SPRING 2020

INSIGHTS

THE BC ASSOCIATION OF CLINICAL COUNSELLORS' MAGAZINE

Responsibly celebrating victories with clients

A ceremonial approach to wellness

Helping mental health professionals in war-torn Ukraine

Transforming Gender Affirming Care

Tips for working with culturally diverse clients

Making Social Justice Accessible for Counsellors

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

BCACC

BC ASSOCIATION OF CLINICAL COUNSELLORS

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INSIGHTS

THE BC ASSOCIATION OF CLINICAL COUNSELLORS' MAGAZINE

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

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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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COVID-19 A MESSAGE FROM BCACC

In March 2020, the World Health Organization declared the COVID-19 outbreak a pandemic, and over the last month, our day-to-day lives, and the landscape of mental wellness around the world, have shifted dramatically. As our Social Justice issue of *Insights* magazine is about to be printed, it is sobering to recognize just how different our world is from a few short weeks ago. Back in January 2020, we sent a request to the membership for thoughts on what privilege means to you. We have printed many of these in One Last Thing on page 38. It's interesting to consider how we might answer that question differently now, having experienced dramatic changes to how we work, play, and connect with our families.

We recognize the content of this issue isn't focused on the most current COVID-19 pandemic, but the work of Social Justice is always timely and always relevant. We hope you will find deep value in the articles within and inspiration from the work being done by Registered Clinical Counsellors all over the world.

We hope you stay safe and healthy.

— MARCI ZORETICH,
EDITORIAL ADVISOR AND DIRECTOR, MEMBER SERVICES

CANINE CARE

TRAINING A CANINE COLLEAGUE

In the teaching, counselling, medical, and social work fields, there is a great opportunity to connect with children using a therapy dog in a classroom and the interview/treatment process. Caring K9 Institute in Kelowna offers therapy dog training in four levels under the direction of Krista Levar, M.Ed and certified dog trainer. The training guides you through the basics of positive reinforcement clicker training, basic obedience, socialization skills, reading your dog's body language, understanding your relationship with your dog, and working with your dog effectively in your desired field.

The program can be facilitated in a group setting, one on one, or online based on your location and needs. Find more information at www.k9s.ca or email info@K9s.ca.

CHECK THIS OUT!

Hunger for Words is a blog that follows the journey of Christina Hunger, a San Diego-based speech-language pathologist and Stella, a Catahoula/Blue Heeler mix. Hunger is using her expertise to demonstrate how much dogs can say when given the opportunity to learn. Anyone interested in dogs, speech therapy, augmentative and alternative communication, and animal psychology may want to follow along. Go to www.hungerforwords.com.

Buddy Check for Jesse

Jesse Anders Short-Gershman was a "gifted child" as well as a swimmer and golfer. By age 20, he was working for Google. Despite his accomplishments, Jesse struggled with obsessive-compulsive disorder, was bullied through school, and, as a young adult, tried hard to fit in at a large company. On October 29, 2014, at age 22, he took his own life, leaving behind three siblings and a family who loves him.

Jesse's dad, Dr. Stu Gershman, wanted to help his other two boys feel supported and developed Buddy Check for Jesse, an initiative for hockey coaches to deliver to their teams to help them understand the importance of mental health. The idea is to create an environment where teammates support one another and are more aware of potential mental health issues so they are prepared to step in with support when they see a teammate, friend, or family member struggling.

Each year, on the last weekend of October, players can put green tape (the colour for mental health) on their hockey sticks to demonstrate their awareness and support of this message. Buddy Check for Jesse provides tape, posters, wallet cards, and notes to help coaches share this important message with their teams. Learn more at buddycheckforjesse.com.

THE WORLD OF COUNSELLING

The International Association for Counselling (IAC) is currently engaged in a major global counselling project entitled the World Mapping of the Counselling Profession. The IAC is compiling data and information about the scale, standards, and contexts of counselling activity in each of the world's 196 countries. Latin America was mapped in partnership with the American Counseling Association. The goals of this two-year project will allow for the attainment of a factual and accurate global view of the profession. Generating detailed knowledge about the counselling profession will significantly raise public and professional awareness of counselling, enable enhanced advocacy nationally and internationally, and improve information sharing for individual counsellors and the wider profession. Learn more at www.iac-irtac.org.

Renew your insurance policies for 2020

Mitchell and Abbott Insurance policies expired March 31, 2020. Members renew with Mitchell and Abbott Insurance directly and should have received email invitations to renew their insurance starting February 24, 2020. If you haven't yet renewed your insurance, you can visit the Mitchell and Abbott website, renew online, and receive your new certificate of insurance by email. To renew visit **mitchellandabbott.com/registration/bcacc/index.php**.

REMINDER

Login and update

BCACC requires all members to log into their member accounts and update their information to indicate they have renewed their insurance for the 2020 year. If you have any questions, please contact Head Office at **hoffice@bc-counsellors.org** or call 1-800-909-6303.

TREADING SOFTLY

TIPS FOR WORKING WITH CULTURALLY DIVERSE CLIENTS

BY CAROLYN CAMILLERI

Depending on the client in her office, Sharareh (Sherry) H. Ghorbankhani, RCC, provides counselling services in English, Arabic, or Farsi. Her clients are mostly immigrants — and she acknowledges that the transition to living in Canada can be tough.

"Often individuals find this integration process challenging, because it's very different than their own personal values and whatever they've learned in their countries of origin."

Moreover, newcomers often struggle to find appropriate counsellors. But the struggles they face are not only from within themselves.

"They find it challenging that, in the country they have moved to, they don't find mutual grounding to connect with other people," says Ghorbankhani. "There are a lot of misunderstandings due to these differences between them and the new culture. It often causes severe anxiety and depression, and many of these clients have previous traumas or PTSD."

Ghorbankhani offers some tips for helping culturally diverse clients feel more comfortable with counselling.

WE ARE ALL DIFFERENT

A key reason for misunderstandings is stereotyping. "Often, unfortunately, people categorize newcomers," says Ghorbankhani.

For example, a specific religion, background, or language is generalized into a whole culture or nation.

"It's very important to differentiate between religion and culture and to understand there is a variety of cultures within a specific culture," she says. "This is something that often gets neglected and causes a lot of misjudgments even within a therapeutic session. When the counsellor is not aware of these specifics, it causes challenges, it causes disconnection, and the clients may not feel safe to continue if they feel they're not being heard or if they're being misunderstood."

A common misconception is that all ethnic Arabic people are Muslims and all follow specific religious practices. In reality, there are Arabic Christians, Jews, and even atheists, and there are variations within each. Not all Muslims cover their hair. Not all Muslims practice Islamic rituals. Some are born with a particular religion because of their parents, yet they don't practice that religion. In all cases, we need to show respect to each individual's personal values and beliefs.

Making assumptions about a specific culture based on appearance is also problematic, particularly within the Middle Eastern and Asian communities.

"See each client individually as a different case, and as much as possible, obtain their history," she says.

Making assumptions about a specific culture based on appearance is also problematic, particularly within the Middle Eastern and Asian communities.

"For instance, it's important that we know which generation of immigrants Asians are from before judging their values or cultural principles," says Ghorbankhani. "Are they first generation? Are they third generation? Fourth generation? Their appearance may be similar, yet, for second or third generation Asians, their values and principles are totally different than the first generation. They are already integrated into Canadian culture."

Client body language and demonstrations of emotion may also vary. For some cultures, particularly Asian cultures, it's unacceptable to cry or to say you're "not okay."

"No matter what, in some cultures, you have to show you're okay. You have to put on a smile. It's within that culture," she says. "If a counsellor is not aware of this, they may misinterpret the client's body language or appearance when doing assessment."

A lack of cultural sensitivity among mental health providers can further complicate the process for diverse clients seeking support.

"Counsellors must avoid stereotyping all immigrants as the same. Especially for new immigrants from war-torn countries, the trauma they endured before coming to their new country can further affect their adaptation process."

One of the major issues counsellors face when working with new immigrants is "acculturation" — the process of individuals adapting to the new culture and adjusting to it.

"If counsellors move too quickly in this process without respecting immigrants' cultural ideologies and identities, they can cause more harm than benefit," says Ghorbankhani.

And if the counsellor is unable to create safety and trust for their clients, clients will be too afraid to talk about the inhuman practices that happen within their family out of fear of their family members being arrested.

"Therefore, it is important to focus on psychoeducation and smoothing the process of integration within Western culture as much as possible, while respecting and being sensitive to immigrants' own values and principles."

RELATIONSHIP COUNSELLING

An area of particular sensitivity, and one where counsellor bias and even outrage can be an issue, is relationships. Unless it is managed carefully, the “help” a counsellor provides can be damaging.

“As counsellors, we need to be very aware of our own personal biases,” says Ghorbankhani. “When a client comes to a session, it’s not about what we think is the best for them.”

Cultural background may influence relationships and family dynamics in ways that don’t match what is typical in Canadian culture. For example, in some Arabic cultures, the man of the house takes care of the family.

“It doesn’t mean females in those cultures don’t take care of their families — actually, they’re dividing the responsibilities in a way that has been working well for them for many years,” she says. “This is something that [in Canada] may be different with responsibilities being shared.”

The client may even be perfectly comfortable with that aspect of the relationship.

