forward with an increased understanding of the unique differences and needs of group members, participants are invited to work collaboratively to create group agreements. These agreements reflect the collective expectations and intentions for how members will show up to the group, as well as how any conflicts or challenges will be approached within the group setting.

Group members are invited to end the first session with a check out, where they share something that was helpful for them, something they are still unsure about, and something they are looking forward to throughout our time together in group. This closing is designed to reinforce the intentions of the session; that is, to begin to develop and foster a community where everyone feels comfortable sharing and being who they are and to recognize the diverse needs and experiences of different group members so everyone might benefit from the collective experience.

As everyone in our profession knows, fostering community in group counselling settings is central to the effectiveness and success of the group counselling process. In closing, I hope this article has provided you with some insights and ideas that might be helpful to you in your practice. ■

Renée Hock, RCC, is an associate director for the Master of Counselling Program at City U in Canada and a Mental Performance Consultant with the Canadian Sport Psychology Association and is actively pursuing her Doctor of Counselling and Psychotherapy at Yorkville University. She is humbled to have the opportunity and privilege to serve and support others as a settler on the unceded and traditional territories of the xʷməθkwəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish), and səl̓ílwətaʔɬ (Tsleil-Waututh) Coast Salish Peoples.

REFERENCES

1. Arao, B., & Clemens, K. (2013). From safe spaces to brave spaces: A new way to frame dialogue around diversity and social justice. In L. Landreman (Ed.), *The art of effective facilitation: Reflections from social justice educators. Sterling*, VA: Stylus.

2. Glasser, W. (1986). *Control theory in the classroom*. Perennial Library/Harper & Row Publishers.

3. Corey, M.S., Corey, G., & Corey, C. (2017). *Groups: Process and practice* (10th ed.). Brooks Cole.

4. Yalom, I. D., & Leszcz, M. (2020). *The theory and practice of group psychotherapy* (6th edition). Basic Books.

5. Scmidt, J. (2022). Personal communication, Vancouver, BC, June 17, 2022

TERMINATION AND CLOSURE

Ethical, clinical, and professional considerations

BRITTA REGAN WEST, RCC-ACS

I have supervised many students, interns, clinicians, and supervisors over the years and have developed my own repetitive statement. Sometimes it is so predictable and annoying, my students finish the sentence for me with an eye roll: "I can't tell you what to do, but I can tell you what you must consider."

As irritating as that statement is, because I am not giving an answer, it serves to create disciplined thinking. Disciplined thinking requires that we consider our decisions with consistent methodology and ethos, rather than a momentary judgment or emotional response. And in our profession, disciplined thinking helps us do the right but difficult things.

I use that sentence with all counselling issues when I am teaching and have brought it to bear in my thoughts about client termination.

ETHICS

Big-E Ethics are immutable. They are enshrined in the professional code of conduct we accept and uphold and cannot be changed. We cannot determine to override or underdeliver on elements of the code when we want to use our own dissenting judgment. That is why it is a code. We adhere whether we want to or not.

Small-e ethics are mutable. They are decisions or behaviours we decide we want to adhere to but are not enshrined in the codes and can change if we like. They are also not able to be imposed on other clinicians. Most importantly, they cannot undermine or ignore the Big-E Ethics in any way.

Client termination or closure is a topic that has been embroiled in the E/e ethical discussion a lot recently. I have some theories as to why noted below, but I want to start by stating this fact: there is no Big-E Ethical standard in our code requiring that all clients be terminated at some point. Conversely, there is no Big-E Ethical standard prohibiting therapists from terminating clients. You don't have to bring therapy to closure, and you don't have to not bring therapy to closure.

NO-CLOSURE THERAPY

Therapists range in their small-e ethics on closure. For those of us on the far end of the spectrum where we have a

No-closure therapists have an immense amount of training and experience with long-term developmental trajectories and dynamics; they are not solution-focused — they are process-based and attachment-immersed and often take on very few new clients.

no-closure ethic (I am one of those), we tend to see the client-therapist relationship as a fundamental treatment in and of itself. We also often have a client base that leads us in that direction.

I practise family therapy and specialize in complex fostering, adoption, and attachment-disrupted scenarios. Most of my clients have children and youth with extensive neurodevelopmental differences, trauma, and abuse histories and complex family scenarios. Most of my clients would be considered acute or high risk, and the adults surrounding them are burnt out, overwhelmed, and terrified. There are no shortages of mental illness and distress, both endogenous and situational. They feel very few people understand their realities (and I agree), and when they find a therapist like me and my few esteemed specialist colleagues, the

prospect of having to already think about the end of support is intolerable.

I chose to be able to say, “I’ve got you as long as I do this.” But this is my ethic (small e), and I would not apply it if I had a different practice or specialty or planned to retire soon. No-closure therapists have an immense amount of training and experience with long-term developmental trajectories and dynamics; they are not solution-focused — they are process-based and attachment-immersed and often take on very few new clients. They must be prepared to hold space and time.

I feel it important to remind my supervisees that we exist. It benefits them to question where the pressure is coming from in their mind to decide there needs to be an “end” to therapy. In fact, when there is an invisible pressure to find an end, it has the recursive effect of creating a solution-focused bias in the clinician. If there needs to be an end, we must solve a problem, is usually how it goes.

I don’t help people change their lives — I help them enrich their experience of their lives. I don’t think that has an end.

MY FAVOURITE FLOWCHART

For those of us who are not no-closure therapists, how do we make these decisions? The following list was taped up at our desks where I did my internship many moons ago. A very complicated multi-disciplinary context, it was crucial to get decisions right every time, as it pertained to consent, disclosure, records, health information, legal jurisdiction, and employer liabilities, etc. It should be rote in young clinicians’ minds in the first year in my opinion.

When you are wrestling with a decision — and not just whether to terminate — this is a foolproof list to consult:

1. **Your specific professional codes of ethics and standards of practice (in all cases)**
2. **Your local statute and law (in all cases)**
3. **Your binding agreement with any insurers (in all cases)**
4. **A risk analysis supported by a lawyer (when needing assistance with the above three)**
5. **Any further limiting variables, such as employer or contractor agreements (where it applies)**

If you can get through this list without a clear answer, you are then free to develop a small-e ethic.

Here are some common scenarios where therapists are required to consider termination or closure and some ethical, clinical, and professional considerations.

JURISDICTION

Closure sometimes must occur when the client moves; this may be for a few reasons. Whenever a client moves within Canada and they would like to continue service, it is crucial to call your insurer. Being armed with information as to whether the other Canadian jurisdiction has a college of counsellors or therapists is helpful as it can be determinative. However, don’t assume it is always a “no” because there is a college in another jurisdiction. People move for many reasons and for many lengths of time. And clinicians are insured differently depending on education, provider, and context. Treat these scenarios like fingerprints — each is unique and requires investigation. Insurers are your key source of information for keeping a client in another jurisdiction.

So, let’s say you are comfortable and able to continue providing services. Clinical implications are not to be underestimated either. If we filter our considerations through the lens of adaptive vs. maladaptive, my biggest question for clients who move is, “We need to decide if keeping me helps your move or hinders it.” If we determine that it may hinder their progress, I terminate the client and refer them in their new jurisdiction.

