FALL 2018

INSIGHTS

THE BC ASSOCIATION OF CLINICAL COUNSELLORS' MAGAZINE

Navigating Issues Between First-Generation and Second-Generation Canadians

A Cycle of Trauma and Grief

Working with Clients Who Have Been Mandated into Counselling

Hope in the Land of the Midnight Sun

PROTECTING YOURSELF FROM SUPERVISOR'S LIABILITY

Trauma and Creativity

A Symbolic Response

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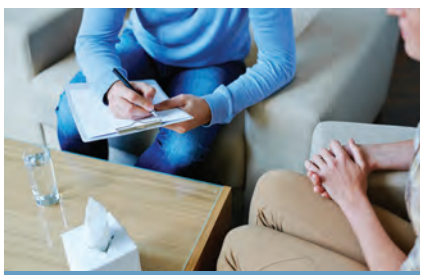
Looking for the latest version of the Code of Ethics? Or maybe you have an idea for an article for *Insights* or a post on the BCACC Blog? You'll find everything you need at bc-counsellors.org.



Counselling Resource

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

Making Connections

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

Members Only

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

TAKE A FEW MINUTES AND CHECK IT OUT.

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

BCACC

BC ASSOCIATION OF CLINICAL COUNSELLORS

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

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INSIGHTS

THE BC ASSOCIATION OF CLINICAL COUNSELLORS' MAGAZINE

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

Kuljit Bhullar, George Bryce, Jennifer Gibson, Ted Leavitt, Coral Payne, Laura Rhodes, Susanna Ruebsaat, Nadia Stefyn

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

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

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More information about submitting article proposals can be found at bc-counsellors.org/media/insights-magazine or by contacting Marci Zoretich, the BCACC editorial advisor, at communications@bc-counsellors.org.

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IS YOUR INSURANCE COVERAGE UP TO DATE?

All BCACC counsellors are required to maintain appropriate insurance coverage. Part of that responsibility means understanding how your insurance works and updating coverage when warranted by changes to your practice. Have you changed premises? Are you working under contract to an agency (see page 6)? Have your services changed? Do you have employees? These types of changes may affect your coverage.

An annual review of your insurance is recommended, and, because insurance isn't something you think about every day, you may want to schedule that review. Mitchell & Abbott policies expired on April 1, 2018. All members are required to log into their BCACC accounts and update their insurance in the member portal to ensure we have your most current information.

If you have any questions about your coverage, contact Mitchell & Abbott, the official insurers for BCACC. www.mitchellandabbott.com

Indigenous elders

are good for Indigenous mental health

According to a study in the *Canadian Medical Association Journal*, Indigenous elders can have a broad range of positive effects on the mental and physical health of urban Indigenous people, who often experience marginalization and barriers accessing health care. The study partnered elders with mainstream health care providers in Vancouver's Downtown Eastside. The study, which explored patient experiences and perspectives as part of a larger project, included 37 participants from 20 different First Nations who were interviewed about the impact of elders on their mental health. Five broad themes were identified:

- Healing after prolonged periods of seeking help and desperation
- Strengthening cultural identity and belonging
- Developing trust and opening up
- Coping with losses
- Engaging in ceremony and spiritual dimensions of care as a resource for hope

"Our findings are consistent with research showing the inclusion of elders in health care initiatives led to a reduction in teen suicides, decreased rates of domestic violence, improved quality of life, reduced depressive and trauma symptoms, and improved understanding and trust between Indigenous and non-Indigenous staff and patients," write the authors of the study.

- Read more at www.cmaj.ca/content/190/20/E608

MOMS STOP THE HARM

Moms Stop the Harm (MSTH) is a network of Canadian families whose loved ones have died due to substance use or who are hoping for recovery. First launched in 2015 by two moms from Edmonton and one from Pender Island, the group is growing rapidly and is getting increasing coverage on national news networks, including CBC.

Recently, MSTH teamed up with groups in the U.S. and Mexico. Their focus is education, reducing stigma related to drug use and mental health, changing drug polices, restorative rather than criminal justice, and recognizing families as support. MSTH is also a resource for families, including grieving families.
Read more at www.momsstoptheharm.com.

Sensible Drug Policies

The Canadian Students for Sensible Drug Policies (CSSDP) is a grassroots network comprised of youth and students who are concerned about the negative impact our drug policies have on individuals and communities. The CSSDP works on local, national, and international levels to promote sensible drug policy, increase harm-reduction awareness, and disseminate evidence-based educational resources.

The CSSDP has developed a resource for educators and parents called *Sensible Cannabis Education: A Toolkit for Educating Youth*, which aims to support adults in having informed, non-judgmental conversations with young people about cannabis.

Given that cannabis remains the most popular illegal drug consumed by young people in Canada, as well as Canada's pending legalization and regulation of cannabis, the development of new cannabis education for youth is of critical importance and a key aspect of developing young people's health literacy. The legalization of cannabis in Canada provides an opportunity to revise our approach to cannabis education for youth and consider pragmatic education that is inclusive of both prevention and harm reduction to maximize effectiveness and protect all youth.

The downloadable resource is available at cssdp.org.

RICHMOND-NEWS.COM

BCACC 2018 AGM

The BC Association of Clinical Counsellors' AGM took place on June 15, 2018 in Victoria. The highlight of the well-attended gathering was an engaging keynote presentation by Isobel Mackenzie, Seniors Advocate, entitled "Seniors in British Columbia." Her presentation included important information on how counsellors and mental health workers can support seniors and their caregivers in the province.

The keynote was broadcast via Facebook Live and is available to watch on the BCACC YouTube page: youtu.be/Fdhsz_L4hjE

SAN'YAS INDIGENOUS CULTURAL SAFETY TRAINING

San'yas is an online training program delivered by the B.C. Provincial Health Services Authority (PHSA) about Indigenous cultural safety (ICS). Of particular interest to counsellors is ICS Core Mental Health, which includes the foundation provided in Core ICS plus two mental health modules.

The training is designed for non-Aboriginal mental health professionals working in PHSA, Regional Health Authorities, Ministry of Health, and their partner agencies. Learning is self-paced over eight weeks and typically takes from nine to 11 hours to complete, though this could be longer or shorter depending on your learning style.

If you are an employee with any of these health authorities, training is available at no cost:

- Provincial Health Services Authority
- Northern Health Authority
- Vancouver Coastal Health Authority (including Providence Health)
- Interior Health Authority
- Fraser Health Authority
- Vancouver Island Health Authority
- Ministry of Health

For those not employed by one of the health authorities listed above, the fee is $250.00. Net proceeds are dedicated to support future continuing-education activities and conferences on Indigenous cultural competency.

Note that the curriculum is intended as introductory training and is supplemented by Nation- and region-specific training provided by regional health authorities or Indigenous groups.

For more information, go to www.sanyas.ca

PROTECTING YOURSELF
FROM SUPERVISOR'S LIABILITY

BY GEORGE K. BRYCE, BA, BSC, MHA, LLB

From time to time, the BCACC is asked by members who supervise or work with agency support workers if they face any risk of being sued by clients who may be harmed by the acts or omissions of support workers. To provide guidance, we must first understand the context of the services these counsellors provide.

UNDERSTANDING THE CONTEXT

A useful starting point is to clarify the workplace relationship the counsellor has with support workers who provide services to agency clients.

Typically, an agency or facility employs support workers to help clients who come to that facility. Often, these non-counsellors have direct, personal experience with the sorts of challenges the agency's clients are experiencing (i.e., "peer" counselling). For example, it is not uncommon for persons who have overcome drug or alcohol dependency to obtain basic training as drug or alcohol workers. In turn, an agency hires these persons to help the agency's clients overcome their own addictions. Whether such non-counsellors are salaried employees or volunteers, the agency would bear the primary legal responsibility for their actions or omissions while they are working for the agency; this is known as "employer vicarious liability." As such, if someone is harmed because of the failure of an employee, that harmed individual might then sue the specific employee, but, in most cases, the employer would be ultimately liable.

If a counsellor is an agency employee, he or she should also fall under the protective umbrella of employer vicarious liability, and it is likely the employer would be liable for any damages that flowed from the employed counsellor's conduct.

However, if the counsellor is providing services to the agency as an independent contractor, often under a service agreement, then any errors or omissions committed by that counsellor are likely not to be captured by employer vicarious liability. The contracting counsellor whose acts or omissions led to someone being harmed could then face their own direct liability.

Thus, a counsellor's liability for harm caused to an agency's clients will likely

A COUNSELLOR'S LIABILITY FOR HARM CAUSED TO AN AGENCY'S CLIENTS WILL LIKELY DEPEND ON WHETHER THE COUNSELLOR IS CONSIDERED AN AGENCY EMPLOYEE OR AN INDEPENDENT CONTRACTOR.

This article is intended to help clinical counsellors gain a better understanding of legal issues relevant to clinical practice. It is not meant to be a substitute for legal advice. If a counsellor has a particular concern about an issue that he or she is facing in practice, that counsellor should seek independent legal advice from a lawyer. Neither Mr. Bryce nor the BCACC can provide individual counsellors with legal advice.

depend on whether the counsellor is considered an agency employee or an independent contractor.

For the rest of this commentary, I will consider only "contracting counsellors" who provide services as independent contractors and not as salaried employees or volunteers of an agency.

THE ROLE OF THE CONTRACTING COUNSELLOR

In the situations brought to the BCACC's attention, the contracting counsellor may be providing an educational or training role to an agency's employees or may be providing some form of supervision of the agency's employees (support workers). For example, the contracting counsellor may meet once a week with the agency's support workers to discuss challenges they encounter in helping clients with addictions and substance use issues. These weekly sessions may involve a review of client problems, and the counsellor may provide training to help support workers better serve those clients. In these settings, the contracting counsellor is providing "supervision" services to the agency: i.e., helping to guide the work of the agency's employees.

THE DEGREE AND TYPE OF RISKS THE COUNSELLOR WILL THUS FACE WILL THEN DEPEND ON THE SERVICES OR FUNCTIONS THEY PROVIDE UNDER CONTRACT TO THE AGENCY.

On the other hand, a contracting counsellor may also provide services directly to agency clients. These services could be performed in conjunction to or separate from services provided by support workers. In these cases, the contracting counsellor is providing "clinical" services directly to the agency's clients.

Of course, it is possible for a contracting counsellor to be providing both supervision of support workers and direct clinical services to clients. The degree and type of risks the counsellor will thus face will then depend on the services or functions they provide under contract to the agency.

LIABILITY RISKS AND HOW CONTRACTING COUNSELLORS CAN PROTECT THEMSELVES

The liability risks faced by a contracting counsellor are going to be greater if that counsellor provides services directly to agency clients. The liability risks are much lower if the contracting counsellor's role is limited to supervising the agency's support workers who, in turn, provide services directly to clients. As such, it is important for a contracting counsellor to clarify the role he or she plays within the agency.

Hopefully, the counsellor providing contract services to an agency has a written service agreement with that agency. Such an agreement would include the scope of services to be provided and how much the counsellor would be paid. One way for the counsellor to protect him or herself from financial ruin if a client sues the agency, its employees, and the counsellor would be for the counsellor to ensure the written service agreement also contains an indemnification clause.

An indemnification clause in a contract creates an obligation of one party (e.g. the agency) to pay for the legal expenses of the other party (e.g., the contracting counsellor), including any losses the contracting counsellor may be liable for as a result of a claim or action. In brief, such a clause sets up a contractual right of one party to claim reimbursement for loss, damage, or liability from the other party.

There are many different types

INSURANCE MATTERS

When a counsellor is threatened with legal action or is in receipt of a civil claim, the first call to make is to notify the insurance company. If the counsellor is working under contract at an agency and the contract includes indemnification provisions, that contract would become part of the details the insurance company uses in the counsellor's defence. In most cases, the insurer would take action to defend the counsellor, and then seek indemnification from the service agency afterwards.

"Insurers can't wait — they have a contractual duty to defend," says Brad Ackles, Vice President of Mitchell & Abbott Group, the official insurers for BCACC members. "They would sort out the validity and value of any indemnity provision as part of the process. The insurer on the other end — for the agency — is unlikely to step forward unless they have to, so a defense has to be made first."

If a counsellor is under contract to an agency and is working without an indemnification provision in the service contract, the insurer still proceeds with the counsellor's defence. In that respect, Ackles says, there is nothing different.

"It just may be harder to defend or deflect the costs to the agency," says Ackles. "The counsellor's contract would have nothing enforceable."

A similar situation would occur if the provision were not broad enough.

"As per George Bryce's article, 'Protecting Yourself from Supervisor's Liability,' clear and concise contracts having to do with services provided, indemnification, etc., are extremely valuable," says Ackles. "If they don't exist or are vague, it may be difficult for your insurer to deflect the claim to another party."

> IN MOST CASES, THE INSURER WOULD TAKE ACTION TO DEFEND THE COUNSELLOR, AND THEN SEEK INDEMNIFICATION FROM THE SERVICE AGENCY AFTERWARDS.

Ackles also notes that the insurer doesn't set limits on coverage after the claim is reported. "It's whatever limit the counsellor purchased," he says, adding that Mitchell & Abbott Group currently offers $2,000,000 or $5,000,000 options.

With respect to determining whether services under contract fit within the scope of practice for clinical counsellors, Ackles says it depends on the scope of services.