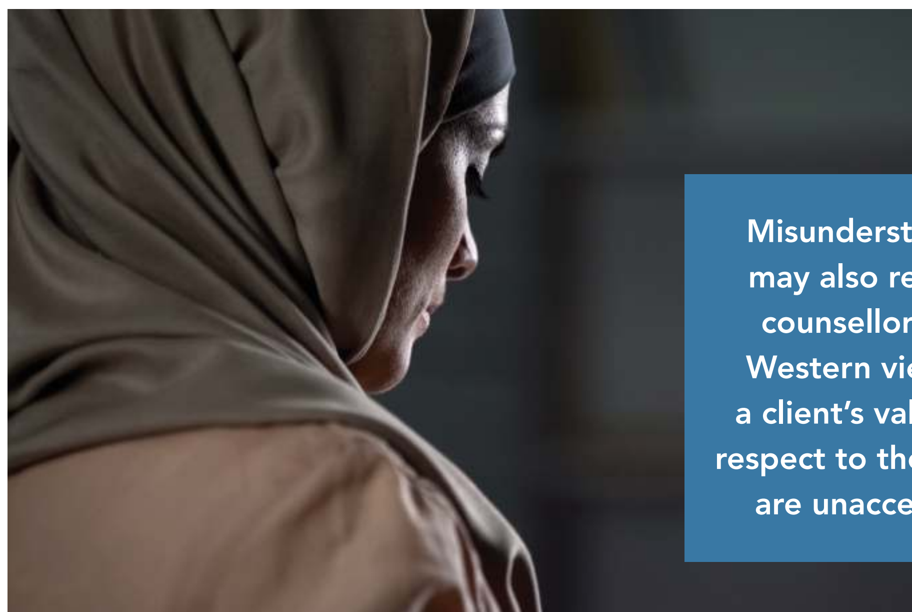
“It’s hard for some counsellors to understand that,” she says. “If we’re going to work with a new cultural background, we need to educate ourselves in that regard. To read, to interact with different cultures.”

Misunderstandings may also result if a counsellor with a Western view feels a client’s values with respect to their spouse are unacceptable. The counsellor may even feel the client is better off without the spouse and start working with that client based on the belief that this is the best course going forward. What gets overlooked is the client’s culture, personal values, and upbringing — and that the stress of immigrating and the struggles the family is having may be temporary.

“If the counsellor thinks, ‘This is not a good relationship and she should leave,’ and that family falls apart, what happens to their children?”

And how does that family support itself, given their lack of connections and the other barriers they face in their new country? Ghorbankhani says we need to stop judging and consider what the client wants instead of what the counsellor thinks is best for them.

“Do they really want to save their marriage? Do they want it to work? And if they want to save this marriage, how can we help them? We need to work with the husband. We need to work with the wife. We need to educate them both. There’s a lot of psychoeducation, for both of them, to familiarize them with Canadian values and principles. Explain the reasons and benefits and positives of the new culture they are in. Change needs to happen but not too fast. This is not a quick fix. It’s a process.”



> **Misunderstandings may also result if a counsellor with a Western view feels a client’s values with respect to their spouse are unacceptable.**

CREATING SAFETY

Verbal and emotional abuse is an issue where it is critical to tread softly so you don’t cause more damage.

“In some cases of abuse where the wife gets counselling support, the husband might feel, ‘Okay, now my wife is going to get ‘educated’ or Westernized or she’s going to get too assertive, and she’s going to stand up in my face and I’m going to lose my family.’”

Out of fear of these changes, the husband may stop his wife from further counselling and the abuse could continue and worsen.

“We have to be sure about the culture and the dynamics. And instead of just telling them, ‘No, this is not acceptable in Canada,’ too fast, too soon, we need to immediately create safety for the wife — and the husband.”

In these circumstances, Ghorbankhani sends indirect messages

to the husband through the wife, educating him about counselling and encouraging him to go to anger management groups and support groups to learn about their new culture and how to deal with their partner, children, and emotions. She believes fully in psychoeducation and integration as a way to help people adapt to the new culture.

"I feel this is the first step: creating awareness for them," she says. "Once that happens, the verbal abuse can stop, and they can learn that the way they were treated back home was not okay and there are better ways to communicate with one another."

She draws a hard line at physical abuse: "You have to interfere immediately."

"I always make sure that the client is safe where they are at," says Ghorbankhani. "In abuse cases, often they don't open up easily, because they're so afraid of the abuser. They're afraid for the safety of their children. When you do counselling for clients who come from diverse backgrounds, there's a lot of fear and clients are often not assertive. Because of the pressures of their culture back home, they're afraid to open up. The first thing I focus on is if the client is safe in their home."

She adds that while it is taboo to speak of these things in some cultures, "If there is physical domestic abuse and there are children involved, we need to intervene and follow our code of ethics and take immediate steps to protect the family members from the abuser."

WHERE TO START

Ghorbankhani begins with every new client by creating safety and showing sincere interest — but not just about their culture: about the person. Tell me about yourself. Tell me about your journey. How was it back home? How is it now? How are you feeling? What is missing for you here? Who are you missing? Do you have any support systems here in case you need help emotionally?

We have to normalize things, understand them, and say, 'Yes, we are different, but we're not here to change you.'

"Once the client feels they're safe and that you're open and understanding and interested in hearing their story and what they're going through and their struggles, and you're expressing to them that they're not alone in what they are going through, it is then that they open up."

She notes the importance of modifying the clinical approach based on each individual culture's values and principles

"It's only then that we, as counsellors, can develop a better understanding of the variety of demographic groups and cultures and the emotional reactions, body language, and expressions," she says. "I really recommend that all counsellors take things slowly and establish collaborative relationships with clients. Educate yourself as much as possible, and obtain experience working with multicultural populations. And, of course, do as much research as possible."

She also encourages understanding when working with new immigrants.

"They're simply very new to Canada, and there's a lot of fear and unknown factors for them. We have to understand that they're new to the culture, they're new to the language, and they are far away from their home."

Some immigrants may even have been warned by friends and families prior to arriving to Canada that, in Canada, people would try to change their values, principles, and religion.

"When there's a fear like that, that's going to prevent them from seeking help. Instead, we have to normalize things, understand them, and say, 'Yes, we are different, but we're not here to change you.'"

All cultures have some negative aspects, and Ghorbankhani tells clients, "Let's let go of these. Forget about them. Take what's working for you. Keep what's positive and gives you safety and comfort."

"I always suggest to all my clients that the beauty of Canadian culture is that you can hold onto the beautiful values of your own culture and learn the beautiful values of our Canadian culture and blend them together." ■

Sharareh (Sherry) H. Ghorbankhani, RCC, CCC, has a private practice in Vancouver and provides counselling services in English, Arabic, and Farsi to individual clients, couples, children, and groups. Her therapeutic approaches are based on individual client needs, and when necessary, she combines EMDR with cognitive behavioural therapy. She is currently working on her PsyD.

UNPACKING THE PROCESS

WEIGHING IN ON RESPONSIBLY CELEBRATING VICTORIES WITH CLIENTS

BY DAVE VASS, RCC

Being a therapist is a unique vocation because its roles are diverse, multilayered, and, at many times, overlapping. We act as trusted confidantes to our clients because they let us into parts of their lives that their closest friends and family might not even be privy to. But in order to have access to these intimate details in a manner conducive to healing, that trust needs to be developed over time. And what establishes that most necessary component of trust comes down to the therapeutic relationship.

Markers of successful attainment of this working relationship can be found within the "Essentials of the Therapeutic Relationship" and include the client feeling they are in an open and safe environment that facilitates self-exploration and change.[1] In ideal conditions, clients can feel comfortable disclosing material without feeling the need to censor or adjust their way of being.

Much of this depends on the therapist's abilities to be present, non-judgmental, empathically attuned, and flexible in their approach. The more the client gets a felt sense of teamwork and collaboration — the therapeutic alliance — the better. What differentiates an ally or teammate from, say, an instructor or educator is that they are there with you, in the muck, offering assistance where they can and celebrating your victories. This is not to say that those in teaching roles do not have these qualities, but the power dynamics tend to be more lopsided.

But how can counsellors go about (responsibly) celebrating those "victories" with clients?

> Generally, the client is not coming to you under duress or because you were the only counsellor in the area; they are coming to each session by choice, which means you must be offering them something of value.

HELPFUL VS HARMFUL

One of the fundamental questions concerning the roles and responsibilities of the therapist is what qualifies as helpful or harmful intervention. Included here is the notion of whether or not a therapist should be offering praise to their client, and if so, when and how.

I have heard a number of responses from fellow practitioners and, as to be expected, there is a spectrum of expressed views on the matter. Many subscribe to the notion that direct offerings of praise in the form of "I-Thou" statements (*I am so proud of you*) are not appropriate, as such statements imply a degree of pressure on the client to perform and please. Instead, suggestions were made to direct the feedback on a unilateral level, which either refracts the statement onto themselves (*If I were to go about doing 'blank,' I imagine myself feeling proud*) or implants the sentiment into the client themselves (*You must be feeling quite proud of yourself at this moment*).

As a collaborative-based therapist, I completely understand not wanting to feel like you are imposing an authoritative power dynamic on the client. It reminds me of an earlier therapy experience I had as a client where, when discussing the goals and projected timeframe of our time together, the counsellor told me something along the lines of, "We are done once I am convinced we have

The intention behind these statements is to provide the client with an external means of validation — a line of support — to help prop them up from the vortex of shame that still resides from past relational trauma.

gotten to the root of your problems." That statement certainly struck a nerve with me, leaving me feeling uneasy and self-protective. That therapeutic relationship didn't last long.

However, I wonder if we therapists, with our post-modern ideals, can fall prey to the other extreme by dismissing the importance of being influential in our client's therapeutic development. I appreciate the benefits of encouraging the client to come to their own insights and understandings — this goes with the saying, "Give a man [person] a fish and you feed him for a day. Teach a man to fish and you feed him for a lifetime." But what stands out here is the word "teach," which brings us back to our roles and responsibilities as counsellors. Can someone work alongside their client, while also embodying the position of teacher at times?

I would posit that yes, we can. I also think that even our attempts at offering indirect praise or feedback will have a direct-approach feel — although the results may be dampened by its muddiness. Direct influencing can be a good thing when properly executed.

