

# INSIGHTS

THE BC ASSOCIATION OF CLINICAL COUNSELLORS' MAGAZINE

## MAID

Counselling those who choose  
medical assistance in dying  
and their loved ones



When counsellors  
seek therapy:  
why more should,  
but so many hesitate

Remaining authentic  
and holding boundaries  
as a counsellor on  
social media

Issues surrounding  
consent related to  
families and family  
breakdown

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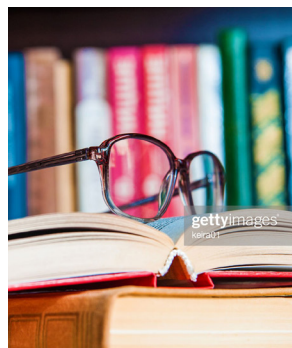
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## INSIGHTS

THE BC ASSOCIATION OF CLINICAL COUNSELLORS' MAGAZINE

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

John-Paul E. Boyd, Martina Nova, Danielle Peloquin, Kate Pinsonneault, Marney Thompson, Michael Towers

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

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## MEET THE NEW BCACC

BCACC is excited to unveil its new logo, as voted for by the BCACC membership. Our new brand identity is bright, bold, and intersectional — just like our members.

# BC ASSOCIATION of CLINICAL COUNSELLORS



## Community in Connection

Practising in isolation and finding a supportive community of colleagues can be difficult, especially when you are balancing work, a busy practice, and life. BCACC is here to help and happy to announce a new virtual event series — Community in Connection.

Community in Connection events will be online Zoom-discussion spaces for members of communities and communities of practice to be able to connect to discuss important and relevant topics with like-minded RCCs. This is your opportunity to connect with each other for meaningful conversations and support.

BCACC already offers online forums for communities and communities of practice in eConnect, and we encourage you to find your communities for peer support and networking.

This new offering takes online community involvement a step further by offering a virtual Zoom-discussion space to support the growth of your communities.

Our goal is to provide an opportunity for you to meet, connect, find support, and learn from each other and from experts in the field.

Watch your inbox for upcoming Community in Connection events soon!

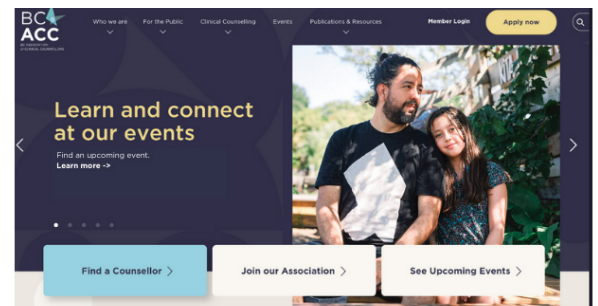


## Community in Connection

A NEW BCACC DISCUSSION SPACE,  
OFFERED TO OUR RCC COMMUNITIES.

## A NEW AND IMPROVED WEBSITE IS ON ITS WAY

We're excited to let you know that BCACC is nearing the end of development on a new and improved website, which will not only reflect our updated look and feel, but will also have improved navigation, a more robust Find a Counsellor tool, and a new Find a Clinical Supervisor tool. It will also achieve an AA conformance level of the Web Content Accessibility Guidelines. Expect a Find A Counsellor tool that enables more search functionalities and ease of use for both members and the public and makes it easier for you to connect with potential clients.



## MEMBER REGISTRY LAUNCH TO DOVETAIL WITH NEW WEBSITE

Housed on the new website, a new Member Registry will display the full BCACC membership list and information such as current status: **Active, Inactive, Reinstated.**

### WHY A MEMBER REGISTRY?

Maintaining a publicly accessible database of members and membership history brings BCACC into alignment with other regulated health professions and provides transparency to external stakeholders, such as insurance providers, health authorities, potential employers, and clients seeking counselling services.

### WHAT DO I NEED TO DO WHEN THE MEMBER REGISTRY LAUNCHES?

Not a thing! Applicable membership information will be pulled into the system automatically.



### IS THE PUBLIC PROTECTED NOW?

While protection of the public will be further enhanced when the counselling profession is regulated under the *Health Professions Act*, RCCs are already practising professionals who meet master's level education and verified supervision entry requirements, adhere to a code of ethics and standards of practice, and deeply care about the well-being of their clients.

There is a current narrative that the public is not being afforded any protection and that only through regulation under the *Health Professions Act* will that be remedied. That is absolutely not true in the case of Registered Clinical Counsellors. The reality is that BCACC does ensure that only those qualified enter the profession and it has a well-established complaint, inquiry, and disciplinary process to hold its members accountable to the public.

## Regulatory modernization

BCACC is taking matters into its own hands to pursue regulation under the *Health Professions Act*.

**S**ome of the recent news from BCACC may lead to you ask the question: Has BCACC abandoned the pursuit of regulation under the *Health Professions Act* (HPA)?

The answer: No, quite the opposite!

Instead, BCACC has chosen a different path to regulation under the HPA — a path that is more concrete, transparent, and pro-active.

### WHY DOES THE BCACC WANT REGULATION UNDER THE HPA?

The primary goal for the BCACC to seek regulation of its members under the HPA is to better protect the public. While the BCACC currently does an adequate job regulating its members under a voluntary, self-regulating model, regulation under the HPA will afford the public increased protection and more transparency.

## CHANGE AT THE PROVINCIAL LEVEL

On August 27, 2020, B.C. Health Minister Adrian Dix announced the release of a report outlining final recommendations for changes to the province's health profession regulatory system. The report, *Recommendations to Modernize the Provincial Health Profession Regulatory Framework*, has implications for all health profession regulatory colleges in B.C.\* The modernization plan recommends significant changes to current regulatory organizational structures. Specifically, the plan calls for a reduction in the number of colleges from 20+ to six. Even without any new legislation, the affected colleges are already moving forward with regulatory modernization.

\*<https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/professional-regulation/recommendations-to-modernize-regulatory-framework.pdf>

## LEARN MORE ABOUT REGULATORY MODERNIZATION

Get all the details and stay up to date on BCACC's progress with regulatory modernization at [bcacc.ca](http://bcacc.ca). New resources include:

- Embracing Regulatory Modernization and Strengthening Counselling Public Protection Measures
- Has BCACC Abandoned the Pursuit of Regulation under the *Health Professions Act*?
- Clinical Supervision and Regulatory Modernization

More resources will be added in the coming months.



While the BCACC currently does an adequate job regulating its members under a voluntary, self-regulating model, regulation under the HPA will afford the public increased protection and more transparency.

## WHAT NEEDS TO HAPPEN TO ACHIEVE REGULATION?

Preparing a profession for regulation under a legislated act is quite an endeavour. While having a competency profile is important, there are many, many more deliverables to plan for and consider, for example:

- A revised complaint, inquiry, and discipline process
- Publicly viewable member registry
- Mandatory quality assurance program (continuing education credits)
- Clinical supervision program
- New set of bylaws
- Entry requirements for new registrants
- Recognized education programs
- Legacy members considerations
- Financial model (fees, costs)
- New governance model as per the HPA
- Juris prudence exam
- Updated code of ethics
- Updated and additional standards of practice including a cultural safety/ Indigenous standard
- Documented labour mobility compliance and requirements

## HOW DO WE ACCOMPLISH THIS?

The BCACC will ensure all the above deliverables comply with the

requirements set forth as part of the B.C. government's regulatory modernization recommendations. We are currently consulting with health regulatory colleges in B.C., including the College of Psychologists, past members of the regulatory modernization steering committee, and government officials engaged in regulation. CEOs/Registrars/ Presidents of the counselling/ psychotherapy regulatory colleges and ex regulatory government officials from other provinces are also being consulted.

Our intention is to learn from others' experiences, proven/accepted methods, and best practices to help mitigate any risks and to expedite the process. We have hired an experienced regulatory modernization manager to support our initiatives.

## WHEN IS THIS HAPPENING?

The BCACC will keep its membership and other stakeholders apprised of progress on a regular basis. By having a "ready to be governed" entity that resembles the other health regulatory colleges, RCCs should be one of the first to be considered for regulation under the HPA by the new oversight committee. At present, we believe this will not happen for at least two to four years.

Learn more at [bcacc.ca/about-us/news/](http://bcacc.ca/about-us/news/).



## Meet **Janice Harvey**, Manager of Regulatory Modernization

**M**y professional background is originally in nursing, and I have a Master of Arts in Leadership from Royal Roads University. With more than 18 years of experience working for a large B.C. health regulator, I've coordinated and managed a number of significant projects related to regulatory program development and administration, as well as the development and delivery of a host of educational activities related to professional regulation in B.C., for variety of stakeholder audiences.

Having lived experience in the complexities associated with preparing for regulatory change and reform, I was drawn to the role of

Manager of Regulatory Modernization and the opportunity to return to my roots, working with a smaller organization beginning its regulatory journey. I strongly believe in an atmosphere of collaboration and the opportunity to learn from each other and everything we do, even if we do fail on occasion; one that celebrates success, role models respect, openness, and accountability, embraces challenge and change, and the pursuit of professional excellence.

I'm excited to be part of the BCACC team and to support the association's work in pursuit of regulation on behalf of the clinical counselling profession in B.C.!

## Ethical Decision Making



**D**ecision making in all areas of practice requires a consideration of the ethical principles. BCACC believes all practitioners continually need to:

- Be aware of the values governing their practice, including those required in the *Code of Ethical Conduct and Practice Standards*;

- Be aware of personal values, the values of others, and the implications for their professional practice; and
- Assess how their personal and professional values interface in their professional practice.


Thanks to the work of the BCACC Ethics Committee, RCCs now have an *Ethical Decision Making Workbook* to help guide them through ethical dilemmas in a meaningful way. Find this excellent new resource at <https://bcacc.ca/wp-content/uploads/2022/08/BCACC-Ethical-Decision-Making-wb.pdf>.

Note: BCACC strongly recommends all members engage in clinical supervision/mentorship, regardless of their experience level.

### ETHICS CAFÉS

Ethical dilemmas can appear at any time for any RCC no matter how much experience they have. There is no better way to learn how to recognize and manage an ethics situation than by learning from your peers and being prepared. To open up discussions on ethics — the circumstances that can lead to problems and how to make good decisions about managing them — BCACC has introduced Ethics Cafés. Lead by Clinical Supervisors and members of the BCACC Ethics Committee, Ethics Cafés are your opportunity to gain new insights into ethics and expand your knowledge in real-time discussions online.

We encourage you to watch our emails for the next Ethics Café event.



“Being a human first means being your authentic self and bringing to your role as therapist your humour, your quirks, your snorty laugh, your silly voices – whatever makes you, you.”

# BEING HUMAN FIRST

Remaining authentic and holding boundaries as a therapist on social media.

BY MARTINA NOVA, RCC

**Do you remember** learning how to sit and present as a therapist in grad school using the acronym SOLER?

**S** Sit squarely to the client, preferably at a 5 o'clock position to avoid the possibility of staring.

**O** Maintain an open posture at all times, not crossing your arms or legs, which can appear defensive.

**L** Lean slightly in towards the client.

**E** Maintain eye contact with the client without staring.

**R** Relax.

Now, how many of us actively practise this way of being? I can tell you right now that I often cross my legs in sessions, take my shoes



off, jump up and down when I'm celebrating something with my clients, and laugh alongside my clients so hard that we both end up crying. Perhaps, if we drop this facade that therapists are stoic blank slates and instead bring our own personalities into sessions, it'll allow our clients to see that we are all human beings and maybe even make therapy more approachable.

