

INSIGHTS

THE BC ASSOCIATION OF CLINICAL COUNSELLORS' MAGAZINE

**Living Well
with Chronic Pain**

**Three Pillars of
Somatic Attachment
Psychotherapy**

Hoarding

This Getting- Old Business

**Counsellors must face their own fears
and bias about aging and being alone**

**MEDICAL
ASSISTANCE
IN DYING**

The issues can
be challenging
to talk about



BCACC REGIONS

LEGEND	
REGION 1 NORTH COASTAL	
REGION 2 SOUTHERN VANCOUVER ISLAND	
REGION 3 INTERIOR SOUTH	
REGION 4 LOWER MAINLAND NORTHWEST	
REGION 5 FRASER VALLEY	
REGION 6 INTERIOR NORTH	



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



10 This Getting-Old Business

For counsellors to work effectively with the aging and the elderly, they must first face their own fears and bias about aging and being alone

FEATURES

6 HOARDING

How the perception of hoarding has changed and how to help someone who is struggling

16 MEDICAL ASSISTANCE IN DYING

Bill C-14 passed in June 2016 and more changes are being considered, but controversy remains and issues can be challenging to talk about

22 THREE PILLARS OF SOMATIC ATTACHMENT PSYCHOTHERAPY

How do we translate attachment theory into embodied clinical practice?

28 LIVING WELL WITH CHRONIC PAIN

Perspectives on therapeutic approaches and self-care practices



IN EVERY ISSUE

4 Check In
News, events, and information

32 Member Profile
Ros Clark Best: Supporting clients with dementia and their families

35 Plugged In
A list for your legacy contact plus an elder-youth mentorship program

38 One Last Thing
Gardening as a social prescription

INSIGHTS

THE BC ASSOCIATION OF CLINICAL COUNSELLORS' MAGAZINE

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

Murray S. Anderson, Gail Barrett,
Lisa Mortimore, Linette Schut,
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.

Insights is published on behalf of the BCACC by Page One Publishing
580 Ardersier Road
Victoria, BC V8X 1C7
Tel: 250-595-7243
pageonepublishing.ca



Contributing Agencies: Getty Images

Insights is published three times a year. To submit article proposals, contact the editor, Carolyn Camilleri, at ccamilleri@pageonepublishing.ca.

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.

Printed in Canada by Mitchell Press.

Ideas and opinions expressed within this publication do not necessarily reflect the views of BCACC or Page One Publishing Inc. or its affiliates; no official endorsement should be inferred. *Insights* writers are responsible for the accuracy of the information in their articles and for obtaining permission to use source material, if applicable. The publisher does not assume responsibility for the contents of any advertisement, and any and all representations or warranties made in such advertising are those of the advertiser and not the publisher. No part of this magazine may be reproduced, in all or part, in any form — printed or electronic — without the express written permission of the publisher. The publisher cannot be held responsible for unsolicited manuscripts and photographs.

BCACC CONFERENCE 2019

November 1-3, 2019 | Richmond, B.C.

Wired Together: Self, Science, Society, this year's BCACC conference, brings together clinical counsellors and allied professionals for discussion and exchange of the most cutting-edge knowledge and insights in the world of counselling therapy.

To be held in Richmond from November 1 to 3, 2019, the conference will include parallel workshop sessions, roundtable participation, and lightning talks, as well as networking events. All sessions are designed to be informative and interactive and to promote dynamic discussion.

▶ Registration opened on April 5. Don't miss Early Bird Registration! More details are at www.bc-counsellors.org.

BRINGING ELDERS AND YOUNG PEOPLE TOGETHER

In Kamloops, a new housing project will bring Indigenous elders together with young people, age 16 to 26 years, who have aged out of foster care. The project is called Kikékyelc: A Place of Belonging and is part of Lii Michif Otipemisiwak Family



and Community Services (LMO), a Métis-led organization in Kamloops. Once complete, the co-housing project will have studio and one-bedroom apartments, a kekuli common space, a common kitchen, social and green spaces, as well as resident elders, cultural mentors, and in-house support workers. The project aims to foster the traditional youth-elder relationship, strengthen the community, and cultivate a sense of belonging in all residents. Learn more at www.lmofcs.ca.

THE SHOPPING CART BOY

Joshua Heath, a 17-year-old from Saskatchewan who spent the majority of his life in foster care, has published a book of poetry about his experiences called *The Shopping Cart Boy*. The book has been gaining attention for its poignant insight and is being used in classrooms. With the support of his guardian, Heath also made a 10-minute video called *Joshua: The Story of a Young First Nation Boy*, which was shortlisted for the 2018 Regina International Film Festival and Awards in the Saskatchewan short documentary category. Copies of the book can be purchased at www.siretona.com.

Read more at www.cbc.ca/news/canada/saskatchewan/from-foster-care-to-becoming-a-published-poet-youth-uses-writing-to-move-forward-1.5019180.



Social Prescriptions

Beginning in September 2018, an innovative Ontario pilot project was launched by the Alliance for Healthier Communities, which represents more than 100 primary health-care organizations across Ontario. Called Social Prescriptions, the concept is based on a U.K. collaborative practice model that brings together a variety of “health champions” who write out “social prescriptions” for patients experiencing depression, anxiety, or loneliness.

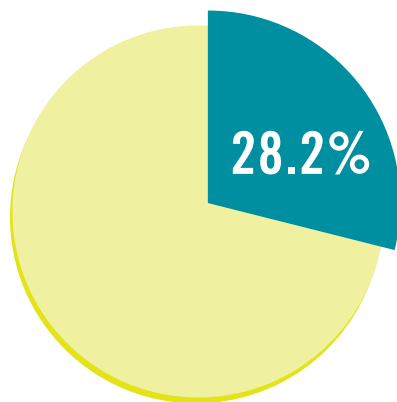
Prescriptions include activities such as taking a yoga class or cooking lessons, visiting an art gallery or museum, joining a single-parents group or a knitting circle, or any of a number of community groups and well-being programs.

The Alliance for Healthier Communities website says: “In the U.K., social prescribing shows promising results in achieving positive outcomes for clients, health-care providers, and communities overall. Clients have improved mental health, are less isolated or lonely, and are more physically active. Providers are able to use their time more effectively by redirecting non-medical clients to more suitable resources. Communities are also seeing improvements in people’s sense of connectedness and belonging.”

Social prescribing has also been shown to reduce medication and the frequency of medical visits. The project goal is to demonstrate in a data-driven, evidence-informed way what we all know already — that people are healthier and happier when they are connected to a community.

Learn more at www.allianceon.org/Rx-Community-Social-Prescribing.

CANADA, 2016



ONE-PERSON HOUSEHOLDS

The 2016 Census indicated that one-person households accounted for 28.2 per cent of all households in 2016 — the highest percentage since confederation. That figure has increased steadily since 1951, when it was 7.4 per cent.



Canada's percentage of one-person households was similar to the U.S. (27.5 per cent in 2012) and the U.K. (28.5 per cent in 2014) but lower than many other industrialized countries. For example, France (33.8 per cent in 2011), Japan (34.5 per cent in 2015), Sweden (36.2 per cent in 2011), Norway (40.0 per cent in 2012), and Germany (41.4 per cent in 2015).

Source: www150.statcan.gc.ca/n1/daily-quotidien/170802/dq170802a-eng.htm



THE LONELINESS PROBLEM

In 2018 in the U.K., a Ministry of Loneliness was created after a year-long investigation revealed that nine million Britons — 14 per cent of the population — suffer from loneliness. Some people have suggested Canada should also consider appointing a loneliness ministry, particularly as our population ages.

Statistics Canada has determined that as many as 1.4 million elderly Canadians report feeling lonely. Health and wellness issues related to isolation and loneliness include lower cognitive function and depression, as well as stroke and injury as a result of falls.

The subject of loneliness was investigated in “Canada’s Loneliest People,” a *MacLean’s* article by Megan Campbell. While 25 per cent of Canadian seniors live alone, within that demographic is a population that lives in acute isolation and are being referred to as “elder orphans” — people who are 65 and older with no living spouse or children, no social groups or friends, and, except for incidental contact with service people, have no connection to anyone. Isolated seniors are four times more likely than average Canadians to live in poverty, and they’re more likely to be women. Read more at www.macleans.ca/society/canadas-loneliest-people/.

Helping Clients Declutter

We are in the midst of a minimizing and decluttering trend, in part due to the influence of Marie Kondo, a Japanese organizing consultant and the author of *Spark Joy: An Illustrated Master Class on the Art of Organizing and Tidying Up* (2016). The popular KonMari Method aims to help people assess

and organize possessions category by category. The goal is to achieve a calmer mindset by living more simply.

For older generations, the motivation to declutter and simplify can be quite different — downsizing to facilitate a move to smaller living space or to dispense with possessions in order to be less of a burden on beneficiaries. It can be a daunting and upsetting task.

The Gentle Art of Swedish Death Cleaning:

How to Free Yourself and Your Family from a Lifetime of Clutter by Margareta Magnusson, while suitable for any age, may be especially relatable for older people. Magnusson, who is 85, uses her Scandinavian humour and gentle wisdom to help readers let go of decades of material possessions.

If you have concerns about a client’s potential hoarding issues, be sure to read Murray S. Anderson’s article on page 6.

HOARDING

FROM AN ACT OF ACQUIRING TO A FAILURE TO RECOGNIZE WASTE

BY MURRAY S. ANDERSON, PHD, RCC

Psychological problems do not exist on their own, nor do they come out of thin air; they are connected to people's social support, employment status, housing conditions, history of discrimination, and overall political power...therefore, promoting complete health means promoting social justice for there cannot be health in the absence of justice.

— Isaac Prilleltensky, 1999

While “hoarding” is understood to be a mental health issue, the roots of the issue escape encapsulation. Historically, hoarding was linked to OCD, while recent changes to the DSM-5 now categorize hoarding as a separate form of mental illness. Additionally, hoarding does not occur in a vacuum and is often linked with depression and anxiety, as well as various forms of trauma.

In my working capacity with Island Health, I provide outreach services to those dealing with mental health and addiction issues. Over the past few years, a significant percentage of my portfolio involves working closely with those impacted by clutter and hoarding concerns. Though I had some understanding of the issue beforehand, it is only through engaging in thorough individual work in the community that I now appreciate the severity of the situation.

To encapsulate the roots of hoarding in North America, three disparate yet linked events are worthy of explication: the story of the Collyer brothers and, in the modern era, Dr. Randy Frost and “hoarding disorder” becoming a stand-alone entity in the DSM-5.

THE COLLYER BROTHERS

Homer and Langley Collyer lived in their Fifth Avenue, New York family home, which they inherited when their mother passed away. Neither married or had children; Homer became a maritime lawyer; Langley worked as a piano dealer. Socializing, interacting with others at public events, the brothers led seemingly normal lives. Then everything changed.

Over the next 18 years, the brothers collected various items and stored them in the family home. Langley, a one-time concert pianist and Columbia engineering graduate, would go out at night to collect. Homer, now blind and limited by debilitating arthritis, was completely dependent

on his brother. The brothers gained worldwide attention in 1939, when Helen Worden Erskine, a reporter for the *World Telegram*, ran a story on the developments. Langley was outraged and blamed Worden Erskine for this invasion of privacy, which made “collecting” more difficult. In 1947, police were alerted and found their home stuffed from floor to ceiling. Homer was found deceased, and for a while, rumours floated around that Langley had fled. In fact, he had also died and was later found deep within a tunnel of debris, less than 10 feet from where his brother had been found. Over 130 tons of material were removed; there was little of value, and the few auctioned items fetched only \$1,800.¹

The Collyer brothers brought a public awareness of hoarding, though emerging discourse was not positive.