INSPIRING HOPE AND OPTIMISM

A key focal point of many therapeutic approaches is incorporating an element of validation somewhere in the process. One of the qualities listed in "13 Qualities to Look for in an Effective Psychotherapist" is "Inspiration of hope and optimism about your chances of improvement,"[2] which I believe constructive praise can offer. Hope in therapy is about promoting an idea that things can get better. This can be presented in dramatic life changes but, more often, this can be revealed in subtle emotional shifts that lead to increased stability. Praise is taking the time to notice and vocalize these perceived developments to the client.

Many people who come to therapy will have some aspects of their stories burdened with shame, which then leads to a felt sense of isolation. When one discloses these parts of their life in front of an empathetic, trusted other, the impact of shame dissolves through connection. This is a courageous act for any person, and as Brené Brown mentions in her well-received TEDtalk, *The Power of Vulnerability*, this expanded openness can lead to immediate after effects of a "vulnerability hangover."[3]

At these times, I feel it is not only appropriate but also critical to find a respectful way to intervene in the form of direct praise. It can be something very simple, such as "great job" or "nice work"; the language will vary, depending on the client. The intention

behind these statements is to provide the client with an external means of validation — a line of support — to help prop them up from the vortex of shame that still resides from past relational trauma. They can then internalize these statements to form a more conducive inner relationship with themselves. In essence, these words of reassurance become the means of teaching them to fish.

MAINTAINING BALANCE

Upon offering this and giving some more space for the client to further integrate the experience, I am also mindful of attending to the process of their therapeutic work which brought them to this point of emergence. It can be easy for clients and therapists to take the experience, then attach it to a "productive" session, which diminishes all the work that individual had been doing up to this moment. Oftentimes when I mention this, clients express gratitude, because it provides them with a sense of pride and achievement in their continued efforts, while also taking the pressure off of recreating these "ah-ha" moments.

To be more accurate, this additional inclusion also acts to remind us of the work both the client and counsellor have done together. Generally, the client is not coming to you under duress or because you were the only counsellor in the area; they are coming to each session by choice, which means you must be offering them something of value. They could have gone to any therapist, but they picked you. The fact that they have decided to open up to you is not a right but a privilege — and one that makes me feel humble and proud.

The therapeutic relationship may differ in some important ways from an outside familial relationship, but elements of reciprocity (within the contained ethical boundaries of a professional setting) still ring true towards a client's overall satisfaction. Sharing one's feelings towards another, especially when it evokes gratitude and joy, can be a powerful thing. The emphasis, however, is that this be done mindfully, respectfully, and tactfully.

> "Client and therapist each bring a particular expertise to the encounter: clients are experts on themselves and their lives; therapists on a process and space for collaborative relationships and dialogic conversations."[4]

Even among therapists who strive for more balanced working relationships with our clients, the power dynamics will never be completely equal. We are not paying them — they are paying us for our professional services. That said, there is still a way to help moderate this difference. As Harlene Anderson, psychologist and co-founder for the Postmodern Collaborative Approach, has said: "Client and therapist each bring a particular expertise to the encounter: clients are experts on themselves and their lives; therapists on a process and space for collaborative relationships and dialogic conversations."[4]

Accordingly, it is the way in which the therapist wields their power — including handling pride-based feedback to their client — which makes a world of difference. ■

Dave Vass, RCC, has a private practice in the Commercial Drive area of Vancouver. He supports individuals and couples through a cultural-relational framework with a clinical focus on burnout, anger management, and trauma. www.connectincounselling.com

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MAKING SOCIAL JUSTICE ACCESSIBLE FOR COUNSELLORS

BY MURRAY S. ANDERSON, PHD, RCC

Counsellors work diligently to provide ethically sound practice to those who come to them in times of great need. However, many counsellors doubt they can account for the tenets of social justice, the weight of clients presenting concerns taking all of their abilities and focus. Counsellors can get stuck in the belief they must change the world for their clients, when, in fact, they can start small by changing the face-to-face therapeutic conversations. What follows is an attempt to make advocating for social justice more accessible to practitioners by using three socially just conversational tools in typical therapeutic conversations.

THE LIMITS OF MY LANGUAGE MEAN THE LIMITS OF MY WORLD [1]

Though it was many moons ago, I vividly remember the last few classes of my MA in counselling psychology. One of these classes involved each member creating a Power Point presentation for the class. We shared laughter and tears as the slides popped up on the screen. But even today, as I review these slides, one stands out above all:

> "As I approach graduation, I can now reflect on the challenges I faced to reach this milestone. Looking forward, I feel that I have the skills to help clients with their issues in therapy. However, with so much to focus on in session, and to keep an eye on progress, I feel overwhelmed with the idea that I can also account for tenets of social justice as well."

Over the next two decades, my career has transitioned across institutional settings, outpatient clinics, outreach teams, private practice, and lately, academia. However, the message conveyed in the above slide has stayed with me, a touchstone of sorts, as I hear similar sentiments from various health care practitioners and students: "I want to be mindful of social justice, but I am just so overwhelmed with the daily demands to take it on."

So, what can be done for the practitioner who wants to account for social justice but is overwhelmed about where to begin?

WHAT IS SOCIAL JUSTICE?

Social justice is a contested term, a concept throughout academia and health care alike, that lacks consensus and is often misunderstood. It is a phrase that implies movement, where it can be used as "a verb as well as a noun, principles as well as action."[4]

According to David Tripp, however, it is not enough to challenge the existing practices of the system; instead, one should seek to understand what makes the system work in particular ways, while remaining open and cognizant of one's own orientation to justice and equality.[5]

Said differently, therapy becomes socially critical when one challenges the status quo, the dominant discourse of particular systems, paying attention to unjust and morally inequitable practices that need to be changed. This "attention" occurs on three different levels: the micro-level, including individuals and families; the meso level, including communities and organizations; and the macro level, including social structures, ideologies, and policies.[6]

In light of the above, a working definition of social justice is, "professional action designed to change societal values, structures, policies and practices, such that disadvantaged or marginalized groups

> A WORKING DEFINITION OF SOCIAL JUSTICE IS, "PROFESSIONAL ACTION DESIGNED TO CHANGE SOCIETAL VALUES, STRUCTURES, POLICIES AND PRACTICES, SUCH THAT DISADVANTAGED OR MARGINALIZED GROUPS GAIN INCREASED ACCESS TO TOOLS OF SELF-DETERMINATION."[7]

REMEMBER THE ADAGE, "THE PROFESSIONAL IS POLITICAL" IN A SOCIETY IN WHICH CULTURAL OPPRESSION EXISTS — THERE IS NO NEUTRAL STANCE.[8] SAID DIFFERENTLY, **INACTION IS AN ACTION THAT SUPPORTS SOCIAL INJUSTICES.**

gain increased access to tools of self-determination."[7]

IT IS THE RESPONSIBILITY OF THE COUNSELLOR TO PROMOTE SOCIAL JUSTICE?

As the trend for graduate counselling programs to include a focus on social justice continues, so too does the responsibility of the counsellor to assist those who are marginalized and disenfranchised through social justice counselling and advocacy work. However, social justice is not only about accounting for the institutional and systemic influences in our society, but also about the promotion of human potential of all clients.

To promote personal growth (and recovery), the counsellor needs to be well versed in the social inequalities that permeate social worlds and limit mental wellness. Further, the socially just counsellor should not just pay lip service to issues of injustice, both societal and internal; the counsellor must take some form of action. Remember the adage, "the professional is political" in a society in which cultural oppression exists — there is no neutral stance.[8] Said differently, inaction is an action that supports social injustices.

Arguably, practising social justice work in the counselling profession can come at a price. For example, an article in *Psychology Today* questions how the focus on social justice from the "Ivory Towers" in academia is little more than lip service and does not translate well into therapeutic practice. The author, psychologist Goali Saedi Bocci, details the impact of burnout, compassion fatigue, and therapist debt, plus the rigours of paperwork and bureaucracy that make social justice work so vexing for the therapist.[9]

It light of the zeitgeist of the times, the need for socially conscious counselling is paramount. The awareness is there, but practitioners are wary of the task. The challenge is moving from theoretical appreciation to practice and action.[10]

What follows is an attempt to locate a platform where new and seasoned practitioners can take on issues of social justice as they happen — in the back and forth utterances between client and counsellor.

THE "MICRO" MOMENTS OF SOCIAL JUSTICE

Those advocating for a greater account of societal pressures occurring outside of the therapy room should welcome the inclusion of social justice training in graduate programs. Rather than psychological issues being an issue solely residing "within" the individual, a social justice lens accounts for the significant impact of societal pressures that can influence one's well-being (e.g., dominant discourses, cultural institutions, and social practices). The work outside of the therapy room usually is comprised of advocacy work to address issues of inequality. However, there are other ways to account for social justice.

While most social justice issues are detailed as occurring at the meta levels, it is at the micro level — those conversations that occur in face-to-face therapeutic interactions — where the most significant examples of justice and injustice occur. This fits with the following statement: "Justice and injustice are always playing out in social interactions. This occurs in the legislative and political arenas where rights are accorded or resources allocated, and also in one-on-one conversations where identities are shaped through meaning."[11] Therefore, I suggest that some of the most accessible ways for a counsellor to use a social justice lens is to account for the wordsmithing that takes place in the therapeutic conversation. While there are many ways to promote social justice in dialogue, two of particular importance

are separating the problem from the person — a process commonly referred to as "externalization" — and acknowledging "sites of resistance."

EXTERNALIZATION: PROBLEMS AS SEPARATE FROM PEOPLE

Issues of social justice are integral to counselling psychology because mental wellness is intertwined with societal values and social systems. At the same time, health care systems are under siege; there is considerable pressure to provide better service, with fewer workers, at lower cost. Teams are stretched to the limit. It is understandable that clients seeking assistance are met with fewer options. Objectivity is promoted at the cost of subjectivity, and practitioners seek ways to standardize treatment.

For example, consider the dramatic increase in the "existence" of mental illness in North America. The latest version of the Diagnostic and Statistical Manual of Mental Disorders, the DSM-5, moved away from a multi-axial system and reorganized the classification of mental disorders. While both the controversy and benefits of the DSM-5 are beyond the scope of this article, it is important to consider if the bloated numbers of those diagnosed with mental health disorders accurately reflect an increase in cases or is this a result of more ways to pathologize the human condition?