I hold the roles of therapist, wife, mother, sister, daughter, and friend. Above all else, I am a human being. This article is about how being a human first comes into my practice as a therapist and how I remain authentic and hold boundaries in my social media presence.

### **HOW THE HUMAN-FIRST MINDSET STARTED FOR ME**

When I was at my grad school practicum site supporting children and families, I was working with a child whose parent was headed to a rehab facility. The family was looking for my help in figuring out how to tell the child that the parent was going to be away from home for six months. I spent hours putting together the perfect script on how to coach the parents to say the right thing. When I brought this to my supervisor, he told me to put the script down and just talk to him about what I was worried about and how I would approach this leading with my heart. He told me to be genuine, be in the moment, connect to the parents, and allow them to put the script together since they knew their child best. This supervisor told me to be myself in the session and to be human instead of trying to be this perfect therapist who had all the answers. This is where the human first mindset started for me.

### **BEING HUMAN ON SOCIAL MEDIA**

I have a social media page on Instagram called @novacaretherapy. On this page, I split up the type of content I post; one third is psychoeducational materials, another third is business updates and notifications, and the last third involves careful personal disclosures of some kind. I have posted videos of myself dancing and being silly, shared precious moments from my life with my husband and son, provided psychoeducation, and showed how mental health has impacted my own life. I have created videos where I was a talking potato, marshmallow, carrot, and croissant. Once I even put my face on a pierogi covered in bacon bits and onions. I do this to destigmatize therapy

and make it more approachable. I have had many clients book with me because they said they felt comfortable connecting with a therapist who comes across as a non-threatening potato.

When it comes to boundaries and social media, there are ethical pieces to keep in mind. For example, I have a social media disclaimer in my highlights around friending, following, and interacting with clients on this platform. For confidentiality purposes, I do not interact with my clients about booking sessions through the IG messenger function and, instead, ask clients to email me for scheduling. Moreover, I do not solicit reviews from my clients, and I remove comments where clients reveal that I am their therapist.

As therapists, we are in a position of tremendous privilege, a power imbalance and assumption that we know all the answers and have our own lives together all the time. But to be human is to be messy, real, raw. When we are sitting with our clients and they are being vulnerable with us, there is no moment more precious than this connection — digging through the mud, laughing, crying, being with. Being a human first means being your authentic self and bringing to your role as therapist your humour, your quirks, your snorty laugh, your silly voices — whatever makes you, you.

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*Martina Nova, RCC, is a Vancouver-based trauma specialist who practises EMDR and talk therapy and is also a LENS Neurofeedback technician. She was born in Slovakia and immigrated to Canada with her family as a child. She grew up on the unceded territories of the xwməθkwəyəm (Musqueam), Skwxwú7mesh (Squamish), and Selilwəta?/Selilwitulh (Tsleil-Waututh) Nations, where she continues to work and live.*

# CONS AND FAMIL



# ENT, FAMILIES, Y BREAKDOWN

A deeper look at some of the issues surrounding consent and what RCCs need to understand

BY JOHN-PAUL E. BOYD, QC

In March, Alyson Jones and I presented a two-day training event for BCACC's "Families, Family Breakdown and the Law." The things we talked about included getting consent to work with adults and children. This issue provoked a lot of questions from participants, as well as a healthy online discussion, and I thought I'd use this opportunity to take a deeper look at consent in the context of families and family breakdown.

The purpose of getting consent from anyone you work with is to make sure the client understands what's going to happen and agrees to what's going to happen. Consent is more than an ethical consideration and a duty under Principle 1 of BCACC's *Code of Ethical Conduct*.<sup>1</sup> Consent helps to protect you from complaints and lawsuits for negligence or breach of your professional standard of care. Consent helps you manage risk.

BCACC's policy on consent is set out in the *Standard for Informed Consent to Clinical Counselling and the Collection, Use and Disclosure of Personal Information*.<sup>2</sup> This is an important standard every counsellor should read.

Many counsellors work with people who are separating or who have separated.

Some also work with children of separated parents. Others are hired to prepare parenting assessments and views of the child reports for use in different dispute resolution processes, including court, mediation, and arbitration. All this work requires the informed consent of the clients or a court order, written agreement, or arbitrator's award saying the work will happen.

## ADULTS AND CONSENT

Most often, people who ask for your services come to you for help voluntarily. When you're working with an adult, you need to get the person's informed consent before you start working with them. The "informed" part of informed consent means the client understands what's going to happen and the risks and benefits of the work you're going to do together. This means you have to give an explanation about the services you propose to provide in a way the client can understand and be satisfied the client understands the proposed services, understands the risks and benefits of those services, and wants you to provide those services. In other words, you have to do more than have the client check a box on your intake form that says, "I consent."

**You have to do more than have the client check a box on your intake form that says, "I consent."**

You have to talk with the client about the proposed services, invite them to ask questions, then decide whether the client understands what you've told them.

Clients can give their consent orally, without signing anything, just by telling you they understand and agree to the services you propose to provide. If the client provides oral consent, be sure to make a note in your file saying they gave you their oral consent and when they provided their consent.

However, it's much better to get the client's consent in writing. It's always possible for someone to argue that your notes are inaccurate, vague, or misleading. It's much harder to make those arguments when the client has signed a clearly written consent form. Keep this form in your file!

You can also infer the client consents to working with you because they've nodded or made a similar gesture after listening to your explanation of the services you propose to provide or because they've started participating in those services. This is risky, of course, as you can't be sure the client really understands the risks and benefits involved just from their behaviour, and intercultural factors may lead you to make incorrect assumptions about the client's consent. It will be easy for the client to argue that they didn't understand or didn't consent.

### **CHILDREN, YOUTH, AND THE CONSENT OF GUARDIANS**

You also need the consent of children before you begin to work with them

or the consent of an adult on behalf of the young person. In B.C., a "child" is someone younger than 19, the provincial age of majority. Not every adult is able to give consent on behalf of a young person. Only guardians may consent to your work with a young person. Unfortunately, it's not always

**To make things a little more complicated, young people may be able to consent to your services without the consent of their guardians.**

obvious who's a guardian. The law about guardianship is in Part 4 of B.C.'s *Family Law Act*.<sup>3</sup> These are the basic rules:

- A parent is usually, but not always, a guardian of their child. You can't be sure that just because someone is a child's parent, they are also the child's guardian.
- A child can have more than two guardians, just like a child can have more than two legal parents.
- People who are not parents can be a guardian of a child.

A guardian who wants you to work with a young person must provide their informed consent to the services you propose to provide. Just as if they were receiving the services themselves, you have to give an explanation about the services you propose to provide in a way the guardian can understand and be sure the guardian understands the proposed services, understands the risks and benefits of those services, and wants you to provide those services to the young person.

Be sure to make a record of the guardian's consent. It is best to avoid oral consent or trying to infer the guardian's consent from their behaviour. Because young people are more vulnerable than adults and

may be or become the subject of a legal dispute, you should always get the guardians' consent in writing. It's important to avoid the risk of someone, like another guardian, arguing that you didn't have the proper consent to work with the young person.

Things get a lot more complicated when a young person's parents have separated or never lived together. In cases like this, the chances are very good the child is or may become the subject of a legal dispute. Legal disputes between parents can involve very difficult, emotionally heated discussions about things like:

- Who is or should be a guardian of a child?
- How will the child's time be divided between the child's parents, guardians, and other important people?
- How will the child's guardians make important parenting decisions on behalf of the child, including decisions about things like mental and medical health care?

When a young person's parents are in an intact relationship, you can be fairly sure the parent who is asking you to work with the young person is the young person's guardian and has the agreement of the other parents to ask you to work with the young person. The risk involved in starting to work with a young person with the consent of just one parent in an intact relationship is low but not zero. The worst that is likely to happen, assuming another parent is unhappy about what's going on, is contact from the parent asking you to stop working with the young person. While a complaint is certainly possible, a lawsuit is unlikely.

The risk of working with a young person at the request of a parent who is not in an ongoing relationship with the other parents is much higher. It's higher because of the possibility that the young person is the subject of a legal dispute, that the parents are fighting about the young person's parenting arrangements, and that the parents are in an elevated level of conflict with one another. You should probably avoid providing services to a young person in circumstances like this without checking that:

- The adult who wants you to work with the child is a guardian and is responsible for making decisions about the mental and medical health care of the child.
- The child's other guardians agree that you should work with a child.

The sort of documents that can help you understand the status

of the parent contacting you include court orders, written agreements, or arbitrators' awards that talk about guardianship.

If you work with a young person without the consent of all of the young person's guardians who are responsible making mental and medical health care decisions, you risk a complaint to BCACC, the court making an order directing you to stop working with the young person, and the possibility of a lawsuit for negligence, breach of your standard of care, or another legal complaint. To be completely clear, you can decide to work with a young person without the consent of the young person's other guardians if you want. Nothing is stopping you from doing that. It is, however, a decision

that exposes you to a higher level of risk than that with which you may be comfortable. Be careful and think twice.

It's important to know that a guardian can not only give their consent to your work with a young person but also withdraw their consent, even if your work with the young person is ongoing. When you know a guardian has withdrawn their consent, it's a good idea to stop working with the young person, at least until you get a court order, a written agreement, or an arbitrator's award saying your work should continue. Continuing to provide services when you know a guardian has withdrawn their consent to those services exposes you to the risk of a complaint, the court making an order directing you to stop working with the young person, and a lawsuit for negligence, breach of your standard of care, or another legal complaint.



## CONSENT FROM CHILDREN AND YOUTH

To make things a little more complicated, young people may be able to consent to your services without the consent of their guardians. (Of course, it's also important to check whether a young person is willing to receive services consented to by a guardian.)

Under section 41 of the *Family Law Act*, guardians' ability to give consent on behalf of a young person is "subject to section 17 of the *Infants Act*." Section 17 of the *Infants Act* says a child may consent to receive health care without the consent of their parent or guardian.<sup>4</sup> However, there are conditions. You must explain the proposed services in a way the young person understands and be sure the young person understands the proposed services, the risks and benefits of those services, and wants

you to provide those services. You must also be sure the proposed services are in the young person's best interests.

The term "mature minor" is often used to refer to young people who are able to understand the nature, risks, and benefits of a proposed service and consent to those services themselves. There is no upper or lower age limit you can use to decide whether a young person is able to provide consent. (In fact, the *Infants Act* doesn't use the term "mature minor" at all.) You must decide for yourself whether the young person understands the proposed service and agrees to the proposed service. This is a decision you'll need to make on a case-by-case basis, thinking about factors such as the young person's age, maturity, and cognitive capacity.

You might want to think of the young person's capacity to consent

as a tiebreaker. If the young person's guardians don't agree on your work with the young person or one of them has withdrawn their consent to your services, the young person's consent can break the deadlock. If none of the young person's guardians agree to your work or all of them have withdrawn their consent, the consent of the young person alone will allow you work with them.

Of course, working with a young person against the wishes of one or more guardians will expose you to the risk of a complaint, the court making an order directing you to stop working with the young person, and the possibility of a lawsuit for negligence, breach of your standard of care or another legal complaint. As long as you made the decisions that the young person understands the nature, risks, and benefits of a proposed service and that the proposed service is in the young person's best interests honestly and in good faith, you are not likely to be found liable for working with the young person against their guardians' wishes.

