WINTER 2017

INSIGHTS

THE BC ASSOCIATION OF CLINICAL COUNSELLORS' MAGAZINE

Recognizing and Treating Disenfranchised Grief

On Death and Dying: The Role of the Counsellor

Recovering from Tragedy

The Sounds of Healing

PATHWAYS TO RECONCILIATION

WORKING TOGETHER TO ADDRESS ISSUES IN INDIGENOUS COMMUNITIES

Fighting fires and promoting mental health for first responders

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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.

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CONTENTS WINTER 2017

30 The Sounds of Healing

Since the 1950s, music therapy has been expanding. Today, there are 1,000 music therapists certified by the Canadian Association of Music Therapists.

FEATURES

8 ON DEATH AND DYING: THE ROLE OF THE COUNSELLOR An overview of this highly specialized area of the counselling field.

14 DISENFRANCHISED GRIEF Recognizing and treating grief resulting from losses that may not be validated or supported.

20 RECOVERING FROM TRAGEDY A demonstration of how Worden's TEAR Model of Grief is reflected in one counsellor's personal experience with tragedy.

24 PATHWAYS TO RECONCILIATION Working together to address issues in Indigenous communities from a culturally appropriate, Indigenous perspective.

IN EVERY ISSUE

4 Check In
News, events, and information

6 Member Profile: Matthew Johnston Fighting fires and promoting mental health for first responders

34 Plugged In
Counsellor safety and the Rewarding Change Group

38 One Last Thing
Self-care for counsellors

INSIGHTS

THE BC ASSOCIATION OF CLINICAL COUNSELLORS' MAGAZINE

The Insights *team wishes to thank the writers who contributed to this edition of our magazine:*

Thank you!

Devan Christian, Tara Field, James Logan, Jasmine McMurray, Coral Payne, Harkamal Sangha, Susan Summers, Tricia Toth

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

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

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NANAIMO'S WALK-IN COUNSELLING CLINIC

Since last February, adults in Nanaimo who are struggling with urgent issues have had a place to go to talk with a counsellor — for free. The Harewood Counselling Walk-In Clinic at Georgia Avenue Community School in Nanaimo opens every Monday (except holidays) from 4 to 8 p.m. The goal is to help adult clients turn their crisis or urgent matter into an opportunity for positive change in a single 40-minute session.

Ian Gartshore, RCC at Island Integrated Counselling Society (www.islandintegrated counselling.com), says they started out offering sessions on Fridays, but have found Mondays better. "Still not much in the way of clientele," he says, but adds that the board is now helping to promote it. The clinic, which is run by volunteer practicum students and community therapists, offers free counselling for up to four clients each Monday. After an initial session, clients can return for one brief session; longer-term therapy is referred to Island Integrated Counselling. "Its biggest problem is it's open only one day a week. It's hard for people to remember that," says Gartshore. "One big take-away is that it should be open for two to three days a week."

Restorative Justice: **Carys Craig's Personal Account**

When Vancouver-based RCC Carys Craig was just 11 years old, her father was brutally murdered in his Calgary home by an intruder. Twenty years later, and despite the reservations of her family and friends, she started writing to the murderer in prison. The two corresponded for a period of two years and then met.

Published in November, *Dead Reckoning: How I Came to Meet the Man Who Murdered My Father*, is Carys Craig's account of the experience and what she learned about the murderer's life and the crime. Her book illustrates how at-risk youth slip through the cracks to enter criminal lifestyles, thus increasing our understanding of the forces driving perpetrators of violent crime, and also looks at the principles of restorative — or transformative — justice.

"Unlike the criminal justice system's dominant worldview that focuses on retributive justice — in which an offense against the state results in a punishment — restorative justice focuses on people, relationships, and communities, repairing harm, and making things right for all people involved. Restorative justice looks different for everyone and is highly participatory rather than prescriptive," Carys says.

Asked if perpetrators should be required to learn about the victims of their crimes, Carys says she believes many things should be required of perpetrators of crimes: to account for what they've done, to rehabilitate themselves, and to show compassion for their victims, to name a few.

"But learning about their victims should be under the victim's control, not a systematized rule. That's the thing about crime: power is the first thing taken away from victims of crime — whether it be assault, murder, theft — and in order for our criminal justice system to improve, power must be given back to victims." www.caryscragg.com

DID YOU KNOW?
In August 2017, Mike Farnsworth, the Solicitor General and Minister of Public Safety in British Columbia, announced plans to expand the province's restorative justice system. There are currently 92 restorative justice programs in the province and 32 Aboriginal justice programs applying restorative justice principles.

Fentanyl Checking at Overdose-Prevention Sites

People can now check their street drugs for fentanyl at any of Vancouver's four overdose-prevention sites, the Powell Street Getaway supervised injection service, and Insite. The drug-checking service was piloted at Insite from July 2016 to July 2017. As of August 31, more than 1,400 checks had been done. Overall, 80 per cent of drugs checked were positive for fentanyl, including 84 per cent of heroin samples and 65 per cent of non-opiate drugs such as crystal meth, ecstasy/MDMA, and cocaine. At Insite, clients who got a positive result were 10 times more likely to reduce their dose, and clients who reduced their dose were 25 per cent less likely to overdose. The test is also effective in detecting carfentanil.

There are approximately 1,000 visits to the overdose prevention and supervised consumption sites every day. www.vch.ca/overdose

The Death Positive Movement: For Dear Life

GRANT BALDWIN

The film *For Dear Life*, directed by Carmen Pollard (above left), highlights the support, heartache, and even darkly comic truth of a terminal illness. Here, James Pollard, whose final three years the film follows, is measured for a coffin.

"There's no positive way to talk about someone dying," said Vancouver theatre producer James Pollard, who was given a terminal cancer diagnosis at age 46 and died on May 1, 2016. His cousin, B.C.-based film industry veteran Carmen Pollard, is working to change that.

Over a three-year period, Carmen followed the life and decline of her cousin to create the documentary *For Dear Life*. At once heavy and heartfelt, *For Dear Life*, a Knowledge Network Original, shines a spotlight on the oft-avoided conversations about mortality — particularly the obligations around remaining time spent with loved ones and home care steward roles, not to mention quirky future-proof burial options involving rodent test subjects and liquid clay. The film weaves family interaction, physician visits, and the natural world to confront our deep-seated social taboos around death.

"In our culture, we don't give ourselves permission to simply look at death. This is considered taboo — disrespectful or morbid. But perhaps by witnessing the dying process right through to death itself, we can learn to embrace this universal event as part of our living experience," says Carmen. "My motivation to make this film was to spark much-needed conversation. For this reason, I'm motivated to find opportunities to show the film in public settings so that people have a chance to talk afterward. The Q&As have been very positive."

To further encourage discussion, Pollard is also leading The Shift, a story-sharing project, which invites people to post their own stories and thoughts about death. "There is a quiet death positive movement afoot," says Pollard. "We would love to hear from people and encourage much-needed dialogue and acceptance of death within our culture."

The Knowledge Network premier of *For Dear Life* is scheduled for early March, after which the film will be available for streaming at www.knowledgenetwork.ca. In the meantime, upcoming public screenings are listed at fordearlife.ca. You will also find information on The Shift at fordearlife.ca/the-shift.

HEALING REFUGEE TRAUMA

On October 18, the Vancouver Association for Survivors of Torture and the Vancouver Immigration Partnership hosted a panel on community approaches to healing trauma as part of the UBC Liu Institute's Refugee and Migration Symposium. The panel brought together a variety of perspectives and practitioners to engage the audience in learning about how community organizations develop trauma-informed and trauma-sensitive activities and connections to complement the work they may be doing with therapists and in groups.

Leaders in the refugee settlement sector believe community collaboration and greater service integration is the key to healing trauma. Panelists from a diverse group of organizations participated. Discussions included the importance of having a trauma-informed lens in all systems, from medical care to community programs for youth. Examples of resilience-building programs using art and other approaches to foster a sense of control, connection, meaning, and community involvement include: Pacific Immigrant Resources Society's trauma-informed English classes for refugee women and ISSofBC's peer-based Multicultural Youth Circle, which has partnered with the Dance Centre and Vancouver Art Gallery to offer dance and art classes for refugee youth.

The event was part of After the Flight: Community-University Refugee and Migration Symposium. liu.arts.ubc.ca/event/flight-community-university-refugee-migration-symposium/

SURVIVORS OF VIOLENCE
SOLIDARITY GROUP

Deirdre McLaughlin, RCC, and Stephanie Meitz have spearheaded a weekly gathering designed to bring together and empower all self-identifying women, trans, and non-binary survivors of all forms of violence in Nelson.

Call Deirdre at 250-551-9933

FIGHTING FIRES AND PROMOTING MENTAL HEALTH FOR FIRST RESPONDERS

From athlete, to counsellor, to firefighter, to occupational-awareness educator for firefighters and counsellors — Matt Johnston's career path could make you believe in destiny. More accurately, though, his journey is a reflection of his own determination, adaptability, and self-awareness.

Matthew Johnston, RCC, is the founder of Centered Lifestyle Services, an established author and public speaker, and a full-time professional firefighter in the Metro Vancouver area, who has attended more than 2,000 calls over five years. "A lot of occupational awareness needs to be promoted to clinicians and fire administration staff. That is where my passion lies at the moment."

A track and field scholarship brought Matt Johnston to Simon Fraser University in 1996, where, by his own admission, he was "an athlete first and student second." But the history of psychology caught his interest, which resulted in grades qualifying him to apply for graduate studies at UBC. Not expecting to be accepted, he joined a world-class running group in Australia, where he planned to train for a year. Ten weeks in, he got word that UBC accepted him — and he also achieved a place on the Canadian National Team. After two very busy years balancing grad studies with travelling and competing, he opened his own practice working with children and youth. Though he had retired from competitive running, he ran in local road races, which led to another career shift: firefighting, the profession chosen by many of his fellow runners. Over a four-month period in 2011, he went from having no qualifications for firefighting to being ready to apply for work.

"Becoming a firefighter for me was such a difficult transition in my life that lasted several years. It wasn't the 400 calls per year or sleep issues that made it hard, however, these issues certainly aggravated it. The difficulty came in learning a new language in my mid-30s, having a young family at home to support, and not knowing when I would get hired. The pressure was certainly on, and by the time I got hired, I felt battered and burned out — even before I hit the floor as an active firefighter."

Matt's counselling career is mostly on hold, but over the past two years, he has discovered a way to incorporate his background: helping to address the troubling trend of suicides and serious mental health challenges facing first responders across Canada. He is now working with the BC Professional Fire Fighters Association to develop educational opportunities for firefighters and mental health clinicians, including his course Occupational Awareness Training for Therapists: Treating First Responder Trauma.

"It took me years to reinvent my identity, and this course certainly helped me in finding meaning and coming to peace with the past six years of my life. This is exciting and something I am proud to be part of."

What are some of the challenges first responders face in terms of stress and trauma?

The challenges are significant and multiple. It is no surprise that recent research has shown that psychological disorders are higher among first responders than nearly any other profession. In any paramilitary workplace, there will be situations where the needs of civilians supersede your personal safety and emotional well-being. In addition, the calls can be so be unpredictable, irregular, and

diverse that no amount of training prepares you for all of them. You have to learn to be comfortable in an unpredictable reality. These stressors may be normal in the animal kingdom but don't mesh so well with the modern human mind. Simply put, no first responder will leave their profession unaffected by this reality.

What helps first responders?

Proper stress recovery practices and patience with oneself are the key ingredients for healing from experiences that may be interpreted as traumatic. First responders and mental health professionals alike have to understand that trauma is complex, and even the same call (theoretically, of course) will affect the same person differently on two separate days. This may be the result of personal life stressors, sleep patterns, lifestyle factors, crew dynamics, etc. The potential responsibilities of the first responder are too complex to understand at an intellectual level, so we have to learn to accept "what is"— only then can we free our minds of the judgements we place on what we witness. Otherwise, we are doomed to experience emotional disturbances that make issues in the workplace even more challenging.

