Games Addiction
IT’S A REAL PROBLEM
— AND NOT JUST FOR KIDS

The Boy Inside the Addicted Criminal

Getting Support for Ourselves and Our Practices

PTSD and Chronic Illness

The Crisis of Vicarious Trauma Among First Responders
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As a BCACC member, your presence in the online RCC directory puts you in front of potential clients to help you build your practice. The Members Only pages give you exclusive access to forums and committees, membership status updates and regional information, legal articles and insurance guidelines, association reports, and other materials to help your practice.

TAKE A FEW MINUTES AND CHECK IT OUT.
Participate in a forum, update your profile, read a blog post by a colleague, sign up for a workshop, review your member benefits, and find fellow RCCs in your region.

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The Crisis of Vicarious Trauma
Suicide rates among first responders in Canada have reached crisis levels. Expressive-based treatment may help.

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DEATH DOULAS: A sign of changing attitudes

How we think about death and dying is currently a topic of much discussion, including rights to dignity in death and doctor-assisted suicide. While these discussions are new in Canada, they are not new in other places.

“There are many cultures and communities throughout the world in which care of the dying and dead is seamlessly woven into life,” says Marco Mascarín, PhD, RP, a director at the Institute of Traditional Medicine (ITM) in Toronto. “Regardless of where our ancestors originated from, we do not have to go far back in our family lines to locate people who knew how to look after the dying and dead.”

In North America, many people are relearning that knowledge, he says. “There is a willingness to speak of dying and all that it touches, not only for pragmatic purposes, but because more people sense that to step closer to death is to invite a life of great depth and meaning.”

With that has come the reemergence of an ancient role: the Thanadoula, a term combining the Greek words for death (thana) and servant (doula) or “death doula.” And for the past eight years, ITM has been offering Canada’s first death doula training program: Contemplative End of Life Care.

“We have had students who are psychotherapists, nurses, social workers, funeral directors, individuals anticipating the death of a loved one, and people who have a terminal illness,” says Mascarín. “We certainly learn from one another.”

Interest in the program has increased significantly, including from people in B.C.

“We originally planned to offer the program every other year, but the interest is so high, we have been offering the program every year,” says Mascarín.

It is a six-month course, consisting of one intensive weekend per month and is only available in person. itmworld.org

Northern B.C. Harm Reduction Study:

With Fentanyl overdoses at alarming rates, especially in northern B.C., Dawson Creek, Quesnel, and Smithers are the focus of a research project aimed at addressing barriers to harm reduction for drug users. The project is being conducted by James Reschny, a PhD candidate at the University of Northern B.C., along with Dr. Heather Peters and Andrea Langlois, who will study community attitudes and harm-reduction readiness, including access to naloxone, a drug that counteracts the effects of opioids.

Toward the Heart:

A project of the provincial harm-reduction program, Toward the Heart has developed Take Home Naloxone (THN) kits. As of April 2016, THN kits have been available for purchase at community pharmacies without a prescription. Instructions for use are provided at the time of purchase; it is strongly recommended that anyone administering naloxone receive this instruction. An educational video is available at towardtheheart.com as well as a site finder for in-person training sessions.

Death Doulas: A sign of changing attitudes

“There are many cultures and communities throughout the world in which care of the dying and dead is seamlessly woven into life.”

Duties to report, consent of minors, and other tricky aspects of counselling

Understanding the laws as they pertain to some aspects of counselling can be confusing, especially with regard to children. Areas of particular sensitivity include duties to report physical and sexual abuse of children, belief or suspicion that a child may self-harm or be suicidal, and belief or suspicion that a vulnerable adult is being abused.

Other sensitive areas include consent of minors, for example disclosure of their personal information; your role and responsibilities when working with the courts; and court-ordered disclosure of mature minor information.

To help you stay apprised of the rules and protect your clients and yourself, Practice Summaries are posted in the members-only area of the BCaCC website. Log in at bc-counsellors.org to review legal and ethical resources to ensure you are up to date on your knowledge.
COUNSELLING FOR REFUGEES

Many refugees coming to Canada experience unimaginable trauma on their journeys. While some counselling services are available through organizations like VAST (vast-vancouver.ca), the Interim Federal Health Program (IFHP) only covers payment to medically referred psychologists. This means the vast majority of counsellors working to assist refugees are volunteering their time. Such is the case at the Vancouver Island Counselling Centre for Immigrants and Refugees (C.C.I.R.), a registered nonprofit in Victoria.