## ORDERS, AGREEMENTS, AND AWARDS

The court orders, written agreements, and arbitrators' awards you get will usually tell you who the guardians of a young person are, tell you to provide services to a family or young person, or tell you to stop providing services to a family or young person. Unfortunately, orders, agreements, and awards aren't always clearly written, and it's important to understand exactly what they say. If you are mistaken in your interpretation of an order, agreement, or award, you risk a complaint to BCACC and possibly a lawsuit for negligence,



**If you have received an ambiguous order, agreement, or award from a lawyer, you should write to the lawyer, explain your concerns, and ask for written clarification.**

breach of your standard of care, or another legal complaint as well.

If you have received an ambiguous order, agreement, or award from a lawyer, you should write to the lawyer, explain your concerns, and ask for written clarification. If there are other lawyers involved, make sure you send a copy of your letter or email to them as well. If there aren't any other lawyers, make sure you send a copy of your letter or email to anyone who doesn't have a lawyer and is shown as a party to the order, agreement, or award.

If you have received an ambiguous order, agreement, or award from someone who isn't a lawyer, you should write to everyone who is shown as a party to the order, agreement, or award or to their lawyers if they have any, explain your concerns, and ask for written clarification.

### **TAKING THE CASE**

This discussion about risks, complaints, and lawsuits in the context of families and family breakdown is probably a little alarming. It should be. Getting complaints is always upsetting and lawsuits can be embarrassing, not to mention costly when they succeed.

Counsellors who work in or through agencies may not have much choice in the clients they take. Taking care to comply with BCACC's *Code of Ethical*

*Conduct* along with your employer's policies help minimize risk. Consulting a supervisor if you have questions or concerns helps as well, especially when you have to respond to complaints.

Counsellors in private practice, on the other hand, usually do have a choice in the clients they take. Remember, there is no case you absolutely must take. If you are uncomfortable with a request for your services, you can avoid risk altogether just by saying you are unable to take the case or provide the requested services. If you decide to take the case anyway, you should consider consulting a supervisor.

### **THE TAKEAWAYS**

BCACC's *Code of Ethical Conduct* requires all Registered Clinical Counsellors to obtain the informed consent of all clients. Informed consent requires you to give an explanation about the services you propose to provide in a way the client can understand and be satisfied the client understands the proposed services, understands the risks and benefits of those services, and wants you to provide those services.

Adults usually are able to provide informed consent for their own work with you. The guardians of a young person are usually able to provide informed consent for the young person's work with you. The parents of a young person will usually, but not always, be guardians of the young person, and a young person can have more than two guardians.

Guardians' ability to consent to the mental and medical health care of a young person is subject to section 17 of the *Infants Act*. This part of the *Infants Act* says young people can provide informed consent for their own work with you. Before acting on the consent

of a young person, you must explain the services you propose to provide in a way the young person understands and be sure the young person understands the proposed services, risks, and benefits of those services, and wants you to provide those services to them. You must also be sure the proposed services are in the young person's best interests.

Providing services to an adult without consent exposes you to the risk of a complaint to BCACC and the possibility of a lawsuit for negligence, breach of your standard of care, or another legal complaint. Providing services to a young person without consent exposes you to the risk of a complaint to BCACC, the possibility of the court making an order directing you to stop working with the young person, and the possibility of a lawsuit for negligence, breach of your standard of care, or another complaint. It is up to you to gauge the level of risk with which you are comfortable. A supervisor can help you decide how to deal with risk.

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*John-Paul E. Boyd, QC is an accredited family law mediator, family law arbitrator, and parenting coordinator practising in Alberta and British Columbia.*

### **REFERENCES**

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- 3 British Columbia *Family Law Act*: <https://www.canlii.org/en/bc/laws/stat/sbc-2011-c-25/latest/sbc-2011-c-25.html>
- 4 British Columbia *Infants Act*: <https://www.canlii.org/en/bc/laws/stat/rsbc-1996-c-223/145538/rsbc-1996-c-223.html>



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# END-OF-LIFE CONVERSATIONS

Counselling those who choose medical assistance in dying and their loved ones

BY MARNEY THOMPSON, RCC

In June 2016, the Parliament of Canada passed federal legislation that allowed eligible Canadians to request medical assistance in dying (MAID). In early 2020, a consultation process with the general public, various stakeholder groups, and expert witnesses occurred, and by March 2020, this legislation was subsequently revised. Most notably, this revision allowed for eligible persons to pursue MAID whether or not their death is reasonably foreseeable.<sup>1</sup>

Currently, persons who wish to receive MAID must:

- Be 18 years of age or older and have decision-making capacity;
- Be eligible for publicly funded health care services;
- Make a voluntary request that is not the result of external pressure;
- Give informed consent to receive MAID, meaning that the person has consented to receiving MAID after they have received all information needed to make this decision;
- Have a serious and incurable illness, disease, or disability (excluding a mental illness until March 17, 2023);
- Be in an advanced state of irreversible decline in capability; and

- Have enduring and intolerable physical or psychological suffering that cannot be alleviated under conditions the person considers acceptable.

## THE MAID PROCESS

For those who believe they meet the qualifications and wish to pursue MAID, the process has four main steps.

### 1) Submitting a request

In B.C., the MAID assessment process begins when the person requesting MAID completes and submits a form called the Request for Medical Assistance in Dying. The form must be signed and dated in front of an independent witness, who must also sign and date the form. The witness must not be anyone who stands to benefit from the requestor's death (i.e., not a beneficiary of the estate).

The requestor then must submit their Request for Medical Assistance in Dying directly to their family doctor or nurse practitioner (NP), or they can contact their local health authority's care coordination service for medical assistance in dying. As not everyone is comfortable with MAID, the legislation does not force physicians or NPs to complete assessments or provide MAID.

## The time between when the medications are administered and when the person dies is especially impactful for those who are in attendance at the death.

### 2) Assessment of eligibility

Once the request for MAID is submitted, it must be reviewed by two medical professionals. After eligibility has been confirmed, a plan regarding the MAID procedure is made. Some people undergo the request and assessment process with a date for the procedure already in mind, and others choose to delay their decision until the illness progresses further.

### 3) Obtaining consent

In order to request MAID, a person must be capable of making medical decisions and be able to give their informed consent. This means they understand the consequences of their decision to receive MAID and also their diagnosis; available treatment options; and options for symptom management, including palliative care.

The person will also be asked to give their consent just prior to the MAID

procedure. If there is a risk the person will not be able to provide consent immediately prior to their death, and their death is reasonably foreseeable, they may be able to enter into an agreement with their MAID provider so that the final consent is not required. This is called a Waiver of Final Consent.

### 4) The procedure

A medically assisted death is achieved via the delivery of a series of medications administered in close succession. In Canada, people may opt for physician- or self-administered MAID. In other words, a person can choose to have a physician or NP provide a prescription that the person can fill and take on their own or have a physician or NP administer the medication in person.

The medications used include agents to numb the vein and treat pain, put the person to sleep, relax their muscles,

and stop the heart and lungs. People can ask questions about these medications, including their risks and effects, during the eligibility review process. With intravenous administration, most people lose consciousness quickly and die within minutes. It can take much longer for the person to die when medications are taken orally, although this varies from person to person.<sup>2</sup>

It is anecdotally reported that the time between when the medications are administered and when the person dies is especially impactful for those who are in attendance at the death. It is reasonable to assume that if the death takes longer to occur than expected, this may cause distress for families, who may worry something has gone wrong.<sup>3</sup>

### GAPS IN COUNSELLING SUPPORT

Depending on where in Canada MAID is requested, dedicated professional resources to inform and support people through the emotional, social, and spiritual aspects of this process vary widely. In B.C., MAID providers and assessors are often the primary source of information and support.

## MAID IN CANADA: STATISTICS

As of the latest census data, 21,589 Canadians have chosen a planned MAID death.\* The percentage of people who opt for a planned death rises each year, with this choice representing 2.5 per cent of all deaths in Canada in 2020. In B.C., MAID deaths amount to four per cent of the deaths overall, the highest percentage of MAID deaths in Canada. Government researchers suggest the higher proportionate number in B.C. versus the national number, may reflect greater acceptance in this province.\* While some provinces have provincial teams that support the MAID process, in B.C., MAID is coordinated by the regional health authorities.

### + MAID statistics for 2020 indicate:

- The average age of people who received MAID is 75;
- 83 per cent of people received palliative care prior to their planned deaths;
- 95 per cent of people received MAID from a physician; and
- 47 per cent of planned assisted deaths happened in private residences, with the remainder in public centres such as hospitals (28 per cent), palliative care units

(17.2 per cent), and long-term care facilities (5.7 per cent).

### + Of people who requested but did not receive MAID, the reasons include:

- Died before the procedure could be carried out;
- Request withdrawn;
- Deemed ineligible, for reasons including:
  - Not capable of making decisions with respect to health;
  - Natural death not reasonably foreseeable;



**“I usually do not have time to follow up more than once and find most people’s family physicians are too overtaxed to pick up the baton.”**

Family doctors may also be a source of early guidance and ongoing support. Although the physicians and NPs who are trained to assess eligibility and provide MAID regularly offer guidance, information, and support, ongoing counselling is not their primary focus or area of expertise.

In one study, MAID assessors and providers from Vancouver Island identified significant barriers in their capacity to provide counselling and

ongoing care to bereaved family members following a MAID death.<sup>4</sup> The barriers identified were: lack of formal-care relationship with family members (their patient is only the person who is requesting MAID) and lack of time (many MAID providers and assessors do this work in addition to their full family practice commitments). As one MAID provider described, “I usually do not have time to follow up more than once and find

most people’s family physicians are too overtaxed to pick up the baton.”<sup>5</sup> Many providers indicated a need for additional resources to provide counselling, such as, “a specialized counsellor or social worker [who] should automatically visit with the family before [a] provision and do follow-up calls. [They] should be dedicated to MAID so that they can take their time.”<sup>6</sup>

- Could not provide informed consent;
- Not in an advanced state of irreversible decline;
- Did not have a serious and incurable illness, disease, or disability; and
- Request was not voluntary.

One Canadian study found that people who requested MAID ascribed their suffering to physical symptoms, psychological symptoms, and loss of control that is irreversible. These three domains of suffering interact with people’s personal histories and contexts to create a reality that is unacceptable and irreversible.\*\*

**+ According to a 2021 Health Canada report, common sources of intolerable suffering were:**

- Loss of ability to engage in meaningful activities;
- Inadequate pain control;
- Loss of dignity;
- Perceived burden on family;
- Loss of control of bodily functions; and
- Isolation or loneliness.

