SPRING 2021

INSIGHTS

THE BC ASSOCIATION OF CLINICAL COUNSELLORS' MAGAZINE

TRAUMA AND RESILIENCE in a First Nation Community

Connection is our Nature

NATURE AS A HOLDING ENVIRONMENT IN TRAUMA THERAPY

Mindfulness-informed trauma therapy during the COVID-19 pandemic

Event-based and relational traumas in the developing child

Top ten tools for grounding and staying connected in the present moment

CREATIVE INSURANCE SOLUTIONS

to better meet your needs

Founded in 1921, **Mitchell & Abbott** is built on relationships. With the client at the centre of all we do, we take a holistic approach to our service model.

As a Navacord Broker Partner, one of Canada's largest commercial brokers, **Mitchell & Abbott** offers increased sector expertise, expanded product offerings and stronger relationships with insurance companies. This means we're able to deliver a more diverse service offering, greater support, and more creative insurance solutions to better meet our clients' needs.

For any questions, please contact one of our team members at **800-463-5208**

BRENDA MATHIESON
bmathieson@mitchellabbottgrp.com

LORRAINE CAVENDER
lcavender@mitchellabbottgrp.com

JOHN PAUL MITCHELL
jpmitchell@mitchellabbottgrp.com

WE ARE PLEASED TO PROVIDE THE FOLLOWING INSURANCE SUMMARY TO BETTER PROTECT THE MEMBERS OF BCACC

- Policies start at $100 annually.
- Professional Liability (Errors & Omissions) and Commercial General Liability coverage will now start at $3,000,000. On renewal, any active member who currently has $2,000,000 will automatically be increased to $3,000,000 at the reduced cost. $5,000,000 option available with higher limits upon request.
- Employment Practices Wrongful Act Liability $250,000 limit included. Higher limits available upon request.
- DAS Legal Expense Insurance included for members who have purchased Professional Liability. The policy provides unlimited personal legal and tax protection advice. Simply call 1-877-255-4269 and provide your BCACC Legal Expense Insurance policy number GRP0016100. *$500 deductible applies to CRA tax audits ($10,000 max per claim).
- Policy pays the full cost of the legal defence up to the limit of liability selected. (Subject to sub-limits for the following: Abuse & Sexual Misconduct, Disciplinary Action, Penal Defence.)
- No deductible for any claim.
- No exclusion for Libel & Slander.
- Legal Entity coverage now includes up to three professionals on staff.
- Options available for clinics with more than three professionals. The additional cost for legal entities with up to 25 professionals is now $100.
- E-counselling is included in British Columbia and or any unregulated province.
- Security & Privacy Liability is included up to $100,000 per member – subject to a shared limit of $3,000,000 for all insured members.
- Cyber Liability available upon request.
- Employers Bodily Injury Liability Extension $2,000,000.
- Employee Benefits Errors & Omissions Insurance $1,000,000 .
- Commercial Property coverage available.
- Accidental Death & Dismemberment coverage available.
- Retiring members have the benefit of seven years reporting for claims during the time they were insured on the program.
- Coverage available for inactive members.

MITCHELL&ABBOTT INSURANCE BROKERS

NAVACORD®

A COMPLETE PROGRAM SUMMARY IS AVAILABLE ON THE BCACC AND MITCHELL & ABBOTT GROUP WEBSITES.

CONTENTS SPRING 2021

16 Transforming Trauma Triggers

Top ten tools for grounding and staying connected in the present moment from an RCC working with clients who have experienced trauma and/or abuse

FEATURES

IN EVERY ISSUE

INSIGHTS

THE BC ASSOCIATION OF CLINICAL COUNSELLORS' MAGAZINE

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

Kuljit Bhullar, Diane Brussell, Monica Dragosz, Mary M. Lang, Sonia Plewa, Gurleen Dhial Sangha, Britta West

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

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

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

Insights is published on behalf of the BCACC by
Page One Publishing
580 Ardersier Road
Victoria, BC V8Z 1C7
Tel: 250-595-7243
pageonepublishing.ca

Contributing Agency: Getty Images, Shutterstock

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

Find more information about submitting article proposals at bc-counsellors.org/media/insights-magazine or by contacting Marci Zoretich or Elana Ilott, BCACC editorial advisors, at communications@bc-counsellors.org.

Printed in Canada by Mitchell Press.

CONTEMPORARY RACISM

THE IMPACT OF MICROAGGRESSIONS ON

Training and education in race and racism is no longer a specialty but a duty. It is our duty and ethical responsibility as practitioners to honour the stories of our clients.

RACIALIZED POPULATIONS

BY GURLEEN DHIAL SANGHA, RCC

For my MA program, I researched barriers to accessing mental health services faced by South Asian Canadians, particularly those born and raised in Canada and who are the children of immigrants. If this population is experiencing racism, I wanted to know in what forms, what the impact is, and what the implications are for clinical practitioners. I did not know it then, but I was about to open Pandora's Box.

I began my research by interviewing 15 participants about their experiences of contemporary racism. Their stories were poignant, heart-wrenching, and a powerful reminder that racism is alive and well in Canada. Participants came from all walks of life, including a cashier, students, teachers, a nurse, doctor, former provincial judge, dental hygienist, accountant, and those working in the human services field.

The impacts of microaggressions include anxiety, insecurity, struggle, pain, shame, mistrust, guilt, humiliation, bitterness, brokenness, degradation, dehumanization, and feeling unsafe, horrified, awkward, confused, and targeted. Visceral responses include wanting to vomit, biochemical responses such as the release of cortisol and adrenaline, sweating, shutting down, crying, shaking, inability to function, and freezing. The cumulative burden of experiencing these affronts negatively impacts participants in a multitude of ways, such as identity development, parenting, vocational decision making, accessing mental health services, and interactions with white people.

Counsellors are not exempt from perpetrating microaggressions against colleagues and clients. The therapeutic environment is not excused from the cultural conditioning that is imposed upon us throughout our lifetimes. Mental health professionals are in positions of power where they can create diagnoses and treatment plans and potentially impact the lives of clients forever. When therapists are uncomfortable with the topic of race and racism, they shut down avenues for clients to explore issues of identity, internalized oppression, erasure, power, privilege, cultural history, code switching, allyship, bias, bigotry, colonialism, colourism, eurocentrism, or xenophobia. When working with racialized clients, counsellors must recognize the systems of oppression clients are navigating and operating within.

Training and education in race and racism is no longer a specialty but a duty. It is our duty and ethical responsibility as practitioners to honour the stories of our clients. We must be able to walk alongside the oppressed and aid in dismantling unhelpful narratives. We must be able to aid in social reconstruction.

The goal of this research is not to convince anyone that racism exists, but instead to give voice to racialized Canadians who have been silenced for far too long. The first step in dismantling racism is to explore deep inside ourselves to truly understand our own power, privilege, and implicit and explicit socialization. Only then will we understand what we bring into the room when we are working with clients who are trusting us with their stories.

Gurleen Dhial Sangha, MEd, RCC, is a clinical practitioner at the Centre for Response Based Practice. In addition to counselling, she is an anti-racism educator and activist. Her full thesis, Contemporary Racism in Canada: Lived Experiences of Canadian South Asians, *is available at is available at www.gurleensangha.ca.*

COMPLEX TRAUMA RESOURCES

Complex Trauma Resources was founded in 2012 by Dr. Chuck Geddes, R. Psych, to provide education and support to the parents and care givers, foster parents, adoptive parents, care teams, educators, clinicians, and professional agencies who care for traumatized children. In addition to a variety of professional online training opportunities, the website includes:

- **A free resource section organized by topic:** e.g., ACES, attachment, brain and neglect, emotional regulation, holidays and trauma, etc., and features tools, information, and videos to help deepen a clinician's understanding of trauma.
- **Healing tools:** Because complex trauma often causes changes in brain integration and organization, resulting in delays in developmental areas, many children and youth require support in areas of sleep, stress, emotions, learning, energy, etc. These tools are based on questions commonly asked by parents and care teams and may be helpful in providing support.
- **The Clinical Director's View** is an online forum to promote thought and conversations among professionals about the implications of a complex trauma perspective on child welfare service practices. Posts include "Bamboo Trees and ABCs" and "Working With Complex Trauma is Challenging: How to Increase Resiliency" written by Dr. Kirk Austin, RCC.

Find more information at www.complextrauma.ca.

CULTIVATING WELLNESS
GARDENING AS THERAPY

BY DIANE BRUSSELL, RCC

I am here to hail the healing potential of gardening in all its glory, as the epitome of magic, growth, and the miracle of life. Gardening is the quintessential collaboration with and connection to sustenance, nourishment, and creation. It is also the most fundamental grounding tool there is, literally and figuratively.

Connecting our bare feet — or any other part of our skin — to the soil grounds the electromagnetic radiation stored in our body and provides release and well-being.

"Multi-disciplinary research has revealed that electrically conductive contact of the human body with the surface of the Earth (grounding or earthing) produces intriguing effects on physiology and health.... Grounding appears to improve sleep, normalize the day-night cortisol rhythm, reduce pain, reduce stress, shift the autonomic nervous system from sympathetic toward parasympathetic activation, increase heart rate variability, speed wound healing, and reduce blood viscosity."[1]

Antidepressant microbes in the soil are said to be as effective as Prozac.

Additionally, antidepressant microbes in the soil are said to be as effective as Prozac. It seems perhaps they are more effective, as they are reputed to have effects lasting for three weeks — and are provided for by nature not human manufacturing.[2]

The bacterium found in soil is called mycobacterium vaccae and has shown a positive link to human health in studies: it stimulates serotonin production, which makes you relaxed and happier, reducing stress with no adverse health effects.[3] The bacteria can enter us through our skin and through our breath, as it is also airborne.

Gardens flourished in 2020 with a huge spike in plant and seed sales. I imagine this had as much if not more to do with providing the perfect anecdote to the fear and uncertainty surrounding the pandemic as it did with having extra time. The core of our being, where we are wired for survival, resonates with growth, is comforted by the proximity of sustenance, and delights in the sensory pleasures the garden affords.

We grow ourselves in the garden: our attention, presence, faith, nurturance, adoration, and gratitude. We meet blockages and have the opportunity to outgrow our limitations with dedication. We learn to cultivate our caring and the pleasurable wellness of getting grounded in the garden soil. So, please, wash off any residual sanitizer, take off your mask, and go heal in the soil.

Diane Brussell, MA, RCC, offers therapeutic gardening sessions as an option for counselling, working alongside her clients in the dirt, engaging metaphors, and supporting their full growth potential.

REFERENCES

1 Oschman J, Chevalier G, Brown R. The effects of grounding (earthing) on inflammation, the immune response, wound healing, and prevention and treatment of chronic inflammatory and autoimmune diseases. *J Inflamm Res.* 2015; 8:83-96. https://doi.org/10.2147/JIR.S69656

2 Glausiusz, J., (July 2007), Mind & Brain/Depression and Happiness – Raw Data "Is Dirt the New Prozac?" *Discover Magazine*, https://discovermagazine.com/2007/jul/raw-data-is-dirt-the-new-prozac?

3 Lowry, C. et al. (March 28, 2017) Identification of an Immune-Responsive Mesolimbocortical Serotonergic System: Potential Role in Regulation of Emotional Behavior." *Neuroscience.* 2007 May 11; 146(2-5): 756–772. doi: 10.1016/j.neuroscience.2007.01.067

OTHER SOURCE

Chevalier G., (2015) The effect of grounding the human body on mood. *Psychol.* Apr;116(2):534-42. https://pubmed.ncbi.nim.nih.gov/256748085

SAVE THE DATE

COUNSELLING IN A CHANGING WORLD

MORE THAN EVER, COUNSELLORS ARE NEEDED TO BRING COMPASSION, HOPE, AND RESILIENCE FORWARD AND TO HOLD SPACE FOR THE CHALLENGES AND GRIEF WE ARE ALL EXPERIENCING.

From June 17 to 19, 2021, BCACC's virtual conference, **Counselling in a Changing World**, will bring together counsellors from around the globe to discuss the many aspects of counselling in a rapidly changing world and globally connected communities.

Find connection, community, and inspiration with your peers both at home and abroad — join us! Registration opens spring 2021. https://conference.bc-counsellors.org.

KEYNOTE SPEAKERS AND WORKSHOP PRESENTERS INCLUDE:

DR. ALFRIED LÄNGLE

DR. BRUCE PERRY

DR. NICOLE REDVERS

DR. DIXON CHIBANDA

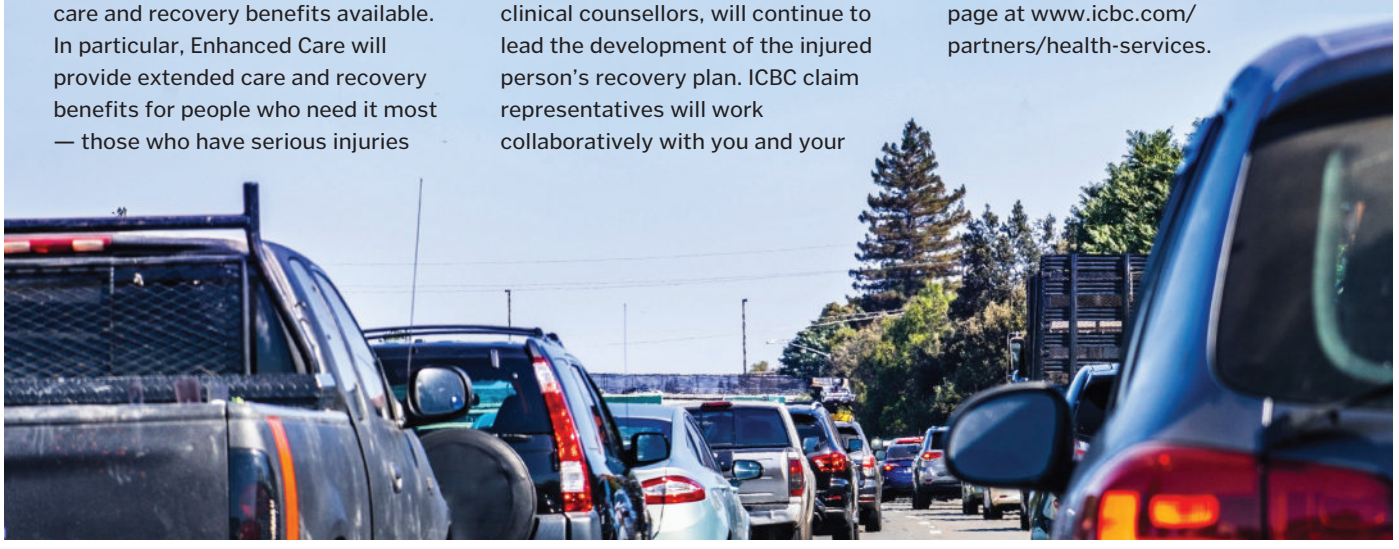
Better coverage for your clients from ICBC

On May 1, 2021, the provincial government, together with ICBC, will launch a new care-based auto insurance system.