THE MODERN ERA

Modern hoarding research owes much to the work of Randy Frost and his colleague Gail Steketee. Together, they



have researched and published widely on this issue, with a significant turning point occurring in 1991. Frost was conducting a lecture at Smith College on OCD. An observant attendee, Rachel Gross, asked if there was any scientific, peer-reviewed work on hoarding beyond the link to OCD. Gross went on to conduct this investigation for her honours thesis and provided the first significant account of hoarding and associated phenomena. It also highlighted some long-standing misconceptions:²

- Until 1991, it had been believed that hoarding involved saving worthless items. However, Gross found that many of the research participants had rooms stacked with new items still in their packaging, clothes with labels intact, and presents still wrapped.
- A second misconception was that individuals who hoard held no strong



IN A LARGER, PEER-REVIEWED STUDY OF CLUTTER WITH SENIORS, OVER 69% WERE WOMEN; 85 PER CENT WERE LIVING ALONE, UNMARRIED, AND CAUCASIAN.

attachment to their items. Gross reported that the majority of participants held strong bonds to even mundane items.

- The study was the first to show that clutter and hoarding issues have a strong genetic link and are deeply enmeshed in some familial histories. Subsequent genetic and twin studies validated the genetic connection.

Of significance, this research created a working definition that formed the basis for the hoarding disorder criteria proposed for the DSM. In May 2013, the DSM-5 was published. Among the diagnoses new to the fifth edition was hoarding disorder (HD), no longer grouped in with the addictions or obsessive-compulsive disorders. In short, the DSM-5 defines HD as an accumulation and failure to discard a large number of possessions of questionable usefulness, extensive clutter in living spaces that



precludes activities for which rooms were designed, and significant distress or impairment in a person's functioning.

The diagnostic criteria also include two specifiers: whether symptoms are accompanied by excessive acquisition: "collecting, buying, or stealing of items that are not needed for which there is no available space"; and whether the hoarding beliefs and behaviours are characterized by good, fair, or poor insight or are delusional.³

A significant change as of May 2013 is that the main behaviour defining the "disorder" is no longer the act of acquiring but a failure to recognize waste. Said differently, this relative lack of awareness regarding the condition's real-world impact is paramount to the formal diagnosis of HD.

HOW COMMON IS HOARDING?

Due to the recent addition of hoarding into the DSM-5, there has been limited

research on the rates of HD. Coupled with the stigma attached to mental illness and the lack of seeking treatment (and lack of access to treatment), it is understandable how these statistics might be inaccurate.⁴ However, with new research initiatives, there will likely be more accurate analysis.

For example, recent studies suggest that out of every 100 people, two to six have HD, which translates into over 1.75 million Canadians. Other estimates suggest that between three per cent and six per cent of the population may be impacted. Roughly speaking, these statistics indicate that the experience of HD is roughly three times the incidence rate of Alzheimer's disease in Canada.

In Canada, research suggests that on average more men than woman engage in hoarding behaviour; however, there is close to equal representation in those over the age of 54 years, with women surpassing men in their senior years. Note that, the research may be inaccurate because HD is often overshadowed by anxiety, depression,

WHERE TO START?

For those seeking to assist someone struggling with hoarding, it is important to acknowledge these individuals are often unaware they have a problem. This lack of awareness can make intervention or structuring treatment challenging. Attempts to help must be gentle, consistent, and collaborative.

THINGS TO BE AWARE OF:

- ▶ Mass cleanouts not involving the person are rarely effective and not suggested.
- ▶ Use of labels ("you are a hoarder") are unhelpful and can further isolate the person.
- ▶ What is junk to you is someone else's treasure.
- ▶ Talk with the individual face to face about concerns whenever possible.
- ▶ There is a story behind the issue; allow the person to tell their story.
- ▶ Use the four C's: contact, collaborate, consistent, consult.⁸

In my experience, consultation is the most important step. Concerned caregivers and counsellors should seek professional help — for example from the Hoarding Action Response Team (HART) in Vancouver and the Hoarding Education and Action Team (HEAT) in Victoria. HART has a property-use inspector, fire inspector, and two mental health workers. Concerned citizens can call 311 to report unsafe conditions throughout Greater Vancouver.

In Victoria, HEAT provides assessment, addresses immediate safety concerns, and offers ongoing support to hoarders in Greater Victoria

through collaboration between fire departments, bylaw enforcement, Island Health services, SPCA, concerned nonprofits, for-profit landlords, volunteers, and de-cluttering services. HEAT also provides referrals to vetted, local resources for individuals outside of Greater Victoria. Those interested can call the HEAT hotline at 250-361-0227 for more information.

Additionally, the HEAT Peer Support Group is a twice-monthly, non-judgmental peer-support group for hoarders to share struggles, victories, and tools for dealing with the emotional and physical aspects of a cluttered home.

and other mental health issues.

In Victoria, our statistics indicate that about four to six per cent of the population meets criteria for HD — that is about 15,000 to 23,000 homes in Greater Victoria or about 40,000 homes on Vancouver Island. As the clinician attached to the HEAT team, I believe this number is inaccurate at best, and with a significant increase in the aging demographic, this number will continue to climb drastically in the next decade.

AN AGING DEMOGRAPHIC

Recent data indicates that hoarding may increase with age. For example, Samuels and colleagues found that hoarding was

to unforeseen physical limitations. For example, a fall, heart attack, or chronic pain can significantly impact a previously functioning individual, resulting in an inability to engage in normal activities of daily life.⁷ Seniors may have items (groceries, food delivery, supplies) coming in but are physically unable to take out garbage and recycling. Rooms quickly become cluttered, further limiting their ability to function and increasing risks to physical safety (fire, falls, infestation).

A FINAL WORD

While hoarding behaviour looks obsessive, it is quite different, hence, the move away from the OCD diagnosis in the DSM-5.

RECENT STUDIES SUGGEST THAT OUT OF EVERY 100 PEOPLE, TWO TO SIX HAVE HD, WHICH TRANSLATES INTO OVER 1.75 MILLION CANADIANS.

THESE STATISTICS INDICATE THAT THE EXPERIENCE OF HD IS ROUGHLY THREE TIMES THE INCIDENCE RATE OF ALZHEIMER'S DISEASE IN CANADA.

approximately three times more prevalent in those aged 54 and up than with individuals between the ages of 34 and 44.⁵

For aging demographics in larger cities, the issues related to hoarding are of contemporary importance. Seniors approaching retirement are often faced with financial restrictions that result in moves to smaller spaces, yet there is little reduction in items collected throughout their lives. Many of these items hold significant memories, providing a sense of security and happiness, feelings that are fleeting due to a decline in personal relationships. In a larger, peer-reviewed study of clutter with seniors, over 69 per cent were women; 85 per cent were living alone, unmarried, and Caucasian.⁶

However, it is important to understand that many seniors live in clutter due

Medication, particularly anti-depressants, has shown minimal results. Forced cleanouts are ineffective as the person usually fills up their space again in half the time.

As counsellors, we can help individuals change their relationships to their possessions. Both CBT and Motivational Interviewing, in combination with skills training, are showing real promise with this population. Above all, an approach that meshes empathy with a desire to establish a supportive relationship will be most valuable — and productive — in the long run.

Murray S. Anderson, PhD, RCC, is a social program officer at Island Health and provides outreach services to people dealing with mental health and addiction issues and those impacted with hoarding concerns. To learn more about resources to assist with hoarding concerns, email murray.anderson@viha.ca.

REFERENCES

- 1 Weiss, K. (2010). Hoarding, hermitage, and the law: Why we love the Collyer brothers. *Journal of American Academic Psychiatry Law*, 38(2), 251-257.
- 2 Frost, R., & Gross, R. (1993). The hoarding of possessions. *Behavior research and therapy*, 31(4), 367-381.
- 3 American Psychological Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC.
- 4 Lauster, N., McKay, A., Kwok, N., Yip, J., & Woody, S. R. (2016). How much of too much? What inspections data say about residential clutter as a housing problem? *Housing Studies*.
Also: Luu, M. & Woody, S. R. (2018). Hoarding: Features, Assessment, and Intervention Strategies. In: Day, M. R. McCarthy G. & Fitzpatrick, J. J. (Ed.), *Self-Neglect in Older Adults: A Global, Evidence-Based Resource for Nurses and Other Healthcare Providers* (Chapter 5 p.41-56) New York: Springer.
- 5 Samuels, J. F., Bienvenu, O. J., Grados, M. A., Cullen, B., Riddle, M. A., Liang, K. Y., Eaton, W. W., ... Nestadt, G. (2008). Prevalence and correlates of hoarding behavior in a community-based sample. *Behaviour research and therapy*, 46(7), 836-44.
Also: Whitfield, K., Daniels, J., Flesaker, K., & Simmons, D. (2012). Older adults with hoarding behaviour aging in place: Looking to a collaborative community-based planning approach for solutions. *Journal of Aging Research*, 1(8). doi:10.1155/2012/205425
- 6 Ayers, C., Saxena, S., Golshan, S., & Wetherell, J. (2010). Age and onset and clinical features of late life compulsive hoarding. *International Journal of Geriatric Psychiatry*, 25(2), 142-149. doi:10.1002/gps.2310.
Also: Dozier, M., & Ayers, C. (2014). Hoarding in late life: Implications for clinicians. *Psychiatric Times*, 31(10), np. Retrieved from <https://www.psychiatrictimes.com/special-reports/hoarding-late-life-implications-clinicians>
- 7 Roane, D., Landers, A., Sherratt, J., & Wilson, G. (2017). Hoarding in the elderly: A critical review of the recent literature. *International Psychogeriatrics*, 1(8). doi:10.1017/S1041610216002465
Also: Woody, S.R., & Steketee, G. (2014). Compulsive hoarding. In J. Smits (Ed.), *Cognitive Behavioral Therapy: A Complete Reference Guide. Part 2: Specific Disorders*. New York: Wiley, 1087-1108. doi: 10.1002/9781118528563.wbcbt46
- 8 Bratotiis, C., & Woody, S.R. (2014). Community interventions for hoarding. In R.O. Frost and G. Steketee (Eds.) *The Oxford Handbook of Hoarding and Acquiring*. New York: Oxford, 316-330.
Also: Frost, R., & Steketee, G. (2010). *Stuff: Compulsive hoarding and the meaning of things*. Boston, MA: Houghton Mifflin Harcourt.

THIS GETTING - OLD BUSINESS

For counsellors to work effectively with the aging and the elderly, they must first face their own fears and bias about aging and being alone

BY GAIL BARRETT, RCC

In most societies, old age begins sometime after the age of 60 and can continue for another 40 years; however, our notion of old age has changed greatly in the past few decades. Better preventive health, medical advances, and a stronger economy have boosted the quality of old-age living for many people.¹ But the fact remains: ageism is alive and well and doing its damage.

Ageism describes an attitude of indifference and neglect towards old people that is often perpetrated by the young — and internalized as an expectation by the elderly.² The prospect of old age brings numerous concerns for young people, as noted by Craig and Baucum: “They fear losses of energy, control, flexibility, sexuality, physical mobility, memory, and even intelligence that they think go hand in hand with aging. These

negative stereotypes not only instill a fear of aging in young people, but many older people embrace them as truth.”³ When the elderly also believe this negative stereotyping, it can disconnect them from one another and their communities and can create deep and lasting loneliness.

THE EXPERIENCE OF BECOMING OLD PEOPLE

At the age of 69, soon to embrace a new decade, I am now seen as an “older” woman. I am not seen as a young woman, nor am I seen as an old woman. I am not even seen as simply a woman. I am, in every sense, an older woman who is well on her way to being an old woman. As this older woman, I have experienced the loneliness of disconnection from community; I have experienced the loss that comes with feeling devalued because of the worship of youthful beauty in our society. In





Ageism appears to be more acceptable than racism and sexism ... views about aging are becoming more negative. **What is interesting is that these myths persist in spite of research suggesting the elderly now have more psychosocial resources, higher levels of health, and, for the most part, do not experience cognitive impairment.**

our culture, people tend to become invisible when they are old people — and I have felt invisible.

