SPRING 2017

INSIGHTS

THE BC ASSOCIATION OF CLINICAL COUNSELLORS' MAGAZINE

INFIDELITY IN RELATIONSHIPS

Polyamory: It's not cheating

DIVORCE WITH A HIGH-CONFLICT PERSON

Lethal risk factors of domestic violence

INTEGRATING **HEALTH PROMOTION** INTO COUNSELLING PRACTICE

TO WANDER AND WONDER
How six months abroad became a counselling education

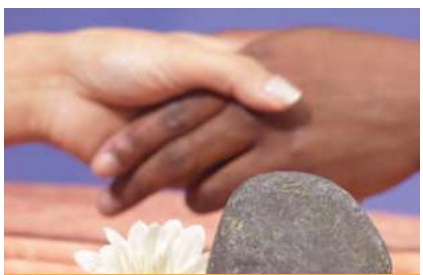
RELATIONSHIP ISSUE

Your best resource for your counselling practice
bc-counsellors.org

Looking for the latest version of the Code of Ethics? Or maybe you have an idea for an article for *Insights* or a post on the BCACC Blog? You'll find everything you need at bc-counsellors.org.

Counselling Resource

The BCACC website is a valuable resource for potential clients seeking counselling and provides them with a wealth of guidance and information to help them make the best choices, as well as address concerns and questions.



Making Connections

Our website is also your best resource as a counsellor. From events, workshops, and networking opportunities to current regulations and standards, the BCACC website serves to provide you with information relevant to your practice and connect you to other members of the RCC community.

Members Only

As a BCACC member, your presence in the online RCC directory puts you in front of potential clients to help you build your practice. The Members Only pages give you exclusive access to forums and committees, membership status updates and regional information, legal articles and insurance guidelines, association reports, and other materials to help your practice.

TAKE A FEW MINUTES AND CHECK IT OUT.

Participate in a forum, update your profile, read a blog post by a colleague, sign up for a workshop, review your member benefits, and find fellow RCCs in your region.

BCACC

BC ASSOCIATION OF CLINICAL COUNSELLORS

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

CONTENTS SPRING 2017

FEATURES

IN EVERY ISSUE

INSIGHTS
THE BC ASSOCIATION OF CLINICAL COUNSELLORS' MAGAZINE

The Insights *team wishes to thank the writers who contributed to this edition of our magazine:*
Kim Boivin, Kathi Cameron, Jessica Ferguson King, Ted Leavitt, Bill Wagg

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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EVA BC
Domestic Violence Resources

The Ending Violence Association of British Columbia (EVA BC) supports 240 anti-violence programs across the province that specialize in responding to sexual and domestic violence, child abuse, and stalking.

► **Finding help for clients**
A province-wide list of services for clients is available at endingviolence.org/need-help/services. The quick, easy-to-use search feature is organized by region within B.C. and by type of service: community-based victim services, counselling programs, outreach and multicultural programs. Contact details put you in touch with organizations that can help.

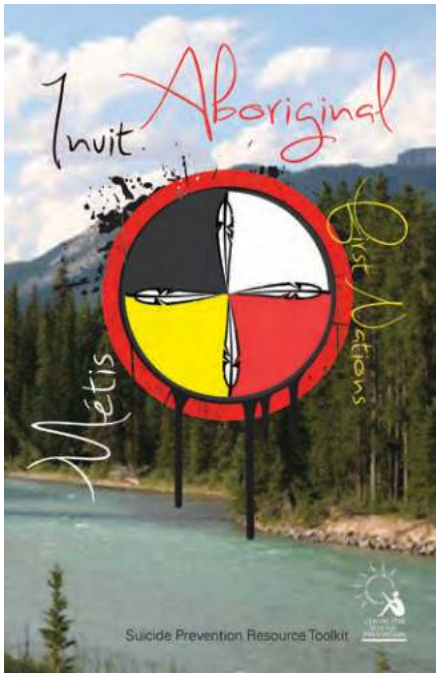
► **Training programs for counsellors and other responders** — EVA BC offers fee-for-service training workshops for counsellors and others on intimate partner violence, risk assessment, safety planning, and how to manage and what to do with disclosures of sexual assault. The goal of EVA BC's training is to improve the consistency and quality of services, increase knowledge and skills, reduce isolation, and create networking opportunities. Customized programs are available for relevant sectors that respond to gender-based violence.

Additionally, EVA BC's Annual Training Forum each fall provides an opportunity for service providers and colleagues to come together to gain new skills and knowledge.
www.endingviolence.org

SUICIDE AMONG INDIGENOUS POPULATIONS

Historically, suicide was a very rare occurrence amongst First Nations and Inuit. Today, Indigenous people in Canada have some of the highest suicide rates in the world. In a 2008-2010 survey by the First Nations Information Governance Centre, nearly one quarter of First Nations adults reported contemplating suicide at some point in their life. Contrast that with just 9.1 per cent of adults from the general Canadian population.* Suicide and self-inflicted injuries are the leading causes of death for First Nations youth and adults up to 44 years of age. Some of the most alarming increases in suicide are among youth under age 25 — and approximately 55 per cent of all Indigenous people are under age 25.

According to Health Canada (2010), the suicide rate for First Nations male youth (age 15-24) is 126 per 100,000 compared to 24 per 100,000 for non-Indigenous male youth. For First Nations females, the suicide rate is 35 per 100,000 compared to five per 100,000 for non-Indigenous females. Among Inuit youth, suicide rates are 11 times the national average.



Understanding the issues behind this growing national tragedy and the risk factors is an important first step in reducing suicide and moving towards a better future. The *Indigenous Suicide Prevention Toolkit* produced by the Centre for Suicide Prevention is a useful resource for self-education and includes additional resources for further study; it is available for download at www.suicideinfo.ca/resource/indigenous-suicide-prevention.

*Source: CTV News health. Suicide among Canada's First Nations: Key numbers. April 11, 2016. http://www.ctvnews.ca/health/suicide-among-canadas-first-nations-key-numbers-1.2854899

$$$ RDSP: An Investment Program for Canadians with Disabilities

The Canada Revenue Agency has a program that may be of interest to you or your clients. The Registered Disability Savings Plan (RDSP) is a savings plan to help Canadians with disabilities and their families save for the long-term financial security of a person who is eligible for the Disability Tax Credit (DTC). Contributions to RDSPs may be supplemented by a Canada Disability Grant and a Canada Disability Savings Bond. The lifetime contribution limit for an RDSP is $200,000, with no annual limit. Anyone can contribute to the RDSP with the written permission of the plan holder. Contributions are not tax-deductible and are not included in income when paid out of an RDSP. Investment income earned in the plan accumulates tax-free; however, grants, bonds, and investment income earned in the plan are included in the beneficiary's income for tax purposes when paid out of the RDSP.

Several Canadian financial institutions offer the RDSP, Canada Disability Savings Grant, and Canada Disability Savings Bond.
www.cra-arc.gc.ca/rdsp

INTIMATE PARTNER VIOLENCE

Keeping the focus on the victims

Last January, when Lionel Desmond murdered his wife, daughter, and mother and then killed himself in Nova Scotia, media reports focused on his PTSD. Ardath Whynacht, a sociologist at Mount Allison University in Sackville, New Brunswick was quick to say the attention on PTSD was inappropriate and counterproductive. She says it is important not to lose sight of the victims in the tragedy.

"In our shock, we tend to look for simple answers, and unfortunately, to make this entire story solely about PTSD is not only incorrect … but it also ignores many of the real factors that as communities, we need to be paying attention to if we want to prevent another tragedy like this from happening."

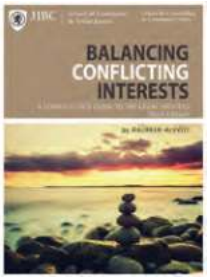
While Whynacht says PTSD may have been a stressor, the more dangerous risk factors were the couple's recent separation and Lionel's discharge from military service.

In addition to taking attention from the victims, focusing on PTSD creates another problem: it increases the stigma of PTSD, making it more challenging for people transitioning out of military, police, and other first responder roles. In her research, Whynacht interviewed retired police officers, who say the stigma is real and entering new careers is more difficult, because there is a misconception that they may be volatile.

"We have a long way to go in terms of reducing the stigma of mental illness and one of the easiest things we can do is whenever we hear someone trying to attribute violence to mental illness, we have to go back to the evidence," she says.

"We need to make sure that we are not pushing stigmatizing messages about [PTSD] on folks coming out of armed forces."

Listen to Wynacht's interview with Terry Seguin at www.cbc.ca/player.play/850667075771.



FOR YOUR BOOKSHELF

Balancing Conflicting Interests: A Counsellor's Guide to the Legal Process by Maureen McEvoy, RCC, (Third Edition, 2013, published by the Justice Institute of British Columbia) is a must-have manual for anyone working in mental health.

The third edition includes changes to the Family Law Act, which addresses issues such as co-habitation outside of marriage, assisted reproduction, and marriage breakdown. It also includes information on the legal implications surrounding client interaction and social media.

Copies are available through the JIBC's Centre for Counselling and Community Safety. www.jibc.ca/programs-courses/schools-departments/school-health-community-social-justice/centre-counselling-community-safety

"Family is not limited to a basic unit — large or small — but rather to an idea, a feeling. It covers so many different types of connections that one makes with other human beings during the course of their life."

—SADHU BINNING, *IT'S ALL RELATIVE: STORIES OF FAMILY BONDS AND BELONGING* (RBCM 2017).

BONDS AND BELONGING

A NEW EXHIBITION ABOUT FAMILIES AT THE ROYAL BC MUSEUM

From June 2 to October 31, Victoria's Royal BC Museum is featuring *Bonds and Belonging*, an interactive exploration of the powerful bonds created by family and the sense of belonging that family can elicit. Peering through the lens of First Nations and immigrant families in B.C., the exhibition challenges the idea of "family" and celebrates the ability of the family to incorporate difference.

The exhibit has been created to mark Canada's 150th year since Confederation and to honour B.C.'s families and their contributions to Canada as a nation. www.royalbcmuseum.bc.ca

HIGHWAY OF TEARS Virtual Reality Doc

It's just four and a half minutes long, but the *Highway of Tears* virtual reality doc is powerful. It focuses on the story of 16-year-old Ramona Wilson, who was murdered in 1994 somewhere on Highway 16, better known as the Highway of Tears. The film was created by acclaimed Anishinaabe filmmaker Lisa Jackson for CBC's *The Current* and puts viewers right into the living room of Ramona's mother, Matilda Wilson, as she talks about Ramona, who she was and what she was like.

"I want people to know we are standing there for our loved ones. The ones that are still missing and the ones that are unsolved murders. I am not going to give up."

— MATILDA WILSON

Imagery of the highway really drives home the remoteness of the beautiful, but very isolated and dangerous area. Twenty-two years later, Ramona's murder has never been solved. The CBC hosted public forums following viewings; details are at www.cbc.ca/radio/thecurrent/features/missingandmurdered/vr.

MAKING THE WORLD A MORE LOVING PLACE

ONE COUPLE AT A TIME

Sue Diamond Potts understands well the effects of dysfunctional relationships. She is the child of two World War II survivors, "who both had PTSD before we had even named it that," she says. Her father was a Polish resistance fighter and her mother was German.

"They met after the war and got married, but the war continued in our home," she says. "I grew up in a home where there was constant threat, violence, and alcoholism."

Sue developed her own alcohol and drug addictions, but then, by chance, she took a job working with youth.

