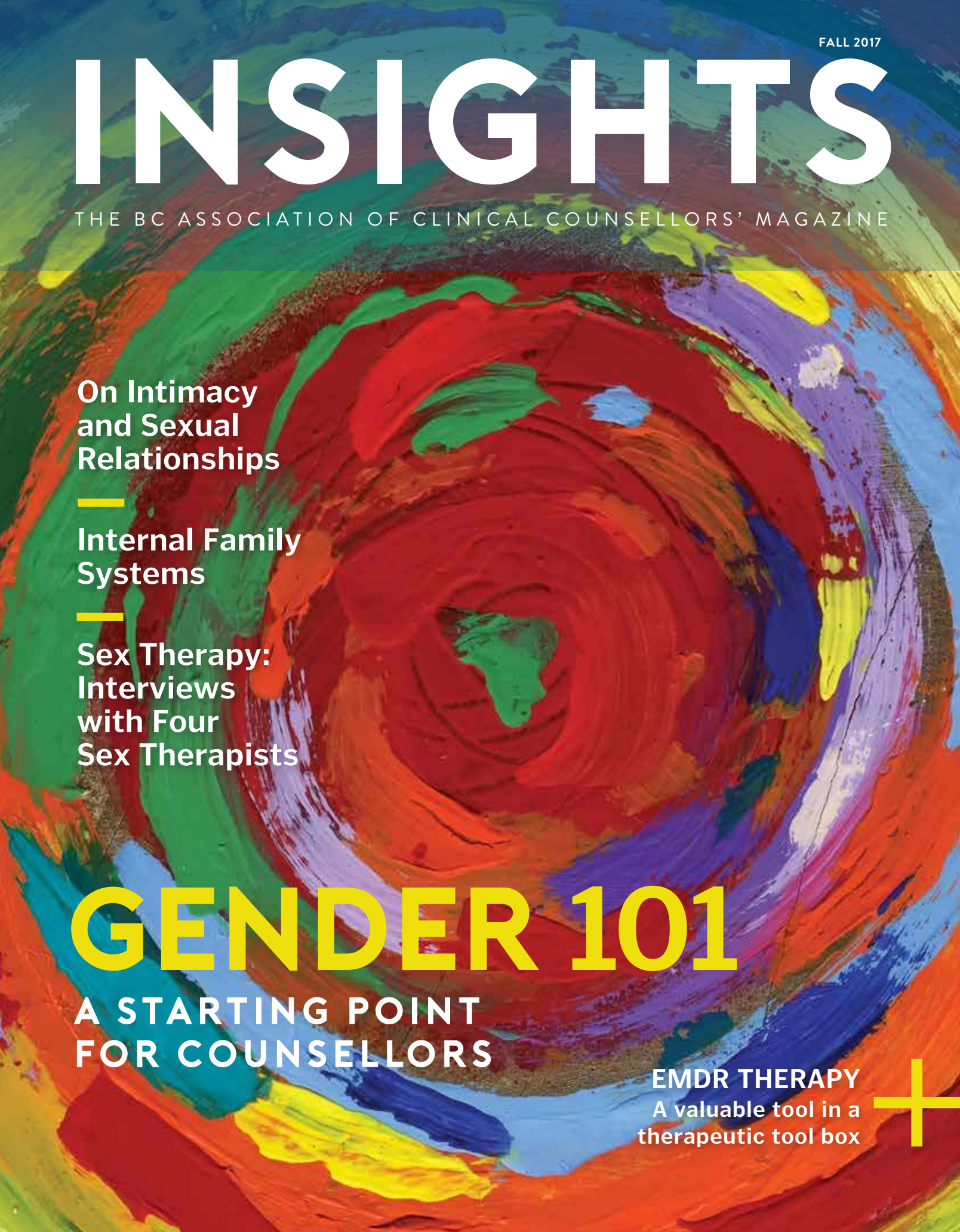
FALL 2017

INSIGHTS

THE BC ASSOCIATION OF CLINICAL COUNSELLORS' MAGAZINE



On Intimacy and Sexual Relationships

Internal Family Systems

Sex Therapy: Interviews with Four Sex Therapists

GENDER 101

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BCACC

BC ASSOCIATION OF CLINICAL COUNSELLORS

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INSIGHTS
THE BC ASSOCIATION OF CLINICAL COUNSELLORS' MAGAZINE

The Insights *team wishes to thank the writers who contributed to this edition of our magazine:*
Mair Cayley, Frances Ferguson, Rodrick Lal, Deirdre McLaughlin, Fernanda Selayzin Souza, Rochelle Sharp Lohrasbe, Vange Willms Thiessen

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

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

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More information about submitting article proposals can be found at bc-counsellors.org/media/insights-magazine.

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GENDER AND SEXUALITY RESOURCES

► **Trans Care BC** is a province-wide information hub offering information about gender-affirming care and support groups and services, including medical options, social-transition tips, advocacy and legal issues, and many other resources. www.transhealth.phsa.ca

► **TransHealthCare** is a worldwide directory of gender-affirmation surgeons, including Canadian surgeons. Developed as an internal, proprietary system in 2009, it is now available for public access. www.transhealthcare.org

► **Qmunity** provides a wide variety of resources to LGBTQ/2S people and their allies. Services include referrals, counselling, social events, support groups (including one-on-one peer support for youth), volunteer opportunities, and consulting and training programs for businesses and organizations. www.qmunity.ca

► **Sexual Rehabilitation Services** at the GF Strong Rehabilitation Centre in Vancouver offers education and resources in the field of sexual health, disability, and rehabilitation. www.vch.ca/Locations-Services/result?res_id=871

Culturally Relevant Sex Education for Indigenous Youth

The Sexy Health Carnival is a fun, educational event created by Alexa Lesperance from Naotkamegwanning First Nation in northwestern Ontario. The travelling carnival aims to break down barriers of fear, stigma, and shame associated with sexuality and gender among Indigenous youth and create safe spaces for learning. Carnival booths focus on such themes as suicide, harm reduction, consent, sexual-violence prevention, STIs, birth control, and masturbation. As of last spring, the travelling carnival had been to more than 30 communities.

For more information, go to www.nativeyouthsexualhealth.com/sexyhealthcarnival.html. The main website also features a wealth of downloadable educational materials for Indigenous youth, including a First Nations Sexual Health Toolkit, posters and memes, and information on safety, cultural, and advocacy initiatives, such as Building a Highway of Hope and the Grandmother Spirit Program.

The *Globe and Mail* featured the Sexy Health Carnival last March, as one of a four-part series about Indigenous sex education. Other topics include consent, gender, and discussions about sex. www.theglobeandmail.com/life/health-and-fitness/health/how-this-indigenous-youth-is-making-sex-education-sexy/article29130773/.

SIDEWALK TALK AROUND THE WORLD

SIDEWALK TALK is a non-profit community listening project launched in 2014 by two therapists with a vision: to help heal that which divides us through the fine art of skilled listening on the streets of San Francisco. They gathered a group of 26 colleagues and practised listening skills. On May 7, 2015, the first Sidewalk Talk was launched at 12 locations throughout San Francisco. For two hours, any passersby who wanted to be seen and listened to, if only for a few minutes, could sit and be heard. The idea has spread, and Sidewalk Talk now has more than 700 members in 19 cities internationally, including Peterborough and London, Ontario. www.sidewalktalksf.com

THE STEPS TO TRANSITIONING

Gender transitioning with hormone therapy and/or surgery is a lengthy process that begins with letter writing by qualified mental health professionals.

For hormone therapy, chest surgery (female to male), and breast surgery (male to female), one letter is required, indicating persistent, well-documented gender dysphoria; capacity to make a fully informed decision and to consent for treatment; age of majority in a given country; and, if significant medical or mental concerns are present, they must be reasonably well controlled.

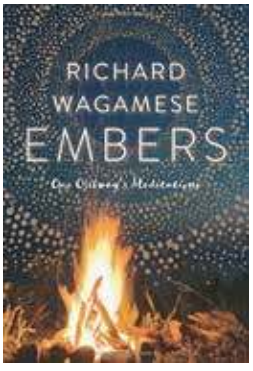
For gonadectomy and genital surgery, two letters are required from qualified mental health professionals who have independently assessed the patient. In addition to the indications listed above, requirements include 12 continuous months of hormone therapy appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones) and 12 continuous months of living in a gender role congruent with their gender identity.

The role of a mental health professional working with transitioning clients would include: assessing gender dysphoria; providing information regarding options for gender identity and gender-role expression and possible medical interventions; and assessing, diagnosing, and discussing treatment options for co-existing mental health concerns. Training programs are available through World Professional Association for Transgender Health (WPATH). www.wpath.org

Source: Information sourced from a Power Point presentation by Gail Knudso.n MD, president of WPATH.

Help for Men with Depression

Depression among men is far more common than many people think. Shattering myths and reducing stigma around depression is a critical part of making mental health care more accessible to men. HeadsUpGuys is a self-directed resource developed to support men with depression by providing tips, tools, information about professional services, and stories of success. It also includes information and advice for friends and family members who want to help. The UBC-based program has been developed by a team of counsellors, researchers, and mental health advocates and is supported by the Movember Foundation. www.headsupguys.org



FOR YOUR BOOKSHELF

Renowned Ojibway writer Richard Wagamese passed away last March at age 61. Despite his appalling life experiences and the trauma he carried, he became a journalist, broadcaster, and the award-winning author of books such as *Indian Horse* and *Keeper'n Me*. His last book, *Embers: One Ojibway's Meditations* (Douglas and McIntyre, 2016), is a carefully curated compilation of personal reflections — many of which were Facebook posts — gathered at the suggestion of his publisher. It is an inspiring, insightful book and one that speaks to everyone and, perhaps, especially to those who struggle.

BCACC 2017 AGM

The BC Association of Clinical Counsellors' Annual General Meeting took place on June 9, 2017, in Victoria. The meeting was well attended and featured keynote speaker Matt Johnston, RCC and professional firefighter.

Matt spoke about his career transition and how his work as both a counsellor and a firefighter for the City of Surrey provides him with a unique perspective on the needs of first responders. Firefighters are starting to embrace mental health treatment, and Matt offered comprehensive information for RCCs to help engage first responders in counselling.

The keynote was broadcast via Facebook Live and is available to watch on the BCACC Facebook page: "Clinician to Firefighter: A Shifting View" at www.facebook.com/findacounsellor/.

AMBASSADOR FOR THE YOUTH

HELPING YOUTH AND CHILDREN FIND WHERE THEY BELONG

JENSTEELE.COM

J. Nicole (Cole) Little, PhD, RCC, pictured here with Beowulf, is a Victoria practitioner who is passionate about supporting queer and trans youth and promoting RO DBT for her clients who identify as overcontrolled. Read her blog at www.islandfamilycounselling.ca.

Her cohorts at UVic's School of Child and Youth Care (SCYC) call Cole Little a "badass Mary Poppins." It is a badge she wears with pride. And just like the adored nanny, Cole is a disrupter of the status quo who stands by her convictions — convictions formed at a very young age.

Cole and her Aunt Donna, who has Down syndrome, grew up together in the same family home. In those days, segregated education was still the norm. Cole was aghast that she had to attend "regular" kindergarten, while her Aunt Donna attended a different school. It was a pivotal moment of understanding that people are treated differently and afforded different resources.

"I cut my teeth on disability inclusion and advocacy, and my social-justice lens was shaped at an early age," says Cole. "Since then, I have worked across the spectrum of health, and this has also included education and advocacy regarding GLBTQA/2S youth, sexual health, and literacy."

Cole works in child and youth mental health as a counsellor on the eating-disorders team. She also has a private practice, where her current specialty is using Radically Open Dialectical Behaviour Therapy (RO DBT) to work with conditions of over-control, which manifest in struggles such as anxiety, depression, and anorexia. Inspired by the unconditional love she has received from animals, Cole shares that love with others by volunteering as president of the Pacific Animal Therapy Society and a Paws and Tales reading tutor. She is also a sessional instructor at SCYC and teaches a broad range of undergraduate and graduate courses. Currently, she is on an education leave to pursue her RO DBT trainer and supervisor certificate.

Having been a student at SCYC and now an instructor, what changes have you noticed? What has stayed the same?

What has been cool is seeing the diversification over time of both curricula and student body; this is especially true for marginalized populations. One thing that has remained constant is the helping profession attracts wounded healers, so there is sometimes parallel work to be done. The other constant is anxiety: Am I on the right path? What do others think of me? Am I good enough? Am I an imposter?

What are some key issues for today's children and youth?

I like to think of my youth as co-philosophers and, as such, ask them about why anxiety, depression, self-

injury, and eating disorders appear to be so prevalent amongst their peers. What they have told me is that the impact of social media and subsequent social comparison have contributed to trying to achieve an ideal that is unachievable, whether that be success, happiness, or body size. While social comparison may not be new, I had one youth comment that I was lucky to grow up without Facebook. In turn, I offered her a free tutorial in rotary phones!

My youth have also informed me that environmental and political concerns are a top anxiety trigger, and they often feel dismissed by both adults and peers for these concerns. They have told me a lack of genuine purpose creates significant existential strife. Finally, many youth I work with are just too busy trying to achieve the next level in life, which leaves little time for daydreaming and fun. When we talk about overcontrol, we can see this pattern progressing into adulthood with lifelong consequences of loneliness, resentment, and lesser capacity to have a sense of belonging.

I often refer to the McCreary Centre research, which suggests many maladaptive habits (e.g. smoking) are on the decline in some youth populations in B.C., but as a counsellor, it can *seem* like some habits (e.g. self-injury) are on the rise. I think the important questions to ask are, what does the research suggest for trends and what are the trends I see in my personal practice? What is the similarity and what is the difference based on my geographical location?

