WINTER 2023

INSIGHTS

THE BC ASSOCIATION OF CLINICAL COUNSELLORS' MAGAZINE

IMPROVING RELATIONSHIPS BETWEEN PARENTS AND THEIR TEENS

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INSIGHTS
THE BC ASSOCIATION OF CLINICAL COUNSELLORS' MAGAZINE

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

Jane Beaumont, Rob Broughton, Celine Cluff, Erin Davidson, Leanne Rose Dorish, Kate Drew, deirdre mclaughlin, John Sherry, Colleen Vantol, Britta Regan West, Jessica Wolf

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

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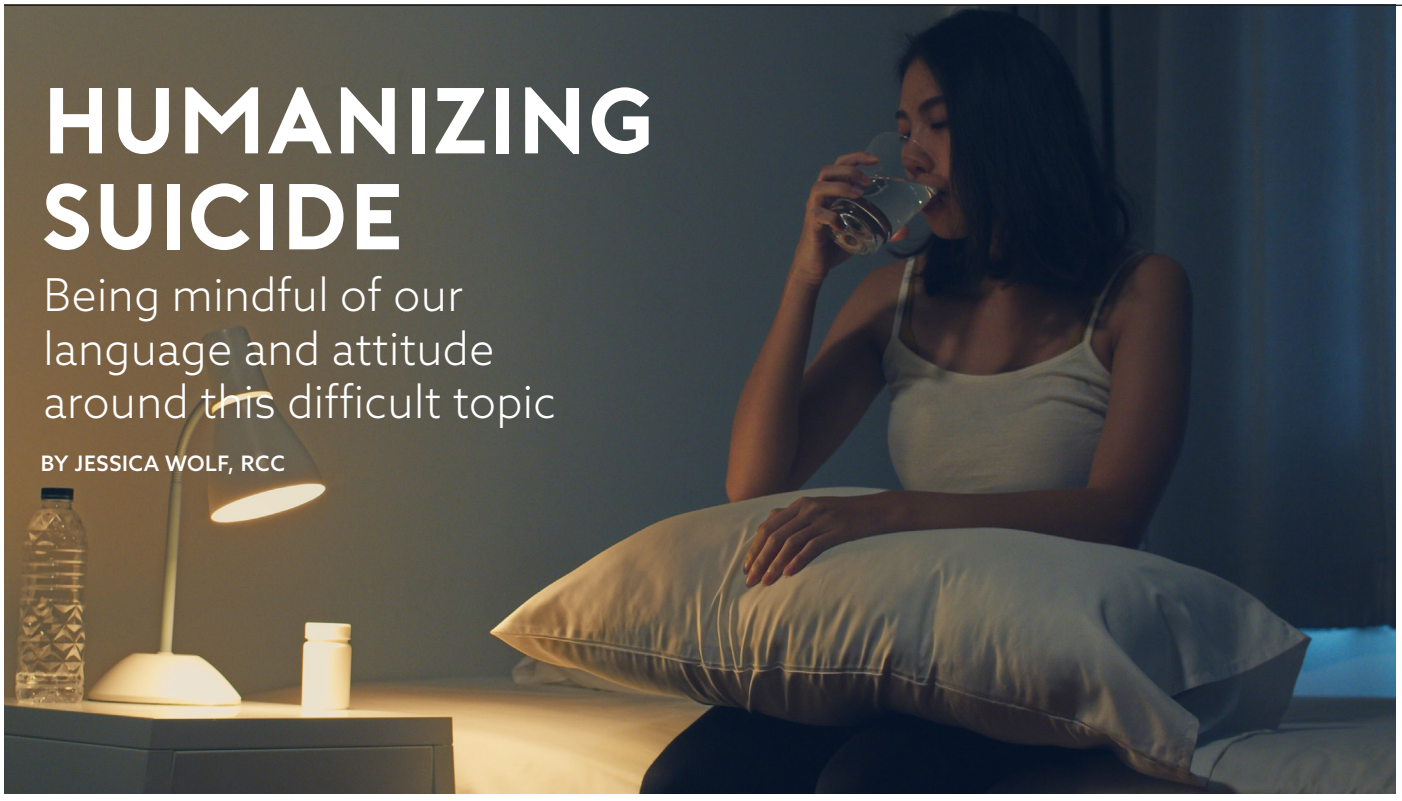


HUMANIZING SUICIDE

Being mindful of our language and attitude around this difficult topic

BY JESSICA WOLF, RCC

As counsellors, we are called to be agents for change when talking about suicide. Even today, suicide holds an unnecessary burden, both of stigma and taboo — stigma and taboo that stem from misbeliefs that have shaped our attitudes around the topic.

The common themes in suicides are emotional pain and hopelessness. As counsellors, we are aware that pain and hopelessness can affect everyone. While mental illness can be a major source of despair, we also know that we are all vulnerable. Suicide is the result of a perfect storm, meaning it is usually multifaceted.

Being agents of change means being mindful of our language around suicide, as the words we use disclose our attitudes. Words imply meaning. It has taken years for small but important changes to be made around the language used when talking around this difficult topic.

Words Matter, a document from the Canadian Association for Mental Health, is a guideline for how to approach suicide in our work. For example, we have moved away from "committed suicide" to "died by suicide" or "suicided." The word "committed" links suicide to crime, sin, and the idea that people are literally committed to suicide.

Additionally, we are moving away from the idea of people being suicidal to people having thoughts of suicide or showing suicide behaviour. An important shift can be made by differentiating the person from the problem and recognizing that suicide is not a static state but something that fluctuates and changes. This shift also recognizes that most people who think about suicide are not certain but are more often ambivalent, and that we can support our clients to see and understand this ambivalence.

Working so closely with people and being intimate witnesses of their life's journey, we have a responsibility for our attitudes and their possible impact on our interactions. We all hold attitudes regarding suicide that can stand in the way of being a good helper. And the invitation is not necessarily to be neutral but to be aware. Our attitudes are also shaped by our experiences; reflecting on how suicide has impacted our lives is key.

Humanizing suicide refers to being okay with asking and talking about suicide, knowing that thoughts of suicide come from facing hardship and hopelessness in life. Emotional pain is, in fact, a price we pay for living. And in many cases, emotional pain can be an important catalyst for change.

When diving into the tumultuous waters of suicide and talking with those who are feeling hopeless, we might find ourselves drowning in the same waters. Hope is the lifeline that can keep us connected to shore. Being hopeful when working with people experiencing thoughts of suicide is essential, yet not losing the capacity to feel for the other

and be empathic.

As our clients' life stories unfold, invitations to talk about suicide will come up. When we accept these invitations and we ask openly about suicide, we are letting our clients know we are a safe space for them to share. Letting clients know it is okay to talk about their thoughts of suicide allows for a deeper connection — a connection where their story of pain can be heard and validated and where, in time, alternative stories can be constructed.

Humanizing suicide is also key in the work we do in the aftermath of suicide. We know each suicide impacts other people as the shockwave of the tragedy spreads through the community. For those who stay, suicide is a hard experience to digest. It is even harder to face without the right support and while dealing with the additional burden of stigma and taboo.

People impacted by suicide often refer to feeling misunderstood, isolated, and judged. They look for sameness and resonance with others who have the same life experiences, since this seems to be the only way they find belonging and compassion. People who have experienced suicide loss may also have a higher tendency to have thoughts of suicide. This can be explained by the excruciating pain they may be experiencing. Still, thinking about suicide does not mean they will follow through — it just means they are humans facing incredible amounts of pain.

We need to move into a more humanized approach to suicide. Not doing so can lead people in general and clients in particular to withhold their stories of pain and possibly thoughts of suicide that may arise.

Reflecting on our roles as helpers working with clients who have thoughts of suicide, have engaged in suicide behaviour, or are dealing with the aftermath of a suicide can feel intimating. Ongoing education can allow us to feel comfortable and confident in the work we do as we move into a more humanized approach to suicide.

The Crisis Centre of BC offers a spectrum of programs and services, including suicide/crisis support, training for professionals and communities, and suicide loss programming. Learn more here: https://crisiscentre.bc.ca.

Jessica Wolf, RCC, is an ASIST trainer and suicide bereavement coordinator at the Crisis Centre of BC.

BCACC TEAM PROFILE: JANE BEAUMONT

RCCs have a new source of support, guidance, and professional development. Jane Beaumont, RCC-ACS, is BCACC's Professional Practice Manager, and she brings with her a wealth of experience and knowledge.

Jane started her counselling career in 1995 in her home country of Australia, where she worked in many different roles, including with high-risk youth in addictions and harm-reduction programs, school counselling, non-government organizations with families referred from child protections services, then with families with a particular focus on eating disorders. In 2015, Jane and her family moved to British Columbia, where she worked in various capacities, including government and non-government organizations, as a specialist on eating disorder teams, family therapy, and team leading. In the last few years, Jane has worked mainly in supervision, training interns in MA programs and consulting with several organizations, including school districts on clinical work, as well as preventing burnout and establishing supportive relationships within teams.

Jane also has a private practice through Quoia Therapeutics, where she focuses mainly on supervision and takes limited clients for family and couple therapy, eating disorders, anxiety, depression, burnout, and mood disorders using attachment-focused

> "I'd seen Australia go through similar changes in mental health policies and strategy a number of years ago, and it had a big impact on the profession in many ways."

models, EFFT, and other trauma-focused models. She teaches in the MA program at Trinity Western University and is an Approved Clinical Supervisor with a passion for "the person of the therapist."

Currently three days a week, Jane is BCACC's Professional Practice Manager, a role she was inspired to take on because she could see the need for support for RCCs through some significant changes in the profession, particularly with government policies and strategies.

"I'd seen Australia go through similar changes in mental health policies and strategy a number of years ago, and it had a big impact on the profession in many ways," says Jane. "One of the things I saw is a real need for someone who could not only be their administrative support, but also be someone who could provide clinical support, continue to advocate for the profession, and improve professional practices. I'm passionate about developing great systems and processes that help people connect to psychotherapy by reducing barriers and supporting our RCCs in their private practices and new therapists coming into the profession."

Jane Beaumont, RCC-ACS, is BCACC's Professional Practice Manager, as role focused on programs and support for RCCs.