Moving is not to be underestimated. Ranging from a reinvention to an escape to the upending of a person’s life, these are immensely sensitive moments for people. The literature is clear in regard to our emotional ecosystem — we are vulnerable entities. I have learned to treat moves with delicacy. When I must close for a professional reason like lack of insurability, we prepare together, and I help them search for a therapist. In

It is hard to end client relationships because of service duration or funding cessation, but the world of systemized mental health is an increasing portion of our sector.

ideal circumstances, I reach out to the new therapist with or for the client.

DUAL RELATIONSHIP AND ITS POTENTIAL

Dual relationships are a common reason to terminate or close. However, it is important we refer to the code. I coach my supervisees to read this portion thoroughly as it does not state what most people think it does:

> *16) Avoid dual relationships or the perception of a dual relationship in circumstances where the existence of a dual relationship may adversely affect the professional relationship.*
>
> *17) Where a dual relationship exists or is perceived to exist, take immediate and reasonable steps to address any resulting harm or the potential for such harm.*

I want to note here that it is the harm to be avoided. Number 16 notes adverse effects to the client-therapist relationship, and 17 notes addressing harm to the client. This is not a blanket prohibition of dual relationship, and this is because it is often impossible to avoid.

In remote communities, the vast majority of B.C., it would be impossible to access services if dual relationships were prohibited. "The Counsellor" (which they are often called in smaller towns) needs to get coffee in the morning, and it is likely the barista could use therapy at some point.

Community is also not just locale. I think of the professional community I move through. So many parents of my client kiddos have become professionals in our world. I manage many dual relationships. Being able to prevent dual relationship or predict it would be fantastic and would make life easy, but when it is unavoidable, it is the harmful impact that should be managed. You can prevent harm without eliminating the dual relationships. But not always.

And sometimes this means closure. I ask my students to play "imagination game" with worst case-scenarios. "Pretend your new client ended up being your child's swimming instructor. Create the worst-case scenario of dual relationship and then tell me if you would terminate them or not."

FURTHER LIMITING VARIABLES

Our ethics and standards can be further limited and constrained. In fact, they often are. The most common arena of further limitation is within a contracting or employer agreement. It is true that your job or contract can limit your professional and ethical latitude, and it is so crucial clinicians understand this. A simple example is contracting with a health authority or ICBC. Within the contract you sign, you agree to submitting reports pertaining to the client's information and situation not typically shared in another scenario. This is a further limitation.

This significantly affects the issue of file closures because, when working for an employer, it is almost always the case that termination or file closure is required. And even though our standards seek to ensure we always position the client's health first, it can be the case that we are required to close a file when we feel it is not clinically appropriate to do so. This is

Therapy can need to have an end, when the end serves to promote the client's health.

hard and can lead to burnout. It is hard to end client relationships because of service duration or funding cessation, but the world of systemized mental health is an increasing portion of our sector, and therapists have had to embrace its structures. These types of closures are often handled by discussing them on the first day and "beginning with the end in mind."

PROMOTION OF PATHOLOGY AND CLIENT RISK

It can be hard to consider this one, but not all clients benefit from therapy. I have worked with several people for whom therapy, and not just me specifically, was worsening their condition. In the mental health world, where we deal with treatments of many organic and complex conditions, it is crucial for us to look out for the promotion or exacerbation of pathology.

People with varying forms of psychosis, for example, must have breaks from introspective therapies. That is not to say they wouldn't be seen by a medical professional, but depending on their treatment cycle and stage, rest from introspection is crucial. Without this rest, some conditions can be worsened by therapy. This can be a very important time to terminate a client and ensure they are prepped to check in with medical supports.

Sexually intrusive or predatory clients can require termination. The increased focus and introspection on the topics can have a reverse effect on their symptoms and require therapists to close. Addictions therapists often decide to close. Again, the theme is that ongoing focus on the issue can sometimes "keep it at home," as my supervisor used to say.

So, client closure relating to client health is a crucial consideration. More is not always better, and forever is not always better. This kind of closure is considered clinically indicated and should be guided by a skilled supervisor, but the consideration is that therapy can need to have an end, when the end serves to promote the client's health.

CLINICIAN RISK

Safety first. I have worked in places where therapist safety has been questioned or compromised by a client who is dangerous or threatening. This is another area that should be guided by a skilled supervisor, because terminating

a client you feel at risk from is a risk in itself and not to be taken lightly. That said, risk is sometimes universal and sometimes unique. There are clients who are a risk to everyone and clients who are only a risk to particular people. Those of us who have worked in correctional situations or with high-risk offenders know the unique world that it is. A skilled supervisor and colleague can help determine the client's risk profile and your level of risk tolerance.

For those of us not interested in working with populations that import this kind of risk, terminating clients who feel a risk to you should always happen sooner than later. If risk is not part of the population you assume responsibility for, and you are not in a supported context, the risk will not lessen over time.

REFER OUT

Most of our code of conduct focuses on a way of being with a client. Passages contain language to help us consider how we treat our client and how we should see the relationship. Envisaging the relationship in a particular way assists us in determining what to do. But there is one element of our code I find to be overlooked, and I ensure clinicians remember it and embed it in their workflow.

We should always refer out when closing. Referring out, as noted in the code:

> *13) If it becomes necessary to limit, suspend or terminate treatment, assist the client to obtain the services of another qualified professional.*

This is something we must do. This is an immutable ethic that applies whether we have an opinion against it or not. The duty of care transcends other details of the situation, and in all cases we must refer. If the client relationship has soured in some way, or they have become difficult to contact, I send a final voicemail or message listing two professionals in their area, so I know the last thing they have from me is a commitment to their well-being.

HOW TO CLOSE

Therapy is relational. The impacts of our communication, behaviour, affect, and approach are significant to our clients. Ending a relationship or closing a process means something. Our brains will insist we make meaning of it.

> When we hold true to treatment ideals and focus on their adaptive functioning right until the end, we enhance their experience of therapy.

I am diligent when supervising therapists on the meaning-making they create when ending with a client. It is crucial therapists create a therapeutic and client-centred meaning out of closure. It is not treatment if we lead a client to believe, even by omission or silence, that they are somehow at fault or failure when closing. As treatment professionals, we must ensure endings are also treatment. Defining closure as beneficial for the client in some way is crucial so they are not hamstrung by our decision to close. When we fail to do this, we cease to be in our treatment role, and the client can sometimes be sent off in a worsened state. When we hold true to treatment ideals and focus on their adaptive functioning right until the end, we enhance their experience of therapy. We set them up for further growth with someone else.

I encourage clinicians to:

1. **Always close in the methodology consistent with the course of therapy. If you were in face-to-face sessions, do not terminate over text or email. However, if you were doing narrative letter work, also do not make the first phone call a termination. Respect the structure of the interactions and give them a final interaction that isn't avoidant or aggressive or out of the norm.**
2. **Always treat closure clinically where possible. Integrate it into treatment and frame it as part of their work. Make it meaningful if you can.**
3. **Always approach it as a care professional and ensure they have information about other professionals or services. It reminds them that the profession is more than just you.**

Closures occur in many scenarios, some forced and some sudden. They can feel wrong at times and poorly timed. We can want to hold on if it feels premature, and we can want to speed it up if we feel the process was difficult. If we are adhering to our code, we create client-centred closures that are clinically relevant and productive and, above all, communicate our duty of care. ■

Britta Regan West, RCC-ACS, is an Approved Clinical Supervisor, Clinical Traumatologist and sitting Board President of BCACC. She runs a specialist child and family clinic in Burnaby and now spends most clinical time providing supervision and supervision of supervision in complex family and acute mental health scenarios.