In your opinion, what does help youth and children?

The youth I work with have an extraordinary mental health vocabulary but not necessarily the skills to address challenges they or their friends face, hence the maladaptive coping skills of self-injury, isolation, eating disorders, and suicide. Many youth I see are the "go to" peer therapists for their friends, so this is a pressing issue. Working closely with school counsellors, I see a tremendous trend to destigmatize mental health challenges and not pathologize these issues, which I applaud. At the same time, we see a pharmaceutical industry that has a strong foothold in treating these challenges, making them normalized "disorders." I am neither pro nor anti medication, but I will say it needs to be one tool amongst many, including teaching effective social signalling for belonging, a sense of genuine purpose, and practical skills that promote a sense of community involvement. This is where an adult invested in youth — a teacher, counsellor, coach, or community mentor — can have a huge impact. I always tell my youth that our goal is to balance the existential angst of life with practical skills for living.

"WHILE SOCIAL COMPARISON MAY NOT BE NEW, I DID HAVE ONE YOUTH COMMENT THAT I WAS LUCKY TO GROW UP WITHOUT FACEBOOK. IN TURN, I OFFERED HER A FREE TUTORIAL IN ROTARY PHONES!"

What about sexuality and gender?

Things have really shifted culturally since my early days doing GLBT education for teachers and students close to 20 years ago. GLBT is an outdated acronym; there are now 55 identity qualifiers on Facebook, Pride alliances, gender-neutral bathrooms, and advances in school policies. Despite the fact that most youth talk to me about gender as a spectrum and gender identity and sexual orientations as fluid, they are still operating in a society where the gender binary persists and cultural stereotypes abound. It is common for my youth to tell me about how unfair the gender rules still are as they apply to sexual expression. For example, heterosexual males are applauded for sexual "conquest" and heterosexual females are still called "sluts." Queer females are either demonized or fetishized. Queer males are still cloaked in stereotypes. I see my queer youth and trans youth struggle with others who insist they "choose" one identity, despite their comfort living as non-binary or gender creative. Queer and trans youth still have a staggeringly high suicide attempt/completion rate, which speaks to enormous pressures that sometimes we, as adults, cannot detect or assume have been alleviated through legal advancement. These youth remain targets of violence, subtle or overt.

All of us, youth and adults alike, are hardwired to scan our environment to ask, am I in the tribe or out of the tribe? For my youth, this is a major component of their sexual and gender-identity development. I use bibliotherapy in this regard and discuss assigned books, movies, or websites that tackle these issues head on.

If you could send one message to youth, what would it be?

We are hardwired to seek belonging, even if we feel alone. We cannot predetermine the spaces that will embrace us, but trust that they are there. ■

ON INTIMACY AND SEXUAL RELATIONSHIPS

AN INTEGRATIVE AND INTERDISCIPLINARY APPROACH

BY FERNANDA SELAYZIN SOUZA, M.ED., MCP, RCC

In the practice of relationship therapy, sex therapy is often organized, marketed, or subordinated academically and clinically as a related though separate field. However, research and clinical experience indicate that complaints in the realm of sexuality are perennial presentations for clients in committed relationships. A common reason for seeking therapy is framed as "sexual disinterest" or "disconnect."

Earlier work in sexual medicine dedicated significant time and energy — with enthusiastic support from pharmaceutical companies — to the physiology of arousal to explain and approach sexual disinterest and the impact of sexual disconnection on relationship distress and individual mental health. And even though symptoms, syndromes, and DSM-based classifications may still correspond to a more linearly defined, biologically and structurally based impairment of genital response, it is now increasingly recognized that most sexual complaints take place in the presence of adequate physical and hormonal health, age-related changes notwithstanding.[1]

In other words, a steroid-infused cocktail is not going to consistently

eradicate declining sexual interest even — and perhaps especially — in otherwise stable long-term sexual relationships. It is increasingly clear that an endocrinological focus is insufficient to account for disconnection in sexual relationships in particular sociocultural (and gendered) contexts and at the complex nodal point where physiological, interpersonal, and intrapersonal experiences meet and unfold.

Luckily, the conversation has shifted considerably — even in sexual medicine — and is now being framed within a humanistic, systemic, sociological, and relational paradigm. Today, the problem is being viewed less as a potential dysfunction located in an individual and more as existing within a relational process.

Indeed, sexual interactions do not occur in a "relational vacuum" — even when described as "casual sex" — and many variables are involved in mediating sexual interactions. In the new relational paradigm, the notion of "intimacy" has come up as crucially prominent. This is a welcome de-pathologizing shift in which relationship distress is seen through an interdisciplinary and much more nuanced lens. Previously unimagined developments in technology and its use in neuroscience research have also served to support this shift with claims of scientific evidence.

AN INTERDISCIPLINARY AND FLEXIBLE DEFINITION OF INTIMACY

Even though the clear-cut differences that used to exist between modern economies and agrarian societies may be gradually disappearing, considering the context-specific ways in which intimacy is conceptualized and experienced still bears relevance. That is the case particularly for relationship work conducted in a Canadian province like ours: the seat of an increasingly post-industrial and service-oriented society with a high influx of global immigrants.

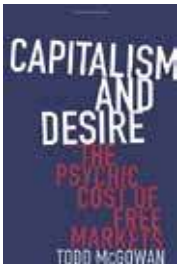
In its broadest contemporary conceptualization, intimacy is defined as a construct of ideas of self and self in relationship with another/others. The notion of "self" indicates that this conceptualization is associated with the rise of modernity and individualism, particularly post Second World War. In this modern sense, intimacy is the process of knowing oneself in the presence of another. But it is also two (or more) selves engaging in self-disclosure and sharing each other's internal lives. It exists in a continuum, and it may refer to an intense, interpersonal experience of intersubjectivity, or it may vary in intensity, quality, and contingency upon cultural contexts and lived experiences.[2]

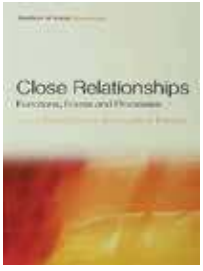
On the low end of the spectrum, intimacy may entail more limited self-exposure and involvement with the other — as measured in attunement, attention, and tracking of another's verbal or less direct communication — as well as engaging in some shared understandings. On the high end of the continuum, it may involve a much higher degree of sharing experiences in which partners may be in touch with and invite the other into the most vulnerable aspects of their inner selves.[3]

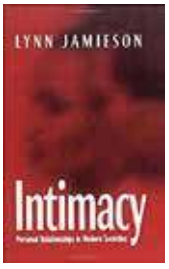
INTIMACY IN THEORIES THAT INFORM PRACTICE

Different theoretical orientations offer specific definitions of intimacy. They also vary in how they signify the connections between intimacy

THE RISE OF ROMANTIC LOVE ▸ RESOURCES







Though intimacy is not the only component of relationship satisfaction, it has a prominent position within sexual relationships predicated on a romantic paradigm. For recent accounts of the rise of romantic love, see Victor Karandashev's *Romantic Love in Cultural Contexts* (2017) and Todd McGowan's *Capitalism and Desire: The Psychic Cost of Free Markets* (2016). For an uncomplicated challenge to this view in which it is argued that romantic love is universal and as ancient as humankind, see Elaine Hatfield and Richard Hapson's in *Close Relationships: Functions, Forms, and Processes* (2006).

For an excellent account of the modern conceptualization of intimacy resulting from the rise of an ethic of individual self-fulfilment, autonomy, and achievement, see Daniel Santore's *Romantic Relationships, Individualism and the Possibility of Togetherness* (2008). Central to his thesis is the modern construction of the "individual identity" as opposed to the "collective" and the social construction of a contemporary notion of "romantic love." For a much more elaborate analysis, see Lynn Jamieson's *Intimacy: Personal Relationships in Modern Society* (1988).

and relationship distress. In important ways, these orientations converge and complement each other and, as such, serve best to support our clinical work.

Intimacy entered the field of relationship therapy in the 1960s, when pioneering family therapist Murray Bowen introduced his notion of "differentiation" as an indicator of mental health in the family and the couple system. In his approach, cognition was radically privileged, and differentiation was measured on a numeric scale in which the greater the degree, the more thoughts were distinguished from emotions, which were subordinated and controlled by rational thinking. In this model, healthy development was seen as dependent upon the ability to achieve emotional independence and autonomy from the family of origin, while maintaining a degree of connectedness as in an ideal balance. The notion of intimacy was not specifically conceptualized, but it was understood that romantic partners who were well differentiated in this Bowenist sense would be able to maintain closeness and achieve intimacy and mutuality without engaging in "fusion."[4] Here we see how a notion of intimacy was signified as involving self and other as in the broad conceptualization above.

With today's advances in neuroscience, Bowen's discernment and hierarchization of rationality is outdated,[5] but some of his contemporary followers consider his notion of differentiation as not necessarily dismissible if understood as a platform for the emergence of a stable sense of self[6] and as one of the necessary conditions for healthy degrees of closeness, intimacy, and mutually reciprocal connection.[7]

Attachment theorists often use the concepts of "closeness" and "intimacy" interchangeably and sometimes refer to "emotional intimacy," "relational intimacy," and "bonding" as equivalent terms. From an attachment perspective, intimacy in adult relationships may involve verbal self-disclosures, physical interactions, and the experience of feeling understood, validated, accepted, and cared for. It refers to a very particular type of interaction, which is critical to the development of secure attachment bonds.

The capacity for intimacy[8] — translated in attachment terms as the capacity to engage in mutually reciprocal care-seeking/caregiving interactions — is a developmental phenomenon and a marker of mental health. Attachment theorists recognize sexuality and caregiving are independent behavioural systems.[9] This distinction is also being further explored in neurobiology where the dynamics of pair-bonding are recognized as based on the same system that informs the infant-caregiver attachment, while the sexual mating system is identified as functionally independent.[10] Though distinct, these systems often coordinate.

According to John Bowlby's original work, the attachment behavioural system is innate, present across the lifespan, and comprised of four defining features, each designed to elicit and warrant a sense of material and psychological security: proximity maintenance; separation distress; safe haven; and secure base.[11] As a developmental model, what becomes different in adult attachment relationships is the degree of symmetry and mutual reciprocity. Whereas in the infant-caretaker dyad, there are clear roles for provision of care; in adult relationships, there is turn-taking.[12]

In an attachment framework, intimate interactions are seen as essential for the development of attachment bonds in early life as well as in sexual

Intimacy entered the field of relationship therapy in the 1960s, when pioneering family therapist Murray Bowen introduced his notion of "differentiation" as an indicator of mental health in the family and the couple system.

relationships. It follows that individual differences in attachment strategies that were generally established in early life influence the degree of intimacy that is perceived, elicited, offered, and tolerated in adult romantic relationships.[13]

Sue Johnson's brand of emotionally focused therapy (EFT) is no doubt the most widely recognized approach to relationship therapy informed by attachment theory. In this paradigm, great faith is placed on intimate interactions to facilitate the development of secure attachment bonds, as well as to maintain them. Relationship satisfaction is associated with partners' mutually reciprocal availability and responsiveness, which therapy is designed to help organize and facilitate. The problem of sexual disconnect is viewed as a problem of attachment insecurity.

Ultimately, the goal is to create enough safety in the relationship so partners provide each other with their primary adult attachment needs.

Individuals whose attachment strategies are informed by security are more inclined to activate their attachment system — and to bid for connection, for increased intimacy — in a balanced, flexible, and mutually reciprocal fashion. Individuals presenting with a more preoccupied inclination (and other variations of attachment orientations) may activate the attachment system and orient towards connecting behaviours in less balanced, less predictably organized, and more asymmetrical ways — for example, by placing higher demands on other/s to regulate self.[14]

Therapies informed by attachment theory, such as EFT, and the research supporting them have indicated that partners who make themselves available and responsive to each other's bids for connection — by mutually and reciprocally responding to each other's emotional needs and concerns — resolve conflict more effectively, develop greater intimacy, and experience more relationship satisfaction.

Gottman and team also subscribe to an emotionally focused approach in which attachment theory has a place.[15] But they argue Johnson's EFT does not make room for the possibility that, in some cases, partners' need for intimacy — and perhaps their internal working models of attachment — will never make for a good fit. In this case, an approach based on fostering further intimacy — strengthening attachment bonds through mutual availability and responsiveness — will not suffice. Gottman makes

Ultimately, the goal of EFT is to create enough safety in the relationship so partners provide each other with their primary adult attachment needs.

Interesting recent work on consensual non-monogamy, open relationships, polyamory, and even hookup culture indicates that there may be a lot more to the development of healthy adult attachment relationships than an uncomplicated reliability on the sexual dyad.

use of affective neuroscience (via Jaak Panksepp's work) to add to the dimensions covered in EFT to improve couple relationships.

TOWARDS A MORE INTERDISCIPLINARY PERSPECTIVE

In attachment theory, mental representations of self and other are mutually confirming. A notion of self as worthy develops according to a notion of other as available and responsive and is internalized in a stable working model of self and other into adulthood.[16] In the context of attachment security, the self feels safe to explore, developing a sense of autonomy that can coexist comfortably with the human reality of interdependence. This secure self is deemed capable of engaging in intimate interactions that, in adulthood, will facilitate the development of a secure sexual relationship bond. In this sense, deep intimate connection requires a self system accurately attuned to both self and the partner experience. This dynamic development is supposed to be innate and its trajectory into adulthood universal.