"They were having drug and alcohol problems," she says. "Of course, I could relate to them, but I didn't have my own house in order. That was the real turning point for me. I realized I had to walk my own walk. I had to get clean and sober and really be able to model what I was asking them to do."

And she did. She also went to Simon Fraser for her BA and MA and worked in just about every counselling setting you can imagine. About five years ago, she incorporated her private practice, renaming it Good Life Therapy Centre.

Currently, seven therapists are contracted to Good Life Therapy Centre, where they specialize in working with couples and individuals who are in the aftermath of addiction and trauma. Their primary approach to couples therapy is the Bader-Pearson developmental model, which Sue says is very effective in creating long-term change in people.

You describe your practice as holistic. What does that mean to you?

You cannot separate body, mind, and spirit. There is no demarcation that says we're just going to work on your thoughts or we're just going to work on your behaviours, because it's all one. We're going to work on whatever part seems to be out of balance, but it's all connected. I do believe there is a spiritual component. It's not religion, but rather is more of an existential connection to life. Aligning with the Bader-Pearson model, we encourage couples to be the best version of themselves and to think about their relationship as one where they can rise above what's going on now and create something of beauty, something loving and wonderful. That, to me, is spiritual. And as they're doing that, all sorts of changes are happening inside of them. They have to behave differently. They have to think differently.

Do couples always come as couples?

No, they don't. According to the Bader-Pearson developmental model, couple relationships go through stages of growth that mirror the stages of development in childhood. What often happens is one partner grows into the next stage, and it creates an imbalance or an impasse in the relationship, and there is no longer harmony. One partner moves out of their comfort zone, and that can last for a while and create a lot of dissonance. Eventually that person will call and say, "We want to come in." Sometimes, they drag the other person

in, which is okay. As long as we've got them both there, we can help them understand that this is not a bad thing but is actually a sign of growth. They just need the tools or skills to manage their way through to the next stage of development and can learn to create something better than they ever had, if they are willing to put in the work.

Are there circumstances when individual sessions are recommended?

Yes, but in collaboration. Let's say there's infidelity. Following Janis Abrahms Spring's "no secrets policy" model, which means we all know that what is discussed in individual sessions is confidential, I want a place where people can be thoroughly honest with me and tell me what is happening. If they're not ready to tell their partner yet, I'm going to try to help them do that. Another example is if one partner has an addiction. I might work with them separately to confront things they're not coming forward with or to support and shore up the recovery.

What happens if there's a concern with domestic violence?

If there's domestic violence, that has to be dealt with. There's no couples therapy going on until that stops. I have a contract for what is acceptable and unacceptable in a fight, and they discuss it in the sessions. I'm clear on it, they're clear on it, and they're expected to follow that.

Does your approach differ with same-sex couples?

No, absolutely not. The approach isn't different at all. My experience has been that the same developmental issues, impasses, and delays have happened because of trauma in early life or neglect. There may be differences in gay and lesbian cultures versus heterosexual, but in terms of the dynamics in the primary attachment relationship, I've found it to be the same.

What's your advice for addressing cultural background?

Most important is to stay open-minded about their cultural practices and the degree of adherence, asking "How do your cultural practices affect this or does your culture influence what's happening here and how do you feel about it?" Then I work with them around autonomy and whether they want to follow that practice or not or can they say something about it. That's pushing their differentiation, and that's healthy for anybody in any culture.

The other important thing therapists have to be aware of is not imposing our own beliefs and practices on them. That's hard to do sometimes, because there are some cultures where what is "normal" for them looks unhealthy to us and even dysfunctional. We walk a fine line trying to impart what we know to be well-balanced emotional/psychological functioning and also respecting that for some cultures, it really looks different.

Divorce rates in Canada have been at almost 50 per cent for a while. Is that unnecessarily high?

My opinion is a high percentage of divorces could be avoided. If you look at the media, where do we see healthy couples? There aren't a lot of role models. There is a throwaway mentality. I think it's fuelled by the fantasy that there is this perfect person somewhere out there, and we just haven't found them yet, rather than the really tough work we need to do. It's hard to live in close proximity with another human being over a long period and learn to make space for our differences and communicate and negotiate effectively. That's the hard work of being a mature adult.

Tell us about the group of Level 2 Bader-Pearson counsellors you meet with regularly.

We're building a community of therapists who meet for supervision and support in order to keep learning and growing. Let's face it: human behaviour is incredibly complex. You put two complex people in a room and attempt to help them quit hurting each other — it's as varied as you can imagine. I never stop learning and growing. ■

> "THERE MAY BE DIFFERENCES IN GAY AND LESBIAN CULTURES VERSUS HETEROSEXUAL, BUT IN TERMS OF THE DYNAMICS IN THE PRIMARY ATTACHMENT RELATIONSHIP, I'VE FOUND IT TO BE THE SAME."

Sue Diamond Potts, RCC is a certified trainer for the Bader-Pearson developmental model of couples therapy. She offers a Level 1 training course, followed by an ongoing Level 2 group that provides supervision and support as they continue to learn.

She is currently developing an online program focused on bringing together addiction treatment and couples therapy. The goal is to heal some of the hurt that addiction causes spouses and families, in conjunction with teaching couples how to rebuild love in recovery. www.goodlifetherapy.ca

INFIDELITY IN RELATIONSHIPS

UNDERSTANDING THE **FIVE STAGES** OF GRIEF

BY TED LEAVITT, RCC

Elizabeth Kübler-Ross, author of *On Death and Dying*, was instrumental in understanding the human experience of grief and loss. While her book focused on the grieving process in relation to mortality, the five stages of grief she outlined — denial, bargaining, anger, mourning, and loss — are equally applicable to a wide-range of loss experiences: the loss of health, opportunity, a job, a role or responsibility, identity, and a host of others. Here, I will focus specifically on a form of trauma and loss with which I am all too often asked to assist — infidelity in relationships.

The meaning of the word "fidelity" may be debated with regard to the line between acceptable and unacceptable behaviour in relationships. Regardless of how it is defined, fidelity is a contract, the terms of which are decided by the people involved in the relationship. It is not for me to define fidelity in a particular relationship or for me to say which forms of infidelity are worse or more painful; that is for each affected individual to determine.

However, despite infidelity's multidimensional aspects, once it has been revealed, the partner of the person who has acted in such a way will usually respond within a certain range of expected behaviours and feelings. By understanding these behaviours and feelings in terms of the stages of grief, individuals may be able to recognize where their own experiences are along the path from trauma to recovery. They will be able to see that their experience is not unique to them, that they do not suffer alone, and that there is a predictable outcome to their suffering.

It is important to note that Kübler-Ross repeatedly clarified that these stages are not necessarily a progressive concept: individuals don't necessarily start at stage one and proceed in order to stage five. In fact, this may only occur in a minority of cases. But while individuals may follow unpredictable patterns in terms of the order of the stages, the stages themselves are almost universal. Different types of social and emotional support, prior-loss history, emotion-regulation ability, and existential spiritual beliefs may function as mediators in the impact of loss.

IT IS IMPORTANT TO NOTE that Kübler-Ross repeatedly clarified that these stages are not necessarily a progressive concept: individuals don't necessarily start at stage one and proceed in order to stage five.

1 DENIAL

The most common way denial appears after infidelity is what I call "premature optimism." After the initial shock of discovery or revelation, the partner may effectively go numb. They may appear relatively unfazed and may speak optimistically about their hopes of reconciliation, of seeking professional relationship help, or of their forgiveness and understanding. They may also "talk tough" about how the relationship is over and generally try to appear like they are ready to move on. While sometimes this optimism is genuine and appropriate, it is often premature in that it is not based on a sound understanding of what has transpired, its true emotional impact, and its ramifications for the future. The benefit of this stage is that by rushing to focus on solutions, the injured partner is able to avoid painful feelings and make it through the day.

This is a very subtle form of denial. In some cases, denial is much more flagrant: the injured party may simply shrug their shoulders and assume there is nothing they can do except let it go. The most flagrant form of denial is the actual denial that anything has happened. Making excuses for the offender, finding alternate explanations, or saying "I don't want to know," all serve the same purpose as more subtle forms of denial: to prevent painful emotions.

2 BARGAINING

Kübler-Ross originally included this stage as preparatory to death or dying, and in that context, it makes more intuitive sense that someone would try to bargain to avoid an unwanted fate. However, when the loss has already occurred, bargaining doesn't seem to be a natural fit. After all, we can't go back in time to make something unhappen. So how can we bargain with respect to infidelity?

Simply put, the bargaining stage entails a lot of 20/20 hindsight coupled with self-blame: "If only I had done this or seen that… How could I not see this coming? Where did I go wrong? What did I do wrong? If only… I should have… They should have …" These all express a desire to change undesirable circumstances after the fact. Of course, we cannot actually do this, but what we can do is imagine ourselves

REINTERPRETING ANGER AS FEAR allows us to get to the bottom of the issue faster instead of getting waylaid in draining resentments.

acting differently. As far as the brain is concerned, this is the next best thing. The brain cannot easily tell the difference between what is imagined and what has actually occurred. The bargaining stage of post-traumatic grief is an unconscious attempt to inhabit a different reality than the one we are confronted with. Denial serves this same end but at a greater distance from the pain. The bargaining stage acknowledges that things are not good and attempts to live in an imaginary world where things are better.

3 ANGER

The anger stage after infidelity is easily recognized. Anger may be directed at the offending partner, a third party, or even at oneself. While anger is recognizable and understandable as a response, it is not immediately apparent that this anger is part of the grieving process. Generally, we associate grieving with sadness, but it is more complex than that. Adding to that complexity is if the relationship was rocky prior to the infidelity, which often means infidelity A) was not entirely unexpected, B) may offer a way out of a relationship, C) is still hurtful, D) removes the veil of denial from the state of the relationship, E) may be a relief… and so on.

The anger stage of grieving also gives the traumatized partner the strength and energy to face the logistical challenges that present themselves if a separation results. This may include becoming a single parent, a single breadwinner, continuing in essential routines connected to both roles, etc. While there is an initial survival benefit of this response, it is also important to recognize the benefit wanes over time.

Another key component of this stage is the realization that, at its roots, anger is fear; it is simply one side of the fight or flight response. No matter which way we follow, the underlying message of the brain is the same: you are in danger and your defenses must be mobilized. Reinterpreting anger as fear allows us to get to the bottom of the issue faster instead of getting waylaid in draining resentments. Asking the question, "What am I afraid of?" also serves as a catalyst for moving to the next stage.

4 MOURNING

Kübler-Ross originally called the fourth stage "depression," but it is now more commonly referred to as "mourning." Albeit subtle, the critical difference between these two terms is that the fuel behind depression is hopelessness. It is one thing to be sad that something happened and quite another to feel there is no hope for improvement.

At this stage of grieving infidelity, the feelings expressed are usually along the lines of "I can never trust him/her again" or "I can't trust anyone" or "I'll never be able to forget and move past this." These are absolute, concrete, black-and-white statements and project a future based on the present. We know past behaviour can be an accurate predictor of future behaviour, but this is not absolutely true. It is true to say that right now, trust seems impossible, but it is not necessarily true forever. If people work through their issues, learn

to communicate better, learn how and who to trust, then trust can once again become a part of their lives. If nothing changes, however, then nothing changes.

When someone is in this stage of grief, reassurance has very little effect. Telling someone in the throes of betrayal that they will be able to trust again one day is like telling someone who is freezing to death that it's not really that cold. But for them to recognize that these feelings are a natural response, that many people have gone down this road and come to this spot but eventually moved past it, is crucial to their progress. We allow someone to make this progress when we do not pressure them to get there faster. We cannot rush trust.

