FALL 2020

INSIGHTS

THE BC ASSOCIATION OF CLINICAL COUNSELLORS' MAGAZINE

Processing the losses of COVID-19

Death in a care facility during the pandemic

Shifting to online counselling

Mental health services for the Deaf community

The healing power of connection with the natural world

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BUT ARE TOO UNCOMFORTABLE TO TELL YOU

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INSIGHTS

THE BC ASSOCIATION OF CLINICAL COUNSELLORS' MAGAZINE

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

Tammy Bartel, Susi Bolender, Alexandra Cope, R. Christina Fenton, Natascha Lawrence, Deirdre McLaughlin

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

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

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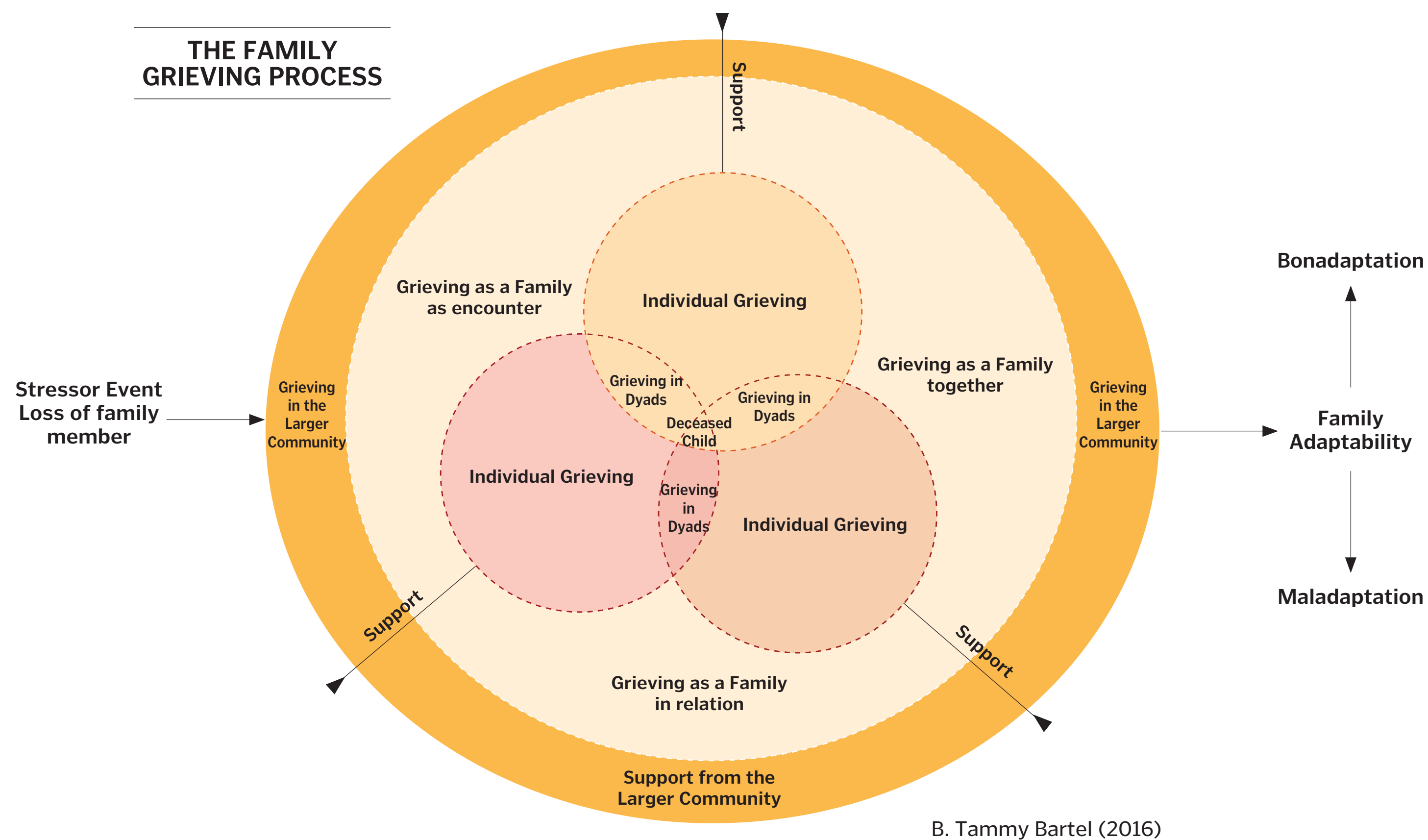
4 Family bereavement **5** Being anti-racist and anti-oppressive **6** Resources for your anti-racism journey



B. Tammy Bartel (2016)

Family bereavement, relational grieving, and continuing bonds

BY TAMMY BARTEL, RCC

I am a bereaved mom and a clinical counsellor. One preceded the other. After the sudden death of my 15-year-old daughter in 2005, I embarked on a journey I never imagined. Bereavement came like a thief in the night, and it threw our family into disarray. This devastating event and the resulting death of one of us dramatically changed our family. Our lives were shattered to the core. This single event changed the course of my life forever. I began seeking answers to the unanswerable, and in this search, I decided to go back to school.

I had a deep desire to know more about loss, death, and bereavement, and I chose a research study focused on family bereavement and relational grieving. Not only did I investigate grief theory and models, I also explored studies conducted on bereaved families. What I found was that most studies were done with individuals as participants who spoke for the whole family. This intrigued me. I wondered why studies had not been conducted with more family members. What I discovered was a gap in the extant literature.[1] Studies were needed on family bereavement with the family as the unit of analysis.[2] And thus emerged my thesis topic addressing the lived experience of families grieving the loss of a family member together.

My study explored the relational dimensions of grieving within the family unit. Three courageous families bereaved of a child participated. Using the Qualitative Action-Project Method developed by Richard Young (UBC) and colleagues, individual and joint interviews were conducted with family members.[3]

EIGHT COMMON THEMES in how families grieved together[4]

- Intentional turning towards the loss and facing the grief
- Participating in mourning events and seeking out support
- Implementing ongoing rituals and remembrances
- Experiencing joy and sorrow simultaneously
- Recognizing and allowing for different grieving styles of family members
- Sharing a pervasive pain and awareness of the life-long process
- Looking for ways to heal and finding meaning in each other's shared grieving
- Sharing an ongoing connection to the deceased child that connected them to each other

The uniqueness of this method was that family conversations were videoed with no researcher in the room. Data analysis illuminated family grieving processes and clearly demonstrated that grieving is an interactive process with individual, dyadic, multi-adic, and community levels of processing (see diagram).

Family bereavement following the loss of a child is a devastating, life shattering event that initiates a family grieving process. This process is pervasive, inescapable, and ongoing. Family members who maintained an ongoing continuing bond with their deceased child felt more connected to each other. Research has only just begun to give attention to this. Research conducted on the bereaved family as the unit of analysis is critical to understanding and caring for this population.[5]

For more from Tammy Bartel, RCC, see "A Pandemic of Grief" on page 22.

Being anti-racist and anti-oppressive

The role of language

BY NATASCHA LAWRENCE, RCC

Language is important. As counsellors, we understand the power of words. We use words to help our clients connect feelings and link experiences and to foster insight and integration. Depending on how you wield it, language can promote healing and empowerment or it can cut down and destroy.

Being mindful of our language is more important than ever. The events on both sides of the border have highlighted the reality of systemic racism and oppression. Language, particularly on social media, has been used to spin the perspective in favour of the oppressors. Language is the easiest way to change our input into these systems.

It may seem tedious, cumbersome, and even pointless to focus on words that seem innocuous. This is not about being politically correct nor is it about the intent of the language. If your language is called out, pause and notice what comes up for you. If you feel the need to defend and justify, you may engage in racial gaslighting. Rather, can you be curious, listen, and focus on the experience and felt sense for the person who has had the courage to speak up? Can you trust their expertise? Can you not use your privilege to speak about experiences you have not felt within your own body?

When we are called out, it can be a beautiful gift. It is in the discomfort that we can examine our own biases, prejudices, and racism, and learn and move towards the opportunity for change. It is our responsibility as counsellors to be more than against racism — we need to be for anti-racism and anti-oppression. We can be helpful, loving people, who need to learn how to speak differently because we were raised in colonial systems that promote racist, oppressive, and indifferent language.

It is the responsibility of the counsellor to unlearn racist stereotypes, language, and behaviour. It is not the oppressed person's job who has spoken up to teach you.

There is a direct link between microaggressions and microinvalidations and the use of language to justify biased, bigoted, and hateful ideology used as the smokescreen to defend systemic aggression, violence, and murder. Racism and oppression exist within the systems we live and work in. In British Columbia and across Canada, racism and oppression are not just historical — they occur right now within our own mental health field every day.

Think back to your education and training — the methodologies you practise from, the teachers you had, the books you read — how many were written and created by BIPOC? The research articles you studied — how many focused on the experiences of BIPOC folx and were conducted by BIPOC researchers?

This article could have provided a list of problematic words and phrases that

should be avoided. I am aware of my privilege and did not want to speak about experiences that are not my own. It is the responsibility of the counsellor to unlearn racist stereotypes, language, and behaviour. It is not the oppressed person's job who has spoken up to teach you. Do not add to their emotional load. Instead, start your retraining with articles, workshops, and courses led by BIPOC folx and organizations.

In our field, we must be careful of optical allyship. Coalition work requires the commitment to decolonize mental health and dismantle systems of oppression while acknowledging our positions of institutional privilege and power.

Natascha Lawrence (she/her/hers pronouns), MA, RCC, is a BC Registered Play Therapist and Certified Synergetic Play Therapist Supervisor working in private practice with children, youth, and adults with neurodiversities, particularly FASD and/or trauma. Natascha is of mixed Asian ethnicity and a first-generation Canadian. Her husband is Indigenous and his family are survivors of the Indian Residential School System. She is passionate about how therapists can be vehicles of change and advocate for the systems we live and work in to be anti-racist and anti-oppressive.

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RESOURCES

IF YOU ARE COMMITTED TO THE ANTI-RACISM AND ANTI-OPPRESSION JOURNEY, START WITH THIS LIST OF A FEW RESOURCES.