There is no doubt that expressive and mindfulness-based practices hold great potential for first responders. However, their integration and expansion into the first responder field is still in its infancy. But we will get there: meditation and yoga trials are happening in firehalls across North America. The irony is that many firefighters have historically done a great job of integrating non-verbal healing routines into their lives in the form of hobbies, athletic involvement, and things such as musical interests. While the profession is changing rapidly, counsellors still have a way to go in terms of packaging expressive-based therapies into a format that will attract first responders.

For civilians who witness tragedies, is the experience different?

The very nature of living in this world is a traumatic experience. With the lack of censorship in the media and online, combined with the frequency of modern disasters, civilians are being exposed to many incidents that only first responders would previously witness. Of course, civilians are not expected to intervene for the most part, but just the visual can leave emotional residue that can last a lifetime.

In terms of counselling approaches, the experience of the first responder and civilian are different. The first responder is wearing emotional armour, has a team of support staff, and is usually armed with the proper equipment to intervene. In addition, a civilian has to call 911 for first responders to show up, so first responders usually do not directly witness the actual accident. This is the complex nature of trauma. If I was to witness a cardiac arrest in a mall while walking with my child, intervening would be much more challenging than being dispatched to the call. It would be like your mechanic driving by your broken-down car and trying to fix it without the tools.

> RECENT RESEARCH HAS SHOWN THAT PSYCHOLOGICAL DISORDERS ARE HIGHER AMONG FIRST RESPONDERS THAN NEARLY ANY OTHER PROFESSION.

What is changing or needs to change to improve the situation for first responders?

The "grin and bear" mentality of fire culture is changing, thankfully. I have been to many training sessions, conferences, and symposiums on this topic over the past few years, and the rooms are filled with engaged firefighters. In my fire service, we eat very healthy meals and find time to engage in volunteering and extracurricular activities with our coworkers. Also, I am proud that over 20 per cent of my membership and their families are accessing mental health services. While I know stigma is still out there, we have been doing very progressive awareness campaigns through the BC Professional Fire Fighters Association and Worksafe in the past year. Firefighters are being taught new courses on how to stay emotionally healthy. Resilient Minds is a new course that started unfolding in fire departments throughout the province in 2017. For counsellors, I have developed a course in conjunction with the BC Professional Fire Fighters Association titled "Occupational Awareness Training for Therapists." We offered the first course last October to a full house and will be offering it in Vancouver and on Vancouver Island in 2018.

I have three goals for this important new chapter in the relationship between counsellors and first responders:

1) To destigmatize reaching out for support among first responders

2) That when a first responder does reach out, the individual in the other chair has had some formalized training in understanding first responder culture

3) That every first responder's extended health plan in the province recognizes Registered Clinical Counsellors for coverage

First responders need regular access to a counsellor of their choice in a part of town that works for them. It is my hope to be part of leading the way in educating chiefs and employers about mental health. ■

ON DEATH AND DYING

The Role of the Counsellor

BY TARA FIELD, RCC

Are you considering becoming a palliative counsellor? Tara Field has worked with thousands of individuals and families facing the most life-altering and confusing challenges of their lives, including terminal illness, sudden death, and Medical Assistance in Dying (MAiD). Here she provides an overview of this highly specialized area of the counselling field.

Counselling the dying is unlike other forms of therapy as its purpose is to support clients through a natural part of life rather than a mental, social, spiritual, or financial issue. At the same time, these issues can be, and often are, also present with the dying.

Death is an event that nobody can avoid, but conversation around death is often avoided. When facing death becomes unavoidable — for example, for people in palliative care — holding space for the dying offers them an opportunity to explore, express, and resolve thoughts, feelings, and experiences in a way they ordinarily cannot.

Counsellors who wish to support the dying and their support networks require a unique set of skills, experience, and knowledge, as well as strong self-awareness and empathy. Beyond the ability to create trust, safety, and connection with clients, palliative counsellors must also possess the ability to journey into the darkness with their clients without living there themselves. Sometimes it means hearing the details of illness and failed treatment. Other times, it is riding the roller coaster of hopes and disappointments with clients. The best of times involve witnessing clients as they transition emotionally from the hope of a cure to the hope for a comfortable life before a peaceful death. More challenging times involve supporting clients who are never able to find peace at the end of their lives. Everyone journeys through their dying time in their own way, and the role of the counsellor is to support their clients' goals without being attached to outcomes or influencing their paths.

SOME REALITIES

Counselling the dying is unique in specific ways, and there are certain realities to consider. One reality is the limited time for therapeutic work to take place: often, this time frame is unknown and unpredictable. Not only is a more imminent death a reality, the ability for the dying to cognitively, energetically, and physically participate in counselling is limited. Symptoms and medications can alter capacity, so counselling may need to be brief and focused. When time is of the essence, having a high level of comfort with the reality of death can help a counsellor establish rapport earlier in the relationship.

Another reality is that counsellors often need to meet clients where they are — emotionally and physically. They may be expected to conduct sessions in hospital wards, private homes, residential facilities, clinics, hospices, or even in public places. Some counsellors only work with individual palliative clients, while others also work with families, caregivers, and/or communities. Some work privately, while others work as integral members of multi-disciplinary teams.

Palliative counsellors are often asked to counsel the dying until and including the moment of death. This may pose a challenge for counsellors who are uncomfortable with the reality of death in general. Moreover, a counsellor who is uncomfortable with assisted suicide and euthanasia will face challenges if a client chooses Medical Assistance in Dying (MAiD). For those reasons,

training and supervision are important. A large part of palliative care education involves discovering, exploring, and resolving our own histories, philosophies, and emotions around death (see training page 13).

WHAT ELSE TO BE PREPARED FOR

Counselling the dying is unlike other forms of therapy as its purpose is to support clients through a natural part of life rather than a mental, social, spiritual, or financial issue. At the same time, these issues can be, and often are, also present with the dying. A counsellor's ability to prioritize a client's concurrent issues within the framework of palliative care is important. The opportunity to tackle end-of-life concerns may be impeded by more pressing challenges and limitations.

Those who are dying experience anticipatory grief — encountering emotional, physical, cognitive, and spiritual reactions to the consecutive losses they undergo throughout illness. These reactions can be intense and include anger, denial, fear, and despair. A solid understanding and familiarity with the grief process is crucial for palliative counsellors. Humanistic, existential, and behavioural therapeutic approaches — including mindfulness-based stress reduction, family systems, and relaxation techniques — are commonly used when counselling the dying.

Palliative care moves away from primarily focusing on the physical care of the dying and toward physical, psychological, and spiritual care of the dying and their support network. The counsellor's role is to support the dying to complete practical and emotional unfinished business, explore their thoughts and feelings, say their goodbyes to friends and family, and find comfort in their finals days. Counsellors

GRIEF RESOURCES

BY CORAL PAYNE, RCC

BC Bereavement Helpline: A non-profit, free, confidential service that connects the public to grief support information and services including: support groups, events, resources, newsletters, and volunteer opportunities. www.bcbereavementhelpline.com

Canuck Place – Children's Hospice: Good source for information and referrals, as well as assistance for families caring for children with life-threatening illnesses. www.canuckplace.org/resources/for-familes

The Compassionate Friends of Canada: International, non-profit, self-help organization, offering friendship, understanding, grief education, and hope to families who have experienced the death of a child at any age from any cause. Free B.C. Chapter meetings. www.tfccanada.net

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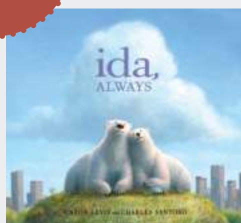
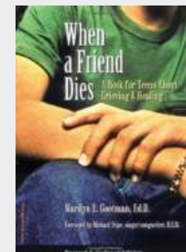


Ida, Always — Story book for children

By Caron Levis, illustrated by Charles Santoso (Atheneum Books for Young Readers, 2016)

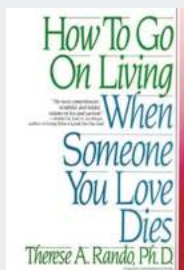
The Heart and The Bottle — Loss and healing for children or people of any age

By Oliver Jeffers (Harper Collins Children's Books, 2010)



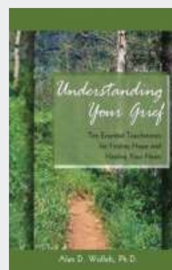
When a Friend Dies: A Book for Teens About Grieving and Healing

By Marilyn Gootman (Free Spirit Publishing, 2005)



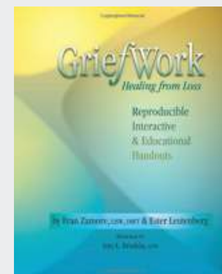
How to Go On Living When Someone You Love Dies — Adult grief

By Therese A. Rando (Bantam, 1991)



Understanding Your Grief: Ten Essential Touchstones for Finding Hope and Healing Your Heart — Adult grief

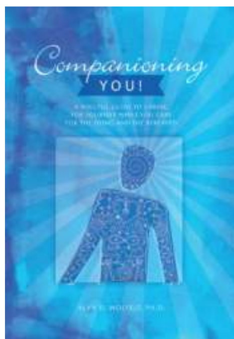
By Alan D. Wolfelt (Companion Press, 2004)



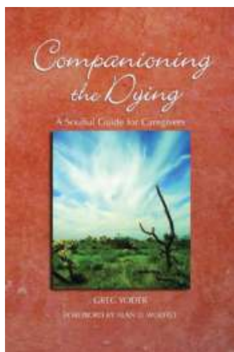
Grief Work: Healing from Loss — Interactive, educational handouts for counsellors

By Fran Zamore (Whole Person Associates, 2008)

RECOMMENDED READING



Companioning You! A Soulful Guide to Caring for Yourself While You Care for the Dying and the Bereaved (2012)
by Dr. Alan Wolfelt
(Companion Press)



Companioning the Dying: A Soulful Guide for Caregivers (2012)
by Greg Yoder
(Companion Press)

PALLIATIVE RESOURCES

What Dying People Want
by David Kuhl
(Anchor Canada, 2003)

Final Gifts
by Maggie Callanan
(Bantam Book, 1997)

Dying: A Memoir
by Cory Taylor
(HarperPrism, 2016)

British Columbia Hospice Palliative Care Association website: bchpca.org

may also facilitate family meetings involving sensitive topics, potentially fragile relationships, and many unknown variables. Some members may not be ready to hear certain terms, such as hospice, or face certain realities. Others may want to control the uncontrollable or have answers to the unanswerable. Counsellors must have the capacity to navigate these meetings with professionalism, empathy, and confidence.

Working with multiple family members has the potential to pose a number of boundary issues. Counsellors must be cognizant of these issues and be extremely diligent to avoid them. Alternatively, a counsellor may only be supporting one client in a family — either the individual who is dying or another individual involved with the dying person in some capacity. Whether working with an individual or a family, it is imperative that the counsellor is clear about exactly who the client/s is/are. Confidentiality must always be considered and privacy laws must always be upheld. For example, medical information must never be shared, directly or indirectly, with those who are not legally entitled to it.

Knowledge of family systems and cultural diversity is essential for palliative counsellors. Supporting family members and friends can often become the focus of our work, especially as the patient gets closer to dying. The earlier we can become involved in a family, the more consistent support we can offer. Facilitating difficult conversations between family members requires empathy, compassion, and flexibility while maintaining a non-directive yet goal-oriented method of communication. Not a simple task when so many unknown variables can affect the navigation. Each person brings to the experience his or her own unique personality, history, goals, and expectations. Each culture brings its own rituals, philosophy, and traditions.

The counsellor's role is to support the dying to complete practical and emotional unfinished business, explore their thoughts and feelings, say their goodbyes to friends and family, **and find comfort in their final days**.

After a death, palliative counsellors may be involved in the ongoing bereavement aftercare of family and friends. This can be beneficial for survivors by offering continuity and comfort for them; having a familiar presence for support can provide family members with a sense of stability when they feel most vulnerable.