Another important point to consider: these highly particularized ways of naming and constructing a person's experience can be marginalizing and stigmatizing. For example, a client may be relieved to know that what they experience fits the criteria for bipolar disorder and that treatments are available to help them; however, another client may feel great shame by being diagnosed with a "hoarding disorder" or with a "borderline personality disorder" and feel this new "title" impacts their future.

As David Paré, counselling psychologist and director of the Glebe Institute at the University of Ottawa, asks, "What, for example, might be the practical utility of developing an equally monumental taxonomy of ability? How might the

ISSUES OF SOCIAL JUSTICE ARE INTEGRAL TO COUNSELLING PSYCHOLOGY BECAUSE MENTAL WELLNESS IS INTERTWINED WITH SOCIETAL VALUES AND SOCIAL SYSTEMS.

EXTERNALIZATION

Here are some examples of ways to "externalize" the problem for clients.

- What influence does this problem have on your life?
- What conclusions have you drawn about your life because of this problem? What does it intend for your life? Is that the same thing you intend for your life?
- What facts or events are in your life that contradict the problem's effects on you and your relationships?
- Was there ever a time when you refused to submit to the demands of the problem?

For more information on externalization, visit https://dulwichcentre.com.au/articles-about-narrative-therapy/externalising/.

influence of this ripple through the way people think and talk about themselves?[12] The conundrum, of course, is that the DSM is meant to both promote discussion amongst professionals and understanding in clients seeking answers. At the same time, the power and prestige placed in such documents can also limit those who it seeks to aid in great times of need.

In 1987, narrative therapist Michael White prophetically declared, "The person is not the problem. The problem is the problem." In this way, helping professionals can view "persons" in ways that avoid pathologizing their ways of being and open up the possibility of new conversations devoid of problem-saturated narratives. Importantly, viewing problems as residing outside of the "person" allows therapists to see how problems reside within or are buttressed by the discourses of social injustice. This process of separating a person through conversation is commonly referred to as "externalizing."[13]

Similarly, how we language things for clients is political. For example, a person is not an "anorexic;" they are a person who deals with anorexia. Another common example is how individuals are referred to as "a depressive" or a "schizophrenic." The practitioner can help reduce the stigma of such labels by saying instead that the person "suffers from depression" or "lives with schizophrenia." Such simple movement away from nouns to verbs can guard against the marginalization that can occur when a person's identity is limited by diagnostic labels, an externalizing practice in alignment with socially just practice.

A healthy separation between the problem and the person provides a platform where the therapist and client can collaborate on preferred understandings of self and directions in life. This approach can help clients overcome real and perceived barriers by acknowledging the power of social injustice and finding ways to navigate agentive ways forward.

ACKNOWLEDGING SITES OF RESISTANCE

Having gone through traumatic, abusive, overwhelming events, clients will often come into sessions reporting that they did nothing to address the injustice: a person who faces workplace bullying, a significant substance misuse issue that leaves a person riddled with anxiety, a person unable to leave an abusive partner. The stories people tell about themselves are powerful, pervasive enough to take over one's sense of being, an overarching negative identity.

Allan Wade describes an approach to counselling where resistance to violence and oppression is understood to be both a "symptom of health and health inducing."[14] Others, such as David Rennie, refer to this as "deliberate, realistic, resistance."[15] In this way, resistance cannot be categorized or judged as being "maladaptive" or "unhealthy." Rather, resistance is contextual, a practice that preserves dignity, and accounts for the socially situated nature of responses at play. From this perspective, counsellors can collaborate with clients in ways that promote a contextual understanding of resistance, rather than evaluate it as being "healthy" or "unhealthy."

Healthy acts of resistance can be defined as: "Any mental or behavioural act through which a person attempts to expose, withstand, repel, stop, prevent, abstain from, strive against, impede, refuse to comply with, or oppose any form of violence or oppression, or the conditions that make such acts possible, may be understood as a form of resistance."[16]

For example, various research initiatives suggest that problem-based models that focus on pathology are problematic, because they ignore significant subjective information while prescribing treatment protocols.[17,18] These studies have shown how many clients, when given the chance, will refute their pre-existing diagnoses in what can be described as an agentic act of avoiding pathological objectification. Some examples of resistance to "medicalization" include opposition to pharmacological interventions for grief (treating it as "extended grief"), sadness (treating it as a form of depression), or badness (treating

RECOGNIZING "SITES OF RESISTANCE"

Contrasting views of "the oppressed": a determinist or "effects-based" view in which oppression is presumed to condition the mind of the individual to the point that they act as an accomplice in the oppression they endure, and a "response-based" view in which the individual responds to and resists subjugation, overtly and covertly, through myriad psychological and social tactics woven into the fabric of daily life (Fast & Richardson, 2019, p.2).[2]

For more information on response-based practice, please visit https://www.responsebasedpractice.com/. For those wanting more details related to social justice efforts and "justice-doing," please consider https://vikkireynolds.ca/writings/articles/ [3]

THREE THINGS TO REMEMBER:

1 To avoid "deficit-based" practice, it is important to keep "context visible" for every client. It is important to highlight for clients how many "problems" stem from societal or institutional practices.

2 Social justice can take place in the therapeutic encounter when a problem is removed from a client through the process of externalization.

3 A response-based practice is an essential component of a social justice stance in therapy. The therapist takes time to highlight areas where the client "pushes back" against a transgression, noting that the client, in some way, was active in their resistance. This attention to client responses can validate their suffering and maintain their sense of agency.

criminal activity as resulting from a psychiatric disorder). It is up to the counsellor to work with their clients and help them appreciate their responses are agentive acts, rather than being passive pawns in therapy, in the eye of their storm. The socially just counsellor can highlight these acts of negotiation by their clients and acknowledge these "sites of resistance."

PROMOTING SOCIAL CHANGE

Arguably, counsellors are not experts but life-long learners in how to practise in socially just ways. For the newer practitioners, it is important to get out of the therapy room and become informed or involved, joining movements and groups in efforts to promote social change. It is equally important to find ways to account for inequalities with clients who are dealing with marginalization and discrimination. Rather than getting overwhelmed with the weight of such practice, however, new therapists can remember that social justice can occur on the micro-level, the utterances that occur within the therapeutic discussion. ■

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TRANSFORMING GENDER AFFIRMING CARE

A TRANS LED INITIATIVE

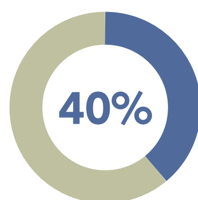
BY J. MATSUI DE ROO, RCC

Are you a clinical counsellor who works with trans clients? Even if you don't think so, it's quite probable you are or will be working with trans people. It's hard to get statistics about the prevalence of gender diversity in our world, since many trans people are not public, or out, about who they are. But trans people are an active and vibrant part of our society, and trans visibility has never been higher.

Despite greater visibility and public awareness, trans people still experience significant challenges accessing medical and mental health care compared to their cisgender* (non-transgender) counterparts.[1] Most clinicians are given little or no training in working with trans clients. Medical or mental health practitioners may refuse to work with trans clients, saying it's outside of their clinical expertise, or else stumble in providing positive care; almost 40 per cent of trans people described having a trans-specific negative experience with their primary care physician.[2] This lack of expertise presents a major barrier to trans clients who need to access gender affirming medical care, including hormone replacement therapy (HRT) and surgery.

It's in this context that I situate my work. I'm a clinical counsellor, supervisor, educator, and consultant with an area of specialization in trans wellness. I'm also a member of trans community, a nonbinary person who is out about my gender identity in both my personal and professional life.

Almost every day in my practice, I talk to people struggling to access gender affirming medical care. Counsellors have an important role to play in changing this. Not only can we support our clients through respectful, trans-informed counselling, but we can also offer hormone and surgical readiness assessments to help our clients access medical gender affirming care.



ALMOST 40 PER CENT OF TRANS PEOPLE DESCRIBED HAVING A TRANS-SPECIFIC NEGATIVE EXPERIENCE WITH THEIR PRIMARY CARE PHYSICIAN.[2]

GENDER AFFIRMING MEDICAL CARE

The World Professional Association of Transgender Health (WPATH) standards of care exist to help guide clinicians working in this area.[3] These standards are meant to be flexible guidelines, providing information and support to help us offer the best possible care to clients. However, the standards were created by cisgender medical professionals, and it's important that we integrate trans voices and representation into trans care. Change is happening in this area; WPATH had a requirement for trans representation in every working group for the new standards of care, which are due out soon.[4] Yet the medical and mental health system in general still treats trans people like anomalies, and systemic erasure of trans voices and identities in health care negatively impacts the well-being of trans people.[5]

I'm well aware that the current systems of care aren't serving everyone. As a member of trans community, I've heard myriad stories from people about how problematic, even traumatizing, it's been to access this care. Due to this, I was initially reluctant to take on the work of being an assessor for HRT and surgical readiness. Yet lack of trans representation in trans care remains a problem, and I realized that as a community member as well as a health care professional, I was uniquely situated to create change.

CREATING CHANGE

I decided to offer hormone and surgical readiness assessments, working from a trans-led, anti-oppression approach. I was fortunate to begin this process already having years of experience working with trans clients, as well as living in trans community. I also took training that helped me understand the expected results, risks, and benefits for hormones and surgeries, as well as how to document as per WPATH standards.