"Typically, we follow the scope of practice for clinical counsellors," says Ackles. "The insurance contract definition refers to clinical counsellors and psychotherapists, providing services that are 'usual and customary' and for which they are 'trained and qualified.' It's very broad, but the insurer would use the contract definition as it applies to each circumstance to determine coverage."

As for services that might fall outside the scope of a contracting counsellor's insurance policy with Mitchell & Abbott, Ackles lists medical services and high-risk adventure counselling as examples. He says counsellors can make separate application for coverage for such services.

In general, Ackles says a counsellor's supervision of an agency's support workers falls within the scope for coverage under Mitchell & Abbott policies.

of indemnification provisions that can cover a range of circumstances. Typically, these provisions address the following: events that would trigger the indemnification; types of claims or losses that would be covered; which parties can initiate a claim (e.g., only the parties themselves or third-parties); the (maximum) amount of the claims to be covered; and setting time limits. Mandatory notifications and a duty of the invoking party to mitigate their damages are also common elements.

Another useful contract provision is a clear, accurate, and sufficient description of the counsellor's services to the agency, its employees, and its clients. Such a description is a practical guideline for the counsellor, but it is also useful if a claim is later filed, because it enables the counsellor to point to this wording to argue that the plaintiff's harm was not related to the counsellor's contracted services.

TO CONCLUDE

Counsellors providing services to an agency as independent contractors should ensure their service contracts contain an indemnification provision and a clear description of the services the counsellor is being asked to provide. If a contracting counsellor faces a threat of or claim for damages, the counsellor should immediately notify Mitchell and Abbott, the official insurers for the BCACC. ■

George K. Bryce, BA, BSc, MHA, LLB, Barrister & Solicitor, is legal counsel for the BCACC.

SELF-HARM AS HARM REDUCTION

PERSPECTIVES ON THE CULTURAL AND FUNCTIONAL CONTEXTS OF NSSI AND HOW TO RESPOND

BY TED LEAVITT, RCC

My first experience with cutting was when I was 17 years old. I desperately wanted a tattoo, but there was no way my parents would allow it. One day, while playing basketball at school, another player tried to swipe the ball away from me and scratched my hand, drawing blood. Like any typical teenage boy, I slowly picked away at the scab until it had finally healed. What was left behind was a perfectly straight, raised line. It was as if I had been engraved, which gave me an idea. I thought, "What if I carved a design into my skin, instead of a boring old straight line?"

The next day, I drew an outline of a shape on my left bicep and took a knife from the drawer in the kitchen. I scraped the tip of the knife along the outline I had sketched and went over it repeatedly until blood was drawn. In the end, my plan worked out perfectly, and I was left with a raised scar in the shape I wanted. This led to a series of such projects in various spots on my arms and hands, using a variety of implements, ranging from knives to thumbtacks. At this point, I believed I was just being creative.

It wasn't until a couple of years later, as I had slowly been adding to my decorative collection, that I began to notice a different purpose to this activity. Whenever I would make a large, regrettable mistake in my life, I would tell myself, "If you carve a shape into your skin, it will remind you of this moment, and you will not make this mistake again." I did this sporadically until I began to recognize the unhealthy pattern and found other ways to punish myself. It wasn't until years later, when I was in university and studying non-suicidal self-injury (NSSI), that I realized what I had been up to all along.

You see, as a 16-year-old kid with undiscovered ADHD and depression, my emotional state was unstable at best and always leaning in a negative direction. The artwork on my skin was not just decoration; it was a form of self-soothing. It was not a conscious cry for help because I did not really know how badly I was suffering, but neither was it a step towards the edge of mortality in the form of suicide. It was a warm blanket to wrap around the cold despair I felt in moments of loneliness, regret, and hemorrhaging emotion.

NSSI encompasses a variety of actions that lead to injury to oneself with no intention of causing death. This may include cutting, scratching, burning, hitting, or constricting (wrapping string or other material tightly around a limb or digit). While these behaviours and their attendant results may be culturally unusual and even considered distasteful or unhealthy, they may not actually be linked to more serious mental health conditions.[1]

When clinicians are exposed to NSSI in clients, it is important they view these behaviours not only in a culturally sensitive context, but also in a functional context. When considered through these important lenses, counsellors may find increased clarity as to the appropriate response required on their part.

Regardless of the function of NSSI, clients and counsellors should always be aware of the inherent dangers involved in the practice.... A person who is cutting on their wrist... runs the risk of cutting in the wrong spot or cutting too deeply.

HOW TO RESPOND TO NSSI

Ascertain the cultural and functional context through the use of curious inquiry:

Explore the functions listed here, as well as any other possibilities suggested by the client.

Determine whether the practice is safe:

What implements or methods are being used? How do they care for the wound? Are they prepared to call for medical assistance if necessary?

Assess the progression of the activity, if any:

Inquire about the timeline of NSSI and try to determine whether the level of risk has elevated or changed over time.

Explore alternate, less risky ways of achieving the same goals:

Help the client see the temporary nature of NSSI as an affect regulator or attention grabber and try to come up with strategies that are healthier and safer in the long-term.

CULTURAL CONTEXT

NSSI is often referred to both colloquially and professionally as self-harm, but this label carries with it a cultural bias. The word "harm" not only describes injury but also carries as its synonyms words like mistreat, misuse, and abuse. While some may view deliberate injury to one's physical self as obvious abuse of the body, others may view it as therapeutic or even decorative. Indeed, the same person who may recoil at the thought of sliding a razor blade across their thigh would think nothing of having a needle pierce their ear, nose, tongue, or other body parts.

And while it may be socially acceptable in our culture to wax poetic about the value of a glass of wine at the end of a long day, if a person were to soliloquize about the soothing effects of a flame applied to the back of the hand or the fingertip, they would be looked upon as seriously unwell or in some other derogatory way.

What is the difference between these activities? The main difference is that one is socially constructed to be an acceptable activity and the other is not. However, it is important to remember that social constructs are not the same as objective facts. The norm describes the statistical area in the middle of the bell curve but does not objectively mean healthy or desirable, except as the dominant culture decides to apply those labels.

FUNCTIONAL CONTEXT

There are many possible functions of NSSI that are easier to recognize when we look below the scarred or scratched surface.

Affect Regulation: The brain's emotion-processing area, the limbic system generally and amygdala specifically, determines the presence of external threats and automatically determines the response to those threats. Because, at birth, physical and emotional threats are one in the same, the amygdala shares responsibility for responding to both and, left to its own devices, will continue to overlap its assessment and response to both. What this means in practical terms is that the brain responds to emotional threats in much the same way it responds to physical threats. This is one of the reasons a person might lash out physically when they have been insulted.

A further implication of this crossover is how the brain responds to pain, which is typically present during external threats. In response to emotional pain and suffering, the brain will release a small amount of endorphins, just as it would if there were a small physical injury. In terms of NSSI, the endorphins are triggered by the physical injury and have a crossover impact on the emotional injury. This results in a temporary blunting of the emotional pain, which is often experienced as a feeling of relief or release by the individual engaging in NSSI.

In addition to this function of NSSI, many individuals who experience depression or anxiety report dissociative feelings or flattened affect. NSSI can provide a brief glimpse of feeling in the midst of a sea of numbness. Indeed, many clients report engaging in NSSI just to feel something. This sentiment is expressed in the song, "Hurt" by Nine Inch Nails, in the lyrics: "I hurt myself today to see if I still bleed."

Suicide Prevention: NSSI may be done to soothe pain or to cause it, as stated above, but not all NSSI is motivated by self-care. In addition to these purposes, it can be driven by anger, self-loathing, self-punishment, and shame. Despite these unpleasant and unhealthy causes, NSSI may also prevent

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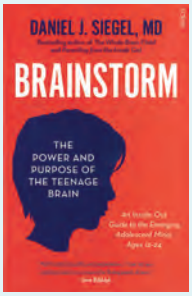

Brainstorm: The Power and Purpose of the Teenage Brain by Daniel J. Seigel, MD (Tarcher Perigee, 2014) provides an overview of what is happening developmentally with the adolescent brain.

SiOS: Self-injury Outreach and Support: A collaboration between Guelph and McGill universities: SiOS is website dedicated to self-injury and offers resources for people who self-injure, as well as parents, schools, and mental health professionals. sioutreach.org

Prevalence and correlates of self-injury among university students, a study authored by S.E. Gollust, D. Eisenberg, and E. Golberstein

This study found that factors associated with a significantly higher likelihood of self-injury included cigarette smoking, concurrent depressive and anxiety disorders, and for men, growing up in a family of low socioeconomic status and having symptoms of eating disorders. Only 26 per cent of those who reported self-injury received mental health therapy or medication in the previous year. The study concluded that students who harm themselves experience high anxiety and distress, yet are unlikely to seek help. Journal of American College Health. 2008 Mar-Apr; 56(5):491-8

further harm in the form of suicide. Some people report engaging in NSSI as a way of temporarily getting rid of suicidal thoughts or ideation.[2]

Attention Seeking: Often, when individuals engage in NSSI, it can be dismissed by both the lay person and professional as simply attention-seeking behaviour. It can be seen as a form of manipulation or attempts to gain sympathy or affection and misinterpreted as a willful act. While this may sometimes be the case, even if it is true, it should give the counsellor pause to ask, "Why does this seem like the best option for this person?" In other words, if we accept that all behaviour is a form of communication, we might do well to ask what NSSI is communicating about the life circumstances, social supports, and affect-regulation realities of the client. Often people go to great and dangerous lengths to gain attention from others, because they feel it is their only chance to get it. Unfortunately for some, they are correct.

In addition to being a form of communication, NSSI can also be a form of connection within cultures or peer groups. It is very common for subcultures to create distinctive identities — visual representations of their separation from other groups. From a team uniform, to the colours, signs, and artwork associated with gangs, to an extended family who all get the same tattoo to honour their deceased grandmother, marking the body and appearance have been around as long as humanity. Sometimes NSSI may be nothing more than group ritual.

While these are just a few of the possible utilities of NSSI, before we proceed in treatment with an individual engaging in these behaviours, we would do well to help them determine the function of NSSI in their life.

RISKS

Regardless of the function of NSSI, clients and counsellors should always be aware of the inherent dangers involved in the practice. In particular, due to the chemical payoff of NSSI, the brain can develop tolerance to the endorphin release, and, as such, the individual may develop an addictive relationship to the practice. This would result in greater risks each time.

It should be noted that in affect-regulation functions of NSSI, the effects are typically temporary and less effective over time. This escalation of behaviour in search of the chemical reward can lead to accidental serious, lasting injury and even death. A person who is cutting on their wrist for any of the above reasons runs the risk of cutting in the wrong spot or cutting too deeply. Additionally, not properly caring for the wound may lead to long-term medical complications up to and including death.

All of these perspectives and considerations aim to broaden our understanding of NSSI as counsellors and increase safety for our clients. ■

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

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2 Curtis, Kate. Non-suicidal self-injury: Suicide risk or social activity? *New Zealand Journal of Psychology.* Vol. 46, No. 3, November 2017. http://www.psychology.org.nz/wp-content/uploads/NSSI-Suicide-risk-or-social-activity-private.pdf

ANYWHERE BUT HERE

BY CAROLYN CAMILLERI

Working with clients who have been mandated into counselling

People are mandated into counselling for many reasons. A spouse threatening to dissolve a relationship, a family threatening to sever ties, or an employer threatening job suspension. Sometimes a completed treatment program will "look better" for someone charged with an offence or making an appeal. Formal mandates are court-ordered and may be part of a probation order for a sexual offence or domestic violence charge. A common pathway to court-mandated counselling: drunk driving. It's the idea of "getting someone the help they need" even when that person hasn't asked for help. And as various as their reasons for being in counselling may be, most mandated clients share one common element.

"They don't want to be there, generally," says Mike Mathers, RCC, who currently works with addictions and spent seven years working with clients convicted of sexual offences. "They come in with a chip on their shoulder about being forced to be there."

As would anyone else.

"Nobody likes being forced to be where they don't want to be," says Dr. Harry Stefanakis, who is renowned for his work with domestic violence offenders. "It actually makes sense that they feel this way."

Mandated programs are often group sessions, and one of the biggest advantages of groups is that clients quickly realize they are not alone.

"They may feel like monsters — very isolated and feeling like they've suffered uniquely — but, in the group, they hear other stories, and it starts to create compassion," says Mathers, adding that if they can accept someone else who did something they disagree with, maybe they can move through their own shame towards change.

Dr. Ross Laird, RCC, who specializes in addictions treatment, agrees that groups can be a powerful way to help people heal. "People can have a clearer picture of themselves and of other people in the group context, and they often can't in individual contexts."

But groups come with challenges, Laird adds, especially as so many people have histories of mental health issues and trauma. "Groups require a very seasoned, professional facilitator. Addiction training programs usually don't provide that level of training, so people have to pick this work up in their own professional way."

Another challenge: the programs are short — 12 to 15 weeks. "It's really a token effort, and not sufficient to do anything other than maybe raise some questions for people," says Laird.

But it's not hopeless.

"Occasionally, I've worked with people who've been mandated and that was their pathway to waking up," says Laird. "It's very difficult to predict. It's always a surprising and humbling kind of work, because it's easy and very tempting to get behind the clients who seem to be doing well, and so often, when that happens, there's a very humbling moment later when their life goes sideways."

So how do you start, when your clients don't want to be there, you've only got a few weeks, and the outcome is unpredictable? Stefanakis, Laird, and Mathers talk about their approaches in different areas of specialty and offer distinctive, enlightening perspectives.