Other cultural contexts may not present the dyadic structure apparently required for the development of an attachment bond in its classical sense, though.[17] An example might be the multiple mothering that can occur when three generations live together. In this or other cultural contexts, notions of self as relational may impact a conceptualization of intimacy that is quite diverse from the one taken for granted in our therapy worlds.[18] Comparably, adult relationships may also derive security from a dynamic that involves bonding with multiple attachment figures. Interesting recent work on consensual non-monogamy, open relationships, polyamory, and even hookup culture indicates that there may be a lot more to the development of healthy adult attachment relationships than an uncomplicated reliability on the sexual dyad.[19]

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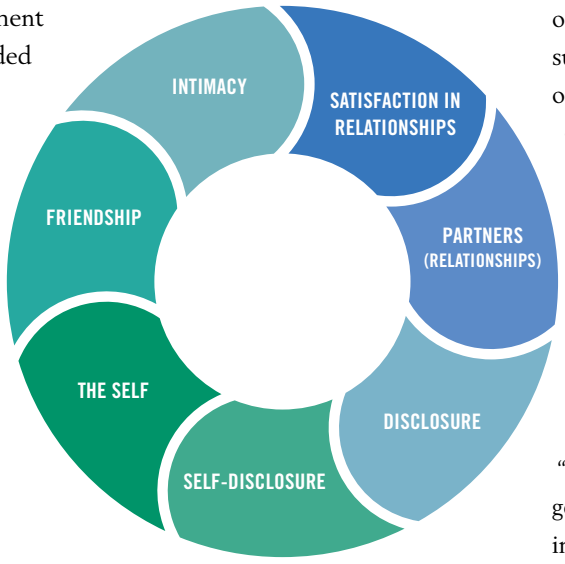
Celebrated speaker and relationship therapist Esther Perel is very sensitive to how cultural contexts inform our notions of intimacy. She speaks specifically about how, in a contemporary romantic relationship, partners are overburdened by each other's needs for the attachment security that is supposed to be provided within the exclusive space of the coupleship bond. She admits that the link between affectional bonding and sexual desire — the focus of her lifelong inquiry — run bidirectionally, with certain physiologically based differences in men and women.[20] But Perel also notices in her practice that a number of couples who speak of being securely attached are showing up with complaints about loss of sexual connection.

In cases like these, I think therapists exclusively informed by attachment theory would search for an internal working model in need of fixing, believing that sexual reconnection would ensue. And maybe those informed by Gottman's work might consider mismatched needs for sexual connection, and then encourage experiences of positive affect, among other strategies. And those of us interested in neuroscience would be curious about whether creating better

Individual differences in intimacy-related needs and fears appear to be systematically associated with attachment expectations[3]



physiological regulation and vagal tone,[21] perhaps through sensorimotor and mindfulness-oriented practices,[22] might create the conditions for rekindling the relationship into a positive change.

Following Perel, we may all benefit from using all of the above and from expanding our therapeutic lenses with a broader interdisciplinary approach to relationship distress and the connection with issues of intimacy. We have moved away from the early pathologizing orthodoxies of sexual medicine and its genital-centric focus and into a relational paradigm in which emotion is prominent and legitimized.

We now need to make better use of interdisciplinarity to historicize the suburban (and sometimes immigrant or cross-cultural) nuclear family and overburdened coupledom. From there, we may be able to borrow certain conceptual frameworks from sociology and philosophy — as the earliest theorists did — and critically rethink them through neuroscience to see where that will take our clinical work. Thinking about concepts such as "transcendence" and "otherness" and getting informed about novel work in affective neuroscience may be an excellent place to begin. I am excited and looking forward to where we will go next in relationship therapy: away from brand-name therapy orthodoxies and towards a more critical and broader perspective. ■

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SEX THERAPY

It's more than just being comfortable talking about sex

INTERVIEWS WITH FOUR SEX THERAPISTS:
DR. DANIELE DOUCET, DR. DAVID MCKENZIE, DR. TEESHA MORGAN, AND DR. PEGA REN

BY CAROLYN CAMILLERI

Let's say a woman tells you she has low libido or the quality of her sex life has diminished. As her counsellor, you start to ask questions and learn she has pain during intercourse. The next step illustrates a key distinction between couple therapy and sex therapy.

Dr. Teesha Morgan would ask, where is the pain located? What kind of pain is it? How often is it occurring? In her mind, Morgan would be assessing for vaginismus, dyspareunia, vulvodynia, clitodynia — medical terms to describe different types of vaginal pain under the broad category of Genital Pelvic Pain Disorder — and then she would provide specific suggestions to treat it.

"We can talk with a woman and empathize, but if you're just tackling it from an anxiety perspective or a relationship perspective, a safety or communication perspective — and those all might be important factors of what is going on — you may be missing a key component or diagnosis, that we're actually dealing with something such as vaginismus, and this woman needs specific guidance to heal, such as seeing a pelvic-floor therapist," says Morgan.

Pain during intercourse is just one common issue Morgan sees in her office.

"With women, it's predominantly low libido or pain during intercourse or a difference in a couple's sex drive," says Morgan. "With couples, much of the time, it's quantity and quality of sex — either one or both has become an issue, and they want to communicate around their sex life in a more effective way."

With men, the predominant problem is erectile dysfunction, which Morgan calls an umbrella term for a multitude of issues. When a client presents with erectile dysfunction, Morgan starts by referring him to, at the bare minimum, a GP to check testosterone, prostate, diabetes, blood pressure, and other possible causes that may be biological. She then addresses behavioural aspects by assessing the client's masturbation tendencies and their effect on his ability to get an erection and sustain it. Treatments for behavioural issues start with what Morgan calls "homework assignments." Once biological and behavioural aspects have been addressed, she assesses for psychological concerns, such as anxiety and depression.

"There are three things to look at: biological, behavioural, and psychological. If you're missing one of those three categories, you're dropping the ball on the whole thing," says Morgan. "You can't just look at one and hope that you've found it, because oftentimes, one is causing the other."

Her holistic approach comes from very specific training in human sexuality.

MORE THAN A DEFINITION PROBLEM

The term "sex therapy" is not protected nor are there official requirements for using it. Technically, anyone could say they are a sex therapist, even without training. "Sexologist" is another term that can be misused. Dr. David McKenzie offers clear definitions.

LEARN MORE ABOUT OUR EXPERTS AND WHAT THEY DO

Dr. Daniele Doucet (Nee Duplassie): www.shanti-centre.com/danielle-duplassie/ | Dr. David McKenzie: www.davidmckenzie.ca | Dr. Teesha Morgan: www.teeshamorgan.com | Dr. Pega Ren: www.smartsextalk.com

"THERE ARE THREE THINGS TO LOOK AT: BIOLOGICAL, BEHAVIOURAL, AND PSYCHOLOGICAL. IF YOU'RE MISSING ONE OF THOSE THREE CATEGORIES, YOU'RE DROPPING THE BALL ON THE WHOLE THING."

"Sexology is simply the study of human sexuality, and sex therapy requires a counselling background," says McKenzie. "Sex therapy has a much broader perspective that takes into account the dynamics of couple relationships, of how to treat sexual problems, how to diagnose them, whereas a sexologist is somebody who could be studying the history of kink. That doesn't make them a therapist."

Nor does training as a couple counsellor make one a sex therapist.

"Relationship counselling has a lot to do with communication concerns, but that is just a piece of what sex therapy is," says Morgan. "Sex therapy is a specialization like trauma or addiction."

McKenzie, who has been a sex therapist for the last 13 years of his 43-year counselling career, began his career as an Anglican minister trained in pastoral counselling. A couple asked him for help with premature ejaculation.

"Medical doctors just have one solution: take Paxil and that should help, but it doesn't always, and I didn't know who to refer to. I certainly didn't know about it myself, and I felt sad about that, guilty even," says McKenzie. "Someone would come to me regarding issues around human sexuality, and I could be sympathetic, I could give suggestions, but I didn't have any training as to how to treat it, where to go, what to do. In my own training, which was extensive, I never got any kind of training in sexuality."

The issue goes deeper than not having training. McKenzie points out that many counsellors don't even ask about sexual issues. "They're uncomfortable. They're not in touch with their own sexuality, or they're just very nervous, because they don't know how to handle it."

Dr. Pega Ren agrees.

"Marriage and family counsellors all deal with sexual issues," says Ren. "And I think most never mention it, don't know how to ask the questions, don't know how to respond when questions are asked of them, don't know how to incorporate sex therapy. And it makes sense to me that that is the case, because most psychologists have between six and 10 hours of training in sexuality. And many counsellors don't have any training in sexuality at all."

The lack of training comes from a lack of training opportunities.

"As it is now, there are no graduate programs requiring training in human sexuality; however, there are people who hang up their shingles as relationship therapists and talk about sex but don't have adequate training to do so," says Dr. Daniele Doucet, adding that most training opportunities are in the U.S.

To date, regulating bodies in Canada haven't made training in human sexuality mandatory. If it were, Doucet believes more graduate programs would offer it. It's an issue in the medical community, too. Ren facilitates a four-hour workshop for graduating medical doctors called Sex Therapy for Non Sex Therapists. She may be the only person who talks to them about sex.

"All I have time to say is, 'These are the things that can change; these are the things that can't change, and you need to know what's on each of those lists, because your first job is do no harm,'" says Ren. "And very well-intentioned people do harm. They meet issues with their own prejudices, their own ignorance, and do their very best to be helpful without the knowledge or training to handle it effectively."

Ethics are the root of the problem.

"We're not supposed to engage in therapeutic activities that are beyond our competence," says Doucet. "But people assume that if they took a basic course in human sexuality or if they took a marriage and family course and read a book on human sexuality, that it makes them qualified to do therapy related to sex, and it's dangerous."

GOOD INTENTIONS GONE WRONG

Ren says her clients contact her about a wide range of concerns, including

relationship issues, unmet expectations, disappointment with trying to follow the cultural script, erectile dysfunction, body issues, painful intercourse, infertility, and GAS: guilt, anxiety, and shame. Much of it starts with a lack of adequate and accurate sex education.

"People don't understand how their bodies work. And they don't understand when their bodies don't work the way they expect them to and whether that's a problem with their body or the expectation," says Ren. "And there are very few avenues for them to get accurate, non-judgmental information."

Sex therapists have comprehensive knowledge of sexuality in all its forms, behaviours, and lifestyles, and an arsenal of solutions to issues that may arise.

"We have to have the answers before we start giving them. We have to know what works and what is appropriate for the person sitting in front of us. And that may be very different from the next person who presents us with the same symptom," says Ren. "We need more than empathy."

Above all, sex therapists need to listen without judgment.

"People hold enormous shame about what they do sexually and can take it nowhere, because we, as a culture, hold negative judgment about sexuality," says Ren. "We slut-shame women. We make men feel guilty for being aggressive and make them feel guilty for being sissies, so they can't win. And being able to say to someone, 'I am a sex therapist so you can tell me anything,' means that for many, many people, the sex therapist is the first person they speak to."

While all counsellors are trained to be sensitive to bias, sex therapy may uncover bias you didn't know you had, despite your experiences professionally and personally.

THE MAJOR PROBLEM OF BIAS

When McKenzie started studying sexology and sex therapy, many of his assumptions were challenged.

"For instance, being an Anglican pastor, I was under the assumption that the only sex that counted, the sex that was good and healthy, all had to be within a committed or loving relationship," says McKenzie. "That's absolute balderdash."

Nor does love and commitment always connect to sex. Once McKenzie started in sex therapy, he found he had some couples coming to him who had very successful marriages, who communicated and loved each other but weren't having sex.

"There's a myth out there that the sex life is the barometer of the rest of the relationship," he says. "Well, that's not always true, though it certainly can point to difficulties in the relationship."

THE PLISSIT MODEL

Jack Annon's PLISSIT model is one of the most favoured approaches to sex therapy. It's an acronym for the series of steps a sex therapist can take to address a wide range of issues. P for permission, LI for limited information, SS for specific suggestions, and IT for intensive therapy.

1 PERMISSION
Counsellors who are comfortable with sexuality and gender give the client "permission" to express issues that may be attached to shame or be difficult to talk about or process. The counsellor accepts the person and the issue without judgment. For example, a client may say they believe they are masturbating too much. The counsellor gives permission by responding with "I'm glad you told me that" and then "What makes you think it's too often?"

2 LIMITED INFORMATION
A counsellor who is quite knowledgeable in human sexuality can offer accurate factual information that puts the issue into perspective and makes the client feel more comfortable: statistics on erectile dysfunction or on how difficult it is for a woman to reach orgasm, how common a behaviour is in different populations or how a behaviour is harmless. For example, "Perhaps you would feel better knowing that there are no harmful effects of masturbation."

3 SPECIFIC SUGGESTIONS
At this stage, a counsellor would need to have good training in sexuality to go beyond empathy and offer guidance that does no harm. Morgan says it may be tempting to assume the sexuality-based problem is a symptom of something psychological, when it may be the root cause. Ren uses the example of helping a client manage masturbation behaviour so it doesn't, for example, become a threat to his employment, which could solve the problem and end the need for therapy. In other situations, specific suggestions could lead to treatments and continued therapy. It takes training to know what to offer in the way of specific suggestions for a wide range of issues.

4 INTENSIVE THERAPY
The final steps require an experienced sex therapist. However, Ren says fewer clients need sex therapy at this stage. More often, the issues are due to the client being frightened, ashamed, or uninformed, and once they have that resolved, they are finished sex therapy. "Then they can go back to their marriage and family counsellors, and do the rest of the life stuff because they've got the sex piece finished," says Ren.

One of his sub-studies was swinging, open, and alternate relationships.