It is also important for counsellors to know when continuing with bereavement support may not be prudent. Strong self-awareness can guide counsellors to know when they have biases, compassion fatigue, conflicts of interest, or specific knowledge that could potentially affect their ability to provide unconditional positive regard to family members or friends.

SELF-CARE AND SUPERVISION

Providing support for the dying and the significant people in their lives is an honour and can be incredibly rewarding and life affirming, leading to compassion satisfaction. At the same time, regular exposure to others' emotional, physical, and spiritual pain can cause vicarious trauma, compassion fatigue, and burnout. Working around death can and will trigger personal challenges for counsellors. This is normal and expected, but it can often catch new palliative counsellors off guard. Regular and frequent self-assessment is crucial to avoid influencing the therapeutic relationship with personal reactions and biases. As with all helping professions, self-care is non-negotiable. Regular participation in hobbies, mindfulness practice, exercise, journaling, therapy, travel, social engagement, and other self-nurturing activities help rejuvenate us and restore our joy for our work.

Participation in ritual facilitates the mourning process, and many counsellors create their own rituals around working with the dying. Death awareness is unavoidable when regularly confronted with death and dying; therefore, rituals honouring clients who have died and rituals that affirm life can improve counsellors' outlook on their work. A deliberate mental and physical transition between work and home can be transformed into a ritual. For example, something as simple as taking off or putting on identification can transition a counsellor's mind and body away or toward work.

Ongoing professional supervision is necessary when considering the emotional well-being of palliative counsellors. Debriefing especially complicated cases and releasing emotional residue can prolong their career longevity, maintain the quality of their work, and prevent their experiences from overflowing into their personal lives. Furthermore, when facing their own personal grief and loss, supervision can support them to determine when and if they can return to work.

PALLIATIVE COUNSELLING TRAINING

Training for counselling the dying can come in many forms. Hospice societies, such as Victoria Hospice (victoriahospice.org/courses/psychosocial-care-dying-and-bereaved-course) and organizations, such as Life and Death Matters (lifeanddeathmatters.ca), offer specialized training.

A CALLING

Interest in counselling the dying typically happens by chance. It is not usually a specialization new graduate students consider, unless personally or professionally exposed to prior palliative experiences. Interest may be sparked during a course or practicum placement. Usually, the interest begins through working around or with the dying in health care centres or private practices. Many palliative counsellors describe their initial interest as a calling. While it is not a specialization for everyone, those who are called to do the work cannot imagine a more fulfilling career. ■

Tara Field, RCC, has a private counselling practice in White Rock specializing in end-of-life, grief and loss, life transitions, and relationship challenges. She also offers consultation services to companies and organizations. Tara recently spent five years on Fraser Health Authority's Hospice Palliative Care Consult Team in White Rock/South Surrey. www.tarafield.com

Disenfranchised grief is experienced while mourning a loss that is not accepted or understood by others — losses that are not given adequate validation and leave the mourner feeling unheard and unsupported.

RECOGNIZING AND TREATING

DISENFRANCHISED GRIEF

BY TRICIA TOTH, RCC

"I feel like my son is dead," Mary* cried, while she sat across from me on a pale-yellow couch. "He is walking the streets, sleeping on them actually, and yet, he is no longer a part of my life."

Five years earlier, her 15-year-old son Dustin began to associate with an older peer group. Mary and her husband Pete had found drug paraphernalia in his room, confronted him, and had him attend a series of meetings for drug and alcohol awareness. However, Mary said, "Dustin slipped away from us. He became defiant and argumentative." The couple experienced their "bottom line" two years earlier, when Dustin had stolen a large sum of money from them along with their family car.

With clinical support, they hosted an intervention; ultimately, Dustin chose not to fulfill their expectations and, consequently, left their home.

Mary talked to me tearfully of her many nights of lost sleep, calls and visits from the RCMP, and Dustin's two near-death overdoses. Although Dustin is very much alive, she and her husband are grieving the loss of the life and relationship they once had with him. Mary feels devastated and alone.

"I have no one to talk to or turn to. Dustin has burned so many bridges that everyone seems relieved he is no longer in our lives. I'm trying to move on, yet there is no one who understands this loss."

I explained to Mary that, like many others in her situation, she is experiencing disenfranchised grief.

DISENFRANCHISED GRIEF

Disenfranchised grief is experienced while mourning a loss that is not accepted or understood by others — losses that are not given adequate validation and leave the mourner feeling unheard and unsupported. The loss often has a stigma associated with it or to the relationship one has with it. Also, because it has not been discussed enough by those experiencing it, the loss — and the depth of that loss — may not even be recognized or understood by others.

For example, disenfranchised grief may occur when others do not appreciate the magnitude of the grief following the loss of a pet, or after an abortion or miscarriage, or associated with the loss of

Disenfranchised grief may occur when others do not appreciate the magnitude of the grief following the loss of a pet, or after an abortion or miscarriage, or associated with the loss of a healthy child for parents who deliver a child with delays.

a healthy child for parents who deliver a child with delays.

There may be a reluctance to discuss the loss due to associated guilt or shame, such as in cases of accidental death, suicide, or overdose.

Disenfranchised grief may also be experienced when there are negative feelings associated with the deceased, such as in the death of an abusive partner or when an affair has taken place. Estrangement from a relationship, rather than a death, may bring about disenfranchised grief. For example, the loss of an ex-partner and/or their family members due to divorce, disconnection due to substance abuse, mental health problems such as dementia or Alzheimer's disease, and family alienation resulting from different belief systems, religions, or political doctrines. Other examples, include disenfranchised grief resulting from unfulfilled goals and aspirations, failed business ventures, and changes felt after an economic downturn, such as losing a home or job, bankruptcy, and alterations to lifestyle and supports. Grief can result from moving from one home, community, or cultural upbringing to another.

LOSS AND SHAME

Others may not acknowledge or recognize our grief for several reasons. One is that there are cultural differences where some losses are considered more significant than others. Within North America, the most recognizable loss occurs when a biological family member dies. However, shame or guilt associated with our loss may prevent us from adequately talking about it or seeking support from others. For instance, when a friend or family member dies due to suicide, surviving members may feel they missed the signs of depression or could have somehow prevented the tragedy. They may even feel they contributed to the death. Consequently, they may be reluctant to reach out for help. For some, asking about the loss is considered taboo, in part because they don't know what to say, and also because they do not want to hurt the person mourning.

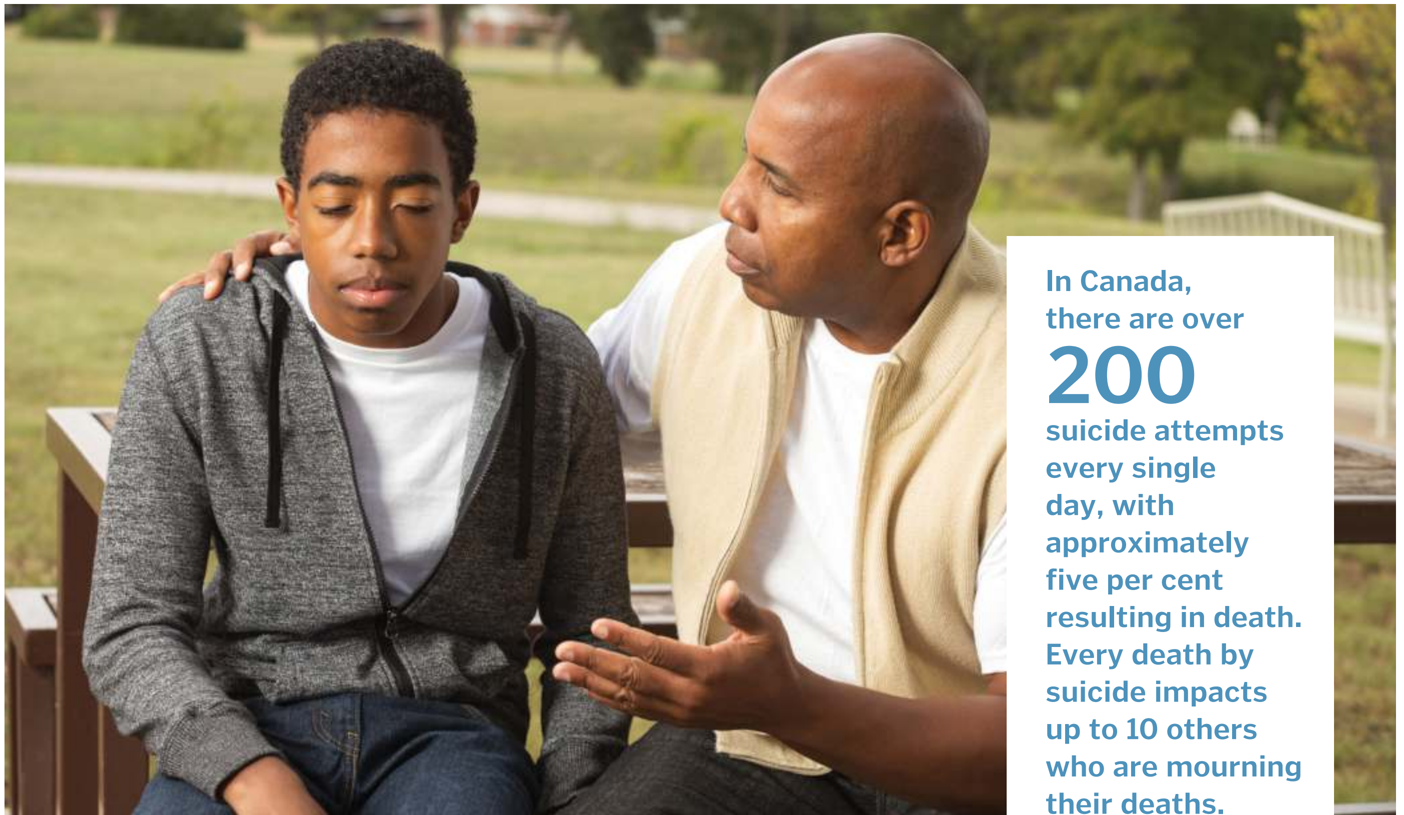
> One of the most popular posts on my blog site was acknowledging the grief people feel after the loss of a pet.

When Jack's daughter Sara committed suicide, he had never felt so alone. Not only had he lost his only daughter, but he also felt he had no one to talk to. He thought he should have recognized the signs of her growing depression and desire to end her life.

"She slept a lot and she was no longer interested in dance, which she usually loved. I just chalked it up to her being a teenager," he said.

Following Sara's death, Jack was reluctant to reach out for help, because he felt others would not understand or may judge him. Ultimately, his own pain became unbearable, and he contacted me for counselling and support. Jack was both relieved and frustrated to learn he was experiencing disenfranchised grief. While Jack was comforted in knowing he was not alone in his grieving process, he was equally disappointed that discussing death by suicide is so taboo.

In Canada, there are over 200 suicide attempts every single day, with



In Canada, there are over **200** suicide attempts every single day, with approximately five per cent resulting in death. Every death by suicide impacts up to 10 others who are mourning their deaths.

approximately five per cent resulting in death. Every death by suicide affects up to 10 others who are mourning their deaths. Yet, those who bereave a death due to suicide often do so in silence.

Doug and Frankie experienced a profound loss and lack of support when their daughter Renay died from a drug overdose at the age of 32. Renay initially became addicted to prescription drugs following a car accident in her mid-20s. As she became more dependent on drugs for pain management, she became more desperate and resourceful in accessing prescription and street drugs.

While Doug and Frankie sat hand in hand, Jack said, "She had her whole life ahead of her. We will never see her marry. We will never be grandparents." Doug and Frankie are both in the health care field and felt they should have recognized the signs of her increasing dependency on medication and intervened earlier.