BUILDING CONNECTIO

TO OURSELVES AND OTHERS

Using Observed and Experiential Integration to help address trauma and facilitate self-knowledge

AUDREY COOK, RCC

All connections are important: family, community, significant ethnic group, majority culture, and so many more. After infant bonding with a caregiver, our first and primary connection must be to ourselves.

This article explores how trauma keeps us from feeling connected to ourselves and to others. I've been working on a trauma response protocol for the past 28 years and would like to share how it has helped me personally and professionally in my work with multi-generational trauma clients, often manifested in early onset multiple trauma.

Self-connection is facilitated by knowing and being comfortable with the self, which in turn paves the way for us to be connected to the deeper structures in our brains. In Observed and Experiential Integration (OEI), the trauma therapy that I developed together with Dr. Rick Bradshaw, we help our clients become comfortable with and to know the self, in part by teaching them to bring awareness to the conscious mind and body, even as they are working with the memories and physical sensations of traumatic abreaction.[1]

Rick and I have worked together since the early 1990s to develop a series of techniques to help our clients, ourselves, and our colleagues. One of the most effective ways to foster

NS

self-awareness is to notice the differences of perception and body sensation — with one eye covered at a time.

Via the optic nerve, each eye connects to and stimulates different areas of the brain. As individuals working with ourselves and as therapists working with our clients, it's easy to "see" and to "feel" how each eye brings up different sensation, affect, and even abreaction. Sometimes the objective of covering one eye or the other is to increase awareness of the sensations and affect; sometimes the goal is to decrease the sensations. But always the goal is to bring this awareness to the conscious mind, so the client is able to mentalize. "I am not my feelings, or perceptions; I am someone noticing the difference between these two parts of myself."

I BELIEVE IT IS USEFUL TO KNOW WHEN THERE IS A LACK OF CONNECTION WITHIN THE SELF AND TO WORK TOWARDS SELF-KNOWLEDGE.

WHAT IS OEI?

In OEI work, therapists work to integrate the two hemispheres of the brain, particularly focusing on the midbrain where automatic traumatic reactions reside. Is the trauma going to happen again, and will I be ready to defend myself this time? Can I believe what happened to me? Can I believe what I witnessed? What am I feeling about my safety in the world? Did the trauma happen last night or 40 years ago?

Though we have developed a series of techniques for doing this work with the eyes, brain, and body, the simplest approach in OEI is switching: the covering of one eye, then the other. The object is to exclude light as much as possible from the covered eye and to allow the brain to receive stimulation and information only from one eye at a time.

The client is asked about what they feel emotionally, what they see, what they experience somatically with one eye covered. The key question to use with the technique is "Is it the same or different?" In this way, the client (or the self) will notice subtle or intense differences between the two perceptions. Sometimes the view and the affect from one eye is markedly different from the other eye.

We facilitate the experience by asking questions like, Where do you feel that? How intense is it? What messages are you getting from your brain? From your memory? From a certain part of the body involved in the traumatic experience? As the therapist becomes comfortable working with this modality, they will develop their own approach to using the questions for gently uncovering.

Tightness in the throat often connects to childhood shame, where we couldn't control what was happening around us. Heaviness on the shoulders might indicate weight of responsibility, or tightness in the chest might indicate anxiety. In the practice of OEI switching, if bodily sensations are distressing, switching can help lower the intensity by having the client cover the more reactive eye, allowing them to "rest" for a time on the "calmer" side. This often brings about increased nervous system regulation. The main focus, though, is on integration of the intensity, so we usually return to switching back and forth until each eye sees and evokes similar emotion, perception, or sensation. The client observes the intensity, experiences it in an increasingly safe way, and integrates it neurologically and somatically.

If the client is partially dissociated from their trauma history, it's often important to increase the intensity of the sensation or to bring awareness of a message, vision, sensation, or emotion to consciousness to help them achieve integration.

OEI SWITCHING IN PRACTICE

In my practice as a marriage and family therapist working mainly with Indigenous clients with multi-generational trauma, I believe it is useful to know when there is a lack of connection within the self and to work towards self-knowledge. In a way, this is parts work for the brain.

For example, the most usual response to checking "same or different" between the two eyes in a child is "sad" and "mad." When a person of any age is feeling sad with one eye covered and mad with the other eye covered, it is difficult to feel either emotion fully, which means it's also difficult, even impossible, to integrate and to come to peace with these emotions. But when a person can connect with the emotions one at a time, through one eye at a time, it's possible to bring those two emotions together into a more complex and layered experience of self. This complex emotion facilitates both deeper self-connection and cognition. Even very young children can achieve this deeper self-connection and understanding.

Switching helps to integrate these

experiences, permitting emotional expression and release. Occasionally a client will have tears pouring out of one eye (with the other eye covered), but no tears from the other eye when it is uncovered (completely dry). After repeated switching, such clients emit tears from both eyes, expressing deep sadness or fear that was previously blocked.[2]

OEI was developed as a therapeutic technique which is used in conjunction with many other types of therapeutic approaches or on its own. The object of the therapy is to help clients (and clinicians) connect with their internal reactions or triggers to events — both traumatic events and everyday interactions with others. Balancing the brain with simple exploratory exercises which isolate body reactions from one hemisphere to the other can be helpful for people of all ages who are struggling with the integration of any intense experience.

Once specific reactions (emotional or somatic) are isolated and identified, people are able to determine if the reaction from one side of the brain is similar to or different from the reaction on the other side of the brain. These reactions are then explored for "same or different" responses. Switching back and forth between the two perceptions

IT IS POSSIBLE WITH A FEW SIMPLE EXERCISES TO BUILD NEURAL CALMNESS EVEN WHEN A PERSON IS EXPERIENCING GREAT DISTRESS.

can, over time, lead to physical and emotional calm: this is integration at the neural level.

Frequently, as the two perceptions are compared and tracked throughout the body, an awareness of the origin of the sensation may be brought to consciousness. This can be a physically

and emotionally tiring experience but very helpful for resolving "stuck states" and treating unwanted body reactions.

BUILDING NEURAL CALMNESS

It is possible with a few simple exercises to build neural calmness even when a person is experiencing great distress. For example, a person who is deeply distressed by the fear of abandonment can be helped to find calmness by finding a body movement which convinces the mid-brain structures that they are safe and not going to be deserted.

To achieve this calmness, a person can ground themself, belly breathe, and explore the "going towards" or "going away" reactions. If we are working with clients around abandonment or boundary violation, for example, we can "move towards" them while they have one eye covered until they want to say "stop" with agency and calmness. We repeat this exercise to have the client learn the power of agency in the body and voice when saying "stop!" We could also lean or pull back until they say "stop," which also creates boundary awareness. The client or the therapist could move towards or away.

Sometimes, when the distress is very great, moving forward with one eye covered is too overwhelming, but moving away with one of the eyes covered is calming. Building on this awareness, a person can repeat the movement and achieve calmness, as the midbrain learns to believe that the person has control and can maintain its safety. In a way, we are tricking the nervous system into believing that the person always had control and was never at risk of abandonment or assault. This is not the literal truth but feeling this level of calm and control as a way of calming an abreaction is extremely effective.