MANDATED PROGRAMS ARE OFTEN GROUP SESSIONS, AND ONE OF THE BIGGEST ADVANTAGES OF GROUPS IS THAT CLIENTS QUICKLY REALIZE THEY ARE NOT ALONE.

DOMESTIC VIOLENCE

"The first thing is to recognize the reality," says Stefanakis. "We start by naming it and saying, 'Yeah, it makes sense to me that you don't want to be here.' Just naming that truth softens people, because you're acknowledging their reality. You're starting by treating them as human beings first."

Stefanakis says men facing domestic violence charges have to figure out how to negotiate through two very real dilemmas. The first is how to accept responsibility for having engaged in abusive behaviour — effectively, accept the identity of a monster — and remain redeemable as a human being. The second dilemma is if you acknowledge abuse, how do you allow for change — especially since the prevailing belief is that the best predictor of future behaviour is past behaviour.

"Because if you can't do that, then you're stuck with the identity of just being an abuser," says Stefanakis.

Excuses, minimization, and denial are the first ways someone is likely to try as a means to negotiate these dilemmas and avoid accepting responsibility. In fact, this is how most of us deal with our transgressions.

"Part of the work involves helping the men accept responsibility, while finding a different way of meeting the dilemmas," he says.

How Stefanakis orients client attention provides context for how he works. "If we put the focus on them being human first, then we're creating some space for them to see themselves as redeemable," he says, noting that he has various ways to access the ability to redeem while helping clients take accountability.

"We also want to break out of the locked-in focus they might be in that there is no way they can lean into any of this without being seen as a bad or crazy or weak person," he says, adding that he may use metaphors and the element of surprise. "Clients expect me to be hard on them for not wanting to be there, and when I don't go in with an attack, it shifts orientation."

The third aspect to understanding the context of Stefanakis's work is the intelligent compassion framework, which he details in his book *CORE Living: 8 Choices for Living Well.* CORE is an acronym for centering, opening, releasing, and extending.

"When people think about compassion, they think about it in a unidimensional way: compassion as a soft, gentle, caring emotion," he says. But an aspect of compassion often gets missed: it's about relieving suffering *and* promoting change. "To relieve suffering and promote life-affirming change, compassion requires us to hold ourselves and others accountable. Compassion can, therefore, be direct and sharp, but it's always got caring *and* the desire to make things better."

Compassion also helps us see the whole person: the capacity to be abusive as well as redeeming qualities.

> Addiction's not really about the addiction — it's about what's underneath the addiction and, typically, that's a mental health challenge of some kind, and often, there's also something underneath the mental health challenge — **trauma or early childhood developmental issues**.

To help people see both perspectives in themselves, he asks clients, usually at intake, to tell him two of their strengths and two things they'd like to change about themselves. This creates a space to talk about change in a context where there is already an assumption the client has redeeming qualities.

Stefanakis also asks clients to identify their "how" values: principles for how we treat others and ourselves. "I've done this internationally. I've done this with inmates in prisons. I've done it with teachers, health professionals, and everybody gives me the same list, for example, respect, honesty, trust, compassion, loyalty, patience, tolerance, equality, fairness."

By simply naming these values, the client is making two claims: "One, that they're redeemable — they're claiming pro-social values. Two, they're also arguing against violence indirectly. Now, the challenge becomes how do you live up to your own values — not how do you change in the way I'm telling you to change," says Stefanakis. "We actually frame giving up your values as an act of weakness and living your values as an act of courage, which works well with men. We've turned the work, not only into a redeemable thing, but also into an act of courage and a thing that promotes change."

ADDICTION

"If you think about what kinds of circumstances lead someone to go so far down the track of addiction that they end up being court-mandated into treatment, that's somebody who has a long history of people trying to convince them to change their behaviour and a long history of resistance towards changing that behaviour," says Laird. "These clients are often deeply committed to their pathway."

To build enough trust to even have a conversation, Laird starts by "taking people where they are at" — even if clients themselves don't know. "I take the approach of being curious, maybe sharing with them what I notice about their behaviour and being curious about it," he says. "It's really important that conversation not be predisposed towards a particular outcome."

While addiction may be the pathway into counselling, the substance doesn't matter.

"Addiction is not really about the addiction, about using — it's about what's underneath the addiction and, typically, that's a mental health challenge of some kind, and often, there's also something underneath the mental health challenge — trauma or early childhood developmental issues. So addiction is almost never about using, and, in that sense, all addictions are the same. Addiction is what we do instead of facing ourselves."

Because trauma is often an underlying issue, it has to be handled carefully in a group setting. "People often want to talk about their trauma, and that can be very activating for other people in the group," says Laird, adding that, for a long time, sharing trauma in groups was encouraged in addictions recovery. It has since been widely acknowledged as a bad idea. He explains: "For a person who is not addicted — a healthy, self-aware person grappling with trauma recovery — that process is going to take several years. Healing trauma is a rich, deep area of inquiry and very personally demanding and we're talking about healthy people who aren't hobbled by addiction or homelessness."

For addicted people, revisiting trauma is a situation of immense vulnerability. So while it's important for people to recognize adaptive patterns of addiction are typically rooted in trauma, revisiting trauma is often counter-productive and dangerous. Instead, Laird focusses on strategies for addressing the response to trauma and resulting behaviours using self-awareness, self-reflection, and self-regulation. Healing the experience of trauma, he emphasizes, is largely about teaching the body to respond differently and developing creative solutions for escaping frozen response patterns.

Laird also focuses on education. "It's important people understand addiction as an adaptive behaviour that's not accidental. Their chosen substance makes sense given their history. It didn't happen because they lack willpower or moral fibre. Addictions provide temporarily effective strategies for coping with difficult circumstances and traumatic situations. Eventually, those coping strategies become persistent habits."

He emphasizes self-awareness practices in conjunction with bodily modalities — for example, physical exercise for healing behaviours associated with depression or mindfulness activities to increase awareness of emotional reactivity. "We spend a lot of time in counselling on the idea of insight, and

LEARN MORE

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insight is important, but it doesn't get you all the way there with trauma and addictions. You can't just 'insight' your way through this. You have to teach yourself new behaviours as an embodied human, and this is largely about working with the body directly."

SEXUAL OFFENCES

Actual participation in counselling is voluntary — even for court-mandated clients. "Essentially, the choice is whether they want to attend this group or face the consequences of a breach, because we don't decide what breaching is going to entail," says Mathers, adding that some do choose to breach court orders. Respectfully framing counselling as a choice does two things: highlights client autonomy and gets them intrinsically motivated in the process.

Mathers incorporates CBT, ACT, Adlerian, and existential approaches into sessions as they progress, but he starts by building rapport using Motivational Interviewing (MI). MI is a style of communication, with autonomy, respect for human beings, empathy, open-ended questions, and reflective listening as key principles. From an MI perspective, Mather's role is as a guide, rather than a leader. A good guide takes what they know about individuals — preferences and strengths, what they do well and not so well — and asks them what kind of experience they want, while pointing to possible outcomes depending on their choices. "Autonomy starts from how you greet them at the door, how you give the orientation, how you outline session structure. Every single thing. It's the first session. And if they walk out thinking it wasn't as bad as they thought it would be, that's a hugely successful first session."

How often do men have a place where they can talk openly about their feelings?

Emotional safety is important in any group, but with convicted clients, physical safety is also critical, particularly with institutionalized clients. "They are literally under threat from the moment they're charged," he says. Once rapport and safety are established, group cohesion is next. Mathers says cohesion is for groups what the therapeutic relationship is for individual therapy. "Cohesion is the single biggest factor, and it usually builds over the first few sessions. Rapport, safety, cohesion — there's a dance between how they all relate."

About three or four weeks in, watching clients during breaks indicates the level of cohesion. "Are they sitting there silently or are people talking to each other? By the end, they actually start to enjoy it, especially men. How often do men have a place where they can talk openly about their feelings?"

After a few sessions, clients may start to self-select goals, but Mathers is cautious about goals: they have to be self-selected and smart — specific, measurable, achievable, realistic, and time-bound. "I never want a client leaving a session saying, 'Maybe I'll do it.' If it's not at 95 per cent, we need to scale it back." There also has to be a link with their values. "Values are the piece that kind of unlocks the mandated client, because value-based focus creates intrinsic motivation. It's centrally linked with how that person wants to show up in the world. If we can align with that and get them to align with that, change proceeds in a simpler fashion."

Goals might relate to exercise or could target mental health (gratitude, changing thoughts, acceptance of painful feelings), or a goal may be relational. "Men convicted of a sexual offenses generally don't have good social skills," says Mathers. "This is a link that runs through everything. We really need other people. When we don't have healthy channels of relationships, we may do something maladaptive that might harm someone else."

It comes back to autonomy: helping clients identify their own issues and ways to make themselves better versus

telling them how to change. "That's how human beings are," he says. "If we try to argue with people or bang them over the head, they're going to argue in the other direction. That is not resistance. We all value autonomy. We need to feel like we're the authors of our own lives."

Mather's slogan: "I don't need to convince my clients of a problem or the need to change."

"However," he adds, "I do have influence in the relationship in how I show up as a human being relating to another human being."

WHAT DO GETTING BETTER AND SUCCESS LOOK LIKE?

It depends on the perspective.

"It can be non-recidivism, or increasing the chances of non-recidivism. That's getting better. Maintaining a relationship they're invested in. I would say that's getting better," says Mathers. "But who gets to define what getting better looks like?"

With court-mandated clients, there is another perspective to consider. "For the purposes of the criminal justice system and what they contract us to do, it's not always about getting better," says Mathers. "Rehabilitation is considered the focus, but public safety is actually what they're there for."

Criminal justice and "getting better" may even be at odds with each other. "Being ostracized, being put on lists, being stigmatized, having to declare your charges to everybody you know around you, not being able to work in certain places, not being able to have certain housing — that does not often help people get better," says Mathers.

That's punishment, a distinction Stefanakis addresses. "If you're just going to punish people, then just say 'I'm just going to punish people' — don't say you're doing therapy. Don't say you're doing corrections. You might as well just call it punishment. But the research is very clear that punitive ventures alone do very little to promote change. In fact, they tend to increase or entrench negative behaviours, so it doesn't help society. It doesn't help those who've been victimized. It may make us feel better in the short term, but it doesn't do anything in the long term and, fundamentally, those are the same excuses guys use when they act in an abusive way. They feel they have some excuse, some justification, for their own victimization."

We really need other people. When we don't have healthy channels of relationships, we may do something maladaptive that might harm someone else.

For clients with addictions, success also depends on perspective. Laird explains: "Does success mean they will never use substances again? Or does success mean they'll make some small amount of traction in improving their lives? Many families and loved ones of people in addiction understandably want to push them in a direction that looks like health, and they want to convince them of the value of changing their behaviour," says Laird. "And I think that's reasonable from a loved one's point of view. But from a counsellor's point of view, you have to take people where they're at."

Most people in addiction are not going to just stop using and suddenly transform their lives, Laird adds, pointing to the challenges healthy people face making incremental changes to eat better or exercise more. "As a counsellor, you must avoid the trap of being tied to particular outcomes."

Mathers brings up another reality: clients may be there simply to "check the box" for a treatment program, or their goal may even be to ensure no one ever finds a way into their issues. So, as a mental health professional focussed on helping people get better, he aims for wellness — whatever that means for the individual, which can lead to increased public safety. "If people are getting their needs met for well-being, they're less likely to do something that's going to harm someone else. Generally, improving quality of life tends to reduce risk. Ideally, you can check both boxes at once, sometimes in small but incredibly significant ways."

Laird says, "Human beings are immensely complex and unpredictable." He adds that, with addiction in particular, healing is punctuated by a moment of readiness. "That moment of readiness is a mysterious thing. It's not something you can predict or shape. It's a deep, internal process we don't understand at all."

And you never know: something in a group treatment program for mandated clients may be the first step to turning their life around. ■

MAJOR MILESTONES CRISES

NAVIGATING ISSUES BETWEEN FIRST-GENERATION AND SECOND-GENERATION CANADIANS

BY KULJIT BHULLAR, RCC

"Why don't your parents just understand?" As a second-generation Indo-Canadian, this is the question, frequently posed by my Euro-Canadian peers, I dreaded hearing the most. How could I explain the intergenerational issues of scarcity, racism, and assimilation that shaped the world concept my elders inherently held? And how could I expect my parents to understand a culture they had not fully experienced, even after years of living in it? I often found myself distressed, caught between my parent's traditional Indian values and conflicting values of the dominant Canadian culture.

Somewhere between newly arrived immigrants and families who have lived in Canada for generations is the second-generation child. Second-generation Canadians obtain a unique perspective when they are born into a culture new to their parents and families. According to the National Health Survey (2011), second-generation Canadians make up 17.4 per cent of the total population — almost six million people. While this group is nearly one fifth of our population, their silent existential crisis is rarely discussed or acknowledged.

Maslow argued that we are all driven by a hierarchy of needs.[1] He identified "belonging" as the single-most important desire one strives for after physiological and safety requirements have been met. Maslow described belonging as experiencing a sense of community, love, and friendship through connection with others. However, when one is "of two worlds," the need for belonging is more complex. A second-generation Canadian strives to maintain inherited connections to family and culture while forming new relationships in territory uncharted by those before them. Internal conflict arises as one manoeuvres between the expectations and cultural norms of the two very different groups to which they attempt to belong.