*\*Health Canada. (2021) Second annual report on medical assistance in dying in Canada 2020. (Publication No. 210148). Retrieved from <https://www.canada.ca/en/health-canada/services/medical-assistance-dying/annual-report-2020.html>*

*\*\*Simmons, J. G., Reynolds, G., Kekewich, M., Downar, J., Isenberg, S. R., & Kobewka, D. (2022). Enduring Physical or Mental Suffering of People Requesting Medical Assistance in Dying. *Journal of Pain and Symptom Management*, 63(2), 244-250.*



## USEFUL RESOURCES

**+ Island Health** – Medical Assistance in Death: A Guide to Support Patients and Families: <https://www.islandhealth.ca/sites/default/files/MAiD/documents/maid-bereavement-guide-patients-families.pdf>

**+ Bridge C14** – MAiD Peer Support: <https://www.youtube.com/watch?v=orT077Fn1lo&t=1332s>

[https://www.youtube.com/watch?v=Y7AXv\\_NITul](https://www.youtube.com/watch?v=Y7AXv_NITul)

**+ Dying with Dignity** – MAiD Advocacy and Support: Get the Facts on MAiD: <https://www.dyingwithdignity.ca/end-of-life-support/get-the-facts-on-maid/>

**+ Canadian Virtual Hospice** – MAiD resources: <https://www.virtualhospice.ca/MAiD>

<https://www.virtualhospice.ca/maid/media/a3ypyltg/maid-10-myths.pdf>

<https://www.virtualhospice.ca/maid/media/3bdlkrve/maid-activity-book.pdf>

**+ BC Bereavement Helpline** – Directory of Bereavement Support: <https://www.bcbh.ca/>

**+ Government of BC – MAiD Information:**

• <https://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/>

[care-options-and-cost/end-of-life-care/medical-assistance-in-dying](https://www2.gov.bc.ca/assets/gov/health/forms/1632_instructions.pdf)

• [https://www2.gov.bc.ca/assets/gov/health/forms/1632\\_instructions.pdf](https://www2.gov.bc.ca/assets/gov/health/forms/1632_instructions.pdf)

• <https://www2.gov.bc.ca/assets/gov/health/forms/1632fil.pdf>

**+ BC Regional Health Authorities – MAiD support programs:**

• Fraser Health: <https://www.fraserhealth.ca/health-topics-a-to-z/end-of-life-care/medical-assistance-in-dying#.W89nok2ovcs>

• Interior Health: <https://www.interiorhealth.ca/health-and-wellness/palliative-and-end-of-life-care/medical-assistance-in-dying>

• Island Health: <https://www.islandhealth.ca/learn-about-health/medical-assistance-dying/medical-assistance-dying>

• Northern Health: <https://www.northernhealth.ca/health-topics/medical-assistance-dying-maid>

• Provincial Health Services Authority: <http://www.phsa.ca/health-info/medical-assistance-in-dying>

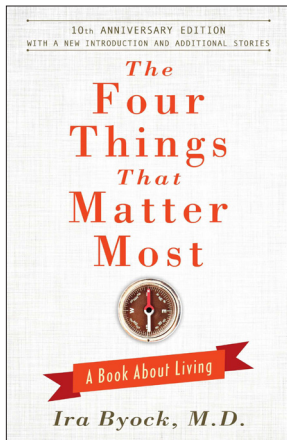
• Vancouver Coastal Health: <http://www.vch.ca/public-health/health-topics-a-z/topics/medical-assistance-in-dying>

## NEEDS AND GAPS

Given contractual and time restrictions on MAiD providers and family physicians, people who choose MAiD and their support people are often without adequate psychosocial support. Their natural concerns relating to anticipatory grief and bereavement, sometimes on top of other confounding life circumstances, leave them under-prepared and inadequately supported.

In Canada, the Dying with Dignity and Bridge C-14 organizations are popular sources of information, peer support, and advocacy related to assisted death. Canadian Virtual Hospice also has some excellent resources for the public and also for professionals. The MAiD activity book made especially for young people is a unique and helpful resource. Many of the hospice programs in B.C. provide individual and group bereavement counselling, some with services specifically for those who are bereaved following an assisted death. A great resource for locating hospice bereavement support is the BC Bereavement Helpline (<https://www.bcbh.ca/>).

However, many individuals and families who choose MAiD would benefit from the skilled support of a licensed counsellor. Interestingly, it seems the grief and complexity of the time leading up to the death is often more impactful for people than the bereavement that follows. Therefore, it is important to keep in mind that there are unique emotional, social, and spiritual features of the MAiD process that distinguish it from other kinds of illness trajectories. The journey that people make through the MAiD process has been characterised as a time of “Bringing death to life,” where the certainty of death initiates a countdown to death and parade of lasts.<sup>7</sup> Indeed, many people become quite reflective and intentional about activities during



In his book, *The Four Things that Matter Most*, palliative care physician Ira Byock provides a very meaningful framework for end-of-life conversations between loved ones.

the time leading up to when MAID is scheduled. The person who is dying may be reflecting on their life and grieving the future they imagined but will not experience. Family and friends are often working very hard to carry out their loved one's final wishes, while also going through their own important reflections and anticipatory grief.

### CORE THEMES AND QUESTIONS

In his book, *The Four Things that Matter Most*, palliative care physician Ira Byock provides a very meaningful framework for end-of-life conversations between loved ones. He encourages people to say these four things to each other: please forgive me, I forgive you, thank you, and I love you.<sup>8</sup> These four statements on their own provide a potent foundation to guide counselling interventions with people facing end of life. Although most of the additional themes outlined below apply to both the person who is dying and their close people, it is also helpful to address them from each person's unique perspective.

Themes to explore with the person who is dying:

**Grief** — In these days leading up to the

date of your assisted death, what thoughts and feelings are coming up for you?

**Unfinished business** — How prepared are you feeling as the date of your planned death gets closer? Is there anything you still need to do or anyone you wish to see or speak with?

**Life review and legacy** — As you reflect on your life now, what accomplishments are you most proud of? What are your future hopes for the people you care about?

**Final wishes** — Do you have any specific wishes or requests for the days leading up to or the day of your death? They might be about where you'd wish to die, or who you'd like to have with you? Or perhaps there are foods you'd like to eat or places you'd like to visit?

Themes to explore with family and friends:

**Caregiver stress** — How are you managing with the preparations and activities related to your loved one's planned death?

**Anticipatory grief** — What opportunities do you have to express your grief? Who comforts you when your feelings surface?

**Coordination and communication** — How is information shared within your social/family circle? Who takes the lead in planning activities? Is this working for you?

**After death care** — Have you thought about what you might need immediately after your person has died? Would you like to have some time together afterwards? Would you want someone else to be with you?

### THE ROLE FOR COUNSELLORS

MAID is a relatively new end-of-life care option in Canada. Our understanding of people's needs as they consider and choose this option is still growing, as are programs and services designed to meet their needs. Counsellors, with the holistic approach they bring, can help to fill some of the current gaps. With a counsellor's skillful and informed care, people are more likely to meet death and grief feeling connected with each other in anticipation of the activities and events to come.

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*Marney Thompson, RCC, is currently the Director of Bereavement Services at Victoria Hospice. Since 1994, she has worked as an educator, supervisor, and clinician in hospice palliative care. Her current interests include prolonged grief and best practices in bereavement care.*

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# THE COMPLEX OF TRAUMA

Right brain, “bottom up” neurological approaches to healing and rewiring the brain

BY KATE PINSONNEAULT, RCC-ACS

**W**hat is trauma? Professionals define trauma in different ways, so I'd like to start by letting you know how I have come to understand trauma based on the research and my clients' experiences.

Trauma occurs when three things happen simultaneously:

1. Something is really wrong.
2. We feel helpless and alone in that moment.
3. Our resources are overwhelmed.

In that moment, the body reacts to survive or die. Other functions will shut down.

In a survival or fight/flight response, a person might scream, run, or strike out at anyone that gets close, even those trying to help. If the person cannot fight or get away, the nervous system will freeze in preparation for death. When an individual drops into a dorsal vagal state of freeze or shock, pain-numbing opioids flood their system. They cannot feel and cannot process what is happening.

The part of the brain that processes information is not accessible when trauma occurs. Individuals may remember up to the traumatic experience but not what happened next. In an attempt to process the traumatic event, their nervous system replays the event but cannot access the experience of how they survived. Common symptoms following a trauma include:

- Intrusive thoughts or flashbacks,
- Avoiding things that remind them of the incident,
- Being hyper-vigilant and easily startled (which can affect sleep),
- Feeling something is wrong or something bad will happen,
- Feeling overwhelmed, and
- Low tolerance/irritation/anger.

## **SINGLE EVENT TRAUMA**

When counsellors see clients for a single traumatic incident, they need approaches such as somatic experiencing, EMDR, internal family systems, or brainspotting to access implicit memories, emotions, and

sensations held in the right brain. This helps them recall what happened immediately following the event and how they survived. Once this is integrated, it brings them to a felt sense of safety.

However, a client's recent trauma may also involve relational traumas, or it may trigger past traumas. In these cases, treatment becomes more complex.

## **WHAT HAPPENED NEXT?**

Many times, clients remember a relational event immediately following the trauma event. These can affect trauma processing. To illustrate, imagine your client was driving along and suddenly a car came right at them. CRASH! Now imagine someone rushes over to their car, asks how they are, and lets them know they have called 911 and will stay with them until the ambulance arrives. Your client feels a hand on theirs and, in that moment of connection, the feelings of being overwhelmed, alone, and helpless are overcome by the kindness of this



**When a traumatized person relies on outside resources and does not receive the compassionate understanding and support they need, the feelings of being overwhelmed, alone, and helpless can be reinforced.**

stranger. Their nervous system begins to relax, and their thinking brain comes back online and can begin processing what happened. The numbness begins to subside as they feel their body again. The trauma has lessened.

But let's say they're in the same accident — CRASH! — but now someone comes over to their car and starts yelling, "What's the matter with you? You idiot..." Now there is an additional threat and the feelings of being overwhelmed, alone, and helpless are heightened. The next thing they remember is being in a hospital with no idea of how they got there.

Consider the first responder who is overwhelmed by a horrific event and goes to a colleague for support but is told, "That's nothing compared to what I've gone through." A couple on a motorcycle is hit by a car, and he hears his wife screaming but is unable to get to her due to his broken leg. The young teen who is sexually assaulted and runs home in tears to mom, only to hear, "Welcome to life as a woman." These clients can't remember what happened

after these relational traumas. In therapy, these become your focus.

When a traumatized person relies on outside resources and does not receive the compassionate understanding and support they need, the feelings of being overwhelmed, alone, and helpless can be reinforced. For some, disclosure can have the added experience of humiliation, rejection, judgment, shame, or hopelessness. And it is these feelings that can trigger childhood traumas.

#### **IMPACTS OF A TRAUMATIC CHILDHOOD**

Think of how many times children feel helpless, alone, and overwhelmed with things they cannot understand or accept. Children need a compassionate, supportive, understanding adult to co-regulate and help them through those big feelings. Some children will face ridicule or punishment. For others, harsh, unfair, or even cruel treatment is part of everyday life.

Children living in a chronically traumatizing environment are alone

in a constant state of overwhelm and helplessness. It is beyond their ability to understand or cope. To survive, their nervous systems must adapt to withstand these adverse conditions.

The ACE's Questionnaire can help identify clients who grew up in adverse conditions. It is important to know that clients who grew up with high stress, abuse, or neglect will have atypical nervous systems adapted to survive traumatic relationships in a traumatic environment.