“Our counsellors are all working pro-bono, including our staff in the lead team and our translators,” says Adrienne Carter, who heads C.C.I.R.

Carter says they were initially trying to bill for services through IFHP, but the requirements made the process difficult. “We’re getting a whole lot closer, but we still haven’t actually managed to get money.”

Moreover, IFHP is only available for new refugees in the first year.

“We’re seeing a lot of immigrant clients who have experienced trauma and have been in the area for several years and are just now coming for help,” she says. “We’re also offering support to settlement workers who are experiencing vicarious trauma just listening to some of the stories.”

Carter is hoping the situation will change in the near future. C.C.I.R. is in the process of applying for charitable status, which would allow them to apply for grants and receive donations. This, in turn, will allow C.C.I.R. to hire and pay regular staff.

RESOURCES

BEREAVED BY SUICIDE*

Those who have lost someone to death by suicide are often overlooked, perhaps because of the stigma attached to suicide or perhaps because of the unthinkable circumstances of the death. But there are resources available to help people cope with their loss. Here are some.

**ORGANIZATIONS/SUPPORT GROUPS**


- BC Crisis Centre: crisiscentre.bc.ca, 1-800-784-2433 (help line)

- Canadian Association for Suicide Prevention: suicideprevention.ca (coping with suicide loss; survivor support centres)


- Need 2, Suicide Prevention Education and Support: need2.ca, 250-386-6328 (suicide support group)

- SAFER (Suicide Attempt Follow-Up Education Research): 604-875-4794 (bereavement group and counselling referrals)

**BOOKS**

- Healing After the Suicide of a Loved One by Ann Smolin and John Guinan (Touchstone, 1993)

- Luna’s Red Hat: An Illustrated Storybook to Help Children Cope with Loss and Suicide by Emmi Smid (Jessica Kingsley Publishers, 2015)

- Night Falls Fast: Understanding Suicide by Kay Redfield Jamison (Vintage, 2000)

- No Time to Say Good-bye: Surviving the Suicide of a Loved One by Carla Fine (Harmony, 1999)

- Touched by Suicide, Hope and Healing by Michael F. Myers and Carla Fine (Penguin Publishing Group, 2006)

- Understanding Your Suicide Grief: Ten Essential Touchstones for Finding Hope and Healing Your Heart by Alan Wolfelt (Companion Press, 2009)

*List compiled by Lynn Cameron, RCC.

Honour Ranch: A retreat for veterans and first responders

Honour House provides temporary accommodation free of charge for veterans and first responders, as well as their families, while they are receiving medical care and treatment in the Metro Vancouver area. Recently, the society received by donation a property in the Kamloops area, which is being developed into Honour Ranch, a treatment centre for veterans and first responders. The ranch is slated to open in March 2017.

honourhouse.ca

Toward Reconciliation: Secret Path

By now, you have surely heard that Gord Downie, frontman for the Canadian rock band The Tragically Hip, has been diagnosed with incurable brain cancer. In what may be his remaining time, he has chosen to dedicate his efforts to bringing to light the injustices inflicted upon Canada’s Indigenous people.

Secret Path combines Gord Downie’s music with Jeff Lemire’s graphic art and tells the story of Chanie Wenjack, a 12-year-old boy who died in 1966 while trying to run away from the Cecilia Jeffrey Indian Residential School near Kenora, Ontario.

Proceeds from the sale of Secret Path (Simon and Schuster Canada, 2016) go to the Gord Downie Secret Path Fund for Truth and Reconciliation via the National Centre for Truth and Reconciliation at the University of Manitoba. secretpath.ca
Laura Rhodes’ mother is Stó:lo and her father is a mix of French, British, and Mohawk heritage. One of her first health-related jobs was as Interior Health’s Aboriginal Liaison for the Thompson Cariboo Shuswap area. She then joined the Lillooet Friendship Centre Society, working mostly with children, women, and people struggling with addictions. Nine years later, Laura completed her Masters in Counselling Psychology and currently works as a mental-wellness outreach clinician at the St’át’imc Outreach Health Services (SOHS) in Lillooet.

The outreach part of Laura’s position deserves special mention. When she was in university, she bought a 4 x 4 so she could work with clients in remote areas. It was a smart decision, because every 10 days or so, Laura drives from Lillooet to Seton Portage on a 70-kilometre route of rocks, cliffs, debris flows, and mud.

