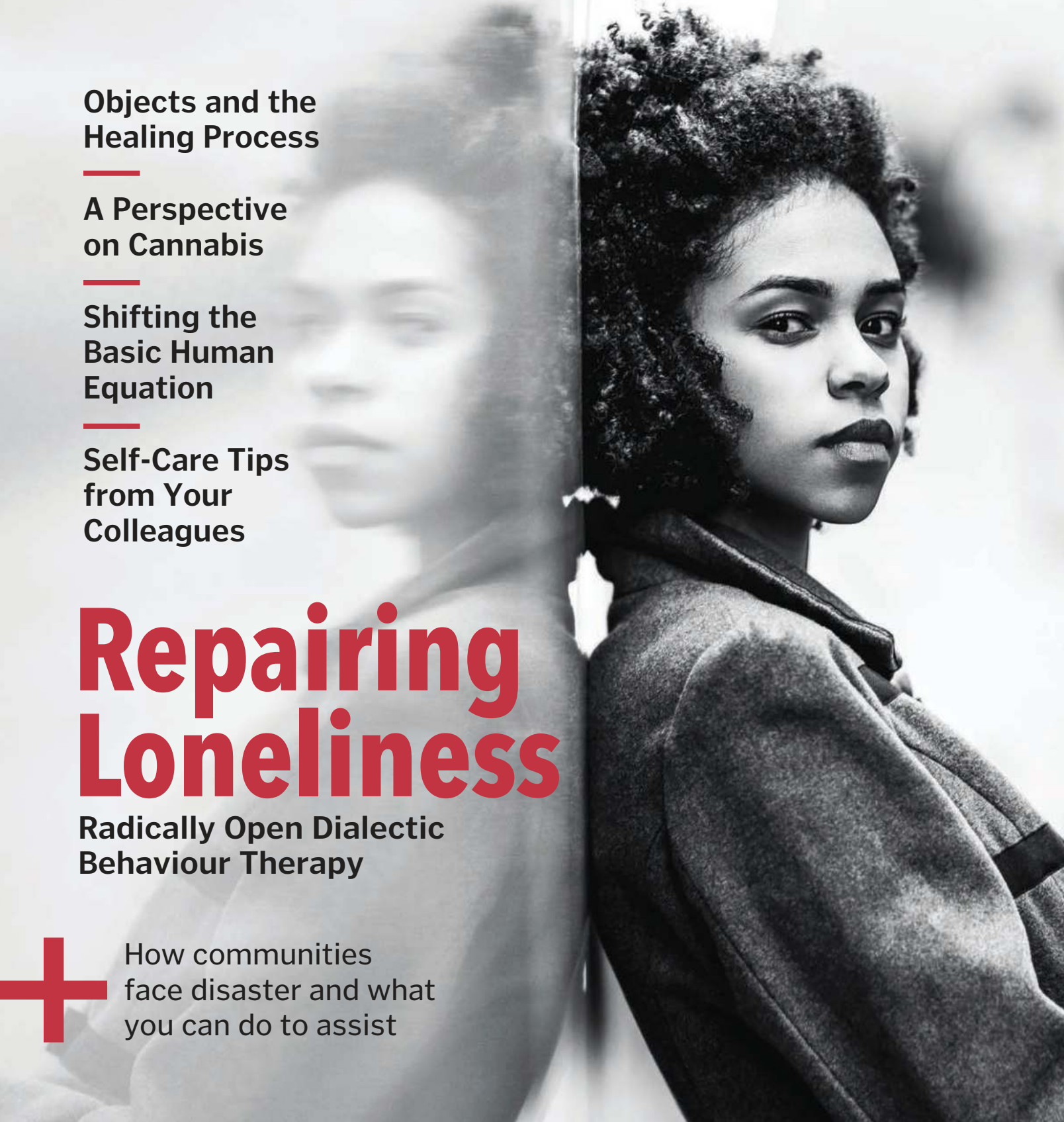
FALL 2019

INSIGHTS

THE BC ASSOCIATION OF CLINICAL COUNSELLORS' MAGAZINE



Objects and the Healing Process

A Perspective on Cannabis

Shifting the Basic Human Equation

Self-Care Tips from Your Colleagues

Repairing Loneliness

Radically Open Dialectic Behaviour Therapy

+ How communities face disaster and what you can do to assist

DID YOU KNOW that BCACC assigns members a region based on where they live in the province? Each region has its own volunteer Regional Council and Council Chair who facilitate workshops and community building in their area. Members might live in one region and work in another and can decide which region they would like to belong to. Members who live outside of BC are in Region 0, which does not have a Regional Council or Council Chair. If you are unsure which region you belong to, you can consult this map or log in to your member account where you can see your region displayed.

BCACC

BC ASSOCIATION OF CLINICAL COUNSELLORS

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FEATURES

IN EVERY ISSUE

INSIGHTS
THE BC ASSOCIATION OF CLINICAL COUNSELLORS' MAGAZINE

The Insights *team wishes to thank the writers who contributed to this edition of our magazine:*
William Klaassen, Ross Laird, J. Nicole Little, Tricia Toth, Marci Zoretich

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

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

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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BCACC Conference 2019

Wired Together: Self. Science. Society.

October 31-November 3

The program is posted and the countdown has started! The 2019 BCACC Conference is bringing together an outstanding lineup of clinical counsellors and allied professionals to discuss and share knowledge on some of the most ground-breaking topics in the world of counselling.

Just a few of many session highlights include:

- *Digital Dependency Dynamics: Informed Practice in Psychotherapy* by Benjamin Shing Pan Wong
- *Tired of Caring: A Transpersonal Approach to Compassion Fatigue and Burn-Out* by Saira Sabzaali
- *Psychological Health & Safety in the Workplace: Applications to Counselling Work Environments* by Joti Samra
- *Using Neurofeedback Training with Counselling to Enhance Client Emotional Regulation* by Douglas West
- *Embodied Trans Affirming Practice: A Culturally Safe and Informed Teaching Approach* by Jenn Matsui De Roo, Lu Lam and Harriet Palma
- *Sex: In A Nervous System* by Geoff Plint

The conference takes place October 31 to November 3, 2019 at the Sheraton Vancouver Airport Hotel in Richmond. See all the program details at bc-counsellors.org.

Speaker Spotlights

SHARON STANLEY

Over the last 25 years, Dr. Sharon Stanley, a psychotherapist, educator, and writer, has integrated a number of somatic practices for healing trauma into a bodily based, relational, and phenomenological model called Somatic Transformation. Somatic Transformation is based on embodied empathy: the practice of feeling into another's inner world with attunement, connectivity, and inquiry. Embodied empathy animates the intersubjective field and guides the use of somatic interventions and reflection. Her book, *Relational and Body-Centered Practices for Healing Trauma: Lifting the Burdens of the Past* (2016), is used as a text in many graduate programs for psychotherapy.

Stanley's keynote address at the BCACC Conference is titled *Restoring the Natural Healing Cycle: Dissolving the Neural Structures of Trauma*. She is also doing a pre-conference workshop on October 31. Read more at bc-counsellors.org.

VIKKI REYNOLDS

Vikki Reynolds, PhD, RCC, is an activist/therapist who works to bridge the worlds of social justice activism with community work and therapy. Her experience includes supervision and therapy with peers and workers responding to the opioid epidemic/poisonings, refugees and survivors of torture, sexualized violence counsellors, mental health and substance misuse counsellors, housing and shelter workers, and activists, as well as alongside gender and sexually diverse communities. Reynolds has written and presented internationally on the subjects of witnessing resistance to oppression/trauma, ally work, justice-doing, supervision of solidarity, ethics, and innovative group work.

Reynolds's closing address at the BCACC Conference is titled *Justice-Doing in Community Work & Therapy: Walking Our Talk*. Read more at bc-counsellors.org.

BCACC'S NEW **CONTINUING COMPETENCY PROGRAM**

In January 2020, BCACC is expecting to launch a Continuing Competency program to support members' efforts to remain competent throughout their tenure. This program was developed by the Continuing Competency Committee and its history and highlights are explained here in an interview with Chair of Continuing Competency, Mary Dolen, RCC.

BY MARCI ZORETICH

What is the difference between continuing education and continuing competency?

"Continuing education speaks to attendance at any kind of course which may or may not be in our fields of expertise," says Chair of Continuing Competency, Mary Dolen. "Continuing competency implies and requires focus on one's particular areas of practice, as well as on the basic entry-level competencies expected by our association, then maintaining competency in all these areas. Focused continuing education activities form a part of this Continuing Competency Program."

What process did the Committee take to develop this program?

"When the Committee first solicited feedback from the membership regarding the need and interest in developing the new program, it received overwhelming support," explains Dolen. "The Committee then did extensive research on other models of continuing competency and met with representatives from other professional organizations to this end."

In building the new program, a number of priorities were identified, including:

- To consider the professional and geographic diversity of BCACC's members;
- To remove barriers to completion and make the program equally accessible to counsellors whether they are in more isolated areas or in urban centres; and
- To align BCACC with continuing competency programs of other professional bodies.

Consultative information was provided by members of BCACC's Ethics Committee, Inquiry Committee, and by staff at head office. Legal support was also provided. A program was then drafted, taking into consideration all the information gathered, then applying and adapting it to the unique needs of BCACC's members. This draft was subsequently presented to and approved by the Board, then piloted by a cross-section of volunteer BCACC members.

"Feedback was then gathered from the volunteer participants and reviewed in focus groups at a Delegate Council meeting," says Dolen. "In response to this feedback, the Committee refined the program and the paper-based model was approved by the Board. Later, this model was adapted for web-based delivery."

How will the program serve members?

The new Continuing Competency Program is designed to provide members with a structure and process to facilitate individualized continuing education and competency. It enables members to reflect on their practice, identify professionally relevant areas of growth, and facilitate a self-directed plan to enhance their competence.

"In short, it formalizes a process that members already complete and provides a format to demonstrate continued competency, accountability, and professional responsibility," says Dolen.

DON'T FORGET! Each year, when BCACC memberships renew, we ask everyone to please log in to update their insurance. While you are online, check your profile to make sure it is up to date as well. Last October, we launched a new member portal designed to be more user friendly.

To log in, visit **bc-counsellors.org** and choose the Member Login button.

OBJECT LESSONS

CULTURAL INSTITUTIONS AS ALLIES IN HEALING AND PART OF THE SOCIAL PRESCRIBING MOVEMENT

BY ROSS LAIRD, RCC

The oil lamp is small and fragile, worn down by almost two thousand years of accumulated grit, corrosion, darkness, and time. It was shaped by hand with unfired clay by a refugee fleeing Roman persecution in the fledgling age of Christianity. Its surface is dark with the grime of the underground tunnels, where it once illuminated secret pathways. It is an avatar of safe passage in troubled times.

And here, in a museum in Derby, England, a Syrian refugee holds the lamp gently between her hands. She has come across a turbulent sea with her children, seeking protection and safety. She has fled persecution and violence and horror. She has survived. Her children now play among the objects in the gallery beyond. We can hear their laughter echoing back to us along the corridor. After such a long journey and the endless trauma of their odyssey, they are beginning to find their way in this new country.