This invisibility often affects women more than men. Ageism activist Barbara MacDonald spoke of the place of old women in our society, a place where a woman is unknowable because of ageism. She said, “Thus you who are younger see us either as submissive and childlike or as possessing some unidentified vague wisdom. As having more ‘soul’ than you or as being over-emotional and slightly crazy. As weak and helpless or as a pillar of strength. As ‘cute’ and funny or as boring. As sickly sweet or dominating and difficult. You pity us or you ignore us until you are made aware of your ageism, and then you want to honor us. I don’t know which is worse. None of these images have anything to do with who we are.”⁴

I have noticed lately that I, too, am seen by some younger people as cute, and even adorable, and I wonder,

“Do you see *me*?” I know I am not alone in wanting to be seen for who I am. My mother and I spoke of the fact that neither of us felt, inside, our chronological age. We both felt like ourselves, without age to define us. The day before my mother’s death, when the pastor came to visit her, I heard my mother say, with intensity and vehemence, “I am Doreen Marcotte!” It was as if, at the hour of her death, she wanted to proclaim once again, “I am me!”

It is this “I am me!” that we as counsellors must heed when an older person reaches out for help. They are human beings with a rich history of unique experience and the full range of emotion that accompanies that experience.

FACING OUR FEARS AND BIAS

As counsellors, it is important for each of us to recognize that being elderly is not a contagious disease, and it is not something we should fear; although,

in full disclosure, there are moments (usually in the dead of night) when I do fear it. As Florida Maxwell-Scott is quoted as saying, “I don’t like to write this down, yet it is much in the minds of the old. We wonder how much older we have to become, and what degree of decay we may have to endure.”⁵

Despite the fact that I am content with my life, moments of feeling starkly alone still punch me in the gut and I, too, fear decaying — and I fear doing it alone. Siblings and old friends live far from me. It was, in part, my loneliness that encouraged me to locate near my daughter and grandchildren, and I do have the gift of meaningful (if not always tangible) connection with and the love of family and friends.

But what if I had neither? Can you imagine it?

To work effectively with our elderly clients, it is important to face our own fears about aging and being alone. We are all going to do it, this getting-old business. In fact, we are all doing it

right now. Sarah-Patton Boyle stated, “The young, like the old, are aging with each passing day. Aging doesn’t start at a certain moment in the life cycle or belong exclusively to an unfortunate, isolated group of ancient people. It is always now and belongs to everyone.”⁶

I believe most of us are likely more afraid of aging than we are afraid of dying. This is not surprising, considering how we are taught to see the elderly. Matthew C. Fullen notes that there is a lack of research on ageism, but that ageism appears to be more acceptable than racism and sexism, and that, in fact, views about aging are becoming more negative. What is interesting is that these myths persist in spite of research suggesting

the elderly now have more psychosocial resources, higher levels of health, and, for the most part, do not experience cognitive impairment.

According to Fullen, the elderly population is growing, but the number of mental health professionals trained to work with the elderly is not — another aspect of systemic ageism. His research shows that we mental health professionals have a negative bias regarding our elderly clients both diagnostically and in terms of outcomes — something we must be aware of in our relationship with them.⁷

In other words, we need to police our own bias.

COMMON ISSUES OF AGING

A variety of factors such as our

economic status, physical and mental health, culture, social connections, and our sense of meaning and purpose will all contribute to our experience of aging. Perhaps the most important factor in our experience of old age is our own attitude.

As we engage with our clients, it is important to be sensitive to the fact that many of their issues have elements of grief and loss, and many of the issues affect people of all ages, not just the elderly.

Transition to care facilities: They may experience a sense of grief, loss, and perhaps feelings of abandonment by their children. Their children may feel a sense of grief and guilt about depositing their parents in the facility,

Research shows that we mental health professionals have a negative bias regarding our elderly clients **both diagnostically and in terms of outcomes.**



even though they are no longer able to care for them. The dreaded nursing home creates fear in our hearts, sometimes warranted, sometimes not.

Diagnosis of a life-threatening or terminal illness.

Addictions: Ongoing issues becoming major health concerns.

Memory problems and dementia: Loss of independence, loss of sense of value, and loss of physical, emotional, and mental safety.

Loss of physical and mental abilities: As I approach 70, I occasionally lament the loss of physical flexibility, and at times, general health. When health issues strike, the focus of one's life can narrow considerably. When my father had a stroke, he lost his ability to speak clearly and a light went out of his eyes; it was as if he resigned himself to a much smaller, sadder existence.

Elder abuse: The elderly often do not talk about the abuse they experience privately or institutionally because of their sense of shame and powerlessness in the situation.

Physical impairment: Loss of vision,



As our circle begins to diminish, we feel not only the absence of our loved ones, **but we also begin to feel and know our own mortality.**

hearing, oral health, and mobility, as well as eating disorders, malnutrition, incontinence, constipation, tinnitus, vertigo — a real loss of independence amidst a sea of felt humiliation.

Sexually transmitted diseases: Elderly people are having fun and they are having sex, but they may be less likely to use protection.

Loneliness: Disconnection from friends and family. Isolation can create a deep sense of despair, a feeling of “There’s nothing left for me.” At the age of 82, McDonald wrote, “Old is

ugly, old is powerless, old is the end, and therefore old is what no one could possibly want to be.”⁸ A rather daunting description, but when we examine our biases with ruthless honesty, is it possible that this is what we sometimes think?

Retirement: If not well planned, retirement can create depression and anxiety, especially if one's identity or one's purpose and meaning are lost.

Financial stress: Not everyone is able to save money for retirement. Canada Pension and Old Age Security

A FEW IDEAS FOR HELPING OUR ELDERLY CLIENTS

- Create a list of resources for the elderly in your community, both public and private, including medical doctors, social workers, psychologists, homecare, occupational therapists, meal deliveries, cleaning companies, peer support groups, day centres, seniors' clubs, senior transportation, fitness programs, geriatric programs, family, friends, neighbours, and church or other spiritual connections.

- Encourage your clients to name their specific needs and provide resources for those needs. Often funds for counselling are limited, and for this reason, it is necessary to focus quickly.

- Help your client arrange daily contact with at least one other person (volunteer, friend, family).

- Be ready to hear long-buried secrets and provide a safe landing place for those secrets.

- Involve family or friends in your sessions, if that is warranted and wanted.

- Emphasize your client's strengths and talents.

- Explore and reframe negative language and thinking.

- Be willing to listen to confusion, and then patiently untangle the knots with your client.

- Encourage volunteer work, if your client is able.

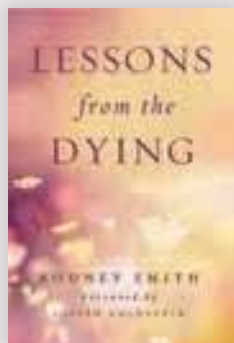
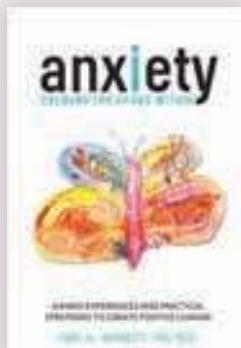
- Encourage social connection, a peer support group, and a daily fitness regime.

- Encourage the practices of boundary setting, the expression of gratitude, daily meditation, and the enactment of rituals of daily pleasure. Teach your client the arts of “no what-iffing” and “letting go of the notion of control” — especially with the things they don't actually control. Teach them the value of using visualization to ease physical and mental/emotional discomfort.



RECOMMENDED READING

Anxiety: Calming the Chaos Within by Gail A. Barrett
(Friesen Press, 2019)



Lessons from the Dying
by Rodney Smith (Wisdom Publications, 1997)

are a blanket of sorts but are often not enough to live on comfortably. The cost of assisted living and nursing homes is exorbitant.

Death of partner, siblings, friends: As our circle begins to diminish, we feel not only the absence of our loved ones, but we also begin to feel and know our own mortality. Even at my age, I am keenly aware of the time I have left. I am now in a frightful hurry to accomplish more and more, to love better, to be more present, to get the most out of each moment, because I know my time on earth is definitely finite. For others, life looms

indefinitely. I recall my aunt, lingering in a nursing home, lamenting that Jesus had forgotten to come and get her.

Mental illness, especially anxiety and depression: Why would elderly people be any different than young people when it comes to anxiety, depression, and other mental health issues? The causes and treatments are unique to each person.

Sexual dysfunction: Losing our sexuality (as perceived by the outside world and as experienced in the bedroom) is a blow. In our culture, we place great value on our sexual attractiveness and prowess.

Loss of independence, loss of control: One small example: how might your life change if you were denied your driving privileges?

Sleep difficulties: The elderly experience sleep issues for myriad reasons: medication salad, physical discomfort or pain, brain changes, anxiety stewing, to name just a few.

End of life issues: Will I die alone? Will I be in pain? Will the treatment be worse than the illness? Will I get to choose how and when I die?

Any issue that any person of any age might have: Old people are, ultimately and simply, people.

LISTEN WITH YOUR HEART

How might we help our elderly clients? As we work to create an emotional and spiritual connection with them, there are practical things we can do and I have included a list of ideas (page 14).

But most importantly, do not be afraid to go to the very edge of your own fear about aging and death. Meet your clients where they are. Listen with your heart. You may not understand the actual experience of loneliness and isolation, but you can understand the fear, anxiety, and sadness that might

accompany that experience.


Help your clients to face uncertainty by reminding them that life has always been uncertain. Rodney Smith says, "With a little more scrutiny, we realize that our safe world was never really safe at all. We have always been living with the unknown but have refused to call it by name. When we understand that both life and death are journeys from an unknowable moment into an unknowable future, we realize that both provide the same potential to grow. The difference between the two narrows."⁹

Until we each take our last breath, there are opportunities for growth and joy. As you sit with your elderly client, encourage them to seek this opportunity. You will make a profound connection when you, just as you are, counsel with love, compassion, and an open heart.

Gail Barrett, a young-old woman, is an RCC with an MA in psychology counselling and certification in trauma recovery and grief support. She uses a wholistic, balanced approach in her work. Gail@AnxietyChaosCalmed.com.

REFERENCES

- 1 Craig, G. & Baucum, D. (2002). *Human development, 9th edition*. University of Alabama, Birmingham, AL: Pearson (out of print), 570.
- 2 As above, 571.
- 3 As above, 573.
- 4 MacDonald, B. & Rich, C. (1991/2001). *Look me in the eye: Old women, aging and ageism*. Denver, CO: Spinsters Ink Books, 127.
- 5 As above, 138.
- 6 Boyle, S. (1983). *The desert blooms: A personal adventure in growing old creatively*. Nashville, TN: Abingdon Press, 12-13.
- 7 Fullen, M.C. (2018). Ageism and the counselling profession: causes, consequences and methods for counteraction. *The Professional Counsellor*, 8(2), 104-114.
- 8 MacDonald (as in #4), 91.
- 9 Smith, R. (1998). *Lessons from the dying*. Somerville, MA: Wisdom Publications, 39.

A photograph of a person lying in a hospital bed, wearing a blue hospital gown. Their hands are being held by another person's hands, one of which has a gold ring. The scene is dimly lit with a blue tint, suggesting a hospital or care facility setting.