Ultimately, Renay passed away after injecting heroin laced with fentanyl. Drug overdoses involving the opioid fentanyl now account for 81 per cent of all overdoses in British Columbia, and the number of deaths by overdose has increased by 143 per cent within the same time period last year, January to July. British Columbia has identified the current drug crisis as an epidemic, but families left to mourn death from overdose are often reluctant to share their experiences.

MINIMIZED OR UNRECOGNIZED LOSS

In some instances, others may minimize the loss. For example, because some people do not consider a foetus a child, they may minimize the experience of loss due to miscarriage. However, for couples who experience miscarriage or stillbirth, they not only lose their child, but also the family they had envisioned for themselves.

The death of a beloved pet is another example of a loss that may be minimized or unrecognized.

After Malcolm's wife Louise died following a battle with breast cancer, his children suggested he get a dog. Initially, he did not want the responsibility, but his daughter and son, who reside a province away, insisted because they felt their dad could use the company. Malcolm explained to me that his companionship with Mowat, a Labrador retriever, was instant.

"As soon as Mowat saw me, he rested his head on my foot. He seemed to know I was missing Louise." Prior to Malcolm's retirement, Malcolm and Mowat were inseparable; Mowat often accompanied Malcolm on his

> A person who experiences the loss of a pet may benefit from discussing the significance of their relationship in depth using narrative therapy or expressing their grief through creative or symbolic work using art therapy.

truck driving jobs. Malcolm described their bond as “totally non-judgemental love — best friends.” Malcolm said that with a pet, the relationship is free of conflict and drama. “Mowat was loyal and happy to see me — more than my kids were,” he joked.

When Mowat passed away following an abdominal infection six months ago, Malcolm was devastated. Malcolm’s daughter, who worried because her father had stopped eating and socializing, initially contacted me. It was difficult for Malcolm to explain to others the depth of his loss. Malcolm said he was deeply hurt and offended when his neighbour commented, “It’s just a dog.” Malcolm considered Mowat to be one of his closest companions.

TREATMENT CONSIDERATIONS

Disenfranchised grief should be given recognition and validation just as any other loss. The loss each of us experiences is real. It needs to be understood that grief is subjective and each person’s reaction to loss can vary. What one person finds devastating may be completely bearable for someone else. We should be careful not to assign our own judgement, but rather gain an understanding of the loss through the perspective of the client.

Just as each person’s experience with disenfranchised grief should be given individual recognition, so should their respective treatment plan. A client who is suffering from poor self-worth and lack of motivation may benefit from cognitive behavioural therapy. The loss of a job may be best treated with a solution-focused approach — a plan of action for exploring new employment or training options. A person who experiences the loss of a pet may benefit from discussing the significance of their relationship in depth using narrative therapy or expressing their grief through creative or symbolic work using art therapy. Working with clients who have experienced loss through miscarriage or abortion may benefit from an exploration of the mind-body-spirit connection through a holistic psychotherapy approach.

Losses can be particularly difficult for children as they often do not have any say or influence in the situation, such as with a move or change in schools. Treatment is beneficial in giving them a voice and opportunity to express and work through their emotions. Play therapy may be especially helpful, as children often lack the skills and maturity to understand the source of their pain.

Let your client know that others

have had similar experiences. One of the most popular posts on my blog site was acknowledging the grief people feel after the loss of a pet. For many, they considered their pets one of their closest companions in life, yet others often minimized the loss. Many who read the post found comfort in knowing they were not alone in their bereavement.

Encourage the client themselves to give the loss appropriate validation. Discussion and identification of the loss may be validation enough for the client, but some clients may benefit by giving the loss symbolic recognition — for example, writing a letter, wearing a piece of jewellery, getting a tattoo, creating an art piece, or performing a ritual or ceremony.

Help your client identify and seek out their support system. It is important for your client not only to know they are not alone but also to recognize where they can go for help. Some losses result in our clients becoming a support to others who have had similar experiences themselves. I have had clients write pieces and share them with others as well as join or initiate support groups.

Although disenfranchised grief is gaining attention, we have a long way to go. Many people still feel unsupported. Stigma associated with disenfranchised grief prevents those affected from opening up and seeking support. Awareness of disenfranchised grief in and of itself is one of the first steps necessary towards intervention.

Stigma associated with disenfranchised grief prevents those affected from opening up and seeking support.

What one person finds devastating may be completely bearable for someone else. We should be careful not to assign our own judgement, but rather gain an understanding of the loss through the client's perspective.

Fortunately, there is a growing recognition of disenfranchised grief, and supports are becoming more available for those facing challenges. Most schools now employ counsellors, provide peer support, and offer preventative programs. Universities and colleges now have counselling and support available for students. Crisis intervention teams are put in place after a loss or tragedy in the work place, and counselling support has become a part of employee assistance packages. Suicide awareness is much more common, and resources are available for families to discuss their loss and share their stories with others.

With continued discussion and a growing initiative to combat disenfranchised grief, those affected will become more confident in sharing their painful experience and their healing, which will in turn benefit both those affected by disenfranchised grief and their caregivers. ■

***All client names and some details have been changed to protect client privacy.**

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

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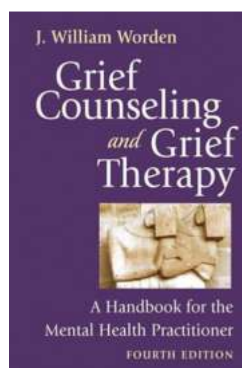
RECOVERING FROM TRAGEDY

Tragedy can take many forms, and a counsellor's role is often to help clients journey through the intense process of grief and mourning. The more understanding counsellors have about that process, the better equipped they are to make that journey with their clients. By sharing her own experience with grief and loss, Jasmine McMurray, RCC, along with her friend and colleague Devan Christian, RCC, demonstrates how Worden's TEAR model can be used to help clients move more intentionally through the grieving process.

THE **TEAR MODEL** OF GRIEF

BY DEVAN CHRISTIAN, RCC

J. WILLIAM WORDEN, the author of *Grief Counselling and Grief Therapy* (2009), developed the TEAR Model to help outline an approach to working with grief. Worden takes the perspective that, in grief, we do not have stages or phases to pass through but, instead, have four tasks (see right) we need to accomplish in order to integrate into a new life after the loss of a significant person. This idea of grief tasks allows individuals to have agency in their mourning and aids in reducing feelings of helplessness.



T To accept the reality of the loss

E Experience the pain of the loss

A Adjust to the new environment without the lost person

R Reinvent in the new reality

When working with clients, I find myself supporting them through these tasks consistently — helping each client to be able to say their person's name and share the stories of their life and death; validating the pain and suffering they are experiencing from the death of their person; discovering who they are now in this world without their person in each day, holiday, event, and anniversary; and helping them discover who they are and how they are going to continue to honour or carry forward the person who has died.

It was through long-term support that I could see clients return to some of these tasks as the year went on, particularly when the client was going through the "firsts" without

The overwhelming nature of grief both paralyzes us and drives us to move. A common belief exists in our society that after a month, the mourner should have stopped crying, and after three months, they should have stopped talking about the loss.

their person — first Christmas, anniversary, birthday, or even doing household chores that had been managed by the other person. By understanding Worden's TEAR Model, and supporting clients with each of the tasks as they come, clients may feel more empowered and supported in their journey towards their new self.

HOW PEOPLE RECOVER DAY TO DAY

The overwhelming nature of grief both paralyzes us and drives us to move. No matter the circumstance or where we are in our journey of grief, mourning gives us power to endure an unpleasant or difficult process or situation without giving way. Meeting each client brings its own learning and teaching, but one common thread I have seen is the change in clients when they give themselves permission to grieve. A common belief exists in our society that after a month, the mourner should have stopped crying, and after three months, they should have stopped talking about the loss. Acknowledging that everyone has the right to grieve in the way they want and for as long as they need to — even the rest of their lives — seems to relieve the pressure to "feel better" and "get over it." I believe it is from this moment in the therapeutic relationship that the clients can begin their movement through the tasks of grief.

The four tasks are clearly reflected in Jasmine McMurray's experience of recovering from tragedy.

JASMINE AND TOM 2017

MY STORY OF RECOVERY

BY JASMINE MCMURRAY, RCC

On November 5, 2007, my world changed forever. I vividly remember returning from a Vancouver Recital Society concert and seeing several voicemail messages from my partner John's sister, asking me to call. It was in the next two minutes that she shared news with me that altered my life in a profoundly painful way. She was angry and scared, because John had not returned from his weekend at Stave Lake, where he had been attending a 4x4 rally.

It takes courage to risk being hurt again — to risk losing someone else that we love — but it has been my experience that it is vital to take this risk, open our hearts, and reach out to find connection with others.

I still clearly remember the feel of that fall day — the decaying leaves and crisp air, tinged with the icy winds of winter, as I searched along rough forest paths calling out for John. I remember watching the Search and Rescue Unit use sonar to scour the bottom of the lake for evidence of his body. Hundreds of people had come to help with the search. John's family persevered and continued actively searching for several weeks,

while I was overcome with pain and began to isolate myself, turning inward and beginning the grieving process.

In October 2008, John's body was discovered in Stave Lake. It was determined that he had fallen into the lake, dragged down by his heavy boots and clothes. It was both a blessing and a curse to have a sense of closure to this tragedy; the pain of the unknown had ended and the pain of knowing he wouldn't come back began.

JASMINE AND JOHN 2007

Even though it felt like my own life had ended along with John's, the outside world kept moving forward.

TO ACCEPT THE REALITY OF MY LOSS

Initially, the grief and pain of losing John felt both physical and emotional. There were days when simply eating and sleeping felt impossible. I found it helpful when friends and family supported me in very simple, practical ways, such as bringing over food, offering to help tidy my house, or just allowing me the space to mourn with them physically present.

The ability to compartmentalize and distract was essential as well, because, even though it felt like my own life had ended along with John's, the outside world kept moving forward. I continued to complete my clinical practicum, and I remember how this activity provided reprieve from facing my empty apartment. In those early days, my fellow practicum students, who I am blessed to call my friends, were life saving. They met me where I was at. They honoured my experience and validated my emotions when I needed that. They also provided the space to help me divert my attention by discussing our own clinical cases.

EXPERIENCING THE PAIN OF MY LOSS

Another essential aspect in those early months was attending weekly counselling sessions. This provided the space to explore the different and difficult emotions that arose. It felt difficult to express the anger and resentment I'd held toward John for dying and for unresolved conflict in our relationship. There were days I felt angry with him for making the choice to go to Stave Lake. These emotions felt unreasonable and wicked. I felt guilty for feeling not only love for him but also anger. Some people I shared these thoughts with reinforced my experience of guilt. I know now that some people found it challenging to see me in pain and wanted to "help" me feel better. It was especially minimizing to be told to focus on the positive — proclamations such as, "You are so lucky you had the time you did with him" or "Don't worry, you'll see each other again one day."

There were days when the thought of discontinuing my own life felt appealing and the idea that, perhaps,

I would see him again only validated this desperate thinking pattern. It is important to highlight that these thoughts of suicide could be better described as a desire to escape the soul-crushing, heart-shattering, suffocating pain of losing someone I loved. I was indeed lucky to be surrounded by counsellors as friends and colleagues. I encourage anyone who has these feelings of ending their life to reach out for support. You are not alone in this struggle to manage and process deep emotional pain, and sharing this struggle can help ease the burden.

ADJUSTING TO THE NEW ENVIRONMENT WITHOUT MY LOST PERSON

On the very first Valentine's Day, when John was still presumed missing, my friend hosted a Valentine's Day party that just included my closest friends. This space allowed me to show up in one of John's shirts, with no make-up and puffy red eyes. The love and acceptance I received that evening was, to this day, transformative. It allowed me to feel a sense of belonging while I dealt with the most painful experience I had encountered thus far in my life. It also helped me to begin re-engaging in the world around me.

REINVENTING MY NEW REALITY

In those initial months, I did feel a sense of hopelessness about being able to meet someone whom I would love as much as John. Life is unpredictable. When Tom, my current partner, walked into my life, I began to believe loving again was possible. His unconditional love and acceptance allowed me to open my heart to loving someone new. It takes courage to risk being hurt again — to risk losing someone else that we love — but it has been my experience that it is vital to take this risk, open our hearts, and reach out to find connection with others.