This information was a useful start, but I needed to integrate anti-oppression principles and practice before I could offer assessments. This started with listening deeply to what clients and people in community were telling me. I learned that standard assessments consisting of questionnaires

**We use the word "cisgender" to provide an alternative to "non-transgender," just as "straight" has entered the lexicon rather than "non-gay." This helps reduce othering and validates trans identities as part of natural human variation.*

Not only can we support our clients through respectful, trans-informed counselling, but we can also offer hormone and surgical readiness assessments to help our clients access medical gender affirming care.

or an interview-like process were often not a good fit for people who had survived trauma and repeated barriers to care. I spoke with many people who had been denied access to hormones or surgery, or who were traumatized by the very systems meant to help them. I listened to clients, colleagues, friends, and chosen family share about their experiences. Emerging themes from these stories included anger at the system existing at all, helplessness and frustration at not knowing how to access needed care, and feeling judged about being "trans enough" to deserve access. Hearing this helped me make sense of where change needed to happen.

I was also aware that many trans people came to see me because of who I am, a nonbinary person of colour. This helped me think critically about how awareness of social location is essential to holding safer space for assessments. Social location refers to the social position we hold in society due to how various characteristics are valued: age, gender, class, race, sexual orientation, and many more factors. It's important to recognize how our own social location, as well as that of our clients, influences this work. This includes acknowledging that gender diversity looks very different from culture to culture and taking time and space to hear people share about their gender in their own words, without trying to fit them into our own cultural frameworks.

Many trans people shared with me that they distrusted the assessment system because it was confusing and hard to navigate. Lack of transparency in any system can increase power differentials and reduce safety. As I began offering assessments, I built in a longer intake to ensure clients had all the information about the process, including options for funded care. Sometimes this meant referring people to other places for care. Since I recognized how frustrating it was to be bounced from person to person when looking for care, I also took the extra time to answer questions first-hand and not immediately send them to another resource.

WPATH STANDARDS OF CARE

The WPATH standards of care are designed to help clients access care. Yet fear of how those standards would be imposed was something I heard repeatedly from community members as a point of tension, trauma, and disconnect. This helped me take a critical look at the WPATH Standards for Care version 7 (SOC7), exploring how to best integrate them within an anti-oppression context.

To access hormones or surgery, WPATH SOC7 criteria for adults require a documented history of gender dysphoria; for mental and physical health conditions to be reasonably to well controlled; and for clients to be capable of giving informed consent.[6]

Gender dysphoria refers to discomfort or distress caused by a discrepancy between a person's gender identity and that person's sex assigned at birth, as well as the gender role associated with their assigned sex.[7] This definition of dysphoria serves as a good starting place, but it doesn't capture the complexity of many trans people's narratives. The emphasis in this definition is on wrongness, which sometimes gets simplified down to the trope that trans people are "born in the wrong body." While some trans people

do have an innate sense of wrongness about some aspect of their bodies, this is far from a universal experience. It's also an intrinsically pathologizing view; many people don't look at their body as wrong, so much as know what feels right. Noted trans scholar Julia Serano reframes this experience by defining subconscious sex, an unconscious and inexplicable self-understanding of what sex/gender one should be.[8]

Also, dysphoria frequently manifests in a social context. Social dysphoria, the distress or discomfort associated with being perceived as the wrong gender, is another way that trans people can experience significant distress,[9] and something that in my clinical experience is much more common. Many people I saw who wanted to access hormones and surgery cited social dysphoria as their primary motive.

I changed some of the language I'd been taught about gender dysphoria. I used open-ended questions and accepted whatever narrative was shared as a legitimate reason for someone to require care. I let clients know that there's no right or wrong way to be trans or to experience one's body. For the purpose of assessment, I considered that anything that led a client to the decision of wanting hormones or surgery could be considered gender dysphoria.

WPATH criteria also asks that physical and mental health conditions be reasonably well controlled to access hormones and some surgeries, and well controlled for surgeries deemed more complex. Many clinicians, including myself, believe that it's consistent with best practice to interpret these standards broadly. After all, trans people can live with complicated medical or mental health conditions and these don't make them less trans. And since trans people face significantly higher levels of discrimination, violence, and other kinds of oppression,[10] it's not surprising that depression, suicidality, and other trauma-based mental health responses are common.[11] Research shows us that for the majority of trans people, access to hormones and surgery improves mental health.[12]

THE GENDER SPECTRUM COLLECTION

Trans is an umbrella term that covers a wide range of gender expressions and identities for people whose gender may be different than their assigned sex at birth. This includes people who are trans masculine, trans feminine, nonbinary, agender, bigender, genderqueer, and genderfluid, to name just a few identities in a rapidly evolving lexicon. Trans can also include culturally situated identities such as Two-Spirit or Hijra people, although other cultures may have different preferred language and understandings outside of Western dominant discourse.

I decided that if I wanted to mitigate the power differential in the process, I needed to move beyond assessing for mental health into actively helping those with mental health challenges connect with accessible supports. Rather than gatekeeping, I envisioned a scaffolding model of care, looking at setting people up with ongoing support as much as possible. This involved doing research on trans-positive places where clients could access low barrier supports.

Informed consent in the counselling context doesn't replace medical-informed consent. This simply means using our best judgement to ascertain that the person is aware and able to consent to treatment, something that's already part of our process as counsellors when agreeing to work with a new client. I looked at expanding informed consent into ensuring clients had the information they needed to make the best decision for themselves. The vast majority of the clients I saw had already researched extensively, but I checked in to see if there was any missing information. As a counsellor, I was well placed to make space for clients to ask questions they may be shy about asking their doctors, including concerns about sexual functioning, mental health, and family and relationship concerns. I shared information and resources, answered questions, and, when necessary, checked in with medical colleagues.

Ultimately, I ended up with a robust, extremely flexible protocol that was consistent with WPATH standards but was informed by community and individual needs. Client feedback remains at the heart of this process and I regularly adjust my approach based on what people share with me.

THE GENDER SPECTRUM COLLECTION

I hope to see a time when HRT and surgical assessment become something any doctor can provide to their patient, and this part of my job becomes obsolete.

I hope to see a time when HRT and surgical assessment become something any doctor can provide to their patient, and this part of my job becomes obsolete. I firmly believe people should not have to pay for this aspect of health care. Outside of my counselling office, I advocate for changes to a lower barrier, MSP-covered system. However, since the system does require these assessments for now, my immediate goal is to help more clients get the care they need. To this end, I eventually decided to offer training and help expand access to respectful, informed, lower barrier assessments.

EXPANDING ACCESS THROUGH TRAINING

I first offered this training through the Catherine White Holman Wellness Centre (www.cwhwc.com), where I volunteer as the clinical supervisor. This centre, located in Vancouver on the unceded and ancestral lands of the Musqueam, Squamish, and Tsleil-Waututh nations, provides low-barrier wellness services to transgender and gender non-conforming people in a way that is respectful and celebratory of clients' identity and self-expression. Since we already provide free counselling and other wellness services, we were well situated to offer HRT and surgical assessments. We expanded our services in this direction and offered to host and organize the training. In the spirit of building community capacity and increasing access for under-served populations, we also opened up the training to outside people who could offer assessments, with priority given to people who were trans, nonbinary, Two-Spirit, Indigenous, and people of colour.

I developed this training with the help of my intern, a trans feminine person who brought invaluable insight from years of working and advocating within trans community. We took my existing structures and created teaching tools, including information about pathways to care, medical knowledge about hormones and surgery, a walk-through template of a flexible protocol, sample assessment questions, and examples of completed assessments. We created experiential exercises, including case studies and role plays. All case studies and sample documents needed to be entirely fictional, because in a small community, even composite real-life case studies could reveal too much information about community members. We still managed to create multi-faceted, realistic personas for training exercises, with a diversity of gender identities and expressions, lived experiences, and cultural backgrounds.

The emphasis throughout the training was how to help practitioners build rapport and connect first and

foremost, using trauma-informed practice, and how to chart the necessary information in a way that was respectful of people's shared truths.

We launched our first HRT readiness assessment training in September 2019 with a cohort of 12 practitioners, including counsellors, social workers, and nurses working in community. Ten out of our 12 learners were trans, nonbinary, or otherwise gender diverse. Five of our learners were people of colour.

In October 2019, we held a smaller surgical readiness assessment training for six people, including our current clinic volunteers and a select number of outside practitioners, prioritizing Indigenous people, trans feminine people, and people of colour. A clinic doctor also volunteered to share more information on surgeries.

After the training days were complete, we offered learners the chance to work with me in a shadowing capacity. We spoke to Trans Care BC, the Provincial Health Services Authority branch which helps coordinate gender affirming care in B.C., and they assisted by sending appropriate referrals for clients who were waiting for HRT and surgical assessments. In this way, we were able to offer free assessments and reduce waiting times for clients as part of our training process.

RESULTS AND FUTURE DIRECTION

The trainings have already had a measurable impact. We have been offering low-barrier, no-cost hormone and surgical readiness assessments at every Catherine White Holman Wellness Centre clinic since the training. One of the trainees has also become the first Indigenous person in B.C. registered through First Nations Health to be qualified to offer gender affirming surgical and hormone assessments. The training protocol remains a living, iterative process that can change in response to community and policy. I hope to gather more input from the trans community through community consultations, advisory groups, and individual feedback and to do more structured data collection and analysis.

I'm now committed to running this training as long as it's needed. The second cohort of HRT readiness assessment training is launching this spring, this time open to all mental health and medical professionals. I'm also offering foundational workshops on gender affirming care for mental health providers.

It's my hope that trans-created and trans-led trainings become standard everywhere. I encourage all practitioners to develop proficiency working with trans clients and to prioritize trans voices in their learnings. It benefits everyone when counsellors can feel comfortable and competent in gender affirming practice. ■

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HELPING THE HELPERS

IN A WAR-TORN COUNTRY

BY STEPHEN BRENDAN CHADWICK, RCC

The longing to act in response to a crisis situation is familiar to many in the helping professions. Here are some observations from an RCC who is seeking ways to assist other mental health professionals in Ukraine, a country at war.

Photos from the Veteran Hub, which was created to provide centralized service to veterans and security sector workers, as well as their families, to support the process of reintegration into civilian life. The author's contact, Ivona Kostyna, is the coordinator.