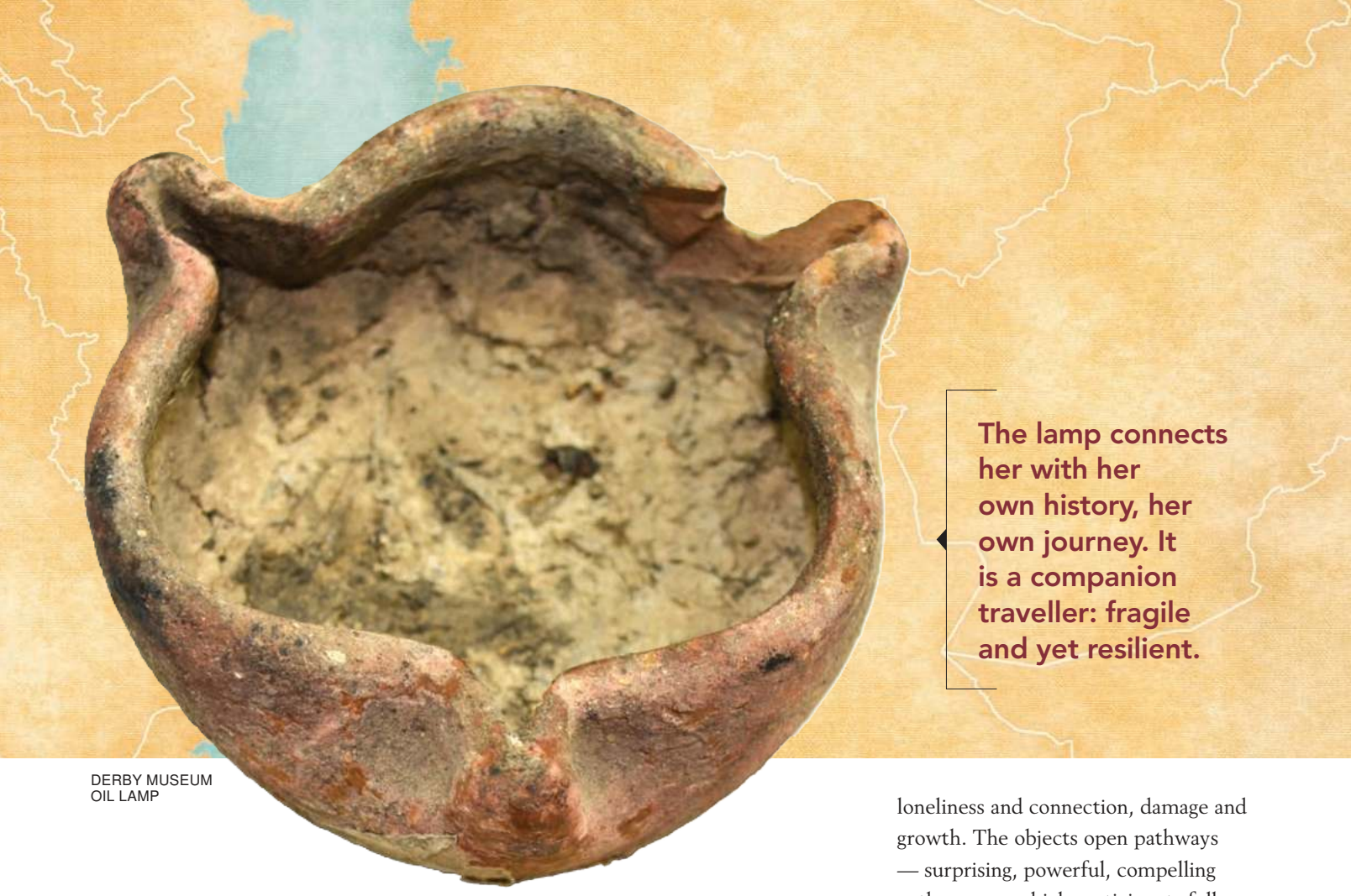
She cradles the oil lamp and wonders at its simple power. "It takes you back to ancient times," she says, "a transportation." The lamp connects her with her own history, her own journey. It is a companion traveller: fragile and yet resilient.

She has come to the museum as a volunteer to participate in a small community project focused on teaching participants how to clean ancient objects. She's not in therapy, and her experiences here have not been facilitated as traditional psychotherapeutic activities. The museum staff emphasize connection, belonging, and well-being — foundations for any counselling or therapeutic initiative — but cultivate these in ways not commonly seen in counselling practice. There's less formality here, fewer signs of explicit mental health promotion, more social connection and fluidity.

In this context of object interactions in cultural institutions, it is the objects themselves that drive the therapeutic process.

PATHS OF HEALING

Over the past several years, I've participated in a number of projects like this, and each time, I've been struck by the ease with which psychotherapeutic themes emerge, by the fluent and organic ways in which people find their paths of healing. And I am consistently reminded in this work of the primacy of the objects: their weight of symbols and of stories, the curious and often synchronistic manner of their involvement with participants. In this context of object interactions in cultural institutions, it is the objects themselves that drive the therapeutic process.



DERBY MUSEUM
OIL LAMP

The lamp connects her with her own history, her own journey. It is a companion traveller: fragile and yet resilient.

In the deepest recess of the bowl of the oil lamp, in a whorl of dried clay, the Syrian refugee has found the thumbprint of the maker. Ancient and persistent, that thumbprint, as though it calls across time with messages of succour and solace. Messages of flickering light across a vast and shadowed sea. As her children chase one another around a display of culinary tools from Mesopotamia, as autumnal light splays across the gallery, as she thinks about her journeying and arrival, the lamp becomes a marker and a talisman. The lamp affirms her path, encourages her, shares with her a personal example — ancient and yet present — of the universal human struggle to heal. The thumbprint carries her towards a feeling of unity, of identification with that distant maker, who crafted this light from the dark earth. In resonance and recognition, she pauses, smiles, then says, "I feel rapture over everything! With the oil lamp, I feel like I could almost be making it."

The museum gallery has a collection of ancient oil lamps, from far-flung times and places, as well as many other cultural objects: suits of armour, masks, jewellery, sculptures, weapons, bowls, clothing, and an array of objects of uncertain or unknown origin. An avalanche of accumulated time, of creativity, of humans roaming the landscape together.

I've had dozens of conversations here with participants keen to share their reflections and impressions of their chosen or favourite objects: a camera, a flag, an amulet, a totem, a statue, a bracelet, and many more. In each of these conversations, I've heard stories about trauma and healing, loneliness and connection, damage and growth. The objects open pathways — surprising, powerful, compelling pathways — which participants follow into themselves. The objects facilitate reflection and discovery, they broaden and solidify the community.

OBJECTS AS GUIDES

These experiences are some of the deepest therapeutic work I've seen: organic and playful, yet at the same time, rich with depth and meaning. Almost everyone I've worked with here shares, with their own objects, the perspective of the Syrian refugee when she says of her interactions with the lamp: "It illuminates me — my mind, heart, creativity."

It's wonderfully engaging and affirming for me to participate in these projects. And humbling, too: the object interactions are much more impactful than anything I could design as a therapeutic strategy. In museum settings, I focus on ensuring participants

are safe, that they do not exceed their emotional capacities, and I routinely use my skills as a trauma specialist to manage situations of overwhelm, dissociation, or freezing. Such moments do happen in this work, as in any work of deep engagement.

But I am also aware that my role here is somewhat different than what I am used to: I'm not the guide or the catalyst for the work participants do. Indeed, it is the objects which fulfill that role in ways that can be opaque and seemingly alchemical. Participants often speak of the objects as though they have agency. It's easy to share that view, especially when I hear participants repeatedly speak of objects as having saved their lives or enabling them to heal. For participants, the objects possess their own authentic power. Emotional power certainly, and often spiritual power as well. The healing that takes place begins with the object, not with a psychotherapeutic invitation.

It's strange, and yet very rewarding, for me to take a secondary role in what is so obviously a profound experience of healing for so many people. It makes me think about who the therapist is and what therapy means.

At the National September 11 Memorial and Museum, at the War Childhood Museum, at the Fashion Institute of Technology (FIT) Museum in New York, and here at the Derby Museum in the UK: in all of these projects, participants have used museum objects in ways that can only be described as therapeutic.

Survivors of 9/11 have used keycards, watches, clothing, and a multitude of personal objects to help facilitate their recovery from trauma. Participants who were children during wartime in Bosnia have found meaning in toys, bicycles, food wrappers, fragments of bomb-blasted masonry, and many stark objects of war. Participants in the FIT project have drawn inspiration from the intimate and infinite ways in which clothing intersects with our personal lives and our healing.

In every case, it is the objects that have guided and shaped the healing of the participants. Insights are gleaned from interactions with the objects, honed by way of conversation with mental health professionals, and shared within the community. In turn, the community is enriched, and the participants anneal their personal challenges by way of cultural and social bonds.

SOCIAL PRESCRIBING

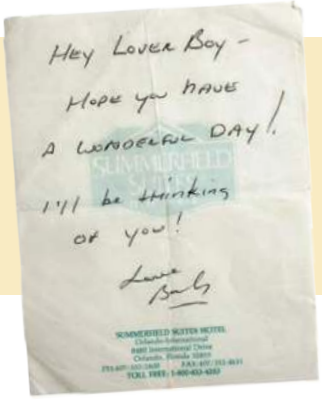
Cultural institutions as allies in healing is a growing field of counselling and therapy which has emerged, in part, because of the very complexity of many contemporary challenges. Pressing issues such as climate change, social isolation, terrorism, war, and economic instability cannot be solved through individual efforts alone and, therefore, lend themselves to initiatives focused on community connection and cultural participation.

REMEMBERING 9/11: THE THINGS LEFT BEHIND

SOME OF THE ITEMS FOUND AFTER THE ATTACK ON THE WORLD TRADE CENTER

A damaged floor sign from one of the World Trade Center towers.

A love note from victim Maynard Spence's wife. Spence, a construction safety consultant, was at the World Trade Center that day for a meeting.



An open Bible fused to a piece of metal that was found by a firefighter.

A cracked helmet that belonged to a firefighter from Department Squad 18.

SOURCE: NEWS.NATIONALGEOGRAPHIC.COM

In the UK, organizations such as The Happy Museum Project are focused explicitly on the relationship between mental health and cultural action. A broad network of such organizations has begun to flourish in the UK and has been instrumental in the movement commonly known as social prescribing, in which health practitioners prescribe cultural and social activities to their patients.

As a result of these innovations, ideas about the nature and process of counselling and therapy are broadening, practitioners are beginning to forge partnerships across disciplines and domains, and cultural institutions are starting to explore new modalities that help us grapple with the always complex and often intractable issues of our age.

Here in Canada, cultural institutions have begun to develop wellness programs on the social prescribing model (such as at the Royal Ontario Museum) and to support the work of mental health professionals in museum settings (such as at the Montreal Museum of Fine Arts). These projects further extend what is already a worldwide movement of museum professionals and mental health experts working together. The most straightforward form of these collaborations is social prescribing, which typically takes the form of free admission to a museum or encouragement to participate in a cultural or arts-based activity. In England, social prescribing is now supported by the National Health Service. Similar initiatives have begun to appear in Canada, with pilot projects underway in Ontario and Quebec.

My own work has been focused particularly on museums: first in the United States, then in Europe, and now in Canada, with organizations such as the Royal Ontario Museum. Objects in museums tell the stories of who we are and where we came from. Stories are maps, repositories of collected wisdom, ciphers and guides for making sense of the human journey. Whether archaic, prosaic, or postmodern, stories render the paths undertaken by all those who seek resolution and healing.