**IN AN ARTICLE PUBLISHED
FEBRUARY 20, 2019, *THE LANCET*
REPORTS THAT, IN 2017, MORE THAN
13,000 PATIENTS DIED THROUGH
EITHER LEGALIZED EUTHANASIA OR
ASSISTED SUICIDE IN COUNTRIES
WHERE THESE PRACTICES
ARE PERMITTED.¹**

MAID

MEDICAL ASSISTANCE IN DYING

Why counsellors need to think carefully about where they stand on the issues

BY CAROLYN CAMILLERI

When Margaret Easton addresses her Bill C-14: The Long History of Suicide, Euthanasia and Assisted Dying class at SFU, she starts by saying she supports Medical Assistance in Dying (MAID). She explains that she is grateful the Canadian government has made this available, in large part, because she has a better understanding today of how difficult some deaths can be, even with access to excellent medical treatment. But while Easton grew up following the stories of Sue Rodriguez and Robert Latimer and has always leaned towards supporting assisted dying, she has serious reservations about some issues.

“Your reservations are unlikely to be the same as mine,” Easton tells her class, “but you should know what yours are and why.”

The same message can and likely should be addressed to counsellors across the country. MAID has been legal in Canada since June 2016 and more Canadians are accessing MAID every year since the legislation passed. Nevertheless, controversy remains, and the issues can be challenging to talk about. As the number of Canadians using MAID continues to increase, mental health professionals will likely see more clients in their practices who are dealing with this issue for themselves or their family members and friends.

“It’s a very complex topic,” says Easton. “Counsellors need to know where they stand.”

FINDING OUT WHERE YOU STAND

Easton has helped to create an End of Life Studies program at Simon Fraser University and teaches several courses in the program. Margaret Isabel Hall, an associate professor in the Faculty of Law, Thompson Rivers University, also teaches in the program. Hall's course, Legal and Ethical Issues in End-of-Life Studies, will be offered for the second time in June of this year. Hall's research and legal work has taken her into the area of mental capacity and dementia and the legal and ethical issues at the end of life. The discourse around MAID was a natural expansion of her accumulated work.

"It's very complicated and I think people have an initial response — an emotional response — and they have to set it aside and then examine the whole thing very carefully," says Hall.

Hall explains that we need to understand that MAID legislation creates an exception to the criminal prohibition of MAID in the Criminal Code.

"The legislation says, these are the circumstances in which an exception

will be made," she says. "Unless a person's situation falls within that exception, they cannot access MAID. The sections of the Criminal Code that prohibit assisted suicide and provide that a person cannot consent to another person causing his or her death are still there. The legislation sets out the limited circumstances where they won't apply."

WHEN WE TALK ABOUT MAID, WE ARE NOT REALLY TALKING ABOUT WHETHER, AS INDIVIDUALS, WE HAVE A RIGHT TO DIE.

The questions we are struggling with now: does that exception go far enough? Is it too narrow? Should it be re-defined?

"The legislation did not create a right to MAID on demand," says Hall. "So the question of whether a person is eligible for MAID is a question about whether that person's circumstances

fall within the exception in which MAID is permitted."

Hall adds that it is also important to realize that when we talk about MAID, we are not really talking about whether, as individuals, we have a "right to die."

"The issue is, under what circumstances will society, through the law, approve of a physician — also a public actor — taking another person's life," says Hall. "Then, society will put in place the structures to enable that. So this is not a purely private question in the way that suicide is a purely private decision — society is involved. The rule that purposefully taking another's life is prohibited has long been part of our law and creating an exception to that is a significant social decision."

JUNE 2016 AND AFTER

MAID is often presented incorrectly as an issue of modern times.

"It goes all the way back to Plato and the Greek times — Greek playwrights wrote about assisted dying, and so it's not entirely new what we're facing today," says Easton. "We're still trying to cope with many of the same issues."

SUICIDE **vs** MAID


There is controversy in Canada about the use of the word "suicide" when talking about assisted dying. Suicide is defined as the act of taking one's own life voluntarily and intentionally. Medical Assistance in Dying, MAID, has been named that to separate it from suicide. Easton encourages people

to think deeply about why they believe MAID is or is not suicide. In some places in the world, the term physician-assisted suicide is still used and is less stigmatized than in Canada. "If you look at the suicide rates in Canada from 2008 to 2012, we've always averaged somewhere between 3,700 and 3,900

suicides," says Easton. "Until MAID was legalized, every one of those deaths was considered a tragedy, a preventable tragedy. As of June 2016, did they stop, or how many stopped, being preventable tragedies and what did they become?"

Hall and Easton both stress the importance of

understanding why we think the way we do about these issues — and not only for clients. "We will make better decisions for ourselves and family members and can participate more knowledgeably in the future as the government considers potential changes," says Easton.



**MEDICAL
ASSISTANCE IN
DYING IS OFTEN
PRESENTED
INCORRECTLY
AS AN ISSUE OF
MODERN TIMES.**

While suicide was decriminalized in Canada in 1972, MAID is the result of recent legislation. In June 2016, Bill C-14 passed federal legislation in response to the Supreme Court's 2015 decision in *Carter v. Canada*. The legislation includes stringent requirements around eligibility and competency. But almost immediately after the new legislation was proclaimed, it was challenged across Canada. It wasn't unexpected. When Bill C-14 was passed, the government of Canada, in response to a request from the Minister of Health, Minister of Justice, and Attorney General of Canada, asked the Council of Canadian Academies to prepare an evidence-based assessment of the state of knowledge on three current exclusions in the act: MAID for mature minors, advance requests for MAID, and MAID where a mental disorder is the sole underlying medical condition. The Council's reports were released in December 2018.²

Currently, depending on the province, a person must be 18 or 19 to be eligible for MAID. The mature minors investigation is looking at whether someone younger might have the mature capability to understand the consequences of their decision.

An advance request for MAID is when a person makes a decision about dying ahead of time — for example, when an illness reaches a certain stage.

“That's how some people want to use MAID, but currently, you can't do that,” says Hall. “An underlying issue is that some people want to do this in anticipation of developing dementia at a later stage — and that's very complicated and something we need to have serious public discussion about.”

For example, the person dying must be competent right to the very end. The legislation provides that a person must be capable of consenting to MAID at the point when the person receives it. A person with advanced dementia may not be capable of consenting to

MULTI-DISCIPLINARY PARTICIPATION

As noted in the recent reports from the Council of Canadian Academies, Belgium, a country that permits assisted dying for mental disorders, encourages the use of assessors with expertise in specific mental disorders and the use of multi-disciplinary teams — for example, the inclusion of social workers on assessment panels or teams.

CANADA'S AGING AND DYING POPULATION

BY 2026, THE NUMBER OF CANADIANS DYING EACH YEAR WILL INCREASE BY

40%

TO

330,000³



YET, CANADA RANKS ONLY

11th

IN THE 2015 QUALITY OF DEATH INDEX.⁴

MAID, meaning that person is not eligible to receive it.

Hall tells her students to remember that we don't know what our experience of illness or dementia will be until we have that experience, and our fear or dread may be very different from the experience itself.

"People change," says Hall. "Would we want our 25-year-old self to make decisions for our 50-year-old self? Our 80-year-old self? How do we feel about taking the life of a person with dementia who is not expressing any fear, distress, or physical suffering — who seems content — because of a directive from her previous self, when that previous self is so profoundly changed?"

When the person cannot tell us herself, directly, when her suffering has become intolerable and that "enough is enough" (in the words of one of the plaintiffs in *Carter*), how do we decide when that point has been reached?

"This is very different from the situation where the person can tell us herself, in real time, that she has now

decided enough is enough," says Hall. "We need real, public conversation about these questions."

MAID FOR MENTAL DISORDERS

Easton says expanding the criteria for MAID to include providing access to people where a mental disorder is the sole underlying medical condition presents many issues, and this is an area where Canada's mental health professionals will have much to contribute. Currently, many psychiatric and psychological associations have reservations about the use of MAID where a mental disorder is the sole underlying medical condition. These concerns include:

1) how to define irremediable in the

context of mental disorders;

2) worries that permitting MAID where a mental disorder is the sole underlying medical condition might alter mental health care in Canada;

3) identifying how to address the unique considerations of specific populations, such as Indigenous peoples, sociocultural and racialized groups, LGBTQ+ people and gender issues, seniors, Canadian Armed Forces Members and Veterans, and incarcerated people; and,

4) the impact of psychosocial issues such as grief, loneliness, stigma, shame, or lack of support for the patient or their caregivers (see The Council of Canadian Academies reports).

In addition, the criteria of what defines a mental disorder continues to change and access to treatment options remains uneven. For example, with each edition of the DSM and ICD, mental disorders are added and deleted. As Easton points out, when she was in her 20s at SFU, homosexuality was listed in the DSM as a mental disorder but was deleted in 1973, while the fifth edition of the DSM includes disorders unknown at that time, such as Gender Dysphoria, Internet Gaming Disorder, and Social Communication Disorder.

Moreover, you have to consider what might be listed in a DSM-6 or ICD-11, and particularly, what might influence those changes.



THE DEATH DEBATE

The Death Debate is a video released in February 2016 that tracks the story behind Supreme Court *Carter v. Canada*. www.youtube.com/watch?v=-Vot5bkR_VQ

AN ECONOMIC PERSPECTIVE

A recent study, “Cost analysis of medical assistance in dying in Canada,” reported in the *CMA Journal*, suggested that medical assistance in dying could reduce annual health care spending across Canada by between \$34.7 million and \$138.8 million, exceeding the \$1.5–\$14.8 million in direct costs associated with its implementation.⁵ While the authors were adamant that health care savings should not be the deciding factor, it may become an issue. Cost of care is also a critically important issue in health care spending for mental disorders. Oftentimes, the barriers to service and treatment for mental disorders are economic. “It is very difficult for counsellors to resolve mental health issues in the four or five appointments that are covered by most extended medical plans,” says Easton. “This unfortunately creates inequality in access to good quality psychological care.”

And finally, with MAID law in Canada defining intolerable suffering in subjective terms, and Section 15 of the Charter of Rights and Freedoms stating that “every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age, or *mental or physical disability*,” it will be extremely difficult to avoid and/or adequately address charges of discrimination about which disorders will be allowed access to MAID.

UNFORTUNATELY, THERE SEEMS TO BE A MOVE TOWARDS SHIFTING THE CURRENT CONVERSATION ABOUT “GOOD” DEATHS TO “SUCCESSFUL” DEATHS, WHICH MAY RESULT IN PEOPLE FEELING THEY COULD FAIL AT BOTH AGING AND DYING.

SUCCESS AS IT RELATES TO DYING

As of 2016, for the first time in history, the population in Canada over age 65 is greater than the population under 50. At the same time, new standards are being set for both aging and dying — successfully.

“I’m doing my PhD thesis on successful aging and successful dying, and I have issues with both of those terms, because the vast majority of us cannot meet the criteria out there now for successful aging,” says Easton.

Unfortunately, there also seems to be a move towards shifting the current conversation about “good” deaths to “successful” deaths, which may result in people feeling they could fail at both aging and dying. Easton sees a growing inclination towards seeing MAID as successful dying, rather than simply as one of the ways we have of ensuring people have access to a good death. It is a development she worries raises serious ethical issues that need careful and thoughtful consideration.

Keep in mind, the idea of death on our own terms with dignity and

autonomy at the end of a long life is not new. In ancient Greece, people would go before city councils to present their case as someone old and finished with life and to ask for a portion of hemlock. Perhaps our approach to MAID is similar and certainly bears close review and consideration.