What is being grieved in this stage is not necessarily the loss of the person or even the relationship but the loss of an ideal. It is disturbing to think my partner has betrayed my trust, but much more disconcerting is realizing the reality that partners sometimes betray trust. If the foundation of our expectations of relationships includes an assumption of loyalty and fidelity and that has now crumbled, we have lost much more than one relationship; we have lost trust in our own expectations.

5 ACCEPTANCE

Referring to acceptance as the final stage is somewhat misleading: it gives the impression that the other stages are over and done with. If only that were true. However, once we have resolved this stage, it does make it much easier to handle and recover from regressions. Coming to some acceptance of what has happened provides a different context in which to deny, bargain, get angry, and mourn.

Coming to a place of acceptance with infidelity doesn't indicate that we condone it, that we are not hurt by it, or that it doesn't affect us. It certainly doesn't mean we are happy about it or tolerant of it. But it does mean we have stopped trying to avoid the truth and we are working to put it in perspective.

With regard to infidelity, acceptance may involve accepting that you no longer trust your partner. It may involve accepting that you now look for evidence of recurrence. So many people battle this part of the process: they don't want to be suspicious and checking on their partner. I tell them it's okay to engage in this behaviour and that it's not uncommon. One of the reasons it is difficult to accept this evolution is because we struggle to see what has happened as a trauma. But if we can recognize it as such, it gives us perspective to understand our responses and have compassion for ourselves. If you were in a traffic accident where someone ran a red light and caused you serious physical harm, no one would begrudge you for having anxiety at intersections. It is an understandable artifact. Why should it be different with trusting your partner? How can we begrudge a person for being overly cautious with their trust when it was already betrayed?

Acceptance may also mean terminating the relationship. Not all relationships are salvageable, particularly if only one of the parties is interested in making changes. Acceptance may mean recognizing our own contributions to the situation while still holding our partner accountable. Ultimately, acceptance is about incorporating what has happened into our lives without letting it define our lives from here on out.

From acceptance, we can move into a realm of post-traumatic experience, referred to as post-traumatic growth, which allows us to find purpose in our pain and, ultimately, to heal. ■

PUBLIC POLL*

10%

About **10 per cent** of Canadians say they have cheated on their spouse, but **22 per cent** have seriously considered it.

6%

Six per cent of Canadians do not find sex with someone outside their relationship to be illicit and **eight per cent** feel the same about sex with a sex worker.

13 per cent of men and **8 per cent** of women admitted to cheating, while **20 per cent** of women and **23 per cent** of men said they have considered cheating.

***SOURCE:** National Post, August 27, 2015. "22% of Canadians have seriously considered cheating on their spouse, poll finds," by Sadaf Ahsan. Statistics by Mainstreet Research for Postmedia News. Mainstreet polled a random sample of 2,459 Canadians across the country. The poll has a margin of error of plus or minus 1.98 percentage points, 19 times out of 20.

Ted Leavitt, RCC works in private practice in Abbotsford as well as at Langley Youth and Family Services. He specializes in aggression, ADHD, and attachment trauma, among other issues. www.connectivitycounselling.com

THE MOST PREVENTABLE HOMICIDE

DOMESTIC VIOLENCE CAN BE PREVENTED, PROVIDED SOMEONE WHO CAN IDENTIFY THE LETHAL RISK FACTORS COMES INTO CONTACT WITH A POTENTIAL VICTIM AND ACTS APPROPRIATELY.

BY CAROLYN CAMILLERI

In 2010, the B.C. Coroner's Office convened its first Domestic Violence Death Review Panel to consider the dynamics of the 153 deaths in B.C. over the previous 15 years. The next Death Review Panel was convened in 2016, but this time, there were 100 deaths in just six years.

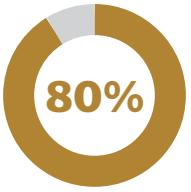
"It does seem that domestic violence homicide, at least in B.C., is on the rise," says Tracy Porteous, Executive Director, Ending Violence Association of BC (EVA BC).

While she says men carry important roles as first responders, partners, family members, co-workers, friends, and allies in speaking up about violence, and there are male victims of domestic violence, the most severe and lethal violence is perpetrated by men against women.

Porteous has been involved in the anti-violence field for over 35 years. One case she worked on was the 2008 Coroner Inquest into the murders of Sunny Park, her 6-year-old son Christian Lee, and both her parents by her husband Peter Lee, who committed suicide at the scene. In 2013, EVA BC did an assessment to determine what had changed since the deaths of Sunny and her family.

"We determined that in various formats from various ministries and institutions, 176 recommendations had been issued since the inquest into the murders. The recommendations related to increasing the safety of families struggling in this area," she says. "By 2013, only four of those recommendations had been partially started."

And yet, of all the homicides in Canada, intimate partner homicide is considered the most



Approximately every six days, a woman in Canada is killed by her intimate partner. Out of the 83 police-reported intimate partner homicides in 2014, **67 of the victims — over 80% — were women.**[1]

Aboriginal women (First Nations, Inuit, and Métis) are **six times more likely to be killed** than non-Aboriginal women.[2]

The rate of domestic violence is likely much higher than we think. **70% of spousal abuse is not reported to the police.**[3]

preventable. It's not 100 per cent predictable, says Porteous, but there is an enormous amount of well-researched evidence that helps us understand the lethal signs. However, it is only preventable if the victim or someone the victim comes into contact with knows how to recognize the signs and what to do about them. Only an estimated 22 per cent of women report domestic violence to the police.

"It's very hard for us to fathom that somebody we love or somebody we once loved would actually be capable of taking such a drastic step," says Porteous. "You need to have the support of somebody helping you understand that what you're disclosing is not usual or healthy."

For this reason, EVA BC is on mission to educate people about lethal risk factors.

"Counsellors, police officers, social workers, anti-violence workers, doctors, clinical health workers, family law lawyers, people in the counselling departments at universities, counsellors in high schools, staff at legal aid, anybody who works at intake for social assistance or child protection — really the entire spectrum of human services should understand these risk factors."

THE LETHAL RISK FACTORS

Risk factors are any circumstances making someone more vulnerable to intimate partner violence. Disclosure may come from primary victims, secondary victims, or perpetrators. Identifying risk factors means drawing on your understanding of the complex dynamics of power and control. For example, the abuser's power and control may be expressed in ways related to the woman's Indigenous identity, immigrant or refugee status, age, (dis)ability, geographic location, sexual orientation, or gender identity. With those dynamics as the framework, here are the factors that point to the highest risk.

◆ Recent or pending separation or change in relationship. Victims trying to leave violent relationships are at heightened risk during the time of leaving and for up to 18 months after.

◆ Escalation or change in abuse or violence. Victims of domestic violence are more likely to have been hurt by their partner many times before they disclose to anyone, and men who abuse their partners are more likely to have done this with previous partners. As violence is repeated, it often becomes more serious and the time between each incident often shortens.

◆ Threats of suicide from the perpetrator. When the abuser is suicidal, it is an indication he is in a state of crisis, a major risk factor for domestic violence.

◆ Threats to kill the survivor, children, or pets should always be treated very seriously.

◆ Criminal harassment, stalking, obsessive jealousy, persistent calling, texting. Stalking and physical assault are strongly associated with murder and attempted murder. Extreme jealousy is also associated with severe violence.

◆ Extreme minimization of the impact of violence or justifying abusive behaviour. Serious and frequent offenders deny and trivialize the violence and blame the victim.

◆ Strangling, choking, and biting are perhaps at the top of the list of possible lethality.

◆ Sexual assault is considered extremely serious and associated with lethality.

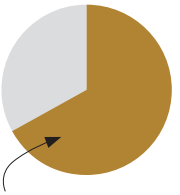
◆ Perpetrator mental illness. Certain types of mental health issues are associated with violence against women, including personality disorders characterized by anger, lack of impulse control, and behavioural instability.

◆ Violation of civil and criminal court orders, i.e., a breach of protection order, are considered quite serious.

Other risk factors include child abuse, animal abuse, pregnancy/new birth, employment/financial problems, substance/alcohol abuse, history of violence, and past assault of intimate partner or other relationship problems.

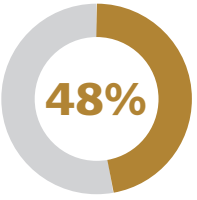
Porteous says people seeking help won't necessarily walk into your office and say, "I'm a victim of domestic violence."

"They might walk in your door and say, 'I can't sleep' or 'I'm struggling with anxiety' or 'I'm struggling with depression' or 'I can't seem



67% of Canadians say they have **personally known at least one woman** who has experienced physical or sexual abuse.[4]

According to the RCMP, **a child who witnesses spousal violence is experiencing a form of child abuse**, since research shows that "witnessing family violence is as harmful as experiencing it directly."[5]

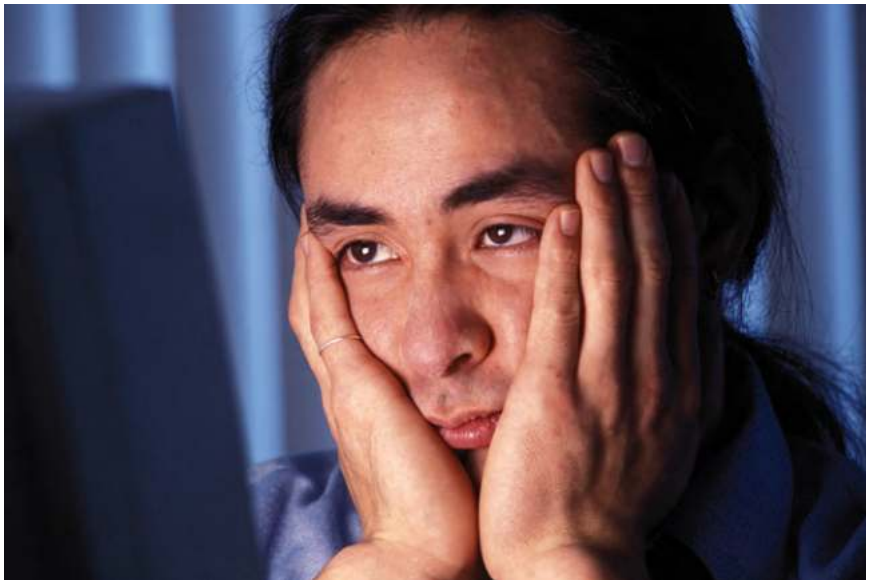


Spousal violence was the most common form of family violence in 2013. **48% of family violence occurs at the hands of a current or former spouse** (married or common law).

In 2013, there were more than

90,300

victims of police-reported violence by an intimate partner (including spousal and dating partners), accounting for over one quarter of all police-reported victims of violent offences in Canada.[6]



When the abuser is suicidal, it is an indication he is in a state of crisis, **a major risk factor for domestic violence.**

to connect with anybody in my life," says Porteous. "There could be myriad initial reasons people seek help, and when we begin listening deeply to people affected by domestic violence, we could begin to hear something that indicates risks factors for possible severe or lethal violence."

Porteous says counsellors with skills to assess and take action on suicide ideation are better positioned than most to deal with risk factors for lethal or severe domestic violence. "In someone who is suicidal, you're listening for an idea, a plan, and the means to carry out the plan. In domestic violence risk, you follow the *Summary of 19 Risk Factors for Domestic Violence*."[7]

If clients are disclosing risks and you suspect they are serious and credible, Porteous suggests telling the client you are concerned for them. For example: "I'm concerned for your safety. What you're telling me relates to all of the evidence that those of us who work in this field understand to be quite serious in terms of your safety. Can you and I work together before you leave today to figure out another place for you stay tonight or figure out how you're going to go pick up your kids and go to another place that's safe."