Enhanced Care will provide British Columbians with access to significantly more medical and rehabilitation care if they're injured in a crash — with no overall limit to the care and recovery benefits available. In particular, Enhanced Care will provide extended care and recovery benefits for people who need it most — those who have serious injuries that significantly impact their daily lives. Under Enhanced Care, your clients will continue to have Early Access treatments within the first 12 weeks following a crash to meet their rehabilitation needs; these are currently known as preauthorized treatments.

Health care providers, such as clinical counsellors, will continue to lead the development of the injured person's recovery plan. ICBC claim representatives will work collaboratively with you and your client to help coordinate the care and services needed to support recovery.

ICBC hosted a one-hour webinar for clinical counsellors on Friday, April 16 at 8 a.m. to provide more information on Enhanced Care and what is changing at ICBC. To find out more and to watch the recorded webinar, visit ICBC's Health Services Partners page at www.icbc.com/partners/health-services.



CONNECTION IS OUR NATURE

NATURE AS A HOLDING ENVIRONMENT IN TRAUMA THERAPY

BY MONICA DRAGOSZ, RCC

For many people, the word "trauma" still conjures up the big T traumas — the experience or witnessing of acute bodily threat. But what most therapists are working with day in and day out are the little t traumas — exposure people have had as children to repeated and chronic experiences of all forms of abuse, neglect, and boundary violations otherwise known as developmental or relational trauma.

While even we, as therapists, may regard the trauma we see in our offices as personal in nature, there are undoubtedly sociocultural and historical influences. This is well known in the field of ecopsychology, a still somewhat new and emerging field of study that explores the relationship of the human psyche to the rest of nature.[1] From an ecopsychological perspective, personal, little t traumas have their antecedents in and are exacerbated by the severance of the human psyche from its roots in the natural world, a condition author and activist Chellis Glendinning has referred to as "original trauma."[2]

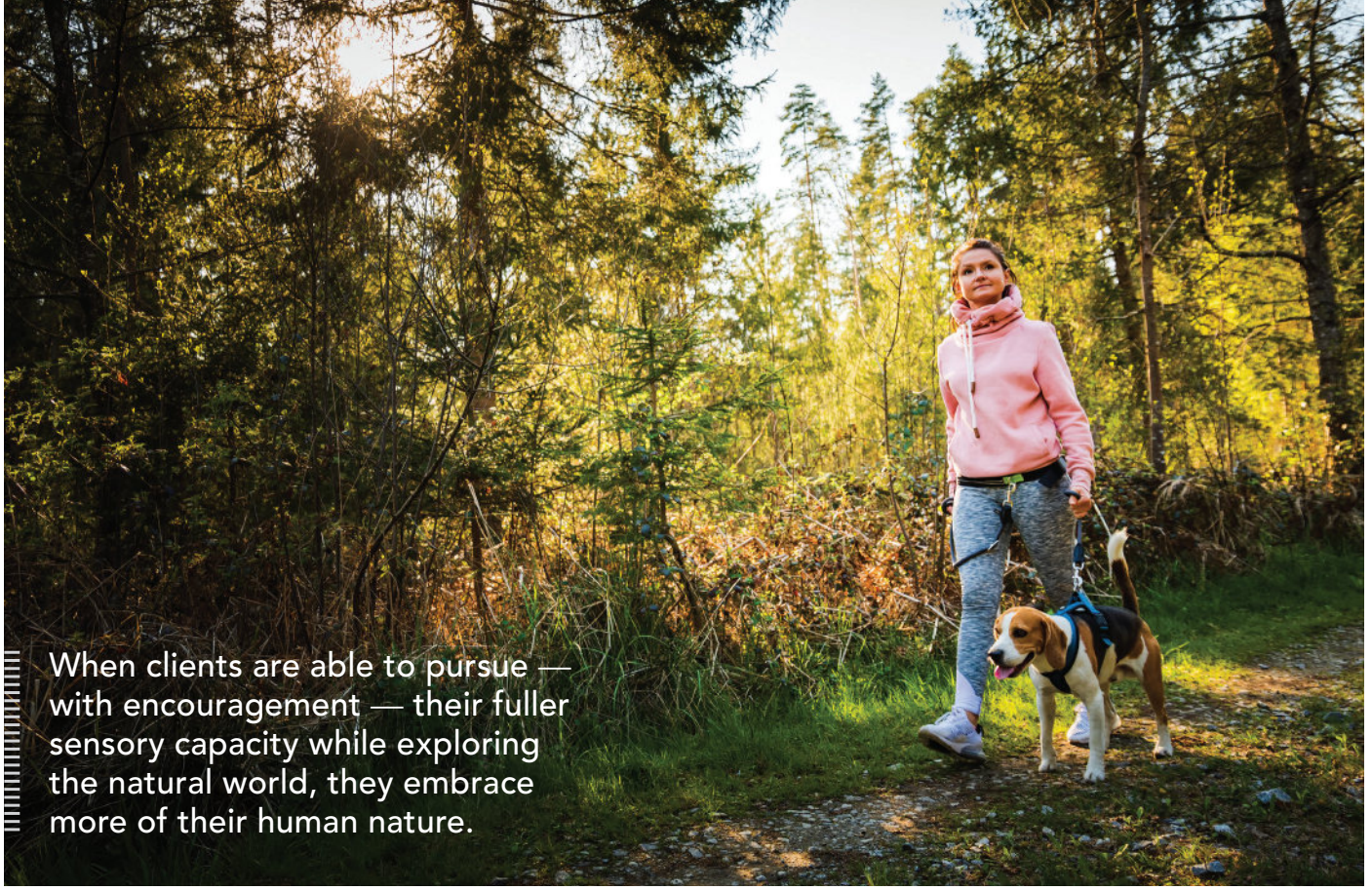
RECONNECTING TO NATURE

It stands to reason that part of our healing, individually and collectively, lies in a reconnection to our nature within nature. A plethora of research confirms nature's health benefits for modern people, evidenced by the growing network of physicians across the country who are formally prescribing time in nature to their patients.[3] But there are those individuals who, in spite of the collective condition of alienation from the natural world, seem to retain a deeper connection and relationship to it. Interestingly, trauma may have a role in that for a subset of this population.

Jerome Bernstein, an author and Jungian analyst, coined the term "borderland consciousness" — not to be conflated with borderline personality disorder — to describe a phenomenon in which some individuals experience a quality of communion and communication with nature he calls transrational — not understood by logic or cause-and-effect structure.[4] This orientation was witnessed to be extremely valuable to these individuals, often more so than their relations with other people and, therefore, even necessary to their functioning in the world. Bernstein came to regard this orientation as non-pathological, but he observed that some come to this orientation through what he calls the "trauma portal" — an experience of childhood trauma, often sexual trauma.[5]

Nature can undoubtedly be an important attachment relationship for clients with relational and complex trauma. With eye movement desensitization and reprocessing (EMDR), one of the first tasks is for the client to choose and establish calm or safe-place imagery for the resourcing phase of treatment. For many, this calm or safe place is within the natural world, and the way it is set up in EMDR is a good example of how, for some clients, nature can function as a primary relationship in the context of their therapeutic process.

Incorporating nature connection is an easy accompaniment to some of the somatic, mindful, and felt-sensing work that has become widespread in trauma



When clients are able to pursue — with encouragement — their fuller sensory capacity while exploring the natural world, they embrace more of their human nature.

therapy. Even for those clients who do not bring experiences with nature or nature symbolism into their therapy sessions on their own, they can be gently reminded of and turned towards what is both an important relationship and an accessible source of strength and support. In the words of therapist Ellen B. Macfarland:

Adults who have been abused as children need to find new ways of being in the world. They need to be open to all the nuances of life. There are rich lessons in the world of Nature that could not be learned when trying to survive in the chaotic world of an abusive family. Being in Nature can literally help in the generation of new neural pathways that can bring calm to the psyche.[6]

NATURE HOMEWORK

I regularly ask clients about the elements in nature in which they find meaning, support, and strength, and many are able to easily answer to this. I then suggest they actively pursue these connections. Sometimes, we lay the framework for an exercise or simple ritual engaging these elements to be undertaken outside of the session to further integrate insights and shifts that occurred within sessions. I find these "homework" assignments can be more readily embraced than other types of cognitive and behavioural tasks. The following example illustrates this, along with the somatic focus that can be woven between trauma therapy and nature connection.

A client of mine who experienced significant abuse in her childhood once spoke of being triggered as similar to being in a hurricane. Much of our work centred around trying to bring more calm to these stormy feelings.

One day in session, she recalled a time in childhood when she had the opportunity to say that she was being abused, but due to threats from her perpetrator, she chose to remain silent. As she sat with this storm inside of her, I looked for something to help ground her. Knowing this client treasured her regular forest walks, I suggested she think of the trees she encountered and focus on their rootedness and solidity. The client felt connected to a particular tree and, spontaneously, she imagined herself becoming that tree. What followed while she maintained this posture was that she imagined telling the truth about her abuse, effectively re-creating that moment. This was very powerful for the client. When she was once again more present-oriented, I suggested she visit this tree in real time to both connect with its strength and give thanks.

The client returned next session reporting that after having visited this tree, she felt an impulse to go to the ocean shoreline in the midst of a mildly stormy evening. She stood there alone with a new sense of her own truth in the face of the wind and crashing

waves. While she was relating this to me, a memory arose in which, some years later, the person who could have protected her asked if she had been abused. In her anger over their not having known at the time, she failed to disclose it then as well. The client then wanted to go back to the shoreline to tell them.

As we spoke, a fuller ritual took shape. I suggested bringing objects with her to signify her important relationships. She decided to take flowers to represent her caregiver, her child, and her grandchild. The client had successfully staged an early intervention in her own child's abuse, and for her, the flowers symbolized hope that the abuse would truly stop there, and that her grandchild would not experience this in their life.

The forest and the ocean shoreline provided a holding environment for this client to process aspects of her trauma that still required attention. Furthermore, I feel the client's simultaneous attention to her own bodily experience and to the raw elements of nature around her — experiencing "nuances of life" somatically in the movement of wind and water — provided a powerful means of integrating this trauma-related material.

I further believe that part of the gift of ecotherapy (the applied arm of ecopsychology) is that it may move clients toward post-traumatic growth in the form of enhanced appreciation for life and increased compassion and altruism.[7] Whereas much of ecotherapy is limited to improving outcomes for human health, Buzzell-Saltzman points out that it is possible to practice "Level 2" ecotherapy, which helps clients go beyond the idea of nature as a personal resource to grow an ecological self that seeks to show more reciprocity with the natural world.[8]

After several months in regular therapy for her trauma, my client came in one day speaking of a confrontation with family members about her attempts to involve them in household recycling. She felt that she had been a bit harsh with her words. As therapists, we know how easily clients with past trauma can default to trauma responses of fight, flight, freeze, and fawn, without ever knowing how to express themselves calmly and directly.

Part of the gift of ecotherapy is that it may move clients toward post-traumatic growth in the form of enhanced appreciation for life and increased compassion and altruism.

We explored the notion of expressing convictions firmly but non-aggressively. I asked her to think about an animal that may model this, and she recalled a startling encounter with a deer — an animal which most would agree has an aura of gentleness — who simply stood her ground. I could see my client was feeling into the deer's stance as she spoke. We spent some time having her contact her own felt sense of this as an imprint of a nervous-system state she could draw upon. This speaks to MacFarland's idea about how nature's nuances can help clients generate new neural pathways. I also like to think of it as a small example of what Buzzell-Saltzman calls the "Circle of Reciprocal Healing," where the client increasingly recognizes themselves as connected to nature, and nature keeps informing them how to live their lives as well as effectively act on its behalf.[9]

EMBRACING NATURE

I've seen the benefits of incorporating nature into work with trauma clients, without even accompanying them outside. When clients are able to pursue — with encouragement — their fuller sensory capacity while exploring the natural world, they embrace more of their human nature. This not only fosters resilience within the trauma-recovery process, but it also leads to becoming more empathetic to various non-human others — a real step toward establishing an ecological self. And as a therapist, it gives me great satisfaction to see clients re-establish their belonging within the greater earth community with more connection, motivation, and bandwidth to be an active agent in its unfolding. ■

Monica Dragosz, RCC, works in the unceded territory of the K'omoks First Nation, treating trauma and incorporating knowledge from the field of ecopsychology.

REFERENCES

1 Buzzell-Saltzman, L. (2016). *The Many Ecotherapies. Ecotherapy: Theory, Research & Practice*, eds. Martin Jordan & Joe Hinds. Palgrave Macmillan, pgs. 70-79.