REFERENCES

- 1 Borasio, G.D., Jox, R.J., Gamondo, C. (February 20, 2019). Regulation of assisted suicide limits the number of assisted deaths. *The Lancet*, online. DOI: [https://doi.org/10.1016/S0140-6736\(18\)32554-6](https://doi.org/10.1016/S0140-6736(18)32554-6)
- 2 The Council of Canadian Academies State of Knowledge Reports, issued in December 2018, can be accessed at <https://scienceadvice.ca/reports/medical-assistance-in-dying/>
- 3 Blueprint for Action 2010 to 2020. (2010, January). Quality End-of-Life Care Coalition of Canada. Retrieved from http://www.qelccc.ca/media/3743/blueprint_for_action_2010_to_2020_april_2010.pdf
- 4 The 2015 Quality of Death Index. (2015) *The Economist Intelligence Unit*. Retrieved from <https://eiperspectives.economist.com/sites/default/files/2015%20EIU%20Quality%20of%20Death%20Index%20Oct%2029%20FINAL.pdf>
- 5 Trachtenberg, Aaron J. and Manns, Braden (2017, January 23). Cost Analysis of medical assistance in dying in Canada, *CMA Journal*, 189(3). Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5250515/>



THREE PILLARS OF SOMATIC ATTACHMENT PSYCHOTHERAPY

BY LISA MORTIMORE, PHD, RCC

ATTACHMENT, THE BODY, AND RELATIONAL REPAIR

The legacy of relational trauma, often our earliest experiences of love, wires the right brain (RB) and forges a template in the infant's neurophysiological body and psyche that endures across the lifespan and over generations. These longstanding patterns and functioning, often the undercarriage of the issues that undermine people's fulfillment or success in life and relationships, bring many to therapy.¹

Often this foundational wound is overlooked or there is difficulty identifying underlying vulnerability, attachment injury/relational trauma, as it is generally less visible than other traumatic experiences to the untrained ear; further, the enduring relational operational system, deeply embedded in daily functioning, can be difficult to discern. Somatic attachment psychotherapy opens the neurophysiological and psychological terrain to understand the intricate relational and regulatory map of one's system and guides therapeutic process.

A framework oriented to the reparation and regulation of the neurophysiological body and wounded psyche calls clinicians to work with an embodied, affectively oriented, relationally focused approach, heeding Kalsched's assertion "what has been

broken relationally must be repaired relationally."² Executing this can be stymied by the scope of what is being called for and often therapists are left with the questions: how do we translate attachment theory into embodied clinical practice? And how do we regulate and facilitate reparation of attachment injury? This article speaks to this in broad strokes.

THE FOUNDATION

The work of regulation and reparation centres on facilitating shifts in affect management strategies, attachment patterning, and re-organization of the body and psyche to support the maturation and development of complex RB functioning rather than merely working with symptom reduction. Inhabiting the body as a living site of knowledge for both

therapist and client is of utmost importance.³ The somatic attachment therapist uses the body as the central perceptual instrument through explicit understanding and use of the RB in terms of relational practice and attunement to the neurophysiological information and fluctuations in the body (client and self). This guides the use of right hemispheric processing (sensation, gestures, emotions, images/imaginal, symbolic/archetypal) towards regulating, metabolizing, and integrating implicit and explicit traumatic material.

The heart of the work reaches beyond regulation of the autonomic nervous system (ANS) as interruption of the narrative, the internal working models⁴ (IWMs – which organizes one's self-perception, world, and identity), and the neurophysiological undercarriage are required to make



shifts to the foundational framework of the self. Back and forth dialogue is commonplace; however, a strong bias towards the body as an epistemological site and engaging the right hemisphere (RH) to work towards congruence of the explicit (narrative) and implicit (body) systems is forefront.

In this way, this work departs from traditional talk therapy and relational practice as there is a consistent return to RH processing and attending to a “discreet confluence of both”⁵ body and mind.

EARLY ATTACHMENT EXPERIENCE BUILDS THE PSYCHE AND BODY

The neurophysiological body begins developing at conception and continues to be shaped in the womb in response to the mother’s physiology which is impacted by her context — the environment and her history —

culminating in her regulatory capacity and relational strategies. During this time, the hypothalamus, pituitary, adrenal (HPA) axis, the neuroendocrine system which governs the stress response and impacts several other major functions in the body (digestion, immune system, emotional regulation, etc.), is forming.

From the last trimester of pregnancy through the second year of life, a brain growth spurt develops the fundamental terrain for the functioning of the RB.⁶ Experiences of love in the primary relationship(s) are “affectively burnt in”⁷ and imprint, encode, or wire the self with specific affect management and attachment strategies that shape the RB, a process which is integral to emotional processing in the limbic system and the ANS.⁸ These strategies, developed in direct

This is not to say that those with insecure attachment were and are not loved; rather, the expression of love by the caregiver(s) was interrupted in its execution, likely due, at least in part, to the caregiver’s own attachment injuries that unconsciously shape their relational behaviour and regulation capacity.

response to the attuned or misattuned primary caregiver(s), underpin the developing regulatory capacities of the self and create pathways through

which relational behavioural strategies are correlated. The psychobiological interaction of the caregiver and infant, the “facial-visual, auditory-prosodic, and tactile-gestural”⁹ communication of attachment, is the construction zone in which these neurophysiological and psychological structures develop.

This is not to say that those with insecure attachment were and are not loved; rather, the expression of love by the caregiver(s) was interrupted in its execution, likely due, at least in part, to the caregiver’s own attachment injuries that unconsciously shape their relational behaviour and regulation capacity. The interactive relationship between infant/child and caregiver(s) creates patterns of relating which are neurophysiologically wired and anchor beliefs about oneself and how the world and relationships work; they are scaffolded onto physiological structures of the body and establish the IWMs. The earliest experiences of love establish the ground for the neurophysiological and psychological self to develop.

THE LEGACY OF INSECURE ATTACHMENT

Disruption in the attachment relationship interferes with optimal development of the growing infant self who is reliant on their primary caregiver(s) to attend, attune, regulate, and respond to the infant’s needs, both bodily and psychologically. If the caregiver(s) is unable to meet the needs of the child or consistently do so, the developing infant’s system and sense of self (IWMs) are distorted by the inconsistent regulation of their ANS and interrupted attachment bids. Attachment strategies are formed (in general) by nine months of age¹⁰ and remain constant across the lifespan

unless there is significant rewiring through relational contact, including psychotherapy.

To put this into a whole body/psyche context, the neuroaffective and physiological states of early life endure and shape our capacity to regulate our ANS and affective state; interpret incoming relational information; respond under stress, particularly relational stress; and, understand ourselves, relationships, and the world. This groundwork has long-term health implications as the chronic stress of dysregulation and bias of high/hyper or low/hypo arousal impact the functioning of our physical body. Moreover, the legacy of insecure attachment wreaks havoc, interrupting the execution and perception in intimate and familial relationships. Suffering of this persuasion can be chronic, cyclical, and confusing.



This increases the client’s capacity to know what has been unknowable, unbearable, or unformulated and supports the processing, metabolizing, and integrating of aspects that have been too much.

INTERRUPTING THE INTERNAL FRAME

As clinicians, we want to disrupt both the psychological and neurophysiological scaffolding that underpins the IWMs, affect management strategies, and relational patterning. What I mean by this is that through an embodied detailed inquiry, “the heart of the treatment process,”¹¹ we bring both bodily based and narrative “inattended material into awareness,”¹² challenging the embedded, distorted (mis) understandings or perceptions of oneself, relationships, and the world; in many ways, our work is to “make the familiar strange.”¹³

In working between the left and right hemisphere, we disrupt the narrative (top down) and invite implicit memory held in the body through somatic right hemispheric processing (bottom up), allowing the silenced/disavowed material to emerge into consciousness and re-organize into “more complex and flexible patterns,”¹⁴ brokering new understandings and re-organization.

Over time, this remediation aids in the development of self-cohesion¹⁵ and forges a “continuity of self-experience,”¹⁶ creating more coherence in the implicit and explicit memory systems and regulation in the ANS, and increases one’s reflective awareness and capacity in the relational realm. This increases the client’s capacity to know what has been unknowable, unbearable, or unformulated and supports the processing, metabolizing, and integrating of aspects that have been too much.

THE BODY

To re-organize a body dysregulated by relational trauma, the therapist meets

body to body, RB to RB,¹⁷ negotiating past the protective LH¹⁸ that works (unsuccessfully but valiantly) to organize the arousal in the system and establish safety through intellectual, logical, and cognitive reasoning. This often severs bodily based experiences from consciousness.

Directing clients' attention inwards to notice their shifting bodily states and body-based information and to track congruence/incongruence between their narrative and felt sense begins the process of re-inhabiting the self disrupted through relational trauma. Theoretical understanding and clinical application of the window of tolerance,¹⁹ the polyvagal theory,²⁰ and RH processing are the bedrock of bringing the body into practice.

The window of tolerance orients clinicians to the regulation of the ANS, while the polyvagal theory explains how hierarchical behavioural strategies, specific ANS states, and psychological feelings correlate and are incited by trauma; RH processing regulates, metabolizes, and integrates unprocessed material. In using the body as a living site of knowledge, we access unconscious material and process what has yet to be integrated.

EMBODIED RELATIONAL PRACTICE AND REPAIR

The "interpersonal theme of the past embedded in the present"²¹ is fundamental to understand unconscious relational ways of being and recapitulation of early relational patterns, often enacted in the therapeutic relationship. As the dyad engages, the therapist notices the client's affect regulation strategies, attachment/relational patterns, and IWMs and begins to build a working theory of what has been interrupted,



interfered with, and impaired. Noting this, tracking connectedness, safety, transference, and countertransference is paramount as is attending to the unattended ways in which relationship was not on the client's terms in their developing years and presently.

Bringing explicit attention to the client's needs begins to re-orient the IWMs to a new experience of relationship. As the therapist listens deeply, mirrors, validates, and responds with authenticity to the silenced parts of story and body, the emotional loop of knowing one impacts the other, comes full circle, and begins to mend the developmental injury embedded in insecure attachment. The "therapist's expression of emotion toward the client served to complete the cycle of affective communication that was insufficiently developed in childhood. In expressing emotion at the appropriate times, the therapist provides an emotional re-education and remediates

Tracking connectedness, safety, transference, and countertransference is paramount as is attending to the unattended ways in which the relationship was not on the client's terms in their developing years and presently.

a developmental void."²² Throughout the work, the dyad attends to the unattended fragments, the disavowed self-states, by supporting the client's adult self to make embodied contact internally through the RH with the dysregulated self in the present moment, working with the distorted/fragmented IWMs of insecure attachment.

During the course of therapy, it

is inevitable that the transference-countertransference matrix, the “continuous, unconscious, mutual influence”²³ of client and therapist, will create enactments. These “interactions occurring between the patient’s relational unconscious and the therapist’s relational unconscious”²⁴ bring into consciousness relational dynamics and recapitulated injuries of the past as “people act out what they cannot remember or what they cannot allow themselves to feel.”²⁵ As the dyad find themselves in dissociated self-states where the RB has disorganized, they are without the “ability to process socioemotional information and without the capacity to understand the complexities of what was happening in each other.”²⁶

The therapist’s embodied witnessing and willingness to regulate, attend, be accountable, and work collaboratively towards repair offer new experiences of relationship: “The power to foster healing lies not only in the therapist’s opportunities to be experienced as an

authority who differs from previous objects of attachment but also in his or her willingness to tolerate, name, discuss, explore, and express remorse for the inevitable ways in which old patterns get transferred to and repeated in the therapeutic partnership.”²⁷

In this way, recapitulated injuries are tended to and, over time, with a renegotiation of relational opportunities, processed through the RH, and new neurophysiological pathways and a re-organization of the IWMs can emerge.

FINAL THOUGHTS

Attending to the injuries of early relational trauma calls for clinicians to be embodied and have a strong understanding of the implications of impaired attachment on the body and psyche. Weaving understandings from interpersonal neurobiology, attachment, trauma studies, relational practice, and somatic processing into a cohesive framework allows an in-depth rendering of interdisciplinary

knowledge into clinical practice oriented towards the reparation and regulation of the neurophysiological body and wounded psyche. Somatic attachment psychotherapy works to increase the complexity and flexibility of functioning by supporting regulation of the ANS and re-organization of the IWMs and relational and affect management strategies.