Porteous feels strongly that, if at all possible, a woman leaving a violent situation should have a plan to ensure her safety and the safety of her children, family, pets, and workplace.

"The best, most ethical thing a counsellor can do is refer the client to the best, most experienced help available in that community," says Porteous.

Anti-violence experts are trained in risk identification, safety planning, and managing immediate risk and safety. In B.C., there are hundreds of anti-violence programs, including community-based victim assistance, outreach, multicultural outreach programs, counselling programs, transition houses, and safe homes.

CALLING IN THE EXPERTS

Porteous says making an effective referral — not just giving the client a list of places to call — is one of the most important skills a counsellor can have. She suggests making the phone call while the client is sitting in your office. That phone call could well be to an ICAT: Interagency Case Assessment Team.

ICATs are innovative, multi-sectoral teams made up of responders to high-risk domestic violence and often include a representative from community-based victim services, police-based victim services, police, child protection, corrections, health, aboriginal service providers, and other agencies. ICATs work to share information appropriately and work to coordinate risk identification, offender management, and victim-safety planning.

The benefits of ICATs include better identification of risk factors, proactive supports to victims and offenders, elimination of systemic barriers to safety, reduction in service duplication, fewer removals of children, and an overall reduction in domestic violence offences. EVA BC has been working to help develop and maintain ICATs since they started in 2010. Currently in B.C., about 60 communities are served by ICATs.

"The outcome of these teams is phenomenal in that they're dealing with the highest risk for lethal violence in communities," says Porteous. "Most important is that if anyone in the community is worried about a domestic violence situation, they can refer the case to ICAT, and ICAT begins to assess risk and build safety."

THE PERMISSION ISSUE

Women in abusive relationships may not be ready to leave — they may not want the relationship to end.

"Domestic violence is complicated by love and sometimes children, extended family, faith, community, housing or the lack thereof," says Porteous. "None of us wants our client to be abused mentally, sexually, or physically, but we also have to respect the agency of our clients and respect when she's ready to leave."

As helpers, we seek to restore agency and empowerment in all the ways we can, says Porteous, especially for people who have been hurt and disempowered. "Respecting a woman's privacy and not acting unilaterally is a huge part of this. Obviously, if children are in danger, if her life is in danger, that's different than her choosing to stay when her partner is abusive but not threatening to kill her."

In extenuating circumstances, counsellors may be in a situation where a client has disclosed a potentially lethal or really serious situation, for example, if a client has left a distressing message and you can't reach her or she left your office in a state of crisis and you're concerned for her safety.

"If the situation is imminent, and you are going to report it yourself, the police are the fastest link to getting help and assessing risk."

And you can make that call. The province amended the privacy legislation that governs public bodies in relation to domestic violence specifically for this reason.[8] And all other privacy rules allow for information to be shared if there is a serious concern for safety.

"Anyone can refer a case to police or an ICAT, although ideally, and in the vast majority of cases, this would be done with your client's permission," says Porteous. "If permission has not been granted, and you believe your client could be in serious danger, or if you are the counsellor to someone who is committing violence and they have disclosed an ideation for homicide, and you believe he has the means to carry out his threat or intent, you have clear legislative authority under all privacy acts to make a report to police, an ICAT, or a domestic violence unit."

Making an effective referral — not just giving the client a list of places to call — is one of the most important skills a counsellor can have.

If sharing that information seems uncomfortable, know that no one sector can help somebody who is struggling with domestic violence.

"A completely important guiding principle of responding to domestic violence is that the response needs to be multi-sectoral," says Porteous. "We know that when single sectors try to manage this by themselves, they have very little access to information and resources to help manage it."

ICATs are B.C.'s answer to a multi-sectoral response and a move toward broader access to critical risk- and safety-related information.

"There's no question: when you have people practising from a coordinated base in a community, there are fewer deaths. We know working together with others saves lives. ICATs are doing phenomenal work."

Porteous compares it to referring your client to a cardiac specialist if they have heart disease; you wouldn't want a family physician alone managing something so specialized.

"It's the same thing with domestic violence: there are specialists that exist in many communities," she says. "Get help. Bring help to that family." ■

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7 http://endingviolence.org/wp-content/uploads/2014/02/MPSSG-Summary-of-Domestic-Violence-Risk-Factors.pdf

8 Government of Canada, Department of Justice. www.justice.gc.ca/eng/rp-pr/cj-jp/fv-vf/mlfvc-elcvf/p9.html. "However, British Columbia has recently gone one step further, by amending its Freedom of Information and Protection of Privacy Act (FOIPP Act) to clarify that it is appropriate to collect, use, and disclose information for the specific purpose of reducing the risk that an individual will be a victim of domestic violence, if such violence is reasonably likely to occur." Reference to Freedom of Information and Protection of Privacy Act, RSBC 1996, c 165, sections 26(f), 27(1)(c) and 33.1(1)(m.1).

DIVORCE WITH A HIGH-CONFLICT PERSON

BY BILL WAGG, RCC

As a family therapist, I've been working with a growing number of divorcing couples fighting over child custody and shared parenting. Typically, one parent comes seeking help, worried the ongoing conflict is harming the children. The parent tells me the children are easily upset and become angry or withdrawn after a visit with the other parent. It may take one to three days for a child to return to normal behaviour. The child may say disturbing things, for example, telling the parent to send support payments or asking how the support money is being spent, which could indicate the other parent is coaching the child to become involved in the conflict and ally with their side.

The parent shares how simple issues, such as managing children's clothes between homes, arranging pick-up and delivery times, or deciding who attends a school field trip, turn into nasty conflicts. The parent receives a barrage of negative, hateful text messages. A phone call becomes a tirade of blame and lectures. Conflict is constant, and the parent always feels defensive.

AN HCP (HIGH-CONFLICT PERSON) CAN BE RECOGNIZED BY THEIR SELF-ABSORBED FOCUS ON THEIR OWN NEEDS AND BY INFLEXIBLE THINKING THAT'S OFTEN SHAPED BY DISTORTED REASONING.

THE HEALTHY / "NORMAL" BREAKUP

Most couples experience a high level of conflict and struggle during the first year of separation. Most have heated arguments and experience a time of emotional turmoil and anger. But over time, the process of grief and loss unfolds, resulting in acceptance. Emotional intensity changes to a quiet resolve to move on. Both people adapt to the new relationship and put aside past hurts and stop or reduce the fighting, making it possible to work out issues, including those around parenting.

When children are involved, even at the early stages of a breakup, most couples put the children's emotional well-being first. There is willingness to set aside personal hurts when discussing the children's needs, and parents strive to set up visitation or living conditions in the children's best interests.

The key points are the ability to accept (let go or manage the hurt), settle their differences (stop fighting), and move on (create a new life). If, however, after two years of separation, intense conflicts are still occurring, something is amiss.

THE NOT-SO-HEALTHY BREAKUP

A small number of people do not get over the breakup and remain stuck in anger and resentment. They are unable to take any responsibility for

HIGH-CONFLICT PEOPLE HAVE GREAT DIFFICULTY PLACING THE NEEDS OF THE CHILDREN FIRST AND REACHING GUARDIANSHIP AGREEMENTS. CHILDREN CAN BECOME A MAJOR SOURCE OF CONFLICT.

their actions, continuously blame the other person for their difficulties and the marriage breakup, and portray themselves as victims. A person acting in this manner may have a mental health condition such as an antisocial or narcissistic borderline personality disorder. Someone with a borderline personality disorder often has great difficulty accepting and coping with a breakup. The stress they experience may exaggerate their condition, for example, heightening feelings of threat, inferiority, being ignored, or being dominated. To cope, they try to control the other person through blame, threats, and continuous conflicts. A very small number of people struggle with these mental health issues.

However, there's another group of people who don't have mental health issues but have deeply entrenched, unhealthy personality traits and beliefs that make it very difficult for them to accept a breakup. Their coping strategy is to use controlling and aggressive behaviours. In trying to understand people with these traits, I've found the work of American lawyer and former counsellor Bill Eddy to be very helpful. Eddy, co-founder of the High Conflict Institute (see page 19), calls this type of person a "high-conflict person"(HCP).

An HCP can be recognized by their self-absorbed focus on their own needs and by inflexible thinking that's often shaped by distorted reasoning. HCPs show many of the following characteristics and behaviours:

- demonstrating inflexibility in their thinking and demands
- making assumptions and jumping to conclusions quickly
- making issues personal either by blaming the other or dredging up the past
- turning small issues into arguments
- petitioning the courts to have their demands met
- recruiting advocates such as lawyers, friends, and family members
- dragging the conflict on for years

HCPs have great difficulty placing the needs of children first and reaching guardianship agreements. Children can become a major source of conflict.

WORKING WITH AN HCP CLIENT

It is a difficult undertaking to work with an HCP who is seeking your support and credentials in order to vindicate their beliefs, decisions, and behaviours. The HCP can be very convincing in their depiction of the ex-spouse as malicious and the cause of suffering. HCPs want your support to achieve their goals and can enmesh you in their mode of operation. If this happens, you can become a negative advocate, supporting the HCP's beliefs and behaviours. To avoid this, which may not be possible, listen to your intuition when something doesn't sound right, note it, and ask questions to explore the issue.

Be careful of your assumptions when listening to the HCP's story. Notice if you are buying into their story. When I catch myself buying in, I try to expand the focus on the story and use open questions to explore the HCP's history

and management of conflict. This often shifts the focus to the HCP's participation and reflects on their own behaviours. The HCP will have great difficulty reflecting on their own behaviours and will strive to focus on the failings of the ex-spouse.

Take your time when exploring the presenting problems; draw out the facts and seek what is truly happening. Note the HCP's inability to clarify issues and skills to solve problems and follow through. HCPs are weak with these skills, which is symptomatic of the dysfunctional ways they struggle with life's challenges. I have often found the HCP will blame others for their problems, presenting themselves as powerless and a victim. I will feel like I am blocked into a corner with no resolution to the problem. There is often a tendency for the counsellor to put more time, energy, and effort into solving a problem, allowing the client to be a more passive contributor. I notice this when I believe I have a solution to the problem, and I am trying to convince the person to take a certain action. Or I find myself arguing with the person about what they should be doing. This is transference and counter transference, and I am now locked into my client's patterned behaviour. To avoid this, provide factual information and coach them through the process of problem solving.

Encourage the HCP to be responsible for their actions and the consequences: i.e., Is this working for you? What is the price you are paying for constantly taking this to court? When there are negative consequences resulting from their actions, coach them through how their reactions, beliefs, and behaviours brought about this result.

At the core of the work, is the HCP's long history of conflict resulting from cognitive distortions and often also emotional dysregulation. The HCP doesn't want to change but wants your support to continue in this mode of behaviour. This I have experienced as a continuous recycling of the negative story of blaming the other and staying in the "head." The storytelling is the HCP safe place, and the person will resist my invitation to explore their contribution to the conflict. I have found myself feeling like a shadow boxer getting nowhere. I strive to remember the HCP lives in a state of conflict and suffering. The HCP can be charming, engaging, and wholly convincing in presenting the emotional intensity of being victimized. By hearing only one side of the story, a counsellor can be vulnerable to vindicating the HCP's position.