Some children will take on the family dysfunction and belief they are the problem and are somehow innately bad. This is easier for a young child to

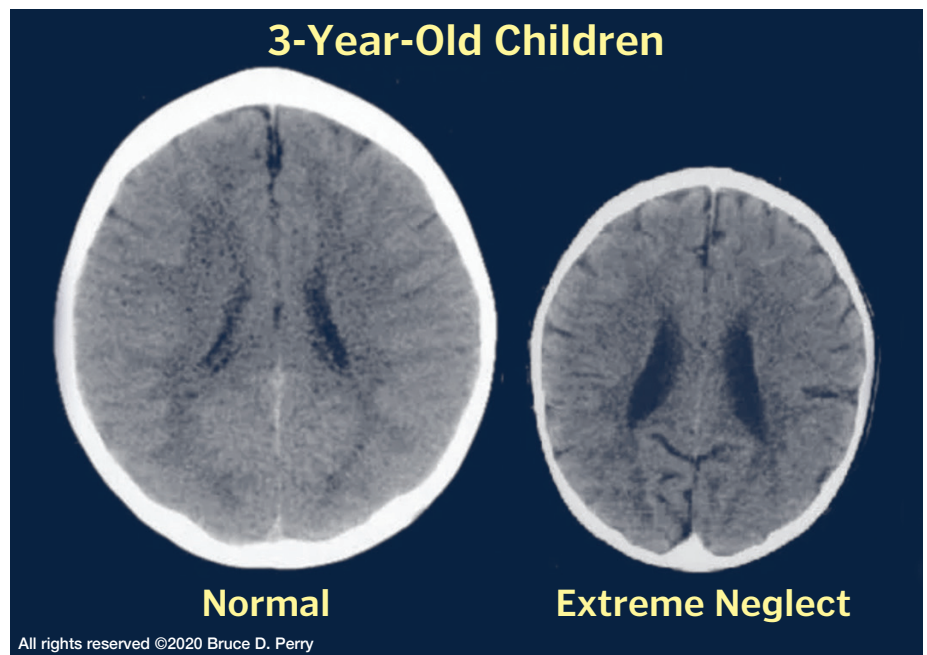
accept than the reality that their parent is intentionally harming them. They often experience deeply felt shame. These children function in a perpetual “red alert state,” ready to fight or run at any sign of danger. To them, everyone is a potential threat because they believe they deserve the mistreatment they receive.

Others will try hard to please their parent in the hope of getting the love they so desperately crave. These children try to psychologically distance themselves from the source of the pain through dissociation. They become the “good child,” striving to do better and trying harder to please others to keep the peace. The child convinces themselves and others that “I’m fine” to avoid attention. These children are compliant and pleasant externally while internally they are in a high stress state, trying to disappear, diminishing themselves by being small, quiet, still, and unseen, or they dissociate to “be somewhere else.”

These two extreme coping strategies interfere with natural neurological development during childhood. These neural adaptations last into adult life and affect learning, problem solving, the ability to understanding cause and effect, self-awareness, social development, and emotional regulation. Later, they impact relationships and physical health. Traumatic stress often manifests as chronic pain/fibromyalgia, sleep disturbances, eating disorders, auto-immune dysfunction, and/or addiction.

### **DEVELOPMENTAL TRAUMA**

As survival takes priority over other developmental needs, children living with chronic stress, abuse and/or neglect have brains that are wired for survival and danger. For these children,



The image above shows abnormal brain development following sensory neglect in early childhood. The left is from a healthy three-year-old child with an average head size; the image on the right is from a three-year-old child suffering from severe sensory-deprivation neglect.

brain development is hampered and altered. Windows of developmental opportunity are often missed, leaving these children without basics skills or the ability to form healthy relationships.

Dr. Bruce Perry has been at the forefront of research on the neurological impacts of child neglect and abuse and was a keynote speaker at Counselling in a Changing World, BCACC’s 2021 conference. Using brain imagery, Dr. Perry shows us how adversity in early childhood impacts neurodevelopment. The picture above compares the brain of a normally developed three-year-old with a child who experienced extreme neglect. You will notice that the neglected child’s brain is 1/3 smaller and has holes and gaps where structural development did not occur.

Dr. Michael DeBellis found that childhood stress resulted in reduced intracranial volume and permanent neural loss leading to lower IQ scores

and cognitive function, reduced blood flow to the cingulate gyrus responsible for cooperation, the medial prefrontal cortex that is associated with decision making, planning, and working memory was smaller, and the hippocampus, which plays a role in emotional memory, was enlarged.

Normal development cannot happen for these children. They become delayed in virtually all areas of physical, cognitive, social, and emotional development. These children have difficulties in childcare or school settings due to their hyperarousal or dissociative states. Their neurological wiring adapted for surviving traumatic relationships in adverse conditions does not serve them outside that environment. Sadly, they are often misunderstood.

Dr. Bruce Perry’s Neurosequential Model of Therapeutics provides a detailed overview of the client’s neurological strengths and challenges. This allows treatment to focus on

specific areas of brain development to improve the client's current functioning. This well-researched approach provides both counsellor and client with neurological information to understand their developmental abilities, inform treatment, and help rewire targeted parts of the brain.

## COMPLEX TRAUMA

Unlike PTSD, which is a psychological response to a traumatic event, complex trauma is rooted in neurology. We need to adapt our approaches to help rewire our client's nervous systems for connection and safety. This is not an easy task when a client has never experienced safety and has a nervous system wired for potential threat on alert 24/7. These clients cannot trust or relax.

Trying to overcome habitual ways of responding when these behaviours secure survival is not an easy endeavour. By age four, how we respond to our environment and our ability to control our emotions have become "hard-wired" in the brain. Changing those becomes increasingly difficult over time.

## TREATMENT

Since survival responses happen in the lower parts of the brain, we need to start there. Fear and trauma are stored

in the right brain's amygdala along with our implicit memories. These are memories our left thinking brain does not have access to. These trauma memories are often sensory, somatic, and emotional and may not be logical or sequential. While they may not make sense, they do hold important truths.

The therapeutic relationship is key. Carl Rogers taught us the importance of, "unconditional positive regard." With traumatized clients, building a felt sense of acceptance and connection is a crucial first step to healing and rewiring the brain. It is from this caring relationship that trust and safety will slowly emerge.

Alan Shore, a pioneer in studying the treatment of complex trauma, emphasizes that non-verbal emotional communication between therapist and client creates a right brain-to-right brain neurological process that helps a traumatized brain to heal and rewire. When our mirror neurons demonstrate a genuine felt connection to the client, their brain recognizes that emotional attunement. In that moment of connection, their body produces oxytocin, reducing stress. The client experiences a temporary sense of safety and connection. Over time, it is this relationship that allows their social

engagement system to come online. When they are in this ventral vagal state, healing can take place.

As Bruce Perry, Dan Siegel, Alan Shore, Janina Fisher, Peter Levine, and others have emphasized, treating complex trauma requires three components to be successful:

1. The therapist must be emotionally attuned to the client,
2. They use a "bottom up" neurological approach that begins with safety and survival, and
3. Right brain therapy is used.

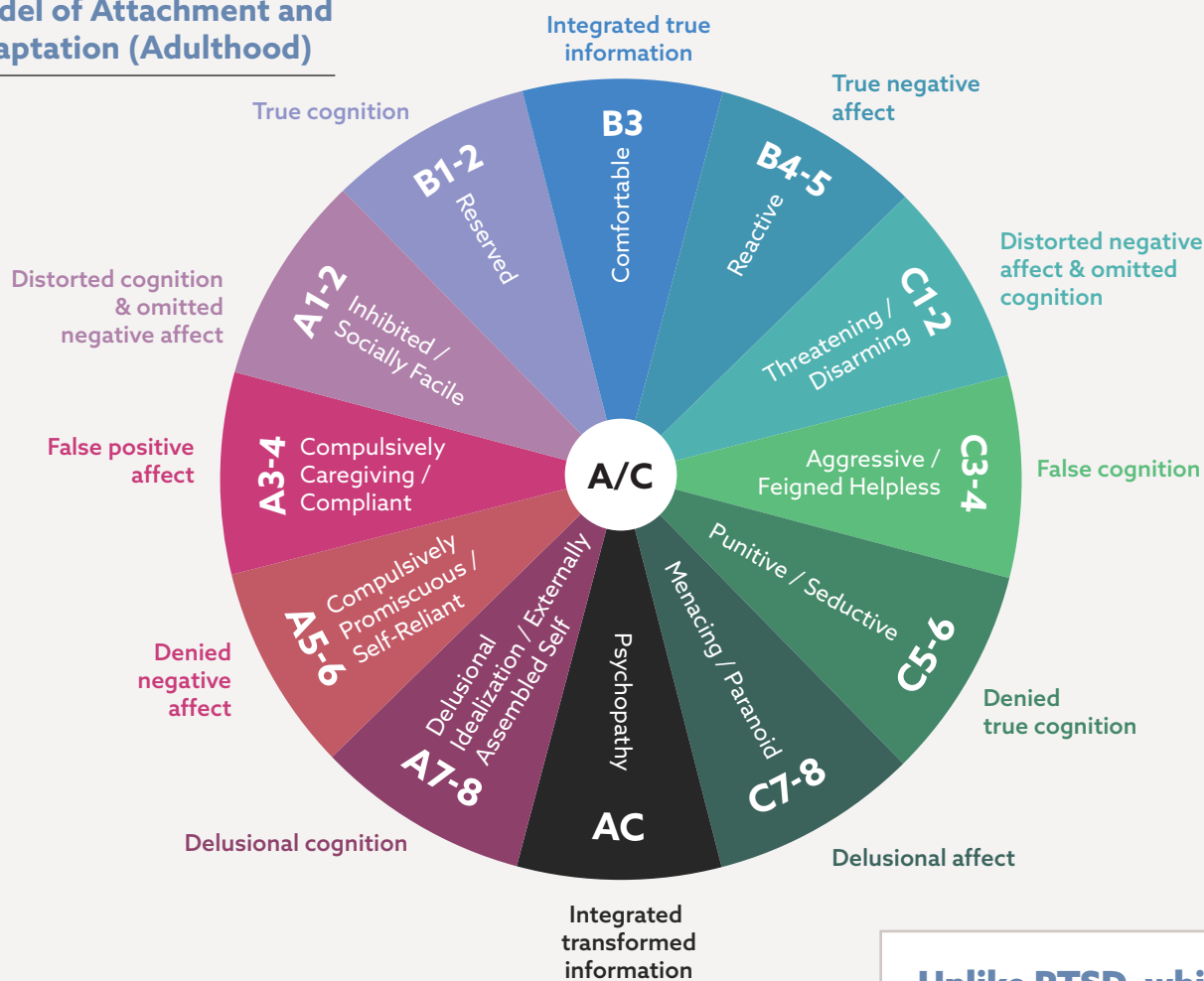
Using right brain therapies such as sand tray therapy, EMDR, internal family systems, art therapy, psychodrama, somatic therapies, expressive therapies, play therapy, etc. will facilitate a "bottom up" healing process that integrates past emotional experiences, implicit memories, and somatic sensations. The client feels present in the here and now, knows you are with them, feels safe in the moment, and has control. Essentially, you are creating an experience that counters the factors that created the trauma.

Right brain therapies allow the client to explore what happened to them from the here and now with a sense of connection, curiosity, safety, and self-compassion. Therapists must also respect the client's protective system that has ensured their survival and continues to keep them safe. Trying to change this will simply be countered with resistance. Instead, we need to facilitate the client's exploration of their protective parts that cause dissociation, panic, reactivity, mistrust, or defensiveness, which in turn will disclose their tender, vulnerable parts that hold shame, hurt, fear, or negative beliefs about themselves or the world.