The Skin We're In: A Year of Black Resistance and Power by Desmond Cole (2020, Double Day Canada)

White Fragility: Why it's so Hard for White People to Talk About Racism by R. DiAngelo (2018, Beacon Press)

They Call Me George: The Untold Story of Black Train Porters and the Birth of Modern Canada by Cecil Foster (2019, Biblioasis)

Micro-Aggressions and Their Effects on the Therapeutic Process by N. Granger (Society for Humanistic Psychology, 2012: https://www.apadivisions.org/division-32/publications/newsletters/humanistic/2012/10/microaggressions)

If You Want To Be Anti-Racist, This Non-Optical Allyship Guide Is Required Reading by M.C. Harper (*Vogue UK*, 2002: https://www.vogue.co.uk/arts-and-lifestyle/article/non-optical-ally-guide)

Indigenous Peoples Terminology Guidelines for Usage (Indigenous Corporate Training Inc., 2006: https://www.ictinc.ca/blog/indigenous-peoples-terminology-guidelines-for-usage)

21 Things You May Not Know About the Indian Act by R.P. Joseph (2018, Port Coquitlam, BC: Indigenous Relations Press)

San'yas Indigenous Cultural Safety Training (http://www.sanyas.ca/)

Racial Discrimination and Mental Health in Racialized and Aboriginal Communities by K. Kafele (Ontario Human Rights Commission, 2004: http://www.ohrc.on.ca/en/race-policy-dialogue-papers/racial-discrimination-and-mental-health-racialized-and-aboriginal-communities)

The Role of the Behavioral Scientist in the Civil Rights Movement by M. L. King Jr. (*Journal of Social Issues*, 2018: https://www.apa.org/monitor/features/king-challenge)

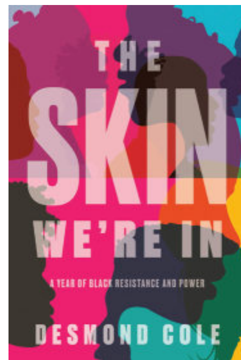
Decolonizing Academia: Intersectionality, Participation, and Accountability in Family Therapy and Counseling by T. McDowell and P. Hernández (*Journal of Feminist Family Therapy*, 2010, 22(2), 93-111)

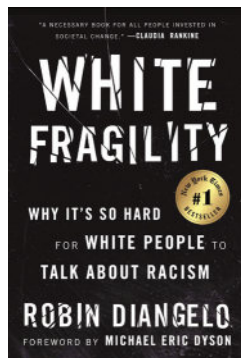
Undoing Racism. The People's Guide to Undoing Racism (https://www.pisab.org/)

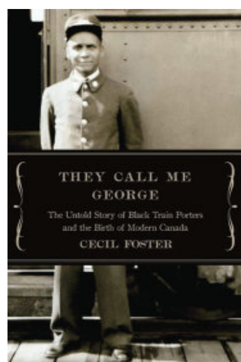
Microaggressions: Intervening in three acts by A. Thurber and R. DiAngelo (*Journal of Ethnic & Cultural Diversity in Social Work*, 2019, 27(1), 17-27)

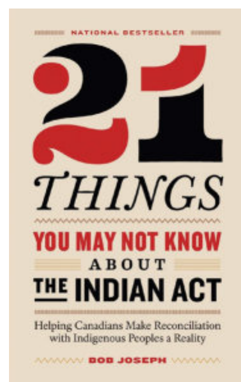
TRACC (trauma response and crisis care) for Movements (https://www.tracc4movements.com/)

Microaggressions in Psychotherapy by T.D. Williams, L. M. Shamp, and K J. Harris (*Psychotherapy Bulletin*, 2017 52(4). https://societyforpsychotherapy.org/microaggressions-in-psychotherapy/)









Have you logged into your BCACC Member Portal lately?

Look for the RCC Login button

Access the member portal from the BCACC web page and connect with your association and the resources offered to members, which include:

Breaking news: Concerned you might have missed a BCACC update? Breaking news brings you up to speed with the most current news for members. Find this information on the landing page once you have logged in.

Update your public listing and your member information: Update your own member information and activate or deactivate your public listing on the Find a Counsellor tool.

New for Fall 2020: BIPOC and Indigenous counsellors can easily identify themselves for clients looking for their services. Look for the BIPOC and Indigenous check boxes on the Member Information page.

"I am looking for": Questions about who to contact at BCACC? Looking for receipts from your recent BCACC transactions? On the hunt for information about member benefits and insurance? The "I am looking for" section of the member portal houses BCACC's most requested information. It is a helpful first stop for counsellors looking for answers.

Introducing eConnect Beta: We are incredibly excited to introduce members to BCACC's new eConnect Beta platform — a comprehensive online learning platform that houses members-only courses and also a private social media sphere where members can connect. Find peers easily for connection and learning in the Communities of Practice area. Take an online course and receive a certificate, watch webinars, access recordings of the AGM, and connect using the private social media platform.

Continuing Competency Program: COVID-19 has been a good time to catch up on professional development. BCACC's Continuing Competency tool helps members establish goals and track learning outcomes. While this program is not yet mandatory, we encourage you to familiarize yourself by watching the tutorial video and using the tool to record your yearly progress.

IMPORTANT DATES

MITCHELL AND ABBOTT INSURANCE EXPIRED ▸ **April 1, 2020**

INSURANCE AUDITS START
▸ **September 15, 2020**

BCACC MEMBERSHIP RENEWALS OPEN*
▸ **November 15, 2020**

BCACC MEMBERSHIPS EXPIRE
▸ **December 31, 2020**

**PLEASE NOTE: Due to COVID-19, BCACC renewals will only be accepted online; we will not receive in-person renewals in the BCACC Head Office.*

THANK YOU

TO OUR COVID-19 SURVEY PANELISTS

Back in April, BCACC invited members to take part in an ongoing COVID-19 Survey Panel. Almost 400 BCACC members opted to take part in this six-month project, and we thank them for their commitment and participation. Our goal is to get a snapshot of how COVID-19 is impacting members personally and professionally, explore areas where BCACC can provide further support, and gather data to inform our planning decisions going forward.

77.8% IN PRIVATE PRACTICE AND **77%** EMPLOYED BY AGENCIES SAID THEIR VIEWS ON VIRTUAL COUNSELLING HAVE BECOME **more positive** DURING THE PANDEMIC.

WORKING WITH DEAF CLIENTS

Understanding some of the challenges of providing culturally competent and accessible mental health services for the Deaf community. BY SUSI BOLENDER, RCC

Sign language isn't something most people think about until they see it. When I was a teenager, someone mentioned to me I might consider working with Deaf children, and I had no idea what that might be like, but it sparked some curiosity.

One of the things I learned is the "D" in Deaf is often capitalized, because a Deaf identity is one of culture, which most people do not realize. Sometimes, you will see it written as d/Deaf which shows it's inclusive of both people who have hearing loss (deaf) and those who identify as a cultural minority with a unique culture, language, and heritage (Deaf).[1]

In Canada, while there are regional differences in sign, American Sign Language or ASL is generally used. One of the most typically asked questions is, "Is there a universal sign language?" While there is an international sign language, it's not commonly used, and many spoken languages have a signed counterpart. Wikipedia suggests there are over 135 different sign languages around the world.

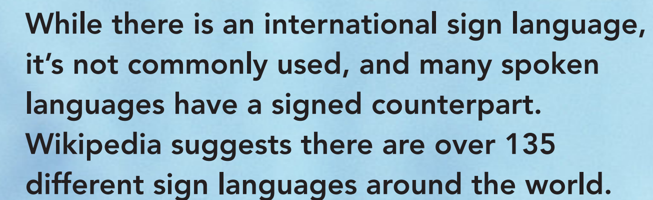
WHAT THE NUMBERS SAY

Statistically, the Canadian Association of the Deaf writes that, while there is no credible census to know accurately how many d/Deaf people there are in British Columbia, they generally use a 10 per cent rule.[2] With a population of over five million people, B.C. has an estimated 500,000 people with some form of hearing loss. While there is no way to know exactly how many of those use ASL, those of us who work with the Deaf signing community know there are significant obstacles in accessing services due to communication barriers.

This is an article about accessibility, not statistics. For a population that a counsellor may not often think about until they show up requesting services, it is important to understand some of the challenges of providing culturally competent and accessible services in mental health when there are such limited options for the Deaf community.

It is estimated that one-fifth of Canadians experiences a mental health or addiction problem.[3] Applying those calculations to British Columbia, an estimated 100,000 d/Deaf citizens may seek professional counselling services. That seems a large number, especially when you consider the barriers to direct services people with hearing loss face in a system that does not realize the significance of the language barrier.

A Canadian Community Health Survey reported that Canadians in the lowest income group are three to



four times more likely than those in the highest income group to report poor to fair mental health.[4] In 1998, The Canadian Association of the Deaf conducted a survey and data collection on the employment and employability of d/Deaf Canadians. They reported that only 20.6 per cent of d/Deaf Canadians are fully employed, 41.9 per cent are under-employed, and 37.5 per cent are unemployed (CAD, 2014). The data reflects that 79.4 per cent of d/Deaf Canadians are either underemployed or unemployed. Using this data, we can estimate that of the almost 500,000 d/Deaf British Columbians, 397,000 of them are three to four times more likely to have mental health needs due to socioeconomic barriers; a counsellor may not have the ability to communicate directly about this.

I am certain that most counsellors reading this article do not have functional fluency in ASL. I know this because I live and work in British Columbia and, to my knowledge, there are three bilingual RCCs in the province fluent in ASL. Fortunately, there are other resources.

RESOURCES TO SUPPORT WORK WITH THE DEAF AND HARD OF HEARING

The Deaf Well Being Program has an office in Burnaby and provides direct services to individuals and their families with hearing loss.[5] They also provide consultation for counsellors working with Deaf or Hard of Hearing clients throughout the province. This is the most valuable resource for consultation on how to work with Deaf clients.

Another resource is the provincial interpreting association: The Westcoast Association of Sign Language Interpreters (WAVLI).[6] This organization offers contact to individuals and agencies who provide professional sign language interpreting services. Most agencies have a minimum charge of upwards of $120 for a professional sign language interpreter. Many clinicians do not realize this is a cost that will fall to them as provincial and federal governments mandate that services need to be accessible.

WORKING WITH REGISTERED SIGN LANGUAGE INTERPRETERS

Interpreting is a relatively new field. To understand the problems faced in interpreting today, it helps to realize who has functioned as interpreters in the past. Some examples are family members (including hearing children), friends, co-workers, or other hearing people, referred to as signers, who have learned some sign or fingerspelling informally. Aside from the fact that these groups of people are not trained in the skill of interpreting, other problems exist. Family and friends can be consciously or subconsciously biased, making it impossible for the hearing person, agency, or business to trust that the interpretation is accurate and impartial.[7]

In the field of mental health, the non-signing counsellor depends on the interpreter to facilitate communication. Problems arise when the counsellor is uninformed about how to judge the skills and abilities of the sign language interpreter and the sign language interpreter is unfamiliar with the practice of counselling. In a variety of surveys, sign language interpreters self-disclosed that their training in mental health interpreting was insufficient.[8]

WAVLI only recently secured title protection and now has legal recourse to intervene if any person uses the protected registered titles: Registered ASL/English Interpreter, Registered Sign Language Interpreter, and Registered Visual Language Interpreter. There have been unscrupulous people who have learned sign language and then marketed themselves as an interpreter — when in fact they are properly referred to as "signers" — and hiring these imposters can greatly affect the quality of care a counsellor provides. Issues like informed consent and limits of confidentiality are components of our professional services that address the accountability of the clinician and client in sessions. If these issues are not conveyed appropriately, we leave ourselves open to liability. Signers, acting as interpreters, can seem appealing due to their tendency to charge lower hourly fees for their services. But while using the services of a signer may seem economical, the lack of training, education, experience, and learned collegial knowledge makes their services ineffective and potentially harmful to both the d/Deaf client and clinician.