Tom and I have a beautiful daughter, Kaeli, who is absolutely the personification of love and light. I sometimes reflect on what I would have missed if I had kept myself closed off and unaccepting of a new chance for love. It will be 10 years this November since John passed, and now, with the easing of my grief, I feel love and connection when I think of him. The pain has faded, and I have been able to seamlessly integrate my memories of him into my life.

While this is the first time I have publically shared my deeply personal experience with tragedy, it feels honouring to share how it has affected me personally and professionally. Our capacity for compassion increases as we honour our own pain and expand our ability to create a safe container for other people's suffering. Being able to empathize on a deep, visceral level about what facing tragedy feels like can aid in our clients' journeys. Holding the space and allowing grief to flow in the therapy office can allow clients to feel safe enough to let their own pain out.

Our capacity for compassion increases as we honour our own pain and expand our ability to create a safe container for other people's suffering.

To conclude, here are my top three tips for working with grieving clients:

1 Understand that grief and sadness have no end date. It can be difficult for counsellors new to grief work to sit with their clients' pain, and this can lead to feeling the need to "fix" the client and take away their pain. It is important to remember that although the pain from grief may fade over time, it may never go away completely, and that's okay. Our role is to sit with a client exactly where they are at in their journey with no expectations of where they "should" be.

2 Acknowledge that life is precious and fragile and that we cannot control when tragedy strikes. Existential angst can arise for clients who have faced tragedy, as they come to the realization that life is unpredictable and ever changing. Initially, this can feel overwhelming for clients, but ideally, over time, therapists can help clients become more present in their lives and able to expand their capacity to cherish each moment they have.

3 The human spirit is more resilient than we think it is. As counsellors, we have the honour of journeying with people as they process their pain. Humans have a far deeper capacity for pain, happiness, suffering, and joy than we know, and being a counsellor who honours this is vital in helping our clients feel a sense of safety and understanding. ■

Devan Christian, RCC, graduated from Adler University and began working in older adult mental health with Fraser Health in 2015. She holds a private practice in Chilliwack.

Jasmine McMurray, RCC, has been in private practice in Vancouver for over nine years, where she provides counselling for individuals and consulting for other therapists. She is also an adjunct faculty member with Adler University.

PATHWAYS TO RECONCILIATION

WORKING TOGETHER TO ADDRESS ISSUES IN INDIGENOUS COMMUNITIES

BY CAROLYN CAMILLERI

To even begin to understand the magnitude of the issues Indigenous communities are facing, you need some framework.

"In B.C., we have over 200 First Nations within our province, so there's an incredible diversity," says Jeffrey Schiffer, PhD, program director for the Office of Indigenization at the Justice Institute of British Columbia (JI) and faculty at the JI's Centre for Counselling and Community Safety. "Given that diversity, there's still a shared history of colonization and residential schooling and dispossession of land and attack on language."

That shared history extends across every province and territory in Canada, and from it comes the devastation that has affected Indigenous people for the last 150 years and which continues today.

"Most Indigenous communities have a high degree of intergenerational trauma and are still dealing with colonization because, really, often we think about colonization as something that happened in the past, forgetting that there are still systems and structures operating today that are essentially doing many of the same things," says Schiffer.

For example, child apprehension into foster care is a continuing colonization and frequently results in the same problems as residential school.

"Dealing with intergenerational trauma but also lived and vicarious trauma is really important in Indigenous communities," says Schiffer. Because it is really, really bad.

Lawrence Sheppard, RCC, is of Cree Métis heritage. He has worked extensively with First Nations, including Squamish Nation, the Burns Lake Band, Nlaka'pamux Health and Healing in the Lytton area, and Heskw'en'scutxe Health Services. He explains what the highly disturbing and violent results of intergenerational trauma look like. "In all of my work with Indigenous people over the last decade, I never had a female client who hadn't been sexually assaulted — not a single client. I had two who I thought had not been assaulted, but in the course of our work together, it came out. So every single female client had been sexually

assaulted, and, of course, a lot of the male clients as well," says Sheppard. "So you talk about intergenerational violence, you talk about trauma within communities, but they're living it."

The sexual violence is almost epidemic — and almost expected. Sheppard says one of his young female clients told him she had been sexually assaulted at a party. When she told her parents, they told her, "Well, suck it up. That's what happened to us, too."

"I don't have many First Nations people I work with who don't have trauma of some sort," he says.

Sheppard says there is not going to be a singular response to addressing the trauma, but there has to be an emphasis — a hub in the wheel — and for him, it's attachment-based therapy. "But there are other pieces. We have to continue to work with trauma. We have to help people to treat each other better. We have to make sure children are safe and protect them," he says. "If we want to look at the long game, we have to teach people how to treat each other respectfully."

Despite the grim reality, Sheppard and Schiffer are hopeful and see signs of progress, provided forward steps are taken carefully and thoughtfully.

BUILDING BRIDGES

So how do you build bridges and repair relationships when trust has been shattered in so many communities and in so many ways over 150 years? Schiffer says part of it is breathing life back into these relationships and starting them over in a good way — but it has to be sincere.

Indigenous approaches to counselling, trauma, psychotherapy, and wellness have so much to add to the wellness of Canada as a nation and to all people.

"It's very difficult, quite frankly, for Indigenous people to know when someone comes in talking about truth and reconciliation whether they're paying lip service to those ideas, or if they have a genuine interest in moving those initiatives forward," he says.

For example, book-ending has become commonplace: acknowledging territory at the beginning of an event, making a show of having an Indigenous person present or having done an Indigenous consultation, and then closing with a prayer by an elder. But how meaningful was that throughout the process and how much Indigenous voice and decision-making was actually included in that process?

"Right now, a lot of it, unfortunately, comes down to power dynamics and how much we're willing to share power, because that's what really meaningful inclusion comes down to," says Schiffer. "It's fine to have somebody in a circle sharing their opinions, but if those opinions don't have the same gravity as others in the circle and don't play the same role in moving that conversation into action, then we're not going to achieve the type of change that we proclaim we're all after through the Truth and Reconciliation Commission calls to action."

So often, when we think about issues in Indigenous communities, we focus on the Indigenous side of the equation, creating a dichotomy.

"It's a really old dichotomy of Indigenous and non-Indigenous," says Schiffer. "The standard for everything is the mainstream, which is basically the white Canadian Western tradition, and we assume that it works for everybody. Everybody can go to a dentist; that's a

SHELLEY MIKE PHOTOGRAPHY/EAGLE FEATHER NEWS

THE GORDON DOWNIE EFFECT

Gordon Downie made it his final mission in life to raise awareness about Indigenous circumstances — circumstances that non-Indigenous Canadians were, as he said, "trained our entire lives to ignore." And millions of Canadians listened to him — and watched as National Chief Perry Bellegarde presented Downie with an eagle feather and gave him the Lakota spirit name, Wicapi Omani — "Man who walks among the stars" — at the Assembly of First Nations.

Witnessing Downie's passion is not only incredibly moving, but also motivating, and it is critical to maintain that momentum. As Chief Dr. Robert Joseph says, "Everyone in the country needs to know that they have a role to play and that there is always something they can do within their own lives and communities to make a difference."

To get you started, check out 150 Acts of Reconciliation for Canada's 150th, a list of ideas for learning about Indigenous culture, history, and people. www.activehistory.ca

Western tradition; dentistry works on everyone. Anyone can get their arm set by a Western medical doctor; that works for everyone. But we don't do the reverse. We don't actually make the assumption that Indigenous tools and approaches can be useful to non-Indigenous Canadians."

For example, in the courses Schiffer is involved with across the country, a majority of the students are Indigenous, but there are always a few others, he says. They talk about the Indigenous perspective on health, which is holistic, with mental, physical, emotional, and spiritual aspects to wellness. "That doesn't just click with our Indigenous students; it clicks with our non-Indigenous students, too, because, ultimately, we're all human beings," says Schiffer. "We've gotten into this very individual mental-enlightenment positivist way of understanding what it means to be. A lot of that can be supported for good through consideration of Indigenous tools and approaches and the relevance of those for supporting non-Indigenous people who want to do the work of truth and reconciliation."

> "WE MUST WALK DOWN A PATH OF RECONCILIATION. TOGETHER, AND FOREVER."
>
> GORDON DOWNIE, 1964-2017

Some concepts overlap — for example, a circle is often thought of as an Indigenous methodology for engagement. "I like to remind people Stonehenge was built in a circle. Before the cultures in Northern Europe were Christianized, those were all Pagan people, and they were all very land based, and they all did everything in a circle," says Schiffer. "There actually is a deeper common history there. When we find some of those threads, it's easier for us to get to a common place."

Perhaps the strongest point is recognizing the diversity of the population. "When I talk to most Indigenous people in the world today, they don't say, 'Oh, I'm Haida,' or, 'I'm Mohawk.' They say, 'I'm Haida and Cree and Dutch,' says Schiffer. "Increasingly people have blended histories and blended identities."

Including Schiffer himself: his mother is Métis from Manitoba, and his father was born in Germany.

So the focus, for good reason, continues to be on intergenerational trauma experienced by Indigenous people, because, as Schiffer stresses, it's really traumatic to be colonized. However, he also points out that it's really traumatic to be a colonizer and that there is a lot of white guilt.

"It's important to understand that we're not all simply Indigenous or non-Indigenous and also to understand that, if we want to innovate our practices and approaches, we need as many tools as

possible in our tool kit, and Indigenous approaches to counselling, trauma, psychotherapy, and wellness have so much to add to the wellness of Canada as a nation and to all people."

Sheppard concurs. "It's not just inclusion of Aboriginal people in the process of government and the institutions within the larger community, but vice versa as well. To welcome people into Indigenous communities and embrace them and educate them."

As for the antagonism that has existed for so long on both sides, Sheppard says, we've got to change that to move forward. "Only through collaboration do things get better. If we isolate, then I think there's little hope."

Chief Dr. Robert Joseph, Gwawaenuk elder and founder of Reconciliation Canada, says it begins with dialogue. "Dialogue creates mutual understanding and changes relationships. It is also important for Canadians to know the history of Indigenous peoples in this country so we can begin to create a new narrative."

For counsellors to be part of the new narrative, they need training from an Indigenous perspective, or else counselling is just another white Canadian Western tradition being forcibly imposed.

SEND IN THE COUNSELLORS… NO, WAIT.

Sheppard tells a story about when he started counselling at Nlaka'pamux Health and Healing. "We were doing a group about two months after I started. I'd said to one group, 'I haven't had a lot of women coming to see me in my first couple of months here, and then, just last week, things started to pick up. Anybody have any insights?'

"One woman looked at me, smiled, and said, 'We needed to know we could trust you. We needed to know you were the real deal. We needed to know you weren't going to be gone in six months. A couple of people confirmed that you were, number one, First Nations and number two, a reputable, trusted male and that we could come and see you. You're going to see lots of us.'

"And sure enough, it picked up. I was booked chock-a-block after that."

But while being First Nations is vitally important in building trust, Sheppard says there is more to it — counsellors need Indigenous training.

Schiffer wholeheartedly agrees. "It's important to have Indigenous counsellors, but perhaps even more importantly, we need Indigenous counsellors who have trauma training from an Indigenous perspective," says Schiffer. "If we have Indigenous folk going into Indigenous communities peddling approaches to trauma that aren't congruent with the folks they're trying to support, we don't always get the outcomes we're hoping for."

As faculty at the JI, Schiffer teaches Aboriginal Focusing-Oriented Therapy and Complex Trauma, a 21-day, 10.5-credit certificate program using Focusing-Oriented Therapy as a safe and effective method of working with clients who experience complex trauma (see www.jibc.ca). One of the reasons Schiffer feels so honoured to be involved with that program is because it draws from the experience of his mother, RCC Shirley Turcotte, a Métis knowledge keeper and survivor of severe child sexual abuse and torture. Turcotte's journey is the focus of the 1987 National Film Board of Canada documentary *To A Safer Place*. Turcotte developed the program over 30 years, and for the past eight, it's been certified through the JI. Schiffer says it's a program that really works for Indigenous people.