“Really, it’s like taking the service to them,” she says. “That’s really important, because many of these communities are isolated. When you are in a state of grief and you’re experiencing trauma, even driving 20 minutes to see your counsellor is hard, but you can do it. But driving two hours… you’re not even going to bother trying until you start to feel better and know counselling is doing some good.”

Recently, the team at SOHS, including Laura, as well as Lorinda Casper and Sue Wilson Cheechoo, have become involved with the development of workshops to address the tragic fallout from the Sixties Scoop.

The Sixties Scoop refers to the mass removal of Indigenous children from their families into the child welfare system, in most cases without the consent of their families or bands. The victims of the Sixties Scoop, some of whom attended phase one of the workshops, have come to be known as the Forgotten People.

And people want to know what happened — and how to start the healing process.

Tell us about St’át’imc Outreach Health Services (SOHS)

We have a different approach from mainstream clinics, because we are more holistic-based and more about meeting the needs of the families than just meeting the needs of the one person we’re having sessions with. It’s about the family and the community. We bring people in to help support the person that is experiencing the psychosis or trauma or unresolved grief or whatever it is. We bring in supports from within the community to make it more sustainable for that client. That means uncles, aunts, sisters, brothers, teachers, soccer coaches, whoever. It’s building capacity within communities. It starts healing the family unity. If there’s some conflict, it starts to heal that. Because a lot of times, just having a sense of purpose in your own family can really improve your lifestyle, your quality of life.

What are the most urgent issues in Indigenous communities? What is needed?

Depression, suicide. Trauma is probably the number one. Unresolved grief and loss. More services are needed in the communities, but it also depends on what age group you’re looking at. Because I work mostly with adults, I would say we need more people qualified to do trauma counselling for both adults and children. I know we have a lot of addiction issues, too, and we need more youth addiction services.
We don’t even have youth treatment centres. That’s a huge gap.

Would you like to see more Indigenous counsellors?
Yes, for sure. We don’t have enough. We need people who want to work in real communities. A lot of people get training and end up working closer to urban centres and may do some outreach work, but there are not enough of us who actually work in real communities. That is partly resources. We don’t have the resources here that draw people. We don’t have all the really cool programs and centres, like after-school programs or day-treatment programs in the hospitals, that pull people to work in the city. Because, really, when you work in these real communities, you’re a jack of all trades. You’re more of a generalist.

What are the goals of the workshops?
We’re developing a manual, and hopefully, we’re going to be sharing that out for all First Nations organizations to use. Then the workshop can be delivered in other communities, because we have only been able to do it at two locations so far. We want to continue with that. It was a lot of information and it was very good. The people who delivered it had to really search for this information in archives and journals. This is not from a textbook.

The workshop isn’t just for education, though; it is also to help those who are interested in finding their loved ones who were adopted out and help for those who had been adopted to find their families. Some people still didn’t know who their families are. They might know the reserve they were from, but they have no idea who they are related to.

The workshops are a guideline. It’s got the information there, but there’s also mental-wellness support to assist the participants and suggestions to keep them well and healthy during the workshop, as it can be very upsetting and triggering to everybody there.

How did people react in those first two sessions?
Everybody is a little bit different. A lot of people are trying to find a sense of belonging. There’s loneliness. There’s anger, a “Why did this have to happen to me?” kind of thing. But then there’s also the looking for reconnection. And sometimes they don’t find that, and it’s just so unfortunate. Maybe there’s no one for them to reconnect with. Maybe it wasn’t just them who was put out to adoption — maybe their whole family went out. How do you connect with somebody who isn’t there? Their parents could be gone. It’s very sad. It’s part of the reason we created things like cultural nights at the Friendship Centre or reconnection programs through all the different cities to help people if they don’t know who their family is. At least they can learn a language or a skill to help them create some connection to their aboriginal heritage. But, in general, there’s a lot of sorrow, that unresolved grief.

Are issues about the current apprehension system coming up?
We had people in the workshop who were adopted as babies back in the 60s, and we also had people in the workshop who had their own children and grandchildren apprehended and were sharing their experiences of the guardianship training. For example, if a grandmother wants to have her grandchild come live with her because the child had been put in care, the grandmother would have to do courses before they would even consider letting her have her grandchildren in her own home. These are major courses in Kelowna or Vancouver. It’s not like you can go down to the ministry office, and say, “I’m a healthy 55-year old woman and I’m willing to raise my grandchild.” The ministry will say, “Okay, prove it to us.” They’ll want to do extensive home visits. It’s a huge list. With that comes a lot of stress.