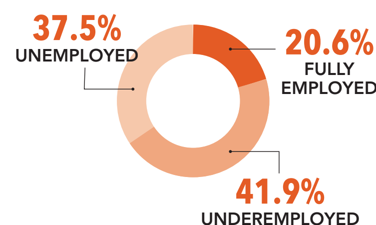
With a population of over five million people, B.C. has an estimated

500,000

people with some form of hearing loss.

Employment Status of d/Deaf Canadians

(CAD, 2014)



Many people use the word "hearing impaired" to describe hearing loss and think "Deaf" is insulting — thinking of Deafness as a disability — but the Deaf community prefers to be referred to as such. To say "hearing impaired" is a negative medicalized view of an aspect of their being that is a part of their cultural identity, so in most cases, using the word Deaf is most respectful. Even more respectful is to ask them how they would like to identify and talk about their hearing loss.

WORKING AS A TEAM WITH A REGISTERED SIGN LANGUAGE INTERPRETER

I often say that a therapist is only as good as the interpreter they hire. A therapist can be an expert in a field of practice but hire a novice interpreter in their sessions and be ineffective. It is crucial to work with a qualified, experienced interpreter and be diligent before engaging their services in understanding their credentials and ability to work in mental health settings.

Developing a working alliance, rapport, and so many of the foundational aspects of our practice are dependent on relationship. When our approach must be spoken through another individual who does not have the same professional training as we do, we need to be sure we are investing wisely for our own professionalism and the success of our clients.

In addition to considering how the sign language interpreter will affect the working alliance, a counsellor should also consider the accuracy of information and the nature of the interpreting process by checking in with the client frequently for understanding and having pre- and post-session discussions with the interpreter about their theoretical framework and clarify goals of therapy.

HOW TO SELECT AN INTERPRETER

An interpreter that both counsellor and client are comfortable with will support the therapeutic process. Knowing the right questions to ask before engaging an interpreter's services will be helpful in determining best fit. Asking about experience in mental health, sharing your theoretical framework, and asking questions about their knowledge and background will help make these determinations. Also, ensure they are a registered member of WAVLI by asking to see proof of membership.

PROVIDING EFFECTIVE AND INFORMED SERVICES

The d/Deaf community faces multiple barriers to mental health services but has an equal right to access services. The most effective way for counsellors to work with the d/Deaf community is two-fold: understanding that, in our society, a d/Deaf person is seen as a disabled person, balanced with recognizing that Deafness is a rich cultural identity with members viewing themselves as a cultural minority. Consulting with clients regarding the acceptable provision of services and ensuring sign language interpreters are qualified and professionally registered mitigates the feeling of difference and brings d/Deaf people into the fold of their mental health service provision. Framing practice from this informed perspective, counsellors must advocate for access and inclusivity and prepare to work with sign language interpreters as colleagues. ■

Susi Bolender works in private practice counselling and consulting, advocating for access and inclusion and advocating for advancement of Sign Language Interpreter training specific to mental health.

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YOU HAVE WORK TO DO

A FATHER'S MESSAGE

AN RCC'S EXPERIENCE WITH THE DEATH OF HER FATHER IN A CARE FACILITY DURING THE PANDEMIC

BY ALEXANDRA COPE, RCC

"I do not want to hear that you love me. I have been abandoned. I no longer have a family." Then, he hung up. That was the last conversation I ever had with my father. At that time, he had just been moved to a transition long-term care facility. The hospital he was in required all beds to cope with COVID-19 patients. The long-term care facility we had painfully chosen to best care for the 85-year-old leader of our family could not yet take him.

I could not call him back because he had no phone. COVID-19 restrictions prevented us from having one installed. We could not visit. We could not send his favourite homemade cookies, photos of his family, music from Leonard Cohen or Neil Diamond, Sudoku puzzles, or his treasured history books. By that time, his vascular dementia had progressed to the point that he needed to be reminded every day why nobody was there, why nobody could come. He did not understand. He felt it was his fault.

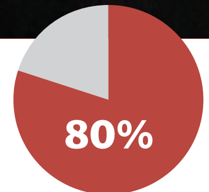
We could also no longer be with him to witness and advocate. To make sure his bedding and clothes were changed. To make sure he was being treated with respect. To make sure his medications were being adjusted as needed. To make sure he was not being asked the same questions over and over again with each shift change. To make sure he was being heard. As a result of COVID-19, we were not there when his staff thought it was appropriate to remove the walker and movement monitor from his room. They clearly did not spend the five minutes required to see that my dad was an independent spirit who would, of course, try to get up and dress himself. One morning, my father fell after getting up unassisted. He broke his hip so badly that he needed surgery. He made it through the surgery but became unresponsive in the recovery room. My father died the next morning. My mother and two of my siblings were allowed to visit him in the hours before his death, but COVID-19 prevented my brother and I from travelling. We were not able to be together as a family for our father's final transition.

HOW WE CARE FOR OUR ELDERLY

The way my father died and our family's experience with this country's geriatric care added trauma to our grief experience. My father spent the last year of his life in mental anguish. Much of this could be attributed to his illness. However, his anguish and desire to die were exacerbated by his experience with our geriatric systems. My father felt stripped of his dignity, autonomy, and right to choose. He felt dismissed, forgotten, and discarded. It has been very hard to process and integrate my dad's final journey. There has been emotional distancing. There have been nightmares. Healing has come only when I connect to our relationship, to who he was prior to his illness. I have found comfort in the belief that he and his essence are now safe.

My dad often expressed to me that the treatment of the elderly and vulnerable in care was disgraceful. In these conversations, he was usually referring to other people in the facility. My dad always had empathy for the underdog. He spoke about his roommate, a man who never received any visitors. He would spend hours screaming "Je suis seul!" — French for "I am alone." He always wanted yogurt to eat and would express it quite clearly. He was never offered yogurt to eat. He chose to not eat at all.

My dad spoke about a smart Parisian lady. All she wanted was to be able to



By May 25, 2020, more than **840** outbreaks were reported in long-term care facilities and retirement homes in Canada, accounting for more than **80 per cent** of all COVID-19 deaths in the country.*

* Pandemic Experience in the Long-Term Care Sector: How Does Canada Compare With Other Countries? June 2020. Canadian Institute for Health Information.

https://www.cihi.ca/sites/default/files/document/covid-19-rapid-response-long-term-care-snapshot-en.pdf?emktg_lang=en&emktg_order=1

Our dad tried to make a run for it when we took him out for a walk. He did not want to go back. He just wanted to go home. His rebellious move resulted in his outing privileges being taken away.

"My father was larger than life."

make decisions for herself. Why did she have to eat at 11 a.m. when she was not hungry then? Why was she not allowed to stay in her room if she wanted to? Why did she have to smuggle in Oh Henry bars? Why could she not have a say about the facility at which she was being forced to live? Her anger was palpable.

Our family noticed how hard it was to get information from the care facility. It was nearly impossible to gain traction or to be seen and heard. Doctors and staff rotate from facility to facility. Patient information did not seem to be shared amongst staff. My father was being asked to share his story over and over again. He was told to wait. He was asked to repeat the same tests. He was told to wait. He was passed off to other staff. He was given the same dismissive advice. He was told to wait. He was often cut off and interrupted. He was often talked to like he was a toddler who could not hear. He was told to wait. My father was so frustrated he once slammed his head against the wall so hard that his face turned black and blue. Losing him was hard enough. Seeing him suffer this way was tortuous. Our family felt helpless and defeated. At times, it was very dark in our grief.

A CRISIS THAT PRE-DATES COVID-19

My father was larger than life. He was the lynchpin of our family and set the tone for behaviour. He taught me about discipline, integrity, loyalty, and fairness. He tried to teach me about reason, but I think I helped him learn about feelings instead. We almost lost him nine years ago to cancer. Our relationship grew closer after that. We did not take our time together for granted and did not leave things unsaid. We were very connected. I felt safer because my dad was in my corner. I knew he was proud of me. Gratitude helps me tremendously in my grief. It feels light against the heavy.

One gift my dad and I shared was the propensity to rise when all the chips are down. We have never been able to keep our heads down for long. We shared the ability to connect to hope when needed for ourselves and our loved ones. We discussed this one time. I used to think that everybody had this ability, and it was just the happy ending to every story. I learned painfully that the world does not work that way. I became a counsellor so I could share hope with those having a hard time connecting to it. I have carried some anger in my grief because it felt like my dad died with his head down. It felt like he chose to keep it down because he did not want to connect to hope. He did not want to be in this world anymore. Could different care have made a difference?

My sister and I spoke about this after a particularly difficult visit at the care facility. Our dad tried to make a run for it when we took him out for a walk. He did not want to go back. He just wanted to go home. His rebellious move resulted in his outing privileges being taken away. He had even fewer choices.

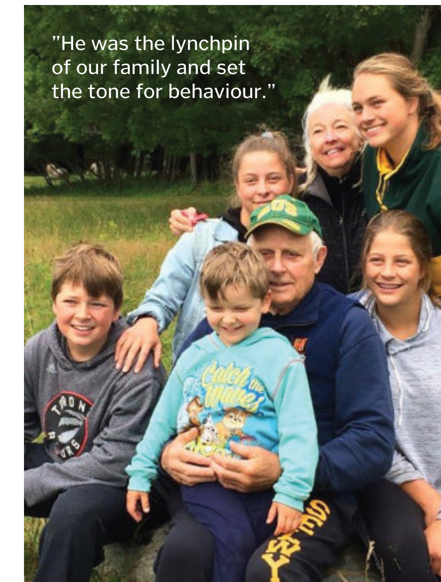
Our dad loved nature and gardens. I am sure he was not the only one. Where was the community garden in this type of facility? Surely, volunteers and donors could make something like that happen if there are funding shortfalls. Where was the call for volunteers to come and visit with elderly who do not have family or who just need someone to listen, help them with puzzles, or read with or to them? Where was the library or the place to be creative? Where was the exercise room? Where were the emotional support animals? Where were the counsellors attending to the emotional well-being of the elderly in our facilities?

Individuals and families need empathic and accepting help with the extremely difficult adjustment to long-term care. Where is the trauma-informed practice? When someone's life has changed so drastically, the priority should be building safety, respect, and as much choice as possible. Our elderly built our families and our communities. There is so much value in their lived experiences. We need to listen. Even if dementia takes away the ability to share, wisdom can still be found in presence. During one of our conversations, my father said to me, "Alex, you have much work to do. People cannot be discarded like this." He said this before COVID-19 came along.