And there are other realities counsellors need to be prepared for. "When you go to these remote locations, you've got no opportunities for good supervision with people who have culturally relevant experience," says Sheppard. "You can't phone your colleague in the city and expect to get the help you need."

Vicarious trauma is an obvious issue, but lateral violence is also a problem. When there is little or no opportunity to express grievances and debrief difficult situations, anger and frustration can be directed laterally, which can be particularly difficult for Indigenous counsellors. "It really helps with clients if you've got some First Nations blood in your veins, but that makes you susceptible to being victimized and being a part of a chain of lateral violence," says Sheppard.

The burnout rate for counsellors in remote communities is high, and clients

5 QUESTIONS TO ASK YOURSELF

Ry Moran, director of the National Centre for Truth and Reconciliation in Winnipeg, says Canadians need to ask themselves these questions:

1 ▸ Do I know any Indigenous people? If not, why?

2 ▸ Have I ever participated in a ceremony? If not, why?

3 ▸ Am I able to name the traditional territory I stand on? If not, why?

4 ▸ Have I meaningfully engaged in deep conversation with Indigenous people? If not, why?

5 ▸ Have I read an Indigenous author? If not, why?

SOURCE: WWW.CBC.CA/RADIO/UNRESERVED/HOW-ARE-YOU-PUTTING-RECONCILIATION-INTO-ACTION-1.4362219/WONDERING-HOW-TO-GET-INVOLVED-IN-RECONCILIATION-START-BY-ASKING-YOURSELF-THESE-5-QUESTIONS-1.4364516

aren't well served when the counsellor-client relationship keeps changing.

"We've got to figure out how to prepare counsellors for those kinds of experiences, because it is a whole other world when you go to those small communities," says Sheppard. "You are not in Kansas anymore."

REPAIRING DAMAGE

While colonization, including residential school and the foster care system, is the genesis of so much trauma, Sheppard has seen success by focusing on the effects of the trauma. Some years back, he realized the gross outcome of colonization and the resulting domestic violence, alcohol and drug abuse, and loss of culture were attachment disorders: damaged relationships.

"Damaged relationships with the culture, damaged relationships between community members, and damaged relationships between family members and parenting relationships — just all of it," says Sheppard. He became especially aware of the underlying attachment disorders — the breakdown between extended family — in the parenting program he taught to help parents deal with difficult behaviours and promote more positive behaviours. He would see children particularly affected as they entered their teens. "I saw it as a problem manifesting within the family and community — those connections, and the guidance, and the attachment was damaged."

Sheppard believes repairing that damage is critical to remedying issues in the community as a whole; however, he is clear that doing so doesn't change the causal factors — the intergenerational trauma. But how do you "treat" residential school syndrome other than realize it was a very bad thing and understand the effects, he asks. You

In 2016, there were **1,673,785** Indigenous people in Canada, accounting for **4.9** per cent of the total population. This was up from **3.8** per cent in 2006 and **2.8** per cent in 1996.

SOURCE: WWW.STATCAN.GC.CA/DAILY-QUOTIDIEN/171025/DQ171025A-ENG.HTM

can only treat the effects. "Despite the fact that some of these people have experienced disorganized attachment and abusive situations within their own homes and communities, we can actually repair that. Because of neuroplasticity, there are things we can do to help re-wire how they relate to others, the partners they pick, how they parent their children. This is something we can teach people. It's therapeutically, educationally possible to do something with it."

And that's why Sheppard likes attachment-based therapy: "It is positive and hopeful and, most importantly, it's doable. If we can create secure attachment and healthy relationships in communities, I think we've got it. I think we've nailed it."

Moreover, Sheppard says attachment-based therapy works in both one-on-one settings and in groups, which present other opportunities, such as lessening feelings of isolation and building in constructive community activities in conjunction with chiefs and councils — for example, feasts. Sheppard talks about pit cooking a meal of venison, wild potatoes, and wild onions. "It's always a happy experience, and people stay and participate in the whole event because of how it's constructed — you craft it in a way that is culturally attractive."

In both one-on-one sessions and workshops, Sheppard covers a range of topics. "Whether it's on parenting or trauma or intergenerational abuse, I always bring up lateral violence, because it's something that perpetuates patterns of victimization, violence, and disconnection, and it's something we can actually deal with," he says. "What we can do to support one another. How we can approach conflict and problem solve more creatively and in culturally appropriate ways, so we don't just pick up the baton that was handed to us and continue behaviours that were clearly, certainly very characteristic of treatment in residential school and colonization. There was a lot of abuse and violence. No question. But to some extent, we have to start owning it, and we have to deal with it ourselves."

INCLUSION AND COLLABORATION

Efforts that bring the most measurable success have a key commonality: Indigenous engagement and perspective. One of the most significant examples in terms of positive influence is language revitalization; Schiffer says a number of studies support that approach. "We do know that in communities where there's a higher percentage of individuals that speak their traditional language — even if it's not completely fluent — we see lower levels of suicide, substance abuse, and domestic violence, so there's a correlation between negative impacts of colonization and language not being present," says Schiffer.

Sheppard has seen it happen. "When

we first started working in the Lytton area, it had the highest suicide rate in Canada, not just in First Nations communities, but in any community. We know that when communities invest in reviving and educating their people in language and culture, the suicide rate drops dramatically."

Providing learning opportunities and valuing and respecting elders for their knowledge help the community get stronger and healthier and build a sense of pride in identity and culture. Sheppard says many people don't have any experience of their culture. "The elders or people who have made a point of learning the culture are actually educating people, sometimes for the first time, about some practices."

"Our future and the well-being of all our children rest with the kind of relationships we build today."

CHIEF DR. ROBERT JOSEPH, RECONCILIATION CANADA

Learning a language is a window to a cultural worldview: an understanding of the world you inhabit, yourself, and your relationships to others in the world around you. "Through bringing back Indigenous language, there's a whole host of cultural practices and understandings that come along with that," says Schiffer. He lists understanding Indigenous practices and approaches to intergenerational trauma and Indigenous medicines and wellness practices; developing identity and feeling good about cultural background; and understanding how to contribute to the health and betterment of the community. "Those things are important in terms of setting up Indigenous people for success," he says. "Language and culture seem to be at the epicentre."

Youth is the most critical area of focus for a better future. "From my experience working with youth, they are increasingly invested in trying to figure out opportunities they can achieve that will allow them to return to their communities and work in them," says Schiffer.

Sheppard agrees and supports investment in education. "I'm adamant about this: we should be sending people out of the communities to get advanced and specialized education, to get knowledge they can meld with traditional practices and their knowledge of their own specific community, and then they become the educators and problem solvers within the community. But, they need to be adequately trained and resourced."

The JI provides opportunities for youth at six provincial campuses and with programs delivered in-community and customized to suit particular needs in culture, protocol, and territory. Last July, the JI offered its first-ever Indigenous youth career camp, with 22 youths from different communities. Indigenous instructors and role models were involved wherever possible.

Another example demonstrating the value of supporting youth with Indigenous-focused programming is the Culturally Relevant Urban Wellness Program, which brings Indigenous youth in foster care together with new immigrant youth at the Indigenous Health Research and Education Garden at the UBC farm. Youth who were in the program six years ago are now in post-secondary Aboriginal youth and family work. "That demonstrates some of the success that can be achieved not only through language and culture but also through land-based practice."

MOVING FORWARD TOGETHER

While progress is being made, there's a long way to go — and it's important not to lose sight of that. "But I don't like that to overshadow the small leaps and bounds we're making," says Schiffer. "When I travel to different places to speak on behalf of the JI, I have the opportunity to hear about what's going on across the country, and there definitely is a lot of great work being done in terms of partnerships and engagement and inclusion that's leading to some quite innovative work."

Chief Joseph also sees progress. "You can see evidence of this by looking at the polls done by Environics to the turn-out at the recent Walk for Reconciliation [50,000 people]. There are now reconciliation initiatives underway across the country. As long as we are inclusive and keep inviting each other to the process of reconciliation, it will continue to grow out."

Sheppard also stresses inclusivity. "Sure, First Nations people need to own their own destiny and strengthen their own cultures. They need to have their own people educated. But not to the exclusion of that cooperation and connection with the larger community, because that's how people start to understand, and that's the weave, that's the texture we get in our communities, both Indigenous and mainstream. When we work together, we get that richness." ■

THE **SOUNDS** OF HEALING

MUSIC THERAPY BRINGS ANCIENT TEACHINGS INTO MODERN COUNSELLING SESSIONS

BY SUSAN SUMMERS

Music is known in every country and culture of our modern world. Musical instruments have been found in archeological cultures dating back tens of thousands of years. Historically, music was used for ceremony, healing, community gatherings, and in life rituals — and it still is. And while people have known for centuries that music is healing, music used as a therapeutic health discipline in the Western world is relatively new.

Music therapy emerged from work with U.S. veterans who returned from the Second World War with trauma and PTSD. When verbal psychotherapy did not heal the psychological wounds of war, listening to music was tried and found to be an effective way for the veterans to connect with the trauma that lay deep within. This led to the development of the music therapy profession. Since the early 1950s, there has been steady expansion of the practice of music therapy, culminating in the establishment of university training programs, research, and professional associations in more than 30 countries, with music therapists working in at least 50 countries around the world.

The Canadian Association of Music Therapists (CAMT) defines music therapy as "a discipline in which credentialed professionals (MTA) use music purposefully within therapeutic relationships to support development, health, and well-being. Music therapists use music safely and ethically to address human needs within cognitive, communicative, emotional, musical, physical, social, and spiritual domains" (2016).[1]

Music therapists have many years of extensive musical training and expertise prior to entering a five-year university training program at a bachelor's or master's level to learn specific music therapy models, theories, and interventions. In Canada, the training programs require more than 1,200 hours of supervised practica in addition to academic, musical, and clinical training. A standardized national exam completes the music therapist's credentialing process. There are currently 1,000 MTAs (Music Therapist Accredited/ Musicothérapeute accrédité) working in Canada who are certified by CAMT. Music therapists use live music primarily, played by themselves and their clients, for transformation, re-education, and rehabilitation. They are required to have a high degree of personal self-awareness and ongoing professional development to maintain their MTA credential.

THE MUSIC OF OUR LIVES

Working in close relationship with people across the lifespan, certified music therapists bring their person-centred expertise to people in health care institutions such as acute care hospitals, NICUs, residential care facilities, hospice and palliative care wards, rehabilitation units, mental health and addiction treatment programs, speech programs, and neurological treatment programs. Music therapists also work privately with those who seek support for mental health, trauma, and other life issues. Music therapy clients have a broad range of abilities and challenges, including: high-risk expectant mothers; children on the autism spectrum or with disabilities; people of all ages with cognitive, physical, sensory, mental health, and behaviour challenges; youth at risk; adults and older adults with dementia, brain injury, trauma, or neurological challenges; and those who are at the end of life.

"Music therapists use the unique qualities of music and a relationship with a therapist to access emotions and memories, structure behaviour, and provide social experiences in order to address clinical goals."[2] To address person-centred clinical goals, music therapists emphasize specific musical elements in songs and music-making and add creative approaches such as improvisation and songwriting for relaxation, stimulation, and redirection. Music can be

LYRICIST E. Y. HARBURG, WHO WROTE "OVER THE RAINBOW" AND "APRIL IN PARIS," SAID: "WORDS MAKE YOU THINK A THOUGHT. MUSIC MAKES YOU FEEL A FEELING. A SONG MAKES YOU FEEL A THOUGHT."

a reflective, receptive experience in listening, imaging to music, accessing memories, and enjoyment, or it can be an active, stimulative experience in singing, making music, moving to music, and engaging in social community participation. Certified music therapists are able to train and specialize in neo-natal intensive care music therapy, neurologic music therapy, guided imagery and music (the Bonny method), and vocal psychotherapy to help their clients regain function and insight and make positive life changes.