Her goal: "To continue to be a voice for RCCs in our profession and to develop that professional identity. Counselling is different than other professions. It's creative, with breadth and depth. My hope is that as an association we can be cutting edge with our research, practice, and continual development of supervisors across the province."

As Professional Practice Manager, Jane is focused on programs and support for RCCs.

"A lot of the questions I receive are about standards of practice and codes of ethical conduct," she says. "What I hear a lot from our members is they want to do the right thing. They want to be serving the public really well, have excellent practice strategies, and use the best of their skills. That's encouraging to me."

Another aspect of Jane's role is supporting relationships with government and significant stakeholders as BCACC continues to advocate for the profession, whether it be related to regulation, ethics and standards, or new areas of practice.

Her message to RCCs: "You may see only one small part of the journey for a client, but your work is significant. My encouragement, my message, is to stay focused on the incredible work you are doing; don't feel hurried, as you attune to your clients and follow the 'golden thread' of your client's story as you co-create a new experience of themselves."■

COUNSELLING IN A CHANGING WORLD:
Re-Imagining Our Environments

On November 3 and 4, 2023, BCACC hosted their bi-annual conference, Counselling in a Changing World: Re-Imagining Our Environments. This dynamic event took place in Vancouver at the Hyatt Regency Hotel. Almost 500 in-person attendees were joined by 200 virtual attendees.

The conference was opened by Elder Bob Baker, co-founder and spokesperson for Eagle Song "S'pakwus Slolem" dance troupe. Sarah Kennell, National Director of Public Policy at the Canadian Mental Health Association, gave the opening address, entitled "Where's My Mental Health Care?"

Clinical Psychologist, author, and professor, Dr Sue Johnson joined the BCACC conference for a rare, in-person, two-hour presentation on the importance of building the therapeutic relationship: "Belonging Leads to Becoming: The Alliance in Emotionally Focused Individual Therapy (EFIT)."

Sessions over the two days ranged from Neurology and Trauma and Medical Assistance in Dying to working with IBPOC youth and so much more.

The Honourable Jennifer Whiteside, Minister of Mental Health and Addictions, closed the conference and thanked attendees for the valuable and exceptional work they do as Registered Clinical Counsellors across B.C.


Elder Bob Baker

BCACC wishes to thank all attendees, sponsors, and exhibitors for helping to make this event a success.

BCACC's 35th Anniversary Gala

BCACC turned 35 this year! To celebrate we hosted a 35th Anniversary Gala event the evening of November 3, 2023. Guests enjoyed a look at the history of the association as well as a look towards the future.

Jonny Morris, CEO of CMHA BC, accepted an honorary BCACC Membership for all he has contributed to the area of mental health.

As well, BCACC awarded four Joan Campbell Awards for 2023. Congratulations to Sher McGillis-Fast, Sediqa Temori, Danielle Raymond, and Kirstie West. The $1,000 annual award is funded by corporate and individual donors and given primarily to new member applicants who intend to work with underserved communities. For more information, visit bcacc.ca/joan-campbell-award.

IT'S TIME TO RENEW YOUR BCACC MEMBERSHIP

BCACC memberships will expire on December 31, 2023. BCACC's online renewal is available to members in the member portal — log in at members.bcacc.ca/login. As always, BCACC Head Office staff is available to assist if you have questions or concerns.

EVER-CHANGING ROLES

When caregivers need care

BY COLLEEN VANTOL, RCC

Many clinical counsellors working with adult populations will meet the "sandwich generation." The sandwich demographic describes the phenomenon that middle-aged adults encounter when they are supporting and overseeing care for aging parents while also actively caring for their own developing children. This group becomes "sandwiched" between competing needs — parents supporting their children's growth at the same time as helping their own parents when their abilities and quality of life are in inevitable decline.

The sandwich generation experiences myriad competing factors that they are continually drawn into and divided over. Moving through this difficult life chapter requires personal, emotional, financial, and social support to negate the potential to become overwhelmed. People who find themselves in this space seek counselling and therapeutic support due to being exhausted and conflicted and are also often managing their own existential challenges.

Some of the challenges associated with people who find themselves in this cohort include the level of care that their parent(s) require, what the family understands of the parents' desires and needs as they experience a decline in their quality of life, who takes on what roles with parent care (where there are adult sibling groups), while also balancing their child's or children's learning and academic needs, social development, and extracurricular activities.

Alternatively, people in this group may also struggle with making choices, parenting, and meeting external demands on them, because they are unable to be present and take care of their own mental health.

For many, further factors that contribute to life stressors include career demands and marital stress. Many people in this demographic report frequent workplace interruptions due to a need to address medical care or coordinate roles and schedules with either children or aging parents. While most workplaces are supportive and understanding, it doesn't change the requirement of job responsibilities or outcomes that are criteria for maintaining gainful employment and can add both workplace stress and potential financial stress if left unaddressed.

Marital stress is also frequently experienced for people found within the space. As one spouse may be consumed with sadness at the impending loss of their parent, complex emotions may arise, leaving spouses unclear about how to support each other and resulting in neglect of the marital relationship in general.

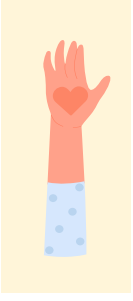
As a clinical counsellor, supporting the client to ascertain their priorities is essential, and assessing triage requires insight into the client's present functioning. Effectively identifying needs and gaps is an area that can prove fruitful in terms of solution focus.

Once these immediate needs are identified, the deeper work comes in supporting the client with their existential process. On one hand, they










are fostering growth and life, and on the other hand, they are observing its decline, leaving many with questions about their own life purpose and relationship with their parents, as well as evaluating their abilities and needs in parenting their own children.

SUPPORTING CLIENTS

People who find themselves sandwiched are occupying multiple competing and ever-changing roles. This may lead to burnout, compassion fatigue, and overall exhaustion unless the people facing these stressors focus on creating space for self-care. Within the therapeutic setting, meeting these people where they are at is the basis for cultivating counselling rapport. This process becomes the vehicle by which all vulnerabilities will be explored, strengthened, and supported, regardless of your counselling ideologies or clinical philosophy. Emphasis on self-care cannot be understated.

Supporting clients to recognize what is absorbing their mental energies most as a focal point is helpful; however, building in an emphasis on self-care is essential to keeping this demographic resilient and fostering the growth and fortitude required to navigate all the novel life events to come. More than most, this cohort needs permission to focus on what they need, when everyone else is requiring something from them.

Through the course of my work as a clinical counsellor, I have worked with clients who have recognized that their self-care requires distancing themselves from their parent's everyday needs and care, whereas others chose their parents end-of-life care as a priority and are comfortable to allow all else to fall to the wayside in order to oversee this. In essence, each client's situation is ubiquitous but there is no one-size-fits-all solution; counsellors

PRACTICAL HELP

Here is a list of resources from Colleen Vantol, RCC, to help the sandwich generation cope with competing factors.

- Self-assessment for compassion fatigue for caregivers: https://ncwwi.org/files/Incentives__Work_Conditions/Compassion-Satisfaction-Fatigue-Self-Test.pdf
- HandyDART (Translink), for support with getting to and from medical appointments: https://www.translink.ca/rider-guide/transit-accessibility/handydart
- 211 British Columbia, for support in finding home care, support for seniors, activities for seniors, and overall family system supports: https://bc.211.ca/?gclid=CjwKCAjwvrOpBhBdEiwAR58-3Hw N7-qAw9C2kB9QUWufc8OgtdqHZtzqpD46KclukXOiSmqWFXfpXhoCVfoQAvD_BwE
- Meal Train, for support in providing meals and food prep for aging parents: https://www.mealtrain.com/
- Resources For The Sandwich Generation: Self Care Leads To Better Caregiving, a video guide featuring Elizabeth Miller: https://www.youtube.com/watch?v=oY7C8B2m1bQ

Books to give guidelines and factors of consideration while caring for aging parents:

- *The Accidental Caregiver: Wisdom and Guidance for the Unexpected Challenges of Family Caregiving* (Sunderland House, 2022), by Dr. Kimberly Fraser
- *The Sandwich Generation's Guide to Eldercare* (Demos Health 2023) by Danielle Dresden, Kimberly Wickert, Philip D. Rumrill Jr.

need to be open to a wide range of coping responses and alterations that occur over this life chapter.

In order to preserve best care practices while meeting people actively navigating the "sandwich," it is essential that clinicians be aware of their own biases so not to influence the client's determination about their own needs. This population is looking to professionals to guide and support them with the parents' medical needs and their children's behavioural, academic, and developmental needs. When they meet with a counsellor or therapist, many are exploring ideas like assisted suicide, medicating their children, and/or separating elder spouses to more supportive care, among other complex family dynamics. For most, emotionally processing this life chapter occurs over many sessions, whereas week to week, changing factors and pressures may force them to make choices. At the core of these complex and competing needs, lie moral positions that the client may be still examining, and they need support to build confidence in their ability to make a sound decision after calculating risks and benefits.

Notably, it is essential for clinicians to ensure that they, too, are doing their own personal work. If you have not experienced these stressors, you may not fully recognize the factors that your clients are facing. Alternatively, if you have lived experience, you want to ensure your personal experience and grief have been resolved in a manner that allows you to be fully present with your clients and their realities to support their continual healing and growth.

Colleen Vantol (she/her) is an RCC practising in the Fraser Valley. She operates from a person-centred approach, drawing in the tenets of CBT, narrative therapy, and mindfulness to support personal revelation and growth.

PERSPECTIVE

FROM INSIDE THE SANDWICH GENERATION

BY CAROLYN CAMILLERI

Leanne Rose Dorish, RCC-ACS, used to tell her friends that when she went to the grocery store, she bought mushy food and diapers for her two-year-old son and for her 95-year-old grandma.

"It was both ends of the spectrum, but they needed the same things," she says.

For Leanne and her partner, factors competing for their attention spanned four generations.

"It's a continuous thing for us," says Leanne. "My husband's mom has frontotemporal dementia and she's just in her '70s. My husband was and still is his grandmother's executor and was power of attorney when she was alive. Because mom was incapable of making the decisions, we made decisions with and for grandma."