Lisa Mortimore, PhD, RCC, is a psychotherapist and educator living and working on unceded Coast Salish land in Victoria. In her Bringing the Body into Practice trainings, workshops, and retreats, Lisa weaves somatic psychotherapy, embodied relational and attachment oriented practice, and connection to the sentient, archetypal world for the reparation of relational trauma. Lisa has the following courses on offer in Victoria: Three Pillars of Clinical Practice: Attachment, the Body and Relational Repair Workshop May 3 - 5, 2019; Embodying the Heart in Clinical Practice: A Therapist Development Intensive July 11 - 14, 2019; and the next two-year Somatic Attachment Psychotherapy training begins February 2020. www.lisamortimore.com

REFERENCES

- 1 Issues include but aren't limited to anxiety, depression, panic, ptsd, complex ptsd, addictions, and personality disorders.
- 2 Kalsched, D. (2013). *Trauma and the soul: A psycho-spiritual approach to human development and its interruption*. London, UK: Routledge, 13.
- 3 Embodiment is extremely important for the therapist in order to use the body as a tool of perception. For some clients with complex trauma, embodiment needs to be carefully assessed to ascertain whether it will be too destabilising for their system and ultimately iatrogenic.
- 4 Bowlby, J. (1969). *Attachment and loss: Attachment* (Vol. 1). New York, NY: Basic Books.
- 5 Northcut, T. B. & Strauss, R. J. (2014). The science and art of integrating the mind and body in clinical social work. *Clinical Social Work Journal*, 2014, 42, 3, 205-207. <https://doi.org/10.1007/s10615-014-0497-y>, 205.
- 6 Schore, A. N. (2012). *The science of the art of psychotherapy*. New York, NY: Norton.
- 7 Schore, A. N. (2014). The right brain is dominant in psychotherapy. *Psychotherapy*, 51(3), 388-397.
- 8 Schore, A. N. (1994). *Affect regulation and the origin of the self*. Hillsdale, NJ: Lawrence Erlbaum Associates Inc.
- 9 Schore, A. N. (2014), 77.
- 10 Main, M. (2010). UCLA Adult Attachment in a Clinical Context Conference.
- 11 Buechler, S. (2004). *Clinical values: Emotions that guide psychoanalytic treatment*. New York, NY: The Analytic Press/Taylor & Francis Group, 18.
- 12 Cooper, A. (1995). The detailed inquiry. In M. Lionells, J. Fiscalini, C. Mann, and D. B. Stern (Eds.), *Handbook of Interpersonal Psychoanalysis*. Hillsdale, NJ: The Analytic Press, Inc., 680.
- 13 Buechler, S. (2004.) *Clinical values: Emotions that guide psychoanalytic treatment*. New York, NY: The Analytic Press/Taylor & Francis Group, 18.
- 14 Levenson, E. A. (2017). The purloined self: Interpersonal perspectives in psychoanalysis: New York, NY: Routledge, 5.
- 15 Buechler, S. (2004).
- 16 Bromberg, P. M. (2011). *The shadow of the tsunami and the growth of the relational mind*. New York, NY: Routledge, 13.
- 17 Schore, A. N. (2012).
- 18 Quillman, T. (2012). Neuroscience and therapist self-disclosure: Deepening right brain to right brain communication between therapist and patient. *Clinical Social Work Journal*, 40, 1-9.
- 19 Siegal, D. J. (1999). *The developing mind: How relationships and the brain interact to shape who we are*. New York, NY: Guilford Press.
- 20 Porges, S. W. (2011). *The polyvagal theory: Neurophysiological foundations of emotions, attachment, communication, self-regulation*. New York, NY: Norton.
- 21 Stern, D. B. (2017). Interpersonal psychoanalysis: History and current status. *Contemporary Psychoanalysis*, 53:1, 69-94, 84.
- 22 Maroda, K. (2009). Less is more: An argument for the judicious use of self-disclosure. In Bloomgarden, A. and Mennuti, R. B., (Eds.) *Psychotherapist Revealed: Therapists Speak About Self-Disclosure in Psychotherapy*. New York: Routledge, 17-30, 20
- 23 Hirsh, I. (2015) cited in Stern, D. (2017), 89.
- 24 Schore, A. N. (2012), 158.
- 25 McWilliams, N. (2004). *Psychoanalytic Psychotherapy: A Practitioner's Guide*. New York, NY: The Guildford Press, 115.
- 26 Hill, D. (2015). *Affect regulation theory: A clinical model*. New York: Norton, 221.
- 27 McWilliams, N. (2004).

LIVING WELL

WITH CHRONIC PAIN

PERSPECTIVES ON THERAPEUTIC APPROACHES AND SELF-CARE PRACTICES

BY CAROLYN CAMILLERI

Ten years ago, when clinical psychologist Julie Desroches was pregnant with her second child, she developed a life-threatening case of sepsis. Fortunately, her daughter was fine, but Desroches spent 10 months in hospital. She had peritonitis throughout her body and came very close to dying. After five surgeries and learning to walk again, she

has been left with fibromyalgia, which includes mostly low-level chronic pain with some acute flare-ups, chronic fatigue, and a body that doesn't work quite the same as it did before.

Professionally, her interest had always been in resilience and helping people to overcome adversity. However, her knowledge and experience were mainly academic until her own difficulties — and then it all got very real.

“I'm fortunate it doesn't debilitate me so much that I can't work, but I've had to be very, very mindful over the years,” she says.

Learning to be mindful came not only from navigating life with a hugely impactful health condition but also by working for a period of time in pediatric oncology. Desroches found that, to cope with the grief inherent in that difficult role, the people she worked with fell

into one of two groups: one that tried not to connect, to disassociate, while the other prioritized self-care. She took the self-care path and launched into an intensive study of self-care practices, including therapies, medications, and alternative approaches. Eventually, she found what worked for herself, and her research provided her with an extensive list of suggestions for others.

“What I’ve done is develop a way to prioritize self-care for myself,” she says. “Because the only way you’re going to manage to do this is if you realize self-care is essential and important. That was the biggest piece for me.”

For Shannon Dikkema, the path to her work in relational somatic therapy and trauma-informed yoga began with fibromyalgia and chronic fatigue syndrome. The pain began at age 18 and, by age 22, it was chronic. It was difficult to get out of bed some days, and she had

some major collapses. Though symptoms continued for years, the medical system could find nothing conclusive to diagnose, and she was offered only painkillers and antidepressants.

Then she joined a yoga class and started to feel better, which led to further exploration. After years of trying different approaches, Dikkema controlled and eventually eliminated her symptoms using yoga combined with somatic counselling, acupuncture, and a lifestyle change, including diet and mindset.

Both Desroches and Dikkema have found ways to live well by creating individualized sets of self-selected approaches.

DIFFERENT KINDS OF PAIN

Dikkema distinguishes between chronic pain and chronic illness.

“Illness often includes pain, but

almost always includes medical system attention on an ongoing level,” she says, also pointing to other differences, including the many and broad categories of illness and varying degrees of agency and hopefulness about healing.

“Stressors with chronic illness are about interruption of normal life, as well as navigating the medical system,” she says. “The pain that comes alongside most illness can be managed with mindfulness, but yoga may not be indicated, and it may not be the time to do trauma resolution therapy either.”

The situation is different with chronic pain.

“Chronic pain is often something that, after a period of time, people are sent home to deal with on their own,” she says.

Chronic pain has categories: event/injury specific, where the pain has a main site, and syndromal, for example, fibromyalgia and chronic fatigue, where, she says, “pain moves around, gets better and worse, and is generally more confusing for those experiencing it.”

While each person is unique, Dikkema says, common themes connected to injury-caused chronic pain include lack of support following the incident, loss of income or significant relationship, challenges with pending court settlement resolution, and issues with prescribed opioid painkillers.

“With syndromes, there is much research to indicate early childhood experiences as the precursors,” says Dikkema. “Often these unresolved childhood pieces create what has been called ‘central sensitization of the central nervous system,’ which means pain signals are always being sent and received even when there may be no specific cause or area which consistently experiences pain.”

“Chronic pain is often something that, after a period of time, people are sent home to deal with on their own.”



FINDING WHAT HELPS

Desroches says the first step to living with pain is managing symptoms with medication, diet, exercise — attending to basic physical health.

“Then the other piece is around mental health,” she says, specifically naming CBT to help with some of the depression and anxiety that comes with living with a chronic health issue.

“It can get very depressing and you re-examine all of your life purposes, and then feel anxiety because you never know when it’s going to hit,” Desroches says. “It’s a very unpredictable condition.”

Other practices that have helped her include gratitude practice, journaling, connecting to other people, and any work that involves mindfulness.

Mindfulness is key to Dikkema’s approach as well, especially combined with yoga. Note that, yoga for chronic pain is not just any kind of yoga. She says many yoga classes are physical and “pushy,” which can be overwhelming for people in pain. In her classes, she incorporates mindfulness and somatic tracking.

“Yoga, the way I approach it, is really about mindful awareness in the body and anchoring attention in the present moment, which is really, really helpful for people with chronic pain because the future can seem like an unforeseeable dark pit of pain and that just brings up more anxiety, and sometimes, it’s people’s pasts that have brought them into that place of pain,” she says.

Mindfulness helps people gain an internal locus of control around where their focus is and how they frame things for themselves. That type of mindful tracking and somatic awareness is foundational in the somatic counselling modality.

“People need to develop the capacity to notice, tolerate, and even enjoy some of the sensations in their bodies in order to



“Anything that brings people more awareness of the muscles in their body rather than the visceral will be more grounding and health-bringing for people who have pain.”

get the information that exists there,” says Dikkema.

While yoga helped to keep Dikkema grounded and functioning, relational somatic therapy eliminated her symptoms. For RCCs without a somatic therapy background, she suggests bridging that gap by offering a self-assessment tool in terms of self-care: ask your clients, “What are you currently doing for yourself that helps you feel more like yourself or helps you feel healthier and more grounded in your life?”

Massage, steam rooms, warm baths, acupuncture — “anything that brings people more awareness of the muscles in their body rather than the visceral will be more grounding and health-bringing for people who have pain,” she says.

Dikkema offers caution around pacing:

people want to have control over their treatments and practices. “They want to be honoured as a person who knows what they’re talking about rather than somebody who needs to be pushed around into a protocol.”

Moreover, healing doesn’t always look like the symptoms are gone.

“Healing can often be about different coping skills or a reframe or a greater level of self-awareness and a lifestyle shift,” says Dikkema. “Allowing people to self-assess their healing with the support of a counsellor, but not primarily based on symptoms decreasing, can be really empowering for people.”

THE SOCIAL CONTEXT

For people with chronic conditions, suffering also comes from how they are

treated by others.

“It was always down to how compassionate and kind the people I worked with were,” says Desroches. “It really ranged. The thing about having chronic conditions, particularly the invisible ones, is that the medical profession is still really not up to speed. There are a lot of mysteries about it. We don’t really know why. We don’t always know the cause. We don’t know how to treat it very well. I would get plenty of doctors saying, ‘It’s all in your head’ or ‘Just tough it out, stop complaining, you could have it worse,’ things like that.”

On the other end of the continuum are the people who believe you.

“They validate what you’re going through, recognize how difficult life circumstances are, and then are kind and compassionate,” says Desroches. “That goes such a long way. That can make a really huge difference.”

That validation is foundational at Pain BC.

“One of the chief concerns for people who live with pain is invalidation,” says Maria Hudspith, executive director at Pain BC. “One of the most impactful interventions that can be made for a person living with pain is validation.”

Putting pain into a biopsychosocial frame, there is physiological phenomena with pain, she explains — the nervous system is agitated and that’s real. “And psychological distress, trauma, all of those things will exacerbate pain, so we know those things are true.”

And consider what is lost in daily life.

“On top of that, layer stigmatization, invalidation, and in the current opioid crisis, a real criminalization,” says Hudspith. “If you rely on opioids for pain management, even infrequently as

part of managing a flare up, you are seen with the stigma of addiction.”