USING OEI IN CLINICAL PRACTICE

When I worked with Indigenous elders who were giving testimony at Indian Residential School hearings, I suggested to some of them to wear an eye patch in order to cover and calm their reactive (abreaction-causing) eye. Covering the more reactive eye allowed them to recount their childhood trauma without regressing to the speechless or chaotic state of the child who was being abused. With the reactive eye covered, they were able to remain in their adult state, while recounting their personal stories of violence and abuse to powerful strangers — an intimidating prospect for any of us. Often, this was the first time the elders had publicly spoken of these events. While this was painful and challenging, they wanted their violent childhood experiences to be witnessed and documented publicly.

When I am working with parents and their children, OEI helps us to determine and bring into conscious awareness visual projections that can keep parents isolated from their children emotionally. I ask the child to stand at a distance from the mom or dad. Then I invite the parent to look at the child, one eye covered at a time, as the child slowly walks closer. Often, children will resemble or remind one parent of the other abusive parent. Through this exercise, a mother is able to see, feel, and eventually integrate the way she projects the child's violent father onto the child who somehow reminds her of him. Because the father has been physically assaultive to the mother, the "resembling" child triggers fear and anxiety in the mother. This loop of association and triggering is outside the parent's awareness.

I also work with new mothers who are anxious with their toddlers. When the children express their anger and frustration, the mothers sometimes get triggered, upset, and reluctant to engage with their little children. When we use OEI to explore their feelings, they realize they're afraid of the child's anger because of their own physically assaultive childhoods. With this awareness, the mothers are able to calm their triggers, remain in their adult states, and support their children to express themselves.

OEI AND TRANSFERENCE

Transference is the projecting of emotion or intention onto another face. The useful part of transference exercises with OEI is that the midbrain doesn't recognize that the face in the mirror is us. This primitive response to the "other" is very helpful in doing work with our own projections in a mirror or with the camera on our phone.

What happens when transference is very different with one or the other eye covered? The brain is complicated; often it's difficult to categorize transference especially when a history of early onset multiple trauma (neglect or childhood abuse) is present. Often with one eye covered, a therapist's face looks engaged and calm, while with the other eye covered, the therapist's face looks frightening or sneering or critical. Integrating these two reactions with switching will lower the limbic reaction and bring calmness and self-awareness.

OFTEN WITH ONE EYE COVERED, A THERAPIST'S FACE LOOKS ENGAGED AND CALM, WHILE WITH THE OTHER EYE COVERED, THE THERAPIST'S FACE LOOKS FRIGHTENING OR SNEERING OR CRITICAL.

How can this type of transference work help us as clinicians? I had a very powerful experience with transference with my mirror image after making an upsetting clinical error. (Both clinicians and clients can do this work on their own by using a simple mirror.) I was so upset after making this error that when I looked in the mirror, I did not register recognition of my face. My brain didn't want to see me! But as I switched from one eye to the other, I was able to see myself, then to identify a very sad and frightened look with one eye covered and a cold rejecting look with the other eye covered. With verbal support, I was able to integrate these two emotional states and to accept that I was a human, and humans make mistakes. This won't necessarily work for everyone, but if you have a hypervigilant brain, you may find a similarly helpful response.

As clinicians, as people in the world, if we don't have authentic knowledge of ourselves, it's difficult to connect authentically with others. As Stephen Porges describes in his work on polyvagal theory, we are either in a place of defence or in a place of receptiveness. Porges explains that when a person is in a state of defence, the entire being is engaged in survival.[3] It's hard to problem-solve or plan when in a state of defence.

How to get into a state of receptiveness when your brain is seeing threat in the faces of yourself and others? With OEI, I'm able to see my own and my clients' defensiveness and measure connection to self. I'm fortunate to know that I have a hypervigilant brain; this understanding helps me connect at times to my own levels of defensiveness. With some fairly simple exercises, I'm able to calm my defended state and open myself up to more empathic connection with myself and others.

When working with trauma clients, OEI is also extremely effective for working with (and eventually healing) strong perceptions of threat. Building the "window of tolerance" is the goal for finding receptiveness. This "window of tolerance" was first described by Dan Siegel in his book *The Developing Mind*, and this concept is an integral part of using OEI when treating attachment disruption.

"We all have different 'windows' due to factors such as significant childhood experiences, our neurobiology, social support, environment and coping skills. The size of our windows can change from day to day but the wider we can make the window, the less likely we are to experience anger, frustration or feel flat, low and lacking energy."[4]

The wider the window, the greater the receptiveness and the stronger the acceptance of and the connection to the self and to others. ■

Audrey Cook, RCC, is a marriage and family therapist who has been in private practice in Vancouver since 1984. This article was written with editorial contributions from Karen Connelly.

REFERENCES

1. Bradshaw, R. A., Cook, A., & McDonald, M. J. (2011). Observed & experiential integration (OEI): Discovery and development of a new set of trauma therapy techniques. *Journal of Psychotherapy Integration*, 21(2), 104–171.

2. Both eyes have connections to both hemispheres of the brain. Additional information regarding OEI theory, techniques, and likely neurobiology can be found in: Bradshaw, R. A., Cook, A., & McDonald, M. J. (2011). Observed & experiential integration (OEI): Discovery and development of a new set of trauma therapy techniques. *Journal of Psychotherapy Integration*, 21(2), 104–171.

3. Porges, S. *The Polyvagal Theory: Neurophysiological Foundations of Emotions, Attachment, Communication and Self-Regulation*. WW Norton; Illustrated edition (April 26, 2011).

4. Siegel, D. The Window of Tolerance, a concept coined in the 1999 edition of *The Developing Mind*, 1st edition; 3rd edition (2020); The Guilford Press.

BRIDGING THE GAP

The intersectionality of chronic illness and mental health

ELYSIA BRONSON, RCC

Over the last few years, there has been an increase in chronic illnesses, as well as a growing care gap due to the lack of understanding of the intersectionality of chronic illness and mental health.

This gap can be seen in the shortfall of mental health providers who treat chronic illnesses, as well as the limited number of doctors who refer to mental health for consultation and coordinated care as a part of treatment.[1]

More education in medical programs about how mental health impacts chronic illnesses can increase understanding and help to bridge the gap.

THE EFFECTS OF STRESS AND TRAUMA

Mental health impacts biology through stress, because stress is linked to conditions which are genetically passed down.[2] Stress, then, is a trigger in predisposed conditions, such as chronic illnesses or central sensitization syndromes.[3] Thus, mental health factors like stress can have a direct impact on our physical health through our genetics and may actually cause these disorders.

CHANGING THE LANGUAGE

Patients often feel shame and guilt about their chronic illness. Then, when they are referred to mental health, they feel they are being viewed incorrectly as having the symptoms "all in their head." Thus, an important part of chronic illness referrals to mental health is simply changing the language used to promote this recommendation to patients. For example, mental health aims support chronic illness clients with skills to cope with stress and lifestyle adjustments resulting from their condition.

Chronic illness is also often compounded by past traumas that have not been addressed.[4] When we think of trauma, it is not about what happens to you, but rather about what happens inside of you and how you perceive it. "It's a restriction of your capacity to respond from your authentic self in a present moment," says Gabor Maté, and therefore, "What happens to humans on a physiological level can be impacted by and even determined by what happens to them on a social level."[5]

Having a chronic illness can affect mental health in three primary areas. The first area is internal body responses like the autonomic nervous system and hormones, which are well understood by the medical community.