Add to that raising their son, who was born nine weeks premature, which meant all kinds of medical appointments well into his fifth year. Then there is work — they both have busy careers.

Leanne's family situation is the perfect "sandwich generation" example. Situations to monitor and address, appointments to make and keep, places to get to and from in traffic, and a plethora of difficult decisions to make — to the point of decision fatigue.

"Grandma has passed on now, so the load has gotten lighter and also because mom is getting the care she needs. She's in a facility finally but that transition was really difficult."

Then there are the emotions.

"All of us were just riddled with guilt and sadness and frustration and exhaustion and the sense of responsibility and anger at the system and anxiety for the future," says Leanne.

Fortunately, Leanne and her husband are very gentle souls, which helps them get through challenges.

"We have that awareness for each other, and we were on the same page, which is huge," she says. "A lot of the time, couples going through this kind of thing don't see each other's position,

or it's a struggle to be on the same page, because they're not getting what they need from the other person. Fights break out and the other person doesn't understand."

Sometimes loneliness would hit and the more existential questions would come up.

"Quite often, my husband and I would be like, 'Why are we doing this? We could just leave and live in Europe and not deal with any of it. Why are we here? What does freedom look like?'" says Leanne. "That's where the exhaustion was, too — we weren't living for us."

Dividing tasks and responsibilities helped, especially during peak times, with Leanne caring for everything related to their son while her husband looked after mom and grandma. They also took short breaks whenever they could.

"We would leave our phones at home and play in the snow with our son for a morning," she says.

Every two or three months, Leanne's husband would spend a couple of hours computer gaming online with a friend. Once a quarter, Leanne would stay alone overnight at a nearby Airbnb and rest.

"We made boundaries we both agreed on, and we allowed the other person to honour what they needed," she says.

What is needed is self-care, but it has to be personalized and flexible to be effective, something Leanne wrote a NICU book about: *Loving Myself Again: Self-care from A-Z after a NICU Stay*.

"What we learned through all of this, my husband and I, is to take mini moments that don't even seem like self-care and frame them in a self-care way," she says.

For example, getting off the bus one or two stops early to make the longer walk a brain break. Playing in nature — even finding an area of grass and taking your shoes and socks off — or just being conscious of your breath once a day.

"Those little mini breaks actually can reset us, let our shoulders down, give our brain a break and our emotions a break," she says. "But even taking those moments, we felt guilty for taking the time for ourselves."

Counselling was an important part of Leanne's coping strategy.

"I was going to counselling to just vent and have someone hold space for me," she says. "It wasn't for answers— it was just for me."

In addition to practical suggestions for managing the caregiving load and personalized, flexible self-care, the sandwich generation needs someone who can really listen. ■

CULTIVATING CONNECTIONS

Tips to help couples improve communication, particularly in challenging times

BY CELINE CLUFF, RCC

Since the onset of the pandemic, families have experienced an uptick of stress collectively and individually. Many of the family rituals and routines couples relied upon to raise happy and healthy kids have gone with the wind and brought new challenges instead. Couples who were able to fall back on their community or inner circle suddenly had no place to turn to for childcare. My husband and I welcomed our second child during the pandemic and have struggled to find time for ourselves and each other ever since.

The gap in childcare services is not the only thing holding couples back. For many, work is another fragment of life that has changed forever. Although working from home has helped people feel more in control of their work-life balance, people in a study conducted in Europe (29 European countries and 5,748 participants formed the data set) expressed feeling the negative effects of home office constraints. Not having a clear distinction between one's personal space and one's work space, no childcare, and a lack of structure with regard to productivity are just a few examples of how life has been turned upside down. In particular, the participants of the study reported feeling isolated due to a decrease in interpersonal contact as well as an increase in misunderstandings.[1]

GREATER NEED FOR COUNSELLING

After everything people have been through during and as a result of the pandemic, it comes as no surprise that the demand for therapists and couples therapists is on the rise. When seeking people to work with, couples need to be encouraged to check therapists' credentials and clinical training background. Not all couples therapists are created equal. Therapists can actually do harm to couples if they are not adequately trained to work with them. The reason for this is that a different set of rules applies

to the modalities used for working with couples, and not all modalities suit all couples.

The approach I count on is the Bader/Pearson Developmental Model. This model represents a comprehensive training for couples that integrates different theories along with neuroscience to offer a cohesive system to manage different relationship dynamics. The model presents non-pathological diagnoses of why couples experience challenging times throughout their relationship by focusing on the improvement of communication.

That being the case, it is quite normal for couples to have to learn how to communicate effectively with each other. This skill lies at the heart of the Bader/Pearson approach and works towards cultivating connection and closeness in couples regardless of their differences. Being different is not something negative; instead, it should be viewed as an opportunity for partners to learn something about each other and practise acceptance — for example, "I can't change my partner and neither can my therapist."

In therapy, this opportunity to learn is referred to as differentiation. Differentiation is the ongoing process of defining and revealing the self while managing boundaries — i.e., "I can't change my partner, but I can change myself." Differentiation is not optional if a couple wishes to take their relationship to the next phase. It is a necessary process whereby couples move beyond the honeymoon phase (symbiosis) of the relationship and embrace who they truly are as individuals while honouring who their partner is as an individual by respecting their values, passions, and desires.

That said, married couples of different age groups have different reasons for deciding to seek out the help of a trained professional. On top of the acute pain they might be in, some concerns couples face include making time to work on their relationship and paying for the costs that are associated with therapy.

Even after a relationship has reached a breaking point, people tend to seek professional help. What this tells us is that getting a separation does not necessarily clear up the issues that cause couples to feel inclined to separate in the first place. Some commonly listed complaints of couples who have separated include unproductive arguing, lack of intimacy, withdrawal, stonewalling, constant conflict without resolution, power struggles, and lack of role clarity.[2] You might wonder: what is the commonality of these problems? The answer is ineffective communication.

It is quite normal for couples to have to learn how to communicate effectively with each other.

COMMUNICATION IS KEY

Two clinical psychologists based out of Menlo Park in California were already onto this truth in the '80s — long before couples counselling was even a thing. Until quite recently, couples therapy was regarded as the stepchild of therapy. This did not stop thought leaders Ellyn Bader and Peter Pearson from offering their unique, in-depth training to clinicians and counsellors working with couples. They founded The Couples Institute and created the Bader/Pearson Developmental Model.

The Couples Institute's website offers a timely selection of free tools and information on how to effectively improve relationships. For example, the site contains quick reads and a wealth of information ranging from techniques to initiate effective communication to how to be an effective listener. Occasionally, Bader and Pearson offer free self-directed learning sessions for clinicians, entailing technical decks and video clips. I encourage you to explore the wealth of information The Couples Institute has to offer you and your clients[3]

In the meantime, I have curated four steps that can help couples mark the beginning of improved communication. Keep in mind that even the smallest changes can make significant differences over time.

FOUR STEPS TO MARK THE NEXT RELATIONSHIP PHASE BY IMPROVING COMMUNICATION

Step No. 1: Get clear on how you want to show up during difficult conversations.

Getting clear on how you want to show up during a difficult or triggering conversation means thinking about how to put your good intentions into actions by putting your best foot forward. It can be challenging to put yourself in the right headspace to achieve this. Work and the division of household chores and childcare can really work against us when we try to be our best selves and live our truth.

Find the right time to do this exercise, rather than push yourself to just "get there." When the time is right and you feel like there is extra to go around, make some mental notes about how you would like to represent yourself during a difficult conversation. For example, when I get triggered, my energy can be a lot for my partner to handle because my energy is already animated as a busy mom of two

young children. My partner then retreats in order to safeguard himself from my level of energy. This kind of dance can give rise to other repetitive behaviours, such as anger and frustration from one partner, which is met with escapement (withdrawal) from the other.

A more sustainable goal is to set the intention to stay curious. This exercise is not about being all the things that would classify you as a unicorn spouse — a spouse of mythical perfection. Start with one change: for example, I will stay calm by making the conscious effort to breathe more deeply.

Step No. 2: Focus on one issue — how important is it?

In the heat of the moment, many things can seem worthy of intense discussion and confrontation. Further, when couples

Make some mental notes about how you would like to represent yourself during a difficult conversation.

Think deeply about the meaning of being mindful of your partner's time.

feel strongly about an issue, it can give rise to the urge to re-hash previously discussed yet unresolved issues. Avoid getting sucked into that black hole and stay focused on one problem. Do not let any of your partner's attempts to sidetrack you get in your line of focus either. Keep circling back to the issue at hand. Like Step No. 1, this step requires thorough pre-meditation (patience is a virtue). For example, when something comes up, try to sleep on it instead of jumping right into the issue. If the issue is ongoing and still in need of resolution

the following day, circle back to Step No. 1 and then skip ahead to Step No. 3.

Step No. 3: Check your partner's readiness.

You have arrived at a crossroads and have decided to initiate a difficult conversation with your partner. Despite the fact that a problem needs resolution (according to you) and you have good intentions to put your best foot forward during this difficult conversation, your partner might not be on the same page. Because your partner plays a role in the success of your attempt to resolve a problem, you want to be sure it's a good time for them to have this exchange.

We've all had to stop doing something when one of our kids runs up to us asking for something (or shouts down the hallway that they ran out of toilet paper). The feeling of being temporarily interrupted while taking care of business (like making dinner) is rarely pleasant. When it is our partner who is interrupting us, the tone in our response can change. Here's how it goes in my head: "Why does my partner ask me to do something for them when I am clearly busy?" We expect an awareness on behalf of our partner, yet we rarely contemplate our own level of awareness.

Think deeply about the meaning of being mindful of your partner's time. Your partner might feel that having that difficult conversation is the last thing they want or can do at that moment. Maybe they are running on an empty tank or had a tough day (week) at work or feel like they can't show up for you in a way they would like. That's why it is important to check your partner's readiness. An example of a check-in could look like this: "Something has come up and I would like to take a few minutes to discuss it with you — is that available?" If the answer is no, then the onus to have the conversation at a later time falls on your partner. This means they are being held accountable for initiating the conversation at a time that is convenient for both of you.

Step No. 4: Hold onto yourself.