Do you see hope in this?
Yes, I do. At this point, it’s a lot of perseverance, but there is change coming. Many aboriginal communities are finding more autonomy within their own communities, with not allowing their children to be removed without their knowledge or authorization. I think once a community finds that voice, they start having a different relationship within their community. The communities that don’t do that are still in some stages of unresolved grief. It’s not that they don’t care, but how can you do something when you’re still in the middle of healing yourself? But they’re getting there. A lot of communities are actually getting there. That’s hopeful. It’s not going to be a ministry of removal; it’s going to be a ministry of prevention and healing, something that goes in and keeps them safe instead of removing them.
Imagine someone who has spent most of his life going in and out of correctional facilities. Now, add to that picture someone who has also been entrenched in addiction for just as long. This is not typically a person many would see as having great capacity for or desire to change. Theft, robbery, breaking and entering, possession for the purposes of trafficking, assault — the charges on a criminal record can quickly become someone's whole identity. In short: a criminal, an addict.

I have been working with men connected with the criminal justice system since 2011, and I have learned that as much as they have harmed others throughout their lives, there is no shortage of trauma they have also experienced. Often they endure multiple foster homes; horrific physical, emotional, and sexual abuse; years of their own as well as family members' substance use; the violence that exists in crime and gang-life; the death of loved ones; and countless other traumatic experiences.

While it might be because I have two young sons myself, I have increasingly seen these men as little boys in the trauma work we engage in together — regardless of how big they are, how intimidating they try to be, or how many tattoos they have acquired over the years. When focused healing is directed to the little boy inside the "hardened criminal," I tend to see the most significant shift in how past trauma currently grips their lives. When that little boy is given the opportunity to voice his experience, the grown man starts to see himself and the world differently.

NATHAN’S STORY
Nathan* was referred to me in the hopes of processing a traumatic experience from his early childhood. When he was four years old, his mother was violently attacked by her boyfriend in front of him. Nathan remembered wanting to protect his mother and stop the attack, but he was held back by his older brother and dragged into another room where he could no longer see what was happening. He went on to spend the majority of his childhood and adolescence in foster care and began using drugs regularly when he was 12. He spent a great deal of time in a juvenile detention facility and eventually entered the adult prison system as he became more entrenched in the lifestyle of drug use and crime.

By the time I met with Nathan, he had almost lost count of the criminal charges he had racked up over the 20 years he had been in and out of correctional facilities. Of all the violence he had been involved in over these years, he said what was causing him the most distress in his life currently was that early experience involving his mother. Nathan often had flashbacks and nightmares, and he blamed himself for not having done more to protect his mother. He described his four-year-old self with contempt, disgust, and shame that he could have been so weak to have allowed that to happen to his mother. At six feet, three inches and 250 pounds of primarily muscle, "weak" was not an adjective regularly used to describe Nathan. He described himself

*Nathan is a composite of multiple clients I have worked with over the years.
as someone who did not deserve to be loved or happy and who would always be a “loser.”

Following the standard EMDR processing protocol, we set up the target memory and began processing; however, over our next few sessions, Nathan kept cycling back to how “weak and useless” he was to not have been able to prevent or stop the attack. I asked Nathan to picture himself as he was at four years old: not as the big and strong man in the session, but as the “skinny rail of a kid” he had described himself to me as being. As I often do, I also asked him to stand up and show me with his hand how tall he was when he was four compared to his current height. When he did so and sat back down, I encouraged him, with this image in mind, to really look at this child part of himself. 2,3

Me: What do you think he is feeling?
N: He’s looking down at his feet.
Me: What do you think he is feeling?
N: I don’t know. That he should have done something. That what happened was his fault.
Me: When you look at his little face, what do you think he was feeling, seeing such violence?
N: Scared…he felt scared.
M: Where is that feeling of being scared in his little body?
N: In his chest and gut. Really tight and hard to breathe.
Me: When you look at this little guy, what do you see now?
N: He’s looking up at me.
Me: What do you see when you look in his eyes?
N: He’s really scared. Terrified.
Me: So, remember how tall you said this little guy was?
N: Yeah.