A second-generation Canadian strives to maintain inherited connections to family and culture while forming new relationships in territory uncharted by those before them.

CASE STUDY*

Karen, a 26-year-old woman, walked into my office with an older woman behind her. This was the first time she had come to see me. Karen sat across from me and had little to say; the woman with her remained standing by the door. I waited to let Karen introduce the woman she had brought with her, but I eventually had to inquire myself. "I am Manjit, her mother," she responded. After some time had passed, Karen and Manjit shared that they had been experiencing ongoing issues within their relationship. Karen had initially planned to see me on her own. However, as more information came forward it was evident both Manjit and Karen could benefit

**Cases and details have been altered to protect client privacy.*

from working through their issues together. We spent the next few sessions exploring the underlying difficulties within their relationship, and it became quite apparent that the primary cause of these issues was their differing world concepts.

Manjit immigrated to Canada in her early 20s after marrying Karen's father. Karen was born two years later to parents who were farm workers with few social ties in their new community. "I want her to know where she comes from," Manjit said, despairingly. Karen yelled back: "I don't get along with most of the family. Why does she keep pushing me to be more like my cousins?"

Their primary wishes became clear in the safety of the counselling environment. Manjit was holding onto a fear that her cultural roots would be lost if she failed to pass them on to her children. Unconsciously, Manjit felt guilty for leaving her native country and was trying to compensate by instilling stringent beliefs and values in her children. On the other hand, Karen, having grown up in a Western individualistic culture, was feeling pressure to differentiate and was separating from her ancestors' communal values. The issues between

them began to resolve as they started to understand the underlying worries driving their behaviour.

JOB VS. CAREER

Choosing a career is in itself a very difficult task. J.L. Holland created a theory arguing that the interaction between one's personality and a compatible work environment determines career choice.[2] What this theory and others like it fail to consider are the beliefs and values one associates with the concept of career.

For immigrants struggling to establish themselves in a new country, the concept of a career may be non-existent. Career choice is not a luxury awarded to all — many immigrants look for any viable work as a source of income to make ends meet. Therefore, many children of these parents witness their caregivers work at jobs they do not enjoy for the well-being of their families. Many second-generation Canadians do not grow up hearing discussions about rewarding work endeavours: instead, they are raised with a pervasive fear of limited income and scarce resources. Choosing a career is a risk and a predominantly Western concept, stemming from individual desires as opposed to family responsibilities. Second-generation Canadians are typically the first in their families to make decisions based on hopes, dreams, and interests, but the parental lack of security may still influence one's decision, even when scarcity is no longer an issue.

"I want to quit my job. It's something I need to do for myself!" Karen cried, voicing her frustration about her job as a bank teller. Karen and Manjit had come in for their fourth counselling session and wanted to discuss an ongoing argument. Karen had been working at a bank for the last three years and was feeling unhappy and unfulfilled with her job. "Her dad and I are heartbroken. She will never find a job like this again," Manjit said.

Karen wanted to pursue her passion for culinary arts, but her parents were unsupportive. "Why do you care what I do? It's my life, not yours!" Karen said with angst. Manjit explained her fear about what Karen's life might look like if she struggled to find a stable job. The inevitability and passion with which Manjit spoke alluded to the probability of some unresolved memories. With further exploration, Manjit disclosed her experience of losing her first job in Canada. "I didn't do anything wrong. I came in early, I worked late. I even offered to work six days a week," she explained, referring to her job at a local bakery. After only three weeks, she was fired because her manager claimed her English was poor. "I was doing everything I could to learn the language. My husband and I listened to the radio every evening to try and learn as much English as we could."

Karen turned to her mother to give her a hug. Moments passed and Manjit looked up at me with despair and said, "The hardest part was, in my heart, I knew it had nothing to do with my English. He just didn't like who I was. Where my roots grew. I was simply too different from the world he knew."

The remainder of the session was spent exploring the disappointment Manjit and her husband experienced that day, and the subsequent fear they carried with them throughout their lives. Manjit described her pervasive sense of financial insecurity, despite the many years she has lived in Canada. It became clear to both Manjit and Karen that the conflict arising from Karen's decision to quit her job was due to the clashing of two different lived experiences.

STAGES OF LIFE

Adolescence is a time in our lives when we begin to gain a greater sense of self and outline who we want to become. The German-American developmental psychologist and psychoanalyst Erik Erikson defined this stage as the period of identity versus role confusion. He argued that, during the ages of 12 to 18, one undergoes an internal examination of personal values and beliefs.[3] Through self-examination, one defines their personality and future direction in life. This theory is based on the Western notion that, at this age, one has undergone enough reflection to begin to form a strong sense of self. However, for the second-generation Canadian, identity formation and role confusion is something many may struggle with throughout their lives.

What is missing in most Western theories of development is the recognition of a different layer of complexity involved with identity formation. The misconception is that most adolescents have individuated themselves by a particular period in their life: what many fail to realize is, when you belong to two different cultures, you continuously navigate through distinct worlds at every milestone. This internal conflict of identity and role confusion does not resolve — instead, it persists either consciously or unconsciously as one decides how to approach life's big questions.

MARRIAGE

Undoubtedly, getting married is one of life's biggest milestones and is highly regarded in both Western and Eastern cultures. However, prior to getting married, one must choose a suitable partner. Walk through any bookstore and you are likely to notice a title or two about finding the right life companion. People may offer advice on choosing someone with similar interests and who "makes you laugh." However, the criteria is defined very differently between cultures.

Many communal cultures view marriage primarily as the merging of two families as opposed to two individual people. Values passed on about how one should choose a life partner are based on decisions about what would be best for all parties involved: parents, grandparents, and even siblings. Marriage may bring huge family pressure to someone who represents two cultures.

Depending on where you stand, many negative assumptions are made about each culture's viewpoint on the collective versus individual notion of marriage. However, a second-generation Canadian has a unique understanding of the rationale behind both perspectives.

"We used to argue a lot about who I was going to marry," Karen said, laughing and reflecting on previous conflicts. I had asked Karen and Manjit to look at obstacles they had overcome in their relationship prior to counselling. Karen and her mother had already come to understand and accept their unique perspectives on marriage.

"I used to worry our culture and roots would be lost if Karen did not marry someone of the same background as us," Manjit said. Manjit was describing issues that come up for many immigrants when they assimilate into a new culture. After losing so many aspects of their roots, they struggle to hold on to any and all parts of their culture still within their reach. These parents strive to pass on their values and rituals to ensure their roots still continue to grow within the next generation.

Manjit explained she had come to understand Karen's happiness was important and forcing values on her would only push her away. She recognized Karen's need to carefully examine her culture was indicative of a split within herself, and Manjit accepted that freedom to explore, not pressure to conform, was necessary for healing the split.

"Being a parent is hard," Manjit laughed. Karen looked at her mother lovingly and nodded in agreement. The wall between them had lifted and they were coming to understand the internal and external factors that triggered their fears.

INTEGRATION

It is evident that the journey of a second-generation Canadian is filled with many questions, challenges, and surprises. Although challenging, the members of this group are given the unique perspective of belonging to two very different worlds: cultures so distinct that members of the varying groups often struggle to understand one another. In between both cultures, the second-generation Canadian begins to develop a sense of self from their enriched viewpoint. Eventually, after many stumbles and falls, one's internal conflict begins to quieten and the influence of both cultures starts to unconsciously flow together like a well-choreographed dance. ■

Values passed on about how one should choose a life partner are based on decisions about what would be best for all parties involved: parents, grandparents, and even siblings.

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A CYCLE OF TRAUMA AND GRIEF

Indian Residential Schools may be closed, but colonization and assimilation have continued under Canada's child welfare system

BY LAURA RHODES, RCC

The legacy and sorrow of Indian Residential Schools (IRS) in Canada is not a secret. The history of IRS has become mainstream knowledge for most Canadians, since the publication of the Truth and Reconciliation Report in 2015. The British Empire operated residential schools in many commonwealth colonies, and the confirmed events of emotional, mental, physical, and sexual abuse that occurred have created a perpetual cycle of trauma and grief for Aboriginal people across the planet. In Canada, IRS provided a means for assimilation, an avenue of colonization, and the cultural genocide of a people.

IN THE BEGINNING

Historically, the Indigenous people resisted the demands of the commonwealth to send their children to IRS. It became mandatory with the implementation of the Indian Act in 1876, which meant Indigenous people were threatened with incarceration if they did not comply. The cycle of children leaving home at about five years of age and not returning until 18 years of age was the start of many challenges to come for Indigenous people.

From 1857 to 1996, approximately 150,000 children attended IRS.[1] For every child, there were two parents, aunts, uncles, four grandparents, and eight great grandparents. The web of connectedness between a child and adults is vast in any family. In Indigenous families, the ties to people are by blood and by community. For example, a woman's best friend is an aunt to her children and the children call each other brothers and sisters. It is a kinship system of cooperation and support that ensures children always have an adult mentor to look up to and learn from.

As children were removed to IRS, parents were left with an abnormal kinship and social system. It was difficult

IRS IS THE PIVOTAL IMPLEMENTATION OF COLONIZATION THAT PROMOTED ASSIMILATION AND THE DECONSTRUCTION OF INDIGENOUS HOLISTIC SYSTEMS.

to pass on language, culture, and traditions if the children were gone. If you have ever counselled someone who has lost a child, you hear their sorrow and feel their deep grief. Imagine a mother who has lost every child and a community of barren homes. A mother and father lose their natural ability to parent when their child leaves at five and returns at 18 — it is impossible to know the returning person — and issues around identity, attachment, and trauma keep the family from healing completely.

That cycle of mandatory IRS attendance is repeated with each generation. Addictions, neglect, and poverty become prevalent among Indigenous people unable to cope with their own abuse in IRS, as well as the abuse they fear their children are experiencing.

LOSS OF CULTURE

Of course, the IRS system is not the only contributor to the social, economic, and political challenges Indigenous people are experiencing today, but IRS is the pivotal implementation of colonization that promoted assimilation and the deconstruction of Indigenous holistic systems.

Indigenous people have a spiritual and physical connection to the land. All levels of existence are based on food from the land, clothing from the land and animals, dwellings built from the land, transportation on land and water, and traditional ceremonies offered on the land to the air, water, all the beings that travel on the earth,

AFTER HIS ATHLETIC SUCCESSES, TOM LONGBOAT WAS INVITED TO SPEAK AT THE INSTITUTE BUT REFUSED, STATING:

"I WOULDN'T EVEN SEND MY DOG TO THAT PLACE."

and our ancestors. Leaving home at the age of five means these connections were weakened and marginalized with teachings of Christianity and industrial vocations. Knowing how to sew on a machine is not going to help much when you need to tan a hide. Knowing how to fix a car motor is not going to help much when your dipping net needs to be repaired.

Very few stories of happiness and appreciation exist around IRS. The vast majority of Indigenous children who attended have bitter, sorrowful memories. In 1899, Tom Longboat a famous Indigenous long-distance runner at the turn of the twentieth century, went to IRS:

"Longboat grew up on a small farm in a poor family. He was enrolled at the Mohawk Institute Residential School at age 12, a legal obligation under the Indian Act at that time. He hated life at the school, where he was pressured to give up his Onondaga beliefs in favour of Christianity, as well as his language. After one unsuccessful escape attempt, he tried again and reached the home of his uncle, who agreed to hide him from authorities. After his athletic successes, he was invited to speak at the institute but refused, stating: "I wouldn't even send my dog to that place."[2]

THE TRANSITION TO CHILD WELFARE SYSTEMS

Though IRS continued operating well into the twentieth century, during the 1950s and 1960s, a new process of assimilation began.

Politically, Canadian Indigenous people were not permitted to hire lawyers until 1951 and did not have the right to vote federally until 1960, which limited their abilities to lobby governments for changes to IRS. After several generations of mandatory IRS attendance, many Indigenous families were struggling emotionally, mentally, economically, and spiritually. The increased rates of addiction, childhood neglect, and abuse became overwhelming, with trauma and grief further compounded by the knowledge of what their children were facing. Natural holistic knowledge and parenting skills were broadly lost. Any remaining culture and traditions were preserved only by pockets of Elders who were fortunate to have teachings passed down to them and who worked to maintain what knowledge they could of the language, land, animals, and spirits.

But connections to identity and purpose were damaged. There was an epidemic of alcohol and drug use, and suicide rates increased to tragic proportions: "The now-defunct federal Indian Residential School System (created under direction of the Indian Act) left a legacy of physical and psychological trauma which has contributed to the disproportionately high suicide rate seen in some Indigenous communities."[3]

All of these factors meant children were being removed from Indigenous homes for their protection. During the settlement of the new world, parents lost their children to mandatory attendance at IRS; by the 1960s, parents were losing their children to the Child Welfare Protection Services (CWPS) for reasons of poor parenting.

LOSS OF IDENTITY

CWPS was a different process. At IRS, Indigenous children left their parents and communities but the children still had each other — the students created family and took care of each other as best they could. In CWPS foster care homes, children were separated/segregated from family members and often lived in non-Indigenous homes void of Indigenous culture and traditions. This was devastating to the child's ability to develop a healthy Indigenous identity. Mental health issues and addictions became increasingly evident as the decades marched on.