Ultimately, providing counselling, being aware of transference and boundaries, and working towards helping the HCP understand their own beliefs, emotions, behaviours, and consequences is a challenging undertaking requiring skill and diligence. ■

Bill Wagg, MA, RCC, is a family counsellor in private practice. He works in a variety of areas such as couples counselling, conflicts with ex-spouses, anxiety, trauma, and domestic violence.

RESOURCE HIGH CONFLICT INSTITUTE (www.highconflictinstitute.com) has a dedicated website to help potentially high-conflict families that are facing separation and divorce: www.newways4families.com.

WHEN YOUR CLIENT'S EX-SPOUSE IS AN HCP

When working with a client whose ex-spouse is an HCP, I strive to help my client understand they are being hooked into an HCP's mode of operation. They cannot change the HCP, but they do have a choice in the ways they engage and respond in order to limit or shut down opportunities for attacks and to take control of their own responses. Here are some helpful skills I recommend they cultivate and apply:

Don't take it personally. The HCP's anger, blaming, and demands are their personal issues, not yours.

Set up personal boundaries. In doing so, it's important to see the HCP as a distinct person with their own issues and agenda. Try to get in touch with a calm, confident inner place where you know you have the right to be treated with respect.

Don't give in to demands or provide support if you disagree. An HCP often has a repertoire of tactics to get what they want. If you give an inch, they will often take a mile. You don't have to take on their emotional state, and you have a right to say no to their demands without feeling guilty or being intimidated.

Recognize bullying for what it is. End the conversation, which sets clear boundaries about which behaviours are acceptable, and more importantly, are unacceptable.

Self-care is critically important. Seek support from good friends and family. Learn about stress and its impact (see Jon Kabat-Zinn's mindfulness talks on YouTube). Exercise, eat well, and make time for fun.

INTEGRATING HEALTH PROMOTION

INTO COUNSELLING PRACTICE

BY KATHI CAMERON, RCC

In many ways, clinical counsellors play a large role in the promotion of health and resiliency. From stress-management skill building to the promotion of addiction-free living, much of our work is focused on preventing chronic disease from a psychosocial perspective.

The practice of health promotion places emphasis on addressing the underlying causes of ill health for the sole purpose of preventing illness. Health is the relationship between myriad determinants from socio-cultural and economic influences to public-policy development and the design of healthy environments and communities.

Depending upon which model of health you align with, health may include emotional, social, intellectual, spiritual, and physical components as they work together to promote resiliency in both mind and body. Some models accommodate more and others less, but each speaks to the fluidity and interconnection of a wide variety of factors. Most importantly, each component of health is equal to the other and may offer similar health benefits.

These days, we are inundated with media messages about nutrition, exercise, and weight management, but this focus represents only one component of health. If a client is feeling less than excited to start walking, why not focus on something he is more interested in? This could include participating in more social events, picking up a new hobby, adding more laughter to his life, or practising daily gratitude. Sometimes making changes to the most difficult aspects of health behaviour (i.e., eating more vegetables) comes easier if the other components of health are attended to and in balance with each other.

Here, I will examine the less familiar terrain of physical activity and healthy nutrition as they relate to the practice of clinical counselling and the promotion of mental health. While these concepts are not new, the challenge is in creating action plans with clients that promote a sense of mastery and success to foster the motivation to continue with the healthy behaviour. As a health-promotion educator, I have found this to be one of the most difficult and interesting challenges. How do we, as helping professionals, use physical activity and healthy eating prescriptions to help build a stronger scaffold to support our clients through the therapeutic process? How can we seamlessly integrate suggestions, action plans, and discussions around health practices without taking precious time away from the primary focus of therapy?

While most counsellors are not personal trainers, nor should they overstep the professional scope of practice, some clinical practitioners are adding walking to their therapeutic tool box.

Interventions such as yoga or mind-body approaches combined with breathing exercises help treat the symptoms of anxiety and depression, and resistance-training exercises may be prescribed for people living with mild and major neurocognitive disorders.

WHY PHYSICAL ACTIVITY FOR MENTAL HEALTH?

When it comes to the positive benefits physical activity has on mental health, the list is long. It is now understood that physical activity (i.e., walking) can reduce mild to moderate depression equal to that of an anti-depressant. In addition, exercise can improve mood, self-esteem, sense of mastery, and social connection (not to mention an elevated sense of well-being). Exercise has been shown to decrease the side effects of certain medications, provide positive benefits to those living with schizophrenia, and reduce the effects of ADD/HD. It is also an excellent anxiety/stress management tool. *Physical Exercise Interventions for Mental Health* offers mental health practitioners a greater understanding of how physical activity is currently used as a mental health intervention for people with a diverse range of mental health disorders.[1]

Not only has research identified the benefits of physical activity for mental health, exercise prescriptions vary depending upon the mental health issue. For example, interventions such as yoga or mind-body approaches combined with breathing exercises help treat the symptoms of anxiety and depression, and resistance-training exercises may be prescribed for people living with mild and major neurocognitive disorders.

Another consideration highlighted by studies emphasizes the effects that exercising with a partner or group has in improving adherence to the regime. In one meta-analysis examining exercise for depression, people in supervised or group exercise programs showed higher adherence rates compared to people exercising individually.[2] It is easier to stay motivated with a friend.

SO WHAT DOES THIS MEAN FOR THE CLINICAL COUNSELLOR?

During the first part of my career, I studied and practised kinesiology and exercise psychology as I worked in the field of exercise prescription for special populations. Now, as a practising clinical counsellor, I see physical-activity counselling is a wonderful opportunity to promote mental health.

Interestingly, physical-activity counselling among exercise professionals is becoming more familiar as personal trainers and rehabilitation specialists integrate motivational interviewing and behaviour-modification strategies into their practice. For example, the Alberta Centre for Active Living has provided fitness leaders with tools and information to address exercise adherence and behaviour change with their clients.[3]

While most counsellors are not personal trainers, nor should they overstep the professional scope of practice, some clinical practitioners are adding walking to their therapeutic tool box.* As simple as walking may be, it is still a challenge to create a plan of action for a client that encourages a sense of mastery and adherence to a program. That said, walking is an excellent modality to promote cardiovascular and muscular strength, while reaping the mental health benefits.[4]

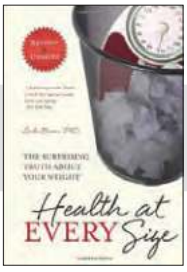
WHY HEALTHY EATING FOR MENTAL HEALTH?

Although researchers have yet to identify, let alone agree on, the best diet for a healthy long life, research has been able to confirm a strong relationship between nutrition and mental health. Studies examining the relationship between processed food and depression show a positive correlation. One study, examining perceived happiness in college students and nutrition, found a positive relationship between eating breakfast, vegetable and fruit consumption, and the self-reported perception of happiness.[5]

A helpful resource that might be of interest comes from the Dietitians of Canada and addresses the relationship between nutrition and mental health, including specific mental health conditions and suggestions for nutritional prescription.[6] But how can we implement this information while respecting our professional scope of practice?

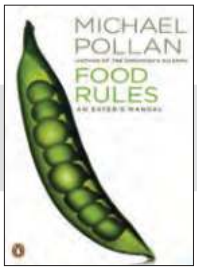
I tend to focus my attention on the addition of whole foods, rather than the elimination of foods, with the goal of promoting intrinsic changes within the client. It is important to avoid terms such as "good" or "bad" food. Our socio-cultural focus on food has reduced it to mere carbs, protein, and fats, removing all other meaning. As counsellors, I believe we can promote healthful eating by fostering discussions around whole foods and vegetable consumption, while keeping a healthy relationship with food and what it means to the client. Also note that by suggesting our clients eat more whole foods and vegetables, we are asking them to commit time to something they may not want or be able to commit to.

SUGGESTED READS



1 HEALTH AT EVERY SIZE
by Linda Bacon (Dallas: Benbella Books, Inc, 2008)

2 HEALTH FOOD JUNKIES
by Steven Bratman (New York: Broadway Books, 2008)



3 FOOD RULES: AN EATER'S MANUAL
by Michael Pollon (New York: Penguin Books, 2009)

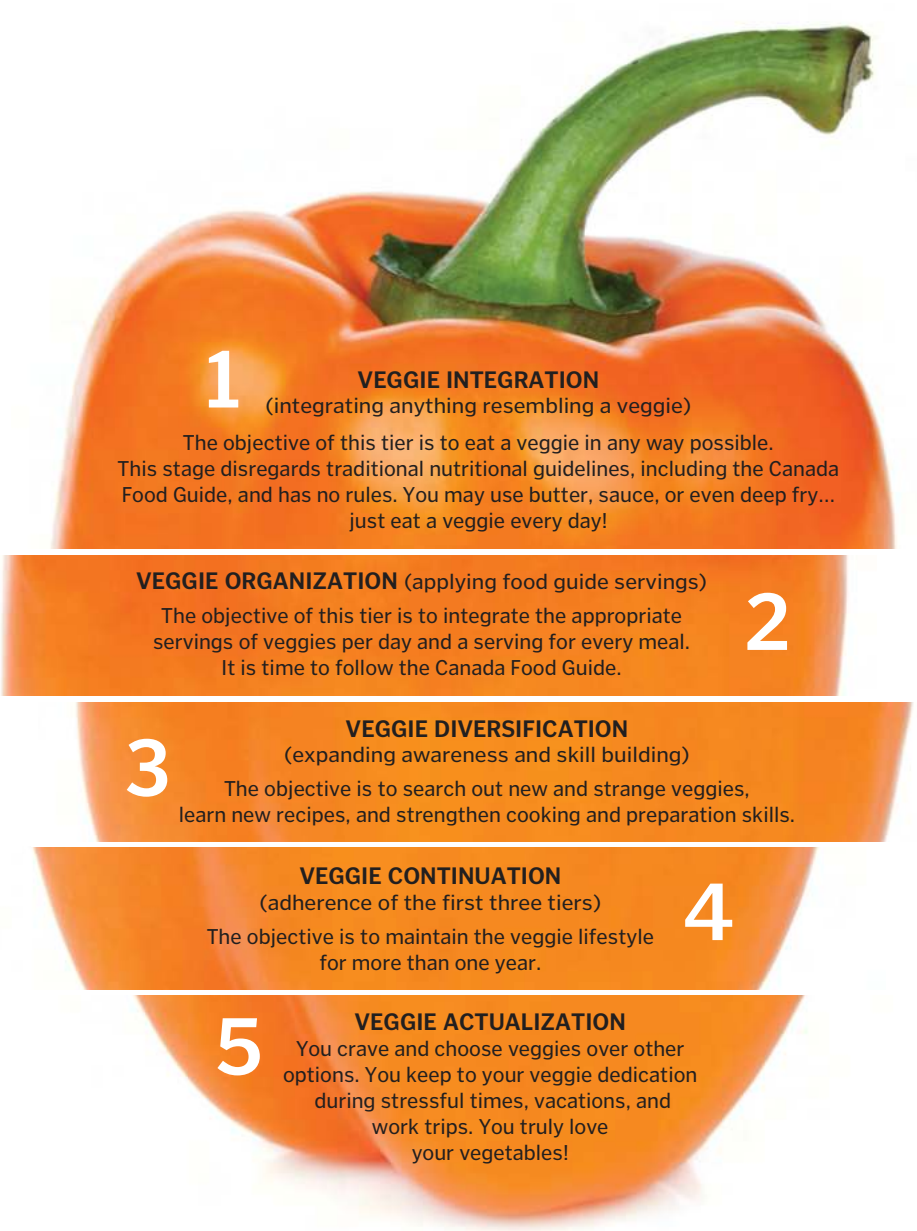
4 CHANGING FOR GOOD
by James O. Prochaska, John C. Norcross, Carlo C. DeClemente (New York: HarperCollins, 1994)

That said, I would like to offer a model I have used in my practice with great success. Taking from the brilliance of Abraham Maslow, I have created my own Veggie Actualization Model (see page 24) to help address eating behaviour in a safe, progressive, and, dare I say, enjoyable way. Although it may appear a little tongue-in-cheek at first, this model is based on behavioural psychology coupled with my years of experience coaching clients from veggie haters to veggie appreciators.