**Children living in a chronically traumatizing environment are alone in a constant state of overwhelm and helplessness.**

## Dynamic Maturation Model of Attachment and Adaptation (Adulthood)



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Dr. Patricia Crittenden's Dynamic Maturation Model of Attachment and Adaptation (Adulthood model above) is a brilliant understanding of these two states — dissociative state and hyperarousal state — and how they evolve through the life span.  
<https://familyrelationsinstitute.org/dmm-model/>

**Unlike PTSD, which is a psychological response to a traumatic event, complex trauma is rooted in neurology.**

### CHOOSING THERAPEUTIC APPROACHES

It is important for us to remember the two ways individuals survive complex relational trauma. Alan Shore described these two response patterns as hyperarousal and dissociation.

The hyperarousal state occurs when the child's attachment figure inconsistently provides for the child's basic physical and psychological needs while also, at times, being a direct threat to the child. It is the inconsistency

and unpredictability that activates the hypothalamic-pituitary-adrenal (HPA) stress axis, putting the individual in a highly aroused, dysregulated, and reactive sympathetic state in which their heart rate, respiration, and blood pressure are elevated.

In a dissociated state, the child disengages from the external world to feel safe. They are helpless and hopeless, shut down and no longer expecting a caregiver to meet their

needs. They believe their feelings, needs, and thoughts do not matter. They avoid attention to feel safe. In this hypometabolic state, heart rate, blood pressure, and respiration are decreased, while pain-numbing opiates are elevated. It is difficult for these children to feel anything. This is also known as structural dissociation.

Using biofeedback such as an

oximeter or HeartMath will let you know whether your client is in a hyperarousal or dissociative state. For clients with complex trauma, the goal is to slowly move them out of the freeze state to fight / flight then into the ventral vagal where they can experience safety and connection. It is there that stress and defensiveness can subside, healing can take place, and the nervous system can find homeostasis.

Dr. Patricia Crittenden's Dynamic Maturational Model of Attachment and Adaptation is a brilliant understanding of these two states and how they evolve through the life span (see page 26). The B strategies at the top indicate secure attachment, the As represent increasing dissociative strategies, and the Cs represent the increasing hyperarousal strategies.

While all traumatized clients benefit from attunement and right brain / bottom-up approaches, there are some specific variations in treatment goals that are important to keep in mind.

When you have dissociative clients with A attachment strategies, cognitive approaches should be avoided as these individuals naturally, "live in their heads," disconnected from their body and emotions. While they may want to understand and make sense of things, it is not what they need to heal. These clients benefit from:

- Somatic activities to move their bodies, feel bigger/take up space, and physically express their emotions;
- Increasing awareness of their body, feelings, needs, wants, beliefs, and values separate from others;
- Being present and responsive rather than dissociative;
- Prioritizing their own their needs and wants without feeling unsafe, guilty, or selfish;

- Practising self-compassion;
- Discerning their emotions, problems, preferences, etc. from others;
- Role plays to learn to tolerate other's distress or discomfort;
- Physical experiences of setting boundaries, pushing back, saying "no"; and
- Learning to pause and focus inward to consider their needs, limitations, preferences, etc. rather than impulsively pleasing others.

For clients with C strategies that easily become hyper aroused, reactive, and dysregulated, these clients require therapies that provide:

- Activities to help them see the bigger picture, consider others' perspectives, and understand that other people's needs may be different from their own;
- Opportunities to practise the give and take of relationships, including respecting others' boundaries, or understanding the benefits of putting a loved one's needs first;
- Support to tolerate moments of disconnection;
- Co-regulation leading to emotional self-regulation;
- Practice in social problem-solving skills;
- Experiential exercises to build trust in self and others;
- Emotional validation and acceptance to override beliefs that they are bad, not good enough, not worthy, etc.; and
- Understanding and appreciation of the protective functions of their reactive parts.

In closing, I'd like to leave you with a lovely quote from Janina Fisher from *The Treatment of Structurally Dissociated in Chronically Traumatized Patients*:

*Throughout treatment, it helps to keep in mind that the goal in trauma treatment is not remembering what happened but the ability to be "here" instead of "there:" to be conscious and present in the here-and-now, to tolerate the ups and downs and the highs and lows of normal life, and to heal the injuries caused by the trauma — the injuries to innocence, to trust, to the heart, to faith — the injuries to the body and the soul. Remembering the past is helpful only to the extent that it helps to heal rather than re-open the wounds, to increase self-compassion and a deeper appreciation for all the parts who helped the client to survive and now deserve to be part of a safe and healthy present.*

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Kate Pinsonneault, RCC-ACS, is a client-centred counsellor with over 40 years' experience working with individuals, children, families, and couples. She is Certified Clinical Trauma Professional (CCTP) and has post-graduate certificate in Infant Mental Health (CIMH). Kate also provides individual and small group supervision, a consultation group for IFS therapists, and professional training and workshops.

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# I HAVE A FRIEND...

When counsellors seek therapy:  
why more should, but so many hesitate

BY MICHAEL TOWERS, RCC

*"HELLO. I'm looking for a counsellor to talk about my counter-tra... um, I mean, ah, to talk about anxiety."*

*"Hi. I am hoping to get some help and insights with my relationship. I can't get them to go to therapy with me. Um, what do I do? Ah, well, yeah... I'm a couple's therapist..."*

*"Really? Your boss is giving you a hard time at work because everyone is missing deadlines, and you can't sleep now? Really? I just lost my dog, my best friend of the last 12 years. Give me a break with your silly problems!"*

*"I can't face another client... what is going to happen when they find out I am an imposter?"*

*"I feel so unsupported and alone in*

*my clinic. The director overloads my casework, and if I don't meet their quotas, I get punished. I have no idea how I am supposed to manage all of this!"*

Those are just some of the many reasons a fellow colleague may feel compelled to reach out for counselling support. But not many do, and perhaps the reason is wrapped up in the clichés of why a mechanic's vehicle barely runs or a doctor suffers from really bad health concerns. Namely, it's the exhaustion of focusing one's skills and talents for the betterment of others at the cost of our own well-being.

Our profession is one of many professions where there is a definite "calling" to the work. There is a level

of deep satisfaction and contentment – even joy — when we can see our client's life transformed, when we can walk them through loss to acceptance, or when we can help them find freedom from many of life's entanglements. It is a privilege to do this work, to walk with our clients, and often we do this at the expense of ourselves.

How often do we make sure we research and stay on top of the latest trends and helps for those most common reasons clients come into our doors? We go to a conference and are taught some new tools, we read a new textbook and discover a new approach, or we talk to a colleague and learn a better way to ask a question. We take all of these discoveries — often with



much enthusiasm — and we bring them to our clients.

Just a little while ago, a colleague spoke of suggesting a book for a client to read. In this case, it was *The Body Keeps the Score* by Bessel van der Kolk. The client got back to the therapist saying how much it had impacted their life and how they plan on discussing the book with the therapist in their next session. This therapist was now reaching out with much anxiety trying to figure out how to consume quickly the 445 pages (including index) of this book in order to be ready for their client. We have a habit of providing these great resources, tools, and problem-solving ideas to our clients but at our own neglect.

### **COUNSELLORS ARE PEOPLE, TOO**

We often believe that because we are the ones sitting in the “big chair,” we have to have our crap together. That there is no space in our lives to be human. Heaven forbid a marriage counsellor should find themselves going through a painful separation. Stop the idea of a grief specialist unable to see any clients because they just lost their spouse. Please let it not be that a therapist assisting someone with their anxiety also struggles with panic attacks on a regular basis. This has hypocrisy written all over it and comes with much judgement by the very people who ought to be reaching out with support and care. The stigma that counsellors are people, too, tends to be a major

**It is a privilege to do this work, to walk with our clients, and often we do this at the expense of ourselves.**



barrier in keeping them from reaching out to their colleagues for help.

This comparative mentality also extends to financial details. There is an acute awareness of how much I charge per hour versus how much my colleague charges per hour and how we process that speaks a lot to how we view ourselves — and measure our own worth and value in the process. Lots of times, we won't hesitate to take our vehicle to a discount shop to get the oil changed versus a dealership, because in our mind, we have justified that it is exactly the same work being done.

But this type of comparison is not present in our profession. We charge what the market can bear. What it can support. What our professional associations encourage us to charge.

What our other counsellor colleagues are charging. And this is all fine and good for the most part — until we need a counsellor. Then we participate with the judgement and the comparison and the justification. We believe that more expensive means better, but we don't want an expensive counsellor for ourselves and we also don't want a cheaper counsellor who, by comparison, could be worse than ourselves. So, we get caught in this endless loop.

We also see a similar loop play out in modality strengths. You might be an EFT-certified couple's therapist who is struggling in their own relationship. You know how great EFT is, so you want to reach out and find someone who is also certified in EFT. But you want to make sure their certification

came from at least the same source as yours — if not better — all subjective, of course. Perhaps a couple's therapist who only has Gottman Level One will bring a brand-new perspective into your relationship that you hadn't considered before. Heaven forbid that we actually get into the counselling room with a therapist who practises the modality "wrong." Just the anxiety of encountering that scenario will keep therapists from seeking help.

### **WE ARE NOT AN ISLAND UNTO OURSELVES**

We are a body of interconnected professionals in a helping profession, working with vulnerable people seeking help for their problem-saturated stories — often in various stages of crisis. The work is demanding, emotionally,



**We are not everlasting batteries. We wear out and we are impacted by our clients' stories. We need each other to help us be the best we can be for our clients.**

mentally, physically, and spiritually. We are not everlasting batteries. We wear out and we are impacted by our clients' stories. We need each other to help us be the best we can be for our clients.

I am a private therapist. In other words, I work alone in my private practice. Early last year, over the course of a few months, I saw a few different clients I would describe as angry, entitled cis males with a heterosexual orientation. I found myself getting triggered by them and although there was an invitation from each of them to find the space to hold their stories — often shame stories — I couldn't do that well. I reached out and found a therapist willing to work with me and began working through my own shame stories and how that related to

significant males in my own life. This was something I thought I had resolved, but there it was — staring at me in my own counselling room.

We don't know what we don't know. Often, as therapists, we will self-diagnose and self-help and although I am a huge supporter of self-care, I am much less a supporter of self-help. I cringe when my clients tell me how they turned to Dr. Google or Assistant Reddit to navigate their complicated situations. The sacred place of bringing our wisdom into a conversation with another trained counsellor to hear their reflections on our wonderings is a beautiful melding of ideas, approaches, worth, and value in harmonious ways. To know and be known is this dance of humanity and community of acceptance and belonging which we work hard to develop for our clients but in a much more profound way — and we need that space for one another.

We bring into the counselling room our sacred language. It is a shared language with all therapists, and we know it. We understand it. We don't need to struggle in translating it like we do for our clients. It is as if English wasn't our native language, and we are now in a place where we can just be ourselves. This is what awaits us in the therapist's room. A chance to be ourselves without filter, without

translation, without barriers. In that place, resources can be shared, and we don't feel so alone in our journey. We have a companion who gets us, who understands us intimately, our experiences overlapping. We are on the same team. The space is easier to hold for one another, and the freedom to choose vulnerability happens when we both look at each other and experience empathy instantaneously because we both have now sat in each other's places.