"Although the practice of removing Aboriginal children from their families and into state care existed before the 1960s (with the residential school system, for example), the drastic

overrepresentation of Aboriginal children in the child welfare system accelerated in the 1960s, when Aboriginal children were seized and taken from their homes and placed, in most cases, into middle-class Euro-Canadian families. This overrepresentation continues today."[4]

In 1951, the number of Indigenous children in care in B.C. was 29; by 1964, there were 1,466 Indigenous children in care and represented an increase from one per cent to 34 per cent of all children in care in B.C.[5] Today, Indigenous children under the age of four make up 50 per cent of children in care in Canada, even though they make up only seven per cent of the total population of Canadian children.[6]

It is not surprising Indigenous people view the CWPS in Canada as being more destructive than IRS. Moreover, it has created an abnormal existence for many Indigenous parents. Most people can have a beer after work without fear of reprisal, even if they have children in their home. An Indigenous parent is more likely to hide that beer out of fear their children might get apprehended due to alcohol abuse. Some parents have anxiety going to schools to see their children or meet with teachers. The possibility of the teachers or the principal reporting them for neglect or abuse is a real fear. Even if they are very responsible parents, poverty and minimal education deflates confidence in attending school functions. This makes education a challenge for both the parent and the child.

IN 1951, THE NUMBER OF INDIGENOUS CHILDREN IN CARE IN B.C. WAS **29**; BY 1964, THERE WERE **1,466** INDIGENOUS CHILDREN IN CARE.

FROM 1857 TO 1996, APPROXIMATELY **150,000** CHILDREN ATTENDED IRS.

A RETURN TO ROOTS

Across Canada, some Indigenous communities with resources of educated people and some political insight have started caring for their own children. According to the National Collaborating Centre for Aboriginal Health, "Indigenous communities began forming their own child welfare agencies in the late 1970s and early 1980s in order to provide culturally relevant child welfare services to children, youth, and families both on and off reserve."[7]

Indigenous communities have realized the key to healing families is culture and traditions. Taking families back to the land for culture camps and family gatherings has become more common in the last decade. It is an attempt to revitalize and share historical teachings held by a few elders. Many contemporary teachers of plant medicines, genealogists, land stewardship, and economics have also come on to the scene.

Returning to cultural roots provides children with the tools and knowledge they need to become part of our holistic system again. Fighting back against electronics, biased history books, lack of government support, inequitable funding, and severe addiction issues, Indigenous people are spending more time learning their language and understanding the land, water, and air and how it connects to them spiritually and physically.

Going back to basics is the trend. Keeping families together is the goal. ■

Laura Rhodes is an RCC is of Sto:lo and French Canadian heritage who works in Penticton facilitating a Recovery Support Bed Program for homeless people with addiction challenges. She enjoys writing, family, and travelling.

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A SYMBOLIC RESPONSE

BY SUSANNA RUEBSAAT, RCC

In essence, trauma is energy that has been trapped in the body (soma) and psyche. It can be triggered by physical or environmental conditions, including, but not exclusively, conditions psychologically similar to those in which the trauma originated. Moreover, because trauma lives mostly in the unconscious, it is hard to work with directly, because the mind wants to solve or fix it, and the body goes into its own conditioned defensive reactions.

Creativity offers an avenue for this energy to become embodied in a less destructive manner, such as art making. The art then becomes the container of the trauma for the time being. In the art, the trauma can be reflected upon and engaged with differently — symbolically — with less of the physical and emotional "charge" with which trauma grips us.

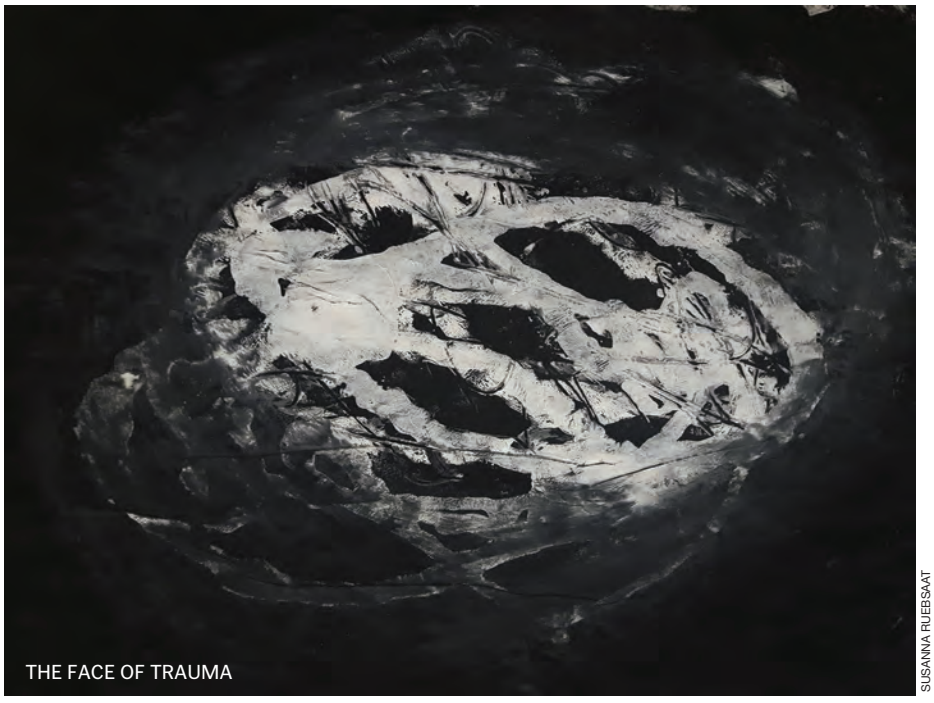
Creativity opens the imaginal — the world of image — a middle pathway between the conscious and unconscious. This world of image is where psychic material can bypass the conscious mind's filtering and editing imperative and invite the body and heart to express previously suppressed energy. The power of the creative act itself can release the individual from the constriction and oppression of trauma's injury and open the capacity to feel. Images invite us to feel into ourselves. Creativity reinforces this core of the life force, which was previously shut down to conserve energy to protect that life. Thus, the creative process can help to metabolize intolerable events and feelings. The body and psyche transmute this raw material into energy then make it available for healing and wholeness. The psyche's inherent symbol-making capacity can distill the destructive, annihilating forces of trauma into creative art making, storytelling, music, science, arts, and culture.

USING ART IN PRACTICE

Symbol-making processes, such as art making, work at both somatic and psychological levels often without any analysis necessary. However, some interpretation or framing of the process itself can be helpful to relax the conscious mind's automatic protective mechanisms against "opening up old wounds."

In my practice, I often ask clients to write and/or tell a fairy tale about the images they have created. Insights gained from the physical and psychological releases that frequent such creative processes (especially heightened in the aesthetic experience) support a re-patterning of energy clusters in the client's emotional and physiological make-up. By including a restructuring of self-narrative, the reconfiguration of self-image that takes shape in the art and the unconscious through the creative process can be drawn upon as resources when trauma is reactivated in our daily living. The "ah has" of the insights act as signposts to get us back on track (become conscious again) in response to questions such as "how do I get out of this?" when caught in a wounded part of our story. Instead of compulsively revisiting these re-traumatizing stories about ourselves again and again in attempts to make our myth whole, the possibility of imaginatively re-storying and re-embodying our self-image in the art and fairy-tale writing allows us to begin to dis-identify from intolerable images of archetypal trauma.

The power of the creative act itself can release the individual from the constriction and oppression of trauma's injury and open the capacity to feel.



THE FACE OF TRAUMA

SUSANNA RUEBSAAT

The symbols in the art can protect the vulnerability we are so often exposed to by the wounded parts of our narrative.

OUR INNER STORYTELLERS

As a path between what we might consider spiritual and material "realities," creativity follows liminal experiences at the edge of consciousness. These margins of reality are where images arise as reflections of the psyche's deep processes. These "soul images" personified are like inner storytellers who call our attention to what we are telling ourselves about ourselves — our self-narrative or myth. They do this from the perspective of the unconscious as it comes into relationship with the ego, our centre of consciousness.

In the relating of the ego with the unconscious through images, something new is animated in the imagination. Picking up subtle cues of the unconscious that can often be sensed through the body can be directed into mark-making activities that express what lies beyond or beneath (the unconscious) what we generally know about ourselves. To facilitate this "dropping in" activity, I have clients close their eyes and work with both hands with the art materials and simply allow whatever energy is present to extend itself onto the paper without judgment.

I am always amazed at how quickly and deeply this inner focus drops clients into a sense of interiority that reconnects them to core themes in their lives. Through the physical act of drawing, they are encouraged to explore these motifs somatically and symbolically — that is, safely — with the art materials.

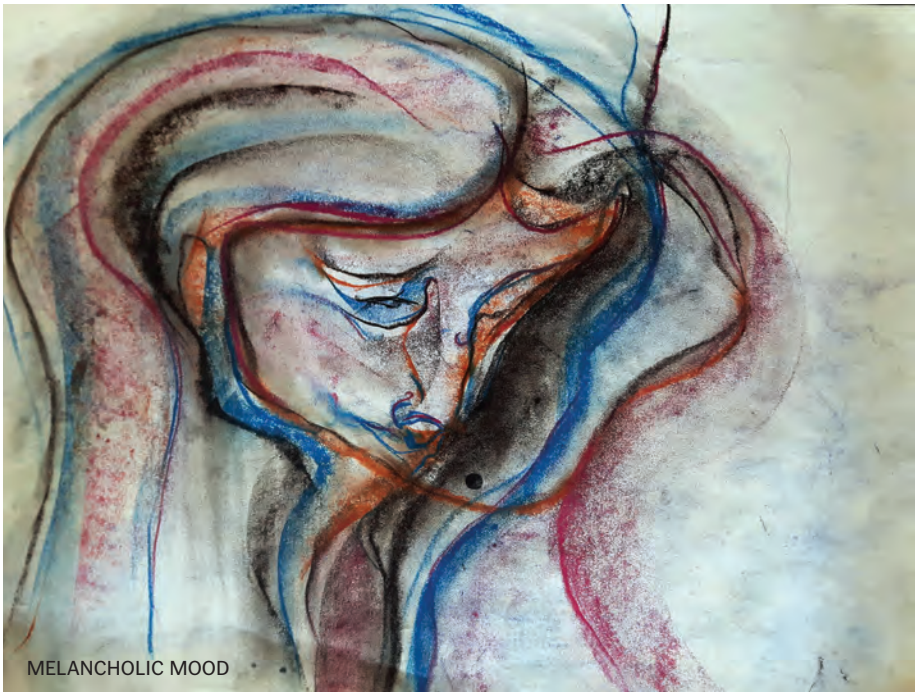
It is very inspiring how our own innate creativity often guides us back to feeling into, as well as seeing through, our story in resonant images. I have often witnessed how the images in a client's art seem to hold a sense of soul even through the colonization of self by trauma. The art as a safe place can open our capacity to feel painful emotions without the often-accompanying self-loathing that comes about unconsciously through having identified oneself with traumatic events.

AN INDIRECT GAZE

Working with trauma symbolically and somatically offers an "indirect gaze" of hidden residues of trauma. In the mirror of the art, we are invited to have a peek into the inner world of trauma — that aching story the body so desperately wants to tell us in its yearning for healing. Here in the imaginal, we can more easily tolerate seeing previously unbearable experiences through their reflections. The symbols in the art can protect the vulnerability we are so often exposed to by the wounded parts of our narrative. As well, these powerful symbols animate a form of consciousness that allows us to integrate these shadow chapters of our lives once they have been transmuted.

As an art therapy practitioner, it is my sense that our innate symbol-making capacity as human beings has an evolutionary ability to metamorphose the dark plots of our wounded stories. When the false self-narrative conditioned by traumatic events torments our sense of self, it is as if our own story and all its characters turn on us mercilessly. To protect ourselves from such vicious attacks from within (both psychologically and physically, such as with autoimmune illnesses), we may, in many cases, unconsciously begin to identify with this destructive self-narrative. We internalize it so we

have a sense of containing it somehow, gaining an illusory sense of control over persecutory-toned emotion — that feeling things are "against us." Or we develop a false sense of union with trauma, such as identifying with the aggressor in abusive relationships.



SUSANNA RUEBSAAT

MELANCHOLIC MOOD

In *The Black Sun*, psychoanalyst Julia Kristeva describes such a predicament with these words:

I live a living death, my flesh is wounded, bleeding, my rhythm … interrupted, time has been erased or bloated, absorbed into sorrow… the disenchantment that I experience here and now… appears... to awaken echoes of old traumas, to which … I have never been able to resign myself. I can thus discover antecedents to my current breakdown in a loss, death, or grief over someone or something that I once loved. This disappearance … continues to deprive me of what is most worthwhile in me. I live it as a wound or deprivation, discovering just the same that my grief is but the deferment of the hatred or desire for ascendency that I nurture with respect to the one who betrayed me or abandoned me.[1]

The constant "interruption" of triggered trauma responses and their resulting symbolic invalidation of the self Kristeva describes so poignantly is illustrated in a negative narcissistic self-image.

Creativity has the capacity to interrupt this endless cycle of despair by bringing us back to the core of healing that lies in the relationship between the conscious mind (ego) and the unconscious

THE MELANCHOLIC MOOD

The negative self-image was originally generated by unbearable experience — disintegration, trauma — and acts as a mirror constructed to block our view of any authentic self. It simply reflects back the same image stuck in its own fixation of itself. Its persistent presence is at the core of the melancholic mood that trauma continues to inflict on us until we break the spell it holds us in.