2 Glendinning, C. (1994). *My name is Chellis and I'm in recovery from western civilization.* Shambala.

3 Metcalfe, Z. (2020, December 7). Take two hikes and call me in the morning. *National Observer.*

4 Bernstein, J. S. (2005). *Living in the Borderland: The evolution of consciousness and the challenge of healing trauma.* Routledge.

5 Bernstein, (2005).

6 Macfarland, E.B. (2008). *The sacred path beyond trauma: Reaching the divine through nature's healing symbols.* North Atlantic Books.

7 Kaufman, S.B. (2020, April 20). Post-traumatic growth: Finding meaning in creativity and adversity. *Scientific American.*

8 Buzzell-Saltzman (2016).

9 Buzzell-Saltzman (2016).

AFTER THEY TASTE THE RAISIN

MINDFULNESS-INFORMED TRAUMA THERAPY DURING THE COVID-19 PANDEMIC

BY MARY M. LANG, RCC

One of the earliest mindfulness exercises in mindfulness-based stress reduction and related trainings is to eat a raisin — mindfully. The purpose of this simple exercise is to initiate a familiar activity with deep attention. It is an invitation to focus awareness on the contents of immediate experience, which might otherwise be overlooked absent the focusing lens of mindful attention. Mindfulness-informed practices are an invaluable adjunct to my clinical practice, which is almost entirely devoted to working with adult survivors of sexualized child abuse and related attachment trauma.

One of the earliest stages of trauma therapy is becoming aware of what triggers post-traumatic symptoms, while learning and practising a repertoire of strategies to self-regulate these reflexive trauma responses. This serves to restore an embodied sense of safety in the "here and now."

The COVID-19 pandemic, however, has presented a unique counselling challenge for therapists. Both clinicians and clients are amidst a shared disaster. As clinicians, we've had to face our own personal fears and concerns, while supporting our clients in their response to the pandemic. We closed our offices in March 2020 and shifted to phone and online services. Many of us who have since returned to indoor settings sit farther away, wear masks, perform health screenings before each client's session, and disinfect surfaces between sessions.

Almost everyone's sense of safety in the "here and now" has taken a hit.

COVID STICKING POINTS

Almost immediately upon the lockdown in March 2020, a pattern began to emerge in my counselling sessions. Many of my clients developed an intractable COVID-19 narrative — specific things that terrified, haunted, or just really, really irritated pinned many of my clients under a barrage of intrusive thought loops. Post-traumatic symptoms long soothed and mastered re-emerged and resisted well-practised self-regulating efforts. As I listened, I wondered why it was one COVID detail for one person, while it was a completely different

COVID detail that got under another client's skin and caused intrusive thoughts and PTSD symptoms to re-emerge.

We were having a shared experience of a disaster, so it took a little while for me to sort through my own countertransference and discern that my clients were inviting me to witness two stories. First, they were debriefing their current experience of living through the pandemic. Secondly, and more significantly, they appeared to be sharing key, unresolved pieces of their personal trauma stories, projected through the lens of COVID-19. I began to invite clients to examine their fixations on the ongoing pandemic experience with more focused curiosity.

The invitation began with questioning why a particular aspect of the COVID-19 experience might be so difficult to accept while others weren't as "sticky." In examining clients' narratives together, we discovered strands reaching from the past into the present. As we viewed the present situation together, using the metaphor of an x-ray, we could see evidence of historical fractures along the "bones" of their accounts of the COVID-19 experience. This, to me, presented an important new level of psychodynamic, mindfulness-informed trauma practice — to work with real-time experience of the pandemic and invite clients to discern the trauma memories colouring that experience. To what trauma

Though the reality of the COVID-19 pandemic is shared the world over, our response to it remains profoundly personal — intimately tied to our own unique history.

memory was the body reacting, while the conscious mind thought it was just coping with a pandemic?

My clients became very interested with this investigative approach. Historical trauma themes, like fracture lines, became remarkably easy to see once we focused conscious attention. As we began to shine the light of consciousness on their particular "sticking point," we inevitably found un-metabolized pieces of their historical trauma story — pieces activated, but previously unnoticed, acting inexorably on their autonomic nervous system to manifest as PTSD symptoms. Mindful attention to particularly problematic COVID themes and parallels in the client's trauma story allowed us to recognize and start working with the difficult trauma pieces currently calling for witness (refer to chart).

A PARTIAL LIST OF COVID THEMES AND PARALLELS

EXAMPLE OF COVID-19 NARRATIVE	UNDERLYING HISTORICAL TRAUMA THEME
"How can people think this pandemic's fake! Why do people dismiss how serious this is?"	Not being believed
"My (family member) says I'm making a mountain out of a molehill with this COVID thing. They think I'm ridiculous. Nobody takes me seriously."	Family members being dismissive
"Why isn't (family member) telling (insert family member) to follow the guidelines for all our safety? They won't even wear a mask when they visit!"	Family members being silently complicit
"I never know when (friend/family member) will post some crazy-assed theory that I'm supposed to accept... I can't open my FB without a barrage of panic posts from (friends/family)."	A terrified, dangerous, or erratic attachment figure
"I feel trapped — I can't get away from it. I'm afraid of being infected by people I love."	The inability to escape harm
"This pandemic feels like it's never going to end!"	Not knowing when it will be over
"I'm afraid of infecting people I love."	Feeling like tainted goods; fear of destroying the family with the truth
"I'm all alone; there's no one to take care of me."	Isolation and having no one who can stop the harm
"Who's right — Dr. Bonnie? Theresa Tam? Fauci? They've changed their minds, too? Is it a hoax or not? I don't know who to believe."	Not knowing who to trust
"I can't tolerate the thought of coming in with a mask and seeing you wearing a mask."	The unapproachable attachment figure

Naming the themes often brought immediate relief. Instead of feeling out of control, many clients began viewing their fixations with compassion. They became enthusiastic observers of how their amygdala, recognizing the vaguest outlines of their historical trauma in a particular COVID-19 theme, would unleash the stress response. Every client has expressed respect for the defensive logic to which their soma and psyche respond.

MANAGING RESPONSES

With curiosity activated, the client's "social engagement"[1,2] system is more easily brought back "online" thus enabling them to analyze or redirect the COVID theme more skillfully. Once the trauma piece, piggybacking on a COVID detail, is brought to awareness, clients exhibit more motivation to employ self-regulation practices during and between sessions. I suspect this is because the trauma piece has been acknowledged rather than encoded in a re-enactment of the theme of being overlooked.

By engaging in discussions and somatic experiments,[3] clients become more adept at differentiating between historical trauma and current stressors. I can invite them to appreciate how this current experience is actually different from the trauma story.[4] Clients are calmed enough to explore felt senses and hitherto unrecognized acts of agency, enumerate current allies or support people, and review current strengths.[5] This exploration paired with somatic practices of centring and grounding become vital to managing clients' responses to the stressors experienced during the current pandemic, while attending to vulnerabilities triggered by parallel themes in their historical traumas.[6]

Once the trauma piece, piggybacking on a COVID detail, is brought to awareness, clients exhibit more motivation to employ self-regulation practices during and between sessions.

MINDING OUR OWN NARRATIVES

By inviting clients to examine their COVID narratives for personal trauma themes, my countertransference has also been better kept in check. Keeping a lookout for trauma parallels in clients' narratives, supports me in maintaining openness to my unique responses to COVID and my own unconscious fixations linked to personal, historical trauma themes. It prevents me from assuming I know what clients are going through "…because we're going through it together." We are, but we are also not. Though the reality of the COVID-19 pandemic is shared the world over, our response to it remains profoundly personal — intimately tied to our own unique history.

Counsellors and clients alike are reverberating to both this present crisis and to un-metabolized pieces of our histories. Mindful inquiry into the thematic significance of our own and our clients' particularly intractable COVID-19 narratives presents an opportunity to soothe and transform historical wounds amenable to change and grants an opportunity to witness, with gentleness, those wounds not yet ready to risk transformation.

With compassion and curiosity, counsellor and client together can investigate parallel themes that reach across time from the distant, personal past into our shared challenging and uncertain present. In so doing, we discover a richer, deeper experience of the present moment and ourselves. ■

Mary M. Lang, RCC, works with clients seeking relief from and acceptance of the legacy of childhood trauma and attachment issues. She draws inspiration from interpersonal neurobiology, attachment theory, narrative theory, and relational psychodynamic theory and is guided by the work of somatic and trauma specialists.

REFERENCES

1 Porges, Stephen. (2011). *The Polyvagal Theory: Neurophysiological foundations of Emotion, Attachment, Communication, Self Regulation.* New York: W.W.Norton.

2 Rosenberg, Stanley. (2017). *Accessing the healing power of the vagus nerve: Self help exercises for anxiety, depression, trauma, and autism.* North Atlantic Books.

3 Ogden, P. & Fisher, J. (2015) *Sensorimotor psychotherapy: Interventions for trauma and attachment.* New York: W.W. Norton.

4 Siegel, D & Solomon, M. eds. (2003) *Healing trauma: Attachment, mind, body, and brain.* New York: W.W. Norton.

5 Wade, Allan. (1997). Small acts of living: Everyday resistance to violence and other forms of oppression. *Contemporary Family Therapy*, 19: 23-39.

6 Van der Kolk, Bessel. (2020). *On the Global Coronavirus crisis: Steering ourselves and our clients through new and developing traumas* (video accessed through https://uncw.edu/counseling/covid-19.html)

OTHER SOURCE

Van der Kolk, Bessel. (2014). *The body keeps the score: Brain, mind and body in the healing of trauma.* New York: Penguin.

TRANSFORMING TRAUMA TRIGGERS

TOP TEN TOOLS FOR GROUNDING AND STAYING CONNECTED IN THE PRESENT MOMENT

BY DIANE BRUSSELL, RCC

Healing from trauma has two main stages: the immediate ability of calming the nervous system, body, and mind and the longer-term, reparative processing of the "undigested," implicit, fragmented, emotional memories. The initial work is aimed to support clients in stabilizing from an activated alarm state of danger to a state that is responsive rather than reactive — alert and conscious, where good decisions can be made. People need to be able to maintain an experience of present-time safety to be able to do the deeper work.

For the last three years, I have worked at a non-profit that provides affordable counselling for people who have experienced trauma and/or abuse. We provide up to 24 sessions to clients coming for the first time. While this is a lot, it is not enough to resolve all the wounding internalized from a life of historical abuse. And the wait list is long.

The tools presented here are those I have found to be the most effective, fundamental tools for grounding and staying connected to oneself in the present moment — tools I am told, again and again, that have given the necessary support to regain and remain in a mindful state, where the transformative experience of healing can occur.

1 NOTICING
SENSORY ANCHORING

Simply recognizing that we are triggered starts to deactivate the "alarm centre" and awakens the "thinking" part of the brain that shuts down in emergency, survival situations. Reflecting on how we know we are triggered continues that shift from alarm to thinking.

Noticing is the most important initial step. The tools are simple. The hardest part is being aware that we need them, then remembering to use them when we need them most. Practice makes new responses stronger.

Noticing our experience in the moment is the basis of mindfulness and can be done in myriad ways. I like to start with the kinesthetic sense of noticing the position our body is in — where we are making contact with whatever is holding our bodies to notice how and where gravity is affecting us and to feel the various sensations of our points of contact. Then proceed to notice what each sensory ability is aware of, one by one, sight, sounds, smells, tastes.

Everything we have ever learned or experienced in the world — memories, perceptions, judgments — came to us by way of our sensory motor system. Our physiological processes are the foundation of emotion and predate thought, the building material of our brain, which holds our schemata of the world.

For many people, dissociation became a habitual response to a life of chronic, inescapable abuse. Dissociation is not a mental illness, but a survival strategy and a way to exit the body when other survival responses are not possible, and it is simply too painful to inhabit and experience sensation.

This practice brings consciousness to all of our chronic survival responses and allows for new skills to be integrated. We want to introduce the concept and experience of feeling the body anew, slowly, integrating the reality of safety in the present.