"Many people think that people who have alternate sexual lifestyles are going to come apart, and they don't, and that was a real shock to me," McKenzie says. Further studies included kinks, BDSM, and sadomasochism. "It was a real eye-opener, but it doesn't mean the person's sick because they practise it."

Doucet says sex negativity is so normalized that people think it's normal. "Through a sexological lens, we see that sexual preferences are as diverse as food preferences. We don't pathologize people who like liver, even though a small portion of the population likes liver. When you live in a society that has these ideas that certain sexual activities are good and normal and certain ones are terrible, immoral, and abnormal, it creates a perspective that permeates all of us at a societal level."

Religion has long played a role in pathologizing sexuality. McKenzie has been a guest lecturer on the subject of sex, religion, and culture at the UBC School of Medicine, SFU, Trinity Western, UVic, and University of Northern B.C. in an attempt to educate professionals on the sexual assumptions and negativity based in religion.

Another pathologizing influence: DSM IV. The DSM V has been updated to recognize that unique sexual preferences in and of themselves are not pathologies, says Doucet, adding, "In my training, I learned how much bias I had based on sex-negative attitudes within our society. I didn't realize I had them."

The process of undoing bias begins with SAR — Sexual Attitude Reassessment. McKenzie describes it as a blunt, in-your-face experience viewing erotic material. "It's desensitization that gets a person used to the idea that there are all sorts of sexual proclivities and kinks," he says.

Sex therapists take SAR repeatedly; in Doucet's case, three times a year for three years. "We did a lot of process-oriented talking about our reactions — our judgments, our biases, our discomfort — and examined that in extreme depth, so we could see the ways sex-negative culture had influenced us," says Doucet.

Part of SAR's effectiveness is that it is done in a group setting with specially trained facilitators. Doucet says even sexuality students and counsellors find it challenging, but it is critical to get past bias to address even basic sexuality issues with clients.

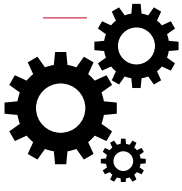
"How comfortable do therapists feel about asking clients about masturbation practices?" says Doucet. "Most are very uncomfortable, but it is so important to someone's sense of self as a sexual person. You need to ask about a client's comfort level around sexual pleasure and being comfortable in their bodies and with their body parts."

Unprepared counsellors can leave clients feeling distressed.

"I've had many clients tell me they didn't feel comfortable talking about sex and sexuality with their counsellors," says Doucet. "They couldn't have those important conversations."

Ren also talks about remedial work as a result of others' good intentions.

"It's unnecessary," says Ren. "There's enough good, valuable work for marriage and family counsellors to do without feeling they have to do it all."



"WHEN YOU LIVE IN A SOCIETY THAT HAS THESE IDEAS THAT CERTAIN SEXUAL ACTIVITIES ARE GOOD AND NORMAL AND CERTAIN ONES ARE TERRIBLE, IMMORAL, AND ABNORMAL, IT CREATES A PERSPECTIVE THAT PERMEATES ALL OF US AT A SOCIETAL LEVEL."

HOW TO BE TRULY HELPFUL

"Not all counsellors are couple counsellors," says McKenzie. "But anybody doing couple counselling who's not asking about the sex life should not be doing couple counselling, period."

For counsellors without adequate sexuality training, McKenzie's answer is clear: "As soon as the issue of sexuality is raised in the relationship as a problem, they need to refer out."

While there are many clear distinctions between couple counselling and sex therapy, there are some areas of overlap with respect to intimacy.

"Marriage and family counsellors can work with couples on communication and empathize with regard to problems with intimacy, especially if some of the major issues are 'We're not communicating. I don't know when my partner's in the mood. My partner doesn't know when I am, and my partner doesn't know what kind of touch I like,'" says Morgan, but cautions, "Even within that realm, understanding things like a person's sexual schema is important and is more into the sex-therapy realm. You might be helping with the communication but not understanding that the main reason they aren't connecting is because there's a differentiation in their schemas."

McKenzie believes strongly that, as Dr. Rosemary Basson of UBC's Sexual Medicine Clinic once stated, "Sex never stands alone. It is always connected to other issues."

"That is why family of origin is vital. We replicate our family-of-origin issues in our primary relationship and that has profound impact on our sex lives," he says. "Most of our sexual issues have both intrapersonal and interpersonal roots, and if these are not thoroughly explored, the sex therapist is only doing band-aid work."

Like any area of counselling, Morgan says, it's important to be aware of the limits of your own training and experience and refer out when progress seems stalled.

"We get to a point where we realize, 'Wow, I'm sinking,' and 'I'm out of my realm of expertise here,'" says Morgan, adding that she may refer once biological and behavioural concerns have been addressed — for example, if the client has severe issues with anxiety or trauma.

For Doucet, it is a question of training to avoid compartmentalized therapy.

"Ultimately, I think anybody doing relationship therapy needs to have some type of training in human sexuality, because our sexualities are an integral part of our everyday existence," says Doucet. "We don't wake up in the morning and say, 'Oh, you know what? I'm queer, but I'm going to put that in a box today and go live my life and then come home and put on my queerness again — or my sexual attractions or my sexual preferences.' Hopefully, humans aren't compartmentalized in that way."

The training isn't to turn every relationship counsellor into a sex therapist: it is to help counsellors manage discussions with their clients.

"We need counsellors to be trained in hearing clients ask for help," says Ren. "We need training so counsellors can hear their clients ask about something sexual without feeling they have to solve it but being able to respond without bias."

Doucet says counsellors who are interested in human sexuality can seek out training opportunities, such as courses and conferences. "Consult with experts who do have training. Learn how to integrate questions about sex and sexuality in intakes. Get supervision. All the things we would say therapists should be doing when they're practising in an area they're unfamiliar with."

Morgan, who is a co-founder of the Westland Academy of Clinical Sex Therapy, suggests the PLISS aspects of the PLISSIT approach to sex therapy (see page 17) are a good areas for counsellors to research, become knowledgeable on, and possibly incorporate into their practices. It's not a quick tool, but rather a framework, and learning how to apply the PLISSIT model for each sexuality-based dynamic requires training and supervision.

And Ren suggests putting together your list of experts. "Counsellors need to have the pelvic floor specialist on speed dial and the sex therapist on speed dial, just like they need the social worker and the person who knows how to get Mom into the nursing home without an eight-year wait list and someone who knows something about autism."

"All of us need the community of therapeutic interveners to do our jobs well. We can't all know it all," says Ren. "Sex therapists know the sex part, and we know it well, because we have doctorates in it. We don't dabble in sex. We come to it with a great deal of expertise and knowledge and not a whit of judgment." ■

Find information on sex therapy resources, training, and professional associations at the BCACC blog at www.bc-counsellors.org.

COUPLE COUNSELLING HOMEWORK

David McKenzie often gets calls from counsellors looking for input on their clients' sexual problems. The first thing he asks counsellors for is the clients' sexual history (he uses an eight-page form).

"You cannot begin to evaluate a couple until you've taken the sex history, relationship history of both of them."

He then asks about the clients' family of origin and depression inventory.

"Their relationship is driven by that family of origin, and depression is one of the leading causes of sexual shutdown in both men and women, especially men," he says.

"Without that information, which tells you about attachment and relationship styles, it's a case of the blind leading the blind. You need to get at the root of why the couple is together."

"That kind of work has to be done in the first session, and usually by the end of the first session, I can pretty well diagnose what the issues are and show them a plan for treatment," says McKenzie.


gender-affirming procedures
AFAB
FTM
transphobia
two-spirit
cross-sex
gender-related body dysphoria
g
gender
how to provide inclusive counselling services to trans and gender-diverse clients*
Sexual orientation/sexuality
transgender
intersex
cross-sex hormone treatment
MTF

101

BY MAIR CAYLEY, RCC

ONE OF THE FIRST THINGS we experience at birth is being declared either a girl or boy. This decision is made immediately and is based only on the appearance of our genitals. These two categories contain a lifetime of expectations about how our bodies will behave, the colour our clothing will be, which hairstyles are appropriate, which toys we will play with, the gender of playmates we will prefer, what our interests and occupations will be, and who we will be attracted to/partner with when we are adults. For many people, this gender-role socialization practice does not evoke any concerns. For others, these gendered expectations do not align with who they feel they are. Disobeying gender roles can lead to rejection, shame, violence, and oppression.

The purpose of this article is to help you as a counsellor adopt a more comprehensive understanding of gender and learn how you can provide inclusive and competent counselling services to trans and gender-diverse clients.

It is my hope that by reading this article, you will have more awareness about the common experiences of being a gender-diverse person, increased knowledge about the spectrum of gender identity, and an improved ability to choose language that is more inclusive of gender diversity.

* For the purpose of this article, the terms trans and gender diverse will be used to encompass all the different types of gender diversity, including, but not limited to, trans, transgender, transsexual, genderqueer, non-binary, androgynous, agender, and gender non-conforming people.

Gender-diverse people present in clinical settings for a variety of reasons, some having nothing to do with their gender identity. However, as counsellors, if we are not informed on issues of gender diversity, we might overfocus on the client's gender, provide unskilled attempts to show support, and, at worst, be disrespectful, judgmental, or intolerant.

OPPRESSION AND INTERSECTIONALITY

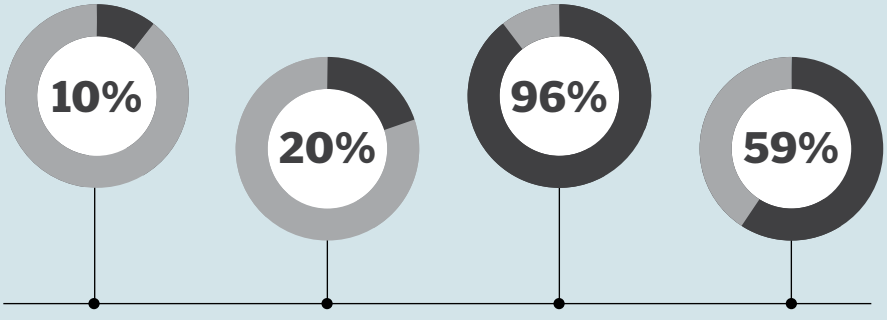
As the statistics demonstrate (see below), trans and gender-diverse people often experience oppression, discrimination, and violence. Gender diversity itself is not pathological or problematic; however, the responses from family, health care professionals, and broader society are what often contribute negatively to well-being in these populations.

As health care practitioners, it is imperative that we have some understanding that these harsh realities might be part of a trans client's lived experience. Understanding your positions of privilege and marginalization as a practitioner is an important part of this work. The Addressing Framework[1] is a great place to start if this topic is new to you. If you do not identify with any minority groups, you may not have a sense of what it is like to experience systemic oppression. Learning about how these social forces impact others will support your work with gender-diverse clients.

Gender is one aspect of our identity that intersects with multiple other identity categories, including, but not limited to, racial and/or ethnic identity, nationality, age, ability, class, employment status, education, immigrant status, sexuality, religious/spiritual beliefs, and geographic location. A trans person of colour who is an immigrant and speaks English as a learned language will have a very different lived experience of being trans compared to a trans person who is white and has had consistent access to education. It is crucial not to group all trans and gender-diverse people into one category and to understand that privileged and oppressed identities influence lived experience.

THE STATS

Gender-diverse people are among an oppressed population that experiences marginalization, personally and systemically. These statistics[2] provide context about common lived experiences of trans and gender-diverse people.



10% of trans people attempt suicide in Canada per year, compared to 3.7% of the general population.

20% report physical/sexual assault due to their trans identity, while 34% report experiencing verbal threats and harassment due to being trans.

96% of trans people have heard that being trans is not normal, 73% have been made fun of because of their trans identity, 78% report their family had been hurt or embarrassed, and 67% feared they would die young.

59% of trans people knew before age 10 that their gender identity did not match their body; 80% knew by age 14.

An American study exploring trans people's experiences with health care (n=7,000) showed that 19% reported being denied access to health care due to their trans identity, 28% reported harassment/discrimination in health care settings, 50% reported having to educate their health care provider on trans health/trans care, 25% reported substance use to cope with discrimination, and 41% reported a suicide attempt.[3]

In eight main counselling journals, there was just one article on gender-diverse populations between 1990 to 2008 and nine articles that used the word transgender/transsexual in the abstract.[4,5]

WHAT IS GENDER?

Gender is a fluid construct that can exist anywhere on a spectrum of feminine to masculine. This means there is no set number of gender categories, and each person has their own experience of gender. This conceptualization of gender directly challenges the archaic gender binary where there are only two options: woman/man, girl/boy.

The term natal sex refers to the sex category we are assigned at birth. The options include female, male, or intersex. The term intersex describes chromosomal, genital, and/or hormonal diversity. Gender identity refers to someone's internal (and possibly private) sense of their gender on a spectrum of feminine to masculine.

Gender presentation/expression is how someone performs their gender, including clothing, haircuts, name, pronoun, and other visible and/or spoken identifiers. Gender expression and identity are dynamic and can change through a person's life. Gender involves both internal (identity) and external (expression) factors. Someone's internal sense of their gender may not align with their external appearance for a variety of reasons. This is why it is crucial you do not make assumptions about how people identify based on their appearance.

Sexuality (or sexual orientation) is who we partner with, have sex with, and/or are romantically or otherwise attracted to (see page 24 for more terms). It is not necessary to memorize every term, as language constantly evolves. The goal is basic competency using inclusive language that involves both listening for and adopting the language your clients use to describe their experiences and identities.