We encourage our clients to seek regular therapy, not just because it is a good business practice for those of us in private practice, but because it is a good mental health practice. We need to practise what we preach. We need to live out the very tools we teach and provide to our clients. We need to model healthy behaviours not just in that 50-minute hour but also outside in the real world. Your clients need you, and they need you to be healthy. How can we talk about healthy living and self-care when we aren't living and caring for ourselves?

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*Michael Towers, RCC, is a father of six and grandfather of four. He resides in Kelowna with his partner of 30 years, where he enjoys cycling, swimming, and learning how to dance. He is in private practice and his partner runs the business side of things.*



# LOOKING IN THE MIRROR

An RCC gives a personal account of their journey and growth through therapy

BY DANIELLE PELOQUIN, RCC

**S**even years ago, my sons and I had a traumatic experience. We were thrust into the helping world through this experience. I am neurodivergent and so are my children. At first, I was only seeking help for my children. I believed I was strong enough to handle it, so I relied on my armour and shielded up to cope through the experience. Along the way, things started to crumble. At one point, help was offered and I took it. This set me on the path to learning boundaries and emotion regulation. A counsellor challenged me in frustration one day. This led me to apply for a master's degree in counselling psychology. I graduated more than a year ago.

## **THE JOURNEY**

We have had many child and family counsellors. The trauma we experienced affected my children's abilities to learn. It affected our previously calm household. One of my boys became very angry and, at times, was suicidal. Through this experience, I was challenged about my behaviours by family counsellors. Eventually, I was diagnosed with ADHD and began medication. Along the way, my oldest son was diagnosed with dyslexia, dysgraphia, ADHD, and oppositional defiance disorder (ODD). Our

commitment to counselling has led to him no longer meeting the markers for ODD.

In the past seven years, I have had five individual counsellors. My coping strategies led to a rocky start that led to relationships breaking down with the first few counsellors. I had trouble with counsellor expectations around my abilities due to my neurodivergence. As I've come to understand my neurodivergence, some of my first experiences were damaging because of the therapists thinking I was disrespecting them by missing appointments or not completing homework. The last two therapists, I have had long-term relationships with and have experienced amazing growth. I am much better at advocating for myself around my neurodivergence.

## I have gained knowledge and relationship-building skills from my own personal therapy.

### BEING A BETTER THERAPIST

During my education, I often wondered why so many students were becoming counsellors but had not experienced therapy themselves. After all, how is it that we would expect others to access our services when we are not willing to commit to it ourselves? I have gained knowledge and relationship-building skills from my own personal therapy. I have had the opportunity to observe counselling techniques and experienced multiple counselling modalities because of my therapy experience. Some of these experiences have significantly informed my practice.

There are many reasons therapy

has made me a better therapist. The following are the ones that helped the most:

- Compassion for my own suffering has made it easier to be compassionate with my clients.
- Working through my inner-child wounds has made observation of transference easier.
- Therapy has allowed me to be vulnerable, in a conscious way, with my clients about my own healing journey.
- It has allowed me to sit in uncertainty with clients while noticing emotions and urges without acting on them.
- It has allowed me to release control of the therapeutic journey with my clients.

As therapists, we are as human as our clients. In "Therapists are human too," Adams explains that sometimes therapists have shame in getting their own needs met and think because they are therapists, they should have things figured out.<sup>1</sup> This prevents them from seeking therapy for themselves. In "Walking wounded or wounded healer?" Conchar and Repper discuss how a healer surviving mental distress is a draw for clients seeking therapy.<sup>2</sup> My lived experience with high shame and ADHD informs my practice. When I'm working with high shame and self-critical clients, I am reminded of the strong armour I carried. I use my own wounding and journey to help clients soften towards self-compassion. I can easily explain "backdraft" associated with learning self-compassion due to my own experience of it.<sup>3</sup> The first time I attempted to use my loving-kindness meditation towards myself, I experienced extreme resistance to it.<sup>4</sup> It was painful and hard but I persisted. Relating this to clients helps them step into the discomfort of bringing self-

compassion to themselves.

I relate to Stone, who states:

*What has consistently surprised me, however, is not so much the value of this caring relationship to clients, but rather the value to myself, and the ways that each session leaves me with, at the very least, a heightened awareness of my own wounds—and a deeper compassion for my own challenges in truly accepting myself as I am. Inevitably I walk away wondering who has been the mirror for whom?*<sup>5</sup>

This quote is a reminder to me why I attend therapy. Working through each wound as it arises whether through my familial or therapeutic relationships helps me journey with my clients through their own healing.

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Danielle Peloquin, MA, RCC, is a neurodivergent therapist working in private practice at Mental Maintenance Counselling in Fort St John. She is passionate about compassion-focused therapy and acceptance and commitment therapy (ACT). She is an active member of the Association for Contextual Behavioural Sciences and is hoping to be an integral part of starting a western chapter.

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# HOLDING SPACE

How two RCCs are supporting Ukrainians in B.C. during the Russian invasion of their home country **BY CAROLYN CAMILLERI**

**O**n Thursday, February 24, 2022, Russia invaded Ukraine in a major escalation of the Russo-Ukrainian War that began in 2014, when Russia invaded and annexed Crimea. While conflict has been ongoing for years, the massive increase in violence and force in February has shocked the world and devastated Ukraine. More than eight million people have fled Ukraine and an estimated one third of the population has been displaced, making it the largest refugee crisis in Europe since the Second World War.\*

For Ukrainians living in Canada, it has been a horrifying time of intense worry and anguish, including for RCCs Viktoriya Fedorchuk and Aliona Sydorenko, who have practices in New Westminster and Vancouver

respectively. Both RCCs have friends and family in Ukraine and felt strongly compelled to offer support in whatever way they could.

“When the war first started, I was definitely in a state of shock about it all, and I think everyone was just trying to figure out how this was going to go and who would be impacted and did we feel like people back home were safe,” says Fedorchuk, who is from Odessa and moved to Canada 23 years ago, when she was eight years old. “As a therapist, I was trying to manage work and all the other kinds of stress humans are dealing with, including the ongoing impacts of the pandemic. Similar to everyone, I was feeling pretty helpless because there’s only so much money and stuff you can donate.”

Fedorchuk, who speaks Russian, could see that her Eastern European

and Ukrainian friends in Canada were struggling and wanted to use her skillset as a clinical counsellor to support people. She reached out to Ukrainian-speaking therapists, and Aliona Sydorenko responded quickly. They then teamed up and, with the help of Marina Vaysman, a counselling student, launched a series of free Zoom sessions for Ukrainians in B.C.

## HOW IT’S GOING

Fedorchuk and Sydorenko have structured the Zoom sessions to follow group therapy norms, starting with setting up a safe space. Participants then share what their experience has been and what has been impacting them the most. Empathy, validation, and support are offered.

The dominant emotion in the Zoom sessions is guilt — a lot of it.

“There’s immense survivor guilt going on in the community,” says Sydorenko, who moved to Vancouver seven years ago from Kyiv. “People who are removed physically from Ukraine, or even within Ukraine but farther from the war zone itself, are expressing feelings of guilt and shame for not being as impacted as the people who are fighting or who have lost their loved ones.”

Fedorchuk adds: “How do I wrap my head around the fact that I’m enjoying this lovely, quiet island in B.C. whereas my friends are in this war back home?”

Of course, there is anger, fear, and grief for the people who have been lost, “and then just deep sadness for the cities that are being bombed and shelled,” says Fedorchuk.

The final part of each Zoom session focuses on practical skills, such as grounding exercises, emotion-focused exercises, mindfulness, and somatic exercises.

“We are really trying to help people leave the group feeling more grounded, but then also with some tools they can take to help themselves through this time,” says Fedorchuk.

While the Zoom sessions support people participating, they also help counteract some of the helplessness the counsellors themselves are feeling.

“It’s a blessing and a curse when you are going through very similar things as clients,” says Sydorenko. “In this case, it has been really helpful for me. Aside from me having my own therapy and supervision, I think one of the things that myself and every Ukrainian I’ve actually spoken to... when witnessing war from afar is the sense of helplessness.”

Both RCCs note that they are not alone in stepping up to volunteer in various projects.

“There are a lot of therapists committing their time and emotional space to this cause,” says Fedorchuk. “Aliona and I are just two of many who have really committed to supporting people through this, so that’s been absolutely encouraging.”

Another rewarding aspect is that the sessions have become a building block for community with some group members connecting and supporting each other after meeting online.

“It’s connecting to my community and being with people who are going through very similar things,” says Sydorenko. “And especially for immigrants, it can be such an isolating experience, because for many of us, the world ended in a way when the full-scale war began.”

#### HOW TO HELP

Both Fedorchuk and Sydorenko encourage RCCs who have Ukrainian and Eastern European clients to hold space for discussion about what’s happening.

“Not to overgeneralize, but we do welcome an opportunity to talk about it, to talk about our feelings, our experience of it,” says Sydorenko, adding, “I don’t think you necessarily need to be from the same community to be able to relate and to have empathy for another person’s experience of the war or witnessing war.”

What does help? Listening, learning, acknowledging and validating feelings, and remembering that the war is still going on.

“This is not a situation that anyone

can fix right now,” says Sydorenko. “For a person who is supporting someone who is Ukrainian right now, I think they might also run into their own sense of helplessness, because there isn’t really anything one can say or do to make things better. But being with people, acknowledging that this war is very wrong and that their feelings are valid, and remembering that even though it seems in the media like the world is moving on, it’s still affecting every Ukrainian.”

She adds: “It may be a type of work where you just metaphorically hold someone’s hands while they’re going

through potentially one of the darkest periods of their lives.”

In addition to the Zoom sessions, Fedorchuk and Sydorenko have been looking into other ways to help. Ideally, they would like government funding allocated to this cause and health authorities

to recognize the crisis — not just for refugees fleeing Ukraine but also for the Ukrainian Canadian community.

“The group we’ve been running has been entirely free and a lot of the services I see other therapists in my community offer are free and that will naturally have limitations,” says Fedorchuk. “There are only so many free things we can all offer and that’s also not a fair expectation to have on a community that’s already burnt out.”

**What does help?  
Listening, learning,  
acknowledging and  
validating feelings,  
and remembering  
that the war is still  
going on.**

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\*[https://en.wikipedia.org/wiki/2022\\_Russian\\_invasion\\_of\\_Ukraine](https://en.wikipedia.org/wiki/2022_Russian_invasion_of_Ukraine)

# A SAFE SPACE

## Making a difference by supporting First Nations children, youth, and families

**P**amela Nevdoﬀ’s decision to become a counsellor resulted from what she witnessed in a previous career as a teacher in First Nations community schools. She saw first-hand the challenges youth experienced that affected their ability to get an education — an education many people take for granted.

“I believed I could help the youth and their families in a better way if I returned to school to get my master’s degree in counselling and psychology,” says Nevdoﬀ, who is of mixed nationality: First Nations from the Adam’s Lake Indian Band and Russian/Ukrainian.

After completing her MA, Nevdoﬀ became a First Nations Health Authority approved counsellor and worked in several First Nations communities and schools as a counsellor supporting children, youth, and families. She currently lives in Vernon, where she maintains a private practice to support clients in her community, the Okanagan Indian Band.