When the unofficial, undeclared war began in Eastern Ukraine in 2014 and the peninsula of Crimea was annexed, I watched in despair as people were being shot on the streets of Kyiv and "little green men" were beginning to creep over the border into the provinces of Donetsk and Luhansk.

As a psychotherapist living on the West Coast of Canada, there was very little I could concretely do to help, but because my heritage is half Ukrainian, it was very painful to watch. I decided to try to do something, although I didn't know exactly what.

Initially, I had thoughts of going there to offer services of psychological support and help to those directly affected, then I paused for a moment to breathe, took a step back, and shook my head. How ridiculous would it seem for a foreigner to come in and offer mental health services? This was a sovereign country with its own health care infrastructure. It was no longer the bad old days of the Soviet Union. Surely there were services there that already existed. Still, I wanted to help.

A year went by and another, and finally, an opportunity arose. Through correspondence with a church member at St. Michael the Archangel in Nanaimo, I became connected with Oleh Romanchuk. Romanchuk is the director of studies in psychotherapy/counselling at the Ukrainian Catholic University in Lviv in Western Ukraine. In effect, he had single-handedly been responsible for creating the Institute of Cognitive Behavioural Therapy in Ukraine, which was unique in the country. I corresponded with Romanchuk for about a year, waiting and determining how I might be of service. He was even kind enough to send me a copy of Judith Herman's classic *Trauma and Recovery: The Aftermath of Violence From Domestic Abuse to Political Terror*, which was first published in 1992 and had only just been translated into Ukrainian for the very first time.

THE 2018 TRIP

In 2018, I was able to arrange a first meeting with Romanchuk. As chance would have it, he was holding a seminar on the neurobiology of psychotherapy, and I asked if I could attend as a foreigner. I anticipated being able to network with other psychotherapists

and determine where the greatest need was and ask them their opinions on ways to help.

I was amazed to discover that the seminar was the first of its kind. Therapists, social workers, counsellors, and frontline workers attended from all over Ukraine. However, I was somewhat saddened by what I discovered in discussions with some of the therapists about the situation in the country.

In the years since the hostilities began, therapists were leaving the country, retiring, or simply no longer working, whether changing professions or quitting outright. I also heard a number of stories of desperation. One therapist who worked in the hospital in Kharkiv told me about her own secondary trauma: seeing soldiers shot up and with limbs missing, lying in hospital beds. Some of the soldiers were the same age as her own son, and she spent her nights at home crying in frustration and fear.

Conversations with other therapists revealed that, though the war seemed to be just simmering in the background, therapists, especially crisis workers or crisis workers who turned to other therapists for support, were burned out by the overload. One of the biggest needs was for supervision to help therapists manage the overwhelm.

In the years since the hostilities began, therapists were leaving the country, retiring, or simply no longer working, whether changing professions or quitting outright.

Another observation: a general impression from all the therapists I spoke to that the West had simply forgotten about what was going on. Ukraine didn't often make the news in the West, at least not in terms of the aggression from Russia. Just as Judith Herman might reference, there comes an amnesia, a wanting to forget that the problem is there, simply due to emotional fatigue.

To paraphrase what Romanchuk said at one of the seminars I attended, there is a lot of emotional pain in the country, stemming most recently from what has happened, but also from decades and centuries of history. This has to be healed.

PLANNING FOR THE 2019 TRIP

After my first trip to Ukraine, I returned to Canada and immediately tried to connect with others who could

Participants at Dr. Oleh Romanchuk's seminar on the neurobiology of psychology, held at the Ukranian Catholic University in Lviv.

A PERSPECTIVE ON LANGUAGE BARRIER

When I lived in Ukraine previously, it was during Soviet times, and the bulk of the population spoke Russian, which is what I learned to speak. While I also speak Ukrainian, Russian is the language I am more familiar with.

Many years later, there was some anxiety on my part about speaking Russian, because there is now a tacit disapproval of speaking Russian within the country and a very strong movement to encourage Ukrainian everywhere.

It is easy to fall into a mishmash of the two languages or what Ukrainians call "Surzhyk" — like beans and peas — somewhat like speaking "Frenglish." Speaking Surzhyk can indicate one is uneducated — neither speaking pure Russian nor pure Ukrainian. However, being a foreigner, I was often forgiven.

tell me more about what was happening and who might assist me to move forward.

Many of the counsellors, social workers, and psychologists who had remained in the country and were practising were left with an even heavier workload to deal with. Many mental health professionals were suffering from secondary or vicarious trauma and burnout due to the sheer overwhelm of numbers. One of the salient features I saw emerging from this discussion was the possibility of helping the helpers — those who were on the frontline or working in the clinics or hospitals and helping them with the volume of clients they saw.

The demographic of those clients affected by the war wasn't only soldiers, although they were the primary focus. Other clients included children who had lost parents and family members. One school principal in Lviv, mentioned how children whose father may be at the front would act out in school with misbehaviour, and how the other parent, usually the mother, would be struggling to cope at home.

And of course there were displaced persons upon the thousands, those who had left behind their homes, families, jobs, friends, and acquaintances to start anew elsewhere. One acquaintance, whose small family were living outside Donetsk, had just finished building a brand-new house at the start of the hostilities. A shell ripped through the ceiling and completely destroyed their home. They decided to relocate to Poland — changing countries and languages, losing friends and jobs. Now both parents in this family of four work to try to re-establish what they had lost, with hardly a day off.

Through personal contacts, I was able to connect with Taras Kulish, a Toronto-based lawyer, who apart from his practice, works with an organization called HOPE Worldwide Canada. Kulish also spearheaded the Helping Hand for Ukraine program to provide assistance for children affected by the conflict — in particular, by providing summer camps with activities and counselling to help the children deal with some of their trauma.

There were displaced persons upon the thousands, those who had left behind their homes, families, jobs, friends, and acquaintances to start anew elsewhere.

It was through connections with Kulish that I was able to connect with more organizations upon my second trip to Ukraine.

RETURNING TO UKRAINE

In advance of the 2019 trip, I was eager to get in touch with others who might be working with people at the front. My first trip to Ukraine confirmed that there were infrastructures in mental health across the country; however, coordination of services was potentially a problem.

A BBC news video about an individual working with veterans caught my attention and after some sleuthing, I connected with Ivona Kostyna. Kostyna is the coordinator of an organization, the name of which roughly translates as "brothers in arms" and Veteran Hub. Situated in Kyiv in an old TV station tower, this organization is a central location for veterans returning from the front. It is a place to connect and find resources for employment, counselling, and general assistance in helping to re-establish their lives.

With grace, I hope to return to Ukraine in 2020 to help the helpers by providing moral support and hosting no-cost or low-cost informational seminars to groups to assist various sectors of the population. Most of this work is still in various stages of formation and is ever evolving.

Ukraine is still trying to eradicate itself from a hybrid war it never started. When the hostilities finally end, it will be years before the country and its population fully recover economically, in terms of its infrastructure, and psychologically as a whole. That's when the work will truly begin. For now, I just hope to be a conduit to this process. ■

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RECLAIMING CULTURE

A CEREMONIAL APPROACH TO WELLNESS

BY DARIEN THIRA, PHD, AND SHAWNA BIRON, RCC

Addiction treatment dates back to 1784. At that time, it meant a short stint to "detox" in a quasi-medical setting. In 1844, "sober houses" were created to provide a safe living environment for those struggling with alcohol. Over the years, our understanding of addictions shifted from a moral weakness to that of a medical illness; the disease model was further strengthened with the reputation of Alcoholics Anonymous.

Today, AA remains the foundational framework of most treatment centres. AA offers many strengths, for example, a social support network, therapeutic model of healing, and shared language of healing; however, it has limitations, especially when applied across cultures. This is particularly relevant as research into Indigenous healing consistently finds that "culture" is the most important factor.

Initiated by the Ktunaxa Nation and funded by the First Nations Health Authority, the Seven Nations Soaring Eagles Wellness Centre has developed programming based on post-colonial philosophy and Indigenous culture. According to Debbie Whitehead, the Social Investment Director of the Ktunaxa Nation, "This is about culture doing what it has always done for healing. It is the strength and wisdom of Indigenous people."

This approach is a radical and intentional shift away from the bio-medical and Minnesota (AA) models; however, it is in keeping with a trauma-informed approach. For this program, trauma is understood as, "Injury where blood doesn't flow,"[1] and a "disconnect from self and the present."[2] The common source of disconnect for Aboriginal people in Canada is the impact of colonial violation, including the intentional theft of culture, lands, identity, families, communities, and nations — a biopsychosocial trauma.

A post-colonial understanding of substance-related problems is that they result from an attempt to medicate the traumatic wound of colonization. Rather than a sign of spiritual or biological weakness (a view which supports the colonial intention of pathologizing those impacted by oppression), they are a solution to the

intergenerational and ongoing impacts of colonization on territory, culture, community, family, and person, albeit a solution with tragic consequences. Even with these acts of violence, Indigenous people are resilient and are taking back their healing with program models, such as this one. Healing is holistic and is being approached by revitalizing cultures, reclaiming identities and meaning, reconciling families, communities, and nations, and re-establishing wholeness.

Culturally, the program uses a ceremonial framework and is an initiation process that offers the opportunity for life transition rather than repair. Rather than focus on problems, with an emphasis on psychoeducation and "relapse prevention," the focus is on how to live a life of wellness, one with a sense of purpose guided by culture and spiritual wisdom. Individuals are understood as an element in an intertwined network of relationships, where their wellness is indivisible from that of their relations (family, community, bioregions, including flora, fauna, water, earth). Participants may come thinking they are addicts, but through a ceremonial process, they will leave "walking the Elder's path" as contributors to the healing and wellness that their families and communities need.

CEREMONIAL FRAMEWORK

Traditionally, ceremonies of initiation or life transition facilitated or marked significant phases or life change — moving from one life stage to another or from one role to another, with an accompanying change in strength, vision, connectedness, and identity. This process is made up of seven steps, common to many Indigenous initiation/ life transition ceremonies:

1) Preparation: Support to safely withdraw and develop emotional regulation and commitment to the process.