The second and third areas — external stressors and internal perception — are perhaps less understood. Examples of external stressors resulting from limited abilities due chronic illness include financial hardships, relationship issues, lack of social support, and limited work depending on mobility. Examples of stress due to internal perception include the patient's adjustment to a loss of capability in fulfilling their roles and responsibilities. From the psychological perspective, chronic illnesses are then compounded by depression or anxiety, which are comorbid with many chronic illnesses.

The impact of diagnosis and onset of symptoms can deeply affect a patient's internal perceptions of themselves and their self-worth. Emotions can be triggered by the losses associated with disorders, then health worsens because of the inability to cope with the adjustments of slowing down or learning to manage energy and pain.

These fundamental areas that impact mental health can also cause flare ups in chronic conditions.

> **The impact of diagnosis and onset of symptoms can deeply affect a patient's internal perceptions of themselves and their self-worth.**

HOW TO HELP

In addition to incorporating a routine mental health consultation into the treatment of chronically ill patients, mental health resources can be given out to patients at diagnosis or when stress symptoms are noticed by their care team. This increases the patient's awareness of the support available as these large lifestyle adjustments are happening. This helps patients learn tools to create lasting behavioural and psychological changes and set them up

for success as they adjust to life with a chronic illness.

I would also like to point out that not all therapy styles are appropriate for chronic illness. I suggest creating a referral network of mental health practitioners who are specifically trained in therapy styles that have shown success in chronically ill patients.

In "Chronic pain: an update on burden, best practices, and new advances," authors Stephen P. Cohen, Lene Vase, and William M. Hooten have gathered research on which therapy styles have been studied in patients with chronic illness and which have shown the greatest effects. Although all studies were small, behavioural therapy and mindfulness therapy had the best results in this patient type.[6] Because dialectical behavioural therapy (DBT) and cognitive behavioural therapy (CBT) incorporate behavioural therapy, they may also have a favourable effect with chronic illness clients.

What I like about DBT is that it provides skills and includes mindfulness therapy techniques, which could be effective with patients who have memory issues or who learn best with visualization and reminders.

I also favour an integrated approach to therapy and have found that integration allows for a better explanation of a client's problems and for more targeted treatments.[7] Working within an integrative model, I have found CBT and DBT complementary, as DBT is flexible enough to add skills from its four modules of mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance to the end of counselling sessions.

DBT also helps CBT's cognitive processing of chronic illness through its use of the dialectic between change and acceptance. In "The Course and Evolution of Dialectical Behavior Therapy," authors Marsha M. Linehan and Chelsey R. Wilks also note that each DBT module holds all that is needed for one specific portion of the chosen treatment. Thus, if patients are uncomfortable with mental health referrals, it is easier for them to accept the idea of sessions to learn coping skills, rather than address the anxiety that can come with cognitive processing. Therefore, DBT integrates well into treatment strategies and therapeutic interventions.

Encouraging clients towards mental health resources can lower their stress levels and help them learn skills to cope with chronic illness.

Ultimately, encouraging clients towards mental health resources can lower their stress levels and help them learn skills to cope with chronic illness. This in turn can help foster an understanding of their emotions and lower their perceived stress, which is a top trigger for flaring pain.[9]

Counselling is also an aid to chronic illness because it supports an ability to manage depression and anxiety instead of simply medicating.[10] Thus, if changes are made and mental health is recommended more often, it could take some strain off of the medical system, because patients will be better equipped to manage stress, and it may even slow the progression of some illnesses that are triggered by stress.

Lastly, because mental health support could drastically reduce the effect of chronic illness on the health care system, I would like to advocate for coverage by MSP. ■

Elysia Bronson, RCC, is the founder of The Woods Counselling Co., where she works to provide trauma and chronic illness counselling across B.C.

REFERENCES

1. 1 Roberts, K. C., Rao, D. P., Bennett, T. L., Loukine, L., & Jayaraman, G. C. (2015). Prevalence and patterns of chronic disease multimorbidity and associated determinants in Canada. *Health promotion and chronic disease prevention in Canada: research, policy and practice*, 35(6), 87–94. https://doi.org/10.24095/hpcdp.35.6.01

2. Maté, G. (2019). Dr. Gabor Maté: When the body says no in psychotherapy. Retrieved 19 September 2021 from https://www.youtube.com/watch?v=7V5qn9dkzIU

3. Arseneau, R. (2008). Chronic Fatigue Syndrome: Your patients' – Not You – So all we could do was to Sit!, Sit!, Sit!. BC Women's Hospital. (2021). Complex Chronic Diseases Program. Retrieved 4 October 2021 from https://mediasite.phsa.ca/Mediasite/Catalog/catalogs/mediasiteadmin-ccdp-introduction-course

4. Maté, G. (2019).

5. Maté, G. (2019).

6. Cohen, S., Vase, L., & Hooten, W. (2022). Chronic pain: an update on burden, best practices, and new advances. Retrieved 17 June 2022 from https://www.cmaj.ca/content/193/8/E270

7. Sperry, L., & Sperry, J., (2020). *Case conceptualization: Mastering this competency with ease and confidence*. (2nd ed.). Routledge.

8. Linehan, M. and Wilks, C., (2015). The Course and Evolution of Dialectical Behavior Therapy. *American Journal of Psychotherapy*, 69(2), pp.97-110.

9. Maleki-Yazdi, M.R., Kelly, S.M., Lam SY, Marin, M. Barbeau, M. & Walker. V. The burden of illness in patients with moderate to severe chronic obstructive pulmonary disease in Canada. *Can Respir J*. 2012 Sep-Oct;19(5):319-24. doi: 10.1155/2012/328460. PMID: 23061077; PMCID: PMC3473007.

10. Campbell, B. (2022). Reducing Anxiety and Worry | ME/CFS & Fibromyalgia Self-Help. Retrieved 17 June 2022 from http://www.cfsselfhelp.org/library/reducing-anxiety-and-worry

Additional resources

Borsook, D., Maleki, N., Becerra, L., & McEwan, B. Understanding migraine through the lens of maladaptive stress responses: a model disease of allostatic load. *Neuron*. 2012 Jan 26;73(2):219-34. doi: 10.1016/j.neuron.2012.01.001. PMID: 22284178.

RETIRING GRACEFULLY

Tips for reframing retirement as way to leave the overwhelm behind and start a new journey

TRICIA-KAY WILLIAMS, RCC

William Bridges is the author of many books about transitions. In *The Way of Transition*, he says the key to navigating change without disenchantment is to embrace the present reality. "If it is deep and far-reaching, transition makes a person feel that not only is a piece of reality gone but that everything that had seemed to be reality was simply an enchantment… the answer is not to refuse to do anything that had been associated with it. But rather to explore and discover what the new reality is."[1]

Easier said than done, right?

And one of life's most significant transitions is retirement. Many see retirement as a thing older people do, even something to dread. We hope to change this perspective to consider retirement as the start of a new journey.

First, let's talk about the growing pains. We know retirement is a transition we all will navigate at some point; however, many things can disrupt this process, making it challenging. Here are four things to consider.

1 – Financial challenges

Statistics Canada's inflation rate is 7.6 per cent as of August 2022. Gasoline prices rose by 6.3 per cent, and average hourly wages rose only by 5.4 per cent.[2] This information is dire for everyone whose cost of living is increasing faster than their salaries. Imagine the worry experienced by people thinking about retirement and considering if they can afford to retire based on the inflation rate.