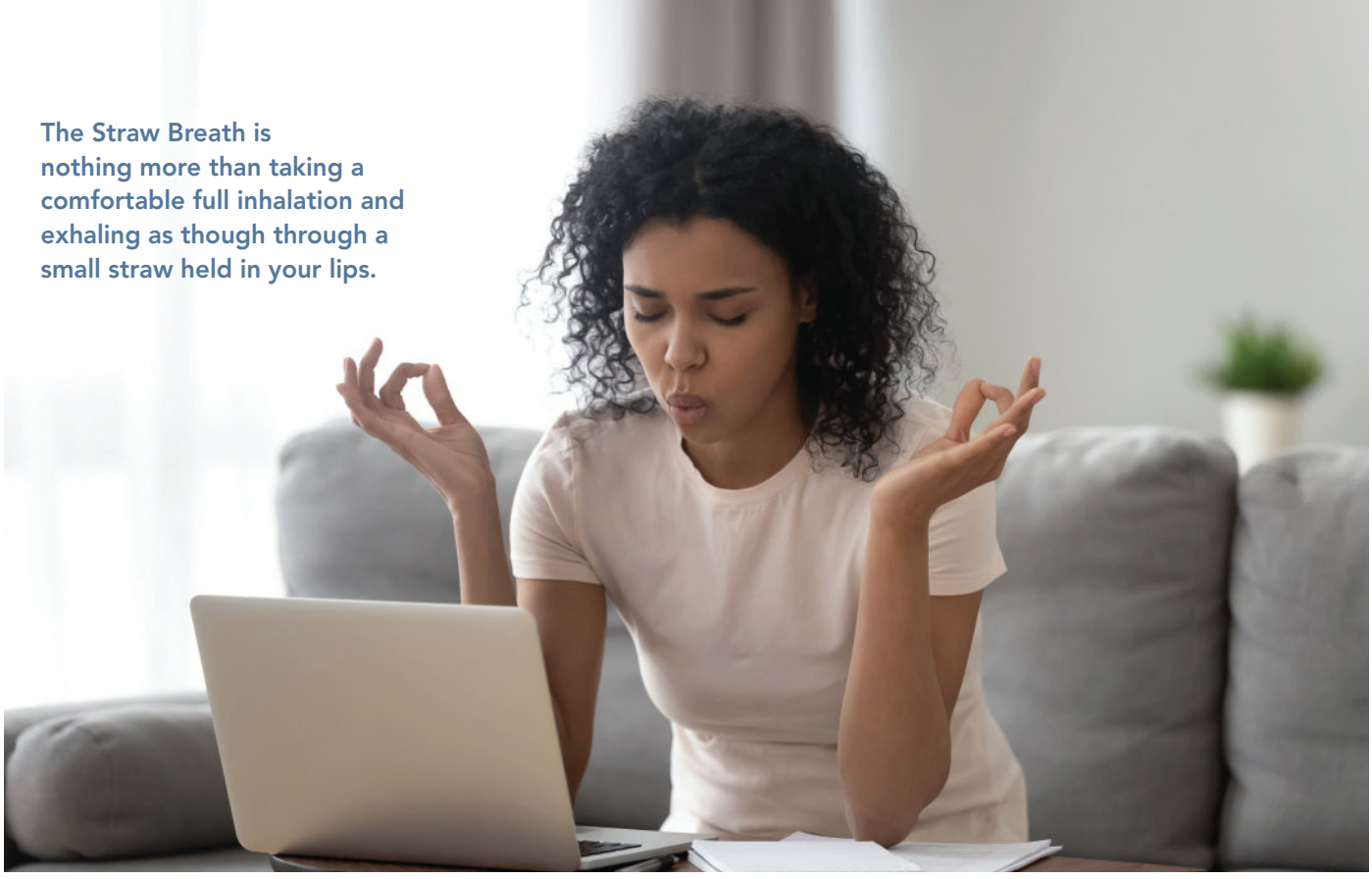
2 SOMATIC AWARENESS
TRANSLATION TO SENSATION

When I studied somatics in the 1980s at Antioch University, I used the definition put forth by Stanley Keleman: "Somatics is the awareness of one's internal experience; the body sensing itself from the inside."[1] Thirty years later, neurobiological studies explain why somatics are beneficial, as the fundamental agent of neuroplasticity and "rewiring" the brain. According to Daniel Siegel, the brain actually grows and thickens in proportion to the amount of time we spend being cognizant of our internal experiences.[2]

I ask that clients learn to "translate" positive and negative thoughts and feelings into sensations, to locate where and how they are experiencing a given thought, feeling, or belief and in this way, re-inhabit their body consciously, deliberately. As we notice patterns, inclinations, and tendencies, we are better able to make choices and expand the "vocabulary" of experience in this world.

It feels abstract enough to ask people who typically "live in their heads" to locate a given thought, feeling, sensation in their bodies, even without historic abuse. For clients whose bodies have been chronically mistreated, it can be very strange and even scary to be asked to feel themselves.

I let them know they are reclaiming their nervous system, because the same nerves that allow us to enjoy our world rally for our survival. Once we know we are safe, we can turn our attention to both the momentary neutral experiences, as well as the pleasurable sensations.



The Straw Breath is nothing more than taking a comfortable full inhalation and exhaling as though through a small straw held in your lips.

3 PRANAYAMA
BREATHWORK AND THE ELONGATED EXHALE

Pranayama is the branch of yoga that involves breathing techniques. Yogis have used breathing practices for millennia to cleanse, calm, centre, and alter states of being, activating or relaxing, depending on the intention and the breath used.

The most common breath practice I offer is for calming: slowing an activated sympathetic nervous system, the nervous system which readies us for action, excitement, enthusiasm as well as survival. If life is full of experiences of actual or perceived danger, we develop a chronic, habitual state of sympathetic arousal, flooded with cortisol and adrenaline and experienced as anxiety. The parasympathetic nervous system is the counterpart and is responsible for relaxing and going to sleep. Activating the parasympathetic nervous system sends a signal to the brain that all is well.

There are two variations of the breath practice, which technically characterize them as different breaths, but because they have the same central principle of activating the parasympathetic nervous system, I present them together.

The Straw Breath is nothing more than taking a comfortable full inhalation and exhaling as though through a small straw held in your lips. By making the exhale as long as possible without stress or strain, our parasympathetic system is activated. Even three of these breaths facilitate a recognizable change, but more is better.

For the Honeybee Breath, or Bhramari Pranayama in Sanskrit, the exhale is done humming, again, as slowly and as comfortably possible. Yogis claim this is the best cure for stress as it lowers blood pressure, heart rate, and cerebral tension. It is also said to soothe the nerves, stimulate the pineal and pituitary glands, and free the mind of agitation, frustration, anxiety, and anger.

4 HANDS ON

Hands on is noticing where in our body we are feeling a given thought, feeling, or belief and placing our hands on that or those parts of our bodies.

I invite people to close their eyes if they are comfortable to do so, and breathe into those hands and the parts of the body that they are contacting. Typically, it is the heart and/or stomach, but wherever it is, I ask that they allow that body part to register the supportive presence of their hands to comfort, care, and acknowledge and to feel the warmth, connection, and love. I then ask the hands to feel what they are feeling and to experience how good it is to show up as a nurturing, stabilizing presence. This positive reflection will amplify the benefits and strengthen the resourceful purpose.

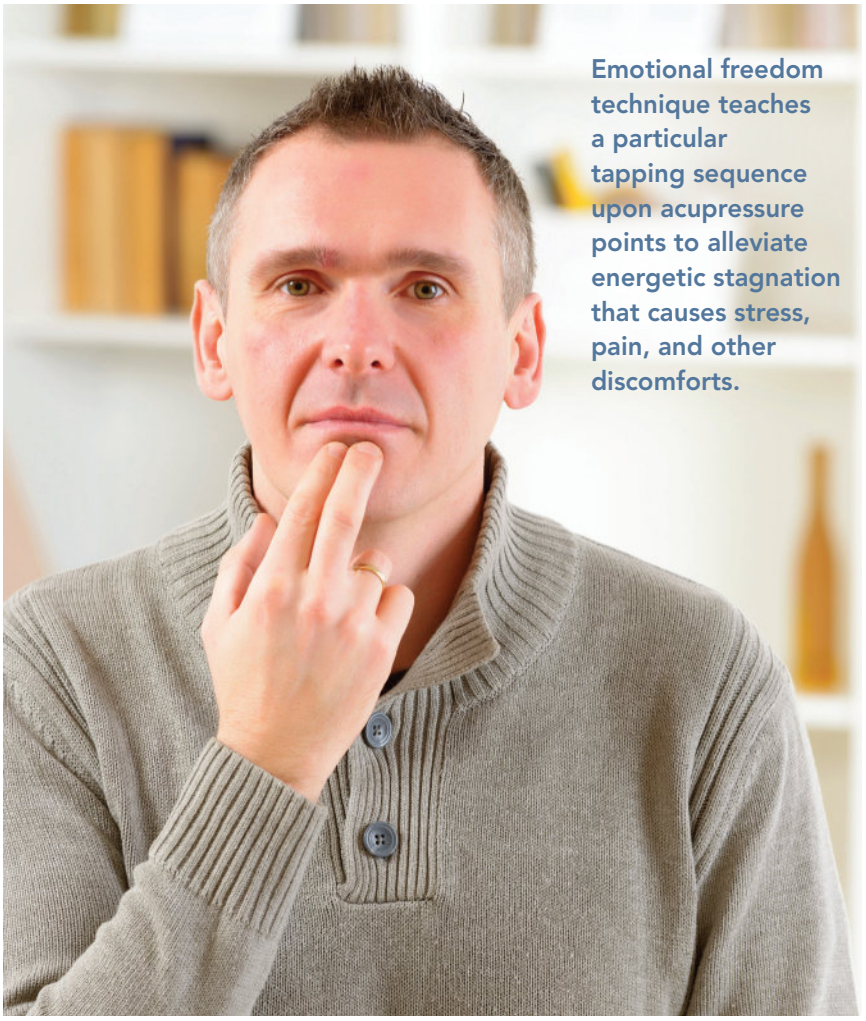
5 TAPPING

Several different practices use tapping to access and enhance positive states, activate resources, and produce a calming effect. In her book, T*apping In*, Laurel Parnell, an EMDR specialist, describes many protocols for instilling a range of resources to manage anxiety, establish a sense of safety and empowerment, boost performance, and enhance creativity.[3]

Tapping can be done as a stabilizing preparation for EMDR or alone. It involves visualizing a resource — a person, place, thing, emotional state, inner experience — and allowing ourselves to feel it both emotionally and physically, then "tapping it in" with taps on alternating sides of our body. In doing so, we are said to be building new networks of positive experiences that are neurologically encoded and can be accessed through tapping as needed.

Emotional freedom technique teaches a particular tapping sequence upon acupressure points to alleviate energetic stagnation that causes stress, pain, and other discomforts.

If nothing else, remembering to tap is itself a form of mindfulness and provides present-moment sensory grounding, which are the building blocks to reset the "breaker switch" when triggered.



Emotional freedom technique teaches a particular tapping sequence upon acupressure points to alleviate energetic stagnation that causes stress, pain, and other discomforts.

6 GETTING GROUNDED

Nature is a huge, infinite resource that helps us connect to ourselves and our place in this world on many different levels at once. Many different studies confirm the grounding effect of connecting our skin to the earth. If possible, take off your shoes and connect bare feet to the soil. Gardening and getting your hands in the soil is also good, and hugging trees literally grounds the excess electromagnetic charge in our bodies.

If possible, connect with the larger, natural world, if not physically, then abstractly through photographs or touching unprocessed natural objects. Mentally recalling a place and positive experience in nature through all five senses can provide stabilizing, calming effects on the body and brain, as does listening to recordings of natural sounds, such as the ocean, wind, and birds.

A commonly known guided meditation is to connect with the sensation of your feet on the floor and imagine roots growing out of your feet, down through the floor, the building, the foundation and into the earth, connecting you to a network of strength below, where energy and nourishment can be absorbed.

7 SWITCHING AND ALTERNATING PERSPECTIVE

A very effective tool for mitigating triggers is to cover one eye for four to five breaths, then switch eyes and breathe four to five breaths. As you switch back and forth between eyes, notice changes or shifts in the level of activation, rated from 0-10, and where in the body the activation is showing up. Usually one eye carries more of our trauma triggered responses. The practice of switching not only mitigates the trigger, but also supports lateral integration of the experience in the brain. If repeated several times, four to five breaths each time, you will likely experience decreased activation and a deeper sense of calm.

8 INVENTORY OF JOY

Create an "Inventory of Joy" by making a grid with eight columns and at least six rows. The columns are for our five senses plus activities, places, and memories. In each column, list at least six things that inspire a feeling of joy, enthusiasm, calm, peace, appreciation, or warmth. Once completed, put it somewhere easy to reference — on the refrigerator, cell phone, computer screen, anywhere it can be easily and frequently accessed.

As we recall and consider these things, we activate the neural networks associated with these states in our brains. In this way, we practise the ability to change our state to a pleasant one. It is a study guide to remind us when we forget that there are things to listen to, places to go, things to do, scenery to behold, pictures to look at or draw, textures to touch, smells, and tastes that can shift our experience to one that is more favourable.

9 FIRST RESPONSE SENSORY KIT

A first response sensory kit is a little customized pouch we put together and keep nearby — in the car or a handbag or backpack — to remind us of our caring, protective self. Put at least one object to activate each of our five senses:

- Something to look at that evokes joy, peace, and comfort: a photograph of a loved one, pet, or favourite place;
- Something pleasant to touch: a favourite rock, crystal, or swatch of silk or velvet;
- Something to remind us of a comforting sound: a seashell, feather, thumb drive with favourite songs, or the first line of a favourite song to sing;
- Something fragrant: a little jar of essential oil, spices, or bark; and
- Something to taste: a mint, gum, or dried fruit.

This is also a good place to put a copy of the "Inventory of Joy" (see number 8) or anything that can bring us back to our senses and provide a sense of safety in the present moment, maybe even gratitude

There is evidence to suggest that while singing and dancing are beneficial, there is even more to be gained when we sing and dance with other people.

10 MUSICAL THEATRE
SINGING, DANCING, ACTING

Admittedly, by choosing musical theatre, I am squeezing in three tools in the space of one, but it also happens to be something I am personally partial to and have resourced as my number one tool for most of my life. I cannot convey my personal satisfaction, joy, and validation when trauma specialist Bessel van der Kolk told me, when I attended his workshop at Hollyhock in 2016, that musical theatre is the best tool there is for healing trauma.[4]

More and more research validates what we as humans know instinctively: singing and dancing have the ability to soothe us when we are upset, lift our spirit, enhance our enthusiasm, facilitate regulation in babies and toddlers, forge connectedness with other beings, and enrich the quality of our well-being. Interestingly, there is evidence to suggest that while singing and dancing are beneficial, there is even more to be gained when we sing and dance with other people.

Sadly, our culture that does not integrate these activities into common daily life, much less welcome and embrace each person's voice, dance, and story. For the purpose of these tools, I encourage everyone I speak to and everyone I support to sing, dance, and share their stories as often as they can.

PATHWAY FORWARD

It takes practice to remember there are things we can do to shift our experience — to use tools to change our state of being from anxiety or depression to one of clarity and choice. However, each time a tool is used, we forge and reinforce a new pathway, making it more accessible and effective. ■

Diane Brussell, MA, RCC, works in private practice in Courtenay and with a non-profit specializing in trauma and abuse counselling. She has studied and practised somatic psychology for over 30 years and has offered a wide array of groups and classes. www.dianebrussell.com

REFERENCES

1 Keleman, S. (1979). *Somatic Reality*, Center Press.

2 Siegel, D. (2008). *The Neurobiology of We: How Relationships, the Mind and the Brain interact to Shape Who We Are*, Audio CD, Sounds True Inc.