ROYAL BC MUSEUM

Objects in museums tell the stories of who we are and where we came from. Stories are maps, repositories of collected wisdom, ciphers and guides for making sense of the human journey.

At the 9/11 Museum, a participant — a man with the most harrowing account of survival I have ever heard — told me that "each object tells a different part of the story of that day." The story coheres and contributes, it grows and changes in the lives of its participants. "The objects make me think of the people that perished," he said. "This object [an ID card] shows that I got a second chance… I got out alive."

The connection between objects in the hand and the path of personal healing is profound, often mysterious, and — for me — always surprising. Objects act as allies and guides, as symbols, and sometimes as challenges or rejoinders. Each one is distinct, and the abundant diversity of their interactions with different people yields new and untrodden paths. A museum is a repository of object stories, colliding and interweaving, carrying forward the embodied past, holding the hardscrabble present, shaping the possible future. The diverse tales of objects, of their curious and potent power, contain many similarities and many shared moments of discovery. The map of healing is revealed by these moments, by the lamplight they cast over a landscape of searching and wandering.

The companionship of stories, the crafting of new scenes and chapters, the collecting of hard-won wisdom: these are all aspects of the unfolding story of every human and of humanity itself. Small and often quotidian object stories are fragments of an ever-evolving tale about what it means to grow, learn, and heal as a human. These stories, collected together in museums and cultural institutions, embody that collective and unfathomable human narrative; they share its richness and warmth. Each story is whole and complete, yet also woven into the larger tales that connect us all. Endless interwoven stories. ■

Ross Laird will be presenting on this topic at the BCACC Conference; see page 4.

Ross Laird, PhD, RCC, is a best-selling author and award-winning scholar, educator, and counsellor. He is the clinical supervisor for B.C.'s largest government-funded addictions treatment program and a consultant to a wide range of organizations on themes of trauma, personal development, and well-being.

ONE YEAR IN

WHAT I HAVE LEARNED ABOUT CANNABIS SINCE LEGALIZATION

BY TRICIA TOTH, RCC

On June 21, 2018, Bill C-45 received royal assent and, on October 17, 2018, was passed into law as the *Cannabis Act*, legalizing the recreational use of cannabis nationwide. In addition, new regulations were introduced to address the medicinal use of marijuana, which was first recognized in 2001 as a "legal" medicinal treatment option for specified conditions, such as HIV/AIDS and cancer. Cannabis use has become widespread, as has the variety of cannabis products. Whether legalization has removed the stigma associated with cannabis is debatable; however, it has got people talking and seeking more information.

As a clinical counsellor, I have had clients report that they are not interested in taking prescribed medication for mental or physical health issues, but for a variety of reasons, they are inclined to treat those issues with medical marijuana. Some individuals choose to self-medicate with marijuana simply because they classify cannabis as a less harmful "natural herb" compared to pharmaceutical medication. One client being treated for severe depression opted for cannabis with a high concentration of CBD in an effort to avoid the stigma of being an anti-depressant consumer and, perhaps, also the perceived stigma associated with mental illness.

These types of scenarios, along with mixed and conflictual information, had me pondering: is cannabis an effective treatment for mental health and, if so, in what form? Some claim cannabis can be useful in decreasing depression and anxiety, increasing creativity, and improving the ability to relax. Others claim cannabis does the opposite by increasing depression and paranoia. What are the facts?

WHAT IS CANNABIS?

Though the term cannabis is used concurrently with marijuana, cannabis is the botanical name for the entire plant that marijuana derives from. It is an annual flowering herb that can grow as high as eight to 12 feet, and it is dioecious, meaning the male and female reproductive organisms are generally on separate plants. Cannabis plants can also be hermaphroditic, with both female and male organs on the same plant, enabling them to pollinate themselves.

There are three primary cannabis species — cannabis sativa, cannabis indica, and cannabis ruderalis. Strains

of the plant can be pure (natural) or hybrid (manmade). The main strains being used for medicinal and recreational use are derived from the indica and sativa species.

The female cannabis plant produces flowers, which, in their mature form, are the source of the "high" for which marijuana is known. Products that derive from the female plant include marijuana, hashish, and hash oil. Hashish is produced from the resin of the female cannabis plant, and hash oil is a sticky black liquid extracted from the plant. Hashish, hash oil, and other cannabis concentrates and extracts are currently illegal in Canada.

Cannabis contains substances called cannabinoids. Two common types are delta-9-tetrahydrocannabinol (THC) and cannabidiol (CBD). THC is a psychoactive phytochemical and has a notably more intoxicating effect on the user's body and mind than CBD. While THC is derived solely from the female plant, CBD is sourced

I have had clients report that they are not interested in taking prescribed medication for mental or physical health issues, but for a variety of reasons, they are inclined to treat those issues with medical marijuana.

from both male and female plants. Both THC and CBD act on specific molecules, mostly found in the brain, called cannabinoid receptors.

THC is the cannabinoid more often associated with recreational marijuana use. THC is reported to have a variety of medical benefits, including reducing aches, pain, arthritis, inflammation, and nausea, as well as improving appetite and sleep quality and aiding people with depression, chronic fatigue, and stress. THC is not suitable for everyone because of its psychoactive components, which may cause an altered state of mind, anxiousness, and paranoia.

CBD is the cannabinoid most known for medicinal purposes and is often used by patients wanting a more natural alternative to prescribed medicines. CBD is used as a sleeping aide and mood stabilizer, to improve immune and reproductive systems, and for pain management and inflammation.

RISKS AND BENEFITS OF USE

Health Canada cautions that cannabis use produces long- and short-term side effects, including impaired ability to concentrate, slower reaction time, drowsiness, reduced memory, difficulty retaining new information, and poor decision making. Cannabis use can cause paranoia and, in extreme circumstances, can induce a psychotic episode that may include mixed and racing thoughts, hallucinations, and lost touch with reality.[1]

Harvard Medical School cautions that people with established heart conditions or who are under stress are at higher risk of increased blood pressure when using cannabis. The risk has been determined because of how cannabinoids affect the cardiovascular system: raising resting heart rate, dilating blood vessels, and making the heart pump harder.[2]

Smoking cannabis can cause lung damage and lung disease. A cannabis joint contains up to four times more tar than a tobacco cigarette. Inhaled deeply, one cannabis joint is equivalent to four to 10 cigarettes.[3]

One of the most prominent risks of frequent cannabis use is developing a dependency, which DMS-5 identifies as cannabis use disorder. Diagnosis criteria requires that an individual be a cannabis user for at least one year "with significant impairment of functioning and distress" combined with at least two of the following symptoms: failed efforts to reduce use, using more than intended over longer durations of time, significant recovery time following use, cravings, continued use despite negative consequences, suspension of important activities, disregard for danger such as operating a vehicle, continued use despite physical and psychological issues, higher tolerance, and withdrawal symptoms.[4]

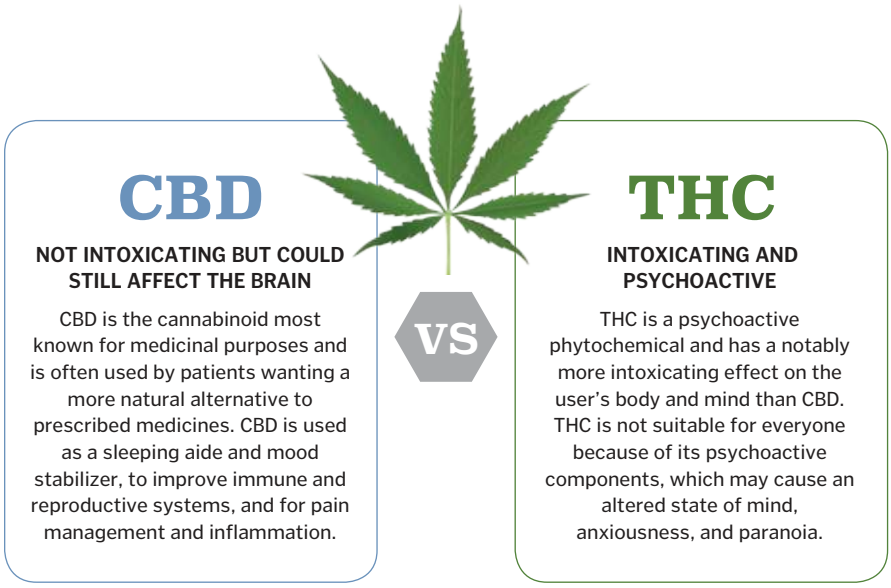
One of the main limitations when measuring risks and benefits associated with cannabis use is that most available research focuses on cannabis with high

Illegal sales can result in criminal charges, with fines ranging from $2,000 to $100,000 and possible imprisonment. It is illegal to share cannabis with anyone under the age of 18; this is enforced under the *Cannabis Act* by a sentence of up to 14 years in jail.

levels of THC. Studies that focus on the effect CBD has on stress, depression, and anxiety levels are limited.

"Existing research on the effects of cannabis on depression, anxiety, and stress are very rare and have almost exclusively been done with orally administered THC pills in a laboratory," reported Carrie Cutler, a clinical assistant professor of psychology at Washington State University (WSU) who co-conducted one such study. Participants were permitted to use cannabis within their own homes, as opposed to a laboratory. Comparisons were made between use of cannabis with high levels of THC and CBD, including the quantity consumed and outcomes. The study found that smoking as little as one puff was effective in reducing levels of stress, anxiety, and depression.[5]

In comparing outcomes for strains high in THC versus CBD, the WSU study found that strains high in both CBD and THC were most effective in treating client-reported stress. Low THC, high CBD was most effective in combating symptoms of depression; however, prolonged use to treat depression tended to have the countereffect of increased depression. In treating anxiety, there was no notable difference between use of strains high in CBD, THC, or a combination. However, women's anxiety levels were reduced more significantly than men's.[6]



Cannabis contains substances called cannabinoids. Two common types are cannabidiol (CBD) and delta-9-tetrahydrocannabinol (THC).

THE LAWS IN B.C.

Access to cannabis varies from province to province. In B.C., the wholesale distribution of cannabis is managed through the Liquor Distribution Branch (LDB). Upon legalization, one retail outlet was open for in-person purchases, located in Kamloops; all other legal purchases were made online. By April 2019, 13 licenced retailers were in operation in B.C.

Retail stores in B.C. are permitted to sell dried cannabis products, oils that meet federal regulations, seeds, and cannabis accessories, such as rolling papers and pipes. The LDB is currently in the process of reviewing applications and approving private retailers.

Cannabis can only be purchased by people over 19 years of age who are permitted to have 30 grams of non-medicinal cannabis in their possession in public; how much is kept at home is at the user's discretion.

The *Cannabis Control and Licensing Act* (CCLA) has been implemented in an effort to decriminalize cannabis, improve health, promote economic development, and encourage safe use. Only licenced establishments are permitted to sell cannabis. Illegal sales can result in criminal charges, with fines ranging from $2,000 to $100,000 and possible imprisonment. It is illegal to share cannabis with anyone under the age of 18; this is enforced under the *Cannabis Act* by a sentence of up to 14 years in jail.

Driving while under the influence of cannabis is prohibited. The police are now being offered specialized training to detect cannabis use and driving infractions. Drivers believed to be under the influence of cannabis and/or a combination of cannabis and alcohol can have their licences suspended for 90 days; there is no tolerance for cannabis use for new drivers in the Graduated Licensing Program.