GRIEVING MY LOSS

There is so much vulnerability in grief. It feels like your heart has been cut open and all your love is bleeding out. There is such a need for tenderness, compassion, and connection. COVID-19 meets that need with fear, harshness, and isolation. It forces disconnect and interrupts the natural flow of healing.

COVID-19 brought many of the atrocities of our geriatric care systems to the forefront. My father's care made him feel sub-human, yet somehow, I am left heartbroken by the fact that he was one of the lucky ones. He had some care and was not subjected to COVID-19 outbreaks. He was not just left to die in disgusting conditions. Some of his staff members were angels, like the one who let part of our family be with my dad that last day, so he did not have to die alone.



"He was the lynchpin of our family and set the tone for behaviour."

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My grief process started well before my father died. I internalized that he was fading and growing tired long before the dementia took over. The grief came in multiple waves. Some waves showed up as sadness, others as terror, and some even presented as gratitude. I found coping with these waves to be overwhelming at times.

When the dementia started to come to the forefront, I enlisted the help of a beautiful counsellor. We worked with imagery because words could not always express how much I was feeling. She helped me to find safety within myself and to keep the energy moving. I am most grateful to her for helping me fight for my connection to my father and to not let it go. She encouraged me to meet him where he was and to hear the feelings behind his often-strange words. She invited me to trust the empathy I had for what he was experiencing and to use it to understand and speak on his behalf. She never once dismissed his voice because he was elderly and living with dementia. She helped me to continue beyond any final image, thought, or feeling to a different and more peaceful and therapeutic place. With her help, I became able to navigate the loss of my dad by accessing our connection as well as the love and hope that transcend dementia, COVID-19 restrictions, and even death.

In the very early morning before my father died, I awoke to a sense of peace that I had never before experienced. It was like all anxiety, tension, and stress had left my body, and I could be fully present. It remained even after my sister called to tell me that my dad had passed. It remained for that whole day. I now believe that it was my dad's way of saying goodbye to me and letting me know he could now, finally, once again lift up his head. ■

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THREE THINGS YOUR CLIENTS OF COLOUR WISH YOU KNEW

BUT ARE TOO UNCOMFORTABLE TO TELL YOU

Some of the most common complaints Black clients have about their experiences with white counsellors

BY R. CHRISTINA FENTON, RCC

Counsellors are called to their profession out of a genuine desire to help others. It is rare to hear someone say they entered into the field of psychotherapy for simple curiosity or by accident. We also have to train very hard to acquire the skills necessary to be a competent counsellor, which often entails digging into our own baggage to ensure our burdens and biases don't negatively impact the vulnerable people we serve. However, counsellors are still people. We have our blind spots, our shortcomings, and sometimes, genuine ignorance about the populations we work with.

The experience of navigating the world in Black skin is a constant bombardment of messages that tell us we don't belong.

Growing up in the Caribbean where there is a lot more racial mixing, I never noticed race very much. There is more of a "colourism" issue where I grew up in Jamaica; that said, for the most part, race relations are amicable. Moving to Canada was an eye-opening reality for me which made me question everything I thought I knew about the world generally and race relations in Canada in particular. For the first time, I understood from a felt place the reality of what it means to be a minority. This experience forced me to shed light on an issue within the field of counselling psychology which must be addressed by those of us within it.

Recently, I have heard a few recurring themes from my clients of colour who have sought me out specifically because I am an Afro-Indo Caribbean woman. Many have seen Caucasian Canadian counsellors before and found themselves not being able to discuss their problems in an authentic manner because of the racial divide. Even with the best of intentions, they report, their counsellors just don't understand them.

Since there is no way that a few counsellors of colour can serve the entire population of people of colour (POC) in Vancouver, I thought it would be helpful to share some of the themes coming from conversations I have had with my clients to promote discussion and awareness amongst my non-POC colleagues. I have chosen to highlight some of the most common complaints I have heard over the past three years, and I hope that, from this, we can start to reform the field to include and address the needs of Black clients.

RACISM IS REAL, EVEN IN THE FIELD OF PSYCHOLOGY.

Most of the people who developed the field of psychology were white, cis-gendered, heterosexual males of European ancestry. Their assumptions about how things are or ought to be were shaped by their particular experiences and worldview. For example, the concept of the "family" within most psychotherapy training is based on the concept of a man, a woman to whom that man is married, and their dependent biological offspring. Deviation from this structure has historically been seen as abnormal

For centuries, the concept of the nuclear family as a unit of society has prevailed, often to the exclusion of other types of families.

or, at best, alternative to the established ideas of psychotherapy's founding fathers. For centuries, the concept of the nuclear family as a unit of society has prevailed, often to the exclusion of other types of families.

In the Caribbean in particular, as well as in other ethnicities of colour, the nuclear model fails to represent our experiences: we tend to have an extended family structure, usually matrifocal in nature, with the involvement of grandparents, aunts, uncles, long-time family friends, and cousins. In our societies, "aunty" and "uncle" are terms not reserved for biological relatives but for any adult closely affiliated with parents who interacts with and cares for the child. Some of these aunts and uncles become part of the family as there is a greater sense of community in the Caribbean than there is in North America.

For this reason, the North American notion of development as a progression toward a more-or-less complete separation from one's family unit is fundamentally at odds with these cultures, where people live interdependent lives, where they may no longer cohabitate with their family of origin but retain strong ties to their communities and extended families across the lifespan. When your clients of colour tell you they feel lonely and displaced, this may be what they are alluding to. The expectation of isolation and self-reliance to flatten the curve of COVID-19 often makes the pandemic experience far more disorienting for Black clients. In addition, many first-, second-, or third-generation migrants still have strong ties to their countries of origin and may be worried about what is happening there.

As the therapist, it is your job to enquire further about their particular culture and what a sense of community looks like and to do so with respectful, yet non-intrusive curiosity. Remember, it is our job to see the world through the client's eyes rather than expect them to conform to ours. Please do not assume or resort to stereotypes. Your client presents as Black, but their ethnic group is more important than their race. This has been known to happen for people who are of African origin where tribes are more important than nationality and for Caribbean people whose cultures are diverse even though there is geographical closeness.

MENTAL HEALTH STIGMA IS A SERIOUS PROBLEM WITH DEEP ROOTS IN GENERATIONAL TRAUMA.

For colonized or formerly enslaved people, there is a lot of distrust in the idea of talk therapy as "white and oppressive." This is because traumatized people are constantly in survival mode. The African slave trade stole people from their homes, and cultural as well as physical genocide occurred for our ancestors across hundreds of years. Families were ripped apart and people were forbidden to speak their languages and were branded (often literally with hot irons) as animals rather than being seen as people.

As we already outlined, the assumptions about family structure by those who developed psychology as a discipline cast the family structure of Black families as abnormal. This is compounded by the racism inherent in the field of medicine wherein half of the people who train in the medical profession believe racist myths that minimize the pain of Black people. Such myths include the idea that Black people have thicker skin, less sensitive nerve endings, and blood that coagulates faster than white people. These harmful myths persist up until today[1] and extend not just to physical pain, but to psychological distress as well.[2] It was once believed by slave owners that it was okay to separate newborns from their mothers because "the negro" did not experience grief in the same manner that whites did.

In situations like this, especially when the descendants of colonizers and slave owners minimize, ignore, or at worst, deny racial trauma, it is not hard to see how a client would feel distrustful. The experience of navigating the world in Black skin is a constant bombardment of messages that tell us we don't belong. It is filled with situations in which we are required to wear a mask in public to hide who we are and to turn down our Blackness so as to not be seen as threatening by white people. Even if we are born in Canada, we are assumed to be of immigrant origin in an othering manner to which even white immigrants are not subjected. Stereotypes of the "angry Black man/woman" abound and, therefore, even in the context of therapy, where people are encouraged to address their anger, we do not feel comfortable doing this with someone from a group we have been conditioned to perform for.

When clients come to see me, the first thing most of them disclose is that they feel like they can finally take off the mask and express everything they need to without fear of bias or judgement. It is heartbreaking to witness and yet, as a Black woman, I know I provide an essential service to this racialized group. The problem, though, is that there are so few Black therapists operating in B.C. that it is almost inevitable that many members of the community must seek service from white providers out of necessity.

BLACK WOMEN CARRY WAY MORE THAN THEIR SHARE OF EMOTIONAL LABOUR IN THEIR FAMILIES.

The stereotypical strong Black woman comes as a result of being thrust into the position of having to be all things to all people as our men are incarcerated, killed, or simply absent from the home. Even Michelle Obama has written about what it was like to be denigrated for simply being Black, a sentiment expressed by many people in relation to Meghan Markle's treatment by British media.

Moving to Canada was an eye-opening reality for me which made me question everything I thought I knew about the world generally and race relations in Canada in particular.

During slavery, the family structure was systematically dismantled, and the men were removed. Women had to do not just the field work and house duties but were also required to act as wet nurses for white women who did not want to ruin their breasts by breastfeeding their own children. These Black women were forbidden to nurture their own children and were expected to cheerfully sacrifice themselves for (white) others. This endures in the figure of Mammy in *Gone with the Wind*. This caretaking, self-sacrificing Black woman is presented as content with a life of enslavement.[3]

Even today, Black girls are sexualised far earlier than white girls even though this phenomenon goes against the World Health Organization's definition of sexual health and sexual rights.

In our families, we are the glue that holds things together despite our own exhaustion. We are relied upon by everyone, often at the expense of ourselves. It is no wonder then that the social determinants of health work against Black women's reproductive health and the outcomes for our children. The disparity between Black and white infant mortality rates in the US cannot be ignored. Black and Hispanic women have two to six times more chance of dying from pregnancy-related complications than white women.[4] It is well known that infant mortality rates among Black women are higher in every state of the US because of the systemic racism to which women at all levels of the socioeconomic spectrum are subject.[5]

Black women were also branded as "inherent whores" and endured 500 years of rape and forcible breeding to produce more slaves for the plantation master. It was illegal for Black women and girls to refuse the sexual advances of those who owned them. Even today, Black girls are sexualised far earlier than white girls[6] even though this phenomenon goes against the World Health Organization's definition of sexual health and sexual rights.[7]

Conversely, Black men were branded as "inherent rapists," who would prey upon vulnerable white women who should be protected at all costs, often in very brutal ways. This is certainly evident today in the numerous shootings of Black men in the US. Black women are their mothers, wives, sisters, and daughters, and they are expected to carry their pain stoically, because to stand and say "Black Lives Matter" is problematic for white society.