3 Parnell, L, (2008). *Tapping In: A Step-by-Step Guide to Activating Your Healing Resources Through Bilateral Stimulation*, Sounds True Inc.

4 Van der Kolk, B. (2014). *The Body Keeps the Score*, Penguin.

OTHER SOURCES

Chanda, M.L.& Levintin, D. (2013). The Neurochemistry of Music. *Trends in Cognitive Sciences*, v.17 (4)179-193.

Fancourt, D et al. (2016). *Ecancermedicanalscience*. 10:631.

Fisher, J. (2017). *Healing the Fragmented Selves of Trauma Survivors; Overcoming Internal Self-Alienation*, Routledge.

Grand, D. (2013). *Brainspotting; The Revolutionary New Therapy for Rapid and Effective Change*, Sounds True Inc.

In a downwards spiral from PP-PTSD, a new mother not only feels detached from her friends, family, partner, but also her child.

POST-PARTUM PTSD

A form of trauma we aren't talking about

BY KULJIT BHULLAR, RCC

As counsellors, we are constantly on a quest to learn everything we can about mental health and how to identify symptoms of struggle in our clients. However, when the roles are reversed and you begin to notice symptoms in yourself, you gain a deeper insight that is simply impossible to attain through textbooks and professional training.

As an avid planner, I was one of those women who had her birth plan ready months before delivering: I knew what my rights were, I knew what options were available to me, and I was determined to be a part of the decision-making process every step of the way. I had also planned for the unknown and was comfortable with knowing things wouldn't necessarily go as I had expected.

Fast forward from my meticulous planning to the delivery room. Everything was going as expected until I suddenly developed an infection. With my temperature spiking, my daughter's heart rate was dropping, and I was told she was at risk of being exposed to the infection. There was an urgent rush to deliver her to minimize harm to her health. After a fast-paced delivery, my daughter was born, but that cry every parent waits for was not heard. Before I could even so much as glance at her, she was rushed to the Neonatal Intensive Care Unit (NICU). All my planning was out the window as this was not a scenario for which I had prepared.

I remember asking my doctor: "Is she okay?" I kept getting the same answer: "The doctors are with her." My mind was filled with racing thoughts: What does that answer mean? Is she okay? Is something wrong? I was not given any concrete information. My only option was to wait. What felt like a lifetime later, my husband came back from seeing our daughter and told me she was safe but needed continued medical attention in NICU.

When I was finally able to meet her, my daughter was laying in an incubator with tubes in her mouth and nostrils and an IV in her arm. I put my hand on her chest

>> I was not in any way prepared for the events that took place during my daughter's birth and the symptoms I experienced during my early post-partum months.

Prevalence of PP-PTSD

The rate of PP-PTSD in women following a live birth is 4.6 per cent to 6.3 per cent.[1] Of those women who did not qualify for a formal diagnosis of PP-PTSD, 16.8 per cent still had clinically significant symptoms.

To put these percentages into perspective, in 2019 there were 372,038 live births in Canada.[2] That means approximately 62,000 Canadian women may have experienced symptoms of PP-PTSD in 2019 alone. Combine those numbers with numbers from previous years, and we are looking at a significant issue impacting many women globally.

62,000 (or 16.8%)
CANADIAN WOMEN MAY HAVE EXPERIENCED SYMPTOMS OF PP-PTSD IN 2019 ALONE.

Chances are, if you asked the average person what affects the mental health of approximately 60,000 Canadians each year, they would be very unlikely to guess the birthing process. This can be attributed to the fact that information on PP-PTSD is not something commonly discussed or readily available.

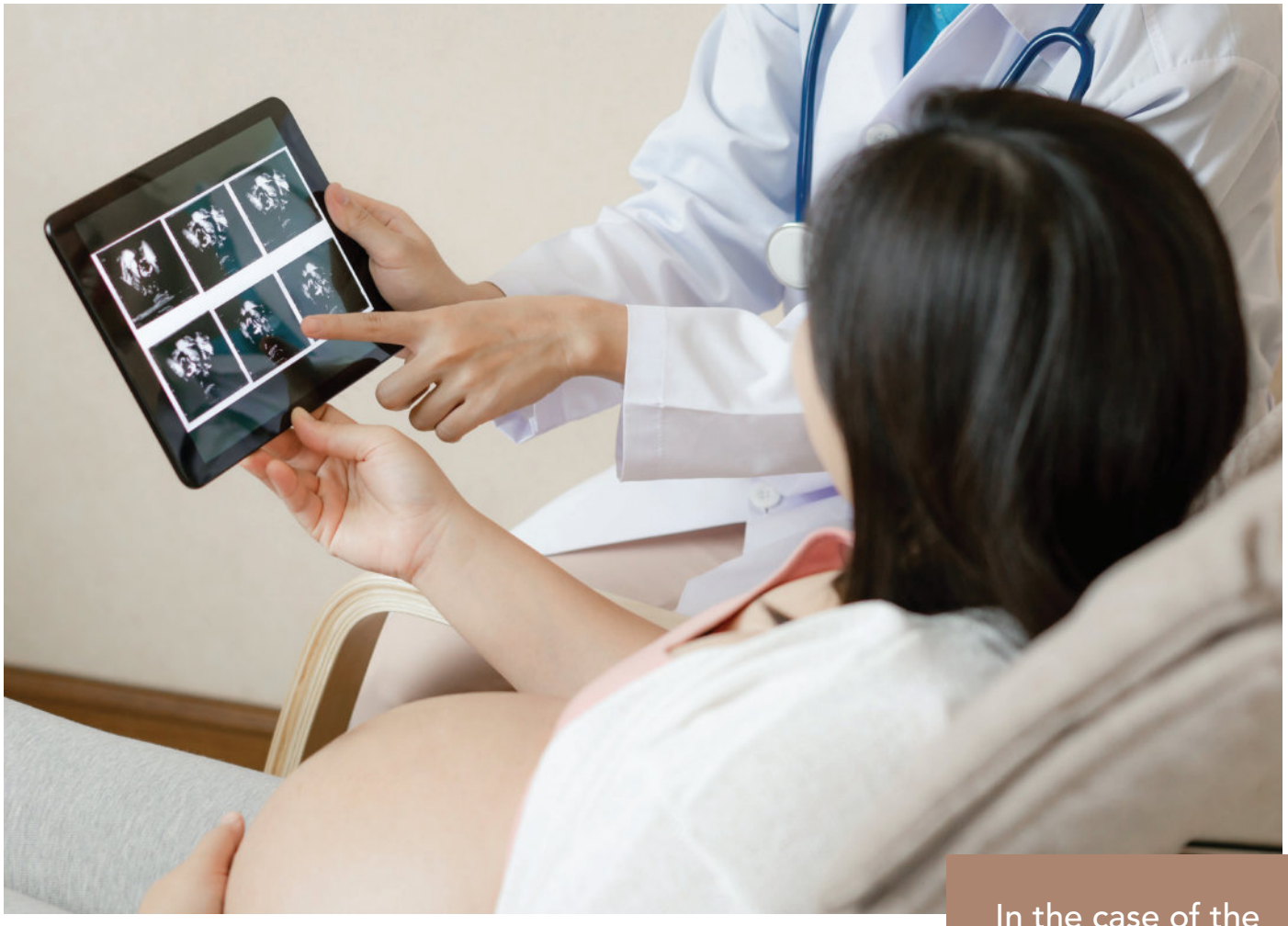
and cried knowing all of these tubes were inserted by strangers and feeling immense guilt that I wasn't there to protect or comfort her.

What followed for months afterwards was a series of symptoms I thought was post-partum depression. Despite being in the counselling field for over a decade, I wasn't able to draw the association between the birth trauma I endured and the feelings I was experiencing. I was not in any way prepared for the events that took place during my daughter's birth and the symptoms I experienced during my early post-partum months. I later learned that the symptoms I had were associated with a unique form of post-traumatic stress disorder (PTSD): post-partum PTSD (PP-PTSD).

DIAGNOSIS AND SYMPTOMS OF PP-PTSD

What can lead to a birth being classified as traumatic? *The Diagnostic and Statistical Manual of Mental Disorders* (DSM-V) defines PTSD as something that occurs when a person or their loved one is exposed to an actual or perceived serious injury or death.[3] In the case of the PP-PTSD, trauma can occur when a woman encounters the threat that she or her child is at risk of serious complications or death during the birthing process. A mother might experience this risk in instances such as premature labour, unplanned C-section, use of instruments to assist with delivery, the baby being admitted into the NICU, or other birthing complications. As a result of the event, a woman could experience a series of symptoms associated with PP-PTSD.

The DSM-V classifies symptoms of PTSD to include unwanted upsetting memories, nightmares, flashbacks, and emotional distress when faced with reminders of the event. PP-PTSD is not



a formal diagnosis that can be found in the DSM-V. However, the symptoms of PTSD can be related to the post-partum experience. Some of the symptoms a woman with PP-PTSD might have include:

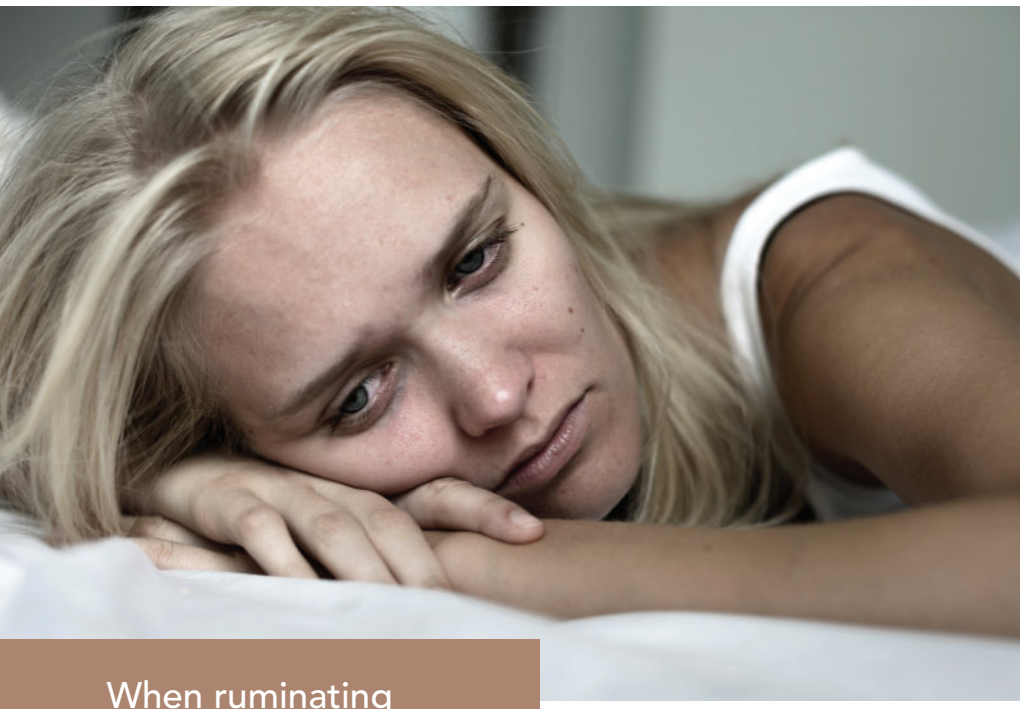
- **Flashbacks:** recurring thoughts and images of the birthing experience. Flashbacks are often accompanied by a strong emotional response when reliving details of the event. Not only are these thoughts upsetting, but they can also impact the ability to focus on the present moment. A mother might find she is not as responsive to her child's cues due to the difficulty concentrating.

- **Sleep disturbances:** Trouble falling asleep could be due to intrusive thoughts, increased levels of cortisol, or being in a hypervigilant state following a traumatic experience. New parents are already sleep deprived from caring for a newborn. When this is compounded with additional sleep disturbances, the effect can be detrimental to emotional and physical health.

- **Avoidance:** Being reminded of the birthing experience can be difficult for a woman, and she might avoid things that bring up memories of the birth. This can include not wanting to see pictures of her newborn in the early days, avoiding the area of the hospital in which she delivered, feeling fearful of medical professionals, and avoiding conversations related to pregnancy and childbirth.

- **Decreased self-regulation:** When one is overwhelmed, frustrated, and exhausted,

In the case of the PP-PTSD, trauma can occur when a woman encounters the threat that she or her child is at risk of serious complications or death during the birthing process.



When ruminating negative thoughts about yourself are combined with the toll of caring for a newborn and a lack of sleep, the outcome can be detrimental.

it becomes challenging to control emotions and reactions towards others. Ultimately, this can impact a woman's relationships with her partner, family, friends, and possibly her newborn. These challenging interactions could further complicate and upset a mother who is trying her best to carry on with limited resources.

■ **Decreased self-esteem:** A woman with PP-PTSD might have irrational thoughts, including blaming herself for the events that took place during delivery. She might carry a strong sense of guilt or shame for what happened. This is further complicated if a new mother compares her birth experience with that of others. Self-defeating thoughts and decreased self-esteem can make it difficult for a woman to want to open up about her experience and reach out to her friends and family for support.

HOW PP-PTSD DIFFERS FROM POST-PARTUM DEPRESSION

Unlike PP-PTSD, post-partum depression can be found in the DSM-V under "Depression with Peripartum Onset." Symptoms of post-partum depression include feeling down or depressed, loss of interest in activities, feeling angry or irritable, withdrawing from others, and feelings of worthlessness.[4] With the similarity in symptoms, it is easy to see how PP-PTSD can be confused with post-partum depression. The comorbidity rate of these two diagnoses makes things more difficult to decipher.