This final step is the most crucial piece of the communication puzzle. Without it, we have to work twice as hard to transform our good intentions into actions, while reaping only half of the results. Holding onto yourself is as much about knowing your worth and what you deem to be true according to your values, as it is about tapping the Achilles heel of your relationship dynamic. When people are triggered, they get emotional; when they get emotional, they are more likely to say things that are hurtful and untrue. For example, accusing the other, blaming them, throwing "shade" — these are possible outcomes of bad communication. And it doesn't take long for a conversation to go sideways.

Holding onto yourself is as much about knowing your worth and what you deem to be true according to your values, as it is about tapping the Achilles heel of your relationship dynamic.

Start to hold onto yourself by repeating: "I know I am a good parent/partner despite the things my significant other says to me when they are triggered" or "Their words are a reflection of the acute pain they are in and have nothing to do with me or my worth." These are great reminders that we are in control of the situation and that we can recognize who we truly are in times of challenge.

This kind of skill ties into the concept of differentiation mentioned earlier. Differentiation is hard work and requires ongoing effort. You can apply the technique of reiteration in this step. For example, reiterate what your partner has said and check in with them by asking them whether or not you got it right. This adds an element of curiosity and can diffuse the urge to want to retort after your partner has made a statement. You might learn something new and interesting about your significant other. Further, we might be surprised that our partner does not, in fact, think and feel the things we assume they think and feel.

These exercises work to break bad habits in communication — like drawing conclusions about the state of a relationship based on one person's experience and perspective alone. There are always two sides to the relationship coin. ■

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THE GOALS OF BEHAVIOUR

Helping parents better understand and improve the quality of their relationships with their teenage children

BY ROB BROUGHTON, RCC, AND KATE DREW, RCC

It is not easy being the parent of a teen. The landscape of their lives changes drastically and rapidly, and it is easy to misstep in this new terrain. Teen behaviour can seem inscrutable and senseless at times. But teens are looking for the same thing as all of us — belonging with those around them. This article uses the Adlerian concept of the four goals of behaviour (attention, power, revenge, display of inadequacy) to help parents better understand their teenage children and to improve the quality of their relationship with their kid.

Belonging is important to all of us. We all want to feel accepted, acknowledged, and understood. For teens, this is an important developmental task. For the vast majority of human history, teens were considered adults. They were physically mature and ready to begin contributing to their community or even start a family of their own. Of course, this is not the case now — teens have so much learning to do before they are ready to take on these roles. But the developmental need to lessen dependence on their family and build a community of peers around them remains. Teens are

highly motivated by their striving to build connection and belonging with those around them.

Teens are also undergoing significant developmental changes. Capacity for risk-taking in the teenage years increases greatly. This makes sense — branching out from one's family is a big risk, and teens need to be physiologically equipped for this. Teens also experience emotional highs and lows more strongly than adults. Physical growth takes on a greater pace, and young people are getting used to being in a new body. And the need to individuate — to become one's own person — is a task felt urgently by youth.

Adler's four goals of behaviour can help us understand what teens are expressing. Adler acknowledges that humans are social beings, and that we are hard-wired for connection (i.e., belonging). He also stated that everyone needs a place to belong, to feel like a "vital part of our social group" (Adler's Social Interest STEP for Teens). The behaviours we use to achieve this can be helpful or unhelpful. In either case though, it is useful to be curious about the goal and to look beyond behaviours to what a young person is trying to achieve, rather than just view the behaviours themselves as difficult or upsetting.

We hope this article offers an opportunity to view teens with curiosity and greater understanding. It can be helpful to shift thinking from viewing teens' behaviour as problematic (although it can sometimes be exactly that) to trying to understand what teens are trying to achieve, and how we can help them to meet their goals in healthy ways.

ATTENTION AS THE GOAL: "I BELONG WHEN I AM NOTICED OR SERVED"

We all need to feel accepted, acknowledged, and seen, but sometimes we can mistakenly feel that we need to be the centre of attention or served by others in order to belong. This may cause us to become overly goofy, disruptive, charming/pleasing, or draw others in through inaction. The goal is to feel included, to experience belonging through behaviours that demand the attention of others.

If your relationship with your teen feels strained, it's possible that they are seeking belonging through attention in unhelpful ways. Active forms of this might look like interrupting or asking for help with things they are able to do on their own. A passive form might look like laziness and needing many reminders to complete simple tasks.

Our emotions can be helpful in interpreting the goal of folks around us. Check in with yourself — does your teen's behaviour make you feel

Emotional highs and lows are more extreme during adolescence, and the pain of not belonging is felt more sharply.

irritated or annoyed? If so, it is likely that attention is their goal.

If your teen is seeking attention in ways that are damaging to your relationship, ask yourself: do they feel accepted and belonged at school, in their friend group(s), at home? Do they have opportunities to cooperate with others and contribute to common goals? Are they engaging with things they are good at in a way that fosters connection with others? Do they have opportunities to contribute in their home and enjoy time with family members? If not, consider making space for a collaborative project or protecting time that gives you the opportunity to hear about what is happening in their life. Support them in engaging with the things they are good at in a community or group setting.

POWER AS THE GOAL: "YOU CAN'T MAKE ME"

The teenage years are a time of rapid physical, emotional, and cognitive development. Things are changing quickly, and new abilities are being grown into. Teens need to have opportunities to exercise these emerging capabilities, but they also need to understand the limits of what they are in control of and that their place in the world is not contingent on being able to regulate everything around them.

Negotiations around power and control are a feature of most if not all parent/teen relationships. It is appropriate that teens push boundaries and that they develop a stronger sense of autonomy. But the misguided belief that strength is contingent on never being told what to do is harmful to our relationships.

If your relationship with your teen feels unnecessarily argumentative, perhaps they are (inelegantly) expressing a need for autonomy and control. It is difficult to be in relationships like these — most of us will feel angry, threatened, or frustrated. It is helpful to be aware of these feelings. Awareness can prevent us from becoming reactive and getting involved in a power struggle that produces a winner and a loser.

If you are involved in frustrating power struggles with your teen, try to be curious about what they are expressing. Ask yourself if what they are trying to achieve is a greater sense of autonomy and control. Agree with them — "I can't force you to do anything" — while engaging with them on constructive ways they can be in control. Try to remember that although boundary-pushing conversations can be upsetting, they are a necessary part of moving into adulthood. Maybe even allow yourself a little bit of pride that they are becoming a person courageous enough to start making their own decisions.

REVENGE AS THE GOAL: "I'VE BEEN HURT, AND I'LL MAKE YOU FEEL HOW I FEEL"

We all want to feel accepted and belonged. It is a basic human need. When we don't experience this, it can be very painful. One understandable response to

Young people deserve an environment where they can be successful.

this is anger and to try to hurt those who have hurt us. This frustration and hurt can also be expressed more generally at one's surroundings and the people around them. The general principle being expressed is misguided but not difficult to empathize with: I have been hurt, and I will make others feel like I do.

Teens are arguably especially sensitive to this. Emotional highs and lows are more extreme during adolescence, and the pain of not belonging is felt more sharply. Teens are also venturing further from their own families and the predictability of their home environment and learning about themselves through the feedback they receive from the world. Teens are also grappling with a significant developmental task — the creation of their own social group, separate from their families.

In addition, teens are venturing into the world as individuals for the first time. If they don't find a fit with the people around them, they lack the experience to know that sometimes, through no fault of our own, it takes time to connect with people. Maybe they are at a different school from their elementary peer group or have moved to a new community. Maybe there is a language barrier or the things they are interested in just happen to be different from the people around them. It may be that no one is to blame but still connection and belonging are hard to find.

When young people are hurt by their feelings of not belonging and angry at those they feel are responsible, it may present as bullying or cruelty towards peers, hurtful and damaging comments towards parents, a general sense of unfairness towards the world, or an

embracing of victim identity. Parents are likely to feel hurt, angry, confused, or even disgusted by what they are seeing. Parents may feel the impulse to lash out in return.

When teens are acting out with the goal of hurting those around them, it is important for parents to remember that these behaviours are coming from a place of pain. The young person wants very much — perhaps more than ever — to be accepted, loved, and connected. Parents can help by not taking things personally and by modelling their own commitment to fairness and harmony.

It can be helpful for young people to connect with social justice initiatives when they are struggling in this way. Ideally, they will come through their experiences with an understanding that things are not always fair and will feel moved to help those who are suffering, rather than seek to hurt those who have hurt them.

Sometimes young people will need outside help to move through their desire to seek revenge on an unfair world. Counsellors who work with youth are well positioned to offer this support.

DISPLAY OF INADEQUACY AS THE GOAL: "I'D RATHER NOT TRY THAN HAVE YOU SEE ME FAIL"

Feelings of incapability can be some of the most difficult emotions that people of all ages experience. Often anxiety stems from this feeling ("I am worried that I am incapable."), as does depression ("I know I am incapable. Things are pointless."). We have all felt this to varying degrees at some point in our lives.

With teens, this usually looks like extreme reluctance to begin or complete tasks. This can happen at school, with friends or family, or at other activities. The idea being expressed is "I am incapable of doing what is necessary to belong."

This often happens at school, when young people are expected to complete academic tasks that are too difficult. Youth with learning differences will sometimes internalize their difficulties as evidence that they cannot participate in or belong to the school community. If one believes themself to be incapable, it is preferable to refuse tasks rather than demonstrate failure to those around them.

Parents and young people are likely to feel similar emotions when inadequacy is internalized. Hopelessness and despair are common responses from parents and teens. Parents may feel a desire to over-help their teen or may come to expect very little of them and stop encouraging them. These are understandable impulses but are not helpful.

Remind your teen that there is a place for them in this world, and that their talents and capabilities benefit those around them.

Young people deserve an environment where they can be successful. If a teen is overmatched by the expectations of their school, it is important to advocate for them and let the school know that expectations need to be adapted. It may be helpful for the school to request a psychological-educational assessment to understand the young person's learning style, or if this is already known, for the school to deepen their understanding of how to support teens with this learning difference.

At home, provide many opportunities to engage in tasks that are manageable and have a guarantee of success. Acknowledge these successes and help them to see growth. Stay patient and draw attention to progress not just results. Remind your teen that there is a place for them in this world, and that their talents and capabilities benefit those around them. Show them and tell them that you will never give up.