While the Veggie Actualization Model aims to encourage people to maintain this new veggie lifestyle, it is about process and providing space for clients to learn from their lapses. If life stressors or changes in lifestyle bump clients off the wagon, it is important to get re-oriented even if it means starting again. If a client reaches Veggie Actualization, it is not unlike the termination stage of the Transtheoretical Model of Change.[7] Vegetables become as day-to-day as brushing one's teeth.

It is important to avoid terms such as "good" or "bad" food. Our socio-cultural focus on food has reduced it to mere carbs, protein, and fats, removing all other meaning.

** It is important to understand the unique legal liability that comes with integrating physical activity into clinical practice. Counsellors may want to check with their insurance provider to ensure their current coverage includes physical activity. For example, personal trainers must ask clients to complete a PAR-Q inventory before engaging in an exercise prescription. Considerations may include the current "fitness" of the client (heart health, joint issues, for example) and approval from the client's general practitioner.*



VEGGIE ACTUALIZATION MODEL

1) The first tier introduces the idea of more vegetables in a fun way. All nutritional guidelines have been removed to focus only on the act of choosing, preparing, and eating anything that resembles a vegetable.

2) The second tier focuses on enhancing understanding of serving sizes.

3) The third level expands vegetable awareness and skill building.

4) The fourth tier focuses on maintaining this new veggie lifestyle.

5) The client reaches the final tier when vegetables are part of their lifestyle without much thought or challenge.

CASE STUDY ONE: KEVIN

Kevin and his wife were going through marital difficulties. Initially, he wanted his wife to join him in couples counselling, but she declined so he pursued individual counselling. During our first session, Kevin verbalized his interest in strengthening his mental and physical health. With a greater sense of quality of life, he hoped he would perceive his marriage and spouse in a more positive way.

After a few sessions, it became clear there were certain components of health Kevin was not comfortable in pursuing yet. He had a history of emotional eating and suffered from a negative body image and low self-esteem. He wasn't ready to address his using food to cope, but he was interested in discussing how he might integrate walking into his day.

After discussing the benefits of walking, Kevin created a plan to invite his wife to join him for an evening walk. Over the course of a month, Kevin and his wife took brief walks while enjoying some talk time away from the kids. He found his wife responded more positively to talking while walking rather than sitting across from each other. In addition, making the appointment with his wife to walk kept Kevin on track and motivated to continue. However, after that initial month, the walking habit fell by the wayside, and it became clear that Kevin needed something he could do independently.

Because Kevin seemed disinclined to walk alone, rather than push physical health, I explained the five components of health — social, physical, intellectual, spiritual, and emotional — and addressed the benefits of each. I asked him to choose a component he felt would be easiest to address. He chose spiritual health, which I defined as a

connectedness with self, others, a higher power, and nature and which provides us with the capacity to love and forgive and enhances our sense of fulfillment. We agreed that Kevin would write in his journal two things he was grateful for each day. Our discussion of this new exercise included appropriate time and place to write, as well as potential barriers. Research suggests that the practice of gratitude may have a positive effect on perceived physical health, and by listing what we are grateful for, we are able to shift our perspective of lack to abundance. So while Kevin was unable to maintain the walking habit on his own, he has stuck to his spiritual health goal and feels an elevated level of appreciation and is better able to focus on the positive.

CASE STUDY TWO: CAROLE

Carole was struggling with obesity and had the opportunity to undergo bariatric surgery as long as she could demonstrate to her medical team that she was making changes to her diet. After visiting a registered dietitian nutritionist, she came to me for help putting the plan into action. Not only did Carole find the change in eating habits daunting, but she also had the added challenge of finding a menu her children and husband would appreciate.

I soon learned Carole worked in a demanding job, had two children in secondary school, and typically opted for processed and fast foods due to her schedule. She enjoyed her evening snacks and feared she wouldn't be able to make the switch to vegetables.

Carole's mission was clear — preparing for possible surgery — and we used our time together to examine her relationship and history with food, her fears of letting go of comfort foods, and how she may feel about eating as a result of bariatric surgery. At the same time, I integrated the Veggie Actualization Model to help her (and her family) get more acquainted with vegetables.

Sometimes making changes to the most difficult aspects of health behaviour (i.e., eating more vegetables) comes easier if the other components of health are attended to and in balance with each other.

The first step and its suggestion of slathering broccoli with cheese sauce not only shocked (and delighted) Carole, but helped her create a menu that met her family's approval. For the first few months, we addressed the challenges and barriers to this first step, such as fatigue and lack of time. Together, we restructured action plans to include frozen vegetables (less preparation and just as many health benefits) and advanced meal preparation. From there, we worked up the hierarchy until Carole would come to a bump in the road and, together, we would find alternatives.

When Carole reached Veggie Diversification, her interest in vegetables and how to prepare them really took hold. We began a "veggie of the week" program wherein Carole and her family chose a new vegetable and would seek out a way to prepare, cook, and enjoy it together. As you can imagine, this exercise not only inspired a greater appreciation for vegetables but also connected the family. Currently, Carole is stabilized at Veggie Continuation. When times are stressful and she slides into old behaviours, she now has the skills and understanding to get back on the wagon.

I believe, as probably most of us do, that to be effective clinical counsellors, we have to consider all aspects of health in our practice and in our own lives. I also believe that, over time, the lines between health promotion and clinical counselling will blur. Until then, the work may be focused on creating the appropriate guidelines that respect all scopes of practice, while providing clients with a more holistic therapeutic experience. ■

Kathi Cameron, MA, RCC, works as a health promotion educator with Canadian Forces Base 19 Wing and as a clinical counsellor with Pacific Therapy and Consulting in the Comox Valley.
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TO WANDER AND WONDER

How six months abroad became less of a counselling sabbatical and more of a counselling education

BY JESSICA FERGUSON KING, RCC

Travel has the remarkable ability to jolt me into direct experience where empathy, authenticity, connection, and community are brought to the forefront. Without my typical routine, I find myself organizing my time and energy using my heart versus my mind. Without the ease of a common language, I rely on non-verbal cues and default to smiles and humility. Without my bearings, I trust in the knowing of others and seek out spontaneous interactions. Without a sense of competency, I enter into new experiences with an open mind and a humble and curious attitude. I recalibrate in unfamiliar settings. I adjust and adapt through a process of noticing, feeling, sensing, processing, and largely accepting. While these skills have the remarkable ability to emerge naturally and often out of necessity when travelling, I consider it important to develop and sustain them consciously throughout my work as a counsellor and in life in general.

My travel reflections continue to percolate and develop into integral guiding principles within my counselling practice and life at home. Travel has a profound impact on my own life journey.

TRAVEL. A Google search for the definition of the word yields many results.[1] Distilled to a single definition, something akin to "to take a journey" remains. In the conventional sense, travel is often associated with traversing a distance or changing geographic location. If expanded to include the figurative, the metaphorical, the definition is more fluid. Parallels between journeys taken as a traveller and other types, including personal, professional, or the change and process journeys embarked on by clients, can be explored.

I appreciate that travel, daily life, and counselling skills are often discrete. When I resigned from counselling work to embark on six months of backpacking travel in Southeast Asia and Japan, I was not anticipating integration. I foresaw a dichotomy of experiences in which I would leave work and my typical day-to-day existence to engage in travel, then return from travel to re-engage in work and life responsibilities. I anticipated travel would enhance future counselling work and reinvigorate other aspects of my life through feeling refreshed and rejuvenated, courtesy of a change in scenery and an extended break from

TRAVEL ENHANCES MY ABILITIES AS A COUNSELLOR THROUGH EXPANDING MY UNDERSTANDING, APPRECIATION, AND GRATITUDE FOR GREATER HUMANKIND.

routine. Pre-departure, travel was to be a counselling sabbatical. Post-return, it was apparent that it was an integral component of my counselling education with continued profound impact.

I discovered that skills acquired and strengthened through travel experiences congruently enhanced my abilities as a counsellor. I should not have been so surprised. Counselling is a unique profession in that I am essentially my own tool. There is an inherent salience between work and life and between related skill development and growth. I have the privilege of connecting with inner worlds in a way that few are privy to. Whether I am witnessing, listening, empathizing, or attuning, I consider it a process of unending curiosity, filled with twists and turns and constant sources of surprise, of joy, of sorrow. Through my clients, I learn of countless life paths and hear limitless narratives. I can be taken to new places, experience new heights or depths, and imagine new possibilities. I often have the sense that the world entered into during a session by counsellor and client is much larger than the office confines. In this sense, I am always a traveller; I am always on a journey.

The following passage comes from one of my more serendipitous used-

TRY IT OUT!

SUGGESTED STRATEGIES FOR TRAVEL SKILL-COUNSELLING SKILL INTEGRATION

TRAVEL SKILL	CULTIVATE WITH COLLEAGUES	CULTIVATE WITH CLIENTS
DIRECT EXPERIENCE	Take extra time to connect with colleagues. Eat your lunch in a different place. Get outside during your work day.	Normally take notes during session? Put the notepad down. Have a present-focused session. Engage in an experiential intervention.
EMBRACE NEW OPPORTUNITIES	Volunteer on a board for an organization you are passionate about. Learn about a different theoretical orientation. Watch a free webinar on a topic outside of your comfort zone.	Encourage your client to explore additional resources (drop-ins, groups, workshops, extracurriculars).
WIDEN YOUR PERSPECTIVE	Ask to present a case during peer consultation or supervision and hear your colleagues' conceptualizations.	Engage your client in creating a family genogram or life timeline.
OPEN AND NON-JUDGMENTAL ATTITUDE	Make a concerted effort to listen more and speak less at the next team meeting. Visualize leading with your heart versus mind. Explore assumptions and judgments you may be bringing to the office.	View an existing client with refreshed curiosity. Imagine you are meeting them for the first time. Encourage your client to explore their relationship with "jumping to conclusions."
THE POWER OF NON-VERBALS	Reflect on your body language at work. Do you appear rushed? Relaxed? Busy? Approachable? Visualize how you would like to appear to others and set your intention.	Think back to your counselling internships where you likely had to record sessions. Consider recording yourself in a current session and review with the sound off. What do you notice?
SELF-AWARENESS	Engage in clinical supervision and explore the topic "The Use of Self." Reflect on your current level of self-care and ensure your own needs are being met.	Begin and end sessions with a regular 'check-in' and 'check-out' process. Consider introducing a scaling question or a body-scan visualization as part of this practice.

bookstore finds and offers an eloquent rumination on the power of travel:

Often I feel I go to some distant region of the world to be reminded of who I really am. There is no mystery about why this should be. Stripped of your ordinary surroundings, your friends, your daily routines, your refrigerator full of food, your closet full of your clothes—with all this taken away, you are forced into direct experience. Such direct experience inevitably makes you aware of who it is that is having the experience. That's not always comfortable, but it is always invigorating... I eventually realized that direct experience is the most valuable experience I can have... travel has helped me to have direct experiences. And to know more about myself. [2]

I return to these words to reconnect with the values that are highlighted naturally through travel and that can be part of any journey, personal or professional.