Me: How big was your mother’s boyfriend?
N: Close to my size now. Little smaller maybe.
Me: Is there any way you, at the size you were when you were four, could have overpowered someone close to your size?
N: I don’t know…maybe not.
Me: You’ve lived a lot longer than that little guy and know a lot of things that he doesn’t. What if he could hear you? What would you say to that little guy, knowing how terrified he was? What would you say to him that might help him?
N: I don’t know…maybe that he tried to stop what happened. It wasn’t his fault that he couldn’t stop it but he tried.
Me: Can you look at that little guy in your mind’s eye and say that to him directly?
[silence while Nathan speaks to his child part of self]
Me: If that little guy could hear you say that it wasn’t his fault but that he tried to help, what do you think he would say back to you?
N: He says he was just so scared and wanted it to stop.
Me: What do you think this little guy needs that would help him with how scared he is?
N: He just wants someone to hold him. He never had that. I never had that.
Me: What do you think it would be like if adult you held that little guy in your mind’s eye?
[Silence while Nathan closes his eyes. He visibly relaxes]**

This session marked the first time Nathan was able to feel compassion towards the part of himself he always considered weak. After this, we started seeing major reductions in how much that memory was invading his present life.

In my practice, I strongly believe that the “criminal” and the “addict” need to begin to view themselves with compassion before any real change can occur, and I have found that this compassion needs to start with the younger versions of self that have often been forgotten. Focusing on seeing the little-boy part of our client’s self can also help us as counsellors get past our own biases and view our clients with true compassion.

In no way do I intend to excuse the actions people have taken in their lives to result in incarceration; however, once that little boy is brought into the present in a way that allows for connection, love, and acceptance, I have been privileged to see the years-long impact of trauma melt away as it is integrated more adaptively into the system. This is also when I see positive shifts in addiction cycles, likelihood to engage in further criminal behaviour, and overall quality of life.  

Meghan Robertson, MA, RCC, is a counsellor at a non-profit organization in Nanaimo, as well as in private practice in the Parksville area. She specializes in individual and group trauma processing, addictions, and grief and loss.

**This interaction represents a general approach and is heavily influenced by Jim Knipe and Sandra Paulsen. It is also absent of the EMDR sets I use on a regular basis as I recognize that not everyone reading this article is an EMDR therapist, and I want to emphasize conceptual rather than procedural processes.

REFERENCES


THE CRISIS OF VICARIOUS TRAUMA AMONG FIRST RESPONDERS

BY MATTHEW JOHNSTON, RCC, PROFESSIONAL FIRE FIGHTER

The call comes in just after noon: a patient in cardiac arrest. Not too unusual for a firefighter working in a community with a high geriatric population. But this call is unique. The patient is an eight-month-old infant with a frantic mother and a family friend who is performing CPR. As the firefighter takes over, he finds no pulse in the small, flaccid body. This lifeless image is instantly engraved in his memory, texturized by the cool moist skin and amplified by the shrieks of a helpless mother. The firefighter is burdened by his senses but swiftly refocuses to begin pediatric CPR. Twenty minutes later, the firefighter enters the emergency room with advanced life-support paramedics. He overhears a hospital staff member say, “I’ve never seen so many doctors and nurses in one room waiting for a patient.” Emotionally numb and physically drained after performing chest compressions, the firefighter’s job is done, yet he now feels helpless. He sees an odd sight: nurses and paramedics with tears in their eyes. He hears the baby’s mother moaning in despair as she learns that her child has died. As he leaves the emergency room, the firefighter passes the infant’s father, knowing that in just seconds, he will learn that his healthy baby boy has passed away from a tragic accident.

The morning of that mid-summer call in 2014, Global news had reported that 13 Canadian first responders had committed suicide over the previous 10 weeks.1 In the 10 weeks that followed, the number of suicides rose to 23 — a firm indication that a systemic mental-health crisis was gripping first responders across Canada.2

TURNING TO MENTAL-HEALTH PROFESSIONALS FOR SUPPORT

Oftentimes, media points to “post-traumatic stress and other mental illness” as the root causes of suicide among first responders, reinforcing the stigma associated with reaching out for support. For mental-health professionals, a significant challenge is reducing this stigma by finding creative ways of drawing first responders into their offices prior to the emergence of a debilitating psychological disorder. In Toronto, it is reported that some of the police officers who had recently taken their own lives were getting some form of psychological services and support.3 Counsellors treating first responders for symptoms consistent with post-traumatic stress disorder often have the daunting task of making swift therapeutic progress in the face of time-limited therapy. As a result, counsellors commonly implement a variety of solution-focused interventions in the hope of temporarily alleviating the layered effects of vicarious trauma. These deeply seated traumatic memories continue to resonate within the individual but are often camouflaged by more recognizable — and oddly more acceptable — personal crises, such as divorce, interpersonal conflict, and substance use. This therapeutic
complexity makes traditional employee-assistance programs inadequate in addressing the traumatic work-related events that underlie many of the personal crises faced by struggling first responders.