One study found that of woman with PP-PTSD, 90 per cent also reported symptoms of post-partum depression.[5] As a result, diagnosing PP-PTSD could easily be overlooked. When women do not get the appropriate support they need, they are left vulnerable to further risks to their mental health.

IMPLICATIONS

Experiencing post-traumatic symptoms after giving birth can significantly impact a woman's identity, self-esteem, and relationships. I remember thinking: "If only I knew what was going to happen, then I could have prevented it." For a rational person, it is easy to say that no one can predict the future. However, in that state of mind, I was convinced there was some signal I must have missed. If only I could go back in time and notice signs, then I could have prevented the complications that arose from my delivery. This constant self-blame can significantly affect one's feelings of self-worth. This is particularly worrisome when new mothers are already questioning their abilities to parent effectively. When ruminating negative thoughts about yourself are combined with the toll of caring for a newborn and a lack of sleep, the outcome can be detrimental.

Another issue that can come up for women experiencing PP-PTSD is resisting the desire to have another child out of fear of experiencing another traumatic birth. This puts the mother in a difficult position, and she might become very hard on herself for these feelings. The strong contrast between wanting another child for herself and her family, but also fearing the experience can leave a mother feeling helpless and significantly impact her mood and self-confidence.

The negative sense of self and feelings of despair and frustration a mother experiences with PP-PTSD can cause her to isolate and distance herself from others. This withdrawal can be

>> Appropriate supports for someone with PP-PTSD include therapy with a trauma-informed counsellor, support groups, and medication, if necessary.

particularly detrimental when it comes to bonding to the new baby. Women with PP-PTSD were found to have lowered levels of attachment to their child, compared to other new mothers.[6] The new mother may blame herself for the difficulty attaching and further question her ability to parent. Thus, in a downwards spiral from PP-PTSD, a new mother not only feels detached from her friends, family, partner, but also her child.

HOW TO HELP

Getting support after experiencing a traumatic birth can be very difficult. On one hand, women might feel afraid to talk about their experience out of concern for other mothers. This can happen if a woman feels she is being selfish by talking about the circumstances she faced with friends and family who are also having children.

On the other hand, when people who experience trauma decide to talk about it, they are often told to focus on the positive. In the case of PP-PTSD, for example, women might hear: "At least you and your baby are healthy, and that is all that matters."

According to Bessel van der Kolk, a best-selling author in the field of PTSD, "Trauma is not the story of something that happened back then. It's the current imprint of that pain, horror, and fear living inside people."[7] Dismissing someone's current experience with trauma by asking them to focus on the positive doesn't allow for appropriate processing and healing.

Society can only become more supportive when information on birth trauma is readily available. Currently, no specific screening tools are available to assess symptoms of PP-PTSD. If such a resource were available to medical professionals, they could identify symptoms and help women seek the early intervention they need. Appropriate supports for someone with PP-PTSD include therapy with a trauma-informed counsellor, support groups, and medication, if necessary. In therapy, the opportunity to safely talk about the birthing experience with a professional can help to process the difficult emotions.

Years before becoming a mother myself, I had a friend who went through premature labour. As a result, her daughter required a lengthy stay in NICU. Although I tried my best to be supportive, I now see other ways in which I could have helped her. In the famous words of Maya Angelou, "Do the best you can until you know better. Then when you know better, do better." The same goes for supporting women with PP-PTSD. We must educate ourselves about the impacts of birth trauma so we all know better. Only with that knowledge can we "do better" when supporting mothers on their post-partum journey. ■

Support for PP-PTSD

- **Pacific Post Partum Support Society:** Services including telephone counselling, weekly support groups, and support specifically designed for partners. Visit www.postpartum.org for more information.
- **Postpartum Support International:** Online support groups on various topics related to perinatal mental health. Visit www.postpartum.net for more information.

Kuljit Bhullar, RCC, owns her private practice, Attuned Wellness, in Kelowna. She specializes in trauma and anxiety.

REFERENCES

1 Dekel, S., Stuebe, C. & Dishy, G. (2017). Childbirth induced posttraumatic stress syndrome: A systematic review of prevalence and risk factors. *Frontiers in Psychology*, 8(560). https://doi.org/10.3389/fpsyg.2017.00560.

2 Government of Canada, S. (2020, November 23). Births, 2019. Retrieved January 30, 2021, from https://www150.statcan.gc.ca/n1/daily-quotidien/200929/dq200929e-eng.htm

3 American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders (5th ed.)*. https://doi.org/10.1176/appi.books.9780890425596

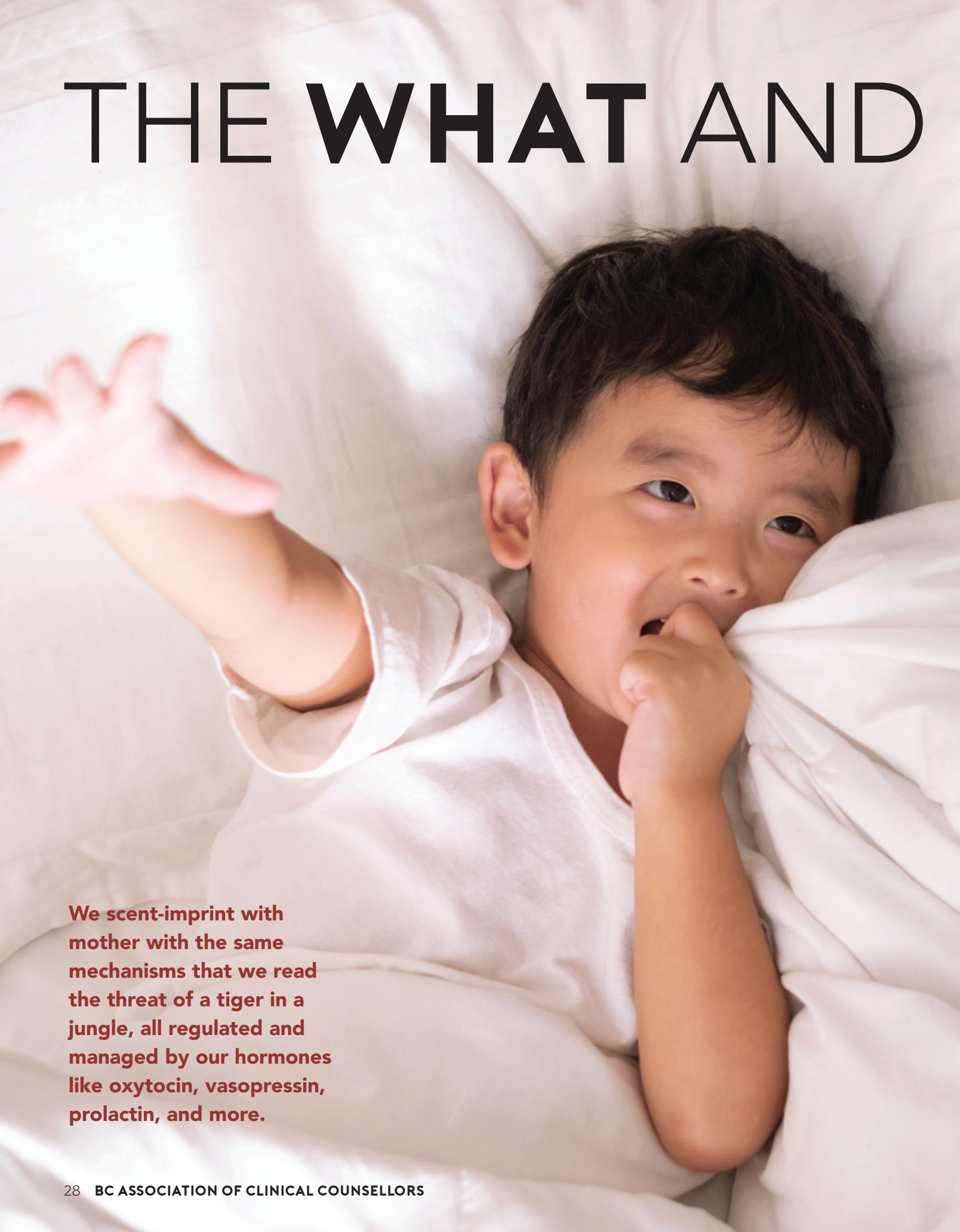
4 CAMH (2021). Postpartum Depression. https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/postpartum-depression

5 Dekel S, Ein-Dor T, Dishy GA, Mayopoulos PA. Beyond postpartum depression: posttraumatic stress-depressive response following childbirth. *Arch Womens Ment Health*. 2020 Aug;23(4):557-564.

6 Dekel, S., Thiel, F., Dishy, G. et al. Is childbirth-induced PTSD associated with low maternal attachment?. *Arch Womens Ment Health*, 22, 119–122 (2019). https://doi.org/10.1007/s00737-018-0853-y

7 Psychotherapy Networker interview with Dr. Bessel van der Kolk. January 11, 2017.

THE **WHAT** AND



We scent-imprint with mother with the same mechanisms that we read the threat of a tiger in a jungle, all regulated and managed by our hormones like oxytocin, vasopressin, prolactin, and more.

THE WHO OF TRAUMA

EVENT-BASED AND RELATIONAL TRAUMAS IN THE DEVELOPING CHILD

BY BRITTA WEST, RCC

Ages ago, a supervisor said to me that "therapy is both an art and a science." I have developed a working theory that the therapy is the art and the clients are the science. I think this conceptualization developed, because my client base is largely people who have experienced trauma of some kind.

The immense amount of data on traumatization that has emerged in the last 15 years compels us to understand our clients from that scientific perspective underpinned by consistent and reliable data. It is truly clear that the trauma response follows distinct patterns of brain, body, and behaviour in humans and the animal kingdom at large. These inveterate responses are connected to the most primordial elements of our nature, and I consider them to be our super powers. Frankly, I wouldn't want to move through this world without my trauma-responding system.

TURN ON THE NATURE CHANNEL

If we are looking to understand the patterns and presentations of the trauma-responding human animal, we need look no further than the nature channel. I kid, but also not. I was raised on Marty Stouffer and David Attenborough, and if you are ever curious to see what PTSD looks like, just find a prey-focused episode, and you will see all you need to know. That's us right there in the camera like an embattled gazelle; exhausted and desperate, but alert… balancing on the line of survival.

So why am I pointing my young clinicians to PBS and not the creators of psychotherapy?

It is important for young clinicians to understand the skew in which much of their training is embedded. The field of psychology, and its technical adjunct psychotherapy, emerged as a branch of philosophy. Thinkers who thought about ways to think about thinking. Psychology and the practice of therapy did not emerge from doing or being at all. The bias in our field towards cognition is bred in the bone.

So, what do Marty Stouffer and David Attenborough know about cognition that we don't? Well, not much. Because they were out there observing doing and being not thinking. And anyone who has an even basic understanding of the brain and body post-trauma could tell you that we don't have much cognition to work with in a traumatized state.

In fact, if we understand the science of the human mammal (shared between biology and neuroscience), we are compelled to treat clients in the limbic system, the amygdala, the brainstem, and nervous system, and, fascinatingly, also the endocrine system.

My supervisees are constantly reminded to "get out of the fancy brain" when they are stuck on cognition and have lost their hold on the visceral distress their clients experience. Traumatization doesn't live in the fancy brain (my short form for the prefrontal cortex); it takes root in our autonomic, unattended, thoughtless, and rudimentary systems. This is why trauma is so unbelievably de-stabilizing. Traumatization hijacks these basic elements of our functioning and turns them upside down in ways we cannot seemingly control or understand. And we certainly cannot think our way out of them. Traumatization lives in us like hunger, pain, or attraction. I haven't ever been able to cognize my way out of any of those.

WHAT HAPPENS TO US

When asked to define trauma at a workshop I am giving, I usually use this sophisticated definition: "Bad stuff that happens to you."

Then the next question: "Bad stuff happens to lots of people, but not everyone is traumatized?"

Then I say "Yes, so interesting, traumatization exists in the respondent, not in the source. One person's war

When asked to define trauma at a workshop I am giving, I usually use this sophisticated definition: "Bad stuff that happens to you."

zone is another person's Tuesday afternoon. We can only know traumatization exists because of the pattern of responding, not the nature of the threat."

Simply put, the body internalizes a stimulus as a threat and codes that threat as serious enough to engage the trauma-responding system. Then it can't turn the responding system off, either because the threats keep coming or everything looks like that original threat. If there was a car accident, then anything that sounds like a car — planes, trains, buses — sends you spinning. If there has been a fall, then anything high — elevators, Ferris wheels, a hike — sends you reeling. Your senses experience anything thematic to the original threat, and they let your system know that it's "go-time." Your body is then sent a series of cues to get you mobilized.

This internal protocol is consistent for people who have experienced event-based trauma. Plane crashes, accidents, injuries are all examples of events that can cause traumatization.

However…

WHO HAPPENS TO US

I can't remember the last time I had a client attend counselling because of an event-based trauma. I am a clinical traumatologist and specialize in the field. I have seen hundreds of clients over several years, and I suppose, if I carefully think, the last time an event-based experience was a client's presenting concern would have been in 2014. That is not to say that the people I see have not experienced horrific events, but the presenting traumas are almost entirely not event-based.

Relational trauma and, more specifically, attachment trauma dominate the client base I see. Even in the presence of other event-based traumas, it is the relational and attachment trauma that really commits the injury.