Paul Hornby is a leading cannabis researcher and the founder of Hedron Analytical Inc. in Vancouver. Hornby, who has a PhD in human pathology, began his career in cancer research and later focused on cannabis research, initially to advocate for the use of cannabis for compassionate care of cancer patients and as an alternative to methadone treatment. Hornby has studied over 15,000 strains of cannabis, clinically split into three main strains: strains high in THC and low in CBD, strains high in CBD and low in THC, and a strain that split THC and CBD equally.[7] These are important distinctions, as much of the confusion around the benefits and risks of cannabis centre around correct strain use for particular conditions. While research is still relatively new in ascertaining which strain is most effective for which ailment, much progress has been made. For instance, Hornby analyzed a strain called Hayley's Comet as having equal parts CBD and THC after it was determined to be effective in reducing seizures. The strain was named after Hayley Rose, who, in 1999, at age six, was diagnosed with Lennox-Gastaut Syndrome, a severe form of epilepsy with as many as 40 seizures per day. Rose, at age eight, experienced a significant reduction in seizures after vaping Hayley's Comet in a Vancouver café.[8]

MOVING FORWARD

One of the barriers to determining the benefits and risks of cannabis use is the abundance of inaccurate and misleading information online.

"Currently, medical and recreational cannabis users rely on the advice of bud tenders, whose recommendations are based off of anecdotal not scientific evidence," says Cutler in a WSU news release.[9]

Existing research is primarily focused on strains high in THC content, and data comparing consumption methods — inhalation vs. vaping vs. edibles — is limited. Studies have been conducted on animals, but results do not always translate well to human usage.

Despite cannabis legalization, many grey areas remain. While recreational use of cannabis is legal, concentrated forms are illegal. Though edible cannabis products are commonly available through dispensaries, under current law, their sale is illegal. The LDB currently manages licencing and issuing of cannabis retailers, though some pre-legalization medical dispensaries have remained. All of this has resulted in confusion for consumers seeking reliable resources and information.

Given its easy access, users may be more inclined to purchase cannabis through recreational sources, even for medicinal purposes.

A cannabis joint contains up to four times more tar than a tobacco cigarette. Inhaled deeply, one cannabis joint is equivalent to four to 10 cigarettes.

Consumption is also a matter to be considered. Patients offered physician-prescribed medications are provided with dosage recommendations and a detailed list of side effects. This information is not consistently offered through cannabis dispensaries. Moreover, given its easy access, users may be more inclined to purchase cannabis through recreational sources, even for medicinal purposes.

With continued research and awareness, these grey areas will likely be resolved. In the interim, given the abundance of misconceptions and misinformation, clients who choose to use cannabis as a treatment for mental health issues are well advised to consult a medical practitioner. It is equally important that clinical counsellors not allow their own biases to influence their clients but instead encourage clients to make well-informed decisions guided by medical expertise and in combination with clinical counselling. ■

Tricia Toth, RCC, MSW, RSW, owns and operates Great Life Counselling in Ladysmith. She supports children and adults working through challenges, such as life transitions, trauma, addiction, and mental health. She is committed to assisting others to live their greatest life. www.greatlifecounselling.ca or ttoth@greatlifecounselling.ca.

WANT TO KNOW MORE?

The Government of Canada has developed a website called Cannabis in Canada: Get the Facts. Information is organized into six sections:

1. What you need to know
2. Cannabis and your health
3. Cannabis and the border
4. Cannabis impairment
5. What industry needs to know
6. Cannabis in the provinces and territories

Each section provides a vast array of information, including videos, printable resources, medical research, and resources for health professionals, teachers, and parents. www.canada.ca/en/services/health/campaigns/cannabis.html

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REPAIRING LONELINESS

Radically Open Dialectic Behaviour Therapy

BY J. NICOLE LITTLE, RCC

Regardless of which population or diagnostic category I work with as a clinical counsellor, a steady — and often unnamed — undercurrent remains. That undercurrent is loneliness. I hear stories from anxious students who tell me they have no friends, depressed adults who tell me love is fake. For myself, the loneliest place I worked was also the most populated. At a time when the population of Earth is creeping up to eight billion people, and we have myriad virtual means to communicate, we are contending with an astounding lack of meaningful connection. In fact, Britain appointed a Minister for Loneliness in 2018, and other countries, including Canada and the USA, also report that loneliness is detrimental to mental and physical health.[1]

Why are we so lonely? And importantly, what can we do to repair it? The answer might be in Radically Open Dialectical Behaviour Therapy (RO-DBT).

WHAT IS RO-DBT?

RO-DBT is a new evidenced-based treatment for what are termed conditions of overcontrol (OC). These include refractory depression, treatment-resistant anxiety, overcontrolled personality disorder, and anorexia nervosa. I was attracted to learning RO-DBT precisely because I felt so stuck treating these conditions; it felt like, despite the client and I doing all the hard work, relapse was the norm not the exception. It was liberating to be exposed to a transdiagnostic model that identified the common denominator to these issues: temperament and deficiencies in social signalling.

CONDITIONS OF OVERCONTROL (OC) INCLUDE REFRACTORY DEPRESSION, TREATMENT-RESISTANT ANXIETY, OVERCONTROLLED PERSONALITY DISORDER, AND ANOREXIA NERVOSA.

Leaning to OC is a temperamental bias, meaning, it is how some of us come into the world wired to perceive and respond to stimuli in our environment. For people who lean to OC, they are temperamentally predisposed to have higher threat sensitivity and lower reward sensitivity. They have superior detail orientation and pattern recognition and have high inhibitory control. When this temperamental bias is matched with an environment that implicitly or explicitly gives messages that winning is essential, mistakes are intolerable, and/or emotional expression is taboo, then it makes sense that the nature/nurture combination gives rise to coping strategies that are reinforced over time. Unfortunately, these coping strategies, such as masking inner feelings, distress over tolerance, risk aversion, and compulsive striving often fall below the radar of health professionals.[2]

In contrast, our clients who lean to undercontrol (UC) have often been sending big signals since childhood: impulsivity, recklessness, and low inhibitory control. As a result, they have likely gotten the attention of caregivers, teachers, and mental health professionals. In fact, most of our therapies are designed to treat emotional dysregulation (UC) not over regulation (OC).

OC children are reinforced by their environment for their capacity to "keep

OC CHILDREN ARE REINFORCED BY THEIR ENVIRONMENT FOR THEIR CAPACITY TO "KEEP IT TOGETHER" AND TO BE GOAL DIRECTED AS THEY ARE GENERALLY RULE GOVERNED, CONSCIENTIOUS, AND PERFECTIONISTIC.

it together" and to be goal directed as they are generally rule governed, conscientious, and perfectionistic. But that does not mean our clients who lean to OC are not suffering; they have often been suffering silently for a long time. And the root of this suffering is emotional loneliness, secondary to social signalling deficits connected to being in a state of perpetual threat.

EMOTIONAL LONELINESS

The therapy's developer, Thomas Lynch, describes emotional loneliness as: "not lack of contact, but lack of intimate connection with others. Thus, rather than focusing on how to do better or to try harder, the primary aim in RO-DBT is to help the OC client learn how to rejoin the tribe and establish strong social bonds with others."[3]

Emotional loneliness and OC coping precede the onset of the above-mentioned conditions. Clients often describe their childhoods as solitary, perfectionistic pursuits, and their adulthood as the continuing saga of the same. When these clients present in therapy as adults, all may look "together" on paper, yet they have been plagued with unremitting mental health problems (including self-harm and suicidal ideation) that none other than you — the therapist — may be privy to.

Many OC clients have also steadfastly worked on solving the problem themselves but mostly through intellectual means and compulsive striving. As Michael Unger wrote in his *Globe and Mail* article, "Put down the self-help books. Resilience is not a DIY endeavour," this is partly what drives the self-help machine: "We take upon ourselves the task of becoming motivated and subject ourselves to the heavy lifting of personal transformation. We mostly fail. We gain back the weight that we lost. Our next relationship is just as bad as the one we left. Our attitudes improve, but the boss is still a jerk."[4] What is more important, he argues, is to be in a community that promotes resiliency through interdependence. From a RO-DBT perspective, we teach clients how to get out of the hell of loneliness and its associated diagnosis by getting back into the tribe.

TRIBES AND SOCIAL SIGNALS

The word "tribe" originated from the Latin *tribus* and reflected the divisions in Rome. Old French also used the term *tribu*. Of course, connotations of tribe are abundant (and some have been taken up as pejorative), but for the purpose of this brief discussion of RO-DBT, it is important to note that at our core, humans are tribal. Our survival depended on our capacity to trust and depend on other humans outside our nuclear families. For our OC clients, who are often hyper-independent,

they have felt outside the tribe for a long time, resulting in mental health conditions that exacerbate this. As Emily White writes in her autobiography on loneliness:

Perhaps all my studying and thinking and reasoning about loneliness was based on the wrong premise. I thought I could subdue the state myself. But I couldn't. I can't. What I need is the comfort that can be provided by someone else. I'm not, despite adequate skill or powerful desire, able to write an end to my own loneliness story. The ending has to come from outside, from someone else, from someone who takes me by the hand and leads me away from the state, away from the word, away from the feeling that has been mine for so long.[5]

Our job, as RO-DBT therapists, is to be that "someone else" who welcomes them back. And we do so through teaching skills that address temperamental bias and subsequent deficits in social signalling.

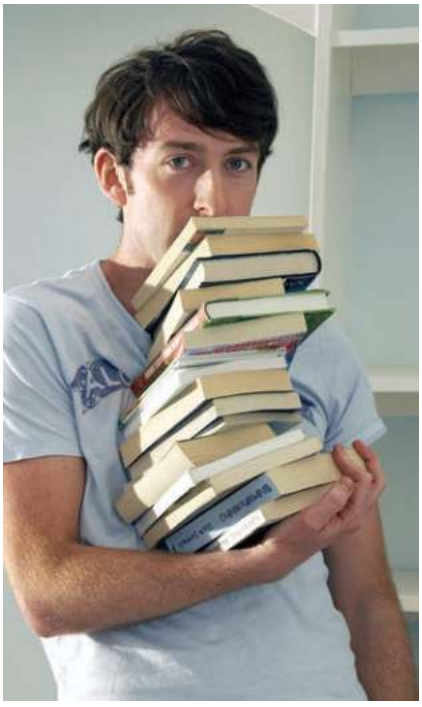
WHAT IS A SOCIAL SIGNAL?

A social signal is anything that is done in the presence of another person, consciously or not. Take a moment to think about your own social signalling today. Did you scowl in a meeting, wave exuberantly at a neighbour, check your phone during a conversation? If you scowled at a meeting, it could have been because you were upset with the content — or perhaps constipated. Whatever the source of the scowl, and whether it was intentional or not, others in the environment read this signal through their own perceptual biases. This is why we teach clients in RO-DBT that "We don't see the world as it is, we see it as we are."

Recall I said that people who lean toward OC are wired to be more threat sensitive; this means they are predisposed to read cues in the environment as more threatening; that is, they are less inclined to believe the person scowling at the meeting was in gastrointestinal distress and more likely to believe the person was upset by something they had said or done.