2 – Ageism/bias

Ageism refers to prejudice and discrimination against a person based on their age. Many people over 50 feel their workplaces are biased towards them based on age; society judges them as suddenly incompetent based on appearance and mobility. Many indicate having to prove competence through metrics and say the merit goes to a younger team member. Many counsellors have private practices where bias is possible; clients may assume the therapist is not trained in modern approaches and, therefore, is not taken seriously.

3 – Perceived diminished sense of self

According to Healthline, "Your sense of self refers to your perception of the collection of characteristics that define you. Your personality traits, abilities, likes and dislikes, your belief system or moral code, and the things that motivate you can contribute to self-image or your unique identity as a person."[3] Understanding our values and belief systems helps us gain more information about ourselves, then enables us to make decisions that align with who we are. Our sense of self also allows us to live our authentic selves separate from others.

Many people over 50 feel their workplaces are biased towards them based on age; society judges them as suddenly incompetent based on appearance and mobility.

When our sense of self diminishes, we no longer trust our abilities to make decisions about our future and we in turn lose our identity. A perceived diminished sense of self takes it to a new level: we perceive that others think we cannot make the right decisions for ourselves. A challenge some may share is holding onto their jobs to feel competent and maintain a sense of respect and status as professionals in the field. Many indicate that they fear losing their mental and physical abilities if they stop working.

4 – Isolation

Another challenge some may experience is holding onto their jobs to avoid isolation. They may fear being alone after they retire, especially if they don't have social support or family. Audience diversity statistics indicate that nearly 913,000 British Columbians were 65 years or older in 2018,[4] and the Seniors Advocate for B.C. reports that 94 per cent of seniors live independently in private dwellings, while six per cent of seniors live in assisted living or long-term care.[5]

Despite these fears and anxieties, endings such as retirement are an essential part of transitioning. But we can look at transition differently.

REFRAMING RETIREMENT

We are taught to think about endings as only a loss of things, people, and experiences. But endings also indicate the possibility of a new beginning. The reframe here is that retirement is the ending of this job and career, but it's also the beginning of whatever you decide. Here are ways to reframe the way you think about retirement.

Reflect on contribution

As you look back at the years of contribution in your work, you can highlight the poignant moments. Indicate the lifetime of legacy you have. Many people spend their retiring years writing a book to share this collective knowledge with the world. A thought here is how to continue to contribute in a new way that doesn't involve going to a nine-to-five job or trading time for money. It could easily be that you are content with what you have accomplished so far and are ready to reclaim your joy.

Reclaim joy

Reclaiming your joy is the freedom to do what brings you joy and not be motivated by a paycheque. You have always wanted to do certain things but have felt you couldn't because of

IS IT TIME TO RETIRE?

Here are some emotional signs that indicate it's time to start a new journey:

- **Current job has lost its meaning**
One thing that can indicate that it's time to retire is an overwhelming sense of not wanting to work anymore because the job has lost meaning and purpose for you.
- **Current job brings no joy**
Another sign could be that there is no novelty, no new lessons, nothing to excite you. Boredom sets in, and you feel irritable because there is nothing more for you to contribute.
- **Feeling content to leave**
You are possibly feeling a little guilt, because you have thought about leaving so many times. You have talked with friends, family, and your partner and they are all supportive. You just need to take the step. A sense of contentment comes over you as you plan what life would be like if you didn't have to work.

work obligations. Many people talk of travelling the world, solo or with a partner. Others talk about spending time with their families and helping to raise grandchildren. Many share their love for exploring hobbies and quiet mornings sipping tea on the porch or balcony. Accessing this joy can lead to a new sense of purpose and meaning.

Age with intention

Aging with intention helps you to accept the life stage you are in and the money you have or don't have — and that acceptance gives you purpose. Each day you awaken, you remember that life is precious and a gift. You live a day of freedom and joy, knowing you have lived a good life filled with a fantastic contribution.

It can be challenging to reflect on contribution, reclaim joy, and age with intention. Asking yourself these questions can help:

- Do you know who you are, your beliefs, values, and the unique things that make you, you?
- Do you constantly compare who you are now with who you used to be?
- Does your job define who you are?
- Other than work, what brings you joy?
- What support systems do you have outside of work?
- What would you do if you won the lottery and didn't need to work?
- What is your retirement plan?
- Would downsizing help with finances?

As you consider these questions, dig deep into your answers to gain a new understanding and appreciation for yourself and the transition you are experiencing. Explore new opportunities and seek support and guidance along the way. ■

Tricia-Kay Williams, RCC, owns Metamorphose Counselling and Consultation Ltd. and an e-store called Meta Transitions Care and hosts a YouTube channel and podcast called Meta Transitions. She is an advocate for diversity, equity, and inclusion in mental health and often speaks and consults for higher education and faith-based organizations. https://www.metacounselling.com/

INVITATION to RCCs who are retiring or planning ahead to retirement

Retiring from practice is an emotional roller coaster for most RCCs. In addition to the practical steps, which can be overwhelming on their own, there are all the mixed emotions that come from shifting into a new life phase, saying goodbye to clients, and reassessing purpose and identity.

To provide RCCs with an opportunity to share their experiences as they transition to post-work life, a new section of the BCACC blog has been launched. RCCs who have retired or who are in the process of retiring are invited to write posts. Your blog post can be anonymous if you choose and can on be on any aspect of retirement you wish to write about. The hope is to create a repository of experiences and resources to support our RCC community.

If you would like to submit a post, email communications@bcacc.ca. The first post, Navigating Retirement Angst, will be published to align with this issue of *Insights* magazine at *bcacc.ca/blog/*.

REFERENCES

1. Bridges, William (2021). *The Way of Transitions: Embracing Life's Most Difficult Moments*. Da Capo Lifelong Books; reprint edition.

2. Statistics Canada. Consumer Price Index, August 2022. Retrieved from: https://www150.statcan.gc.ca/n1/daily-quotidien/220920/dq220920a-eng.htm

3. Healthline. 'Who Am I?' How to Find Your Sense of Self. Retrieved from: https://www.healthline.com/health/sense-of-self#importance

4. Government of British Columbia. Audience diversity. Retrieved from: https://www2.gov.bc.ca/gov/content/home/accessible-government/toolkit/audience-diversity

5. Seniors Advocate of British Columbia. Monitoring Seniors Services Report 2021. Retrieved from: https://www.seniorsadvocatebc.ca/app/uploads/sites/4/2022/02/MSS-Report-2021.pdf

TRANSFORMATION HAPPENS

Listening to the guidance, following the path, and accepting the opportunities and help along the way

"There's something much greater than me that's actually been guiding me, sometimes pulling me, sometimes pushing me," says Dixie Black, RCC. "I have had the good fortune to be able to hear it and the good sense to listen."

Dixie Black, RCC, has been in private practice in Vancouver since 1987. From 2009 until 2022, she was also deacon at Vancouver's Christ Church Cathedral. While she has recently been appointed Deacon Emerita in retirement, her counselling practice is busier than ever. She also recently retired as adjunct faculty at the Vancouver School of Theology. The story of how her career has unfolded is inspiring not only for her work and dedication but also for how she met opportunities that appeared along her path.

A childhood trauma that today would be called adverse childhood experiences with symptoms diagnosed as complex PTSD led to a referral in 1972 to a psychiatrist who used Gestalt therapy.

"I didn't know what Gestalt therapy was at the time, but he literally saved my life," says Black.