GENDER-INCLUSIVE COUNSELLING

Common-factors literature consistently reports that the quality of the therapeutic alliance has a significant impact on the outcomes of psychotherapy.[6,7] We build and maintain a high-quality relationship with our clients when we listen, attune, and demonstrate respect and understanding — when we see them for who they are and not how we assume them to be. Supporting gender-diverse clients is simple but not always easy, especially if the language is new to you. It is not appropriate to become overly apologetic if you make a mistake; simply correct yourself and move on. Just having an open mind is not enough. If the language is new to you, practice is essential.

INCLUSIVE LANGUAGE

The currency of counselling work is language, and this is one of the most important variables to consider when supporting trans and gender-diverse clients. It starts with pronouns and other gendered words. Ask clients their pronoun, and then make every effort to use that pronoun. Your clients are likely to notice when you get it wrong and when you get it right.

Ensure you use appropriate language in your clinical notes and supervisory consultations, and consistently use your client's correct pronouns even when they are not present. Example: Sam identifies as genderqueer and uses they/them pronouns. They are a 23-year-old graduate student at Simon Fraser University. They are presenting with symptoms of anxiety and depression. If Sam is your client and you are discussing their family of origin, you might use non-gendered words for "little Sam" such as kid, child, sibling, rather than boy/girl/daughter/son/sister/brother (see right for Quick Tips for other non-gendered language examples). Inclusive language is critical for inclusive care.

Be careful not to make assumptions. If Sam has two gay dads as parents, and we ask where their mom and dad live, we are incorrectly assuming they come from a heteronormative family. Similarly, if

QUICK TIPS

1. **Ask about pronouns with all clients, even if you assume they are cisgender.**
2. **Pay close attention to the language your clients use to self-identify and use it.**
3. **If you make a mistake, correct yourself and move on.**
4. **Use non-gendered language when describing others:**

Child/kid/little one (instead of daughter/son/girl/boy)

Sibling (instead of sister/brother)

Nibling/sibling's child/children (instead of niece/nephew)

Lover, date, partner, sweetheart (instead of wife/husband/girlfriend/boyfriend)

Person who is pregnant (instead of pregnant woman)

People with uteruses, people with testicles (instead of women/men)

Folks/friends/everyone (instead of ladies and gentlemen)

If you have a client who is curious about gender-affirming procedures, it is best to refer them to a supportive physician so they can ask questions and receive all of the necessary information to make their own choices.

Sam has a partner, and we immediately attach a pronoun to that partner, we are assuming both Sam's sexuality and the gender identity of their partner. These are all situations where it is best to begin with neutral language with all clients or to ask. It is not appropriate to be overly cautious or apologetic or to ask unnecessary questions; this behaviour can make the client feel like they are in the role of educating you and can take the focus away from their reasons for seeking support. This is why using inclusive language requires practice, so it feels more natural to you and increases the likelihood that clients feel safe with you.

Trans people often experience rejection from their families of origin, so as a counsellor, it is helpful that you not assume their biological family is a source of support. Open-ended questions such as "who is in your family" are more suitable than questions that assume the client's current relationship with their blood relatives.

Research has shown that family and social support are protective factors against suicidality and depression and contribute to increased self-esteem and access to adequate housing (see page The Stats page 22). Helping clients to augment their social-support network could be an important part of your work with them, whether it is with blood relatives, community, or chosen family.

ACCESSIBILITY

Beyond language, another common aspect of gender-inclusive care is having accessible space. Pay attention to questions on your intake paperwork, your signage, and bathroom facilities. If you have intake paperwork asking clients to identify their gender, consider why you are asking, and make room for gender-diverse identities on the paperwork. Knowing the natal sex of a client at an intake session is usually unnecessary, whereas knowing their pronoun, name, and other identifiers (and correctly using these) is likely to

GENDER GLOSSARY

AFAB: assigned female at birth.

AMAB: assigned male at birth.

Cisgender: a person whose natal sex aligns with their internal sense of gender identity.

Cissexism: the assumption (socially, culturally, interpersonally) that all people identify as cisgender.

Cross-sex hormone treatment: when a person chooses to take hormones that are not produced by their body in order to align with their identified gender. Taking these hormones stimulates a variety of physiological and psychological changes.

FTM: a natal female who identifies as male; this may or may not involve social and/or physical transition.

Gender-affirming procedures: single or multiple procedures, which may include cross-sex hormone treatment, top and/or bottom surgeries (previously called "sex reassignment surgery").

Gender-related body dysphoria: having unease, dissatisfaction, and/or discomfort with one's primary or secondary sex characteristics.

Gender expression: the way an individual performs their identified gender, including clothing, haircuts, posture/gait, voice use, and chosen language; also called gender presentation or gender performance.

Gender identity: an individual's private sense and subjective experience of their gender; also called gender orientation.

Gender dysphoria: a diagnosis located in DSM V (previously Gender Identity Disorder in DSM IV TR). This diagnosis is controversial; however, in the current medical system, it allows people in Canada access to gender-affirming procedures covered by health care.

Genderqueer: a term used by some people who do not identify as female or male. Other words used by people fitting this description include androgynous, genderfluid, agender, and non-binary.

Intersex: a term used to describe variance in

make them feel safe and engaged in the therapeutic conversation. A simple way to gather this information: Gender: ___; Pronoun: ___.

Bathrooms are a common space where gender-diverse people often feel unsafe and are exposed to harassment. If your workplace does not have gender-inclusive washrooms, inform clients about this when discussing the facilities: "There are gendered washrooms on the second floor." Become aware of other options (for example, coffee shops often have single-stall washrooms) and communicate these options to your client. These efforts often get noticed, as they demonstrate sensitivity to some of the common challenges gender-diverse people face. If there is a single-stall washroom, it can be used as an "all genders" washroom. Make this clear by adding signage if it is not already visible.

MEDICAL INTERVENTION

Trans and gender-diverse people might seek gender-affirming medical procedures to make their body feel like a more comfortable place to exist. This is often to alleviate what is referred to as gender-related body dysphoria, which could mean discomfort or unease with their external genitals, their chest shape, the lack or presence of facial hair, and the sound and tone of their voice. These are all characteristics that can be changed with medical intervention typically involving cross-sex hormones and/or surgery.

If you have a client who is curious about gender-affirming procedures, it is best to refer them to a supportive physician so they can ask questions and receive all of the necessary information to make their own choices. The Transgender Health Information Program at http://transhealth.phsa.ca (operated through the Provincial Health Services Authority) has information about medical and social-support services.

BEING INCLUSIVE

Supporting trans and gender-diverse clients involves intention and awareness on the part of the counsellor. Don't make assumptions; listen carefully to the language your clients use and follow it. Be willing to learn, make mistakes, and recover calmly. Remember that clients may be presenting with concerns that have nothing to do with their gender, and if we can demonstrate inclusive language and understanding, we are increasing the chances that they will feel safe and understood, and that we will be able to support them with their presenting concerns. ■

Mair Cayley, RCC, is committed to systemic changes that increase the safety and accessibility of mental health services for gender-diverse populations and is engaged in research and clinical work in this sphere. They are currently a staff counsellor on the unceded land of the Halkomelem-speaking Musqueam people at UBC's Counselling Services.

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chromosomes, hormones, and genitals. Intersex people are often, but not always, identified at birth. This term includes, but is not limited to, people who are born with ambiguous genitals and/or who are identified as having chromosomal differences.

MTF: a natal male who identifies as female; this may or may not involve social and/or physical transition.

Natal sex: the biologically differentiated status of female, male, or intersex, which is determined at birth. It includes genitals and secondary sex characteristics, as well as invisible features such as chromosomes and hormones.

Non-binary: a term used to represent people who do not align with either male or female identity.

Queer: a term used to refer to people who identify as a gender and/or sexual minority. Some use queer as an alternative to gay, because it is more inclusive of gender diversity. Queer can refer to a person's sexual orientation and/or their gender identity.

Sexual orientation/sexuality: a term to describe a person's sexual identity with regard to the gender of people they are romantically, intimately, and sexually attracted to. Sexual orientation is independent of gender identity.

Trans: an umbrella term to refer to gender-diverse groups, including transgender, genderqueer, non-binary, transsexual, and other identities.

Transgender: a person whose natal sex does not align with their gender identity.

Transphobia: antagonistic, prejudicial, or otherwise discriminatory feelings, thoughts, and behaviours towards gender-diverse people or towards people who are perceived as not conforming to gender norms.

Two-spirit: an umbrella term to describe gender variance in North American Indigenous cultures. Two-spirit people participate in a variety of gender roles, yet the precise meaning of this term varies across Indigenous sub-groups.

EMDR THER

DESPITE CONTROVERSY, THIS INTEGRATIVE APPROACH IS A VALUABLE TOOL IN A COUNSELLOR'S THERAPEUTIC TOOL BOX

BY ROCHELLE SHARPE LOHRASBE, RCC

Francine Shapiro tells a story describing how she "discovered" EMDR — eye movement desensitization and reprocessing — in the 1980s by noticing that moving her eyes while thinking about a troubling circumstance decreased the degree of angst she felt. She published her first write up on the EMD "technique," as it was referred to initially, in 1987. The first clinical studies were published in 1989.

Along with CBT, EMDR therapy is one of the most investigated approaches in psychotherapy. Despite this fact, the integrative approach has been plagued by controversy and criticism from researchers and clinicians over the past 30 years.

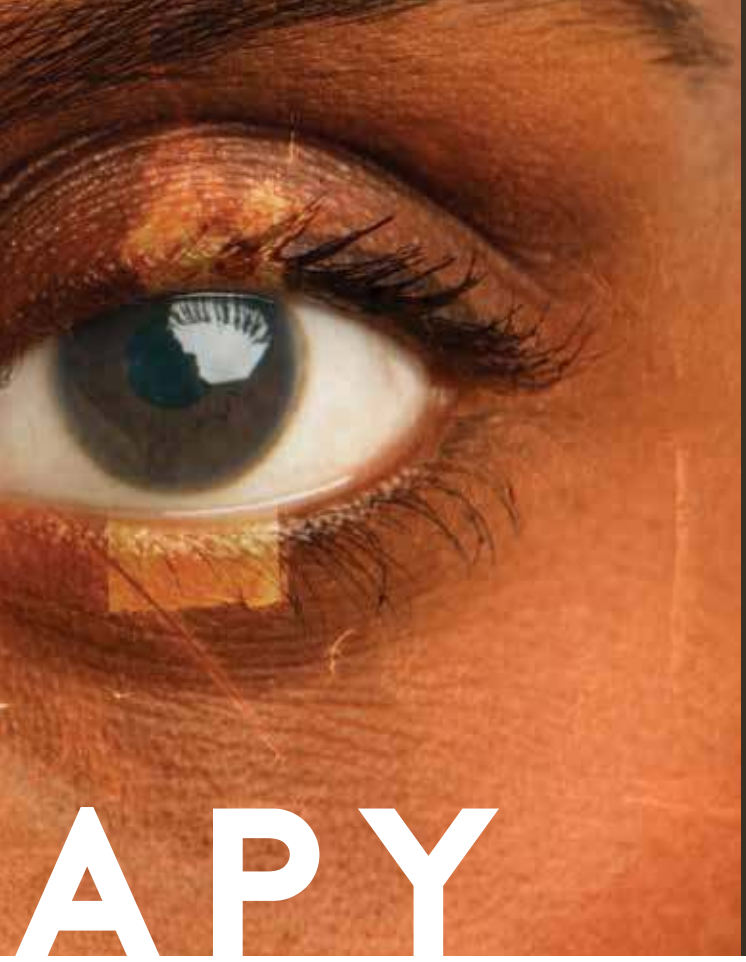
Also, despite the research, EMDR has yet to identify the mechanism of its effectiveness. Nevertheless, it has proven to be a flexible, valuable approach lauded by counsellors around the world.

ADAPTIVE INFORMATION PROCESSING (AIP)

In 1995, Shapiro advanced the notion that given the right information, people tend towards healing following traumatic incidents. Her work with veterans revealed that when bilateral eye movements were paired with the provision of new information or alternate information (to what the person got stuck on at the time of the event), the veterans could change beliefs and arrive at new meanings from past experience.

Shapiro describes the AIP as "a neurological balance in a distinct physiological system which enables the information to be processed in the perspective of an adaptive processing. (…) Useful information is learned and stored with the appropriate affect and is available for future use."[1]

The AIP differs from extinction-based exposure techniques, because it relies on the intrinsic capacity of



APY

CONTROVERSY EARLY ON

The late 1990s marked the advent of the "evidence-based treatment era." An efficacy turf war pitted exposure therapies, CBT, and EMDR against one another to determine which was the best. The anti-EMDR front began with the war cry, "Where's your research?" among other critiques. Several critics of EMDR emerged. In 1999, Richard McNally likened EMDR to mesmerism, suggesting there were many and striking similarities between the two and proposing any treatment effect could be reduced to suggestibility.[4] Lohr, Devilly, and others expressed concerns with methodological deficiencies in EMDR research.[5]

Today, EMDR therapy has a body of research spanning a few decades, and it has the seal of approval of several governing agencies and joint commissions in the U.S. and abroad. Recently, and based on a single Institute of Medicine report published in 2012,[6] the APA guidelines for PTSD treatment downgraded EMDR from strong to conditional.[7] Since then, a thoughtful and comprehensive response has been published by the University of Western Australia that disputes the APA position on EMDR.[8]

So, while the politics of efficacy persist, despite and in response to critiques, EMDR continues to grow with thousands of counsellors providing real-life help for clients.