As with "revenge," it can sometimes be helpful to reach out for support when a young person has internalized a sense of inadequacy. School counsellors, trusted teachers, or RCCs who work with youth are good places to start.

Good relationships are founded on understanding and acceptance. Adler's four goals of behaviour can help us better understand the young people in our lives and can encourage us to be curious rather than judgmental about what we are seeing. In doing so, we help show young people through example how to have healthy relationships, and we can improve our relationships with the young people in our lives.

The ideas shared here are part of a much larger body of work. If you are interested in learning more, consider taking the S.T.E.P (Systematic Training in Effective Parenting) workshops through the Adler Centre in Vancouver: https://www.adlercentre.ca/education. ■

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THE STRUCTURED RELATIONSHIP

and post-modality psychotherapeutic mindset

BY BRITTA REGAN WEST, RCC-ACS

Therapy is all about the relationship. We have all heard that refrain from the time we stepped into the sector during training and certainly from our supervisors as we mature in the profession.

As I have aged in this profession, I hear this refrain ebb and flow. There are periods of time where the sector believes this and embraces it. There are periods of time where it is rejected or resented. When rejected as a concept, it is often from the therapist's own frustration and despair for their client. As a supervisor, I see clinicians encounter their own despair all the time. We are helpers by nature, and at the back of our brains is a bias towards healing, correction, development, and change — even when all the client has available to them is acceptance. We work with someone, sometimes for extended periods, and our mind-behind-the-mind seeks change. Usually change that provides relief because as a relational person with empathy, we want that for the people we are connected to.

But is it their relief or ours? And why do we universally seek that relief of distress? And is relief of distress always therapeutic? And is relieving distress our only role?

STRUCTURING A THERAPEUTIC RELATIONSHIP

We seek distress relief for a client because we have entered into a relationship with them. Therapists being high in relationality, empathy, idealism, and compassion tend to seek relief for people they are connected to. Another's distress becomes a distress for us. That is empathy.

Of course, I am not saying this is a negative thing — but it is a thing. It forces us to unpack this concept of relationship in therapy, because we must structure the relationship in a clinical sense, not in a personal sense. The way in which I would like to alleviate my best friend's suffering is not the same as the way in which I should want to relieve my client's suffering. Our empathy, compassion, care, and urge to support cannot be the same as a friendship, as it will create an improperly structured therapeutic relationship and cause emotional damage. This nature of caring that we tend to have must be properly mediated and crafted as a component of the therapeutic relationship.

Additionally, care and empathy are not the totality of the "treatment bond." If it were, we would stop at support. We would embrace our client's distress and perceptions. We would provide empathy and unconditional positive regard.

Then we would get stuck — and so would our client.

Instead of being a friendship, we craft a relationship of psychotherapeutic care. We leverage the social learning brain within attachment to elicit growth in the client. In other words, we create a treatment bond. We connect, as people do, then we utilize the nature of our structured connection to move a person towards growth and improved adaptive functioning. This can look an infinite number of ways in the specifics, but it is always the same in process and structure.

We are not teachers that download information into another mind for learning and applying. We are in relationship with the other in the way of a biologic state of social learning, and emerging from that is the client's growth. The closest relationship equivalent outside of the therapy room is the parent-child bond.

> Care is universal in its purpose and process but specific in its demonstration.

IN THE PLAYGROUND

I am often reminded of a playground incident when my daughter was four. We arrived at the park for the millionth time, and she began to play with another little girl. I was drinking coffee on a bench beside another woman who I did not know. About 30 minutes later, in a very dramatic frenzy, my daughter and another girl came running towards the bench, screaming and crying with dirt and gravel all over their faces and clothes, and no shortage of tears. Two crying four-year-old girls are senseless, so it took a minute to realize that they had both tried to do the slide at the same time for fun, gotten tangled up in each other's sliding, and catapulted themselves into each other and the gravel at the bottom faces first. What started out as fun had turned into blaming each other for why they were hurt. Their moms just happened to be on the same bench.

The next moments were fascinating and I have never forgotten it as a therapist. Both of us mothers comforted and consoled the children. Both of us cared for them in making sure they weren't hurt. Both of us settled the girls' distress first. Both of us put our coffees down, tied the dogs, and focused

our attention on our child's state — we were in lockstep and on autopilot. It was lovely. The girls both told the same story almost in unison — and both blamed the other child. The other mother and I then completely fell out of sync.

I immediately reframed the blame by saying to my child versions of: "We don't have to think about it like that. You are hurt, but it wasn't her fault; both of you caused it. Now you know the risks of sliding like that, you won't want to lose a friend by blaming them for things you were a part of. Just because we find cause, doesn't mean we find fault. Let's make sure she is okay and say sorry for your part in it." I was working to strengthen her adaptive functioning by growing her mindset. I was developing her mind that talks to her brain.

The other mother took a different tack, one I recognized as being spectrum sensitive. She was not doing any of the metacognitive stuff I was. She said nothing about blame or fault but instead used body-based and sensory tactics that told me her child needed a different approach than mine. Once settled, she instructed her child specifically to repeat: "Are you okay? Do you want to play again?" Then the girls got back to playing.

I will never forget how clear this experience was in showing that care is universal in its purpose and process but specific in its demonstration.

IN THE THERAPY ROOM

Why does the playground story matter for our purposes? Therapy, like parenting, is a relationship with a duty of care. The therapist is responsible to care for others in a psychotherapeutic way, not a familial, personal, or adversarial way. Care does not stop at empathy and connection — it starts there and responds to a higher purpose. In the playground, the children wanted to relieve their distress by blaming the other. As their carers, we got them away from that maladaptive mindset. We attended to them differently because of their unique humanity but achieved the same goal.

In therapy with different clients, it is very similar. The client's mind is the domain in which you are working, and the clinical relationship or treatment bond is how you access that domain. Much like a parent, the more empathy, compassion, unconditional positive regard, trust, and connection there is, the more receptive, open, and flexible the client's mind. This is why the way we structure the therapeutic relationship is the most important thing we have.

Psychotherapy is the act of assessment, engagement, and treatment of cognitive, behavioural, emotional, and relational distress and disorder, delivered through structured communication within a psychotherapeutic relationship of care. Note in the definition that it isn't just any relationship; it is a relationship that has a clinical structure. The clinical considerations are always the psychologic well-being and growth of the client and that the psychotherapist has a role in that.

What does this mean on the ground? It means that in everything we say, do, and consider when it comes to the client, we must consider their unique constellation of variables and their psychologic best interests in how we assess, engage, and provide therapy. Our relationships must be structured such that the client can receive our approach. All therapeutic relationships balance support and growth. We are responsible for knowing which spots we are able to push for growth and where we have gotten. How do we find our way through this one?

> If we get stuck at wanting to relieve distress, we haven't created a treatment bond.

If we get stuck at wanting to relieve distress, we haven't created a treatment bond. In fact, distress relief is a component of almost every interpersonal relationship we have. With my best friend, I want her to stop feeling distressed and may go to absurd lengths to achieve this goal, because my empathy for her leads me to my own despair and urgency to action results. Therapists are interesting: when they feel this despair about a client, they often go into a state of urgency and humility at the same time. They often feel simultaneously compelled to respond and the more urgent that feels, the more likely they are to take themselves out of the equation and forget they are instruments of change. They are likely to refer on or consider terminating as they feel they aren't as effective as they should be. Because therapists are a good and selfless bunch of folks.

POST-MODALITY MINDSET

Selflessness can trip us up, because this is where I see clinicians obsessed with modality and technique. The sector has become inundated and overwhelmed by a plethora of modalities that promise distinct treatment and efficacy for every mental health ailment. When this trend leans into its extreme, we become the professional that treats a symptom rather than a clinician who

provides therapy for a person. When we lose sight of the importance of the clinical relationship, we can slip into over obsession with modality. And clients complain of this a lot. Many clients I see would never have preferred to be referred on for a better modality or technique but would have instead elected to stay with their therapists.

The reality is that most clinicians who are engaged in supervision with me have underestimated the time and effort it takes for people to make substantial psycho-emotional change in their lives. They have also not attended to the creation of the treatment bond as much as they have been preoccupied with using the right modality. Very few times do I see that my supervisees are engaged in contra-indicated approaches or are lacking in skill, insight, conceptualization, or any clinical elements. But what is almost always the case is that they did not realize that they are required to sit connected and empathetic with a client for the entirety of the client's distress. That is the foundation of treatment. In fact, we see time and time again when clinicians "refer on" because they feel nothing is "working," clients feel deeply abandoned and decline to continue in therapy at all.

What clinicians have forgotten in these scenarios is that the relationship is the mechanism of action in all psychotherapies. Period. And when we get so distressed ourselves that we want to find a modality or technique as a stand in, we are in fact deconstructing the psychotherapeutic relationship, and we leave the client with emotional impacts that are clinical in nature. I find it fascinating that clients often intuitively understand this better than many therapists. But I attribute this to a current trend in the field where we are not embracing the importance of the clinical relationship. We are swung on the pendulum to the other side, where we are looking for answers and fixes in the modalities being marketed to us, many of which are not psychotherapeutic at all.

When we lose sight of the importance of the clinical relationship, we can slip into over obsession with modality.

Regardless of what approach, modality, or adjunct techniques you use, they are an accoutrement to the psychotherapeutic relationship itself. Because of that, there is no other profession like this. In medicine, the practice of medicine is external to the physician. This is not the case with therapy.

LEVERAGING THE SOCIAL LEARNING BRAIN

So how do we employ the relationship? And why does it work? The simplest elucidation of this principle that I have read is "Why Therapy Works: Using our Minds to Change our Brains" by Louis Cozolino. As a person well versed in interpersonal neurobiology, Cozolino aptly describes the structure of the clinical relationship as leveraging the social learning brain. We are wired to connect. When we connect properly to a carer, we are the most flexible we can ever be. Then we grow.

The therapist is the psychologic carer, and to care means we must transcend the client's distress-relief motivation to the higher order of growth and adaptive functioning. That requires us to rest our decisions and judgments in bodies of clinical data about client functioning in general and the specific wants and desires of the client in front of us. We must then articulate a vision or conceptualization of what it looks like to move towards improved adaptive functioning.