When working with Black women, it is very important to help them access their internal emotional experiences as many of us are divorced from our feelings, because we have been forced to be all things to all people. The word therapists are likely to hear from Black female clients when describing their internal world is "tired." This tiredness is wrapped up with the unspoken grief and loss that this group carries. It would be helpful to explore what the concept of tiredness means to start helping them to tease out the underlying emotions which they have suppressed to survive.

THIS IS YOUR WORK.

Finally, I would urge all my colleagues to remember that for Black clients, Canada is a very unwelcoming and dangerous place, especially since Canadians deny their racism. The sight of a Confederate Flag or a MAGA hat in downtown Vancouver triggers our trauma. For us, maintaining a blank expression and simply walking past someone displaying these symbols of racial hate is a major act of resistance. Inside, we are quaking in our shoes, because we know our very skin is seen as a threat despite our age, gender, or country of origin. Remember that it is not our fault that the world views us this way and that it is not our job to educate you in our history and how to view us. That is your work.

What you can do is to make sure you don't recoil from us when we broach race with you. Do not deny our experiences or try to explain them away. This is not helpful, and it gives us the message that, yet again, our lives don't matter. Instead, try to understand that our experiences are real even if you have never shared them, and validate the feeling instead. Don't refer to your one black friend, your love of Barack Obama and hip hop, your allyship, and definitely don't act like we did not just say something about race.

In Canada, particularly, there is a widespread tendency to just stay quiet and ignore conversations about race because of an inability to tolerate the inherent discomfort of such conversations and the assumption that Canada isn't racist. Don't do this. It is most invalidating. As therapists, it is our job to model leaning into discomfort for the benefit of the client. Avoiding your own discomfort around race tells your clients you don't care about them and it tells your Black colleagues not to trust you. I cannot count the number of times I have experienced this personally nor the number of times clients have reported it. Instead, learn to tolerate discomfort, find Black colleagues who are willing to help you understand, but come from a place of humility with a recognition of your privilege.

Please do not think that Canada is not racist and that, somehow, Canadians are better than their southern neighbours. The Japanese internment camps and the cultural genocide of the Indigenous people are clear evidence that racism is part of the fabric of Canadian society. You may not have participated in the Trans-Atlantic Slave Trade, but racist immigration laws against Black member states of the British Commonwealth and ridiculous language requirements for immigrants from these countries exist. If the Prime Minister can name Canadian racism, so can you.

Canadians engage in microaggressions when they assume that Black foreigners escaped horrific lives in their countries of origin. They do it when they ask "Is your country a dictatorship? Do women have rights in your country?" etc. Read about the country of origin of your clients and educate yourself about their history. Learn to accept the reports of those who work with POC clients as true whether or not you experienced it. Please do not act surprised when your Black client discloses that they have a white partner. If you feel shocked, you need to ask yourself why.

There is so much more to say about this timely subject, but this is a start. On a hopeful note, no one expects you to just *know* what to do. We hope you would be transparent with your ignorance and seek understanding instead. Your clients will appreciate it, and you will find it easier to connect with them. ■

R. Christina Fenton, RCC, is a recent Caribbean immigrant. As a BIPOC, she relates to racialized groups recognizing systemic oppression and its effects on immigrants and refugees. She is happy to be contacted through her website www.rchristinafenton.com.

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A PANDEMIC OF GRIEF

PROCESSING THE LOSSES OF COVID-19

We are certainly living in unprecedented times. The COVID-19 pandemic is affecting us as a global community, and even though we are finding comfort in statements reflecting that we are all in this together, the uncertainty is wreaking havoc in our individual daily lives.

BY TAMMY BARTEL, RCC

As human beings, we desire certainty, and this pandemic is shining a spotlight on the reality of how little we can control when faced with a crisis of this magnitude. This uncertainty is generating a whole spectrum of emotions from feelings of anxiety and fear to shattering assumptions of being safe and secure in our world. Each day, we are bombarded with new information adding to the layers of complexity and the initiation of many unfamiliar feelings. Amidst the changes to what was normal and somewhat predictable in our lives, we are facing losses of all kinds.

DEATH AND NON-DEATH LOSSES

"Grief is a response to losses that are death and non-death related. [One] does not have to lose a loved one to death in order to grieve; grief can occur with the loss of hopes and dreams, and with the loss of self that may accompany life-altering events."[1]

The COVID-19 pandemic has been a life-altering event, and many are feeling the weight of grief. Grief is the response to a death, but many don't realize that grieving is necessary whenever there is a loss of any kind. Living in a world with COVID-19, we have been forced to face the unimaginable: the loss of the world as we once knew it. Every person is experiencing loss coupled with uncertainty, as we don't know what each day will bring. This has rocked the very foundation on which we stand. One day, everything is going along fine and the next, we are in lockdown.

Darcy Harris, PhD, a grief expert, shares in a recent interview, "When events happen that don't make sense, our assumptive world is somehow violated. If things don't go back to what they were, we must grieve the loss of these parts of our lives."[2] These losses include loss of normalcy, routines, jobs, income, connection, security, loved ones, and many more. How are we to be in a world that has changed so much, when life's familiar rhythm no longer anchors us in safety and security?

As clinicians, we are experiencing our own losses, as well as trying to hold the space for our clients and what they are experiencing. Each client has a unique story, a unique

Grieving is a necessary process, and we need to be open to encounter it in our own lives and with our clients. It's the only way to come out healthier on the other side of this.

set of losses, and these losses impact them in different ways. For the death losses, there is finality and a known loss, but COVID-19 has added a new set of circumstances to further complicate an already devastating time. Many have not been allowed to see or be by the bedside of their dying loved ones. The deaths have been sudden, family members have felt helpless, traumatized, and some are experiencing survivor's guilt. Having a loved one die is already difficult, let alone not being able to be with them for those final hours. The injustice will intensify the grief.

Non-death losses are less defined and depend on the person and how they respond. These losses are unique in that they are subjective and often ambiguous. Each person will see the loss in a different light. There are many variables to consider. Some have more work than they can manage, others have lost their job; some are health care and essential workers putting their lives at risk every day, others are at home in isolation. Fear, anxiety, and depressed mood are rampant. The complexities and layers for each client are unique and require individual assessment. Processing these losses is vital and central to our work in this time of crisis.

UNDERSTANDING THE GRIEVING PROCESS

"Loss, change, and death are all universal human experiences, and each one of us will become intimately acquainted with the grieving process at many points throughout our lives."[3]

Even though this statement is true, we are often ill prepared. Many of us have been taught to avoid grief, pain, and sadness at all costs. We are known as a death-denying society,[4] and this has not served us well. We are flooded with messages of positivity, which are great to help pick us up when we are down, but often invalidate a person's lived experience of suffering. One of the most important aspects to keep in mind about grief and loss is that grieving is a normal, natural, necessary process. When we lose something, there is a felt loss, and in order to integrate this loss into our lives, we are required to process and grieve it. The process involves telling and retelling the story to others who can hold the space for, validate, and bear witness to our pain and suffering. It involves feeling all of the feelings and being allowed to grieve. Grievers do not need to be fixed, and losses cannot just be accepted and moved on from. Grief needs to be shared. Grief requires compassion, empathy, and attention.

I have compiled a list of what we know about grieving from research and practice in the field of death, dying, and bereavement to better understand the grieving process:

- ♥ Grieving is a normal and adaptive process that needs validation.
- ♥ Grieving includes the full spectrum of emotions: sadness, anger, guilt, regret, anxiety, depressed mood, etc.
- ♥ Grieving is unique to each individual; there is no right or wrong way.
- ♥ Grieving never ends; it is a life-long process that continues to unfold for years.
- ♥ Grieving is not linear and does not follow specific stages.
- ♥ Grievers have a right to talk about their losses; grieving is a healthy part of life.
- ♥ Grieving requires a turning towards the felt loss.
- ♥ Grieving requires caring, acceptance, and understanding from others.
- ♥ Grieving involves integrating the loss into one's life.
- ♥ Grieving can be facilitated through rituals, remembrances, and continuing bonds with loved ones.[5]

GRIEF THEORY AND MODELS

There are many theories and models from which to look at the grieving process. I will highlight one called Grief Therapy as Meaning Reconstruction (GTMR) based on Robert A. Neimeyer's Reconstruction of Meaning theory.[6] Neimeyer just recently opened a training centre in Portland called the Institute for Loss and Transition (www.portlandinstitute.org). I highly recommend this facility if you are interested in taking courses, workshops, or the full certification in grief therapy.

GTMR consists of three basic components:

1) Assessing for adaptive versus complicated grief;

2) Processing the event story of the death; and

3) Accessing the back story of their relationship to the deceased.

GTMR uses a variety of narrative and artistic tools to encourage grievers to reconstruct meaning in a world without their loved ones, and at the same time, build the continuing bond relationship with the deceased person. Numerous techniques in each component help clinicians direct clients in processing their losses.[7]

Since taking this training, I always think of these categories in how I will work with my clients. Sometimes, we begin with the client sharing about their loved one, and other times, we begin with the story of how their person died. I listen for the love story, I listen for the suffering, and I direct the client to turn towards the loss, and together we face the pain. We walk together in these sacred spaces trying to make sense of the incomprehensible. Processing the death event story, getting to know their person, and helping clients decide how they want to carry their loved ones with them (continuing bonds) is a significant part of this integration.

We can apply this model to non-death losses as well, in helping clients name their losses, discussing how the loss has impacted them, and processing these aspects with the client. Usually, there is an event and a relationship that is lost even in non-death losses.

HOW TO GRIEVE THE LOSSES OF COVID-19

- › **Keep the 10-item list that we know about grief at the forefront (page 24).**
- › **Name your losses; help your client name theirs.**
- › **For death losses, get to know the person who died; say their name.**
- › **Talk about the loss; share it with others who are good listeners.**
- › **Tell and retell the loss narrative.**
- › **Tune into the pain.**
- › **Feel the feelings, all of them.**
- › **Express the feelings with words or other creative processes.**
- › **Journal about your experiences.**
- › **Look for meaning through restorative retelling.**
- › **For death losses, facilitate continuing bonds with the person who died.**[8]
- › **Commemorate with rituals and remembrances.**[9]

APPLICATION

So how do we put this into action? We begin by having the courage to look at our own losses. We boldly ask people how they are doing. We listen and empathize. If it's a death loss, we ask about their loved one by name. If it's a non-death loss, we listen to how this loss has impacted their life, and we validate and empathize. We hold the space and allow others to feel what they are feeling. We don't correct them or respond with empty platitudes. One of the most difficult things to do is to listen and not say anything. This is essential if tears flow. Remember, we cannot fix the loss, we cannot make it better, but we can be with them in the pain, in the fear.

We can also make space in our own lives to feel our feelings. Fear, anxiety, and depressed mood are all part of grief. In grieving any loss, giving ourselves permission to grieve is essential, and when it comes, we allow it to be, we talk about it with

safe people and/or counsellors, and we express it.