EMDR therapy uses an eight-phase approach that includes having the client recall distressing images while receiving sensory input, such as side-to-side eye movements.

the mind to favour health. During an overwhelming event, our minds cannot retain a broad view of the experience, because we narrow our perceptions to critical aspects necessary for survival.[2] For example, if we are faced with a weapon-wielding attacker, we often become fixated on the weapon in the moment and are unable to include in our awareness other details of the experience. Thus, treatment approaches that focus on exposure might have us reduce our reactions to weapons while we are in the comfort of a safe office environment. The AIP model suggests that if we revisit the memory, we can attend to other details while safe, and that will influence memory reconsolidation. On subsequent recollection, the memory is not as distressing.

To attempt to deepen the understanding of EMDR and the AIP model, it has been suggested that three types of memory reconsolidation are in play: associative chain (a memory is linked to other memories); change of scene/change of perspective (the traumatic scene is visualized through different angles and different colours); and archiving (verbalization evokes storage metaphors, emotional vividness weakens).[3]

THE DETAILS: EIGHT PHASES OF EMDR THERAPY

EMDR therapy uses an eight-phase, top-down approach: thoughts, beliefs, emotions, and body.

PHASE 1 History Taking and Case Conceptualization

Typically, taking an EMDR history centres around significant events relating to limiting beliefs. Often, events such as parental separation, the first day of kindergarten, being bullied at school, not being picked for the team, all the way through to witnessing domestic violence, being molested, surviving a terrorist event, or becoming a refugee have a profound effect on our beliefs about

WHAT IS EMDR GOOD FOR?

PTSD
EMDR is helpful for revisiting the physiological dysregulation that contributed to belief sets acquired during life-threatening circumstances related to survival, choices, and responsibilities. "I'm going to die > I should have done X > It was my fault." Events might include natural disasters, vehicle accidents, falls, traumatic death of a loved one, or witnessing violence. The event is not as important as the neurological residual stored as fragments in the person's memory.

CHILDREN
In addition to safety threats, many experiences children have that relate to power and control are amenable to EMDR therapy: abuse, neglect, bullying, acrimonious divorce, selective mutism, attachment difficulties, anxiety situations, and others have been addressed from EMDR's conceptual framework.

ADDICTIONS
Several protocols exist for targeting the urge to use, routing out associated experiences, and developing management strategies.

ANXIETY
There is published data of EMDR therapy's efficacy in cases of GAD, OCD, and other related anxiety conditions.

self, others, and the world in general. Such events become potential targets for EMDR processing.

It is more interesting to the counsellor who uses EMDR to gain an understanding of the meaning the client attached to an event or the belief they adopted, than to hear all the details of the event (although details become more important in later phases). Some clients may report one or two significant events in their lives, while others will have many and complex events to convey.

PHASE 2 Preparation

The degree of complexity, age of occurrence, and robustness of resources (internal, external to keep this simple, when really it isn't) help the therapeutic dyad determine the client's readiness for subsequent stages. Some clients already have what they need to revisit distressing memories, while others will spend significantly more time in this phase laying the groundwork for processing. Within the EMDR therapy approach, there are several protocols and suggestions for the development of resources for stabilizing and preparing clients to move forward.

PHASE 3 Assessment

The use of assessment within the eight-phase approach speaks to the usual way in which targets are identified and brought to present-moment recall. EMDR therapy is a top-down approach, so it begins with beliefs or thoughts and includes emotional and also physical aspects of the target in order to "light up" the memory network and associated networks, such as adaptive networks, prior to moving towards taking the sting out of the memory. Essentially, this brings the client to a state of having one foot in the past and one foot in the present, so the event can be reviewed with all the advantages of what is known now (in safety and perhaps with the benefit of maturity). A subjective rating is obtained and periodically checked to determine progress during the next phase and to indicate the completion of Phase 4.

PHASE 4 Desensitization

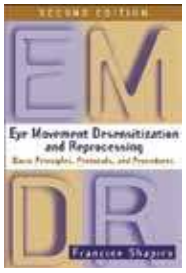
This phase often resembles exposure techniques in that the client is allowed to run through all their reactions to the event while in the presence of a safe, caring observer. Eye movements are used during this phase and clients are encouraged to notice what happens as they recall their experience. Metaphors such as watching a movie or riding a train and watching the scenes roll by are often used to keep the progression moving forward. Eye movements, or their variations — like taps or auditory clicks — are delivered in sets, and pauses are taken to check in with the client's experience.

Often, new insights emerge ("Oh, I didn't realize there was a way out" or "I had to do that to stay safe"), vehement emotions (rage, terror, panic) move through, and the body becomes clear of tensions and distress and returns to a more relaxed stance.

Checking in with the distress and the subjective rating periodically guides the counsellor and client through Phase 4.

PHASE 5 Installation

This phase approaches the event from a positive perspective. We began by identifying a negative belief, and now we move towards a more positive counterpart by answering the question, "What would you have rather believed about yourself?" In theory, the client shifts from "I'm going to die" to "I survived" or "I'm a failure" to "I did the best I could and that's good enough." Switching over to the positive perspective



If you want to start exploring EMDR, begin with the Internet: www.emdrcanada.org and www.emdria.org.

The best book to start with is Francine Shapiro's *Eye Movement Desensitization and Reprocessing (EMDR): Basic Principles, Protocols, and Procedures* (2nd ed., The Guilford Press, 2001) and, for clients, Shapiro's *Getting Past Your Past: Take Control of Your Life with Self-Help Techniques from EMDR Therapy* (Rodale Books, 2013).

might elicit a few more memory fragments that need processing.

PHASE 6 Body Scan

EMDR therapy relies heavily on the client's capacity for self-awareness, reflection, and articulation. It mostly accesses explicit or autobiographical memory available upon request in the client's memory banks. In order to aim for a more complete resolution, the body scan addresses implicit memory systems where information is held as tensions, heart rate, breathing rate and quality, among other physiological data.

PHASE 7 Closure

Memory banks may hold much more information than can be processed during a session. Phase 7 brings processing to a close and ensures clients do not leave the office in some altered state. Frequently, clients are informed that their AIP networks may continue to process the information released during the session. Safety plans, follow-up, and a reminder of resources are frequently discussed to bring the session to close.

PHASE 8 Re-evaluation

Since processing may continue between sessions, it is important to check in on events of the previous session. Images may have changed, emotions may have shifted, and beliefs may have undergone revision. Re-evaluation allows us to ask, "What is still upsetting about this memory or issue we have been working on?" The client's response takes the session back up into Phase 3, and we repeat.

Treatment is not complete until EMDR therapy has focused on the past memories that are contributing to the problem, the present situations that are disturbing, and what skills the client may need for the future.

THE EMDR COMMUNITY

It is important to distinguish EMDR therapy from pure talk therapy. EMDR has a kind of a script that many who are beginning to learn it fear will detract from the relationship and from the client's sense of being heard. However, this does not seem to bear out once clients experience a significant reduction of distress and are able to make life changes.

Finally, a note on community and resources: EMDR therapy organizations, local educators, and peer study groups all offer opportunities to collectively review cases and approaches, which says something about the dedication of counsellors trained in EMDR therapy.

Formal avenues of receiving support via EMDRIA-approved consultants are available, as well as informal special-interest groups, online forums, and listservs where counsellors can ask questions and receive a breadth of responses to inform sessions with clients.

If you are interested in incorporating EMDR therapy into your practice, reaching out to the EMDR community is encouraged. ■

Dr. Rochelle Sharpe Lohrasbe, RCC, is a clinical counsellor in Victoria, seeing "children of all ages" with adverse experiences and developmental wounds. She offers clinical consultations and teaches Sensorimotor Psychotherapy internationally.

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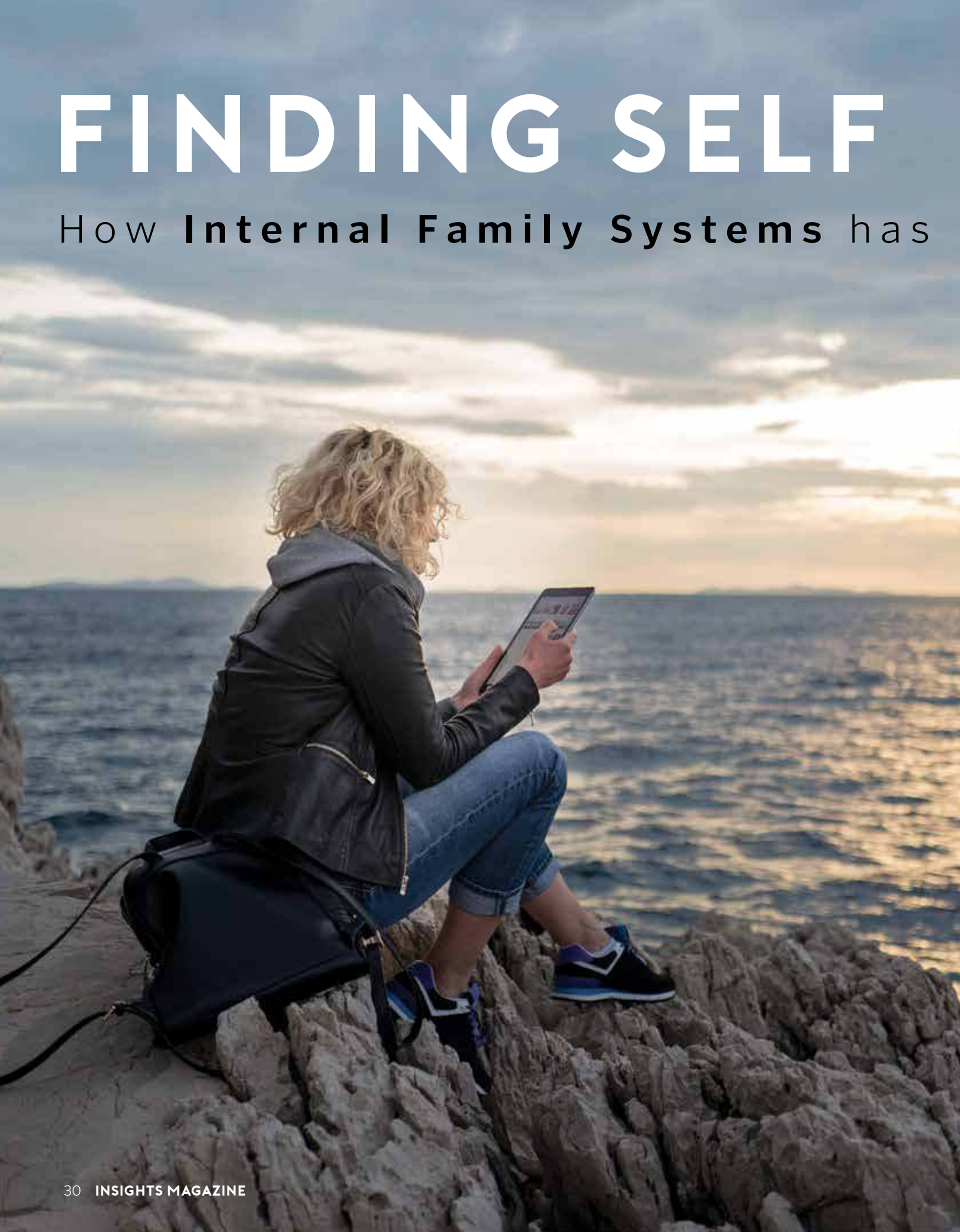
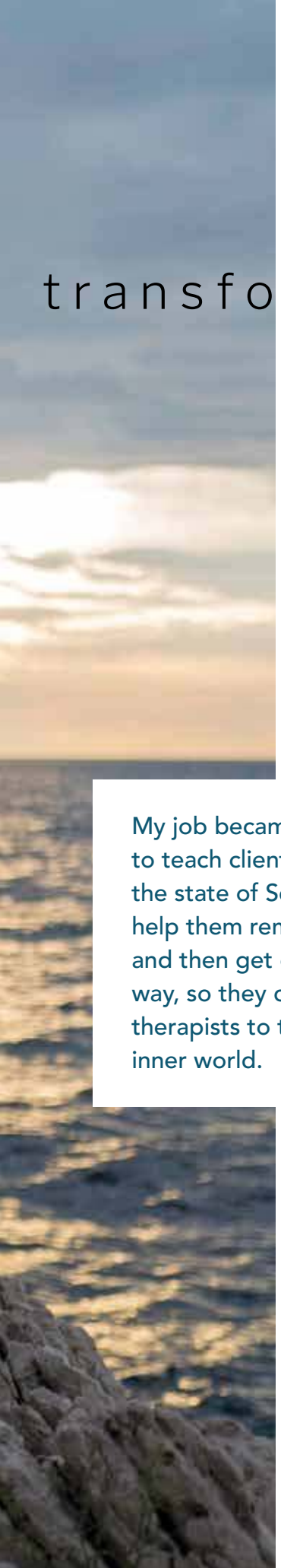
FINDING SELF

How **Internal Family Systems** has





transformed me and my practice

BY FRANCES FERGUSON, RCC

Several years ago, I travelled to Vancouver to attend the Marriage and Family Therapy Conference. I wasn't a member of AAMFT, and my motivations weren't all that pure. I needed a break, and the idea of a little getaway in Vancouver was appealing. The logical, rationalizing part of me justified the cost of a trip to Vancouver for continuing education credits. Little did I know that my life would be transformed.

Dr. Richard Schwartz, founder of the Internal Family Systems (IFS) model, was the second speaker after lunch, so I wasn't sure if I'd still be awake. However, as he stood and talked about his own parts, parts that felt anxious and worried, self-critical, or inadequate, I felt a resonance, sensing that here was someone who walks the talk. It was refreshing to listen to a psychologist of renown who was so humble, sharing vulnerability and confidence with congruence and presence I hadn't seen before. I asked myself, "Could it really be that there's a way of working with ourselves, and with our clients, that frees these parts from their suffering — effectively and rather effortlessly?" Richard's video demonstrations offered my first glimpse into IFS in action and proved the answer is a resounding, "Yes."