Back to the kids in the playground. It is not adaptive for a child or any human to blame another person for a result when they participated in the cause. As my child's carer, I used the opportunity to help her create a more adaptive mindset, and I did that because it is more important for me to care than to relieve distress. The other mother was taking a caregiving approach as well, but her child was speech delayed and on the spectrum and barely understood what was going on. In fact, her child was probably mimicking mine in laying the blame. That child's mother would have to take a different, more behavioural approach. This analogy elucidates that caregiving relationships are universal in their duty yet specific in their approaches.

This is why we must never get locked into modality-specific thinking when conceptualizing clients; rather, we remain accountable to the highest order of treatment — the relationship of psychotherapeutic care itself. We then work with the specific client, remaining in the correct relationship structure and interweaving modality or not when it is clinically indicated. But at no time should we stop paying attention to the structure of the relationship; we are not to let it slip. In fact, I would contend that every supervisee I have worked with who has had a client they have struggled with has suffered the deconstruction of the relationship of care.

> We are wired to connect. When we connect properly to a carer, we are the most flexible we can ever be. Then we grow.

Clinicians often think it is the modality that doesn't suit — as if they are a physician using the wrong medicine — but they miss that they are the medicine. When they go into distress about their client, they are inclined to exit the relationship and seek other medicine. I would say most of my supervision is assisting therapists in the ongoing nurturance and crafting of the relationship of care. Staying with the person and the growth, not getting stuck at distress relief, and working on the maximization of the treatment bond to facilitate the client's adaptive functioning.

We work in a really interesting way. It is like nothing else in the clinical or professional world. It is why it can be the most profound experience for some and go so terribly wrong for others. But I encourage young clinicians and educators to remember the foundation of the psychotherapeutic relationship, because we are in a time in the profession where we seem to be forgetting it. In writing this, I hope to offer a simple reminder of the clinical basis from which we work and to put our eyes back on the longstanding universal mechanism of action in therapy. When we remember this, we have lessened despair and urgency in the clinician, and fostered a more secure and efficacious result for the client. We cannot forget how crucial the construction of this bond is and that above all else, our clients are situated in it in a deeply vulnerable way. The nature of the treatment bond remains the most significant variable of efficacy across all modalities and disciplines in our profession — and that is a good thing. ■

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BECOMING AN AASECT-CERTIFIED SEX THERAPIST

An interview with Erin Davidson, RCC, CST

BY CAROLYN CAMILLERI

Erin Davidson, RCC, CST, knew she wanted to be a counsellor since the days she watched Oprah after school.

"I loved the parts where she would go really deep and talk about what I thought were important topics that I didn't often hear people talk about," she says. "I thought it was such a privilege to be let in in that way with somebody else."

From high school, she went right into psychology at the University of British Columbia, then went back to do her MA. She was drawn to sex therapy from the start.

"The job I had in my master's program was working as a counsellor at an abortion clinic, and I was having lots of conversations about sex and intimate topics," says Erin. "Then, for my thesis, I researched sexual assault and did a study where I was interviewing survivors."

At the time, she had a misguided notion about sex therapists — a notion she laughs about now.

"I had this idea of a free-spirited person, who wears a lot of bracelets and has long flowing hair," she says. "And I thought, 'Wow, that would be really cool, but that's not really who I am.'"

Then along came acclaimed psychotherapist Esther Perel.

"I was amazed by her and I thought everything she was talking about was so interesting," says Erin. "She's still very different from me, but she expanded who I envisioned could be a sex therapist. All those pieces came together early on in my career to inspire me to look into what it would take to get certified."

Erin is glad to be able to state that she's a CST — it brings certain people to her office.

"I find it gives people permission right off the bat that sex is something I'm comfortable talking with them about, and that's really helpful for people," she says.

Not all counsellors are comfortable talking about sex in all its variations. In fact, some of Erin's clients came to her because they weren't comfortable talking to their counsellors about sex.

"Because sex is such a key component of people's lives, I think it's a shame that their last therapist didn't just ask some questions or give the kind of opening for that to be brought up," she says.

Or maybe the client did bring something up and felt embarrassed and ashamed when they noticed the counsellor's surprise or discomfort.

We could all integrate a little bit more sexuality training into our practices.

"As with any topic in counselling, if we feel like our own stuff is getting in the way or we can't put our own stuff aside or we feel like we're continually triggered by our clients, but we're not able to work through it with a supervisor, that's a sign to refer," says Erin. "And in our culture, sex is particularly ripe for bringing that kind of stuff up."

For example, if you're not comfortable working with people in open relationships or in non-monogamous relationships, know that about yourself and know you need to refer out. Erin has had clients who have felt judged by counsellors for their relationship style.

Questioning biases, examining assumptions, and learning more is critical for anyone in the counselling profession. Even for Erin, sex felt like a more daunting discussion topic in the beginning.

"I think the reason I had that kind of apprehension or nervousness is because we make it that way in our society, when

it really should be more integrated, and I think it stops people from taking on certain topics related to sexuality or doing certain trainings," she says. "Maybe they think they aren't qualified or don't know enough, but I think we could all integrate a little bit more sexuality training into our practices."

Erin did more than just a "little bit" of training — she opted for a fully guided program.

HOW ERIN DID IT AND WHY

A connection through a Facebook post led Erin to Diana Sadat, RCC, an AASECT-certified sex therapist and the founder and clinical director at Allura Sex Therapy Centre in Vancouver. Erin was hired as a contract counsellor, and Diana introduced her to the Institute of Sexuality Education and Enlightenment (ISEE) in the U.S. Erin signed up for a full ISEE program.

"I liked their program because they outlined everything I needed to do to get certified through AASECT, the American Association of Sexuality Educators, Counselors and Therapists, which is the only organization you can get certified with," she says. "There's no certification program in Canada."

She describes the program and certification process as "quite involved and pricey."

"It was before we were so used to everything being virtual, and I did two different stints of in-person classes in Portland," she says, noting that the ISEE program is offered in a few different locations.

"One of the great things about the in-person training was that I was in a room of 30 people who all looked different, all different backgrounds and cultures and races and genders, and they all had something unique to bring," she says. "It has been so beneficial for the field to learn more about queer relationships and all sorts of bodies and not to be so focused on penetrative sex but to be more about pleasure."

The ISEE program is divided into three components — recorded webinars, two papers, and live-streamed classes — plus clinical hours that are sex-therapy specific.

"I felt lucky that I was working at a group practice that was sex-therapy specific, so clinical hours were no problem for me," says Erin.

For her supervision hours, she worked with Paula Leech, an AASECT-certified supervisor provided through ISEE.

"I'd highly recommend her," says Erin. "I learned a lot from her and it was really nice right out of school to have such consistent and focused supervision. That really helped give me a foundation."

Once all the requirements were met, Erin was designated an AASECT-certified Sex Therapist.

OTHER WAYS TO BE CERTIFIED

While signing up for a fully guided program is one way to become certified, there are other routes to AASECT certification. According to the AASECT website (October 1, 2023), you need a combination of:

1- Sexuality education (90 hours minimum) in core knowledge areas of human sexuality;
2- Specialty training (60 hours minimum) in sex therapy;
3- Attendance in a sexual attitude reassessment (SAR) workshop (14 hours minimum);
4- Documented field experience (minimum of 300 hours providing therapy);
5- Approved supervision (50 hours minimum) in sex therapy with an AASECT-certified supervisor of sex therapy; and
6- AASECT membership and adherence to the AASECT Code of Ethics.

Among the various online options for fulfilling the education component is a five-day intensive program at the University of Guelph.

"I've heard really good things about the Guelph program," says Erin. "It's really focused on the information about human sexuality and sexual dysfunction that you need to know."

That said, an intensive course may not be for everyone.

"I'm glad that I did the program I did," she says. "It was more experiential and there was more space for my own processing, but I think some people would criticize it for that, in that there was almost too much of that, and they may want more hard and fast information."

Aside from the learning as it relates to clients, a vital aspect of sex therapy education is self-reflective.

"So much of it is doing your own work," says Erin. "We live in a society that's quite sex negative and working through your own shame or things you may be judgmental about is really important. If you've processed that in your own way or grew up in a more sex-positive environment, the Guelph training would be perfect."

Another step is sexual attitude reassessment (SAR) — an intense, group-based process that requires participants to examine their own biases.

"In the training environment, you get exposed to a variety of different sexual material and topics that are often challenging," says Erin.

The purpose: to allow you to interrogate yourself about the biases and judgments we all have but may not know we have.

"In counselling in general, it's so important for us to question our biases and learn more about ourselves an ongoing basis, but particularly when it comes to sexuality and working as a sex therapist — it's a really key component."

Without training, even the most liberal counsellors may find themselves reacting to a topic. Having those reactions in a training space where you can work through them is why SAR is a required component of certification.

Documented field experience and supervision by an AASECT-certified supervisor is attained in the same way in all cases, followed by AASECT certification, which includes membership.

Erin's big takeaway is that you have options in attaining certification.

"Other people have accumulated courses from different places and pieced them together for their certification," she says. "You could pick and choose different things, too, if you do SAR and bring some of your cases to an AASECT-certified supervisor. I am glad I did the guided program. I liked the roadmap of it. It gave me something to follow and I learned a lot."

Even if certification isn't the goal, perhaps everyone could benefit from more sexuality training.