“We recognize that the social context in which chronic pain exists will create distress,” says Hudspith. “We need to mitigate that and understand and communicate that understanding of the social context in our interactions with people living with pain. Because not doing so just contributes to a feeling of, ‘This is all me. I’m crazy. I’m alone. Nobody gets me’ — a kind of personalization of social factors that really makes the pain experience so much worse than it needs to be.”

Counsellors are skilled at seeing the invisible.

“We’re already aware of things like depression and anxiety. We are aware that people can look a certain way and feel quite different,” says Desroches. “I don’t think it’s a far stretch to recognize that physical pain can be like that.”

While Desroches says her personal experience has deepened her understanding and empathy for clients, it isn’t a prerequisite for counselling in this area.

“However, we are going to do a much better job if we inform ourselves,” she says.

We need to learn about pain — and also about resilience.

“Even though this is hard, it’s the resilience, it’s the working through it, it’s the overcoming the obstacle, that’s where you end up growing the most,” says Desroches. “There’s a Leonard Cohen quote, ‘In the broken places, the light shines through.’ I really believe that of clients. Now when I see them, I see that because I’ve been through it myself.”

Resources: For a list of resources for managing chronic pain, go to the BCACC blog at bc-counsellors.org.

PAIN BC

Pain BC is a Vancouver-based organization offering a variety of in-person, telephone, and virtual programs province-wide for people living with chronic pain, as well as education programs for health-care professionals and others.

Services include the Pain Support Line, which people living with pain can call for emotional support and to access connections to resources in their communities.

Coaching for Health pairs clients with volunteer coaches for telephone sessions to provide support around decision making, problem solving, goal setting, and action planning. Dorota Hedzelek, RCC and director of support services, says counsellors most often refer clients to Coaching for Health when counselling benefits run out to create a transitional plan with some consistent support.

“I would also encourage counsellors to use our program in a complementary way to their therapy,” says Hedzelek, noting that it would depend on the counselling modality. “Screening happens at the intake, and the reason for the referral is really to have a collaboration with a referring source.”

Counsellors who want to work together with their clients can access Live Plan Be, an online repository of evidenced-based, interactive resources.

Pain BC is soon launching a program of in-person, peer-led support groups.

Providing health professionals with an understanding of pain physiology is a key focus at Pain BC with the goal of transforming the way pain is understood and treated. Education programs range from online interdisciplinary initiatives to discipline-specific workshops. New initiatives include online training so health care professionals can begin in-person gentle movement programs in their own communities. Pain Foundations, a five-module, 10-hour online course, is another new program for health professionals.

“It’s suitable for any health care provider to get basic knowledge around lived experience of people with pain,” says Hedzelek. “Pain physiology, assessment, treatment, that whole package is at a foundational level, and the program is free for any registered health care professional in B.C.”

Find more information at www.painbc.ca.

CONNECTION IS POSSIBLE

SUPPORTING CLIENTS WITH DEMENTIA AND THEIR FAMILIES

How do our multiple identities — family member, spouse, parent, person of colour, gender identity, person with undiagnosed learning and/or physical differences, singer, athlete, immigrant, second-generation immigrant, visual or auditory learner, slow processor with genius-level thinking, task-oriented/field-oriented/divergent thinker — come into the therapy room, and how does a therapist take all of these parts into consideration?



Ros Clark Best, rosbestcounselling.com

This question is very alive to Ros Clark Best, a certified Adlerian counsellor and soon-to-be-certified EFT therapist, with an extensive background with people with learning differences: ADHD/D, dementia, processing issues, and chronic disabilities and illnesses.

Before becoming a counsellor in 2011, Best was a high school teacher for 24 years, working with French immersion international baccalaureate students, students with learning differences, and general population students. With her family and closest friends, she has had immediate experience caring for parents with vascular dementia and Alzheimer's, as well as supporting and advocating for a family member with severe, lifelong degenerative illness and a friend with schizophrenia.

In short, Best has a soft spot for the people who fall through the cracks.

Here, we focus on therapy as it

pertains to elder care and, particularly, dementia care for elder clients and their families.

■ How would you describe healthy aging?

I'd rather *ask* a senior. Is healthy aging about carrying as much responsibility as they safely are able? Having a role and being able to contribute? Knowing *their* children are well looked after (or as well as possible)? Their legacy? How they will be remembered when they are gone? Perhaps, for our clients, it might be about being good enough, forgiveness, relationship repair, if possible, or making peace if repair is not possible. And do they matter? Who will hold their story when they're gone? As counsellors, we're pretty good at this type of work.

■ On a really basic level, how might a counsellor adapt their therapy room for older clients?

For sure, we need brighter lighting, no tripping hazards, a high toilet and grab-bars installed in the washroom, and a chair in the therapy room that's tall, not too soft, and has solid arms to push off from when the client stands up.

It is good to check how wide the therapy room and washroom doors are so we know in advance if we can accommodate clients with walkers and wheelchairs, assuming an elevator and good parking are close by. If they do have a wheelchair, I make sure I have made space in the therapy room *before* they arrive.

We may know to check in if the person is hearing us well and make a point of speaking to the client while looking them in the face for better hearing and comprehension.

We *do* know to treat older clients as humans first.

Where therapists may have less knowledge is around dementia care, from the point of view of the person

with dementia and the points of view of family members. By the way, there are more than 200 types of dementia already diagnosed, and scientific knowledge in this field is growing very quickly.

■ **What is the first thing to know when dealing with possible dementia care issues?**

You should know how people hold things in memory in language accessible to a person in the early stages of dementia and to their family members. Specifically, I am referring to the work of Dr. Gemma Jones. People hold memory in:

1. the hippocampus — facts, logic, my daughter's name, how much tip I owe, all held in chronological order;
2. The amygdala — for the emotional feeling of things, held by category: women I've loved/who loved me, men I've loved/who loved me, pets, people in authority I disliked, etc;
3. Other parts of the brain used for

“YOU SHOULD KNOW HOW PEOPLE HOLD THINGS IN MEMORY IN LANGUAGE ACCESSIBLE TO A PERSON IN THE EARLY STAGES OF DEMENTIA AND TO THEIR FAMILY MEMBERS.”

kinesthetic learning — how to dance, songs I sang as a kid, the feel of reading a newspaper.

With dementia, it is the hippocampus — memory of facts — that is affected first; the amygdala is damaged much later. So, does it matter that my mom called me by her mother's name? Not at all. It means I give her the same feeling as her mom did; I take it as a compliment. She knows the feeling of connection we have, and that is what counts. I can let go of facts falsely asserted if I understand the feelings being expressed.

Another example: if Mom, in a 24-hour-care home, keeps wandering into someone else's room or keeps asking

to go home, how do I understand this? Mom is looking for a *feeling* of home. She may already have forgotten the physical place of her earlier residence, but there is a feeling that something is missing. A feeling of connection. A familiar face gives her lots of eye contact, a hug, and chats with her, and she regains the calm of feeling of home.

■ **What are some other examples of behaviours that would *feel like home*?**

Reading a newspaper even if she can't read anymore — it feels and smells, so that's kinesthetic memory. Helping to prepare dinner — ask if the kitchen can give her a task. For my Dad, attending meetings, even if he doesn't really track what is being said. Or having a workshop where he can give me advice. It creates the *feeling* of home. The *feeling* of having a valued role.

Here's another crucial point to understand about dementia and aging in general: think of the brain like a computer. An older person has good storage, but the RAM is getting smaller. They can hold less in their working memory at any one time. This is why attending a birthday party with people Mom hasn't seen for a while is very taxing for her. Her memory quickly gets overloaded and she zones out. Smaller, more intimate parties work better. Post-it notes, super short and sweet, work for remembering personal hygiene and safety in the early and middle stages.





“WHEN ... WE UNDERSTAND HOW THE BODY WORKS WITH AGING, WE CAN FOCUS ON THE EMOTIONAL BOND MORE AND NOT FUSS ABOUT LENGTHY EXPLANATIONS AND CHALLENGING FALSE BELIEFS.”

■ **On a practical level, what other points have made a difference in your ability to support families when a loved one has needs related to dementia?**

There are several. For example, with normal aging, a person’s field of vision narrows and ability to see colours diminishes. With dementia, this is especially so. Whereas a younger person can see all the way from side to side, a person with advancing dementia cannot see wider than about the sides of their glasses when the glasses have slid a bit down their nose. So if a family member is feeding them from the side, each bite would come as a surprise. Better to feed them from in front and hold off on conversation until after eating to avoid multi-tasking.

Colour also makes a big difference. People with advancing dementia cannot see blues and greens, and darker colours get even darker. Is the elevator floor tiled in dark green? It will look like an elevator shaft — wouldn’t you put up a fuss about getting in there? Is the carpet green with swirls? Easy to interpret as a goldfish pond — would you walk into a goldfish pond? Want something to be super visible to a person with dementia? Serve chicken on a red plate. Serve water in a red mug. In a study, elders drank 40 times more water from a red cup than they did from a clear glass, and we all know how crucial good hydration is to

avoid bladder infections, keep organs healthy, and to think clearly.

A few more dementia-specific points: tasks such as getting out of a bathtub and swallowing are much more complex than I had realized. There are many actions to coordinate — seven just for swallowing! A main reason for bathroom falls is the inability to multi-task getting out of the tub: turning, moving feet, balancing, grabbing hand-holds, not slipping, etc. And if you can’t remember the last fall, how can you learn from your mistakes? Better for the family member to change the environment without asking permission but firmly informing the person.

Incontinence is another dementia-related concern. With slower processing, the message gets to the brain about needing a washroom too late. So at a restaurant, mention going to the washroom about five minutes before heading in and invite Mom to come with you. Fewer mistakes, and more connection.

A word on bladder infections (UTI’s): in older people, the urethra narrows, so the likelihood of bladder infections increases greatly. Do older women know to use toilet paper from front to back to avoid infections? And lots and lots of hydration is needed so the urethra gets flushed frequently. With my own father I thought he was going to die — that he had had a major stroke. Nope, just a UTI. I learned to

get my parent checked for a UTI as soon as I noticed fears or behaviours that were out of the ordinary. He didn’t notice any sensation younger people would normally notice for a UTI.

■ **Any other advice for counsellors?**

We are social creatures, bonding mammals. When, as family members and therapists, we understand how the body works with aging, we can focus on the emotional bond more and not fuss about lengthy explanations and challenging false beliefs. Family members need to facilitate an environment that helps the older person with dementia feel secure.

In therapy, knowing these simple things can help us help family members reduce stress and get the relationship they crave with their parent. As counsellors, we can help ease the anticipatory grief.

For the person with dementia who comes to therapy, we need to hold the space a little longer, giving them time to find the word or thought or memory. We need to be skilled at staying with the emotional feeling of what happened and what the client needs.

And when communication gets hard, there will still be touch, singing, dancing. Watch Gladys Wilson and Naomi Feil on YouTube. Connection is possible all the way to the end of life. The person with dementia *is* still there. You may just have to be a detective to connect.



PREPARING FOR THE UNEXPECTED: A guideline for appointing a legacy contact

BY MARCI ZORETICH

During the 2019 membership renewal period, BCACC asked members to provide information for their legacy contact (or practice trustee). In the event of a member's incapacitation, this information assists BCACC in providing a contact for clients looking to access their records. BCACC has received numerous requests for information on how to choose a legacy contact and what a legacy contact might provide in the way of services. The following is a guideline for consideration.