She also didn't know then that she would become a Gestalt therapist. Married out of high school and soon a mother, Black took a certificate course in peer counselling. By age 27, she was volunteering as a counsellor in Calgary while her paid job was selling life insurance. After a move back to Vancouver, she continued volunteering as a counsellor and was so good at it, her supervisor started paying her $10 an hour.

"I was thrilled to be getting paid for what I was doing — I couldn't believe my luck," she says.

She was naturally but unwittingly using a Gestalt approach, which a colleague noticed and directed her to the Gestalt Experiential Therapy Institute of Vancouver. Though she didn't have an undergraduate degree, she was admitted to the program conditionally and graduated. Black and some colleagues then opened Canada's first clinic for over-spenders, which launched her practice.

She continued her training and education throughout her career and later got a master's degree at the Vancouver School of Theology, but how that came about… well, that's another story.

WHAT BROUGHT YOU TO CHRIST CHURCH CATHEDRAL?

I didn't have a religious background or spiritual training. I went to Sunday school as a kid for a few years, but I didn't really believe in anything. As an adult, I explored many spiritual traditions, mainstream and alternative. While doing so, I felt called to Christ Church Cathedral. My first thought was, "I don't want to go to a Christian institution." It took me two years of discerning and thinking I had the wrong message. But it was a persistent voice so I joined; everything fell into alignment and my work began.

Fortunately, there was a woman curate who helped me understand the mystical side of Christianity, and two RCCs who founded the Cathedral Centre for Spiritual Direction, offering spiritual and philosophical education to counsellors and psychologists. I went back to school at age 55 and got a master's degree, and in 2009, I took vows for ordination as a deacon. I also had a full-time counselling practice as an RCC.

TELL US SOMETHING ABOUT GESTALT THERAPY.

Gestalt therapy isn't just a model of therapy. As a whole philosophy of life, it completely changed me. I started having some experiences while doing the psychological work I needed to do for myself. I did holotropic breathwork and was having altered state experiences — entering a trance state to access other dimensions of reality. I soon realized that this was something bigger than me, so I studied more deeply into other traditions and therapy models, such as Carl Jung's depth psychology, Buddhism and Buddhist meditation, and Wiccan ritual.

> "New beginnings and new endings are happening all the time in a cyclical way. Transformation is not an event but a process."

YOU HAVE SAID THERE IS LITTLE DISTINCTION BETWEEN CLINICAL AND SPIRITUAL WORK. CAN YOU EXPLAIN?

Well, there really isn't any distinction except that when people come for clinical work, it's typically issue oriented. The client has a goal to change behaviours and patterns or a desire to heal past experience. Spiritual work emerges out of that healing. It brings the client to the broader perspective of the meaning of life — those existential questions.

Sometimes a client will choose to use a spiritual lens for their work — called spiritual direction or spiritual accompaniment. In that case, psychological barriers to awakening can appear, and we work psychologically with unresolved relationship issues or past trauma. Either way, I find that they go hand in hand.

A common temptation is spiritual bypass, a term introduced by psychotherapist and Buddhist teacher John Welwood to describe a "tendency to use spiritual ideas and practices to sidestep or avoid facing unresolved emotional issues, psychological wounds, and unfinished developmental tasks." This is common in most religious communities. Some people believe that to be spiritual means that life should be smooth and untroubled when a state of spiritual status is attained. Contrary to that idea, the reality I experience for myself and others is that life often asks more of us than it did before we became "spiritual."

WHEN YOU SAY, "TRANSFORMATION IS POSSIBLE," WHAT DOES THAT MEAN TO YOU?

Typically, we see life working in a straight line — I'm here now and I want to get over there. I make progress and it feels like one step forward, two steps back. But it's a very linear model and

not how healing works at all.

Transformation is actually done through working in spirals. We come to the same issue or defence or behaviour in the spiral again and again. But each time we come to that place in the spiral, we come with everything we've learned since the last time we were there, and we continue to grow. So new beginnings and new endings are happening all the time in a cyclical way. Transformation is not an event but a process.

HOW DO YOU HELP PEOPLE COPE WITH UNWANTED CHANGES LIKE DEATH, DIVORCE, JOB LOSS, OR COVID-19?

Through a psychospiritual lens — if people come with a religious perspective, or a spiritual perspective that isn't religious, or even a scientific view, as quantum physics has a way of explaining life — there are often teachings that help make sense of what's happened. Buddhism is very good at this, much better than Christianity actually. Even though it wasn't a change you wished for, how do you get to a place of integrating that meaning into your life? It requires coming to some acceptance that this did happen, I didn't want it and I'm powerless to change it. The only thing I can change is my attitude towards it. That helps prevent an identity as victim from forming. Grieving is really critical — the grieving process is named and honoured whatever the loss.

WHAT KINDS OF CHANGES ARE YOU SEEING IN SOCIETY? WHAT MAKES YOU FEEL HOPEFUL?

Many people are more afraid and when we're afraid we are vulnerable to acting out. Many have lost trust in major institutions like school, church, government, policing, even our medical system. Disillusionment, economic uncertainty, and climate crisis all contribute to additional mental health stress.

What brings me hope is that while crisis can bring out the worst in us, it can also bring out the best. After hurricane Fiona hit in the Maritimes, people abandoned individualism and came together as a collective to help neighbour and stranger alike. It gives me hope that when things are hard, most of us will come together and help each other.

"While crisis can bring out the worst in us, it can also bring out the best… It gives me hope that when things are hard, most of us will come together and help each other."

Young people make me hopeful. I have three grandchildren in their 20s and they, along with their friends, continuously impress me with their thoughtfulness. They're much more sophisticated than I was in my 20s. As a generation, they are better informed and see through some of our typical political and media speak. They are more transparent about mental health issues and quicker to ask for help. Though not religious or even spiritual, their values demonstrate goals of a meaningful life rather than material pursuits. They know there are limitations in their lives.

WHAT KINDS OF CHANGES HAVE YOU SEEN IN COUNSELLING? HAS YOUR OWN ROLE CHANGED?

I have noticed a shift in emphasis towards the models of therapy used with clients and less attention to the importance of the therapist's relationship with the client. It takes months, even years, for a client to develop enough trust in a therapist to allow the vulnerability of their core wounds to surface. For many valid financial reasons, the delivery of short-term issue-oriented counselling is offered. It is helpful to solve problems but doesn't replace the long-term work towards true transformation.

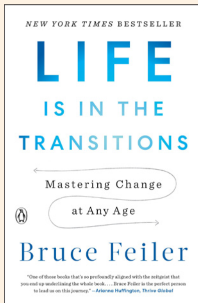
My sense of my role as a counsellor hasn't changed because my training required self-awareness, self-honesty, and ruthless self-investigation. I went through three years of very intense training with the same 14 people. Then I was in a supervision group for seven years with the same six people. I worked with one therapist for 17 years. I was expected to continue to do my own work to be accountable as a therapist. My role is to stay out of the way and use my skills to help the client find answers relevant to them. That hasn't changed.

WHEN YOU LOOK AT IT ALL, HOW DO YOU FEEL ABOUT YOUR CAREER THUS FAR?