But this is not "all in our head," which would lend itself to cognitive reappraisal. It is physiological in basis as we are continuously scanning the environment, unconsciously asking, "Will this help my survival or curtail it?" And depending on what neuro-substrate is being fired up (safety, novelty, threat, reward, or overwhelm), different areas in the brain are also fired up, resulting in changes to our capacity to gesture, vocalize, seek touch, or meet eye contact. Since our OC clients often live in threat, this means the neuro-substrate of safety (which activates the ventral vagal complex) is disengaged most of the time, resulting in stilted or phoney social signals and less inclination to demonstrate vulnerability. As White discusses:

If other people are perceived as risky, it can start to seem reasonable to try to reduce that risk by retreating from them. The lonely person who does this will start displaying the supposed "skills deficits"… she will say less, disclose less, and end interactions more quickly. These behaviours are actually effective and sensible in the short term, since they insulate the lonely person from potential threats and rejection. But in the long term, the behaviours can become self-defeating. As isolation becomes more entrenched, threat perceptions will become more acute, and it will be harder for someone to pursue the relationships she needs to fend off loneliness.[6]



MANY OC CLIENTS HAVE ALSO STEADFASTLY WORKED ON SOLVING THE PROBLEM THEMSELVES BUT MOSTLY THROUGH INTELLECTUAL MEANS AND COMPULSIVE STRIVING.

AS MICHAEL UNGER WROTE IN HIS *GLOBE AND MAIL* ARTICLE, "PUT DOWN THE SELF-HELP BOOKS. RESILIENCE IS NOT A DIY ENDEAVOUR."

Where this can be most apparent is in our facial expressions when under threat, where we are likely to be less expressive or a "deer in the headlight."[7]

FACIAL EXPRESSIONS AS UNCONDITIONED STIMULI

In fact, all of us, regardless of leaning to UC or OC, are hardwired to read neutral facial expressions as threatening; facial expressions are unconditioned stimuli. My OC clients get this immediately when asked why the bad guys in movies are often not larger than life or loud, but stoic and stone-faced: because we don't know what they are thinking. Unfortunately, our OC clients are often the ones who hold these neutral expressions (e.g. pervasive lack of pro-social signals) or disingenuous expressions (e.g. pervasive, overly social signalling, like fake smiling) and both serve to be off putting, which keeps our clients out of the tribe and from being invited into the tribe.

At some point in your practice, you likely have had a child, adolescent, or adult lament "people just don't like me!" And our general response as caring therapists is to challenge the thought. We might point out their positive qualities or relay why we like them or tell them to apply more social skill effort. But you cannot think your way out of isolation. Many of my RO-DBT clients are relieved to hear this, because, as perfectionists, they have either tried to fix the problem through willpower or been in therapies that suggested the same. Our role as RO-DBT therapists is to model that we don't necessarily need to work harder or get more serious and that we have a way out of this.

SO WHAT IS THE WAY OUT?

Adherent RO-DBT is a model that uses individual sessions alongside skills classes. In my private practice, this means 25 to 30 individual sessions, plus 25 skills classes. There is evidence to suggest that skills class alone can promote lasting change[8] and this is the model I facilitate in my role in provincially funded mental health. Regardless if clients are in private or provincial care, it is not uncommon to hear that these skills change their life in significant ways. And why? Because of our focus on social signalling and giving people tools to activate their social

safety (ventral vagal complex/VVC). Clients have a lot of fun learning about the brain, and we enjoy sharing the language of "getting your VVC on."

Take, for example, the role of eyebrows in therapy. Some of you may be thinking, "What the heck do eyebrows have to do with therapy?" Well, lots as it turns out, quite a lot, and not just in therapy. Consider your own training as a therapist. Likely you were trained in "expressions of concern" and body language that actually heightens threat in our already threat-sensitive clients. RO-DBT therapists teach our clients universal pro-social signals that not only activate their own social signals but also, thanks to mirror neurons and mimicry, activate the social safety in those they are interacting with. In trainings, we teach something called the greeting exercise (which is hard to replicate in print), but essentially, we instruct people to greet a long-lost friend as they would imagine they would. Then, we instruct them to do so without moving their eyebrows. I encourage you to try this at home; with raised eyebrows, you will note an invigoration of both gestures and vocal expression. Without eyebrows, it is actually more difficult to engage. What does this mean? The flat affect that comes with an activated threat system serves to lower our desire for engagement, perpetuating the cycle of loneliness.

WALKING THE TALK

A key point to facilitating RO-DBT is that we teach clients that practicing radical openness is not an intellectual pursuit — it is experiential. While it is outside the scope of this brief introduction to attend to the nuances of each skill taught, suffice it to say the therapist is also responsible for modelling this practice (see www.radicallyopen.net/blog/ for examples).

It may not be surprising to learn that a great number of therapists lean to OC (Radically Open Ltd.) and this makes sense on many levels. For example, it takes enormous inhibitory control to achieve an MA or higher degree. Chances are if you are reading this as an RCC, you have had to delay gratification to achieve your credentials for membership and could not have achieved a career based solely on mood dependency — which we tend to see with our emotionally dysregulated client population (e.g. "Work? I don't feel like going").

WE TEACH CLIENTS THAT PRACTICING RADICAL OPENNESS IS NOT AN INTELLECTUAL PURSUIT — IT IS EXPERIENTIAL.

Clients see us as the bastions of emotional health — for better or worse — and for therapists who also lean to OC modelling, RO-DBT principles can be liberating for our clients. This means practising our own expression of vulnerability, modelling some playfulness, and teaching our clients to tease and be teased. Dialectically, these are held with compassionate gravity. All of these topics can be found in the RO-DBT text book.[9] And as I teach other therapists, standard DBT enhanced my life, but RO-DBT transformed it.

Consider for a moment people in your practice who may fit the profile of OC — or perhaps yourself! Due to their inhibitory control, they may be presenting well but suffering all the same. Their OC coping has likely been reinforced over time, making change harder. There is also real grief for those who believe they have lived their lives "correctly" due to this social reinforcement.

A part of RO-DBT therapy is focused on story and metaphor, so I will end with one such metaphor. For clients who lament that their OC coping has resulted in being emotionally lonely, we remind them that learning about OC is like waking up in your house to discover it is painted purple. Except you hate the colour purple. And we say, guess what? We can decide together on a new paint colour. ■

J. Nicole Little is a certified RO therapist, supervisor and trainer who believes RO-DBT has been personally transformative. She is currently co-authoring a book with Thomas Lynch, RO-DBT developer, and she is a regular RO-DBT blog contributor. She is excited to co-host the first Canadian RO-DBT intensive training in 2020. She would like to thank Thomas Lynch and Erica Smith Lynch for welcoming her into the RO-DBT tribe.

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SHIFTING THE BASIC HUMAN EQUATION

A proposition for our clients and ourselves to improve communication with others and make life's disappointments more manageable

BY WILLIAM KLAASSEN, RCC

You are on your way to a conference, and although you left home later than you should have, the timing is working out perfectly. Well, it was working out, until that red car swerved into the lane ahead of you and clipped the bumper of the UPS delivery van merging from the opposite lane. A feeling of frustration wells up inside you. As you step out of your car, you have an urge to yell something at this driver. After dealing with the legalities of the incident, you quickly get on your way again and start to feel more elated as the traffic seems to be moving faster than usual. The closer you get to your destination, the more optimistic you feel; you might make it after all.

Surely, you can imagine dozens of similar situations that occur daily. Theoretically, there are many skills we could try to learn to deal with these situations. However, I believe we all have the skills already and that the solution is much simpler.

We will come back to this scenario, but first, let's take a step back and consider what I call the Basic Human Equation.

THE BASIC HUMAN EQUATION

Everything that occurs in our lives is always, and only, made up of two parts: the expectation of an event or situation and the experience of that event or situation. Let's elaborate.

First, we have the expectation of what we anticipated or expected would happen. Our expectation is not always explicit. In fact, sometimes it could be cultural, something we rarely give thought to, or even something in nature. We expected it to be sunny this morning. We expected our alarm clock to go off at 7 a.m. We expected our client to show up at 9 a.m.

Second, we have the actual experience of the event. We experienced the sound of rain as we woke up. We experienced waking up at 8:30 a.m. We experienced our client not showing up.

Notice that when the expectation and the experience of each situation are juxtaposed, there is a dissonance. In each case, the expectation was greater (more desirable) than the experience. We

We usually feel a negative or uncomfortable feeling when our expectation exceeds our experience — feelings like stress, anxiety, frustration, and anger. This is when conflict and violence tend to arise.

usually feel a negative or uncomfortable feeling when our expectation exceeds our experience — feelings like stress, anxiety, frustration, and anger. This is when conflict and violence tend to arise.

Like any equation, the inputs always affect the result. If the expectation and experience are the inputs, what is the result? The most overt result is the feeling we have — and, surely, we can all attest to how strongly feelings affect the way we communicate and relate to others.

Let's put our opening scenario into perspective. You left late and expected to arrive late for the conference. You experienced mild relief (positive) when the traffic was moving smoothly; your expectation was less than your experience. When the incident occurs, you feel frustration; your current expectation of arriving on time is suddenly greater than your experience. Back on your way again, you feel elation because the light traffic means your lowered expectation of being late is now again replaced with an experience of possibly being on time; expectation is less than your experience.

THE ROLE OF FEELINGS

When our expectation equals our experience (what we expected to happen actually happened), we typically get a neutral result; the moment may pass by without any noticeable feelings. If we do take particular notice for some reason, we may experience some positive feelings, even a small moment of celebration, then we move on. When this happens, we typically take this as confirmation that our expectation was good.

Alternatively, when our expectation is less (more undesirable) than our

experience, we will definitely experience strong positive feelings. When this happens, we pass accolades all around and consider ourselves quite "good." We achieved an experience that exceeded our expectation.

As mentioned earlier, typically, it is only when our expectation is greater than our experience that we run into conflict.

At this point, you may be thinking, "Well, okay, that's pretty obvious, and this all makes sense, but how do I put this into practice and what difference will it actually make?"

The first step is to categorically understand that every event in our respective lives is always a melding of our expectation and experience. Our bodies have a very effective mechanism to communicate the overt result of this equation to us: feelings.

So in terms of the equation, the following is typically true:

Expectation < Experience ▼ Positive Feeling
Expectation = Experience ▼ Neutral (possibly positive) Feeling
Expectation > Experience ▼ Negative Feeling

Looking at this from pure mathematics, to change this equation, we would have to switch the sign, which ultimately means we must either change the experience or the expectation. Naturally, we cannot change anything after the event has happened, so this is simply unfeasible.

Thankfully, the solution is not found in mathematics, but rather in our perspective and focus. And no, it is not about simply being more positive or focusing on believing the best or even learning a new model or method. Instead, we need to shift our focus from where it habitually goes. For example, when we have a negative feeling (expectation > experience), our focus usually goes to the experience we are having and possibly the effects of that experience. Notice where our focus and thoughts go for these little scenarios:

"What does that weather forecaster know anyway? She said it would be sunny! How is our company picnic going to turn out now?"

"That stupid alarm clock didn't ring again! Why do they make alarm clocks like that anyway? Now, I have to walk into my meeting late and feel embarrassed!"

"Why didn't she just call to say she wasn't coming? How disrespectful of her to just not show up. I could be doing so many other things right now."

As you will notice, each of these thoughts or expressions are an explicit focus on the experience of the event and, possibly, the effects that follow. In a sense, we focus only on the second part of the equation, then express the result in those terms. To affect change, we need to focus on the first part of the equation instead, and when we do this, a multitude of things shift to completely change the outcome of the situation.