Many people have told me they are afraid if they start crying or start feeling, it will never stop. We know that just isn't true. It's not always easy, but the more aware we become of our feelings, the more we can regulate them. And when we are validated, we learn that others care about our pain and suffering, and it softens it, and we don't feel so alone in the world.

Grieving is a necessary process, and we need to be open to encounter it in our own lives and with our clients. It's the only way to come out healthier on the other side of this.

RITUALS AND REMEMBRANCES

"When words are inadequate, lean on ceremony."[10]

Rituals and remembrances are so important in the grieving process of death and non-death losses. When the world feels out of control, rituals provide order in the midst of the chaos. A Harvard study in 2014 looked at the impact of mourning rituals after losses of loved ones and lovers and found that rituals, in all cases, mitigated grief through regained feelings of control. Engaging in rituals helps people feel more grounded and connected to others. Grief rituals and remembrances are a key part of the grieving process.

"Mourning activities help us make the painful but necessary transition from life before the death to life after the death. Our grief is our love in a new context and like our love, sharing it and expressing it in ways we find comforting or meaningful as much as and as often as it tugs at us — makes all the difference."[11]

Ceremonies foster healing after traumatic death and will be essential in response to COVID-19 circumstances. Every time we have a ritual or remembrance, it helps us process and integrate the loss a little more.

THE LONG ROAD AHEAD

"How we survive this pandemic depends on how well we take care of each other during this time."[12]

There is a long road ahead in walking alongside, holding the space for, and witnessing the very difficult things that our clients will have experienced. The losses due to COVID-19 are still occurring — they are pervasive, and too numerous to count — but one thing we know for certain: we will spend a lifetime processing them.

A Harvard study in 2014 looked at the impact of mourning rituals after losses of loved ones and lovers and found that rituals, in all cases, mitigated grief through regained feelings of control.

Let's take a deep breath together, vow to process our own losses and make time for self-care. This will better enable us to hold the space for others who will desperately need us in the years to come. The mental health of our communities depends on it. ■

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SELF-CARE FOR COUNSELLORS IN LIGHT OF COVID-19

Typically, caregivers are not great at taking care of themselves. Now more than ever, we must ask ourselves if we are taking care of our own needs as well as the needs of others. The COVID-19 pandemic has added a huge load to most mental health care workers. Many are busier than ever; others are finding it difficult to switch to tele-health platforms. And most recently, we have been faced with decisions of whether or not to see clients in person. Some have already navigated this, and others are waiting.

These are really difficult decisions to make. We are living a moment in history that is unprecedented with looming uncertainty of what lies ahead. It is essential to step up our self-care practices to prepare for what is to come.

The most significant thing I have done for my personal self-care has been to set up a sacred space for me: my own calm corner.

The most significant thing I have done for my personal self-care has been to set up a sacred space for me: my own calm corner. I recommend this to all of my clients, and I recommend it to each one of you. Begin by finding a place in your home or on your deck. I have a spot on my deck I have claimed as my own. It overlooks a green space and has become my refuge. I have a wicker chair with comfy cushions and an ottoman. I also have a beautiful, soft, cuddly, lumbar pillow. I have used this chair as my place of rest for three years now, and I wouldn't trade it for the world. I also have a favourite blanket, a favourite mug, and essential oils for grounding when I am in my space. Every time I sit there, I take in a few deep belly breaths and feel the weight of the world lighten just a little. I can breathe in this space, I can cry in this space, I can zone out in this space. This space holds me when everything around me is spinning out of control. Sometimes I sit out there too often. But maybe it's just enough.

10 self-care must do's for uncertain times

1. Get rest whenever possible.
2. Stay hydrated and eat reasonably well.
3. Connect with others (hug those in your circles often).
4. Establish routines but expect disruptions.
5. Express yourself.
6. Be kind to yourself and others.
7. Limit media intake.
8. Breathe; practise calming strategies daily.
9. Move; repetitive movements can be self-soothing and self-regulating.
10. Set up your own calm corner.

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SHIFTING TO ONLINE

COVID-19 forced many people to re-think how they work. For many RCCs, that meant moving their practices online — and some are going to stay online.

BY CAROLYN CAMILLERI

When Heather Pattison, RCC, first started working with her clients online, she didn't expect to like it. She works at a multi-disciplinary child-development centre in Kelowna that offers a range of programs, including clinical counselling.

"That's me four days a week," says Pattison, who has been in the position for nine years. "I take internal referrals from our centre, so if somebody else in the team identifies a family that could use some mental health support, then they send them my way. It might be focusing more on the child, or it may be focusing more on the parent or parents."

Pattison's work has always been face to face — until COVID-19.

"When we couldn't see people face to face, as an agency, we had to transition massively for everybody to work at home," says Pattison. "I would say that my work probably transitioned to home more easily than most people, because I could do so much work with parents. A physiotherapist really needs to see a baby or a younger child and do the work hands-on, but I can transition really easily to working with parents."

Turns out, she likes working online.

"I found the Zoom sessions to go really well and have been very successful, and the work gets done," she says. "I feel comfortable connecting with even new clients, meeting them for the first time over Zoom. It just feels very natural. And I like working from home."

So far, her clients mostly seem to like it, too, and are adapting quite well. "It's interesting getting the feedback from clients. I just assumed clients wouldn't like it as much, but when I ask, 'How is this working for you?' I've had a lot of clients say they even prefer it."

Some clients commented that they find it easier to open up when they are at home, and others like the flexibility of being able to be in different locations, especially for those in couples sessions.

While Pattison did have some experience with Zoom previous to COVID-19 — as a participant in meetings and online courses — she had never been the person setting up the sessions.

"I didn't find Zoom that challenging to figure out, and I think by the time I was contacting my clients, they had already figured out Zoom, because everybody's life went on Zoom," she says.

SO WHY DIDN'T WE DO THIS YEARS AGO?

While the big push towards online counselling has come largely in the wake of the pandemic, many people hesitated to even try it until they had no choice.

"Uncertainty and fear of change are the main reasons I believe people avoid working digitally," says Amanda Poitras, RCC. "I believe that with adequate exploration and open mindedness, these fears can be addressed, and solutions can be found."

Poitras is the director of Strength Counselling Services, a practice she built in 2010 in Alberta. When she decided to move to Victoria, she checked her ethical requirements, then invited her clients to join her online — and about 80 per cent agreed. That decision sparked a journey that turned Strength Counselling Services into a team of 14, including leadership, clinical, and marketing divisions.

Poitras says supervision is a key part of resolving fears about digital counselling.

As a culture, we have all become more technology based, and digital services speak to that demand and comfort level.

"For example, seeking supervision from a counsellor who is experienced in the field of digital counselling can help alleviate these fears and help people become familiar with this new way of offering therapy," says Poitras, who specializes in eating disorders, addiction, and gender identity/sexuality issues.

Another holdback is the misconception that connection cannot be made the same way in a digital setting.

"I would encourage clinicians to look to the growing body of research out there demonstrating the effectiveness of digital services to help alleviate their fears and, perhaps, some of the misconceptions of digital services," Poitras says.

And she has had personal experience with those misconceptions: "I was told by mentors and colleagues that I would not be able to grow and sustain a digital practice."

And yet, over the past 10 years, not only has she grown her practice, she and her team have become proficient at navigating the pros and the cons.

BOTH SIDES OF THE COIN

On the pro side, Poitras says they have found that a digital relationship with a client offers much the same opportunity for connection.

"We have found the relationship between a clinician and their client is the foundation of a client's ability to trust the process of healing," she says. "Through this trust, the process then enables them to walk through the difficult emotions, decisions, and actions that could be vital for their growth. This relationship, without any doubt, has been cultivated hundreds of times within this company through digital channels alone."

Poitras points out that, as a culture, we have all become more technology based, and digital services speak to that demand and comfort level.

Another positive is the convenience of attending sessions from home or work. "Removing the need for travel to a counsellor's office allows our clients to have greater flexibility with their time," she says.

Increased confidentiality and safety, the ability to acquire support when in remote communities, and the ability to choose a practitioner from a larger geographical area are other positives Poitras says their clients have come to appreciate.

"The strongest disadvantage that some clients have reported to us is the physical and geographic distance that occurs in an online practice," says Poitras. "However, we have easily navigated this with the strong working relationships we build with our clients and the sense of connection that comes with that."

Another area they have learned to navigate is that some clients do not have credit cards or use online banking, which can pose a challenge with payments.

"We believe there are always adaptable solutions, so we are continuously working with our clients to fine-tune and individualize our services to best meet their needs," she says.

Another more obvious challenge is internet quality during a session.

"We have had to troubleshoot countless times to arrive at standards of practice to avoid operational challenges due to internet issues," says Poitras. "Given that many clients become deeply vulnerable in sessions, it can be detrimental to the flow of a session if the internet connection is poor."

Sometimes internet functionality is out of your control, and you need to be prepared for that.

"For example, during a session, a storm cut the power from my home, so not only did I lose the internet, but I was also unable to power my computer," she says. "Instead of leaving the session and simply rebooking, we completed the session over the phone. The client reported that she was able to receive what she hoped for from the session despite the consequences of the power failure."

But aside from power and internet glitches, RCCs shifting to online have a few other factors to consider.

ONLINE **TIPS**

AMANDA POITRAS, RCC, HAS SOME KEY CONSIDERATIONS FOR COUNSELLORS SHIFTING TO AN ONLINE PRACTICE.

1. Ensure you are fully familiar with the digital platform you choose to use. In the event of a disruption in the session, you need to know how to resolve the issue immediately to maintain session integrity. New clients may move on if they find the digital process challenging, or if they feel the counsellor does not know how to operate digitally despite their clinical abilities.

2. Ensure you have tested your internet connection (via speed tests and test calls with friends/family) to be certain your internet will be reliable during sessions.

3. At times, internet connection issues will be out of your control, so it is vital to be aware of how to troubleshoot connectivity issues rapidly.

4. Ensure your camera and microphone offer quality picture and sound, and that you are in a location with little to no background noise as this could cause disruption.

5. Ensure you are regularly accessing supervision from a supervisor who understands digital service delivery, because not only do we have an ethical duty to monitor the content that travels through our sessions digitally, but we also ought to be monitoring how we are delivering this content.

6. Understand the needs of the demographic you work with. For example, offering digital services tends to work well with younger generations. Older generations, notably those who have not grown up in the digital era, tend to require more assistance navigating online platforms. Furthermore, older clients tend to request in-person services when offered a choice. Counsellors working with an older demographic may need to consider these factors and the suitability of digital services for their practice. Counsellors must be knowledgeable enough about the online service platform to be able to teach clients how to navigate the platform successfully.

ONLINE FUNDAMENTALS

Pattison is quick to point out that the agency she works with managed the critical background details of working online — details RCCs in private practice need to manage on their own.