THINGS TO CONSIDER

While it can be common for a counsellor to name a spouse, close family member, friend, personal executor, or lawyer as their legacy contact, counsellors are strongly

encouraged to consider appointing a counsellor or mental health professional familiar with clinical practice operations to wind up a clinical practice. This decision will help ensure client confidentiality is maintained through follow-up contacts and, most importantly, through any disposition of clinical records. Additionally, appointing a professional to manage the closure of your practice will ease the burden on a grieving or stressed family member, friend, or spouse.¹

Is your legacy contact prepared to administer your practice in the event of your unanticipated death or incapacitation? The following questions will help guide your choice of a legacy contact. Could your legacy contact answer these questions or complete these tasks:²

- What appointments have been scheduled with clients over the next few weeks that need to be cancelled?
- What new counsellor could those clients be referred to?
- What bills need to be paid? And what invoices need to be sent out?
- Could the legacy contact make sense of the office filing system, billings, etc.?
- What should be done with mail, magazine or internet subscriptions, etc.?
- Can the legacy contact access the counsellor's work computer? Are electronic files protected by a password?
- How would the legacy contact notify the counsellor's clients if the counsellor became incapacitated and was thus unable to practice for some period of time, or, worse, if the counsellor died?

- Where are closed client files kept? When can those and other files be destroyed?

For counsellors interested in reading more about preparing their practice for the unexpected and the legalities of setting up a formalized agreement, they can refer to an article by George K. Bryce, former BCACC Legal Counsel: “Planning for the Unexpected: How Counsellors can prepare their practices in case they become incapacitated or die before they retire,” available here: [at bc-counsellors.org/wp-content/uploads/2015/10/Nov9PreparingforUnexpected.pdf](https://bc-counsellors.org/wp-content/uploads/2015/10/Nov9PreparingforUnexpected.pdf)

TASKS A LEGACY CONTACT COULD ASSIST WITH

This comprehensive list of tasks is meant as a guideline for consideration. Some of these tasks might not apply to your private practice, or you may choose to have another individual besides your legacy contact complete them. However, it is meant to provoke thought about who will assist with maintaining and closing your practice if you are not able to. Above all, consider the issues of confidentiality with respect to your clients and the clinical records of your work with them.

- | | | |
|---|--|---|
| ○ Access and secure your physical office | (including file retention policy) | ○ Cancel office equipment leases |
| ○ Access and secure your work computer (passwords, etc.) | ○ Transfer current clients and clinical records | ○ Employee termination notices, compensation in lieu of notice, prepare records of employment, T4 slips, notify CRA |
| ○ Access your phone and email systems (change messages, forward messages, etc.) | ○ Locate your closed files (electronic and hard copy) | ○ Notify students who might be under your supervision |
| ○ Access and secure your appointment schedule | ○ Access your financial records | ○ Contact your legal and accounting partners |
| ○ Access and secure your electronic and physical files (passwords, keys, etc.) | ○ Understand your filing and billing systems | ○ Inform the BCACC or other professional associations (in the case of incapacity or death) |
| ○ Assess clients for need/risk | ○ Locate confirmation/ authorization from your financial institution regarding power of attorney | ○ Notify colleagues |
| ○ Locate your “notification to clients” letters (current and former) | ○ Pay outstanding bills and taxes | ○ Notify broader community (newspapers, if necessary) |
| ○ Contact your current and former clients | ○ Send out invoices | ○ Place notification on your website |
| ○ Prepare file transfer notes | ○ Prepare inventory of assets and debts | ○ Maintain your insurance for the duration of time it takes to wind up your practice |
| ○ Identify incomplete test results or reports | ○ Terminate leases | |
| ○ Locate and adhere to your privacy policy | ○ Locate inventory of assets (and/or sell business assets) | |
| | ○ Cancel your mail, subscriptions, internet, credit cards etc. | |

REFERENCES

- 1 Bryce, G. (2010, November 4). *Planning for the Unexpected: How Counsellors Can Prepare Their Practices In Case They Become Incapacitated or Die Before They Retire*. p. 4 <https://bc-counsellors.org/wp-content/uploads/2015/10/Nov9PreparingforUnexpected.pdf>
- 2 Bryce, G. (2010, November 4). *Planning for the Unexpected: How Counsellors Can Prepare Their Practices In Case They Become Incapacitated or Die Before They Retire*. p. 5 <https://bc-counsellors.org/wp-content/uploads/2015/10/Nov9PreparingforUnexpected.pdf>

INDIGENOUS ALLY TOOLKIT

The Montreal Urban Aboriginal Community Strategy Network has recently launched a toolkit to help non-Indigenous people become allies. The toolkit is organized into three steps — be critical of any motivations, start learning, and act accordingly — and provides information so people can become more self-aware and confident about protocols. While the text specifically references Montreal, the content is suitable across Canada and the notes include additional resources. Printed copies have been much in demand and are in short supply; however, an online PDF can be downloaded from www.reseautmntnetwork.com.



The Office of the Seniors Advocate

The Office of the Seniors Advocate (OSA) was established in 2014 in Victoria and was the first office of its kind in Canada. The OSA monitors and analyzes seniors’ services and issues in B.C. and makes recommendations to government and service providers to address systemic issues.

A variety of practical resources for seniors and their families and caregivers is available on the website, including information on housing, health care, transportation, income supports, and personal supports. Learn more at www.seniorsadvocatebc.ca.

CARRIER SEKANI FAMILY SERVICES

Elder Youth Mentorship Program in Northern B.C.

BY LINETTE SCHUT

Throughout much of Northern B.C., many First Nations children who are in the care of the Ministry of Children and Family Development have been separated from their home communities, causing them to lose touch with their heritage and culture. Although many efforts are made to help facilitate these connections, the reality of the long distances between communities in the North makes it difficult for these children and youth to stay connected.

Carrier Sekani Family Services (CSFS) provides holistic health and wellness services through myriad different programs for Carrier and Sekani people of all ages in North Central B.C. For many years, Mary Teegee, the executive director of CSFS's Children and Family Services, had been considering ideas that would allow for a beneficial and holistic way to engage these children with their home communities and, particularly, with elders in their communities who would be able to pass on vital knowledge and culture.

In 2017, the opportunity came for the Youth Services department to implement what has now become the Elder Youth Mentorship Program. As Kayla Brownscombe, team lead for Youth Services, describes it, "We received funding for a mentorship project in which elders and knowledge holders from the community would meet regularly with the youth and do some sort of structured mentorship activity in the community."

Brownscombe reiterates the importance that these activities happen in the community, as a big part of the vision of the program is to "bring kids home" and break down common barriers that make it difficult for kids and their

caregivers to feel comfortable coming to the communities.

"We know that when kids age out [of care] they go home; that's where they want to be," says Julie Scoble, who coordinates the program. "It's good to try and have those healthy relationships for them when they do go home."

The Youth Services team piloted the program in Saik'uz First Nation, identifying the natural leaders and knowledge holders in that community, while simultaneously working with numerous agencies in the area to identify which Saik'uz children were in care throughout the greater region. The program has since expanded to the Lake Babine Nation, and, due to its great success, CSFS has plans to continue to expand it to all of their member nations throughout Carrier and Sekani territory.

The elders and children in both communities meet about twice per month, doing a variety of activities, such as ice fishing, berry picking, cooking traditional foods, and teaching the Carrier language. Barby Skaling, coordinator for the Cultural Program, has been instrumental in helping to facilitate these activities, as a knowledge holder herself, who speaks her Carrier language fluently.

The elder mentors have taken a lot of ownership of the program since the beginning. "The elders have so many ideas for how they want it to go and what they want to teach," says Scoble.



The elders and children in both communities meet about twice per month, doing a variety of activities, such as ice fishing, berry picking, cooking traditional foods, and teaching the Carrier language.

As Brownscombe explains, "Unlike many middle-aged people who are too busy, elders have time and they want to share and they want to be involved in something." Moreover, the program has helped to address loneliness among the elderly population by providing them with an opportunity to hang out with a group of youth twice a month.

"For some of the elders, these youth were their grandkids and their families, who had not been in the community for years," she says.

This has been an unexpected blessing of the program: numerous family connections have been strengthened, and some children are getting to know their parents and grandparents. Caregivers are also becoming more comfortable in the communities, which, in turn, helps children to feel comfortable and to gain ownership of their own land and heritage.

Linette Schut, MEd, RCC, lives in Burns Lake and works for Carrier Sekani Family Services as a child and youth mental health clinician.

GARDENING: A SOCIAL PRESCRIPTION FOR YOU AND YOUR CLIENTS

BY CAROLYN CAMILLERI

In the spirit of the social prescribing movement, gardening may be one of the most effective ways to feel better — at least, anecdotally.

Last December, the *National Post* ran an article by Joseph Brean with a title that kind of says it all: “In medicine, social prescribing is catching on despite a lack of evidence.” Brean says social prescribing is considered by some to be a “gimmick” that’s gone mainstream, especially in Britain, where it’s been adopted as a key government policy.

Brean points out that the lack of strong evidence is at least partly due to the fact that most studies of social prescribing have been “small, anecdotal, qualitative, and poorly designed.” Nevertheless, social prescribing is “logical and intuitively attractive, especially for elderly people and the so-called worried well,” he says.

However, as the social prescribing movement continues to grow, more studies are sure to follow. In the mean time, does it matter if there is a lack of evidence, as long as it helps people feel better and doesn’t hurt anyone?

Taking gardening as an example, some studies do support its therapeutic benefits. In “Why gardening therapy is being prescribed by doctors,” Karen Gordon references studies that suggest being near vegetation improves physical and mental health and lowers depression. Other studies suggest gardening boosts brain health, reduces pain, improves memory and concentration, and benefits people with dementia. One study even suggests soil may contain microbes that act like antidepressants.

That aside, gardening is a practically perfect opportunity for mindfulness practice, which has been proven effective.

“...research shows [mindfulness] can have a huge impact on your stress levels, helping to stave off anxiety, slash depression risk, boost productivity, and ease insomnia,” says Gordon.

But whether there is hard supporting evidence or not, even simple gardening projects are creative, present-moment activities that get people outside in the fresh air, connecting with nature, getting some exercise, and doing something that brings tangible, beautiful rewards.

And surely that can help some people feel a little bit better.



No garden? No problem.

Opportunities to garden abound for everyone from absolute beginners to avid green thumbs.

Large public gardens, community parks, and heritage properties often seek volunteers to assist with regular maintenance as well as special projects.

Other places to check out include the Victoria Horticultural Society, City of Vancouver (search “Green Vancouver”), Fresh Roots, LifeCycles Fruit Tree Project, and Earthwise Society Garden Buddies. There are many more!

Community gardens are another increasingly popular option across the province.

- **The City of Vancouver** has more than 110 community gardens operated by community groups and listed on a helpful map. vancouver.ca/people-programs/community-gardens.aspx

- **In the City of Victoria**, choose from three different types of community gardens: commons gardens, allotment gardens, and community orchards. A map is available online, as well as information on how to start your own community garden. www.victoria.ca/EN/main/residents/parks/community-gardens.html

- **In the B.C. interior**, community gardens are fenced, shared land divided into garden plots for use by anyone in the community. www.interiorcommunityservices.bc.ca/programs/food-security/community-gardens

SOURCES

Brean, J. (December 21, 2018). In medicine, social prescribing is catching on despite a lack of evidence. *National Post*. <https://nationalpost.com/news/in-medicine-social-prescribing-is-catching-on-despite-lack-of-evidence>

Gordon, K. (April 10, 2017). Why gardening therapy is being prescribed by doctors. *Net Doctor*. <https://www.netdoctor.co.uk/healthy-living/wellbeing/a26431/gardening-as-a-therapy-for-health/>

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.

Our new plan can be purchased as a standalone health benefits plan, or as a health and dental benefits plan. A basic travel insurance plan and coverage for fractures and breaks are also included in the cost.

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.

Coverage you can afford and no medical questions on the Basic plan.

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.

BCACC

BC ASSOCIATION OF CLINICAL COUNSELLORS

WHY SHOULD YOU JOIN THE BCACC?



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

Be Recognized

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

Save Money

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

Grow Community

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

BCACC
BC ASSOCIATION OF CLINICAL COUNSELLORS