I can't see through the image in the mirror as it keeps bouncing back the same "me." It has captured my gaze and frozen it. Calcified, I am fixated in this image in the mirror that is a disguise, a mask of trauma. A fossil from an old life passed. To protect myself against the dissolution that facing this betrayal directly might bring, I blindly stare at this intolerable image of myself. I cannot take my eyes off it; I keep looking for what I cannot see. I cannot see through the charade here that is pantomiming the deeper story. [2]

Working with clients in art therapy and using the fairy-tale approach mentioned above, this "spell" can sometimes be playfully rearticulated in a manner that changes the role the person is inadvertently and unconsciously playing over and over again in relationships. The habitual position taken in the story essentially locks the person into the same dynamic in which trauma occurred. It reinforces the image in the mirror of the traumatized self — that self-invalidating subject of the wounded story we are telling ourselves.

A creative response to this predicament offers a bigger narrative, a larger perspective in which we can imagine the authentic self engaging the wounded self-image in the mirror symbolically rather than literally. What this means is that we are able to realize that the other side of trauma, archetypally speaking, is wholeness: dark and light.

INTERRUPTING THE CYCLE OF DESPAIR

Overwhelmed and feeling powerless in the face of our own reactions to traumatic events and relationships, the psyche ironically identifies with the dark images of such inner or outer encounters. These psychic images often then manifest themselves through varying physical and psychological symptoms, including addiction. Symptoms reinforce the neural pathways of the brain to repeatedly send the same signals to the nervous system. Over time, this generates the recycling of energy in the psyche and soma, that of the trauma vortex.

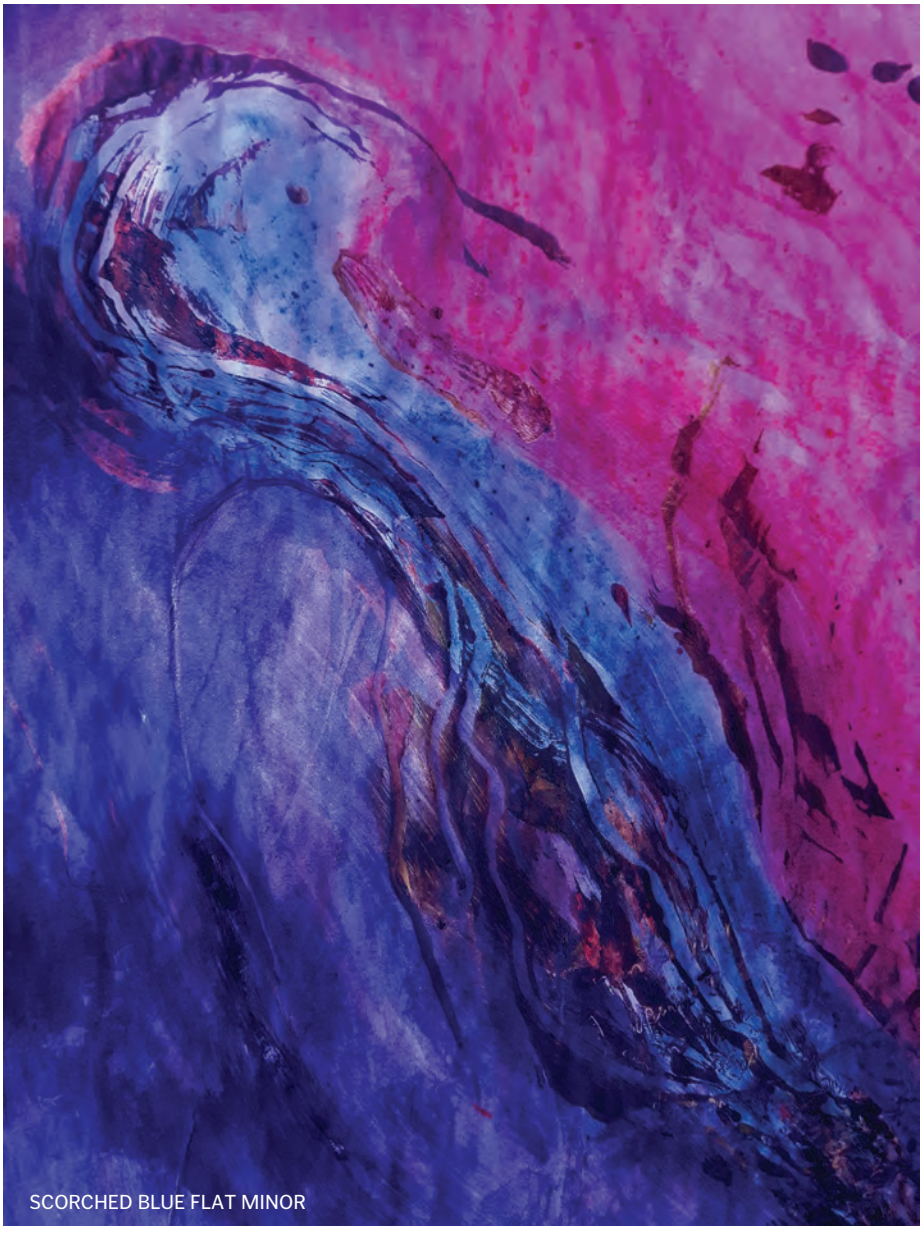
Creativity has the capacity to interrupt this endless cycle of despair by bringing us back to the core of healing that lies in the relationship between the conscious mind (ego) and the unconscious — the middle pathway described above. Because creativity requires the activation of both conscious and unconscious engagement, the ego can learn to recognize an energetic link between trauma and transformation. It can do this through the body and the body of the art materials, which create symbols for us to work with. The embodied symbols act as guides through the unknown.

Both trauma and transformation are "going beyond oneself" phenomena. They are journeys that take us into the liminal realm where we do not know ourselves so well. We encounter a void, a seemingly impossible experience: no-self. This could be devastating — a process of disintegration — or it could be a leap of faith in which a metamorphosis can take shape.

METAMORPHOSIS

"Scorched Blue Flat Minor" is an embodied poetic enactment of a profound metamorphosis. The figure in this painting is trying not to look at death (someone very close to me had died). Even looking at this image now hurts and reminds me of how I turn intolerable experiences against myself, and how I then turn the unbearable image of the experience into a self-image. This figure, painted spontaneously, is an embodiment of the intolerable; the body's posture is arching backwards, no longer able to brace against the inevitable, surrendering but

The art as place of transference and witness holds a space in the therapeutic process that can invite different feeling constellations, introducing a re-patterning of experience.



SCORCHED BLUE FLAT MINOR

SUSANNA RUEBSAAT

without the relief that gesture might imply; soma is no longer able to shield what the heart cannot bear and becomes a blue fire burning in its agonizing stoicism.

While I was painting, my body burned, scorched raw from the heat of the pain, yet simultaneously left cold, frozen in a grief that only the melancholic minor chord of B flat could express. A fathomless symbiosis was taking place between psyche and soma. "All this suddenly gives me another life. A life that is unlivable, heavy with daily sorrows, tears held back or shed, a total despair, scorching at times, then wan and empty."[3] I was imprisoned inside this intolerable self-image of "Scorched Blue Flat Minor" until it moved through me and onto the paper before me in paint.

HEALING INTO ART

SUSANNA RUEBSAAT

Through embodying the experience in the art and seeing its image as separate from "me" — autonomous in its own right — the painting now had a reflexive effect on me. It helped me have a relationship with the trauma of the death without becoming overwhelmed. Being with the painting, as opposed to being alone in my terror, I was able to remain conscious without splitting into the victim/persecutor polarity so common in traumatic states.

The art as place of transference and witness holds a space in the therapeutic process that can invite different feeling constellations, introducing a re-patterning of experience. I was taken by my new ability to experience pure sadness without the usual accompanying fear that could have sent me flying into an abyss of despair. Seeing my experience of death in the mirror of the art would not have been possible had I been unable to see symbolically. Unmasking the wounded narrative by seeing through its clever disguise, seeing it symbolically, rather than unconsciously continuing to act it out or identify with it, is the creative journey towards self-actualization.

Creating an image and stepping into it — this might be that leap of faith that calls upon the generative life force within and carries us through the midst of a turbulent unconscious.

FACING THE IMPOSSIBLE

My question for myself as a practitioner and to my colleagues is, "How far can we go in respecting our own and our clients' traumatic experiences at a symbolic level and assist in opening ourselves and them to the ensuing creative inquiry?"

An engaging way to approach this might be to ask, "Who do I become in the presence of the impossible?" The impossible, it seems, is what we feel we are facing in trauma. It might also be what we are facing in the moment before the natural creativity of the human mind leaps into the unknown. Creating an image and stepping into it — this might be that leap of faith which calls upon the generative life force within and carries us through the midst of a turbulent unconscious.

The art of healing is healing into art. I believe creativity, that symbolic function of the psyche, is evolutionary and plays a key role in our individual and collective survival. ■

Susanna Ruebsaat, PhD, BCATR, RCC, Jungian art therapist, clinical counsellor, and supervisor, has developed a mythopoetic mentorship for practitioners wanting to bring an archetypal lens to their practice. Her experiential sessions in Alchemical Art Therapy working with soma and symbol shape a mythopoetic inquiry that acts as a container for the metamorphosis of trauma: Psyche's ulterior motive towards wholeness. Dr. Ruebsaat also teaches Group Art Therapy at the training institute in B.C. She specializes in organ transplant transitions.

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INNER RESOURCES

How one Vancouver counsellor found new hope in the Land of the Midnight Sun

BY JENNIFER GIBSON, RCC

Last year, I decided to leave my wonderful but financially challenging job as a counsellor in an addictions treatment centre in Vancouver and try the same position but up in the land of the midnight sun: The Yukon.

Looking at some of the statistics around alcohol consumption from the Yukon, it's little wonder why the locals are rarely envious of me when I tell them what I do for a living. The Yukon leads in having the highest alcohol-consumption rates and alcohol-related mortalities in the country. Between 1950 and 2000, Yukoners consumed twice the national average of alcohol and saw the most deaths due to liver failure or where alcohol was explicitly named as the cause of death.[1]

The effects of heavy alcohol consumption have been devastating for all Yukoners but particularly for Indigenous communities navigating the ongoing impacts of the residential school system. In one rural Yukon community, Fetal Alcohol Spectrum Disorder rates were suggested to be as high as 90 per cent among second-generation residential school survivors.[2] As an acquaintance once told me, "It doesn't take long to learn that the drinking culture in the Yukon distinctly stands out from the rest Canada." Enter the therapist tasked with assisting clients' in their recovery and the light at the end of the tunnel gets about as dark as the winters here.

> **CREATING MEANINGFUL CHANGE HAPPENS FROM AN INTERNAL TRANSFORMATION, EVEN WHEN EXTERNAL CIRCUMSTANCES CHANGE.**

Or at least, that tends to be the perception of the general public.

While I can only agree that the resources here are fewer and the barriers unquestionably significant, I have failed to observe any difference in client outcomes. Seemingly, against all odds, I see many clients create and sustain successful changes in their lives, including stopping drinking. In spite of the pervasive culture of heavy drinking, isolation, intergenerational trauma, and lack of services compared to our southern neighbours, clients here continue to accomplish their goals and experience success. I still come to work with just as much optimism and hope for change as I did in Vancouver based on the many successes I've seen.

The only real difference is I have to scrape off my frozen windshield first.

Noticing the similar success rate has led me to wonder if perhaps the true question I came to uncover while working in the north is not about what makes it hard for clients to address their addictions — but what it is that really creates change.

As therapists, we know how to spot an unsustainable change. This might sound like a client coming in and suddenly reporting that the problem they were once so concerned about is no longer bothering them. As if Insoo Kim Berg herself made a miracle happen over night! Oftentimes, the shift is perceived to be caused by something external in their world, which, as therapists who know about the importance of an internal locus of control, makes us leery. For instance, a psychologist once told me about a client who suffered chronic anxiety; however, one day, she reported no symptoms whatsoever after having met someone online she was certain she soon would be happily dating. Anxiety: gone in a poof. As therapists, we know the pitfall of this magical thinking: creating meaningful change happens from an internal transformation, even when external circumstances change.

Yet, as a therapist in Vancouver, I caught myself using the same magical thinking about my clients. As soon as I would start to feel hopeless, I would start to think of all the referrals I could make. If only my client could just make it to the group, the treatment program, the gym, etc., that I referred them to, their suffering would finally end. In particular, I catch myself thinking this way with my most challenging clients who seem the furthest from completing their goals.

Moving from B.C. to the Yukon, I quickly saw how few resources exist for clients. Sometimes, on the surface, my clients' situations can look truly bleak in comparison. For instance, a client might be returning to a community where they do not have a living, sober family member; or where the only addictions counsellor is also their uncle; or that they have no housing options except where drugs are sold. I once had a client who had to drive eight hours just to access the resources for an online conference with me. Since I am often unable to refer to other services or resources, one would think I might feel a bit hopeless for my clients. And yet, just the opposite is true — I see just the same amount of success and change as I did in Vancouver. However, I am far more aware that my clients are using their internal resources to reach their goals — there are no magical referrals to hide behind.

Thus, what I've come to observe is that, as a therapist, I can just as easily fall into the same problematic thinking that something on the outside will create change for clients. Rather than looking for the internal locus of control, I have too often made a shortcut to praying for the miracle. In reality, the motivation, courage, willingness, and mindset that change is possible and you are worthy is needed regardless of resources.