"It is vital for the clinician to understand the security measures in place for whatever digital platform they are utilizing to deliver their sessions," she says.

Gaining that understanding means doing your homework and getting some training. Pattison, who is a member of BCACC's Ethics Committee and very familiar with discussions on technology standards for practice, highly recommends Lawrence Murphy's webinar on online counselling, which is available to BCACC members. In addition to covering how to manage online sessions, Murphy's webinar includes information on critical topics such as privacy, encryption, and server locations, as well as things you may not have even considered — from positioning and lighting, emergency contacts and safety, and consent to issues around who might not be an appropriate online client, where your clients are when you see them online, and who else might be in the room with them.

"I have clients who, if there are family members in the other room, are more inhibited," says Pattison. "You sometimes have to look at scheduling at different times or be more flexible, because sometimes they're talking about their spouse, who's in the next room."

Don't forget insurance, which is provided through BCACC.

"It is important to ensure that the insurance one acquires clears the clinician to work in a digital capacity," says Poitras. "There are also legally binding restrictions to consider when working with clients in different provinces and/or countries. An RCC can consult with [BCACC] and their insurance provider to ensure they are permitted to see clients digitally and further consult governing bodies of other provinces and countries if they wish to work with clients who reside in those provinces and countries where counsellors are regulated."

EXPANDING HORIZONS VIRTUALLY

While COVID-19 may have been the reason to try online therapy, many counsellors may not go back to in-person sessions even when it becomes possible.

"Offering online services does not just provide for greater flexibility for clients but also for the clinicians who provide the service," says Poitras. "It is a fun and effective way to deliver services."

For Pattison, the transition to online has allowed her to continue her work through the agency but also to expand her private practice.

"I found I really quite liked working this way [online]," says Pattison. "A former colleague and I are going into business together to do an online counselling practice."

She and her colleague have been talking about it for years, but there were always barriers such as working around her agency schedule, finding suitable office space for just six hours a week, and covering the expense of that office space.

"I was procrastinating and just never really got there, but this seemed like an opportunity to start that private practice," says Pattison. "[Online], I can do as much or as little as I like, I can do it on my day off, I can do it in the evening."

Pattison acknowledges that she is still in transition with the private work and says there is a whole other level of responsibility

"And I'm still in the process of learning about that," she says.

For counsellors considering making the leap to online, Poitras says some good resources are available.

"One I would recommend would be the *Guidelines for Uses of Technology in Counselling and Psychotherapy* published by the Canadian Counselling and Psychotherapy Association," she says. "Additionally, I would recommend anyone interested in exploring digital practice to consult with others who have ventured down this road."

Maybe a Zoom session to discuss it? ■

While COVID-19 may have been the reason to try online therapy, many counsellors may not go back to in-person sessions even when it becomes possible.

ONLINE **TEACHING**

Lisa Mortimore, PhD, RCC, has a clinical practice focusing on the reparation of early attachment injuries through a framework that weaves together attachment theory, trauma studies, affect regulation, interpersonal neurobiology, interpersonal/relational practice, somatic psychotherapy, and deepening connections to the sentient world. Collaborating with Stacy Jensen, M.Ed., Mortimore also teaches workshops, two-year trainings, and advanced practices programming for graduate-level therapists, many of whom are BCACC members.

When COVID-19 struck, Mortimore had to make some changes to how she teaches and find ways to adapt.

"We've been really fortunate to move all of our teaching online," says Mortimore. "One difference is the lack of impromptu connections that happen while training. Those are difficult to replicate — that beautiful way that community is built and connections and safety are created. We've had to find ways to build those opportunities into the training structure."

Previously, Mortimore never needed to think about teaching her courses online.

"When COVID-19 hit, I thought about the isolation and overwhelm for therapists as we all navigate the shared trauma of this pandemic," says Mortimore. Their first thought was to connect their training community.

"We offered several 'teach ins' to orient folks to transition their somatic attachment practice online," says Mortimore. "It also gave us an opportunity to teach online and see how it felt and landed."

The response from participants was positive.

"Our next hurdle was a four-day advanced practices training which sealed my belief in the potential of online training," she says.

The biggest barrier was keeping the integrity of their relational pedagogy in a virtual teaching space.

"Once we recognized that we had to plan and make space in the curriculum for explicit opportunities to connect, my heart rested, and I could further sink into online as a viable venue," she says.

The first four-day clinic was a wonderful surprise as so many gems that we hadn't anticipated emerged.

In sorting the technology, they spent hours consulting with different online providers to determine regulatory compliance and find a platform that performs in ways they need.

"This was probably the most difficult piece as there really wasn't anyone offering clear guidance, and it came down to us to decipher the route forward," she says.

"The first four-day clinic was a wonderful surprise as so many gems that we hadn't anticipated emerged," she says. "We shifted our days, offering longer breaks to mitigate online fatigue, and people took that opportunity to connect with their families, walk their dogs, do art or yoga — do what they needed to regulate their systems and integrate the material. This ultimately supported a deepening of our work together."

Mortimore says participants were surprised at how comfortable, workable, and depthful the online clinics have been, as well as at the group connection and benefits of learning in the comfort of home.

"Viewing demonstrations in split screen, which allows them to view the client just as I do and see my face as if they were the client, affords another new rich learning opportunity," she adds.

Mortimore and Jensen are also offering a two-year training online, starting in March 2021.

"As we increase our online offerings, I anticipate it will open opportunities for folks where travel and other obligations are a barrier," she adds.

Mortimore offers some final advice: "Flexibility is key as you move online, as there will be unforeseen glitches with student's internet stability, connectivity, and technological misfires that disrupt and call us to stay regulated and think outside the box to find solutions."

THE HEALING POWER OF CONNECTION WITH THE NATURAL WORLD

Kathryn Rose, RCC, and David Segal, RCC, are co-founders at Human-Nature Counselling and Consulting, which offers services in Greater Victoria, Saanich Peninsula, Sooke, and the Cowichan Valley on Vancouver Island, as well as Squamish/North Vancouver. Their nature-based therapy services are available for children, youth, adults, couples, families, and groups. Supervision and training programs for counsellors and practicum students in counselling psychology and related disciplines are also available. Learn more at humannaturecounselling.ca.

Human-Nature Counselling and Consulting is a unique counselling service grounded in the belief of the healing power of connection with the natural world. Established in 2011, Human-Nature was created after Kathryn Rose, RCC, and David Segal, RCC, met working on a collaboration between the Sooke Family Resource Society, Boys and Girls Club, and Power To Be, where they developed a multi-family, outdoor-adventure program called Family Roots, a program still being offered annually with the support of Power To Be.

In the years that followed, Human-Nature evolved and expanded into a group practice of clinical counsellors and child and youth support workers who specialize in offering nature-based therapy (NBT) for people across the life span. Along with the Family Roots program, they design and deliver numerous other nature-based group programs in partnership with municipalities, schools, and First Nations. Supervision and training for mental health care professionals and practicum students has also become an important aspect of their practice, allowing them to extend the reach of this approach.

With the current COVID-19 distancing restrictions in place, many more organizations, social service agencies, and private counsellors are exploring the benefits of NBT as a great option for serving clients in safe, effective, and meaningful ways during these difficult times.

Here, *Insights* talks to founding partners Kathryn Rose and David Segal.

Respecting and acknowledging the land you practice on is an important part of Human-Nature's approach to NBT. Tell us more about this.

A critically important aspect of NBT is negotiating the reality that the lands upon which we do our work, in many cases, are the unceded traditional territory of First Nations people. In my specific case [Segal], I am grateful to practice on the traditional unceded territory of the Songhees, Esquimalt, Tsartlip, Tsawout, and Tseycum Nations. This is a crucial topic to consider as many First Nations people have been forcibly removed from their land and the earthways and lifeways that have sustained them for centuries. It is something we strive to ensure we are paying attention to in our work by constantly asking ourselves some hard questions: How is it that we have been granted access to these lands? At what cost to other people? Who are the First Peoples upon whose land we are uninvited guests? What can we do to support efforts of reconciliation and decolonization?

We recognize that our organization is composed of people who are mainly from European settler ancestry. As such, we believe it's essential to continue to ask questions, reflect on our privileges, and work hard to build and maintain relationships with First Nations Peoples. NBT approaches overlap with other traditions that view nature as sacred. Thus, we need to be careful of appropriation in our endeavour to help people reconnect with nature and (re)member their inherent belonging.

The healing power of the natural world: tell me something about this and where this comes from.

Partnering with nature is not new. Many earth-based cultures have a worldview that sees themselves as an integral part of the natural world, not separate. Living beings are whole systems that are moving towards health and wholeness. We see humans as part of nature, not separate — a term David Abram calls "the more than human natural world." Nature has so much to teach us whether that be mirroring back our pain, sorrow, hopes, strengths, and aspirations or teaching us about cycles of life, letting go, and resilience. By opening up to the possibility that we are part of a much bigger whole, you can claim your birthright as someone who belongs to the web of life. Isolation and loneliness are pervasive problems in our society and cultivating one's connection with nature is a powerful way to not only enrich one's own life but also to contribute to the reciprocal healing of humans and planetary systems.

Can you tell us something about how your approach to NBT was developed?

We speak about NBT being relational and systemic, meaning that we see people as embedded in webs of relationships. Thus, family systems

work, and an eco-psychological approach is critical. We also draw on attachment research, which highlights the crucial need to have secure connections from which you can head out into the world, including a secure relationship with "mother earth" as an important attachment figure that helps us to regulate and provides a sense of meaning. When the health of the earth is threatened by forces such as climate change, or our lives leave us disconnected from contact with nature, we can experience a sense of "dis-ease" and despair/fear.

Further, we are interested in the mammalian nervous system and insights from neuroscience and interpersonal neurobiology, which help to explain the therapeutic benefits that play and nature connection have on our ability to regulate and heal from trauma. We have training in somatic therapy and, specifically, are influenced by the work of Dr. Sharon Stanley. We are also interested in the vitality affects that emerge in playful encounters in nature with caring others. We strive to bring out these vitality states and assist people to amplify them in order for them to be incorporated into their body/mind. We also draw on our backgrounds in outdoor adventure and experiential education as a medium to help clients build resilience and expand their self-esteem and confidence in abilities.

Finally, we are influenced by narrative therapy and value how it can integrate with our NBT approach by helping clients with the creation of an embodied story of health and connection. NBT is a systemic/relational, experiential, processes-oriented, strength-based, and bottom-up approach to facilitating change, health, and vibrancy.

In September 2020, Human-Nature will officially become a not-for-profit organization. What inspired that decision? How does it change what you do?