The following scenarios are snapshot memories pulled from a repertoire of travel experiences. There are consolidated recollections where once stressful experiences fade into the best kind of stories, tinged with humility and humour. There are perspectives captured in vivo through volumes of detailed travel journals, completed near daily and diligently. There are hard drives and memory sticks full of photos. There are grainy phone videos, emails, postcards, and souvenirs. There is a well-worn backpack, flip flops which outlasted the most liberal estimate of lifespan, and a collection of bug repellant that would likely impress the most seasoned of exterminators. And most important of all, less tangible but nonetheless ever present, there is a repertoire of strategies; a skillset honed and developed that accompanies me on every kind of journey, whether at home, at work, or afar.

SNAPSHOT MEMORIES

As I open the door and step outside, a bucket of ice cold water is emptied on my head from several floors above. I knew this was a possibility but still find myself stunned and now also incredibly soaked. I look up to see how this event may have transpired and am greeted with three wide smiles, waving arms, and choruses of "Happy New Year."

YANGON (RANGOON), MYANMAR (BURMA)

I am napping on a sun-warmed rock face when a phone screen appears in front of my face. "Look at what was in our bathroom!" exclaims my husband. My freshly opened eyes focus on what looks like a picture of a green snake. That can't be right so I rub my eyes, blink, and look again. Yes, it is definitely a snake, approximately five feet long. "Apparently, it shouldn't be too much of a problem because it was off the ground when I saw it. That should mean it's a tree species, which should mean it's non-venomous," my husband continues, these newfound wildlife facts offering little comfort.

KOH TAO, THAILAND

I begin to realize the boat has not moved for a while. Then I notice the captain is not in his usual spot. In fact, he is no longer even on the boat. I spot him perched on a floating tree that blocks the river passage, hacking at the thick trunk with a machete. Yesterday, I learned about the origins of this body of water's name, how the surface of "Black River" reflects like a mirror, making the water appear incredibly opaque. I also learned of the crocodiles that teem in its murkiness with crocodile-to-human in-water approach time estimated at under two minutes.

BORNEO, INDONESIA

My relationship with travel remains one of gratitude and awe. It contributes to a deep sense of fulfilment, ongoing curiosity, and an ever-expanding global perspective, and it lends itself easily to an inherently mindful way of being. Travel invites continued opportunity to embrace diversity and reinforces the value of direct experience. It increases self-awareness and interactions with others. Travel enhances my abilities as a counsellor through expanding my understanding, appreciation, and gratitude for greater humankind. This perspective can be heightened through travelling to far-away locales, though it can also be practised at home, through connecting with colleagues or clients. I believe this skillset is an important part of counselling work and a significant component of existence. Travel offers a catalyst for growth. ■

Jessica Ferguson-King, RCC, has worked in non-profit community agencies and research institute settings in B.C. and Ontario. She engages with individuals and families in various therapeutic contexts, most recently providing counselling to Syrian refugee families new to Canada. jfergusonking@gmail.com

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POLYAMORY IT'S NOT CHEATING

BY CAROLYN CAMILLERI

An increasing number of people are in committed relationships that ethically and consensually include other people — and it is not the same as adultery and it is not just an open relationship. Polyamorous relationships are often ongoing and emotionally involved and based on a set of very clear, mutually agreed-upon terms, ethics, and shared responsibilities.

Constance Lynn Hummel, RCC, says there's a joke among counsellors who work with members of the poly community: "If monogamous couples were as clear about expectations, boundaries, and communication as poly couples, we'd go out of business."

She explains that in monogamous relationships, there is often an unspoken (and unconscious) set of rules and expectations that each partner assumes the other will follow when it comes to "being monogamous," even though the definition of being in a committed, monogamous relationship is different for every person. For example, one partner

These can be very serious, committed relationships, in which emotional maturity, self-awareness, and empathy are paramount.

may think it is not okay to have drinks with a colleague of the opposite sex after work, while the other partner thinks it's fine as long as they're not having sex.

"With poly clients, there's no room for assumptions," says Hummel. "Communication and boundaries are key. Partners must get clear on, 'How would you feel if I did this, and would you be okay with that' and 'Yes, in this context but not in that context.' It's about really getting explicit about expectations and being clear about your own needs and values."

"People outside of the poly community often have many preconceived notions, like thinking people who are poly can't handle a relationship and are just out to have sex with every person they see, when in fact, these can be very serious, committed relationships in which emotional maturity, self-awareness, and empathy are paramount," says Hummel.

Helping People Get Clear

When clients come to see Hummel for poly-specific reasons, the sessions may focus on establishing the terms of their unique relationship and determining what is and isn't permitted — essentially the relationship code of ethics — which can be incredibly complex and nuanced, particularly the more people involved. Each relationship is entirely unique that way.

"Often a big piece of the work is really helping clients think it through," she says. For example, "You're saying you want to open up your relationship to other partners — What would that really mean for you? Do you want the power to approve the other person's partners? Do you even want to meet the other person's partners? Do you want them to be able to have completely separate relationships, or do you want them to be somebody that gets brought in and is maybe known to you as a couple? What happens if both (or multiple) partners get sick on the same day? Who do you take care of first?"

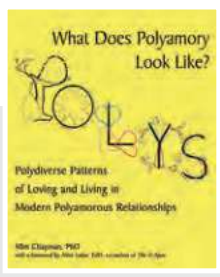
Hummel says that sometimes during the process of really thinking about it, people realize they like the idea of having multiple partners, but in practice, it is more complicated than they bargained for — there is so much more to this relationship structure than just being allowed to have sex with other people.

"It's different than an open relationship," says Hummel. "In an open relationship, there is also consent required by both partners, but there is usually no ongoing emotional relationship with the other person, and contact is generally limited to specific sexual activity with someone outside the existing relationship but nothing else."

Being open and vulnerable with one partner is hard enough; it is a delicate balancing act when multiple partners' needs and values must be taken into account.

But polyamorous relationships are different because they allow for an emotional connection outside the primary relationship and that can open up old attachment wounds. Being open and vulnerable with one partner

POLY RESOURCES



WHAT DOES POLYAMORY LOOK LIKE? Polydiverse Patterns of Loving and Living in Modern Polyamorous Relationships

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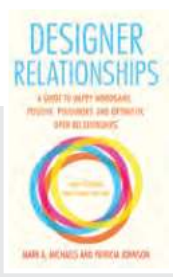

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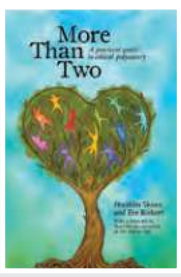

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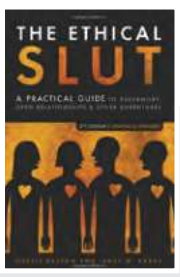

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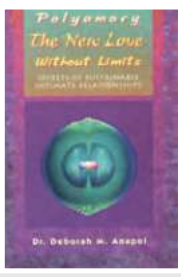


POLYAMORY: The New Love Without Limits: Secrets of Sustainable Intimate Relationships

by Deborah M Anapol. Intinet Resource Center, 1997.

is hard enough; it is a delicate balancing act when multiple partners' needs and values must be taken into account. Hummel says people in poly relationships must be honest with themselves and their partners about what will and won't work for them and be checking with each other every step of the way.

"Often people don't know something is a trigger until they've run head first into it," she says. "You can only prepare so much for the unknown."

From a therapeutic perspective, Hummel says you have to be watching for coercion and true consent of both partners. An example of coercion may be if one partner is going along with a poly structure because they are afraid of losing their partner. "This is not true consent. This is consent under duress," she says. "There's no safety in the primary relationship if you're saying, 'I'm halfway out the door. Do this or I'm gone.'"

Hummel adds that in her experience, couples that are trying out a poly arrangement as a last-ditch measure to save a struggling relationship are seldom successful. "In those cases, it's usually the fastest way to blow that relationship out of the water. For some people, it becomes just a bridge to getting out."

For it to be successful — and Hummel has seen many successful examples — there has to be unwavering commitment to honesty, communication, and respect, even when it is hard and messy. While she acknowledges that there are several schools of thought on what constitutes a true polyamorous relationship, mainly because the terms of the relationships can vary so widely, Hummel has observed that stable poly relationships seem to be those that put their primary partners first.

"From a therapeutic standpoint, I believe there has to be a primary partner who comes first, no matter what, in order for the relationship to be maintained in the long-run. The more secure the primary relationship is, the more they can manage the anxiety evoked while exploring secondary relationships, because it's

MUST-WATCH FILM

ORGASM INC.

Award-winning director Liz Canner's documentary *Orgasm Inc.* (2009) features the filmmaker working as an editor of erotic videos for use by a pharmaceutical company doing a drug trial. The company is developing a Viagra-type drug for women afflicted with Female Sexual Dysfunction. Canner's original plan was to focus the film on science and pleasure, but soon began to suspect her employer's motives. Canner refocused her attention and *Orgasm Inc.* became a documentary about the medical and pharmaceutical industry, the marketing campaigns, and the pursuit of profit. Described as both shocking and hilarious, the film has been shown around the world and has received numerous awards.
www.orgasminc.org

COUNSELLING LGBTQ/2S CLIENTS

INCREASE YOUR KNOWLEDGE AND UNDERSTANDING OF RELATIONSHIP DIVERSITY AND THE CHALLENGES FACED BY THE LGBTQ/2S POPULATION.

Qmunity is a Vancouver-based non-profit organization that works to improve queer and trans lives, provide a safer space for LGBTQ/2S people and their allies, and empower all to be their best selves.

In addition to counselling and support, including youth support, Qmunity offers consulting and training for individuals, service providers, and organizations to help them understand how best to make services more welcoming to local LGBTQ/2S communities.

A variety of resources is also available at their website. Of particular interest for this issue of *Insights* magazine, check out *Supporting LGBTQ Folk Experiencing Relationship Abuse* and *Safety in Relationships for Trans Folk*, both of which were developed by Qmunity in partnership with the Legal Services Society and are available for download at http://qmunity.ca/learn/resources/.

known, if push comes to shove, they are emotionally safe with their primary partner."

Preventing Bias

But poly clients are not always coming into counselling for poly-specific reasons and counsellor bias can be a challenge for them. Just because someone is in a polyamorous relationship doesn't mean all (or any) of their issues stem from that, and this assumption can sometimes prevent clients from getting support for other concerns. Hummel says many of her poly clients are happy with their relationships and really just want to address their anxiety, depression, parenting concerns, or their struggles at work or in other relationships, etc. When counsellors assume a poly relationship is the source of all issues, or keep bringing conversations back to their multiple partners, it can be a frustrating and invalidating experience for clients.

As with anything else, if counsellors plan to work in this area, it is the counsellor's job to educate themselves about this relationship structure, the community, and its culture, as well as to explore any personal biases that may impede work with this population.

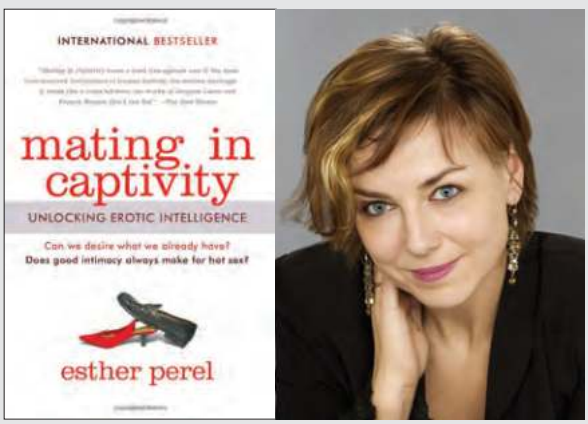
For counsellors with polyamorous clients, Hummel says it's like dealing with any other client situation — the relationship is only a problem if the client says the relationship is a problem — otherwise, focus on what your client wants to work on. If the relationship is actually an issue, with time and trust, it will come up on its own.