Researchers today know that human beings are hardwired for music and have strong physiological, neurological, and emotional arousal responses (especially pleasure) to a musical stimulus. Because music transcends language, it can engage people to enjoy the experience of listening, moving to, and/or singing even without understanding the song's language.

In choosing specific music for a client, music therapists work with a central principle that the songs and music we will identify with and have a lifelong emotional connection with are comprised primarily of the songs and music we grew up with from our childhood, through our youth, and into our mid-20s. These years represent moments of impactful influences and milestones. For example, memories associated with our mother singing lullabies may bring immediate feelings of safety and warmth and of being loved and comforted. Songs and music that remind us of other family members — grandparents and siblings — will bring these important family members to us in memory, and we re-experience those feelings many years later. An example of this is a grandchild knowing songs from the Second World War, because their grandparents sang or whistled the songs from their own childhoods. Songs from our teens and 20s document important journeys and events such as dating, relationships, completing high school and university, friendships, entering the working world, and, often, meeting our life partners and having our own children. The songs associated with these milestones become the soundtrack of our lives — for the rest of our lives. Lyricist E. Y. Harburg, who wrote "Over the Rainbow" and "April in Paris," said: "Words make you think a thought. Music makes you feel a feeling. A song makes you feel a thought."

In essence, the music of our lives (music and songs that have meaning and relevance to our lives for the entirety of our lives) comes from the voices (singers, family who sang, recordings we listened to, community experiences, etc.) and genres (jazz, country, classical music, hymns, etc.) that we heard when we were children. Music that was listened to by our families and that we heard in our home and participated in will, in general, have strong emotional content for us. When we hear a familiar song that has importance in our life, we are brought back immediately to where we were, who we were with, what we were wearing and doing, as well as what we were feeling in that situation where the song was played. Emotional life memories are experienced more strongly when music is present, and that song or piece of music becomes the gateway to that memory and experience. This can be especially useful and important for clients with repressed memories from trauma and abuse, where cognition that relies on verbal dialogue may not be able to break through to the somatic and held emotions and memories that live within the body.

ELEMENTS WITHIN EVERY PIECE OF MUSIC AND SONG — RHYTHM, LYRICS, TONE AND TIMBRE, MELODY, HARMONY, DISSONANCE, DYNAMICS, PITCH, METRE, AND TEMPO — ARE PROCESSED AND ACCESSED IN DIFFERENT PARTS OF THE BRAIN.

THE POWER AND SCIENCE OF MUSIC

Neuroscientists studying the musical brain for the past two decades now know more about why music is such a powerful influence in our lives. Music therapists know the power that music and music therapy interventions have in their clients' behaviour and progress.

Elements within every piece of music and song — rhythm, lyrics, tone and timbre, melody, harmony, dissonance, dynamics, pitch, metre, and tempo — are processed and accessed in different parts of the brain. Specially trained music therapists use these elements in specific ways with clients with neurological trauma and disease to support rehabilitation and relearning of functional skills such as speech, gait, mobility, and balance.

For example, for someone with a degenerative disorder like Parkinson's disease, walking to a certain rhythm can help the person maintain a regular gait longer than without music. Someone who has had a stroke affecting the left-brain speech centres that results in aphasia can learn to speak again through a series of progressive singing responses that emanate from the undamaged parts of the musical brain. The skills are enacted and experienced in the musical brain and relearned by the left-brain over time with repetition, determination, and a strong relationship with a music therapist.

Music can do great good; it can also do great harm if not used with intention, mindfulness, and expertise. Music therapists are sensitive to cultural considerations, because music is diverse and completely intertwined with a person's cultural experience. They are mindful of which music may have a positive, life-affirming, therapeutic effect, and which music is contraindicated for use with certain clients at certain times. In many cultures, certain music is only played or heard at certain times of the year, for certain festivals or celebrations, or for death and dying rituals.

Music and sound have also been used during times of war and conflict and in torture, and any counsellor working with immigrants, refugees, and people who have experienced trauma needs to be mindful of their possible musical triggers. Clients who have experienced sexual abuse may have music that reminds them of the person who abused them or the situations in which they found themselves to be vulnerable. Trained vocal psychotherapists (the Dr. Diane Austin model[3]) guide clients to use sound and vocalization as a way to express subconscious, pre-verbal experiences, where there are no words to describe a somatic and emotional experience that may continue to impact their lives.

THE SONGS AND MUSIC WE WILL IDENTIFY WITH AND HAVE A LIFELONG EMOTIONAL CONNECTION WITH ARE COMPRISED PRIMARILY OF THE SONGS AND MUSIC WE GREW UP WITH FROM OUR CHILDHOOD, THROUGH OUR YOUTH, AND INTO OUR MID-20s.

INTEGRATING MUSIC WITH YOUR PRACTICE

Music therapists can provide professional consultation for other therapists and health professionals on how to best use music in their practice. For example, counsellors may want to use recorded music to enhance the treatment plan for their clients; this could include playing recorded background music to create an ambience of safety, calmness, and relaxation or to redirect or distract from outside noise and inner chatter.

The iso principle — which is a technique by which music is matched with the client's mood, then gradually altered to affect the desired mood state — is applicable here: meet the client where they are and slowly move towards change together. This is particularly applicable to the choice of musical selections, instrumentation, lyrics, and genre. Choosing music that matches where a client is at the beginning of a session or matches the mood they need/want in order to share deeply is critical for rapport building and to align them with their stated goals and purposes for being in therapy. An example of this might be a therapist who encourages listening to favourite recorded music to elicit emotional responses where words are not available: what lyrics in a favourite song say best what I am feeling?

Music and sound have been used in healing for thousands of years. Certified music therapists bring these ancient teachings to the therapy room to support clients and patients to more fully engage with their lives and to increase functioning levels physically, mentally, emotionally, and spiritually. Used with intention and knowledge, music is a powerful co-therapist and ally. As Jimi Hendrix said, "Music doesn't lie. If there is something to be changed in this world, then it can only happen through music." ■

Susan Summers, PhD, AVPT, NMT, MTA, is a music therapist, vocal psychotherapist, and faculty member in the music therapy department at Capilano University, North Vancouver.

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34 Lessons From an Outreach Counsellor **35** Safety Tips **36** The Rewarding Change Group

BEING SAFE AT WORK

LESSONS FROM AN OUTREACH COUNSELLOR

BY JAMES LOGAN, RCC

Everyone needs to feel safe at work, and we must take steps to ensure we are safe and confident to do our jobs. It is also our responsibility to ensure the safety of our clients during sessions. And while we must remain aware and vigilant, we must also be cautious not to project fear, which clients can pick up on or may appear as a lack of confidence.

As an outreach counsellor, I have a different frame of reference. My more than 25 years of experience working in the homes of people with addictions, criminal lifestyles, high-conflict relationships, and various mental health diagnoses prepare me to not be intimidated. I meet clients where they are and show them respect. My job is to help them express their emotions and be respectful, and I model acceptance in my sessions when clients get angry and vent. In all situations, I take steps to ensure my own safety and my clients' safety.

No matter where you work, it is important to have an exit plan for two reasons: to prevent your client from feeling trapped and to allow you to leave if you need to. Here's an example of when that did not work out. I went to a single mother's home. She greeted me at the door, telling me she had forgotten I was coming but invited me in to meet the fathers of her five children. I entered the kitchen and

My agency has a computerized check-in procedure

I activate by text before entering a home and indicate a set amount of time; I then check out when I am safely in my vehicle.

sat at her nook alongside three bikers who were head and shoulders bigger than me. The fourth father sat down on the other side of me, sliding us along the nook bench. Fortunately, they all got along and appreciated that she was a good mother to their children. They were respectful to her, to me, and to each other, and it became a good reminder not to judge — and to choose my chair carefully.

WorkSafe BC has requirements for employees working alone on site or in the community. My agency has a computerized check-in procedure I activate by text before entering a home and indicate a set amount of time; I then check out when I am safely in my vehicle. If I don't do this, the system notifies a program manager to take action.

However, in private practice outreach counselling, I have to judge each situation myself — which counsellors always have to do — and be aware of my surroundings, whether walking in a neighbourhood, entering a home, or returning to my vehicle.

Of course, there have been situations that tested this. For example, at most homes, I wait for an adult to answer the door. Occasionally, in the past, if someone replied to my knock by calling out for me to come in because, for example, they were busy in the kitchen or changing a baby, I would do so. But on one occasion, when I stepped in, I discovered the client was in bed with bare shoulders and arms on the top of a pulled-up sheet. I told her that obviously she wasn't feeling well, and I left, saying I would return next week at our regular time. Since then, I ignore invitations to enter through a closed door and, instead, phone clients from their doorstep or my vehicle if they are not answering the door in person.

HERE ARE A FEW MORE TIPS

Sexual Safety In our role of trust, we must be vigilant about any possible sexual implication, distortion, or suggestion indicating a lack of boundaries or innuendo on our part or the client's. At times, we work with people who are confused, and we respond in caring, respectful ways that can be misinterpreted. Partners can become jealous of the intimate conversations we have with clients, and intimacy can often be confused or aligned with sexual interest, especially for people unaccustomed to intimate conversations. The potential for distortion increases if the conversation takes place in a client's home or the counsellor's home office. It is critical to have a prescreening conversation to determine the client's issues, know whom you are inviting into your home office, and maintain ethical boundaries.

Emotional / Psychological Safety
I remember hearing 40 years ago that you can't do psychotherapy except in an office. To use the terms loosely, the "holding environment" or the office becomes "the containment" clients need to feel safe and to open up to do deep work. Yes, you have to create emotional and psychological safety for the client, for your work, and for yourself. And yes, we need to have clear boundaries and not be seen by the client as a visiting friend. To achieve that, we need to create a professional atmosphere, as well as purpose in the counselling session and the use of the session time.

Physical Safety In addition to having an exit plan, you may want to consider training to manage aggressive or agitated persons. Even if you feel confident managing your own clients, outreach workers, in particular, have to consider that safety risks may come from your clients' relatives, partners, or neighbours. For example, once when I arrived at the home of a client in addiction recovery, her boyfriend, just out of jail, stopped me on the walkway and refused to let me speak with my client. He appeared to be getting agitated, and so I left and contacted the social worker. Even the social worker did not want to challenge the boyfriend, and outreach counselling was discontinued.

Work Safe BC requires that agencies have procedures in place for working alone. Counsellors need to be vigilant and not put ourselves in danger and should arrange office sessions if needed. To prevent looking or feeling vulnerable, we have to walk with purpose, have our keys ready, be alert, and show confidence. A self-defense course could be useful, so that you have measured, realistic, and practised movements. By being prepared, you present as formidable or not intimidated.

OFFICE SAFETY

BY CORAL PAYNE, RCC

- **Screen potential clients** Do an intake over the phone, and if you sense a reason to worry, at least for the first few sessions, make sure you are not alone in the office and make sure you have a safety plan in place.
- **Set clear boundaries** During your first session, inform clients of your expectations, including how you will respond to unacceptable, disrespectful, or threatening behaviour.
- **Arrange your office carefully** Position furnishings so they are not blocking the door so you and your clients can exit quickly if needed. Keep heavy objects and sharp items (paper weight, letter opener) that could be used as weapons out of clients' reach.
- **Establish a safety plan** Arrange a system with coworkers or family members where you agree to call or text at a certain time, and if you don't, they know to check up on you. Some offices have panic buttons to alert other colleagues to a dangerous situation.
- **Leave your door ajar** If you suspect you are going to be working with a potentially violent client, let your coworkers know your concerns and leave your door slightly ajar so others can hear if there is an escalation. Give colleagues permission to "pop in" if they hear clients edging towards violence.
- **Avoid taking risks** Don't go to a house when a client is in crisis and is threatening to hurt someone; call the police. Don't chase after a client who storms out of a session. Make sure your facility or home is well lighted. Avoid working alone at night. Park in a well-lighted area.
- **Trust your instincts** If something feels unsafe or a bit off, act on that feeling, make an excuse, get out of the session, and ask for help, because, at the end of the day, we have rights and shouldn't put ourselves in danger.