### **What types of concerns do your clients most commonly want assistance with?**

So far, my clients have been mostly First Nations adults, children, youth, and their families. I have taken cultural sensitivity training and have experience with clients from a diverse mix of cultures and ages that range from children to elders. The issues I often see are symptoms related to childhood trauma and inter-generational trauma. Issues can include all forms of abuse, parenting skills, family dynamics, anger, anxiety, depression, suicide ideation, and gender/sexual identity issues, to name a few. People often seek counselling services to work on an issue they specifically have in mind and find they would like to do more work

on something else as it affects many of their behaviours and thought processes — more than they realize.

### **You use several modalities: how do you determine what is best for each client?**

I have found that an eclectic mix of modalities benefits most people. People are multi-faceted in their being and forever growing and changing. An eclectic mix of modalities supports the fact that humans have different needs at different times depending on experiences, situations, and relational challenges they may face. Sometimes, the modality that works for a period of time may need to change depending on what fits the issue or what demonstrates greater results.



Pamela Nevdoﬀ lives in Vernon, where she is establishing her private practice in her community, the Okanagan Indian Band.

Clients can learn to be adaptive in navigating counselling modalities just as they can learn to be adaptive in their own lives. A few of the modalities I draw from are cognitive behavioural therapy, eye movement desensitization and reprocessing therapy, humanistic therapy, strengths-based approach, and narrative therapy.

### **Now that restrictions are easing, are you seeing differences in client concerns?**

Now that the COVID-19 pandemic restrictions are relaxing, I am seeing that people are starting to realize how deeply their lives and behaviours were affected. They are realizing they were in survival mode and the stress is catching up to them. Most clients are in the process of determining what the new normal will be for themselves and their families. I do my best to use this realization as an opportunity for change and growth and to help them make their new normal.

**You offer both in-person and online sessions: will you continue offering both?**

Most of my time as a counsellor has been in-person sessions. The pandemic started the switch over to Zoom and telephone counselling. The other factor for online sessions is that many of my clients come from different communities so a digital format is what works best for them. For the most part, my clients find this format most convenient for them and it allows them to be in a space that’s comforting to them. There are clients who prefer one-on-one counselling, and I do my best to help my clients find someone providing in-person services if that is what they determine they need. Since I am establishing my private practice in my home community, I will look at in-person sessions if the need is there.

**Tell us something about training Oreo and Grouse to be therapy dogs.**

Oreo and Grouse took training with a dog trainer in Penticton who used therapy dog international standards to test them to see if they were suitable to be working therapy dogs. There were many tests that challenged both dogs, such as weaving through plates of hot dogs without touching them, interacting with people in wheelchairs and walkers, being swarmed by people, being handled by others without me present, and demonstrating an outstanding temperament. Grouse and Oreo passed and were deemed suitable to go to “work.”

**What are the benefits of having Oreo and Grouse as part of your practice?**

I have been bringing Oreo and Grouse into sessions for the past three years and it has been a blessing. Oreo is an elder pug who loves to cuddle and seems to sense when to show love and affection and when to be silent, held,

and stroked. Oreo does an amazing job of being present and supportive during counselling sessions, and most clients love petting her while talking. I do have to let people know she will even give some of herself to take home for continued support as she is a shedder.

Grouse’s specialty is definitely different than Oreo’s. He is younger and has more energy so is good for when I support clients in interactive ways, such as walk and talks. Grouse is also perfect for when youth need time to just be children and play. Grouse has come on walks with youth and been a part of youth camps I have been contracted to support and loves his time supporting people in his own ways.



**“Like counsellors, my therapy dogs have different approaches and their own way of providing kind and authentic assistance.”**

Like counsellors, my therapy dogs have different approaches and their own way of providing kind, authentic assistance. Therapy animals can support people who have been resistant to traditional counselling modalities to be more open to starting a process, as they can provide a means to connection.

**How do you address boundary issues when you live and work in the same community?**

I have found it is important to develop clear boundaries and stick to them

so I can provide consistency in my practice. There are boundary issues that are easy to address as it is plain to see that a situation has crossed ethics and, in most instances, ethics are black and white and need to remain constant. Then there are personal and practice boundaries that are up to each individual counsellor to address. These types of boundaries are best to include in your intake documentation, so they are reviewed right from the start of counselling services.

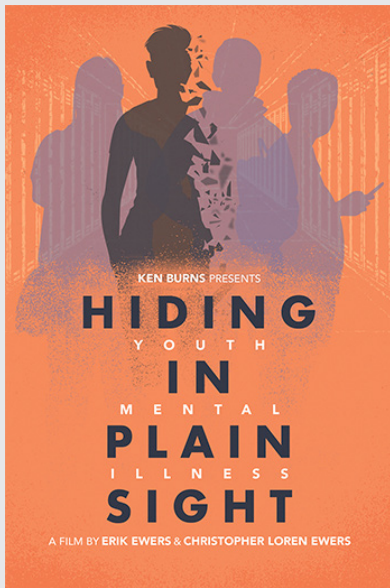
**What’s your advice for RCCs who may be confronted with boundary issues?**

The advice I have to offer colleagues who are dealing with boundary issues is to have trusted colleagues or advisors and debrief situations in a confidential manner. It is important to have other counsellors in your contacts in case it is apparent that you need to refer the client on as they are too close to you and it would be crossing ethical boundaries. Having the BCACC ethics document to review is helpful, and most of all, if you are questioning something, there is usually a reason.

**What inspires you and keeps you going?**

There are many ways I get inspired when doing the work of a counsellor. One of the most inspiring things when counselling adults is when people let go of the things and people that are holding them back and make themselves the number one priority so they can realize their true self. When counselling youth, I find it so inspiring when they realize there are people and places that can provide a measure of safety and that opening up in counselling is not so bad. These moments make all the challenges of getting there worth it.

## Watch



### **HIDING IN PLAIN SIGHT: YOUTH MENTAL ILLNESS**

Streaming now at [www.wellbeings.org/films/hiding-in-plain-sight-our-mental-health-crisis/](http://www.wellbeings.org/films/hiding-in-plain-sight-our-mental-health-crisis/)

While the subjects of this documentary are youth in America, viewers will find the experiences and insights shared translate across country lines.

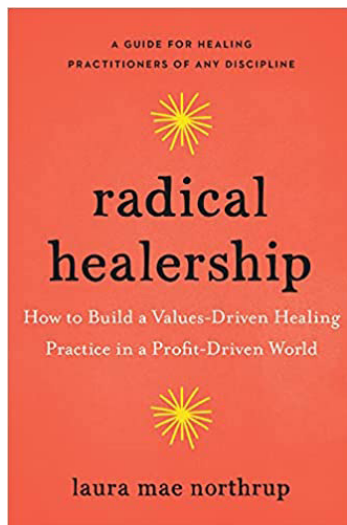
The Storm, the first two-hour episode of *Hiding in Plain Sight*, focuses on more than 20 young people who provide an intimate look at what it's like to experience the symptoms of mental illness, from depression to addiction to suicide ideation. The film includes insights from families, providers, and advocates and explores the impact of childhood trauma, stigma, and social media.

## Listen

**Dr. Kristen Neff**, co-founder of the Centre for Mindful Self-Compassion, offers free meditations online. Visit [www.self-compassion.org/guided-self-compassion-meditations-mp3-2/](http://www.self-compassion.org/guided-self-compassion-meditations-mp3-2/) to tune in and take some time for yourself.



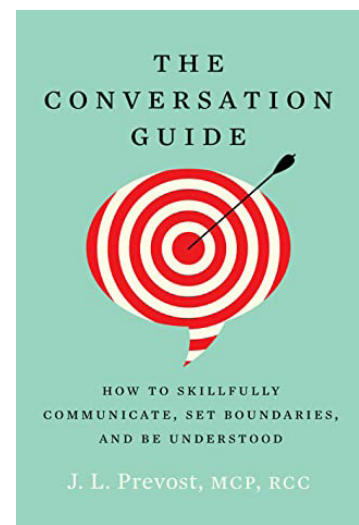
## Read



### **RADICAL HEALERSHIP: HOW TO BUILD A VALUES-DRIVEN HEALING PRACTICE IN A PROFIT- DRIVEN WORLD**

BY LAURA MAE NORTHRUP

Therapist Laura Mae Northrup navigates the complexities of being a healer today — and shows how you can stay true to your calling in a world built from systems designed to extract, oppress, and exploit.



### **THE CONVERSATION GUIDE: HOW TO SKILLFULLY COMMUNICATE, SET BOUNDARIES, AND BE UNDERSTOOD**

BY J.L. PREVOST, MCP, RCC

In *The Conversation Guide*, BCACC member and teacher J. L. Prevost teaches 10 skills for making all types of conversations less stressful, easier, and more effective.

# BCACC Member Health Benefit Plan



## A Message from BCACC's Senior Benefits Advisor, Stephanie A. Ritchie

I am pleased to bring the best Canadian Insurers to meet the needs of BCACC members for **Health & Dental, Disability & Critical Illness Benefits, through Edge Benefits,** who are permanent BCACC benefits sponsors.

This past Spring, we announced the addition of a new permanent BCACC benefits sponsor: **IA Financial Group (Industrial Alliance) for Mortgage/Life/Loan Insurances** – with over 125 years of experience, the IA Financial Group are Canadian leaders in the financial industry.

BCACC members who are interested in learning more about Mortgage/Life/Loan Insurances should log in to the member portal to review this information in the **I Am Looking For** section.

For a no obligation quote for Life, Disability, Critical Illness and Health & Dental benefits please contact me at **[stephanieritchie@shaw.ca](mailto:stephanieritchie@shaw.ca)** or at **778-533-4676**

BC ASSOCIATION

**of CLINICAL  
COUNSELLORS**



# THANK YOU

## TO OUR VOLUNTEERS

The Inquiry Committee is part of the regulatory arm of the BCACC and is concerned with the public interest and protection. This foundational Committee is tasked with reviewing and adjudicating complaints received from the clients of our members. In addition, this committee is involved in creating and reviewing policies and procedures that support the bylaws of the Association. The Inquiry Committee helps advance the Association's strategic mission and goals of:

**Professionalism:** High standards; Integrity; Lifelong learning; Collaboration; Collegiality

**Accountability:** Transparent; Ethical; Fair; Trustworthy

**Respect:** Responsiveness; Compassion; Sensitivity; Social responsibility; Diversity

The Committee members volunteer many hours each month to deliver rigorous case reviews. Their focus on resolving complaints by consent agreements in which members are assigned corrective actions to address errors has resulted in over thirty years with only a single disciplinary hearing.

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### Committee Members (alphabetically)

- ▶ Jane Goranson-Coleman (Chair)
- ▶ Jette Midtgaard
- ▶ Janine Orlando
- ▶ Liisa Robinson
- ▶ Lisbet Rosenfeld
- ▶ Mario Testani
- ▶ Mitra Jordan (resigned in February 2022 after 7 years of service)
- ▶ Asli Kucukbumin
- ▶ Susan Butland
- ▶ Natasha Bacchus

**JOIN WITH US IN APPRECIATION OF THIS DEDICATED GROUP OF VOLUNTEERS!**

BC ASSOCIATION  
of **CLINICAL**  
**COUNSELLORS**

The logo consists of a stylized, abstract shape made of overlapping triangles in shades of teal and grey, resembling a compass rose or a star.