2) Separation: Separating their identity from the problems with which they have been struggling.

3) Death: Releasing and learning from their previous wounds.

4) Rebirth: Envisioning a life of wellness and developing a wise and purposeful identity.

5) Teachings: Gathering the knowledge and skills to support a life of wellness.

6) Ordeal: Confronting shame and fear with a new strength-based identity supported by cultural and psychological teachings.

7) Return: Preparing to go back as a force of wellness with their relations and maintaining their wellness on the Elder's path.

HEALING VISION

Participants experience their healing as relational and their challenges within a wholistic interconnected biological-psychological-sociocultural-historical-ecological-spiritual perspective.

› **Anti-Colonial:** Participants shift from seeing themselves as a problem with some deficiency, moral weakness, pathology, or bad luck, to seeing their dependency as rooted in a history of colonization that is still alive and contributing to their problems.

› **Strength-Based:** Participants gain a different perspective of themselves, seeing their past choices and substance use as a solution to pain and suffering and as an outcome of trauma and colonization. This perspective liberates them from shame, empowering them to move forward in life.

CLIENT OUTCOMES

WELLNESS VISION: Participants have the opportunity to live in wellness by practising and visioning how to live on their return home. They serve purposeful roles within the wellness community and enhance their cultural/ spiritual wisdom.

VALUES: Participants are encouraged to identify values that guide their actions and behave in accordance with their personal/cultural values.

BALANCE: Participants have the opportunity to discover and practise balance, as guided by traditional values, so they can live in wellness within themselves and with relational connections.

HOLISTIC AND RELATIONAL VIEW OF WELLNESS: Participants have the opportunity to develop a greater capacity for and deeper experience of relational connections, their community, and the natural world.

WORTHWHILE LIFE: Participants have the opportunity to rise above their colonial/ victim identity and dependency-related behaviour to find their unique strengths so they can claim empowerment as a contributor to healing and wellness in themselves and their relational connections. They will release the colonial shame that wounded them in order to live a life of wisdom (i.e., in a manner congruent with becoming an Elder) and purpose (i.e., in a manner that contributes to their relations as a protector, provider, and teacher).

› **Self-Determination:** Participants liberate themselves from the victim identity and claim responsibility for their life choices. There is no "fixing" or "doing for," which steals empowerment and, ultimately, decreases chances of healing. Instead, participants feel respected and encouraged to take the lead on a self-determined healing path.

› **Trauma-Informed:** Participants experience a safe, supportive environment based on the knowledge of the staff and their sensitivity to trauma impacts and vulnerabilities. Behaviour is understood through the lens of trauma reactivity and relation patterns. Participants are active in co-creating their healing journey.

› **Safer Use:** Participants gain a compassionate perspective of substance misuse: not as bad or morally wrong but as serving purposes for individuals. Participants are encouraged to develop a beneficial relationship with substances with control and safety woven in.

› **Intergenerational Healing:** Participants come to understand the connection between their ancestors' wounds and the need for healing now. They recognize that wellness will break the cycle of colonization and contribute to healing their family, community, and relations.

› **We are All Healers:** Participants feel a human connection with staff and fellow participants that transcends roles and credentials. They honour the strengths and struggles within themselves and others and actively contribute to healing those around them.

› **Four Paths of Healing:** Participants experience activities that offer the opportunity to travel the four paths of healing and grieving: growth, cleansing, transcendence, and transformation.

Participants may come thinking they are addicts, but through a ceremonial process, they will leave "walking the Elder's path."

› **Culture is Medicine:** Participants embrace culture as they understand it. They use teachings they carry or receive in order to live a life guided by cultural and spiritual wisdom.

› **Traditional Way of Life:** Participants are encouraged to live an active lifestyle guided by traditional ways of life. They embrace the gifts that living a physically healthy life gave their ancestors: the capacity to thrive as physical beings.

› **Indigenous Knowledge Complemented by Western Approaches:** Participants benefit from the wisdom in Indigenous teachings as well as western psychology and medicine and experience the strengths both visions offer.

› **Experiential:** Participants are active agents in creating their transformational experience. Participants benefit from cultural and therapeutic activities and healing community processes, which are then integrated into their wellness vision.

› **Crises and Trigger Responses are Seen as Healing Opportunities:** Participants no longer live in fear of triggers. Triggers are viewed as short-term visitors that offer opportunities to heal. Participants develop their confidence and ability to regulate themselves to work towards micro healing moments in which they build resiliency and liberate themselves from trauma.

› **Balance Compassion and Responsibility:** Participants feel pride in that any healing and progress was a result of their choices and efforts. They have confidence that they can take the steps to achieve their own wellness.

MOVING FORWARD

The program described expands the parameters of current substance-related therapeutic approaches to embrace culture and socio-historic realities. While designed for Indigenous participants, many of these values and approaches are applicable to wellness across cultures. Psychotherapy has been described as a form of ceremony and originally emerged to take the role from clergy. Because this was part of the movement to the medical model, the cultural foundation of the practice of psychotherapy has been lost. We hope this article can contribute to the conversation about the cultural relevance of our practice. ■

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Shawna Biron, RCC, is a member of the Adam's Lake Band from the Secwepmc Nation in Salmon Arm. She works with non-profit Aboriginal organizations, the Regional Health Authority, and First Nations Health Authority on planning, program development, health administration, and direct mental wellness support.

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JUSTICE-DOING
IN THE ZONE OF FABULOUSNESS

Vikki Reynolds identifies as an activist/therapist with a deep commitment to justice-doing and an intention for a decolonizing framework. She is a white settler of Irish, Newfoundland, and English folks and a heterosexual woman with cisgender privilege. Reynolds works and lives on xʷməθkwəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish), and Səl̓ílwətaʔ (Tsleil-Waututh) territories, which are unceded and have never been surrendered. This frame for social justice activism and accountability for colonization has deep roots.

While she has been an advocate for social justice from a young age, starting with reproductive rights and women's health, the idea of being a counsellor came after she received an honours degree in outdoor recreation from Lakehead University in Thunder Bay. She was working with youth who were incarcerated — a "hoods in the woods" program — and ended up loving the youth more than the woods.

"Because of my working class background and critical analysis around the prison industrial complex, racism, and class, I realized there's a reason these young boys were incarcerated probably for life — all of them poor, most of them boys of colour, many of them had been in 'care' — and that got me involved," she says. "It became

obvious to me that, in order to have a more effective voice to advocate and to promote structural change, I would need to get a master's degree."

She got that MA in counselling from Adler University, where she has also taught, and a PhD in social sciences.

You mention your "real education" — what do you mean by that?

My "real education" for my practice comes from four decades of activist

Vikki Reynolds' RCC experience includes supervision and therapy with peers, activists, and workers responding to the opioid epidemic/poisonings, torture and political violence, sexualized violence, mental health and substance misuse, homelessness, and legislated poverty and working alongside gender and sexually diverse communities. She is an adjunct professor and has written and presented internationally on "Witnessing Resistance" to oppression/trauma, resisting "burnout" with justice-doing, and other topics.

solidarity and teachings from activists, mentors, co-workers, and, most especially, the people I have had the honour to work alongside who have survived the political violence of colonization and asylum seekers and refugees who experienced acts of political violence and torture. I have been nourished, inspired, and shouldered-up by networks of social justice activists, communities of resistance, teams of practitioners, and people I aim to be of use to, across four decades of struggle, activism, and community work. My work alongside people who are suffering has informed and transformed me. I owe a huge debt, in particular, to asylum seekers and refugees who have survived torture and political violence, people who were inmates on Death Row in the USA, and Indigenous people from Turtle Island (North America) who have survived and continue to resist the political violence of colonization, genocide, and assimilation.

What I call the "zone of fabulousness" is when we're fabulous — when we're in solidarity, when we're enacting our ethics, when people are really at the centre, when we're taking on our organizations and transforming them, when we have collective care.

Rupture & Repair: Morally Courageous Dialogue with Vikki Reynolds at Peak House in February 2020

What does "moral courage within cultures of accountability" look like for counsellors?

I was recently on a PhD committee with Hans Scott Meyer and he invited us to think of ourselves as water. Water is always moving and we're looking for the cracks and we're going to get in. I think every counsellor needs to reflexively question, where is my privilege and our collective access to power? From where I'm standing and the context I'm in, how can I be of use? What is something I can take on and actually make a difference? And who is with me? And not just personally, who is in solidarity with me, systemically?

I think about bus drivers who treat homeless people with dignity and help them carry their bags of cans onto the bus in Vancouver. They are doing justice. Wherever you are, you're well situated to take the next step to move towards dignity and to try to do justice.

In organizations, the point is not to go find a perfect place to work. The question is how do we collectively transform our organizations to better enact justice-doing? Structurally, what are the barriers in our work? Who is not hired where you're working? Whose voices are you informed by? Whose voices have been disappeared? What have you done collectively about being on colonized territory? These are good questions many good workers are on fire about right now.

I help teams commit to their collective ethics for justice-doing and look to our practice to see if we are "walking our talk," as activists say. You can't keep yourself ethical. We need to create relationships of respect and dignity that can structure enough safety for us to create cultures of accountability, so we can offer critique and hold ourselves collectively accountable. This requires moral courage, a resistance against smoothing-it-over practices, and resisting the politics of politeness that prioritize harmonious relations between staff over just relations with the person we want to be useful to. It's about transformation and solidarity.

Social justice issues are hard and heartbreaking. How do we sustain ourselves without burning out?

Burnout is language I don't like. It accuses workers of not having a quality like resilience or not doing enough "self" care, as if drinking decaf coffee and water is going to change homelessness… Here's what I believe. If what you are doing is ethical, even though it's hard and heartbreaking, you will be sustained in this work. I think burnout is better understood as an ethical or spiritual pain that results from working in ways that transgress the ethics at the heart of our work, transgressing the values that drew us to community work.