When our language changes and our focus is off the other person's behaviour, we are more open to discussing our expectation and the possibility that it plays a more important role than the experience.

SHIFTING FOCUS AND PERSPECTIVE

OUR ULTIMATE GOAL IS TO FOCUS ON OUR (UNMET) EXPECTATION RATHER THAN THE MANIFESTED EXPERIENCE.

	OUTCOMES IF THE FOCUS IS ON EXPERIENCE	OUTCOMES IF THE FOCUS IS ON EXPECTATION
1	We continue to experience the feelings by reliving the dissonance between expectation and experience. From a positive perspective, this is true as well. During celebration, each time someone yells out, "We WON... can you believe it?" others join in and erupt into cheers. Just by repeatedly highlighting the gap between our expectation and experience, we feel the same elation again. This is also true when I say, "I can't believe they hit me"; even days after the incident, I may feel the same irritation and vulnerability all over again. Just reliving the feeling over and over does not create change or even impetus for change.	We take our body's message (feeling) and work with it to change the result rather than amplify the feeling. Validating the feeling calms it down and allows us to work in a place where we are much less emotional.
2	We all know strong feelings hijack our mind and inhibit learning. For example, if you are nearly drowning, you are not learning in that moment — you are just reacting. It is only after you have been rescued and have "calmed down" that you can learn from what you have experienced. By continuing to focus on the experience and the dissonance, we revive the feelings and continue to block learning.	Without these strong feelings present (because they have been heard), we are putting ourselves in a prime learning environment.
3	We typically take a "me versus you/them" blaming mentality, which only perpetuates the judgement and shaming. Too often, by focusing on the experience, we try to change our experience by demanding that the other person change.	We not only stop the "you vs. them" blaming mentality, but we also invite the other person to become our partner in meeting the expectations. We typically also become more curious about the dissonance rather than judging it.
4	In line with the previous point, the language I then use is much more about changing the other person's behaviour; we all know how well conversations go when we try to change someone.	When our language changes and our focus is off the other person's behaviour, we are more open to discussing our expectation and the possibility that it plays a more important role than the experience. Our language shifts, making conversation more human and collaborative.
5	Ultimately, when we focus on the experience, we are giving all the power to the other person (or experience). When we perceive that the other person or experience has control of the result, we become quite powerless, which perpetuates our negative feelings. Inversely, and just as dangerous, it could exaggerate the power and control we have in a "positive" situation.	Finally, we remove the ability of the experience or other person to control the result. This puts us in the driver's seat with enough power to change the outcome without overpowering the others involved.

Too often, by focusing on the experience, we try to change our experience by demanding that the other person change … we all know how well conversations go when we try to change someone.

This small, subtle shift has the potential for huge transformation in our conversations and, ultimately, our relationships.

PUTTING IT INTO PRACTICE

As I promised, there is a lot that shifts when we simply move our focus from our experience to our expectation. Applying this to my previous examples demonstrates what it might look like in actuality.

We wake up to rain. Immediately, our cue that we have an unmet expectation is the negative feeling we experience. Rather than focusing on the experience, focus on the unmet expectation with the following expression, "I was expecting it to be sunny today for our picnic."

At this point, you may say "But yeah, that's just semantics." And yes, it is just a small shift. But, when we do this, firstly, we implicitly validate our feelings and own them. Secondly, we shift our focus away from amplifying the feelings and, hence, allow our brain to switch into learning mode. And thirdly, we are more willing to negotiate that our expectation may need to shift for us to be prepared for the picnic.

We wake up at 8:30 a.m. We immediately know we have dissonance and already imagine the unpleasantness and embarrassment. However, when we focus on the expectation of the alarm clock ringing at 7 a.m., we put ourselves in a much better place to learn and be in control of the result. Furthermore, when we express ourselves by saying, "I expected my alarm to ring at 7 a.m. and realized I had set it for 7 p.m." versus "My stupid alarm clock didn't go off." I will let you judge which one is more authentic and believable.

So the next time we have a client or co-worker who doesn't show up on time, let's not focus our language/thoughts around:

"Why did you not show up?"

"I notice you have been late the last four days; what's going on?"

As you will now notice, both statements focus on the experience and the other person's behaviour. Rather, let's focus our language/thoughts on:

"I expected you here on Monday; I am wondering if we can chat?"

"I notice you were having difficulty being here by 9 a.m. the last few days; can we chat?"

This small, subtle shift has the potential for huge transformation in our conversations and, ultimately, our relationships. The net result is a completely different way of communicating and relating to others that is less judgmental and more collaborative and compassionate. ■

William Klaassen, RCC, works in private practice in Chilliwack and specializes in reframing communication resulting in better relationships. Specifically, he works with youth and adults helping them become judgement-free and collaborative when resolving differences. www.bluegiraffe.ca

BUILDING RESILIENCE BEING PREPARED

In early August 2018, a wildfire broke out about 40 kilometres from the northern B.C. village of Burns Lake. Within two weeks, Burns Lake was surrounded by wildfires on three sides, and evacuation orders were in place throughout most of the region of ranches, farmland, and First Nations Reserves.

"Many folks decided to stay behind and fight for their homes, but children had to leave," says Linette Schut, RCC, mental health clinician at Carrier Sekani Family Services. "Some people evacuated to Prince George or Smithers, but many stayed in town with friends and family. There were many animals that had to be evacuated as well, and volunteers set up a space for livestock at the fairgrounds, and a local kennel took many cats and dogs. One of the First Nations — the Burns Lake Band — opened up their hall to evacuees and, quickly, that became the hub in town. They served meals three times per day and had cots for people to sleep."

Support came in from around the province, including Indigenous healers from Tsow-Tun Le Lum Society on Vancouver Island, support people from First Nations Health Authority, and volunteers from the Disaster Psychosocial Services (DPS) Program. Almost every day for the next two weeks, Schut was at the hub, checking in with people and helping to stay organized.

In other words, she provided what was needed most during a disaster.

PROVIDING EMOTIONAL SUPPORT

Irene Champagne, RCC, has worked in the mental wellness field for over 35 years. Her initiation to post-disaster emotional support work came in the late 1980s.

HOW COMMUNITIES FACE DISASTER AND WHAT YOU CAN DO TO ASSIST

BY CAROLYN CAMILLERI

THE NORTHERN B.C. VILLAGE OF BURNS LAKE

JOHN CALOGHEROS

> Remember, the distress that emerges in the wake of a disaster is normal and healthy. Compassionately holding space for normal reactions to an abnormal event is often all that is required.

"Friends of mine — doctors — were serving as volunteers for a number of international aid organizations," says Champagne. "I had studied CISM [critical incident stress management] and volunteered to provide debriefing for the members of the medical teams."

Since those days, she has learned the distinct differences between CISM and post-disaster emotional support, along with many other lessons on how to support individuals and communities impacted by disasters.

"At first, just like the physicians I had debriefed, I found volunteering a bit overwhelming — I was tempted to over-function as a therapist," says Champagne. "But the past 30 years have proved that providing Psychological First Aid (PFA) — which is endorsed by the World Health Organization — is a wonderfully effective, destigmatizing, respectful, and empowering intervention in the wake of a disaster."

Champagne's volunteer work has taken her to Australasia, Central America, US, Far North, Europe, and numerous locations in Canada. In the early 90s, she recruited RCCs to volunteer in the wake of disasters on Vancouver Island, and when the DPS Program was established in 2001, she served as a field team volunteer, a role she continues in, as well as a field team leader. Currently, she represents BCACC on the provincial DPS Council.

"The DPS Program provides support immediately after it is safe to respond, and if needed, we continue to support for the first couple weeks or as the need is assessed," says Champagne. "The authorities in the community must request our help, and we assess the need as the recovery proceeds."

The goal for DPS Program volunteers is to help stabilize community members, so they can make wise decisions about next steps.

WHAT HELPS?

As a DPS volunteer, Champagne works with groups, families, individuals, people waiting for financial support and in temporary shelters, seniors, adults, children, people with disabilities — as well as people who are helping in the recovery process. Local resources of mental health and spiritual support are vital in the recovery process, and she notes that the most important indicator for optimal recovery seems to be sources of comfort, compassion, connection, and confidence.

"Some communities and individuals can find this within themselves, while some need a social context for these supports," says Champagne.

Sometimes the compassionate, comforting presence of a fellow human is enough.

"Remember, the distress that emerges in the wake of a disaster is normal and healthy," she says. "Compassionately holding space for normal reactions to an abnormal event is often all that is required."

The work of mental health practitioners becomes more important later in helping people who experience long-term effects.

"Disaster psychosocial work is often a tiny part of supporting people through the early stages," she says, noting that when there are deaths, the recovery process takes a more painful turn. "Individuals with traumatic loss and/or additional complications benefit from counselling."

But in the immediate situation, the direction from PFA is Look, Listen, and Link: Look for distress. Listen for what is needed. Link to the appropriate resource.

"Most beneficiaries of post-disaster emotional support are not seeking counselling — that could pathologize the recovery process," says Champagne. "They are seeking comfort, connection, and confidence. Our counselling training helps us to 'Look' and 'Listen,' but this work calls for Psychological First Aid — not counselling."

Anyone with a will to be supportive can take PFA training.

"I am often moved by the deep presence and 'pre-skill' that emerges in my fellow volunteers," says Champagne. "It is a willingness to be fully authentic and human(e), without bringing one's skills as a counsellor or therapist to the fore."

Disaster Psychosocial Services Program

Developed under the Provincial Health Services Authority, the Disaster Psychosocial Services (DPS) Program provides psychosocial support to the public and responders affected by an emergency or disaster. Training opportunities to become DPS Program volunteers include two free online courses: **Introduction to Disaster Psychosocial Services**, a series of eight 30-minute modules, and **Introduction to Emergency Services**, through the Justice Institute of British Columbia.

WHEN DISASTER STRIKES

When disaster does strike, there is no predictability. Champagne says every community and every disaster is different. Even when a similar disaster hits the same community more than once, it is impossible to predict the psychosocial responses to the crisis.

"In communities where stability has been enjoyed and taken for granted, the catastrophic nature of disasters can be deeply shocking and paralyzing," she says. "In communities where chronic chaos has been endured, the impact of a disaster can be depressing and numbing. There is no template or reliable predictor for how a community responds."

However, it is troubling when communities and individuals underestimate psychosocial damage, or when people are encouraged to conceal distress, which can lead to serious consequences.

"If there is an attitude that outside help is not needed or people should 'suck-it-up,' we may see people who feel shamed for being victims of the disaster on top of feeling shame for being upset by it," says Champagne.

"Many communities have strong social connections that are wonderfully helpful in supporting resilience, but it is troubling when impacted people — victims — are subtly or overtly shamed for experiencing psychosocial disturbances in the wake of a disaster."

Because each individual responds differently, post-disaster emotional support workers are watching for diverse signs of distress, from being loud and angry to numb and dissociative.

"Delayed reactions are also common — a person might appear stable and 'on the ball,' pitching in with disaster relief in the early stages — then collapse," says Champagne. "We watch for this among the workers."

Volunteers also have to watch for reactions in themselves. When disaster occurs in our own communities, Champagne calls it "a double whammy" of our own reactions and the need to be a helper. Self-care and healthy self-awareness allow us to stay strong when needed.