We know from the data and from the experience of the professionals who work in the field of attachment trauma that the abused and abandoned child presents differently than the soldier who returns from war. The abused child has almost all the same shell shock as the soldier but is saddled with other symptomology that the soldier will never demonstrate. The myriad symptoms that can occur, including bedwetting, hoarding, sexual intrusion and abuse, feeding disorders, hygiene refusal, self-harm, toileting issues, and many more, are known among us who devote our time to their treatment and care. But this profile is often left out of the literature and discussion when we talk about trauma. It is uncomfortable to discuss and heart-wrenching to see. The distress that attachment-trauma kiddos endure is unmatched. It is distress embedded in the body through a specific conduit that is not activated in event-based trauma.

BEHAVIOURAL NEUROENDOCRINOLOGY

The branch of biology that elucidates attachment, and therefore the systems that are compromised in attachment trauma, is behavioural neuroendocrinology.

Attachment exists in the space between us. It is a tie that binds which you cannot see but certainly can smell. Olfaction is a key sensory input for the creation of attachment, as our scent-imprinting to our food and love source is crucial. We connect to our sources of safety, love, nurturance, and survival,

and we will turn the world upside-down to stay connected, regardless of the quality of the connection. That we are connected is far more important than that we enjoy the connection. And, of course, the brain manages this connection in the same region it manages threat. If we weren't alert to the danger of those closest to us, we wouldn't be good at staying safe. That safety radar system is precisely the same system used to send signals of attachment and connection. We scent-imprint with mother with the same mechanisms that we read the threat of a tiger in a jungle, all regulated and managed by our hormones like oxytocin, vasopressin, prolactin, and more.

Hormones also do other things, though, like make much of the rest of our body function. When we must fight/flee, our body is activated by hormones released from our endocrine system. Considered cell-signallers, hormones function as messengers from the brain that control our bodies. You need your heart to beat faster? A hormone. You need to sweat? A hormone. You need to eat? A hormone. So, we bond with the endocrine system (sometimes to our trauma source), and then we manage our threat response with our endocrine system as well.

This dual functionality of the endocrine system is a major component not present for consideration in the same way with event-based trauma. This is why we see such dysregulation of basic bodily functions and behaviours in abused children, where we do not see this in soldiers back from war. The soldier's damage exists in their heightened sensory input and over-active central nervous systems responses. The abused child's damage exists in the endocrinologic systems that:

1) create attachment, and
2) regulate basic bodily systems.

In attachment trauma, unlike event-based trauma, because the source of trauma flows through the attachment system, the damage the trauma does occurs in that system as well. And because of the dual functionality of the endocrine system, the damage cascades to various systems of the body that are also managed by the same hormones.

THE THERAPY IS THE ART

We need to distinguish this kind of trauma response. The DSM has not afforded us this, but we cannot wait. There are clinicians working in the field forging ahead with a widely accepted definition of attachment trauma, as well as treatment models that are distinct from traditional treatment of event-based trauma.

My breathing, heart rate, affect, temperature, vocal pitch, and cadence are my treatment — and some Lego and a few colouring books. It doesn't sound like much, but it takes a lot of focus and self-regulation. When attachment trauma clients are asked to sit in a room with you and bond, be vulnerable, remember things, and speak it all out loud, we are asking them to enter the tiger's territory in ways that the plane crash survivor is not asked. And this is why I think the therapy is the art. I can predict the patterns of the client's distress. The art of therapy is in developing a bond with them that can restructure the basic coding of their brains and bodies. Retraining their attachment brains and resulting hormonal signals to not be set alight just by being in the room is the therapy. We don't think about thinking at all.

I have one kiddo who doesn't really speak most sessions. We sit, colour, listen to music — we co-regulate. I am not sure his little heart has ever been near a steady-beating heart in his life. The value of the time isn't what he learns about himself or his past. His treatment, for now, is being able to breathe and sit and regulate, while I am breathing and sitting and regulating right with him.

From relationship to body to mind. ■

FASCINATING IMPLICATIONS*

FROM A CORRELATIONAL STUDY

- Indigenous and African American women are among the populations most exposed to attachment trauma. Oxytocin, a key player in attachment bonding, is also responsible for a healthy pancreas. Indigenous and African American women have higher than normal rates of diabetes.
- If you have a skin lesion, your wound heals faster when you are sitting beside your partner, as compared to an injured person who is sitting alone.
- Vasopressin, which is responsible for attachment bonding in males, also happens to regulate urination. We see increased rates of bedwetting in children who have had attachment trauma.

**Derived from course materials used in Britta West's attachment trauma training program.*

Britta West, RCC, is a clinical traumatologist specializing in attachment and developmental trauma with extensive experience in the treatment of multi-axial and neurodevelopmental diagnoses alongside traumatization.

A nation is not conquered until the hearts of its women are on the ground. Then it is finished no matter how brave its warriors or how strong their weapons.

— TSISTSISTAS, CHEYENNE PROVERB

TRAUMA AND RESILIENCE
IN A FIRST NATION COMMUNITY

BY SONIA PLEWA, RCC

We cannot talk about trauma without acknowledging the resilience, strength, power, and creativity of the human spirit, which has the ability to survive, and even thrive, in spite of — and sometimes because of — horrific life circumstances.

May this small piece of writing be a tribute, an acknowledgment, an honouring of my relationship with all the beautiful, brave, resilient Indigenous women, whom I was privileged to encounter over the last three years in my therapist office in a small reserve community on the central coast of B.C.

May it also serve as a platform to publicly express my deeply felt gratitude for the time we have been able to work together. Gratitude for the trust you put in me, an outsider with a strong East-European accent, trust in the therapeutic process and in your own healing powers. When I kept apologizing for my real or imagined cultural inadequacy, you kept reminding me about our common humanity. How much you have taught me about trauma and resilience, suffering and strength, pain and forgiveness, so hand in hand, inseparable in your everyday lives from a very young age.

It has been a fascinating, rewarding, and, at times, heart-wrenching, gut-wrenching journey. Here, between the four walls of my counselling office, we closely examined all possible (and seemingly impossible) combinations of the little t and capital T traumas you have encountered and endured: the pain of loss and grief, violence and sexual abuse, neglect and abandonment, chronic pain, self-harm, suicide, murder.

In time — actually, I think it was quite early on — it became clear to me that we cannot talk about t and T traumas without acknowledging G and H trauma: the generational and historical trauma of 150 years of colonization and genocide against the Indigenous People in Canada. Always, in every case, we needed to remember the bigger context. After attending to the personal wound, we had to give attention to the collective hurt of your people, to bear witness to the pain of dislocation, loss of culture and identity, confusion, despair, anger.

Interestingly, for many of you, becoming consciously aware of how the bigger, historical picture informed your intimate, personal reality has brought relief and given voice to a long-stifled compassion towards self, your close relatives, and even towards the very

people who had hurt you. "Now, I get why mum never showed me or told me that she loved me." "Now, I understand why he did this to me; the same must have happened to him." I heard these comments over and over and over again.

GETTING MYSELF OUT OF THE WAY

Our rich therapeutic journey offered all of us incredible opportunities to grow. As you gained more courage and trust to share your story and cry in front of a stranger, I learned to get myself out of the way. "Don't just do something, sit there" became my therapeutic motto, even though at times I felt the strong pull of a well-known temptation to "make things better." But when, in the face of unimaginable events of your life, no words of comfort would come, we learned to take respite in the silence.

In that safe and quiet therapeutic space that grew between us, you slowly started to befriend your body. We know now that the body keeps the score,[1] and we cannot ignore the body on the healing journey. Trauma nuggets are stored in the nervous system and in the muscles, and they manifest in sometimes strange, mysterious symptoms of aches, pains, rushes, depression, anxiety, and many other forms of expression. Trauma robs us of that precious relationship with the body: we no longer feel or hear, no longer understand why we do what we do. Therefore, it was really important for us to focus on the body (and drop, for a moment, the narrative or the story line), ask into it, attend to it with kindness so it could reveal its wisdom. We decided not to judge the symptoms or simply try to get rid of them; instead, we got curious and even inquisitive, trying to understand.[2] I think there is usually a hidden answer in a question, the same way a symptom often offers the medicine needed for healing. And indeed, once we started shining the gentle light of attention onto the body, solutions for healing came.

I never assumed the position of an expert telling you what to do. Instead, I acted out of a place of curious not-knowing, encouraging you to lead the way towards healing by highlighting your strengths and getting in touch with your intuitive ways of being and knowing.

"Don't just do something, sit there" became my therapeutic motto, even though at times I felt the strong pull of a well-known temptation to "make things better."

For some of you, the medicine meant connecting more strongly with the culture and the village Elders: doing the river baths, dancing and singing in the Big House, being part of a traditional cleansing ceremony during the Potlatch, smudging and brushing. Once, the Elder told me we are never alone: there is always the land and there are always the ancestors. It was beautiful to witness how both came to the rescue: the forest, trees, and ocean provided respite for all. Many of you went fishing, made jam, and baked bread.

Others found the strength in simply remembering that your ancestors have been on this land for 14,000 years. Some of you reconnected with the image of the powerful grandmother or the loving grandfather, and some wrote them letters and burned their favourite food as an offering. At times, their presence in the counselling room was palpable: we could feel their blessing, support, wisdom — and also hope. I believe the same hope informed all our sessions, the hope that nudged you to ask me for help: hope for the future of your people, for healing, for life in wellness, dignity, and grace, for a life where your dreams and plans and visions can be nurtured and realized. You knew your healing was making that kind of a future that much more possible. And you felt responsible to keep going.

There was also humour. Let us remember the laughter that came to the rescue in the darkest, most intense moments. The metaphor of the shit always brought a smile onto your face: we compared our counselling sessions to shovelling manure and transforming shit from our lives into valuable compost.

As the work of self-discovery continues, some of it is beginning to pay off. Many of you have created some pretty potent compost concoctions, and the inner and outer landscapes of your lives are being patiently, lovingly transformed and beautified. I have been privileged to witness some of those radical changes: you depend more on the support of family and friends, you have patience to play with the children, you are walking to work, you had your first sober Christmas in years, you got a new job and are exploring what a healthy relationship looks like, you write a journal, you smile. You are beginning to bloom. ■

Sonia Plewa, RCC, has been living as an invited guest on the traditional Heiltsuk territory, working for the independent Heiltsuk Nation in Bella Bella since 2018.

REFERENCES

1 A phrase borrowed from the title of Bessel van der Kolk's book, *The Body Keeps the Score: Brain Mind, and Body in the Healing of Trauma* (2015).

2 See Indigenous (formerly Aboriginal) Focusing-Oriented Therapy (IFOT) and the founder Shirley Turcotte. https://focusinginternational.org/about/aboriginal-focusing-oriented-therapy-initiative/

Bruce Tobin, RCC, has been a member of BCACC since 1982. He worked for about 20 years with Health Canada providing psychotherapy in First Nations communities in the Victoria area. He also worked for many years with School District 63, serving four middle schools on the Saanich Peninsula, and taught Expressive Therapies at the University of Victoria for 25 years. Throughout this time, he also maintained a private practice centring on treatment of anxiety, depression, and emotional trauma.

THE RIGHT TO TRY

RAISING PSYCHEDELIC-ASSISTED PSYCHOTHERAPY UP FROM UNDERGROUND

Bruce Tobin, RCC, began exploring research on psychedelic-assisted psychotherapy nearly 15 years ago, after realizing over time just how limited and ineffective conventional pharmaceuticals and clinical skills are in so many cases. Certainly, he witnessed many clinical successes over the years, but he saw far too many clients for whom the "state of the art" simply wasn't up to the job.

The research he discovered was promising. Several large North American research centres were showing evidence that psychedelics could be gamechangers for some of the great mental health challenges of our age: anxiety, depression, addictions, PTSD, and chronic pain. Some of Tobin's clients were also coming across this research and were asking him about it.

"I knew some clients were being treated by 'underground' therapists, but I decided I wanted to take this issue above ground — to open lawful psychedelic options up to Canadians in need," says Tobin. "My ultimate goal has been to see psychedelic options become available within Canada's public health systems — hospitals, hospices, provincial mental health centres — as well as private clinics."

Tobin was encouraged in his quest by two significant developments. First, in 2000, legal medical cannabis came into effect after the Ontario Court of Appeals ruled that prohibition of cannabis for medical purposes violated the *Canadian Charter of Rights and Freedoms*.

"This ruling appeared to apply just as much to psilocybin as the court affirmed it did for cannabis," he says.