The Yukon has taught me to hold on tight to the unflinching belief that change is possible for anyone in any circumstance, because each client already walks in the door with all the internal resources they need. While I'm certainly hopeful that increased access to resources will come to the Yukon, presently, I am grateful for how my practice has transformed by learning to be weary of hopelessness. ■

Jennifer Gibson, MC, RCC, is a clinical counsellor currently working in Whitehorse, YT, specializing in addictions, mental health, and trauma with youth and adults. She can be reached at jennifermgibson@gmail.com

RESOURCES

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RECOVERY AT THE TOP OF THE WORLD

Surrounded by 28,000 acres of crown land, 600-acre Top of the World Ranch in Fort Steele is certainly up there among the most beautiful properties in the province. In its present-day incarnation as an addictions treatment centre, it has retained the luxuries of its guest-ranch past: beautiful accommodation in cabins and a main lodge, high-end food, and a long list of activity options, such as canoeing, hiking, mountain biking, golfing, fishing, kayaking, and more.

But while it sounds more like a vacation destination than a detox and recovery centre, there is serious work being done here for clients committed to recovery through abstinence.

Top of the World Ranch began operating as a residential substance abuse treatment facility in October 2005. Up to 24 clients can be accommodated in regular programming, with four clients in detox. A rotating roster of staff stay on site overnight in the lodge and detox centre to ensure quality care 24/7, while all other staff live off site, usually around Cranbrook or Kimberley.

Joanna Copeland-Butt, MOC, RCC, is an addictions counsellor on staff at the Ranch and makes the trip from Cranbrook.

"It's about a 20-minute drive door-to-door each way, which helps me prepare for and then process my day," she says.

Counselling is a profession Joanna came to after a previous career in private business.

"Addictions work had been an interest throughout my training because I couldn't wrap my head around it," says Joanna. "My family of origin was affected by addiction, so I had some personal experience with it, saw how widespread and devastating it is, but wanted to know more, especially how it develops and grows."

At the Ranch, she counsels clients through their recovery process from addictions to drugs, alcohol, and prescription drugs, as well as coping with other problems.

"Our clients also increasingly present with a variety of co-occurring mental health disorders that require immediate attention in tandem with their needs for recovery."

Programs at the Ranch range from 30 days to 90-plus days, with 45-day stays as the most common, she says.

"Many clients initially arrive with a 30-day commitment, but after they begin to work the program, they

understand the value of investing in a longer stay and hear from other clients about why they extended, and then they decide to stay longer," says Joanna.

They stay the course because it works.

Between November 2010 and June 2017, about 90 per cent of the clients who began treatment successfully completed the program, and of that number, 91 per cent of clients reported that they were completely satisfied with the program upon completion.

What are some key factors that contribute to the success rate at the Ranch?

Our client's success first stems from the fact that we are a holistic facility that supports overall client wellness using individualized treatment plans, especially given the increase in polysubstance use and the concurrent disorders that we see. The therapeutic community we foster is transformative in and of itself. We encourage clients to explore and use spirituality and mindfulness practices in their recovery, and we also facilitate their design of a strong after-care plan throughout their treatment. The Ranch partners with local First Nations elders who hold regular client sweat lodge ceremonies (and for alumni also), which attend to spiritual and social needs.

Yours is an abstinence-based program: why is this important for your clients?

Peer-reviewed data and research supporting the disease model of addiction hold that addiction is a chronic, lifelong illness, which has no cure. However, a continuum of services can support successful recovery through abstinence. Our clients represent a wide variety of socioeconomic groups, but they all share similar experiences: powerlessness over their drug of choice, multiple relapses, with "just one" never being enough. If using in moderation were possible, our clients would be doing that while living more balanced, healthy lives. That simply isn't possible over the long term when they drink or use.

MANY CLIENTS INITIALLY ARRIVE WITH A 30-DAY COMMITMENT, BUT AFTER THEY BEGIN TO WORK THE PROGRAM, THEY UNDERSTAND THE VALUE OF INVESTING IN A LONGER STAY.

Tell me about the counselling part of it. What approaches do you use and why?

For me, the cornerstone of clinical practice is to be client-centred, working with clients to create a safe therapeutic alliance in which they feel accepted as they are. Any other technique or theory comes second. That said, CBT is extremely helpful in illustrating to clients how behaviours, thought patterns, and emotions — and sometimes chronic pain — affect the development of their illness and what is necessary for recovery. My practice is informed by DBT, which helps clients tolerate distress and regulate their emotions in more adaptive ways. This is crucial with this population and tools, including mindfulness and radical acceptance, are essential. Studying Motivational Interviewing helps me work with ambivalent clients in a way that engenders less resistance. The Stages of Change help identify areas of growth, and trauma theory supports sensitivity to the unique needs of clients who have experienced horrific life events and losses, which make up a large percentage of our clients.

Is there a difference in how you treat different addictions? For example, alcohol compared to other drugs, chemical versus behavioural?

All drugs have similar effects on the reward centre of the brain and present some common challenges and physiological responses. However, all addictions express themselves in ways that are unique to each client given their biopsychosocial-spiritual life experiences and traumas. All addictions are maintained by behaviours that have many common characteristics but, again, express themselves differently with each person, hence, our individualized treatment plans.

Your program is holistic in that it attends to mental, emotional, physical, spiritual, and social needs. Can you tell me briefly how that is accomplished at the facility and after they graduate from the program?

We look at the whole person, not just the addiction, and, as such, we are driven by the unique needs of each client. We support the discovery of self by providing opportunities to learn a wide range of new information through our information and skills training seminars and outdoor group experiential activities. Clients experience new practices like yoga or mindfulness, and explore what spirituality might mean to them, often for the first time. We also help clients rediscover joys lost to their addiction, like a passion for group hikes, or reading quietly by a fire; things that help them feel alive, grounded, and connected to who they really are, not to who they were when they were disconnected and using.

With support, clients design an after-care plan that reflects their own needs and values in all those domains and, prior to their departure, connects them directly to supports in their community who can help them maintain a life that is balanced and recovery focused. ■

DIRECTIONS YOUTH SERVICES

BY NADIA STEFYN

With the opioid crisis taking thousands of lives each year, harm reduction has never been more important as a strategy for saving lives — especially when dealing with a young vulnerable population.

"Harm reduction is an essential first step and the basis of everything we do," says Kyrsten Boucher, manager of Directions Youth Haven, a new five-bed, low-barrier safehouse for youth under 20. "Our resources are fundamentally low barrier, meaning we acknowledge clients may be engaging in risky behaviours, and we meet them in their journey — without judgment. By removing shame and stigma, the harm reduction approach helps Directions staff build authentic connections with youth."

Haven is the newest addition to Directions Youth Services, a collection of services around Vancouver supporting youth who are at risk, street-involved, or experiencing homelessness. Run by Family Services of Greater Vancouver, Directions Youth Services includes a 24/7 drop-in centre, outreach teams, pre-employment programs, two safehouses, and a youth detox centre. The trauma-informed and client-centred philosophy creates safety for youth to access a full spectrum of supports, including primary care, mental health, and substance-use resources. For more information, visit www.directionsyouthservices.ca.

Since opening in Vancouver in January 2018, Haven has had a 95 per cent occupancy rate. Youth can stay at Haven for a night, a week, or as long as a month. From Haven, they can work on goals, get one-on-one counselling, and connect with medical professionals, Indigenous elders, and other service providers in a confidential, comfortable, home-like environment.

"Harm reduction is especially important when dealing with youth who may not be familiar with all of their options or know where to seek help," explains Boucher.

MLA Mike Smith, Sheila Robinson and BC Minister of Children and Family Development Katrine Conroy at the opening of Directions Youth Haven, with Family Services of Greater Vancouver CEO Karin Kirkpatrick, Director of Youth Services Marnie Goldenberg, and Haven Manager Kyrsten Boucher.

Run by Family Services of Greater Vancouver, Directions Youth Services includes a 24/7 drop-in centre, outreach teams, pre-employment programs, two safehouses, and a youth detox centre.

"Whether it is drug use, survival sex work, smoking, eating disorders, or gang-related activities, if youth are going to engage in these behaviours, we want to minimize their risks. We provide youth with the education to make safer and more informed choices, all while respecting their autonomy by allowing them to make decisions for themselves."

"When youth begin to feel cared for and aren't shamed for their choices, their feelings of self-worth increase and they're more likely to care about themselves," says Boucher. "We spend time with youth, and once connection and trust are in place, we discuss how they can reduce harm and better protect themselves. It can take time to get to this point, but by regularly checking in and demonstrating that they matter, eventually youth feel comfortable enough to speak up and ask for help without fear of judgement."

Boucher recalls one client who felt a lot of shame around his drug use. Haven staff engaged in open conversations about his drug use and encouraged him to exchange his used needles for clean ones. Eventually he obliged, admitting to staff: "I never realized I was worth using a clean needle before." Since then, the youth, who had previously been living on the streets for several years, secured his own housing and is working on building a healthier life.

As part of education and conversations about harm reduction, supplies such as naloxone kits and clean using materials are distributed. Youth are trained by staff on what to do in the event of an overdose and youth support each other by discussing safety options and making sure they carry their kits. Naloxone kits made available to youth through Directions Youth Services have already provided life-saving assistance to youth experiencing overdoses.

"As a community, we've made some progress in terms of recognizing the devastating opioid crisis and offering support through drug test sites, safe injection sites, and naloxone kits and training. By slowly removing the stigma, lives are being saved. And we still have such a long way to go," says Boucher. "The more trauma-informed we can be as a society, and the more compassionate we are with our fellow human beings, the more positive impact we can make together."

Nadia Stefyn is the marketing and communications manager for Family Services of Greater Vancouver. Contact her at 604-731-4951 x4023 or by email at nstefyn@fsgv.ca.

THE REVIEW PROCESS

UNDERSTANDING VOLUNTARY SELF-REGULATION AND THE CREDIBILITY IT GIVES BCACC MEMBERS

"I write to inform you that BCACC has received a complaint regarding an aspect of your counselling practice."

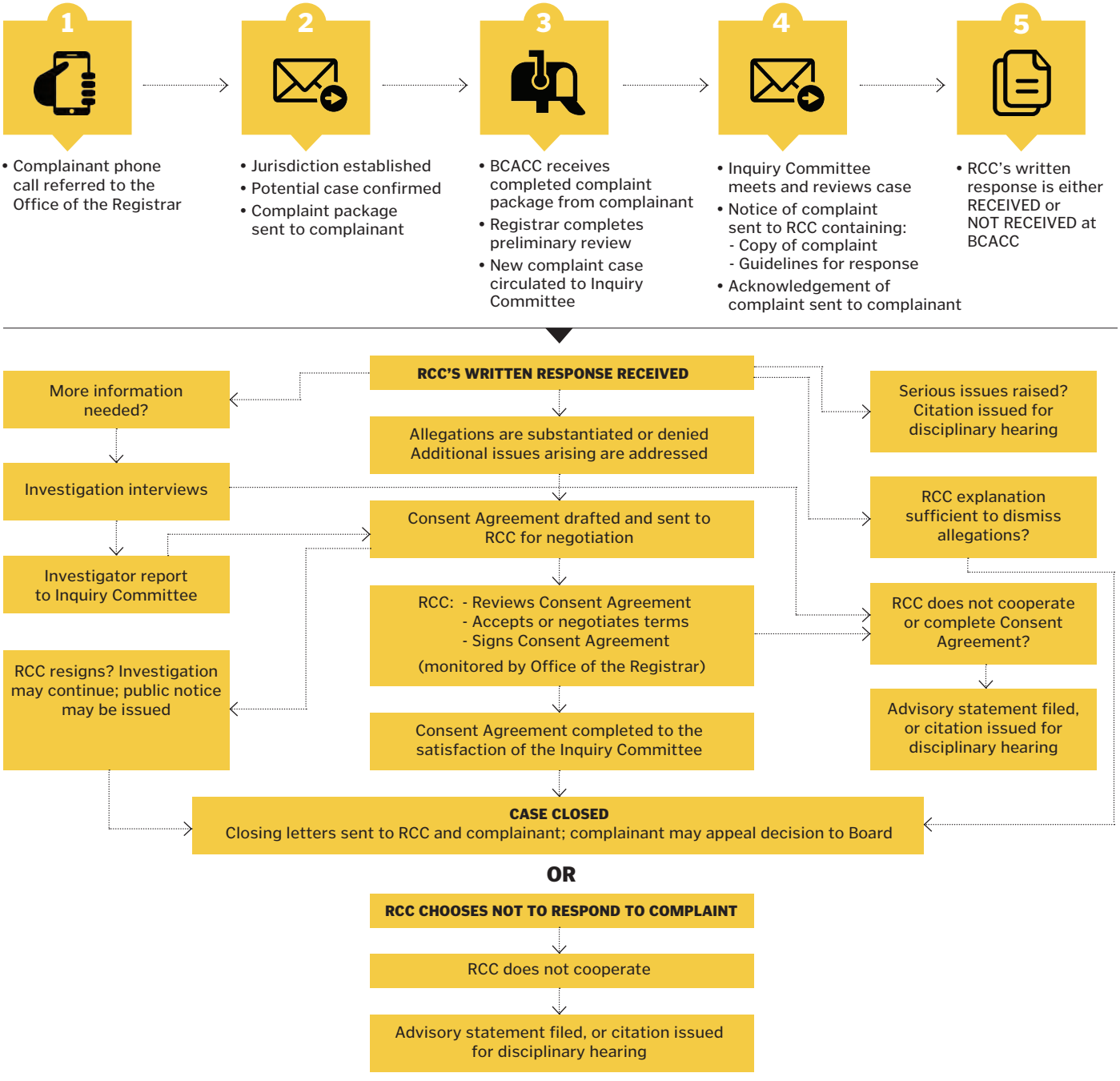
No matter how many years of counselling experience you have, receiving a letter that starts like this is upsetting. Even when you know you have done the best job you can, receiving a complaint and having your work questioned and scrutinized is uncomfortable at best.