"Know your limits. Seek and offer peer support. Stay humble — avoid over-functioning," she says. "It is really important to be gentle with ourselves and each other."

PREPARATION: THE KEY TO RESILIENCE

While disaster can't be predicted, we can prepare to a certain extent.

"Frank and realistic acceptance of risk and preparation for disaster is most helpful, but we continue to encounter under-prepared folks," says Champagne. "One direct consequence of volunteering with the DPS Program is regularly reviewing one's insurance policy and assessing one's own recovery strategy."

While only experiencing disaster can really tell us what we need, we can learn from other examples, such as Burns Lake. Wildfire is not the only disaster Burns Lake has experienced in recent years. On January 20, 2012, the Babine Lake Mill explosion killed two and injured 19, some severely. Lawsuits continued for years. The mill was rebuilt and re-opened in April 2014 with about half of the number of employees as previously.

Schut says the people of Burns Lake are incredibly resilient.

"Tragedies happen regularly — fatal car and farm accidents, wildfires, drug and alcohol overdoses, and accidents, I could go on — and everyone knows each other or has connections to each other, so when these things happen, it affects the whole community to some degree," she says. "People have learned how to cope with a lot and have learned how to move on from tragedies. The community comes together to support each other in big ways."

In early May, a wildfire broke out near Burns Lake, putting the community on edge. Schut says her Facebook feed lit up with people reacting and remembering the previous summer's fires and evacuations. "Right now, it's just facilitating positive conversations and looking on the bright side — anxiety-decreasing strategies, like 'What are the chances it will happen again?' or 'We survived last year, and we'll work through it again.'"

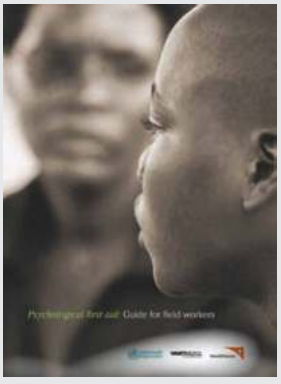
That community connection and support is a demonstration of resilience.

"Most people are incredibly resilient," says Champagne. "The miracle of human strength and resilience is what I am most moved by — that and the wonderful experience of witnessing and participating in the humanitarian efforts with other fantastic people."

Champagne continues to be student in disaster psychosocial response, noting that both the field experience and research findings are evolving and helping to build capacity and competency.

"The recent five years, with the terrible effects of climate change spectacularly increasing the need, have pushed us to learn faster than ever before," says Champagne. "Over the past decade, I have gained far more experience and developed an even stronger passion for the DPS Program."

And as disasters continue around the world and here in B.C., having the skills and knowledge to provide responsible support may prove more valuable than you could ever imagine. ■



Psychological First Aid

Psychological First Aid: A Guide for Field Workers (2011) is available for download in more than two dozen languages. It covers everything from preparation, communication, and respect for rights and culture to recognizing distress responses, helping people feel calm, and taking care of yourself in a disaster. Anyone can download this manual and get a handle on how to be better prepared and helpful in a disaster.
www.who.int/mental_health/publications/guide_field_workers/en/

UNDERSTANDING HOW WE "WORK"

AS SELF-DETERMINING BEINGS

MARCI ZORETICH

Duncan Shields, PhD, RCC, is a clinical counsellor and an Adjunct Professor in the Faculty of Medicine at UBC. His work focuses on culturally relevant initiatives to assist first responders and military personnel maintain or regain well-being while coping with operational stress and trauma. He co-founded The Men's Initiative, which mobilizes men in projects that benefit families, communities, and the world, and developed a First Responder Resiliency Program that catalyzes a more inclusive, supportive work culture. He has published and presented his work internationally and is the recipient of a number of awards and recognitions for his research and service, including from Wounded Warriors Canada, the CCPA, BCACC, and the BC Professional Fire Fighters Association.

Duncan Shields, RCC, has always had a curiosity about how things "work." In his early years, that curiosity was mostly focused on the physical world. "My parents were often challenged by my propensity to dismantle complex objects and machinery – I was not as adept at reassembly," he says.

Growing up, he was exposed to stories from his mother, a nurse, and his father, a Presbyterian minister turned high-school art teacher. He fell into the space in between. "I wanted to get out of disciplinary silos and look for the converging evidence that could help me understand how we 'work' as self-determining beings influenced by our social history, ecology, culture, and biology."

While gathering prerequisites for medicine, he had an opportunity to pursue an MA in clinical psychology that included coursework in health psychology and an internship in psychosocial oncology. He never looked back and spent the next 16 years building a counselling practice exclusively serving physician-referred clients.

He also volunteered as BCACC's Chair of Member Services in 2005, then as Association President starting in 2007. "Without a doubt, volunteering for the Association for those 10 years opened new doors for me."

One of those doors led to a shift in career focus: tell us about it.

In 2011, I began an interdisciplinary doctorate at UBC, bridging counselling psychology, medicine, and gender studies to look at how rigid compliance to the stoic hyper-masculine strictures of military training and identity impacted male veteran experience of post traumatic stress from an ecological biopsychosocial perspective. In the process, I discovered a previously unknown love of research and the methodical pursuit of understanding.

After graduation, I took a position as an Adjunct Professor in the Faculty of Medicine at UBC as a co-founder of The Men's Initiative, an endeavour to mobilize "men of influence" to work to enhance the integrity and well-being of men for the benefit of families, communities, and the world. Some highlights included working with TMI co-founders to consult with corporate executives on supporting gender diversity in traditionally male-dominated workplaces, and looking at how beer advertising could be used to educate men in Latin America about domestic violence. Closer to home, this work included the development and evaluation of a First Responder Resiliency Program to support men and women in public safety roles who are coping with operational stress injuries and to foster more inclusive and supportive work cultures. Today, I divide my time between this work and my private practice.

When did your interest in uniformed service trauma and PTSD begin?

At age five, I received a postcard depicting the Guards at Buckingham Palace in their red serge and bearskin hats, and I decided I was going to do that, too. Twelve years later, I found myself on a bus heading to CFB Petawawa to complete basic training and infantry school to serve as a member of the Governor General's Foot Guards and getting ready to post to the ceremonial guard duty on Parliament Hill and at the Governor General's residence. That time in uniform gave me a life-long respect for the service and sacrifice of those in uniform and gave me close contact with members who had deployed overseas in various peacekeeping and wartime roles. My awareness and interest in war trauma and operational stress started there, and my brief service gave me a cultural awareness to work with people serving in military and public safety roles.

How have attitudes/treatments changed with respect to war trauma and PTSD?

War has always been horrific, but our creativity as human beings has meant that the sheer magnitude of our capacity to destroy one another has advanced beyond the endurance or capability of the human mind to withstand its traumatizing effects. Arguably, over the last 20 years, we have also seen the rhetoric and role of Canada's military change from peacekeeping to war fighting, which changes how society sees its soldiers and how soldiers see themselves.

What about PTSD and first responders?

Here in B.C., the volume of calls and the current fentanyl crisis are stretching our first responders beyond capacity, with rising incidences of post-trauma reactions, compassion fatigue, and moral injury. Yet there is also incredible opportunity for post-trauma growth and restored health, meaning, and connection. Informed, culturally competent counsellors play an essential role in helping public safety workers maintain or regain their resilience. We belong to a society that tasks men and women with difficult and traumatizing work on our behalf. I see it as a social obligation and question of social justice to assist those individuals to return to health and well-being. If a society is judged by how it treats its most vulnerable, the ill, the injured, the addicted, or the poor, then we must attend to those who are at the

War has always been horrific, but our creativity as human beings has meant that the sheer magnitude of our capacity to destroy one another has advanced beyond the endurance or capability of the human mind to withstand its traumatizing effects.

front line, responding everyday in our most disadvantaged and marginalized communities.

Would you say men have changed or are changing?

Gender roles help people know how to behave and what to value and are scripts that serve as a navigation system that is fundamental to a person's identity. Yet masculinity is also not monolithic or unified — there are multiple masculinities that are performed and constructed in social interactions under the shifting influence of socioeconomics, culture, race, and even vocational identity. The male police officer, banker, and biker might all be showing up with a "dominant" form of masculinity in those roles, but the three performances look very different and are only dominant in relationship to a specific social context.

Rather than saying that men are changing, I would say the masculine gender expressions that help men know how to "show up" are in flux. This isn't a bad thing, but it's disorienting to many men, particularly if they have previously identified closely with a rigid expression of masculinity that is under criticism and reconstruction. It will take time and good models of healthy masculinity to reconstruct positive masculinities for men that allow a healthier, more generative place in society, and that eliminate the more negative impacts of masculinity on families, communities, and the globe. We'll also see reactive backlash as some men cling to, and some women defend, more traditional forms of masculinity. Some men will seek the security of the known rather than tolerating the ambiguity of not knowing how to be in the world.

Do you believe today's world (social, political, environmental considerations) affects people more than in the past?

My mother tells a story about being 18 and thinking about her options after high school. In the early 1950s in rural New Brunswick, her options were homemaker, secretary, teacher, and nurse. She wanted to travel so nursing was the most obvious choice — and off she went. When my own daughter was contemplating her next steps after high school, the choices were almost infinite and so was the pressure she put on herself to "get it right."

Here in B.C., the volume of calls and the current fentanyl crisis are stretching our first responders beyond capacity, with rising incidences of post-trauma reactions, compassion fatigue, and moral injury.

We live in a more complex world, where the social roles and expectations that guided our parents are now more complex, less visible, or have simply vanished. The pressure to present a curated or manicured life full of successes and continuous fun over social media adds to the sense that everybody else has this complex world figured out. Everyday, I see people who struggle with unrealistic expectations of themselves and for their lives and relationships, and yet, who strive to present an "all together, always progressing" front.

As a contrast, the feminist writer Judith Jordon talks about the complexity of our connections; how we aren't whole and complete waiting to walk on the stage, but we instead emerge most fully into our potential through our relationships. When we have interactions that make us feel dumb or interactions that make us feel brilliant, the real difference is about the quality of the dialogue that draws out or stifles our potential. I find this idea appealing. I believe we overemphasize autonomy today and forget the richness that emerges from deep dialogue in safe relationships.

What do you think is the potential of such dialogue in today's world?

In Canada, many or most of us enjoy a level of comfort and security that 90 per cent of the globe could only dream of. It should give us pause to reconsider what we actually need in this world, to think carefully about what is most important, and to take action to make a good life together possible for us all.

To come together in mutual tolerance, then acceptance, and finally celebration of our diversity does not happen by chance. It takes effort and determination to build opportunities to come together in common purpose, to engage in inclusive and respectful dialogue, to show our respect for the dignity of individuals, for collaboration and consensus building. Whatever our own sphere of influence, no matter how small or large that might be, we are called upon to take leadership and take action to build a world where we can all thrive. ■

Working Towards Competency in Indigenous Cultural Safety

BY CAROLYN CAMILLERI

Indigenous cultural safety is not a new concept. The Transformative Change Accord was signed in November 2005 by the province, federal government, and First Nations Leadership Council, and it speaks to the development of cultural competency training.[1]

The Truth and Reconciliation Commission released its final report in 2015. Calls to Action 18 to 24 refer generally to health care, with number 23 specifically referencing cultural competency training for all health care professionals.[2]

In 2015, all the CEOs from BC Health Authority signed the Declaration of Commitment to advance cultural humility and cultural safety within health services.[3]

In May 2016, Canada officially removed its "objector status" from the United Nations Declaration on the Rights of Indigenous Peoples and committed to a renewed, nation-to-nation relationship with Indigenous Peoples based on recognition of rights, respect, co-operation, and partnership.[4]

So this is not new. What is "newer" is the increasing awareness among many non-Indigenous counsellors that they have some work to do.