Financial Safety Avoid situations that are unsafe or create doubt or mistrust. If you are in the community or at the home of a client, don't carry loose cash in your pockets that could fall out in the home or tempt anyone to help themselves, affecting your trust relationship with your client. Don't lend money or hold money for clients. Keep payment agreements professional and clear. Transparency, including for debt-collection procedures, keeps everyone informed of responsibilities and consequences.

DID YOU KNOW?

Walk and Talk Sessions

The question has come up about whether there are insurance issues for counsellors who offer their clients "walk and talk" sessions as a regular or occasional therapy option. Brad Ackles, Vice President of Mitchell Abbott Group Insurance, the official insurers for BCACC members, says there are no "walk and talk" restrictions to their coverage.

"Our scope of coverage is very broad in that it covers those services 'usual and customary' to clinical counselling or psychotherapy," says Ackles. "There's also no restriction to providing services within a designated premises or office location, so these types of activities don't provide us with any problems or coverage obstacles."

However, Ackles does recommend that anyone in private practice have both Errors and Omissions Liability and Commercial General Liability to enhance their coverage to include most types of injuries, including "slip and fall" type claims. Get more information at mitchellandabbott.com.

PROJECT OVERVIEW

THE REWARDING CHANGE GROUP

Prize-based contingency management intervention is helping clients achieve goals in reducing or quitting illicit stimulant use.

BY HARKAMAL SANGHA, RCC

"Out of the shame spiral. This group breaks the monotony of being in the shame spiral all the time. When you're with people and see the progress they're making, you know it's attainable for you as well."

PROGRAM PARTICIPANT

The Pender Community Health Centre (PCHC) in Vancouver's Downtown Eastside (DTES) provides trauma-informed primary care, home health, mental health, and addictions services to inner-city clients. Clients, particularly those from marginalized backgrounds, are affected by poverty, street entrenchment, housing insecurity, unemployment, social isolation, and discrimination.

Although PCHC offers myriad psychosocial interventions, a challenge amongst clinicians has been finding ways to respond to the prevalent use of illicit stimulants (i.e. crack, cocaine, crystal meth) in the community. With the steady rise of crystal meth usage in the DTES over the past decade (a seven-fold increase reported in 2016 by the *Globe and Mail*[1])along with a gap in treatment services targeting stimulant addiction in the DTES (DTES 2nd Generation Strategy Report, 2015), this has created hardships for clients looking for help and clinicians wanting to offer treatment. In addition, approximately 40 per cent of clients receiving opiate-substitution therapy (i.e. methadose or suboxone) at PCHC have had a recent urine drug screen (UDS) for stimulants, which amongst methadone patients are associated with high attrition rates, poor treatment outcomes, and increased risk of HIV infection.[2]

Moreover, British Columbia is experiencing a public health emergency related to opioid overdoses; it is estimated that approximately 876 people died from a suspected drug overdose between January 2017 and July 2017, most often from fentanyl combined with cocaine, heroin, and crystal meth.[3]

In response, PCHC has been providing prize-based contingency management (PBCM) intervention in a group format for clients struggling with problematic stimulant use, many of whom present with polysubstance use and want to either cut down their stimulant use or quit altogether.

CONTINGENCY MANAGEMENT

Contingency management (CM) is a treatment intervention that involves reinforcing behaviours using incentives and is founded on principles of learning theory. A robust body of literature examining CM provides empirical support for the efficacy of this treatment in addressing problematic stimulant use.[4,5,6] Additional studies have shown CM's efficacy when targeting problematic stimulant use amongst methadone patients, leading to improved treatment outcomes primarily indicated by reduced stimulant use.[7] Research also supports the use of PBCM across a variety of clinical populations. In a study examining concurrent use of cocaine and opiates amongst clients enrolled in a methadone maintenance program, compared to participants receiving treatment as usual, participants receiving PBCM were four times more likely to demonstrate continuous abstinence for 12 weeks. One explanation for these outcomes is related to PBCM's unpredictable reinforcement.[8]

PCHC'S REWARDING CHANGE GROUP

We aptly named our PBCM group at PCHC the "Rewarding Change Group." Based on CM research designs using variable-based reinforcement therapies, we developed a fishbowl lottery in accordance with our budget by using 100 tokens and a fixed ratio of tokens to prizes: 20 per cent draw on no-value prizes (congratulatory certificates), 68 per cent draw on low-value prizes ($5 vouchers), seven per cent on medium-value prizes ($10 vouchers), and five per cent on high-value prizes ($25 vouchers). Clients draw once from the lottery every time a stimulant-free UDS is submitted and a maximum of two draws for consecutive weeks of stimulant-free UDSs. Increasing the frequency of incentive distribution often increases the power of the reinforcement in accordance with the principles of using PBCM interventions.[9] The budget we normally draw on for each group is approximately $250, which, in comparison to the amount researchers spend for 10-12 weeks, is quite low and, thus, feasible in community settings.

The Rewarding Change Group is a closed group held weekly for 10 to 12 weeks and typically consists of five to 10 participants. We try to limit barriers to access the group, so inclusion criteria usually involves clients who reside in the DTES and present with complex medical and psychosocial needs, including polysubstance use with a goal to either cut down or arrest illicit stimulant use, and may or may not be on opiate substitution therapy.

Group structure follows a format: the first half of the session time is often used to check-in and go over weekly goals and facilitators review a topic involving psycho-education or a CBT exercise related to relapse prevention or coping skills; the second half focuses on the fishbowl lottery and UDSs. Clients who submit a stimulant-free UDS are eligible to draw from the fishbowl lottery and win a prize.

WINNING RESULTS

We have done several rounds of treatment with the Rewarding Change Group over the last three years, and in each, we often are amazed by the results, not only in terms of reduced illicit stimulant use (i.e. in one group we compared the average percentage of stimulant-free UDSs for clients 12 weeks prior to the group compared to after completing the 12-week group and results consistently indicated an increase in the percentage of stimulant-free UDSs following treatment), but also other factors that contribute to successful outcomes. For example, as facilitators, we have often witnessed clients breaking out of social isolation and forming supportive relationships, receiving validation and non-judgemental support from peers regardless of submitting stimulant-free UDS and witnessing clients employ new coping skills to deal with daily stressors.

Client feedback is rewarding. "This group is the highlight of my week, because I receive so much support, and I never know what prize I'm going to win, which makes it so fun!," said one client. Another commented, "My goal was to get at least a couple of days clean from using crystal meth, and this group made that possible!"

Providers in our community have also started to use a similar group model in other clinical settings. As well, as there is a paucity of studies focusing on the use of this psychosocial intervention amongst vulnerable populations, we applied for a research grant through the VCH Research Challenge offered in partnership with the VCH Research Institute to investigate the effects of PBCM group intervention on stimulant use as well as psychosocial well-being amongst DTES clients on opiate substitution therapy. Our proposal was awarded a research grant, and we were approved by the UBC Research Ethics Board to go ahead with our study. The project is ongoing.

WANT TO LEARN MORE?

A story of our group was posted in June 2016, on the Vancouver Coastal Health news website at www.vchnews.ca. You can also contact me at harkamal.sangha@vch.ca.

RESOURCES

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BEING CLEAR, STAYING WELL

"THE SELF-CARE PIECE IS ESSENTIAL FOR THERAPISTS," SAYS MARIE-JOSÉ DHAESE. AND YOU OWE IT TO YOURSELF TO FIND AN APPROACH TO SELF-CARE THAT WORKS FOR YOU.

BY CAROLYN CAMILLERI

"The essence of our work comes from our capacity to attune to ourselves first and then to others, and then how we hold the space for them — it's bound to call upon our boundaries," says Dhaese, founder of the Centre for Expressive Therapy in Parksville and a pioneer in expressive play therapy and animal-assisted therapy. She has been teaching for more than 30 of her 43 years in practice and offers "Therapy for Therapists" by phone, in person, and at healing retreats.

No matter what emotions and issues your clients bring with them to session, you need to maintain a level of clarity and stamina to hold that space, and then know how to "clean it up" afterwards. "It's very difficult to keep finding ways of cleaning yourself up each day — and after each session — and reconnecting to yourself, re-grounding yourself, and getting ready for the next client," says Dhaese. "It takes a lot of practice."

Another problem is information overload. "People are becoming disconnected from what they really know, from their natural instinct, and it's very hard to attune to yourself when your head is full of things you're supposed to do."

Self-care helps you maintain your stamina, clear toxicity, process new information, and restore your own energy to prevent health problems and to allow yourself to grow as a counsellor. Finding a self-care approach that works well for you means thinking about what you like to do.

"I always look for what gives this person pleasure and what's easy for them — things they need in their lives at different times for different parts of themselves," says Dhaese.

She believes there has to be an aspect of self-care that is physical. "I'm 70 years old, and I walk an hour and a half each day at the end of my day. That's what's kept me going."

Rhythmic, physical release allows you to "flow and flush," she says. "It's like natural EMDR, where there is bilateral movement, and you let it reconnect you to your body, especially when you spend a whole day sitting in a chair — or on the floor, as we do as play therapists."

If Dhaese finds walking isn't enough, she listens to inspiring podcasts until her mind gets quieter. She also suggests colouring, which provides that EMDR-like, back-and-forth effect. "With some people, a cup of tea while knitting and listening to music might be what they do."

You may want to explore music, art, or sand therapy and make it part of your self-care regime. And sometimes you need to take self-care to the next level. For example, if you are dealing with an issue of transference or counter-transference or if you've been activated in own your issues.

"I can't imagine having been a therapist for 43 years and not having had somebody I could go to regularly if something stirred me up, because no amount of walking is going to take care of that."

Supervision or consultation is also important so you have someone to debrief cases with and to discuss new information with.

"I would say to any therapist, it's really important that you come back to how you view human beings, what it is that you know, and digest it really well before you start using it in therapy with your clients. It's like a compassionate understanding that allows you to have boundaries — that neutrality and clarity are really what makes a therapist."

The hardest lesson, she says, is to value and cherish yourself. "And really remember that if you don't have your health — your physical and emotional health — you cannot keep swimming in toxicity and not be affected," she says. "It has a side effect to be a therapist. I have seen so many people come and go in this field over the years. You have to make self-care a priority."

One of Dhaese's favourite ways to "flow and flush" is making snow angels. "There's nothing like it, to let yourself fall into the snow and look up at the sky."

SELF-DATING

Do something special for someone you love — yourself. There is nothing selfish about treating yourself to some extra attention to boost your spirits and help you better appreciate your own company.

▶ Make a reservation for dinner somewhere nice, then dress up and go. If you are nervous about dining alone, bring a book.

▶ Go to a concert and sing, dance, and get lost in the music.

▶ Pack a gourmet picnic lunch, go to a park, and enjoy nature.

▶ Light candles, play some soothing music, turn off your cell phone ringer, and relax in a warm, fragrant bath.

▶ Sign up for a class in painting, pottery, poetry, cooking, gardening — whatever creative endeavour takes your fancy.

▶ Tour a vineyard or a farm and stay for lunch to enjoy the setting.

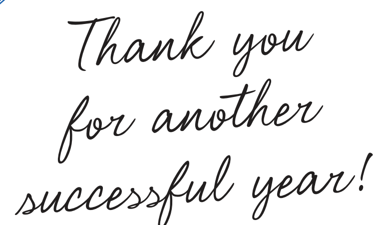
▶ Imagine someone is visiting you from out of town. Plan a tour to show them the sights and then take yourself.

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

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

Some of the areas in which they work include:

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



BCACC

BC ASSOCIATION OF CLINICAL COUNSELLORS

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

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