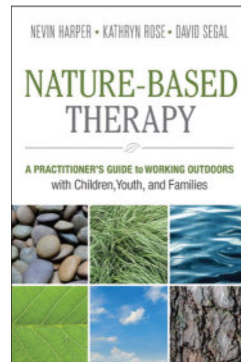
Throughout the past nine years, we have developed and refined our services, including many partnerships with non-profit and charitable organizations. We have always believed that NBT services should be accessible to anyone who needs them, and thus, we decided to transition our organization, so we are able to apply for grants and donations ourselves, versus having to rely on other organizations. Our hope is to be able to offer the same services — individual, couple, and family counselling, as well as group programming — but expand our ability to remove the financial barriers associated with accessing NBT services.

How can your programs be adapted to other locations? How can other RCCs get involved?

Last year, in collaboration with Dr. Nevin Harper, associate professor of child and youth care at the University of Victoria, we published our book *Nature-Based Therapy*. Our goal was to describe the core elements of NBT with children, youth, and families in the hopes that people would venture beyond their office walls with their clients. We would be very excited to see some of the ideas and programs we describe being developed in other parts of the province or beyond. We are also working on creating the Nature-Based Therapy Training Institute, where we hope to focus on the development of practitioners who want to integrate connection with nature into their work. We have been running online courses and will be expanding this in the future with the hope to offer certification and supervision groups.

COVID-19 has had an enormous effect on everyone. What do you recommend as a way to begin the process of recovering from the effects on our mental wellness?

This has been a time of profound uncertainty, where everything is changing and unstable. It is an opportune time to attune to the natural world as a source of strength and constancy. The sun still sets and rises, the tides ebb and flow, the songbirds sing, and the gardens grow. These consistent and familiar rhythms are powerful at regulating our nervous systems and helping us remember that, on a fundamental level, life is resilient and goes on. ■



GET THE BOOK, TAKE THE TRAINING

Nature-Based Therapy: A Practitioner's Guide to Working Outdoors with Children, Youth, and Families by Dr. Nevin Harper, Kathryn Rose, RCC, and David Segal, RCC (New Society Publishers, 2019) was created for counsellors, therapists, youth and social workers, educators, and parents working in educational and therapeutic settings who want to take their practice beyond the office walls and into the powerful terrain of the wild, partnering with nature as a co-facilitator to create lasting change.

CHECK IT OUT

IDEAS TO MOTIVATE AND INSPIRE

Podcasts

UNLOCKING US: BRENÉ BROWN

#1 New York Times best-selling author Brené Brown unpacks and explores the ideas, stories, experiences, books, films, and music that reflect the universal experiences of being human, from the bravest moments to the most brokenhearted.

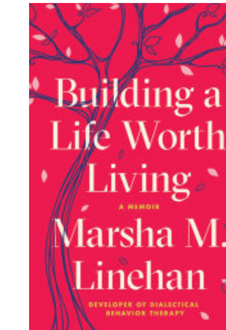
https://brenebrown.com/podcast/introducing-unlocking-us/

ABUNDANT PRACTICE PODCAST

Practical advice for counsellors starting and building a private practice. On "Consult Mondays," Allison Puryear of Abundance Practice-Building consults with a therapist who needs help building their practice. On "What I Wish I'd Said Wednesdays," she chats with another consultant about the therapist's conundrum to get more support for them. On "Follow Through Fridays," Allison provides clear homework for anyone else struggling with the same problem.

https://podcasts.apple.com/us/podcast/abundant-practice-podcast/id1207650846

Books

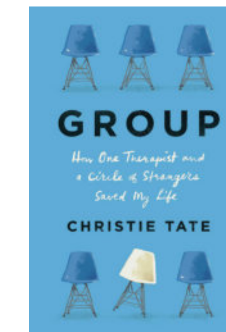


BUILDING A LIFE WORTH LIVING: A MEMOIR

Marsha M. Linehan | Released Jan 7, 2020

Marsha Linehan tells the story of her journey from suicidal teenager to world-renowned developer of the life-saving behavioural therapy DBT, using her own struggles to develop life skills for others.

https://www.penguinrandomhouse.com/books/225252/building-a-life-worth-living-by-marsha-m-linehan/



GROUP: HOW ONE THERAPIST AND A CIRCLE OF STRANGERS SAVED MY LIFE

Christie Tate | Release date is October 2020

The refreshingly original debut memoir of a guarded, over-achieving, self-lacerating young lawyer who reluctantly agrees to get psychologically and emotionally naked in a room of six complete strangers — her psychotherapy group — and, in turn, finds human connection and herself.

https://christietate.com

Shows/Movies

THE SKIN WE'RE IN – documentary streaming free on CBC Gem

Acclaimed journalist Desmond Cole explores what it is to be Black in 21st-century Canada. Do Black Lives Matter here?

https://gem.cbc.ca

THE BODY REMEMBERS WHEN THE WORLD BROKE OPEN – Canadian film streaming on CBC Gem

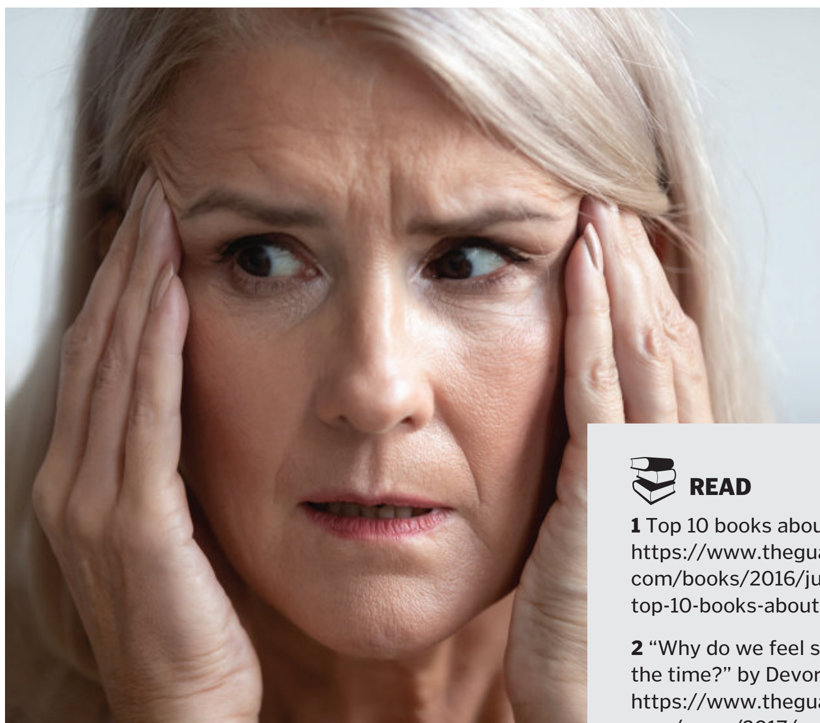
This film weaves an intricately complex, while at the same time very simple, story of a chance encounter between two Indigenous women with drastically different lived experience, navigating the aftermath of domestic abuse.

https://gem.cbc.ca

GUILT

If you have been noticing the guilt theme coming up in your counselling practice, you're not alone.

BY DEIRDRE MCLAUGHLIN, RCC



2020 has given rise to many situations for which guilt may be an appropriate response: having work when others don't, screen time for children, climate change, the legacy of racism in North America. How do we tend to guilt, both inside and outside the counselling space?

We can begin by determining whether the emotion is guilt or shame. Brené Brown makes the useful distinction of guilt being "I did something wrong" and shame being "I am wrong." Shame has an inhibiting effect, disconnecting us from others. With guilt, there exists the possibility for action, responsibility, and repair.

Critical theorist Devorah Baum explains that in the German language, guilt and debt are the same word: *schuld*. In this light, perhaps, if we're fortunate enough to be working during the pandemic, we're indebted to those who are not. We may provide a more generous sliding scale, or pro bono work. If, as caregivers, we feel guilty about extra screen time during the pandemic, we can offer children our attuned presence when we're able. Systemic issues like racism and the climate crisis are inherited, ongoing, and collective.

Baum cites German Jewish post-WWII critic Theodor Adorno, who contended that anyone (meaning everyone) who was party to the thoughts, beliefs, and behaviours that created Auschwitz was culpable. If so, Baum writes that "guilt is our unassailable historical condition… our contract as modern people." Both Baum and Adorno assert that it's our collective and individual responsibilities to continually work to extinguish the conditions that create inequality, oppression, and destruction.

Returning to the original question of tending to our own and clients' guilt, here are a few calls to action:

- Don't be afraid to come to the work: expect to try and fail. Keep coming back.
- If you feel isolated and immobilized, it may be shame rather than guilt. Guilt holds the possibility of movement and connection.
- We can begin to pay the debt of guilt by showing that we HEAR:

HUMILITY - to accept responsibility

EDUCATION - of ourselves and others

ACTION - using resources (time, money, privilege) to create meaningful change

REPAIR - returning to the work again and again

Deirdre McLaughlin, RCC, is a counsellor and sexual health educator living on the unceded traditional land of the Ktunaxa, the Sylix, and the Sinixt peoples. She's listening and learning every day. www.deirdremclaughlin.ca

READ

1 Top 10 books about guilt: https://www.theguardian.com/books/2016/jun/08/top-10-books-about-guilt

2 "Why do we feel so guilty all the time?" by Devorah Baum: https://www.theguardian.com/news/2017/oct/03/why-do-we-feel-so-guilty-all-the-time

WATCH

1 "Listening to Shame" by Brené Brown: https://www.youtube.com/watch?v=psN1DORYYV0&feature=emb_logo

2 "Unleash the Mom Guilt" by Tiffany N. Stallings: https://www.youtube.com/watch?v=ch-0bX4GS0k

LISTEN

1 "The Secret Life of Canada" highlights the people, places, and stories that probably didn't make it into your high school textbook: https://www.cbc.ca/radio/podcasts/documentaries/the-secret-life-of-canada/

2 "No Place Like Home" is a podcast that gets to the heart of climate change: https://podcasts.apple.com/us/podcast/no-place-like-home/id1158028749?mt=2

BCACC Member Health Benefit Plan

Message from BCACC Membership Benefits Senior Advisor, Stephanie A. Ritchie

We have all realized over the last few months how quickly our ability to earn an income can change due to unexpected illness or injury. COVID-19 has affected members in differing degrees, but universally, it has highlighted the importance of designing a strategy to cover unexpected income loss and an increase in medical expenses due to an Illness.

BCACC is proud to offer our members an excellent **Loss of Income Disability Benefit** that will help put that strategy in place and can be purchased either as a stand-alone plan or together with the Health and Dental plan.

The Disability benefits offered are unique as they can be purchased in two parts:

Loss of Income Disability – INJURY – no medical questions to qualify

Loss of Income Disability – ILLNESS – simplified medical underwriting

Please contact BCACC's Insurance Representative, Stephanie Ritchie, who would be happy to provide you with a no-obligation personalized email quote and discuss how to design and put an affordable strategy in place.

Stephanie Ritchie (778) 533-4676 or email stephanieritchie@shaw.ca

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

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