The work is a privilege I continue feel grateful to have the capacity to offer despite my age of 74 and living with Parkinson's disease. People appreciate the experience and wisdom I bring to my work, and I continue to learn from them as we work together in such an intimate way. One of my own excellent Gestalt teachers went from her last session to her death within about 10 days. I remember deciding then that that's how I want to finish my life. ■

CHECK IT OUT IDEAS TO MOTIVATE AND INSPIRE

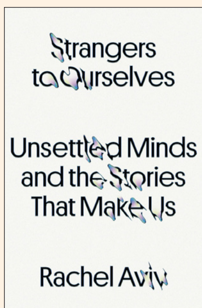
Read



LIFE IS IN THE TRANSITIONS: MASTERING CHANGE AT ANY AGE

BY BRUCE FEILER

We live in a world in which transitions are becoming more plentiful and mastering the skills to manage them is more urgent for all of us. The idea that we'll have one job, one relationship, one source of happiness is hopelessly outdated. *Life is in the Transitions* introduces the fresh, illuminating vision of the nonlinear life, in which each of us faces dozens of disruptors. One in 10 of those becomes what Feiler calls a "lifequake," a massive change that leads to a life transition. *Life is in the Transitions* can move readers of any age to think deeply about times of change and how to transform them into periods of creativity and growth.



STRANGERS TO OURSELVES: UNSETTLED MINDS AND THE STORIES THAT MAKE US

BY RACHEL AVIV

Strangers to Ourselves poses fundamental questions about how we understand ourselves in periods of crisis and distress. Drawing on deep, original reporting as well as unpublished journals and memoirs, Rachel Aviv writes about people who have come up against the limits of psychiatric explanations for who they are. Aviv asks how the stories we tell about mental disorders shape their course in our lives — and our identities, too. Challenging the way we understand and talk about illness, her account is a testament to the porousness and resilience of the mind.

Listen

HIDDEN BRAIN PODCAST

Available on all major streaming platforms

Shankar Vedantam uses science and storytelling to reveal the unconscious patterns that drive human behaviour, shape our choices, and direct our relationship.

Watch

INTEROCEPTION: OUR REAL-LIFE SUPERPOWER

CARRIE DEJONG, RCC, *TEDxChilliwack*

Watch at https://www.tedxchilliwack.com/2022-talks

Interoception is one of our least-known senses. It provides our brain with important information from our body. This information is necessary for managing our bodily needs, but it is also vital to emotional processing, decision-making, rational thought, and good mental health. In a TEDxChilliwack talk, Registered Clinical Counsellor Carrie DeJong explains why interoception is a secret superpower.

WHAT'S YOUR AILMENT?! WITH MARIA BAMFORD

Streaming on CBC Gem

Maria Bamford talks candidly with fellow comedians and artists about their experience with mental health, past or present.

5 AUTISTIC TRAITS we would all benefit from embodying

BY KERRY SCHROEDER, RCC

Showing up as an autistic person in a neurotypical world can be exhausting. Fluorescent lights in grocery stores, required meetings at work, and even small talk with strangers can be excruciating. There's a flipside to everything though. Where there may be challenges in one area, there can be strengths and specialization in another.

Instead of pathologizing autistic traits, isn't it about time we, as mental health professionals, change the narrative to value and emulate neurodivergent ways? Here are five autistic traits to consider noticing, appreciating, and exercising yourself:

1 – DIRECT COMMUNICATION

Participating in the social world is a communication game of reading body language, de-coding linguistic nuances, and guessing intentions. Many autists naturally say what they think and mean what they say. No guesswork needed! Perhaps we can try speaking more directly, too, leaving less room for misinterpretation.

2 – SENSORY SENSITIVITY

While autistic individuals may need to wear sunglasses outside, headphones at the grocery store, and tag-less clothing everywhere, they also may experience beauty intensely. Visual overstimulation and sensitivity may have them avoiding crowds, but also marvelling at nature. We could all benefit by slowing down and noticing the sun sparkle through running water or the intricate veins of a leaf.

3 – ROUTINE ORIENTATION

Autists may struggle with sudden change, but many thrive in the intentional confines of ritualized structure. Life has natural segments: seasons, tides, moon phases, and daily darkness and light. Many autistic folks embrace these rhythms intuitively in ways that neurotypicals often overlook. Why not pick up calendaring as a hobby, scheduling in daily, weekly, and seasonal routines that match your needs and circumstances?

4 – MONOTROPISM

The autistic brain seeks specialization. When there's a topic of interest, it's more than a "hobby" — it's an all-encompassing fixation. And with fixation comes specialization. The world needs individuals obsessed with even the most obscure topics, and often, it's the autists who are up to the task. Next time you notice yourself abandoning a hobby or educational pursuit, consider instead diving in deeper.

5 – EMPATHY

It's a misconception that autistic people lack empathy. In fact, they often experience it in an extreme manner. Some refer to this misconception as the "double-empathy problem" — neurotypical and autistic people tend to express empathy differently, which can cause misunderstandings. That said, it's often the autistic folks protesting injustice, standing up for the marginalized, and fighting for animal rights. We may have similar intentions, but perhaps we can lean in a little closer, learning from justice-sensitive neurodivergent voices.

Although neurodivergence brings challenges, the neurotype may not be the problem. Environments can be disabling, and under intentional conditions, many autists can operate optimally. Instead of "treatment plans" and "interventions," we might consider accommodating and embracing autistic individuals so their natural strengths can shine. And perhaps more importantly, we might seek their help in speaking directly, noticing beauty, embracing ritual, pursuing specialization, and standing up against injustice. ■

Kerry Schroeder is a neurodiversity-affirming RCC who specializes in autism, PDA, ADHD, SPD, giftedness, and anxiety. From her private practice in Vancouver, she offers online parenting courses and support groups, as well as a free parenting e-newsletter. Her two neurodivergent children fuel her passion for her work.

BCACC Member Health Benefit Plan

EDGE BENEFITS

BCACC offers our members an opportunity to enroll in a **Health and Dental benefits plan through Edge Benefits Inc.** This Health & Dental plan is designed to reduce medical, drug and dental costs for individuals and their families.

This fall, we invited Stephanie Ritchie, BCACC Benefit's Advisor, to a Lunch & Learn information session where she answered some of the most common questions from BCACC members including:

- What's included in the plan and available add-ons
- Who can purchase the plan
- Disability and loss of income, and understanding the difference
- Health and Dental coverage
- The difference between individual and groups plans

Watch the recorded Lunch & Learn at your leisure by visiting **https://learn.bcacc.ca/health-benefits/**.

For a no obligation quote for Life, Disability, Critical Illness and Health & Dental benefits please contact me at **stephanieritchie@shaw.ca** or at **778-533-4676**.

BC ASSOCIATION of CLINICAL COUNSELLORS

THANK YOU

TO OUR VOLUNTEERS

BCACC's Clinical Supervision Committee is tasked with the development, launch, and refinement of an amended RCC designation for Approved Clinical Supervisors: RCC-ACS. Designed to enhance the culture of clinical supervision and consultation among BCACC membership, the Approved Clinical Supervision program was launched in the Winter of 2021.

As part of good ethical practice and in alignment with the expectations of the counselling profession, the Clinical Supervision Committee is committed to fostering the upgrading of clinical supervision and consultation within our membership. The new designation, RCC-ACS, allows qualified members practising as Clinical Supervisors to have a recognized designation that honours their training and experience.

This Committee has worked hard to bring the Approved Clinical Supervision program to the membership.

Committee Members

- Vange Thiessen
- David Stewart
- Deborah Verkerk
- Susan Armstrong
- John Sherry
- Susie Lang-Gould

JOIN WITH US IN APPRECIATION OF THIS DEDICATED GROUP OF VOLUNTEERS!