The context of my activism and

counselling has always been in the margins. I spent much of the 80s and 90s fighting the death penalty in the USA and in the world, and I worked for 20 men on death row who were all executed. Those men did not burn me out. They transformed me and taught me an adage from abolitionist movements: everyone is so much more than the worst thing they have ever done.

I've been involved for three decades in work with people who have survived torture and political violence. I have worked with asylum seekers and refugees who were denied refugee status in Canada and returned to countries where they were tortured and executed. This is ongoing.

I work alongside many peers and other workers responding to the opiate catastrophe. Our country has inured itself to throwing up its hands and letting 17 people a day die, when all we would have to do is change drug policy. This isn't cancer or AIDS. We have the answer right now. Donald MacPherson, the executive director of the Canadian Drug Policy Coalition, says these are all deaths by bad drug policy. In my understanding, that means these are politicized deaths. This is the source of my spiritual pain, not burnout from being in the face of suffering.

With this much hardness, and this much darkness, and this many people dying, how can you be sustained?

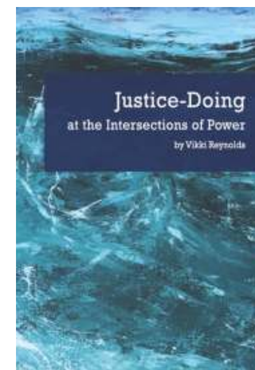
I'm sustained because I know I'm part of movements for just change. I'm not isolated. I'm connected to others. We're all in this together. I hold onto a believed-in hope that we can and do resist oppression on all fronts, and that inspires me. For me, sustainability is about collective care, solidarity, enacting our collective ethics, bringing a spirited presence, and being of use across our lifespan in all of our paid and unpaid work.

How does this connect to the "zone of fabulousness"?

What I call the "zone of fabulousness" is when we're fabulous — when we're in solidarity, when we're enacting our ethics, when people are really at the centre, when we're taking on our organizations and transforming them, when we have collective care. We resist enmeshment and disconnection and really hold people at the centre of our work in connection. I think this is connected to Paulo Freire's ideas of revolutionary love that means commitment to others and working for justice.

Final thoughts for counsellors?

A hopeful assumption I hold is that no workers came to our work to oppress other people, and we don't want to accommodate other people to lives of suffering. We want to respond to people's suffering and use our collective powers as a profession to change the contexts of structural oppression that promote suffering. Psychology can be used as a tool to blame people for their individual pain and oppression. We can resist neutrality and objectivity about contexts of oppression and work towards more liberatory practice and a more just society. I think we're required to collectively use our access to power not just to help one person with their own personal struggle with suffering, but also to change something like homelessness, like the Canadian state going into Indigenous territories for resource extraction. We're required to do something collectively to transform these contexts of suffering. ■



READ MORE

In her book *Justice-Doing at The Intersections of Power: Community Work, Therapy and Supervision* (Dulwich Centre Publications 2019), Vikki Reynolds describes the ways she works to bridge the worlds of social justice activism with community work and therapy.

WATCH THE VIDEOS

Vikki Renolds' videos, articles and keynotes are available free on her website www.vikkireynolds.ca.

In particular, under the Opioid Catastrophe Responses tab, see the video series on *Resisting Burnout & Vicarious Trauma with Connection: The Zone of Fabulousness*.

Kindness in thought, word, and deed

Some research suggests that being kind has a physical effect on the person performing the kindness — boosting levels of the hormone oxytocin and the neurotransmitters dopamine and serotonin, all of which are believed to play a role in regulating mood.[1]

While improving our own mental wellness is a good reason for being kind, there are many other reasons to be kind: it builds community and social networks, it shows respect to and consideration for others, it can help others in small and large ways, and it sets an example for others to follow. Being kind is simply the right thing to do. The fact that it also happens to make us feel good is a pleasant side effect. But genuine kindness is not about ourselves — it is about others.

Random acts of kindness groups have sprouted up all over the world, including a Random Acts of Kindness Foundation,[2] which lists hundreds of kindness suggestions organized into categories, such as seniors, kids, environment, work, online, and more. There is even an annual Random Acts of Kindness Day that takes place on the first Friday of November.

With the new social distancing recommendations, some acts of kindness may be inappropriate, but many others will be more appreciated than ever.

With the new social distancing recommendations, some acts of kindness may be inappropriate, but many others will be more appreciated than ever. For example, reaching out to people who may be struggling with stress and loneliness, offering to pick up groceries and supplies for neighbours who are unable to, staying in touch with family and friends using online video apps, putting together activity suggestions for families stuck at home, volunteering to assist others when opportunities are presented, and just having a friendly chat with people even if it means staying two metres apart.

The COVID 19 crisis is unfolding now, and expectations are that the situation will worsen before it improves. Finding ways to be kind may become more important than we can imagine.

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Curious Questions

Professionally and in life, the courage to be curiously questioning opens us up to worlds of possibilities

DON'T BE AFRAID TO ASK QUESTIONS. WELCOME THE QUALITY OF WONDER.

RECOGNIZE THAT ENQUIRY IS A FORM OF INTELLIGENCE. FROM THE IGNORANCE OF "NOT KNOWING WHAT YOU DON'T KNOW," MOVE TO "KNOWING THAT YOU DON'T KNOW," AND FROM THERE, TAKE STEPS TOWARD DISCOVERY.

I'M SORRY IS NOT ALWAYS GOOD ENOUGH

HOW TO GIVE A GOOD APOLOGY

BY KIM BOIVIN, RCC

Knowing how to effectively apologize is one of the most important skills we can develop in life. It has a huge effect on our overall quality of life.

When I work with couples, I get to see how people give and receive apologies. I get to see the kinds of apologies that don't work and may do further damage, and I also get to see apologies that work and create more closeness and bonding.

As counsellors, often it's a key part of our job to help couples learn how to give and receive good apologies and to experience their healing benefits. When we receive a good apology, we know it. It's like we have a built-in system in our bodies, hearts, and brains that recognizes a good apology. We feel acknowledged, and we feel relieved.

While helping our clients learn better apologizing skills may be a positive part of therapy, as counsellors, we can also benefit from honing these skills in our own lives.

HOW TO SAY SORRY IN SIX SIMPLE STEPS

1. Apologize before it's too late.
2. Examine the situation.
3. Realize the hurt you caused.
4. Take charge for the damage.
5. Make sure to seek forgiveness.
6. Promise it won't happen again.

BE AWARE AND SELF-REFLECTIVE. SEARCH FOR HIDDEN BIASES AND ASSUMPTIONS YOU MAY HAVE.

SEE ASKING AS A FORM OF HUMILITY. IT IS GRACIOUS TO SHARE YOUR VULNERABILITY WITH OTHERS AND FOSTERS UNDERSTANDING AND CONNECTION.

ASK OPEN-ENDED QUESTIONS THAT CANNOT BE ANSWERED WITH YES OR NO.

BE PREPARED TO BE SURPRISED. BE PREPARED TO BE WRONG. CELEBRATE THIS!

What does privilege mean to you?

Last January, we asked RCCs what privilege meant to them. As one RCC succinctly put it, "Where do I start?" Here are just a few of the many, many responses we received.

I am so used to having vast amounts of privilege from being a white male with economic and professional status that it is a real temptation to think about any diminution of that privilege as oppression.

In public, I am routinely met with civility and respect and not automatically subjected to suspicion, mistrust, or caution.

Not having to worry about getting employed because of the religion you practice.

Feeling confident that my voice matters; that I will be listened to and can make an impact.

I am educated, employable, have access to birth control, health care, and pension.

People automatically refer to me by the gender and pronouns that mostly fit my experience of myself.

If I receive poor service or unresponsive health care, I never have to wonder if it was because of the colour of my skin.

I am so used to having vast amounts of privilege from being a white male with economic and professional status that it is a real temptation to think about any diminution of that privilege as oppression.

While there were many people working at residential schools who were purposefully there to harm children, this is not true for all. Some truly believed, through their privileged experiences/beliefs/values, that they were not only justified in assimilating children and removing them from their families, but also that it was in the child's best interest.

I have such **easy access to clean water** that I can waste gallons of it just because it's not the temperature I would like it to be.

My white privilege means I am assumed to be the professional in the room; I never have to "prove" my expertise.

Being able to go to school, obtain a job, and receive a paycheque I can deposit into a bank.

Being physically able to walk, sit, travel with freedom because barriers like steps, curbs, gravel, narrow walkways, inaccessible bathrooms, and more are not an issue.

As a humanitarian field worker, I feel privileged when people in the most dire straits open their hearts and homes to me. And I am uncomfortable with my privilege knowing I can leave whenever it gets too tough or dangerous, leaving those I have witnessed behind.

Knowing each day that I am returning home to a safe environment.

I can address my experience of injustice to a service provider without fear of repercussion.

Awareness of my own privilege in the context of counselling means an awareness that notions of health and well-being and research in the fields of "therapy" and "counselling" are traditionally grounded in white privilege and white supremacy.

To me, having the ability to speak about privilege in an abstract, clinical way is a sign of privilege itself.

BCACC Member Health Benefit Plan

We know the current COVID-19 crisis may result in Registered Clinical Counsellors losing income due to illness.

While this affects RCCs to various degrees, it does highlight the importance of designing a strategy to cover unexpected income loss and an increase in medical expenses due to an illness.

It's not too late to start planning.

We offer our BCACC members excellent stand-alone plans that will help put a strategy in place:

Health & Dental or Health-only plans

Loss of income plans (Injury & Illness)

We recommend contacting our Benefit Specialist, Stephanie Ritchie (778) 533-4676 or email stephanieritchie@shaw.ca) to obtain a no obligation quote and to discuss how to design and put a strategy in place for you.

It is going to get better out there — but let us help you plan for the unexpected.

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**