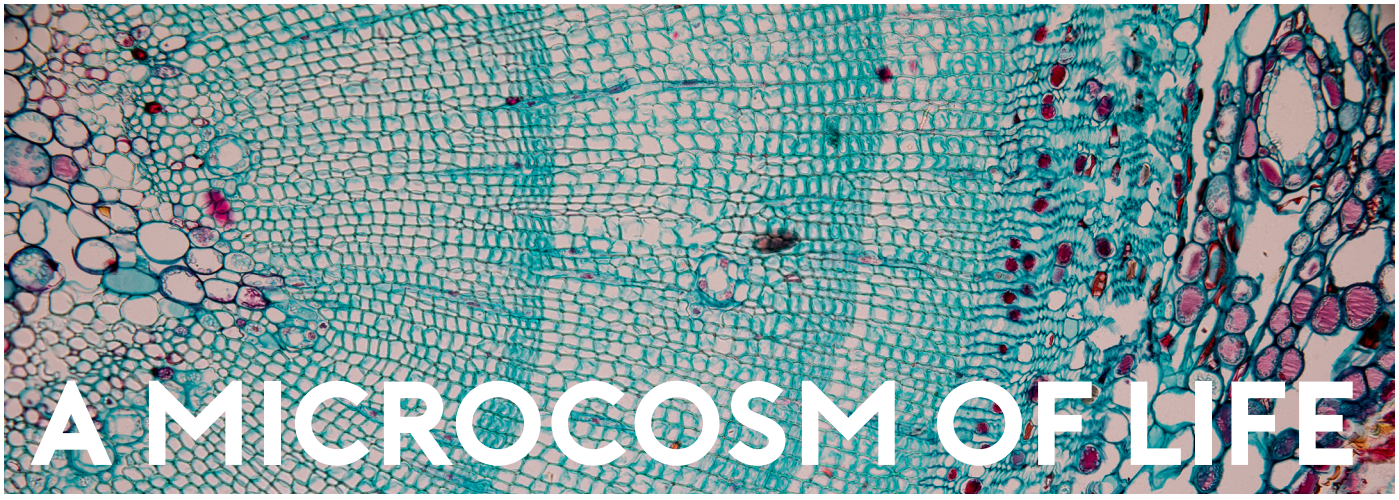
"We all come to this work from such a variety of knowledge and experience," says Erin. "Sex is such a big part of who we are as humans, that it feels almost funny to separate it into another category. I imagine certain places in the world they might even think it's strange that we separate it out."

Perhaps in the future, more sexuality training will be a requirement for all counsellors. Until then, AASECT certification is the standard. ■

Erin Davidson, RCC, is a Certified Sex Therapist (CST) and completed the program through the American Association of Sexuality Educators, Counselors and Therapists (AASECT). Her areas of specialty are personal growth, couples and relationships, and sexuality. She's also published two books: Break Through the Breakup and Thriving in Non Monogamy An Ethical Slut's Guide: Overcome Jealousy, Enjoy Sex, and Honor Yourself. Learn more at https://erinedavidson.com.

LEARN MORE

- American Association of Sexuality Educators, Counselors, and Therapists (AASECT): https://www.aasect.org/certification/certification-faqs#:~:text=In%20general%2C%20one%20needs%20a,)%3B%20(4)%20documentation%20of%20field
- Institute of Sexuality Education and Enlightenment (ISEE) (Oregon, Massachusetts, Arizona/ online): https://instituteforsexuality.com/
- University of Guelph five-day intensive (Ontario): https://courses.opened.uoguelph.ca/search/publicCourseSearchDetails.do?method=load&courseId=2451003
- Sexual Health Alliance (California/ online): https://sexualhealthalliance.com/
- Bianca Laureano: Ante Up – trainings, including SAR trainings: https://www.anteuppd.com/sars/
- Modern Sex Therapy Institute (Florida/ online): https://modernsextherapyinstitutes.com/
- Tammy Nelson's program (online): https://drtammynelson.com/isti/
- Paula Leech, AASECT certified sex therapy supervisor – group and individual training: https://www.paulaleech.com/ Note: she also provides Sensate focus trainings which is a fantastic mindful touch sex therapy approach.
- Diana Sadat from Allura Sex Therapy Centre (online): https://www.alluracentre.com/trainings



A MICROCOSM OF LIFE

Providing collective support in a safe, healing, validating space with group therapy

AN INTERVIEW WITH JOHN SHERRY, RCC

The idea of collective healing and mutual support has existed in various cultures and communities for centuries, for example, Indigenous healing circles and self-help groups. A few moments in history where many people needed support, such as patients with tuberculosis and soldiers returning from World War I, contributed to an increase in psychiatrists using group therapy to treat patients. This growth continued after World War II, and well-known group facilitators like Jacob Moreno, Samuel Slavson, Hyman Spotnitz, Irvin Yalom, and Lou Mormont led its effectiveness and popularity.

Moreno believed in the therapeutic power of role-playing and spontaneous dramatization, with psychodrama laying the foundation for later group therapy techniques. They were followed by the work of Kurt Lewin in the '40s, who believed groups alter the individual behaviour of those involved in group work. In the '50s and '60s, the movement to encounter groups focused on self-actualization, personal growth, and exploring one's potential. In more recent times, where the variety of group approaches is endless, a few of the more popular methods include psychoeducational, psychodynamic, cognitive behavioural, dialectical, and interactive experiential.

Additionally, Irv Yalom, Moyln Leszcz, and Scott Rutan's writings discussing group therapy have been very influential worldwide. Leszcz, a Canadian psychiatrist, has been instrumental in promoting and growing group counselling and is currently the president of the American Group Psychotherapy Association (AGPA). Today, group therapy is widely accepted as a valuable therapeutic modality for treating diverse conditions and is often used alongside individual therapy.

WHICH CLIENT CONCERNS IS GROUP THERAPY ESPECIALLY COMPELLING WITH?

Group therapy is as effective as individual therapy for a wide range of symptoms and conditions, and it is more efficient, allowing a therapist to reach many people at once and address long waitlists. Some groups are designed to target a specific problem, such as depression, obesity, social anxiety, chronic pain, or substance abuse. In contrast, other groups generally focus on improving social skills and helping people deal with low self-esteem, loneliness, and self-acceptance. In both cases, the group is very effective, and evidence suggests group counselling might be even more beneficial than individual counselling for treating substance misuse. Group counselling is especially effective in addressing interpersonal struggles.

HOW (OR WHY) DOES IT WORK?

Group members can give and receive feedback in a safe, supportive space. It allows group members to reflect on how others see them, and if open to feedback, it challenges group members to see and experience themselves

differently. There is a good amount of interpersonal learning, as a group is a social microcosm.

Looking at the group from a psychodynamic perspective allows group members to work through family concerns, with group members representing siblings and group facilitators symbolically in the role of parents. Many issues can be addressed, including competition, people-pleasing, scapegoating, and exploration of inter- and intra-personal struggles. Perhaps some roles that they even want to retire. Group members can have corrective emotional experiences — what you possibly could not do when you were younger, you now have an opportunity to do differently in the group.

Recognizing that you are not alone in your struggles, and seeing others who had similar struggles share their progress, gives group members encouragement that change is possible. In addition to support, group members can hold each other responsible for change, and as time goes on, group members develop a sense of belonging to the group and come to value the group.

HOW LONG HAVE YOU BEEN USING GROUP THERAPY AS A MODALITY?

Probably since I was five — at least, that is what I tell the students I teach at UNBC. This was how I coped with some of my struggles around family issues growing up in the late '60s. Informal as it may have been, I found much support in being with others who supported and validated my experiences. At that time, it was childhood friends. Feeling like you are alone with your issues or the only one struggling with a particular issue can be quite isolating.

Professionally, I was drawn to the group from my first group class in graduate school. Early in my career, I led both psychoeducational and process-oriented groups. In addition to facilitating weekly groups, I would often take college students on retreats and facilitate back-to-back groups throughout three-day weekends. I saw tremendous change and development — students struggling with low self-esteem without a clear direction not only graduated from college but often went on for advanced degrees. Time and time again, group members could tap into those often-buried strengths overshadowed by a past and showed so much resiliency through challenging themselves in groups.

WHAT DO YOU LIKE BEST ABOUT GROUP THERAPY?

I like the immediacy of the group, along with the support and validation you usually experience in the group. If one is open to it, you can challenge yourself in a way you may not be able to outside of the group. In a sense, you have an aerial view of yourself, watching and experiencing yourself. There is tremendous personal growth in being able to give and receive feedback. However tricky, being seen and finding and using your voice is empowering. Group can be a great sense of support and an excellent sounding board. It is not always easy, and a safe, supportive environment needs to be established, but in those challenges comes personal growth. It can be a relief to hear others discuss what they are going through and realize you are not alone.

Diversity is another significant benefit. Group members have different backgrounds and lived experiences, and they look at situations in different ways. Being open to learning about how other people who may be very different from you address problems and make positive changes can provide insight into your coping skills. Additionally, you experience intense connections with people who can be very different from you on many levels, including very different cultures. I have been facilitating various groups for 25 years and have training in psychodrama approaches to groups, and I am drawn to more process-oriented approaches to group counselling.

WHAT OTHER MODALITIES DOES GROUP THERAPY WORK WELL WITH?

There are many opportunities to be creative as a group facilitator. I do not necessarily see myself as a creative person in the artistic sense, but I can be very spontaneous and creative in facilitating groups. Suppose you think about approaches on a continuum from more structured goal-focused groups such as DBT or CBT to more process-oriented groups guided by analytical theory. In that case, groups can encompass a wide range of modalities.

It is best to reflect on the group format most effective for the issues or subgroups of clients you address in your work. For example, you may run a purely DBT group for emotion regulation or a CBT group for substance misuse, which has proven very successful. You may opt for a psychoeducational group focused on a particular issue, such as self-esteem enhancement or parenting skills. Process-oriented groups examine the unconscious processes of the group as a whole and help group members see themselves more clearly in relation to others. As you can see, there are many options.

One of the most memorable group experiences I had was nature-based.

A FEW OF JOHN SHERRY'S FAVOURITE RESOURCES

- *The Theory and Practice of Group Psychotherapy*, 6th edition, by Irvin Yalom and Molyn Leszcz
- *Psychodynamic Group Psychotherapy*, 5th edition, by J. Scott Rutan, Walter N Stone, and Joseph J. Shay
- *Attachment in Group Psychotherapy* by Cheri L. Marmarosh, Rayna D Markin, and Eric B. Spiegel
- *Introduction to Group Therapy: A Practical Guide* by Scott Simon Fehr
- *The Living Stage: A Step-by-Step Guide to Psychodrama, Sociometry and Experiential Group Therapy* by Tian Dayton
- *Healing the Soul Wound: Trauma-informed Counseling for Indigenous Communities* by Eduardo Duran
- Establishing Culturally Inclusive Safety in Group, presented by Latoyia Piper and offered by AGPA, is a free e-workshop at https://portal.agpa.org/commerce/store
- Templates for Psychoeducational Groups are available from Whole Person Associates at https://wholeperson.com/store/
- Group Interventions for the Treatment of Trauma is an AGPA training module available at https://agpa.org/home/practice-resources/group-interventions-for-trauma/general-information-on-trauma-for-clinicians-and-the-public-at-large/group-interventions-for-treatment-of-psychological-trauma
- AGPA educates clinicians and the public on the benefits of group psychotherapy in the introduction to their YouTube channel at https://www.youtube.com/@agpa01

The group completed numerous tasks in the wilderness, and members took on different roles for these tasks. There was so much insight in the processing that occurred after the event. The point is that a wide range of approaches to facilitating groups exist.