"The poly community is very much its own culture. It has its own rules. It has its own norms," says Hummel. "However, people who identify as poly are also just everyday people. They identify as all genders and sexual orientations. They come from all backgrounds. They are loving parents. This is not acting out or proof there is something wrong. I would say most of the people who are actively involved in the poly community are highly aware of their 'stuff' and have done significant amounts of healing and personal development work. As with any group of people, some members may have trauma histories or were abused and that would need to be addressed, but that's not necessarily connected to why they have chosen to be polyamorous."

"I think that's the key: poly relationships are really no different than any other type of relationship — sure, they're more complex — but at the end of the day, it's just a relationship with more people trying to find love, be heard, and be seen."

Constance Lynn Hummel, MA, RCC, is a psychotherapist and leadership coach in private practice. She specializes in relationships, sex therapy, and substance addictions and provides case consultation for therapists and wellness professionals working in these areas. www.constancelynn.com

Esther Perel Rethinking Infidelity



The *New York Times* called her "the most important game changer on sexuality and relationships since Dr. Ruth." Esther Perel is one of the world's most respected voices on the topic of intimate relationships.

Mating in Captivity: Unlocking Erotic Intelligence (Harper Paperbacks, 2007), Perel's landmark book, explores the "paradoxical union of domesticity and sexual desire" and was translated into 25 languages.

Her TED Talks, *The Secret to Desire in a Long-Term Relationship* (February 2013) and *Rethinking Infidelity... A Talk for Anyone Who Has Ever Loved* (May 2015) have collectively reached over 17 million viewers.

The Belgian native is a practising psychotherapist in New York, speaker, and consultant. From her website: "Couples therapy is probably the hardest type of therapy to be in and to practise; and I have been on both sides. In my work as a therapist, I see despair, entrenched patterns, loneliness in the presence of another, contempt, violence, lack of any physical touch; so many couples come to me way beyond due date. I learn, daily, how to master the art of couple therapy." www.estherperel.com

10 CRITICAL DIMENSIONS

The Infidelity Recovery Institute has a number of resources for counsellors and their clients. One you may find useful is a free, downloadable, client-directed handout called *10 Critical Dimensions*. While it was originally developed for people experiencing infidelity challenges, it is mainly focused on strengthening a committed relationship and could be a useful tool for any couple seeking relationship help.

1. Emotions
2. Romance
3. Responsibility
4. Companionship
5. Appreciation
6. Trust
7. Family Relations
8. Intimacy
9. Sex
10. Letting Go

Each section includes details on what each dimension means, as well as a list of questions to prompt deeper thinking and suggestions to encourage positive change.

The 10 Critical Dimensions handout is available under Free Tools at www.infidelityrecoveryinstitute.com.

HOW TO GIVE A GOOD APOLOGY

BY KIM BOIVIN, RCC

Knowing how to effectively apologize is one of the most important skills we can develop in life. It has a huge effect on our overall quality of life.

When I work with couples, I get to see how people give and receive apologies. I get to see the kinds of apologies that don't work and may do further damage, and I also get to see apologies that work and create more closeness and bonding.

As counsellors, often it's a key part of our job to help couples learn how to give and receive good apologies and to experience their healing benefits. When we receive a good apology, we know it. It's like we have a built-in system in our bodies, hearts, and brains that recognizes a good apology. We feel acknowledged, and we feel relieved.

While helping our clients learn better apologizing skills may be a positive part of therapy, as counsellors, we can also benefit from honing these skills in our own lives.

WHAT A GOOD APOLOGY LOOKS LIKE AND SOUNDS LIKE.

A good apology is heartfelt, sincere, and deep. It is given with eye contact that is soft and body language that is open. The words are said in a soft/gentle, slow way. It's obvious through this body language, tone of voice, and the words used that the person feels remorse and feels the hurt the other person feels. While the words "I'm sorry" are offered, they are offered along with the following:

- Acknowledgement of wrongdoing (in a specific way)
  "I should not have reprimanded you in front of everyone."
- Acceptance of responsibility (no blame or defensiveness)
  "It was unprofessional of me to speak to you as I did."
- Expression of remorse and empathy
  "It must have been very upsetting for you, as well as for the others present."
- Offer of compensation (that is meaningful to the receiver)
  "I will acknowledge and apologize for my behaviour at today's meeting."
- Communication not to repeat the transgression in the future
  "In the future, I will address any concerns I have constructively and privately."

Sometimes, it helps to write your apology in a card, and then sit and read it aloud to the one you've hurt.

We can see that a good apology offers much more than "I'm sorry." It helps to recognize offering a good apology is a process involving multiple steps. Sometimes, depending on the transgression and the damage done, a good apology needs to be offered more than once.

Initially, learning to make good, effective apologies may seem like a daunting process — for clients and counsellors alike — because it means taking the (sometimes very) difficult step of sincerely accepting responsibility for the transgression and deeply understanding how that transgression was felt by the other person. But the benefits of a good apology are felt immediately by both the giver and the receiver, and the relationship is all the richer for it.

HOW TO APOLOGIZE APPROPRIATELY

"I'M SORRY" IS NOT ALWAYS GOOD ENOUGH

The secret ingredient to offering a sincere apology is **INTENTION**.

FOLLOW THIS FOUR-LINE FORMULA

1	I'M SORRY FOR...	1
2	I WAS WRONG BECAUSE...	2
3	IN THE FUTURE, I WILL...	3
4	WILL YOU FORGIVE...	4

HOW TO SAY SORRY IN SIX SIMPLE STEPS

1. Apologize before it's too late.
2. Examine the situation.
3. Realize the hurt you caused.
4. Take charge for the damage.
5. Make sure to seek forgiveness.
6. Promise it won't happen again.

APOLOGIES THAT DON'T WORK

Non-apologies dressed up as apologies do nothing to repair and can even make an uncomfortable situation worse.

- ▷ I'm sorry, okay!
- ▷ I'm sorry but...
- ▷ I'm sorry if you feel...
- ▷ I hope you don't feel...
- ▷ It wasn't my intention to...
- ▷ If you hadn't _____ then I wouldn't have_____
- ▷ Look, I said I was sorry!
- ▷ I'm sorry but that's your perception.
- ▷ And of course, not saying anything at all and expecting it to be a "given" for the person to know you're sorry is not an apology.

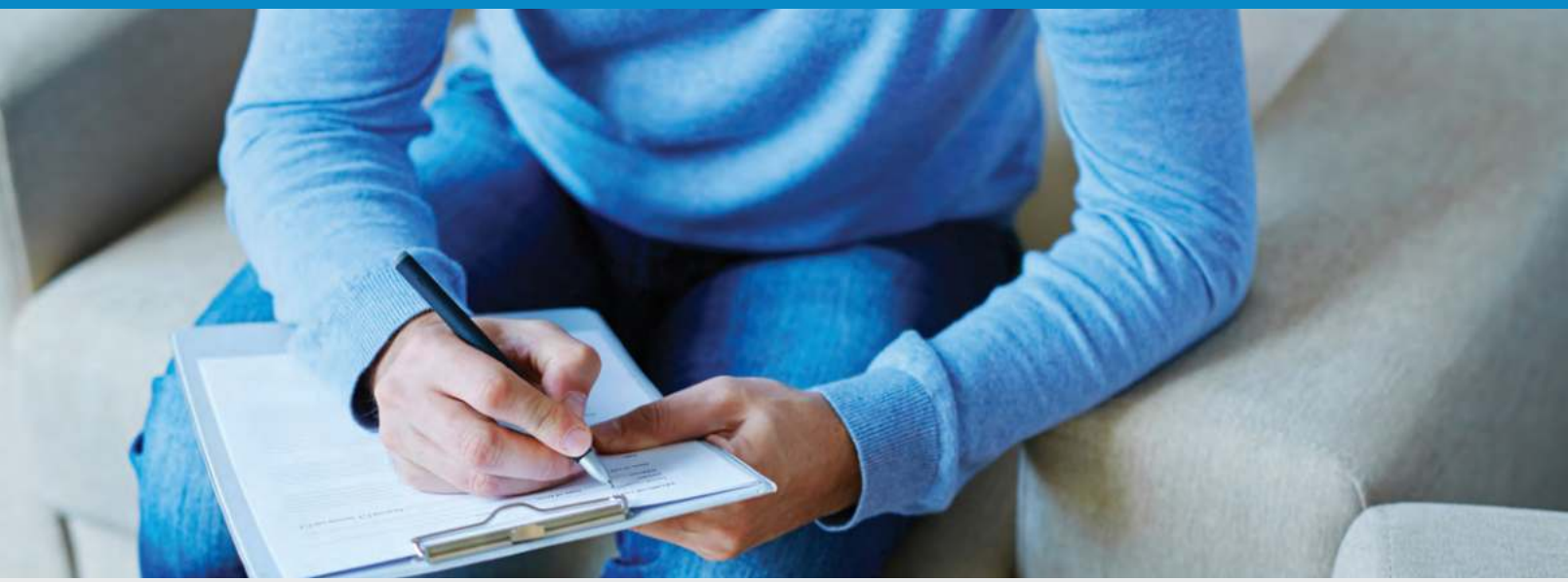
Kim Boivin, RCC, is CEO of Positive Change Counselling in Vancouver. Since her own first therapy session at the age of 13, she has been passionately engaged with emotional, mental, and relationship health.

RESOURCES

http://national.deseretnews.com/article/4226/the-process-of-a-heartfelt-effective-apology.html

Hold Me Tight by Dr. Sue Johnson (Little, Brown, and Company, 2008)

DID YOU KNOW?



Right now ANYONE in British Columbia can claim to be a counsellor.

FACTBC thinks this needs to change.

BRITISH COLUMBIANS DESERVE BETTER.

Citizens need to be protected, services need to be accessible, and counsellors need to be accountable. Associations like BCACC do all they can to ensure high standards and client safety, but can only do this for registered members. Only a regulatory college has the authority to regulate anyone claiming to be a counsellor whether they are an association member or not. A regulatory college of counselling therapists will serve the needs of British Columbians and ensure counsellors are qualified to help people in need.

ABOUT US

The Federation of Associations for Counselling Therapists in BC (FACTBC) is the unified provincial voice of our member associations as we pursue the development of a College of Counselling Therapists to protect British Columbians.

We are a society of 12 professional associations that collectively represents more than 5,000 counsellors and therapists practicing throughout British Columbia.

OUR ADVOCACY

We have been advocating for a regulatory college for years and recently asked counsellors across B.C. to help us by contacting their local MLAs directly. More than 200 supportive emails have been sent to MLAs throughout B.C. but we still do not have a firm commitment to make the regulatory college a reality.

WANT TO GET INVOLVED?

If you would like to advocate for increased public protection, accessibility, and accountability of mental health services, contact FACTBC Lobby Coordinator, John Gawthrop (jcgawthrop@gmail.com).
Or if you want more information, check out our website (www.factbc.org).

FACT BC

The Federation of Associations for Counselling Therapists in British Columbia

WHY SHOULD YOU JOIN THE BCACC?

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

Be Recognized

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

Save Money

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

Grow Community

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

BCACC

BC ASSOCIATION OF CLINICAL COUNSELLORS

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