My job became mainly to teach clients about the state of Self and help them remain in it, and then get out of the way, so they could be therapists to their own inner world.

Since that afternoon, I have completed three levels of IFS training, and I have incorporated IFS extensively into my private counselling practice. With the help of an IFS therapist, I have transformed my own inner critic, parts sensitive to rejection and other childhood issues, into sources of positive, creative, life-affirming energy.

I have watched in amazement as clients, once they are in a state of Self, establish relationships with parts of themselves that had previously been a source of tremendous torment and pain, seeming to know exactly what to say or do that would lead to ways to help the part. My job became mainly to teach clients about the state of Self and help them remain in it, and then get out of the way, so they could be therapists to their own inner world. It took me a while to trust that they — and I — could actually do that.

The Internal Family Systems (IFS) model has evolved over the past 30 years into a comprehensive approach that represents a new synthesis of already existing paradigms: systems thinking and multiplicity of mind. As early as 1983, Richard Schwartz was working with eating-disordered clients when he began paying close attention to their language: part of me wants to binge and then another part attacks. He began to conceptualize these subpersonalities and view a person as an "ecology of relatively discrete minds, each of which has valuable qualities and each of which is designed to — and wants to — play a valuable role within." The internal world of the client became like a family. Parts had been forced out of their valuable roles by external circumstances, but once it seemed safe to do so, they gladly transformed into valuable family members.

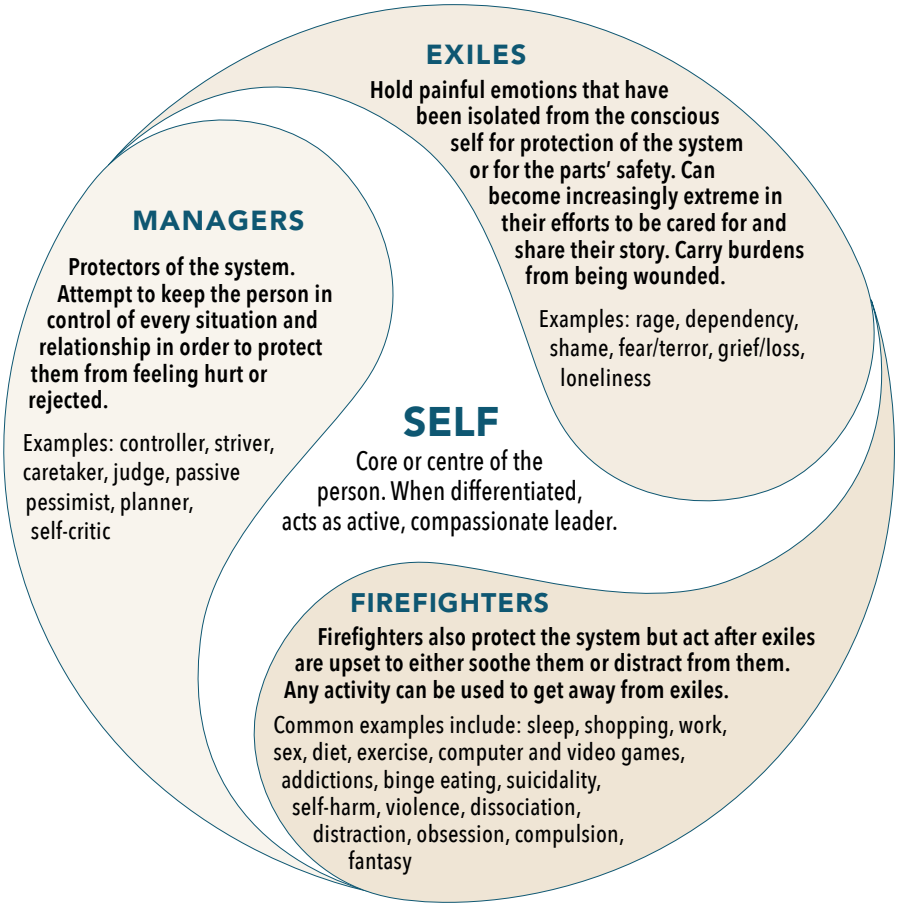
MANAGERS, FIREFIGHTERS, AND EXILES

Over time, Richard Schwartz found patterns emerging among the many clients he saw. People had wounded parts, parts that tried to keep them functional and safe by trying to keep control of both the inner and outer worlds, and parts that jumped into action whenever a more vulnerable part appeared. "Manager" was the name given to parts whose roles are to keep a person in control — for example, to prevent a person from being too dependent, to avoid criticism, or to focus on taking care of others' needs. When a person feels hurt, shamed, frightened, or humiliated, they have parts that carry the emotions, memories, and bodily sensations from those experiences. The pain these parts carry from the past is often perceived to be a threat to the system, so the tendency is to try to avoid or get rid of them, which is why Schwartz termed them "Exiles." Managers are often proactive at keeping those painful feelings out of conscious awareness to protect the person from ever experiencing that pain again. However, life has a way of triggering circumstances, and when Exiles do get upset, another group of parts called "Firefighters" instantly reacts to try to douse the flames of feeling as quickly as possible. Firefighters are often highly impulsive and will do anything that will override or distract from the Exiles' feelings, regardless of the consequences. Common firefighting activities include drug and alcohol abuse, as well as behavioural issues connected to work and food.

SELF

A central aspect of the IFS model is the belief that, in addition to all of these parts, everyone has a core Self that carries crucial leadership qualities, such as compassion, curiosity, acceptance, confidence, and understanding. Self is not a passive state of mind, but an active presence. Everyone has this core Self, untarnished by any event or circumstance of the person's life. The foremost goal of IFS is to differentiate this Self from the parts, thereby releasing its resources to assist parts that are suffering. We know when we're in the presence of someone with Self-energy — we feel safe, the person is authentic, unpretentious, without an agenda, and naturally compassionate. It's the same on the inside. The parts know when they can feel like "there's somebody home" and can relax and trust the Self to lead towards healing.

THE INTERNAL SYSTEM



This approach makes IFS a hopeful framework for psychotherapy, and one that is non-pathologizing. Because IFS locates the source of healing within the client, Schwartz says, the therapist is freed to focus on guiding clients' access to their true Self and supporting clients in harnessing its wisdom: "It provides an alternative understanding of psychic functioning and healing that allows for innovative techniques in relieving clients' symptoms and suffering."

MY STORY

For many years, despite my efforts to quiet them, I heard voices in my head that said, "You're fat, lazy, stupid" and "Don't think too much of yourself" and "Who do you think you are? You can't do that." I carried parts humiliated and

ashamed by being the last person chosen on the baseball team, and for years, lived in the shadow of fear of rejection or failure. At the same time, I had a deep sense that I had something to offer — I just didn't know what that was. For years, I have struggled with the polarizations of being good enough and being rejected. IFS gave me the tools to finally understand those voices in my head, and appreciate their roles as protectors against further suffering. I learned how much my life was constricted by fear, and underneath the protectors, found and freed many of the isolated and lonely exiles. The sense of freedom is palpable and is reflected in all my relationships and activities. I find myself enjoying my husband, rather than being critical. I am able to speak "for" parts that let me know when something is out of whack, and I listen deeply when parts let me know they need some gentle attention. People who weren't real friends have dropped off, and true friendships have deepened as I strive to be more authentic and congruent in all aspects of my life.

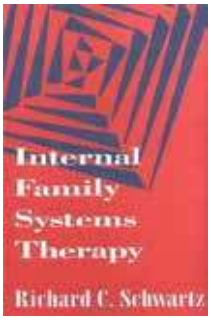
Not surprisingly, as I gradually become more Self-led, it's easier for me to light the path for clients to access their own Self-energy as well. In Self, there is space where all parts are welcomed, and I find great joy in teaching people how to communicate with their parts. Some examples illustrate the transformation. A client who had suffered a lengthy history of sexual abuse and dysfunction in her family of origin learned to use IFS to provide comfort and resource parts. A client who had a baby out of wedlock was able to transform the shame she'd carried for over 50 years into positive energy and passion. A client suffering from longstanding depression, who had tried many other approaches, found relief as he attended to a young part that had experienced early trauma.

Although IFS is not yet well known in Canada, interest in it is growing around the world, with over 4,000 therapists trained in 10 different countries, since Richard Schwartz developed the Center for Self Leadership in 2000. IFS has been recognized as an evidence-based practice by the National Registry for Evidence-Based Programs and Practices. As a clinical treatment, IFS has been rated effective for improving general functioning and well-being. It has been rated promising for improving phobia, panic, and generalized anxiety disorders and symptoms; physical health conditions and symptoms; personal resilience/self-concept; and depression and depressive symptoms. Further clinical research is ongoing to examine the efficacy of IFS and the vast potential of the model.

Because IFS locates the source of healing within the client, the therapist is freed to focus on guiding clients' access to their true Self and supporting clients in harnessing its wisdom.

Like many of my colleagues, I was trained in more traditional approaches to psychotherapy. They worked, more or less, but I always felt something was missing in my approach. After 15 years in practice, I feel like I've "come home" to a model that honours both the psychological and spiritual dimensions of being human. I've been using IFS for about five years now, and therapy has never been so fulfilling, rewarding, or as easy. Instead of being exhausted by the end of the day, concerned about whether or not I was any help to a client, or what on earth I might do to help them, I feel inspired and energized. It's the most transformative approach I've found in all my years in practice. ■

Frances Ferguson, M.Ed., is an RCC in private practice in Campbell River, B.C. She practised in Winnipeg before moving to the West Coast in 2003 and has also lived and practised in Powell River and Courtenay. Fran uses IFS extensively in her practice with individuals and couples. For more information, go to www.talktofran.com.



Richard Schwartz, PhD, has written five books and authored over 50 articles on Internal Family Systems and was the co-author of *Family Therapy: Concepts and Methods*, the most widely used family text in the United States. He has appeared as a featured speaker for many national and international psychotherapy organizations. Information on training opportunities, publications, and video resources are available on his website at www.selfleadership.org.

CLINICAL SUPERVISOR PREPARATION AND COMPETENCY

To give and receive supervision is part of the reciprocal conversations within the psychotherapeutic system.

BY VANGE WILLMS THIESSEN, RCC

Sounds of Pachelbel's Canon created a calm ambience as I entered the waiting room to collect my clients. Even as a newly minted family therapist, I sensed a high level of anxiety as I invited the three adult women into the therapy room. In a sudden burst of emotion, the first woman to speak said, "That was our musical connection, Pachelbel's Canon." In disbelief, the other two women cried out, "No, that was our special song."

These women were not biologically related. What brought them together was a shared experience of violation by a distinguished college professor: stalking, sexualized assault, and trauma in an educational context that should have been safe. The stories were shocking. An uncanny thread of deception and manipulation had woven their lives into a tangled tapestry.

This was the beginning of a process of discernment, advocacy, and therapeutic response: witnessing each woman's story,

It was the weekly conversation with my on-site clinical supervisor and the consultation I sought with other professionals that allowed me to see the way forward in a daunting therapeutic challenge.

inviting spousal participation, initiating contact with college administration, responding to civil and criminal investigations, and, finally, coordinating a mediation process. I had learned about clergy and professional misconduct and the breach of fiduciary trust while a student in a Master of Marriage and Family Therapy program. But just one year after graduation, was I competent to respond to these women who had experienced such betrayal and violation?

Two years later, together with multiple players, a partial degree of healing and closure was accomplished — much less than what I had hoped for. It was the weekly conversation with my on-site clinical supervisor and the consultation I sought with other professionals that allowed me to see the way forward in a daunting therapeutic challenge. My early experience as a therapist taught me well; for the next 13 years, I participated in a monthly supervision group with AAMFT-approved supervisors.

Supervision is the primary pedagogy whereby we, as counsellors, learn to be competent practitioners. To give and receive supervision is part of the reciprocal conversations within the psychotherapeutic system. As a master's-level psychotherapist, like many others, I was expected to provide supervision to other counsellors at the agency where I worked. However, most of us completed our degrees without any academic or clinical training to become supervisors. We may be competent, experienced counsellors, with specialized training in various therapeutic modalities, but does that make us effective supervisors?

As a longtime BCACC member as well as an AAMFT clinical fellow and approved supervisor, I am passionate about promoting a culture of supervision as an integral part of therapeutic competency and professional mentoring and leadership.

What does supervisor preparation and competency look like?

Becoming immersed in a collaborative learning community

Harlene Anderson (2000) states that at the heart of her philosophy and practice of supervision is a collaborative learning community that includes connection, collaboration, and co-construction. Central to this notion is a dynamic creative conversation that engages two-way exchanges and the criss-crossing of ideas, thoughts, opinions, and feelings. These reciprocal interactions among supervisors and supervisees bring forth new knowledge, understanding, and best practices.

Implementing the goals of clinical supervision

Outcome-based learning requires supervisors to carefully examine how the task of clinical supervision is best accomplished. A brief summary of supervisory goals includes: first and foremost, protecting the well-being of the client/family; facilitating the therapist's personal growth and awareness; promoting therapeutic competencies in service delivery, including conceptualization, clinical assessment, and intervention skills; promoting ethical awareness and accountability; socializing less experienced supervisees regarding professional expectations and development; and, finally, gatekeeping for the profession.