ARE THERE ANY CLIENT ISSUES WHERE YOU WOULD NOT RECOMMEND GROUP THERAPY?

There are several things to think about when it comes to this question: what type of group for this type of client addresses this issue? Research shows that screening for the group is one of the most critical tasks that contribute to the group's success. Screening is when you can educate the client about the group, and a practitioner can determine if the person is a good fit for the group based on ego strength and flexibility to shift one's view or opinion. The more information group members have, the more comfortable they feel, not eliminating participatory anxiety for members entering a new group. Of course, for some, it is a unique experience, and you will not know the full impact until you are in the group, but screening can address some myths and fears.

Also, from a trauma-informed approach, it is helpful to think about the group on a continuum from very structured (psychoeducational or CBT) to more process-oriented (psychodynamic). Those with severe trauma are not always comfortable with how quickly and unpredictably a group can move around, giving and receiving feedback. In this case, structure and predictability might work better. It does not mean that at some point, this same client cannot progress to a more process-oriented group as some of the trauma-inducing situations get worked out. In your screening, you may also meet with clients who are severely depressed, suicidal, or struggling with thought disorders and may not be ready for the group.

WHERE CAN RCCS LEARN MORE / GET TRAINING IN IT?

The Canadian Group Psychotherapy Association is no longer active, which is unfortunate since most clinicians only receive a semester of training in group therapy, if that, in their graduate school programs. In Prince George, a group of us "groupies," those interested in group work, occasionally meet to discuss group topics. This type of support goes a long way. Additionally, throughout the years, I have offered process groups for clinicians in the Prince George area and numerous training courses in group leadership skills at local agencies and national conferences.

The Toronto Institute of Group Studies (tigs.co) provides excellent, extensive group training with instructors with many interests and years of experience. They generously offer many free presentations, many of which are saved on their website. Other sources of information include the American Group Psychotherapy Association (agpa.org), American Society of Group Psychotherapy and Psychodrama (asgpp.org), and International Association for Group Psychotherapy and Group Processes (iagp.com). The lists of resources that these organizations have is exhaustive. ■

Dr John Sherry, RCC, Acting Chair of the Psychology Department at UNBC, has over 25 years of experience as a clinician, and his academic and clinical work has focused on group, couples, family counselling, and clinical supervision. If you are interested in training in group counselling or have any questions, please feel free to email sherryj@unbc.ca.

HEALING FROM JUSTICE, JUSTICE FROM HEALING

Supporting survivors of sexual assault

BY DEIRDRE MCLAUGHLIN, RCC

As a counsellor who supports survivors of sexual assault, I find that this work exists at the border of healing and justice. Specifically, the sexual assault counsellor works in the healing domain; not infrequently, clients also turn to the justice system as part of their recovery journey. Though survivors sometimes seek justice through legal recourse, with regard to sexual assault in particular, outcomes are not always as one might have hoped. Moreover, the process itself can take a toll on an individual's well-being.

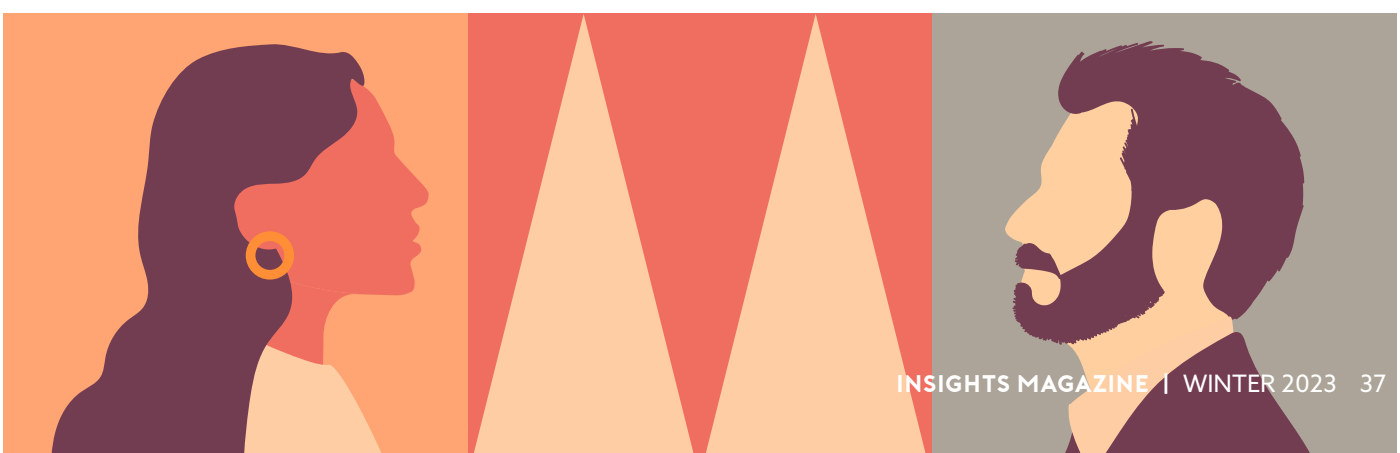
The role of a counsellor is to support clients on this path — sometimes from the very beginning stages of choosing whether or not to pursue legal action. If unfamiliar with the legal system, this is a task for which both counsellors and clients may find themselves underprepared. Lack of knowledge can impact a counsellor's ability to support clients in deciding from a place of informed consent; for clients, the depth to which they understand available choices may influence long-term mental health outcomes.

My intention is to create a curriculum for counsellors who work with adult sexual assault survivors. I address the question: what is the role of the counsellor in helping the client navigate and heal through (and sometimes from) the justice system in the wake of sexual assault in Canada?

The research includes an intersectional analysis of survivors as it pertains to gender, sexuality, ability, race (in particular, Indigenous women, girls, and two-spirit people), sex workers, BDSM practitioners, and more, examining the way outcomes differ depending on how individuals interface with various histories, systems, and institutions. The curriculum will provide: an overview of rape culture and rape myths; sexual assault law in Canada; record keeping; alternatives to the justice system; helpful therapeutic approaches; and the possibilities of activism for both survivors and counsellors.

My dissertation committee is composed of committee chair Dr Tracy Rodriguez-Miller of the International Institute of Clinical Sexology; Dr Lise Gotell, Landrex Distinguished Professor in the Department of Women and Gender Studies at the University of Alberta; and Dr Liam "captain" Snowdon of the Institute for the Study of Somatic Sex Education. I'm fulfilling this project through the Clinical Sexology PhD program at the International Institute of Clinical Sexology. ■

deirdre mclaughlin, RCC, is a somatic therapist, sexual health educator, and PhD candidate in clinical sexology. they live and work on the ancestral, traditional, and unceded territories of the tmixʷ, sn̓ic̓kstx tmxʷúla?xʷ, and ?amak?is peoples, as well as many other diverse Indigenous persons, including the Métis.



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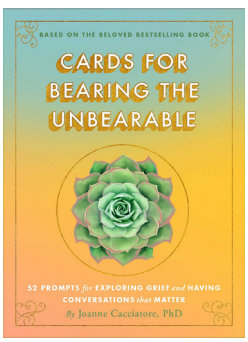
Use in Practice



CARDS FOR BEARING THE UNBEARABLE
52 Prompts for Exploring Grief and Having Conversations That Matter

Joanne Cacciatore

Available Now

From the bestselling author of *Bearing the Unbearable*, here are 52 cards with prompts for exploring grief and starting conversations about those we've lost. The cards can be used as part of a contemplative practice, as journaling prompts, by or with therapists, or in community with family, friends, or grief support groups. They can be read aloud, alone or with others. You can read one card prior to meditation or simply reflect deeply on what arises. However you use these cards, take time to dive deeply with a spirit of love and compassion for all beings, including yourself.

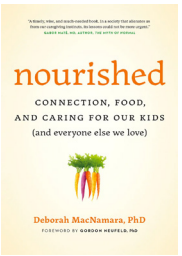
Watch

MIND CHECK 1-2, 1-2

Documentary short streaming on CBC Gem

Internet sensation Akintoye is a Nigerian-Canadian rapper who is open and vulnerable about mental health struggles. He's making space for young people to express themselves through art.

Read

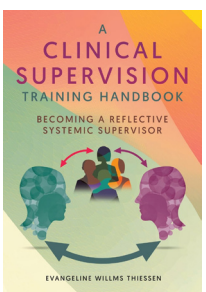


NOURISHED: Connection, Food, and Caring for Our Kids (And Everyone Else We Love)

By Deborah MacNamara, RCC, with foreword by Gordon Neufeld

Available Now

Nothing could be more basic than food. However, food is only one part of the concept of nourishment, but it has consumed our focus and eclipsed something far more critical for thriving — connection. We have lost sight of the fact that feeding our families is about human relationship and emotional well-being. In *Nourished*, Deborah MacNamara, RCC, shows us how feeding is part of the caretaking relationship and cannot be separated from it.



A CLINICAL SUPERVISION TRAINING HANDBOOK: Becoming a Reflective Systemic Supervisor

By Evangeline Willms Thiessen, RCC-ACS

Available Now

Published by the BC Association of Clinical Counsellors, *A Clinical Supervision Handbook* by Evangeline Willms Thiessen, RCC-ACS, provides a solid framework for curriculum development for supervision instructors/facilitators and participants. It aligns with an eight-module clinical supervision course and offers experiential and reflective exercises for both instructors and participants. This training resource meets the criteria of Canadian professional associations and regulatory bodies as an approved clinical supervision fundamentals course. Get your copy at Barnes and Noble and Amazon.

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

For consultations and quotes please contact:

Stephanie A. Ritchie, BCACC's Member's Benefits Senior Advisor
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