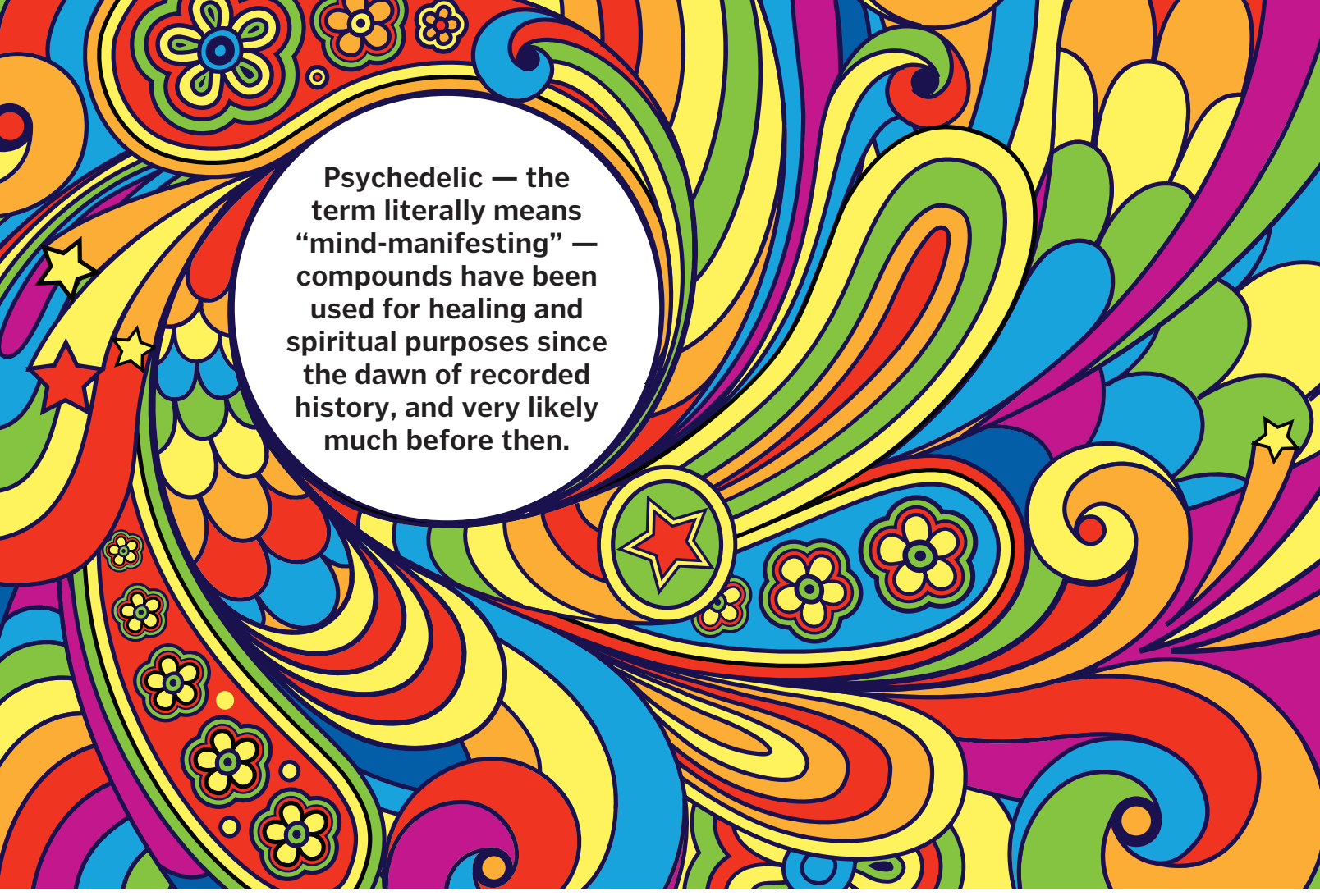
Second, the *Medical Assistance in Dying (MAiD) Act* came into effect in 2016, permitting physician-assisted death in certain situations where patient suffering cannot be relieved.

"Our argument became 'If we have the right to die, we certainly have the right to try' — to try psilocybin in trying to make life better," he says.

It's hard to argue with that reasoning.

What is the historical context of the use of psychedelics in counselling?

Psychedelic — the term literally means "mind-manifesting" — compounds have been used for healing and spiritual purposes since the dawn of recorded history, and very likely much before then. Their merits as therapeutic agents within a clinical context began to be appreciated in the late '50s. Through the '60s, about 40,000 people in North America were successfully treated for alcohol-use disorder, depression, and emotional trauma. But psychedelic research and treatment were abruptly and irrationally terminated in the early '70s after psychedelics such as LSD began to be misused as "street drugs," and there were a few widely publicized tragedies because of that



misuse. Back in this period, Canada was a world leader in psychedelic research and treatment; I'm proud to say that Canada is again at the forefront today.

Tell us about the process with Health Canada.

In 2017, I filed an application with Health Canada for an exemption to Canada's *Controlled Drugs and Substances Act* that would allow me to treat cancer patients with psilocybin for end-of-life distress — that combination of anxiety, depression, and demoralization that often accompanies the diagnosis of a terminal illness. In 2019, I founded TheraPsil — silent P, as in 'psilocybin' — a non-profit humanitarian organization to advocate for legal access to psilocybin, the active ingredient in "magic mushrooms." After nearly four years of dialogue, Health Canada approved the first four patient applications in August 2020. I provided treatment to Canada's first six patients through the latter half of last year.

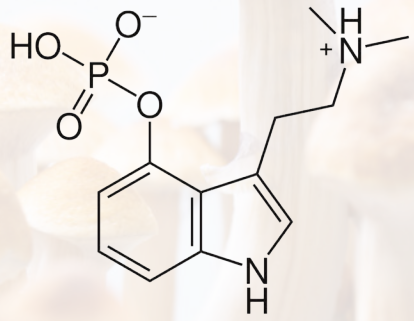
Does TheraPsil simply encourage the use of psychedelics in counselling?

Psychedelic medicines are still considered experimental; none have yet completed the phase-three clinical trials required before a drug can go to market. But even in their current stage of development, they are to the point that future research is much more likely to confirm their promise than to discredit them. We currently support their use only for compassionate treatment — only when the patient is suffering and all other treatment alternatives have proved to be ineffective.

What are the dangers of *not* following the protocols you have established at TheraPsil?

Our treatment protocol highly emulates the one used by the Johns Hopkins research team in their ground-breaking 2016 clinical study on end-of-life distress. We also strongly follow their patient-inclusion criteria. The most important takeaway from the protocol is that psychedelic therapy is not just about a person being helped because they took a psychoactive substance. The most accurate term for this treatment is "psychedelic-assisted psychotherapy," with the emphasis being on "psychotherapy." It's not just about what the medicine can do for you, but

PSILOCYBIN IS THE ACTIVE INGREDIENT IN MAGIC MUSHROOMS



Psilocybin
$C_{12}H_{17}N_2O_4P$

Psilocybin psychotherapy done properly is a very low-risk treatment, if clients are treated by trained clinicians according to our proven inclusion criteria and treatment protocol.

what you can do with the assistance of the medicine.

As a psychotherapy process, we place a huge emphasis on the development of the therapeutic relationship; little of significance will occur unless the therapist has earned the deep trust of the client. Psychedelic medicines have the effect of relaxing rigid, dysfunctional thinking patterns and emotional defenses to allow greater access to unconscious material and the release of repressed material and a softening of body armour and letting go of stored physical tension.

But this state of openness and release that allows for deep healing is also one of extreme personal vulnerability and suggestiveness. The session must therefore involve special provisions for emotional safety and physical safety. This entails special ethical precautions. Without this therapeutic crucible of trust and physical security, patients will be unable to open to the depths that they need to in order to heal and may be left with residual anxiety and confusion.

Psilocybin psychotherapy done properly is a very low-risk treatment, if clients are treated by trained clinicians according to our proven inclusion criteria and treatment protocol.

What is the right and legal way to engage in this work?

Canadian patients can now obtain a "Section 56 exemption" from Health Canada that permits them to use psilocybin under the care of a professional psychotherapist. TheraPsil assists clients in making those applications. But we first engage them in a comprehensive assessment process to ensure they are suitable candidates for treatment. When they receive their approvals, we refer them for treatment to therapists whose competency we trust.

A psychedelic medicine session — usually about five hours — occurs in the context of a multi-session psychotherapy process. In the case of end-of-life clients, it is preceded by at least three preparatory sessions in which the therapeutic relationship is built, client presenting issues are explored, and clients learn what to expect and how to most benefit from the medicine. The psilocybin session is followed up by at least three "integration sessions" in which therapists assist clients in making meaning of their experience and weaving their gained insights into their day-to-day lives so as to promote lasting favourable change.

Our BCACC ethical code requires that we practise only in areas of established competency, so specialized training is essential. TheraPsil is now moving forward with a training program, and Health Canada has now granted some approvals for therapists to use psilocybin in the context of their training process.

Why psilocybin? Are there other psychedelics being explored?

Psilocybin is only one of several classical psychedelics, including LSD, mescaline, peyote, and a handful of new "designer" drugs. MDMA, now looking promising in the treatment of PTSD, also has some psychedelic-like properties. LSD continues to be regarded as an effective therapeutic agent, but it still carries some "baggage" because of its demonization in the '60s.

Psilocybin is the medicine of choice for many because it is naturally occurring in the form of mushrooms and is available in many places throughout the world. Psilocybin also has the advantage of a long tradition of ceremonial use, and many people can easily agree that contemporary psychotherapy shares many similarities with those ancient healing traditions. Over the past 15 years, psilocybin has established a compelling record of both safety and efficacy in scientific research.

Would you like to see psychedelic therapy made available beyond end-of-life care? If yes, in which situations?

We began with end-of-life cancer patients, because that was where the research was most robust at the time. But research is moving smartly forward in relation to other disorders.

[Back In the late '50s and through the '60s], Canada was a world leader in psychedelic research and treatment; I'm proud to say that Canada is again at the forefront today.

I'm confident that over the next year or two we'll be receiving approvals for things like anxiety, addictions, treatment-resistant depression, and trauma-related issues. Treatment for these issues will most certainly involve a longer-term therapy format than what has worked well for end-of-life patients. Psilocybin may also play an important role in the treatment of chronic pain, such as cluster headaches or trigeminal neuralgia.

What are the barriers preventing broader use of psychedelic treatment?

Barriers to psychedelic treatment are falling quickly. When I began my quest in 2015, there was next to no support within the local medical community. Now, many doctors and psychiatrists are interested and open to psychedelic treatments, and we have had a number of them working in our assessment and training programs. There's also been a massive amount of positive coverage of psychedelic medicine in the popular media: print, TV, and internet. One recent survey shows the majority of Canadians support psychedelic therapy. At present, the biggest barrier to more widespread use of psilocybin-psychotherapy may be that we don't have enough qualified therapists to refer patients to.

Do you have suggestions for other RCCs interested in learning more about this?

Psychedelic-assisted psychotherapy is the most exciting development I have witnessed in our profession in my 40-year career as a therapist. I think it's going to change the face of our profession over the next two decades. So, I encourage you to explore it and grow your competencies in this area. A big part of your professional growth will be your personal development. In addition to gaining specialized knowledge and training, we're looking for psychedelic therapists who have a high degree of personal integrity, who deeply know themselves, and are seeking to help others for the right reasons. ■

THERAPSIL

Formed in 2019, TheraPsil is a non-profit coalition of healthcare professionals, patients, community members, and advocates dedicated to helping Canadians in medical need access legal, psilocybin-assisted psychotherapy to treat end-of-life distress. As of January 2021, TheraPsil had supported 24 patients in five provinces to access legal, psilocybin-assisted psychotherapy. Learn more at therapsil.ca.

Watch

THE WISDOM OF TRAUMA
A FILM BY ZAYA AND MAURIZIO BENAZZO

In *The Wisdom of Trauma*, travel alongside physician, bestselling author, and Order of Canada recipient Dr. Gabor Maté to explore why our western society is facing such epidemics. Dr. Maté gives us a new vision: a trauma-informed society in which parents, teachers, physicians, policy makers, and legal personnel are not concerned with fixing behaviours, making diagnoses, suppressing symptoms, and judging, but seek instead to understand the sources from which troubling behaviours and diseases spring in the wounded human soul.

***The Wisdom of Trauma* was released in February 2021.**
Learn more at thewisdomoftrauma.com.

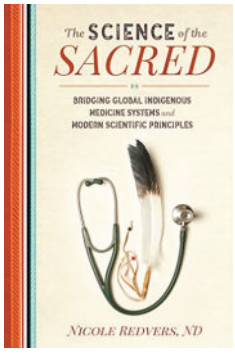
Listen

OTHER PEOPLE'S PROBLEMS

RCC Hillary McBride and her clients want to help demystify mental health. Normally, therapy sessions are totally confidential — but this podcast opens the doors. This is what people really sound like when they talk about traumatic births, turbulent divorces, eating disorders, and tough childhoods.

Stream on CBC Listen

Read



THE SCIENCE OF THE SACRED
BRIDGING GLOBAL INDIGENOUS MEDICINE SYSTEMS AND MODERN SCIENTIFIC PRINCIPLES

BY NICOLE REDVERS, N.D.

In *Science of the Sacred*, Nicole Redvers, who has travelled and worked with Indigenous groups around the world, shares the knowledge and teachings of health and wellness that have been passed down through the generations, tying this knowledge with current scientific advances. Knowing that the science backs up the traditional practice allows us to have earlier and more specific interventions that integrate age-old techniques with the advances in modern medicine and technology.

BCACC is thrilled to welcome Dr. Redvers as a keynote speaker at Counselling in a Changing World, a BCACC virtual conference happening June 17 to 19, 2021.

BCACC Member Health Benefit Plan

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

ATTENTION BCACC MEMBERS WITH EXISTING LOSS OF INCOME DISABILITY POLICIES

If you chose a "Wait Period" of 120 days, this is now a 112-day "Wait Period" with no change in your monthly premium amount.

As of October 1, 2020, the **120-day** Wait Period has changed to a **112-day** Wait Period in reference to the recent EI changes. The Edge Benefits is the 1st Canadian Insurer to make this change, which means if you become disabled either by injury or illness, you can now claim 8 days earlier.

Did you know that you can purchase Loss of Income Disability Benefits as a standalone plan?

Many BCACC members who are self-employed have now enrolled in the Loss of Income Disability Benefits, which do not require you to purchase the Health & Dental plan.

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

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

Loss of Income Disability — ILLNESS — simplified medical underwriting

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

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

BCACC

BC ASSOCIATION OF CLINICAL COUNSELLORS

THANK YOU TO OUR VOLUNTEERS!

BCACC offers our sincere thank you to the dedicated RCC volunteers who sit on the INSIGHTS Editorial Advisory Committee. The volunteers on this Committee plan the themes and structure of INSIGHTS magazine and advise on potential content ideas. BCACC and the INSIGHTS team would like to recognize this group of volunteers for the work they do to make this publication great.

Thank you for the time you give to your association and all the work you do to make INSIGHTS such a great publication. We celebrate you!

The INSIGHTS Editorial Advisory Committee

- Constance Lynn Hummel
- Dave Vass
- Deirdre McLaughlin
- Linette Schut
- Nicola Doughty
- Shahin Jones
- Shawna Biron

BCACC

BC ASSOCIATION OF CLINICAL COUNSELLORS