"We acknowledge that receipt of a complaint can be stressful," says the BCACC's Registrar, Angela Burns, RCC. Because of the obvious conflict of interest, BCACC cannot provide member consultations with respect to a complaint while also investigating the complaint. However, BCACC strongly encourages RCCs in these circumstances to get peer support and/or a clinical supervisor not only to assist with understanding the complaint and review process, but also for support — a measure of self-care in a difficult situation.

It also helps to remember why the review process is such a valuable part of your BCACC membership.

"Counselling in B.C. remains unregulated — anyone can call themselves a counsellor and open a counselling business,"

COMPLAINT RESOLUTION PROCESS



says Burns. "Membership in BCACC is voluntary. Our members are rigorously screened to meet our entrance criteria, and they open their practices up to scrutiny when one of their clients lodges a complaint. Voluntary self-regulation is definitely morally and ethically above that required by statute."

As a BCACC member, your clients have access to a fair complaint review process, which is reassuring for clients and gives you professional credibility.

"Third-party payers, like EFAPs and insurance companies, recognize the RCC credential and make referrals based on BCACC's regulatory processes," says Burns. "Clients of non-regulated counsellors — those operating in isolation outside of any association — have no recourse other than civil suits if they receive unethical or unprofessional treatment."

Understanding the process also helps to ease some of the discomfort. One of the first points to note is written right into the Registrar's letter: "This is not a disciplinary process — it is a formal peer inquiry. As you continue the dialogue initiated here, you remain a member in good standing throughout."

Moreover, if the Inquiry Committee's investigation determines the complaint allegations are justified, the

recommendations for the counsellor are educational.

"This is a non-punitive review," says Burns. "It can end up in someone having to take a course, having to do clinical supervision, having to write a reflective letter about what they've learned going through this process — it's not the same thing as a disciplinary process."

As a BCACC member, your clients have access to a fair complaint review process, which is reassuring for clients and gives you professional credibility.

THE COMPLAINT IN PROCESS

In 2016, BCACC received 15 complaints, and 29 in 2017. Mid-way through 2018, 13 complaints have come into the BCACC office. To date, only one complaint received at the BCACC office has ever resulted in a referral to the Disciplinary Committee, a circumstance that could occur if a member chose not to cooperate with the inquiry or its recommendations.

"The majority of our complaints have been successfully addressed by Consent Agreements," says Burns.

The full review process (see page 40) takes about a year.

"The Inquiry Committee meets monthly and reviews completed investigator reports and comes up with recommendations in the form of Consent Agreements," says Burns. "Head office works with potential supervisors with regard to committee approval and receipt of investigation materials."

In some cases, experts are called in to review reports, such as "Parenting Coordinator" or "Views of the Child" reports.

"A complainant may not like or may disagree with the content of such reports," says Burns. "Once the court has used the report to frame an order, we do not step in, but if the court has criticized or thrown out a report, we have room to examine the report and provide feedback."

In almost all cases, the counsellor continues to practise as usual; the only stipulation is if that counsellor is also a member of the BCACC Board or a BCACC committee, they are expected to take a leave of absence until the complaint is resolved or to resign.

"In very rare circumstances, we have suspended a member pending the outcome of an investigation — mainly if we hold evidence that could lead to criminal charges," says Burns.

The complaint letter also indicates counsellors may be required to inform their insurance provider that a complaint has been filed.

It is also important to note that not every complaint becomes an official complaint.

"The Deputy Registrar and I screen all of the potential complaints by telephone — often without any names," says Burns. "A potential complainant may ask about issues that are outside of our jurisdiction, such as a counsellor making a complaint to the ministry about possible child abuse. We use these opportunities to educate the public about counsellors' legal responsibilities."

Burns says the office has received a number of calls from people claiming they had perfectly good relationships until their partners sought counselling — that counselling was ruining their relationships.

"Again, it's an opportunity to educate," says Burns. "This is a type of third-party investigation we cannot undertake. Counsellors cannot reveal the names of or speak about any client without that client's permission, and while some exceptions apply, generally a subpoena is required."

Other examples include a potential complainant asking about access to their own clinical record or that of their child, issues about how termination was handled, and questions about confidentiality.

"Many complaints are not formalized because we have no jurisdiction — the person in question is no longer a member or was not a member during the period in question, for example — because the client is deliberating the consequences of bringing forward a complaint due to their current stress level, because the issues discussed are not unethical — for example, making a referral to other professionals if the counsellor deems the client issues to be outside their area of expertise," says Burns. "We do not keep a record of RCC names mentioned in these preliminary conversations."

WHO IS ON THE INQUIRY COMMITTEE?

The Inquiry Committee is a provincial committee with representation from every region. When a spot becomes available on the Committee, the Office of the Registrar for BCACC sends out a call to particular regions and reviews submitted resumes to find the best fit for the role, taking into consideration such factors as background and diversity.

COOPERATION IS KEY

Cooperating with the review process and Inquiry Committee is written right into the BCACC constitution and bylaws.

"Part of being a member of BCACC is, right at the door, you have made the declaration that you are willing to open up your practice to scrutiny in the face of a complaint," says Burns. "Our credibility comes from the fact that we will accept complaints and we will review them with the intention of bringing all our members up to speed."

And when the Inquiry Committee dismisses cases, members have the BCACC backing and receive confirmation that they are fully operating within the Standards of Practice.

While no one welcomes a complaint about their work, the review process aims not only to protect clients but also to protect our standards of professional excellence.

BEING A GOOD BOSS... TO YOURSELF

KEEPING PROFESSIONAL ISOLATION AT BAY WHEN YOU WORK IN PRIVATE PRACTICE

BY CORAL PAYNE, RCC

By establishing relationships with a clinical supervisor, a few trusted colleagues, and a peer supervision group, you'll have accessible resources in place when you find yourself in need of support.

At one time or another, I think we all dream about the day we can move into private practice, where we can set our own hours and be our own boss. We find a suitable office space, furnish it the way we like, get our website up and running, and open our doors for business.

But one thing we may not adequately plan for is the loss of day-to-day interactions with co-workers, quick debriefs with a colleague after a difficult session, and the feeling we are not in this work alone. When we work in private practice, we need to find replacements for those daily interactions with colleagues. And it's more important than you might think when you first open your private practice doors.

We have all heard about the detrimental effects of loneliness and social isolation on general health and well-being. Working in isolation can also have a negative effect on us and on our clients, and it can be especially problematic when dealing with ethical dilemmas.

A critical part of being your own boss in private practice is keeping professional isolation at bay. After all, you have a responsibility to maintain a healthy, happy work environment for your star employee — you. By establishing relationships with a clinical supervisor, a few trusted colleagues, and a peer supervision group, you'll have accessible resources in place when you find yourself in need of support.

Many options are available to connect both personally and professionally. On the personal front, you might get involved in your community with schools, local clubs, activities, and theatre, etc.

On the professional front, seeking regular supervision, organizing and/or joining peer supervision groups, signing up for chat rooms on topics you are interested in, and taking advantage of BCACC workshops, counsellor cafes, and training sessions are all ways to connect professionally and avoid the pitfalls of working in isolation.

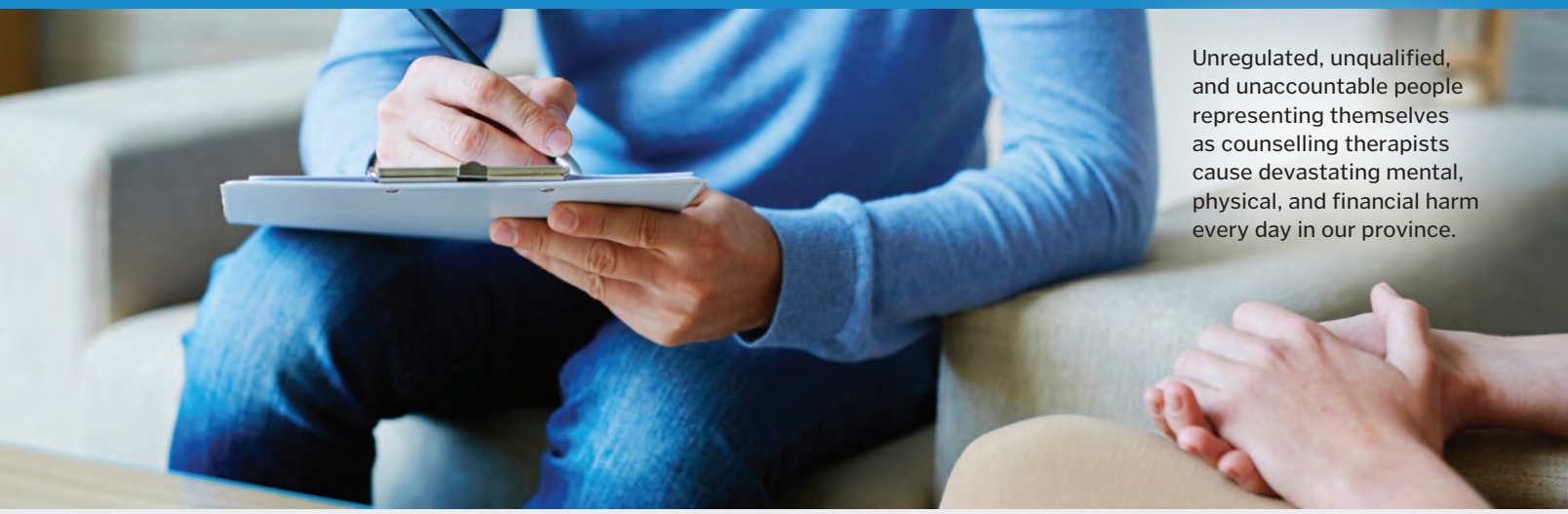
Volunteering with the BCACC also offers excellent opportunities for meeting other professionals. Keep an eye out for recruitment communications from Head Office advertising opportunities to join a committee or task force.

Soon BCACC members will have the opportunity to join any number of association-wide networks of RCCs who have opted to participate based on a common interest (e.g., Somatic Therapy) or characteristic (e.g., new RCCs). One of the core purposes of these "communities of practice" is networking opportunities.

You might also plan to attend the BCACC conference in fall 2019. We are building in lots of opportunities for networking during the conference.

Being in private practice comes with many responsibilities, including staying connected with supervisors and colleagues and avoiding the pitfalls of working in isolation. So be a good boss — make professional and personal social interaction a priority.

DID YOU KNOW?



Unregulated, unqualified, and unaccountable people representing themselves as counselling therapists cause devastating mental, physical, and financial harm every day in our province.

Right now ANYONE in British Columbia can claim to be a counsellor. FACTBC thinks this needs to change.

PUBLIC PROTECTION AND ACCOUNTABILITY

The Federation of Associations for Counselling Therapists in BC (FACTBC) wants the provincial government to protect all British Columbians by advocating for the creation of a College of Counselling Therapists under the Health Professions Act of BC.

WHO ARE WE?

FACTBC is the unified provincial voice of 13 professional associations, including the BC Association of Clinical Counsellors, that currently provide voluntary self-regulation for counselling therapists. We represent more than 5,000 counsellors and therapists practicing throughout British Columbia.

WHAT ARE WE DOING?

Associations like BCACC do all they can to ensure high standards and client safety, but can only do this for registered members. Only a regulatory college has the authority to regulate anyone claiming to be a counsellor whether they are an association member or not.

FACTBC is calling on the provincial government to take up its responsibility to protect all citizens. The means to do this is by establishing a College of Counselling Therapists under British Columbia's Health Professions Act. A regulatory college backed by the authority of legislation and with the tools to provide meaningful title protection will protect and serve all British Columbians and ensure that anyone identifying as a Counselling Therapist is qualified and accountable.

Across the province through July and August, counselling therapists volunteered to meet face-to-face with their Member of Legislative Assembly (MLA) to bring this message home to political decision-makers.

WANT TO GET INVOLVED?

- Watch our promotional video on our website and share it!
- Write a letter to your MLA or a letter to the editor of your local newspaper. Sample letters are on our website.
- Ask your MLA for a meeting about the issue of counsellor regulation. Get preparation and support for your message by contacting FACTBC.
- Write to the Minister of Health, Adrian Dix, and to the Minister of Mental Health and Addictions, Judy Darcy, and Premier John Horgan telling them that it is shameful that British Columbia does not provide basic protections against the devastating emotional, physical, and financial harms that follow from incompetent and unethical counselling practice—especially when no money or legislation is needed, just political will.

FACTBC | The Federation of Associations for Counselling Therapists in British Columbia

If you would like to advocate for increased public protection, accessibility, and accountability of mental health services, contact FACTBC at

info@factbc.org | www.factbc.org | www.facebook.com/RegulateCounsellingBC

WHY SHOULD YOU JOIN THE BCACC?

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

Be Recognized

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

Save Money

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

Grow Community

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

BCACC

BC ASSOCIATION OF CLINICAL COUNSELLORS

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