Facilitating the supervisory relationship and process

In what situations do you learn best? One of the most important elements in the supervisory process is the person of the supervisor and his or her ability to establish and maintain a good connection with the supervisee. In a

Participating in a collaborative learning community

Clinical supervision is the signature pedagogy for developing competency and professionalism in the practice of psychotherapy. Here are some suggestions for ways to benefit.

- **Stuck in a singular perspective?** A multi-voiced supervision dialogue stimulates new ideas and multiple therapeutic alternatives.
- **Functioning on auto pilot?** Learn to be more intentional in matching case conceptualization with your clinical interventions.
- **Increased personal reactivity to client issues?** Person-of-the-therapist work with a supervisor provides a process of self-reflection, awareness, and creative mindfulness.
- **Caught in difficult ethical or legal interactions?** Check out interference of dual relationships, complex court cases, legal requests for information, etc. within supervisory conversations.
- **Feeling bored and stagnant in your therapeutic practice?** Group supervision dialogue stimulates and restores passion for lifelong learning and application.
- **Presence of blind spots?** Explore blind spots where at times "one doesn't know what one does not know" until we process clinical and personal material within a supervisory context.
- **Experiencing interpersonal conflict or transference/countertransference within the therapeutic system?** Supervision helps us explore ongoing dynamics, projections, and reactivity in therapeutic relationships.
- **Isolated and alone in private practice?** Consider clinical supervision for confidentiality, support, and mentoring.

triadic system of client, therapist, and supervisor, relationships are multi-layered and complex. The clinical supervisor is responsible for creating a safe, secure holding environment that provides emotional nurturing and facilitates space for creative, interactional dialogue.

Enhancing skills in the methods and modalities of supervision

Supervision literature describes the postmodern supervisor as one who fulfills a variety of roles and functions: trainer, teacher, supporter, coach, advocate, consultant, mentor, administrator, and supervisor. From within these multiple and intersecting roles, supervisors and supervisees assess the presenting needs and thoughtfully draw from specific methods and modalities of supervision. In mutual and collaborative conversations, new ideas, possibilities, and interventions emerge.

Monitoring ethical and legal responsibilities

The ethical use of power is a key responsibility of supervisors. In addition to attending to ethical issues that surface during client-therapist interactions, the supervisor has the fiduciary trust to maintain an ethical relationship with their supervisees.

Increasing awareness of culture, diversity, and social justice

In the presence of increasing global influences and diverse world views, effective supervisors develop cultural awareness, sensitivity, and competency. They learn to facilitate respectful conversations where multiple voices and perspectives are welcomed.

Constructing a personal philosophy and practice of supervision

For many untrained supervisors, their supervision practice has been informed by their previous personal and professional experiences. Intuitively, you may have decided what is good supervision and what is not. As supervision theory and practice has developed into a professional entity of its own, we now have access to formulate new ideas and ways of being as supervisors.

After years of providing clinical supervision and teaching clinical supervision courses to professional counsellors, I conclude that experience alone is not sufficient to guarantee effective supervisory outcomes. Let us consider together how the future of our therapeutic practice and professional organization will benefit from the emerging generation of trained supervisors who are carrying the torch as leaders, mentors, and gatekeepers of our profession.

Vange Willms Thiessen, MAMFT, DMIN, AAMFT-approved supervisor, RCC, and an MFT therapist, has provided individual and group supervision for the past 26 years to student interns and graduate therapists. Contexts for supervision have included educational/training settings, community agencies, and private practice in both Canada and Kenya. Vange teaches a 30-hour, professional-development clinical-supervision course once a year for MA-level psychotherapists.

STRENGTH IN UNITY

Supporting Asian men to become mental health ambassadors and to seek mental health care

BY RODRICK LAL

Research suggests the mental health needs for ethnic minority communities are seldom met, especially for men. In particular, men from Asian communities, such as Chinese, Filipino, Korean, South Asian, and Vietnamese, to mention a few, are among the least likely groups to seek help for mental health problems in Canada. The hesitation to seek help is frequently attributed to stigma, shame, blame, and saving face.

While mental health stigma cuts across all cultures and backgrounds, research suggests stigma takes different forms in different communities and is compounded by masculinity and experiences of racism and discrimination — what is sometimes referred to as "double stigma."

Fortunately, the Strength in Unity (SIU) project (2013-2017), funded by the Movember Foundation, has become the largest intervention study in Canada aimed at developing individual and community capacity to reduce the stigma of mental illness among Asian men and youth.

For many Asian families, especially for men, a diagnosis of a mental health problem such as depression can bring shame to the family, often leading to denial and a breakdown in communication. The control of personal feelings is considered very important, and men are taught not to express their emotions. As a result, seeking help is sometimes seen as bringing shame on the family honour. Within some Asian religious or spiritual traditions, it is the case that families are taught to surrender to divine will, to

The central focus of the SIU study was to examine the effectiveness of two intervention workshops in addressing internalized and social stigma: Acceptance Commitment Training (ACT) and Contact-based Empowerment Education (CEE).

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accept their lot in life, be thankful for what they have, and not feel downhearted about difficulties in their lives.

For many Asian men, religion is a central part of family life. For immigrants, worship can take on an additional role of maintaining identity and sustaining a social network within their community. As such, religious leaders are often the first point of contact for men experiencing mental health difficulties.

THE PRESENT STUDY

The SIU study involved numerous community partnerships with key settlement, mental health, and immigrant-serving organizations. Through a community-engaged process, the SIU study was privileged to engage 1,600 men and youth from Asian communities in Toronto, Calgary, and Vancouver with the aim of encouraging and supporting them to become ambassadors for mental health in their communities.

In Vancouver, the study involved participants from a wide age range (16-80) and from diverse ethno-cultural backgrounds. Ninety per cent of the participants were born outside Canada and, of those, 30 per cent were newcomers to Canada. Twenty per cent of study participants were people living with mental illness, and 25 per cent of study participants were family members of people living with mental illness.

The central focus of the SIU study was to examine the effectiveness of two intervention workshops in addressing internalized and social stigma: Acceptance Commitment Training (ACT) and Contact-based Empowerment Education (CEE). ACT is an empirically tested, intrapersonal intervention that promotes psychological flexibility to seek help. It nurtures self-awareness, mindfulness, value-guided living, and compassion for self. CEE is a distinctive and innovative intervention that deepens the readiness of people to engage in anti-stigma mental health advocacy. It aids people to understand mental health and mental illness, motivates people to speak out against stigma and discrimination, and develops skills that aid community engagement and mobilization to seek care and treatment.

FINDINGS OF THE STUDY

Preliminary findings from the Vancouver site indicate that a combination of ACT and CEE interventions is the most effective in reducing internalized stigma among Asian men living with mental illness and their family members. The ACT intervention helped Asian men to improve their psychological flexibility, in order to face current and future mental health challenges. Further, ACT was most effective in helping participants address internalized stigma through mindfulness, acceptance, commitment, and behaviour change processes. CEE is showing effectiveness at helping people better understand mental health through direct contact with people with lived experience of mental health problems. It is important to note, all participants, regardless of whether they were in the ACT, CEE, or the combined intervention group, reported improved attitudes, intentions, norms, and behaviours in relation to social justice and anti-stigma activism.

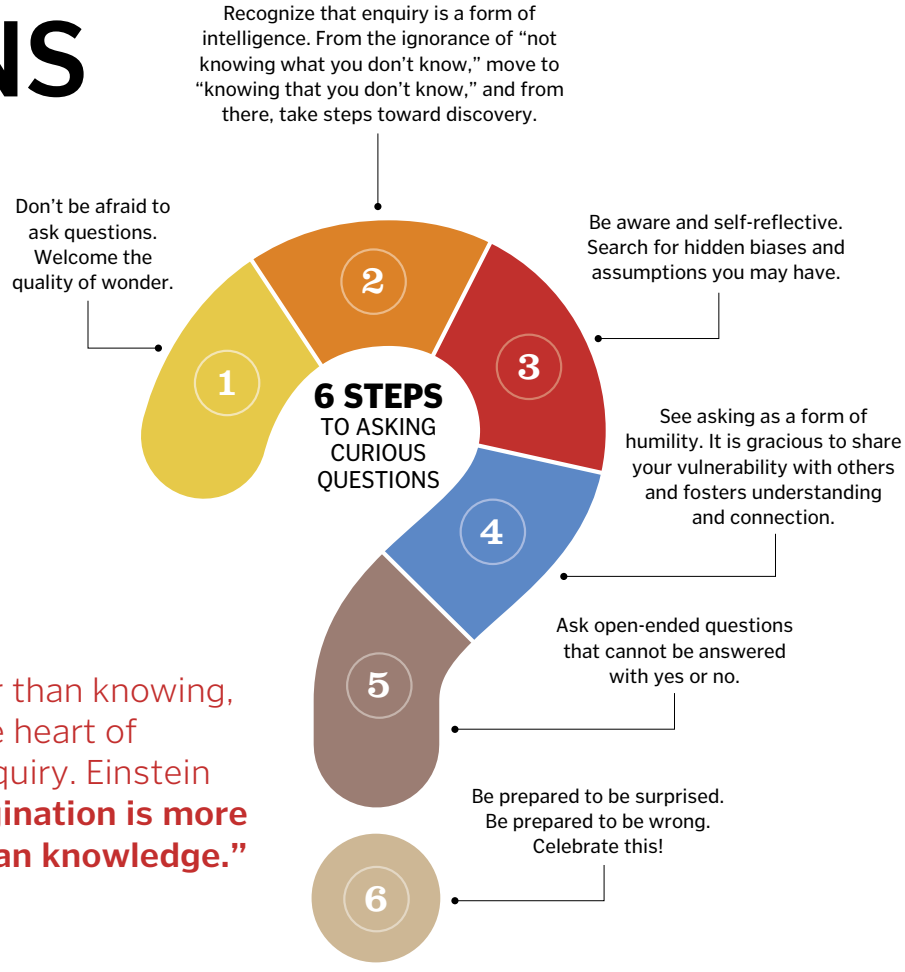
Changing stigma and becoming empowered to make a social impact is a gradual process that requires ongoing support. Together, ACT and CEE provided participants with the individual and collective support to achieve these goals. Currently, men are applying their new knowledge, skills, and networks to encourage their families, friends, and communities to engage in dialogue concerning issues of stigma, mental health-seeking behaviour and illness. Through this process, men may become more receptive to seeking mental health support from clinical counsellors in British Columbia.

Rodrick Lal is an RCC and educator. Currently, he is a co-investigator for the Strength in Unity project and completing his PhD in the Faculty of Health Science at SFU.

► **For more information about the SIU project, go to www.strength-in-unity.ca or email rodrickl@sfu.ca.**

CURIOUS QUESTIONS

BY DEIRDRE MCLAUGHLIN, RCC



There's no such thing as a stupid question. Or, as one of my teachers said, "Yes there are, but those are outliers and they don't count."

As counsellors, we sometimes think our job is to be the "expert," and our clients might even expect that from us, too. The simple truth is that we often don't know where an encounter will take us, and that's the good news: this is where the magic can happen. Professionally and in life, the courage to be curiously questioning opens us up to worlds of possibilities.

It requires vulnerability to ask a question for which you have no answer. You risk exposing yourself as a non-expert, and many of us fear looking ignorant, as well. Yet, as Brent Atkinson says: "The way our brains are wired, the most effective way to solicit cooperation is by exposing vulnerability." Many of us can identify with the feeling of relief when someone else asks a question we are too afraid to pose. Thank goodness, we think. People trust sincerity. It puts others at ease when we reveal vulnerability. It's honest; it's human.

When you wonder in the spirit of open-ended enquiry, seeking to learn rather than to prove, you will likely expand your horizons and minimize the chance for bias in your thinking. On the other hand, asking leading or close-ended questions can promote a false sense of certainty and garner premature conclusions. Assuming we already know the answer before we ask a question puts us in the same quandary as bad science: we risk making the facts fit our theories rather than the other way around.

Asking, rather than knowing, is really at the heart of intelligent enquiry. Einstein stated, **"Imagination is more important than knowledge."**

It's okay to begin with an idea — we often do. But from that point, try to see where the enquiry takes you. Your destination may come as a surprise and perhaps (hopefully) you will learn something along the way. Asking, rather than knowing, is really at the heart of intelligent enquiry. Einstein stated, "Imagination is more important than knowledge." The poet e.e. cummings put it this way: "and even if it's sunday may i be wrong/for whenever men are right they are not young." Not knowing can be a good thing indeed.

The journey to embracing wonder and curiosity is fundamentally one of humility. The very act of asking is an invitation for feedback; it allows for connection and attunement with others. In essence, we are saying, "Are we on the same page? Have I understood you?" or, posed in the language of richer enquiry, "How may I understand you better, and what would you like me to know?"

What awaits us when we follow the path of an open-hearted question? Adventures, wonder, and even magic, both in our practices and in our lives.

Deirdre McLaughlin, RCC, is a counsellor, speaker, and facilitator, who assists clients with anxiety, depression, anger, and self-esteem and specializes in addictions, eating disorders, gender, and sexuality. www.deirdremclaughlin.ca

Thank you!

The BCACC would like to thank our amazing team of volunteers for all the work they do to make this association great.

Our more than 90 volunteers provide a staggering 13,000 hours of service a year to BCACC. The various capacities in which they work help promote and grow the profession of counselling in British Columbia.

Some of the areas in which they work include:

- **Workshop Presentations**
- **Community Outreach**
- **Governance**
- **Communications Strategies**
- **Membership Registration**
- **Regional Committees**
- **Continuing Professional Development**

Thank you for another successful year!

BCACC

BC ASSOCIATION OF CLINICAL COUNSELLORS

WHY SHOULD YOU JOIN THE BCACC?

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BCACC

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