Vanessa Mitchell joined Interior Health Authority in 2015 as an Aboriginal Cultural Safety Educator and has built the program. Now, she is program manager for a team of three educators, a knowledge facilitator, and an administrative assistant.

"When I think about this work that I do and that I'm engaged in and that I'm working on with my team and this journey that I've been on, I very much talk about how it's not just hard work, it's heart work," says Mitchell.

LOOKING FOR RESOURCES?

Interior Health Authority has a number of resources available on its website, including a podcast series called *Interior Voices* and a YouTube channel featuring a storyboard and a number of engagement videos about cultural safety.

Interior Health also has an extensive library of resources listed on its website under Aboriginal Health. While the library belongs to Interior Health, publishing details are included so you can source the materials on your own.

▸ https://iha.andornot.com

A TRAINING STARTING POINT

The San'yas Indigenous Cultural Safety (ICS) Training Program is an accredited, online program designed to enhance self-awareness and strengthen the skills of those who work directly and indirectly with Indigenous people. ICS has a module designed for non-Indigenous mental health professionals.

▸ http://www.sanyas.ca

Note: The curriculum is intended as introductory training to be supplemented by Nation-specific and region-specific training.

That comment is important not only because it demonstrates her commitment, but also because it carries an essential message for non-Indigenous counsellors: attaining Indigenous cultural competency is hard work — and heart work.

"As people engage in this journey, they're going to realize it's not just at the professional level," says Mitchell. "To be real and to be transformative, it does become personal."

Competency in cultural safety is not a "tick box" on a list of requirements: there are layers in this learning journey and each person has to define what that work involves.

"We have the ability to determine how much competency we build — competency meaning the skills, the knowledge base, doing some research, reading some books, engaging in dialogue," she explains. "But a big part of it is self-reflection and critical thought. How important is this work for you? Because when I think of our Aboriginal communities, we've been doing this for a very long time. Right now, it's called cultural safety, but, really, it was always about social justice and about access, reducing barriers, trying to have a voice."

Mitchell has some key messages that may assist non-Indigenous counsellors.

KNOW WHO YOU ARE

Mitchell introduces herself very intentionally: "My name is Vanessa Mitchell. I am an Okanagan woman, mother, daughter, sister, aunt, niece, friend. I was born and raised in Inkumupulux, which is colonially referred to as the Okanagan Indian Band Reserve. I have two children and I have four stepchildren for a total of six children, ranging from 14-25 years of age. My partner is from the Nlaka'pamux Nation. My parents are Eric Mitchell and Chris Marchand. My father has family ties to the St'at'imc Nation through his father and grandfather."

Behind that introduction is a solid grounding in her identity. She knows the stories of her ancestors from her family but also through community involvement, including working in theatre, Friendship Centres, her Nation, and with youth and Elders. She devoted her education to Indigenous studies because she needed to understand the colonial narrative and how it impacts her.

Having that in-depth knowledge of your identity is an important part of cultural safety. Mitchell says she sometimes hears Canadians introduce themselves as second, third, fourth, or fifth generation Canadians.

"It's wonderful that they introduce themselves that way, but I also think, who else are you? Go to your roots. Who are your people? What are your stories? What are the teachings that come from the land you might be from? Whether it is on the continent of Turtle Island or on other lands, that's such a rich piece in the grounding of who are you and where you come from."

Attaining Indigenous cultural competency is hard work — and **heart work**.

UNDERSTAND THAT OUR EDUCATION SYSTEM IS INCOMPLETE

It is not uncommon to have completed post-secondary education and still know very little or nothing about the colonial narrative.

Some people respond to the colonial narrative by saying they weren't there and weren't part of it. Mitchell's father's response is astute: "You know what? Neither was I. And yet here we are."

"There certainly have been strides [in education] — I don't want to minimize that there have been strides — but when we think of the longevity of colonization and the colonial narrative, it's only been a blip in time by comparison," says Mitchell.

Learning that colonial narrative — and how it persists within our structures and systems — is not easy.

“Some people want to learn only the culture of a people, without getting to know the full story and the impacts of the colonial narrative. Mitchell calls this ‘cultural voyeurism.’”

“We have to remember that growth does not happen in our comfort zone,” she says, referencing Brené Brown. “Courage takes great vulnerability.”

Mitchell talks about survivors of the Sixties Scoop and Residential School and their tremendous vulnerability in sharing stories of trauma and endurance. “If people who are survivors can share that, then we, too, should be able to show and practise vulnerability as we’re learning.”

KNOW THAT CULTURAL SAFETY IS NOT ABOUT TEACHING CULTURE

Some people want to learn only the culture of a people, without getting to know the full story and the impacts of the colonial narrative. Mitchell calls this “cultural voyeurism” — a form of entertainment and pleasure. At the same time, she doesn’t want to discourage anyone from participating in community events.

“If you’re not engaged in doing the work and the self-reflection and the research and you just go for pleasure, there’s a risk of it being cultural voyeurism,” she says. “But if you’re doing the work — you’re making connections on the ground, you’ve been invited or you see a public event and you’re going to experience that from a community lens in addition to your work — that’s where you’re going to have that avenue open up to you around culture.”

Culture and teaching culture must come from the grassroots — from the people. Cultural safety is about unpacking the colonial narrative today.

“Cultural safety is really speaking to power imbalances, structured systems, and self-reflection,” she says. “When we think about power and the imbalance of power, recognize that as health care providers, you have power and privilege, because our recipients of care, no matter who they are and where they come from, they’re vulnerable by the simple fact that they’re asking for our help.”

RECOGNIZE THAT THIS IS A JOURNEY

Some questions everyone should be able to answer. Do you know who the Indigenous people are around you? Do you know which First Nation’s land you reside, work, and play on? Have you connected with the Métis, Urban Aboriginal, and First Nations communities?

Take it up a level and ask yourself: Who are you including in your sphere of influence or your circle? Who are you not including and why not?

Mitchell says that’s part of the self-reflection, because each individual has to examine the reasons behind answers. Are there stereotypes? Are there fears? Are there worries about offending?

“Again, I encourage vulnerability, because we need to take that first step in this journey of cultural safety,” says Mitchell, comparing it to a path where we stumble and fall. “It’s about that commitment to get back up and keep going.”

And be gentle with yourself.

“It’s about recognizing your humanity and being aware, because when we’re not aware, the potential of harm to occur is high, intentionally or unintentionally.”

REFERENCES

1 Transformative Change Accord: First Nations Health Plan. https://www.health.gov.bc.ca/library/publications/year/2006/first_nations_health_implementation_plan.pdf

2 Truth and Reconciliation Commission’s Calls to Actions. http://trc.ca/assets/pdf/Calls_to_Action_English2.pdf

3 Declaration of Commitment. First signed in July 2015 by all BC Health Authority CEOs, the declaration has since been signed by a long list of regulatory colleges and health care associations. A First Nations Health Authority release from June 13, 2019 provides insights and updates: http://www.fnha.ca/about/news-and-events/news/signing-declaration-of-commitment-to-cultural-safety-and-humility-with-doctors-of-bc-represents-two-families-coming-together

4 United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP). In 2010, Canada endorsed UNDRIP, which was considered inspirational rather than legally binding. In May 2016, Canada officially removed its “objector status” and supports UNDRIP without qualification. https://www.aadnc-aandc.gc.ca/eng/1309374407406/1309374458958

SELF-CARE TIPS
FROM YOUR COLLEAGUES

Has your self-care routine become too routine? Do you even have one? To inspire you, we invited BCACC *Mind|Full* readers to send us their favourite self-care practice. We were overwhelmed by the enthusiastic response. Thank you to everyone who submitted — it was really difficult to choose among them!

Connecting with nature, often with activities like hiking, walking, wilderness rafting, and camping (in B.C or Hawaii or Ireland), was, without question, the top suggestion. Coming in at a close second place to nature (and often combined with nature) were yoga, mindfulness, and meditation, with Shin Rin Yoku and Sass Gras Simran given specific mention.

Other suggestions included eating wholesome foods, taking daily tea breaks, relaxing in a warm bath (with a glass of wine), and establishing an end-of-workday ritual. Several people wrote about the joy of spending time with pets and connecting with family and friends who are outside the profession. Practicing gratitude, limiting exposure to negative people and media, having a source of inspiration outside your career — and one RCC recommended taking nine weeks of vacation a year, but not all at once.

HERE ARE SOME MORE TIPS FROM YOUR FELLOW RCCS

* Singing keeps me sane and healthy. Studies prove it. Group singalongs offer the benefits of exercise without the humiliation of Spandex.

* I'm part of a women's hockey league, and we play all winter one or two times a week. Our ages range, as does our experience, but we show up to play and encourage one another.

* For me, gardening is a super energy booster, and I can feel the stress leaving my body shortly after getting my hands into the dirt.

* I have taken up the practice of Wild Goose Gigong, which is an ancient healing practice. It is very good for physical health and helpful for "clearing negative qi" and bringing in new qi after working with clients.

* I perform as a musician. I find it helps me maintain a balance between the introverted and extroverted parts of myself.

* I do 40 to 60 hours a month of volunteer work in partnership with a centre in Uganda, supporting life struggles from an emergent nation's perspective.

* Believing God can work through trials and stresses brings meaning, hope, and thankfulness to my life.

* I sing with a community symphony orchestra chorus. Seven hours a week of musical bliss fills my heart and calms my soul.

* I colour code my agenda: clinical work time is green, personal errand time is red, family time is blue, social time with friends is purple, and time for myself is bright yellow. It gives me a visual sense of what I am missing and helps me balance my life and my mind.

* Create a no-brainer routine where you drink lots of water and stay well nourished. Exercise to a good sweat for at least 15 minutes per day. Get and give hugs to and from loved ones. These habits create a prophylactic layer between you and stress.

* Wear clothes you feel good in, with an equal, if not greater, focus on shoes.

* I keep a "success stories" journal at work, where I record client successes; it helps keep my spirits up when I've had a particularly challenging session or day.

* If you are not on Facebook, congratulate yourself. If you are on Facebook, consider getting off or trying a six-month break, noting changes.

* Break up with Twitter.

* Brushing the lustrous blond mane of our elderly lab — it's like rolling tumbleweed in the soft summer breeze.

* Knowing we cannot save the world (or each other) but we can fully belong.

* Reminding myself between each client and at the end of each day how resilient and incredible people are!

BCACC Member Health Benefit Plan

Introducing a Health and Dental Benefits plan just for you.

We are pleased to offer our BCACC members a health and dental benefits plan to fit your needs.

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In addition, you have the option to add on other components that would cover you in the event of loss of income, critical illness or for more robust travel insurance.

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We invite you to download the information package from the BCACC website and contact our Plan Representative, Stephanie Ritchie.
You can call her at (778)533-4676 or email her at stephanieritchie@shaw.ca.
Stephanie can answer your questions and assist you with the enrollment process.

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BC ASSOCIATION OF CLINICAL COUNSELLORS

WHY SHOULD YOU JOIN THE BCACC?

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

Be Recognized

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

Save Money

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

Grow Community

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

BCACC

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