Moreover, the duties associated with paramilitary workplaces spawn a unique subculture that extends into the lived emotional reality of first responders. Police, fire, paramedic, and prison staff are required to perform actions within a command structure where personal decision-making is restricted by industry protocols and department guidelines. This paradigm of training creates dependable, logic-based behaviour that dominates personal thoughts and actions in the face of very stressful situations. Psychologically, the value of these protocols enables first responders to be reassured they “did everything they could” when they witness what may be considered a traumatic situation. However, what training and protocols do not capture is how first responders are to deal with these memories once they return to their personal lives.

In order to appreciate this unique situation, counsellors may benefit from understanding how first responder subculture impacts human neurobiology.

THE INTERPLAY OF SUBCULTURE AND NEUROBIOLOGY

Our limbic system consists of brain structures that largely govern emotions, behaviours, and long-term memory. During a traumatic encounter, the first responder is trained to remain calm so that emotional and behavioural patterns follow a predictable pathway, reflecting industry best practices. This consistency requires first responders to place personal feelings, beliefs, and sensations on hold as the analytical mind overrides the emotional challenges of the circumstance. In order to achieve this state, the limbic system is suppressed to cope with the demands of what most would consider a very stressful situation. The “fight, flight, or freeze” reaction to stress and anxiety — responses integral to human evolution — is simply not a behavioural option for first responders attending emergency situations.

Civilians depend on emergency-services personnel to intervene swiftly during a crisis while possessing a calm, competent, reassuring presence. For first responders attending calls of this nature, a strong dissociative barrier between risk and action is formed that enables them to run into a burning building, confront a robbery suspect, or quell the bleeding of a young child. In these moments, the needs of civilians supersede the physical and emotional harm that first responders may experience. While such actions may be well suited for risk-taking personality types, it also shows the power a well-trained analytical mind can have in overriding the natural emotional and behavioural reactions to a dangerous situation.

However, unless released using various techniques, the effects of vicarious trauma can build up like a dam in a first responder’s analytical mind, creating a barrier that interrupts the natural flow and range of emotions. This restricted emotional energy leaves a struggling first responder to experience a fast-flowing, albeit limited, range of thoughts and feelings. These buoyant thoughts and feelings have a tendency to fuel a hyperaroused state of mind that can produce raw, unprocessed emotional reactions. As vicarious trauma continues to build, the integrity of this emotional and cognitive dam is often breached, releasing uncontrollable images that prevent rejuvenation and healing. The lost sense of internal control can ultimately progress towards a debilitating, pervasive state of mind generally referred to as post-traumatic stress disorder.

THE ROLE OF TALK THERAPY

The common assumption is that conventional talk therapy is an effective means for processing and experiencing relief from traumatic memories. The cognitive behavioural model is built on the notion that verbalizing one’s thoughts and feelings creates a positive effect on emotional health. However, recent research has shown that internalized traumatic events are uniquely imbedded within one’s nervous system in such a way that makes access using traditional talk therapy challenging. In other words, talk therapy alone cannot dissolve the barrier between the analytical mind that is dominated by thinking and the imagery that is trapped in limbic memory, which has the strength to elicit strong, unprocessed emotional reactions.

Traumatic imagery has the power to dominate attention and is intensified by the thoughts and feelings accompanying
this emotional pain. This closed loop of traumatic thinking and feeling fuels a hyperaroused state, whereby the first responder has difficulty unwinding from work and experiences sleep disturbances that exacerbate anxiety-based symptoms. No matter how hard the analytical mind works to control the traumatic material, it falls short of aerating the pain and fostering a calm state of mind. Thus, clinical approaches and interventions should be tailored towards cultivating a peaceful state of mind that calms restlessness while enticing the trauma loop to project imagery within a contained, non-judgmental space.

MOVING TOWARDS EXPRESSIVE-BASED TREATMENT

Expressive-based therapies offer a variety of techniques that transcend words and foster an expression of healing that comes from within the client. The counsellor’s role is to skillfully bring forth an approach encouraging mindfulness, wherein the first responder pays full attention to the present without judgment and learns greater tolerance to face “what is.” While this state of mind – which shares similarities to flow — is inherent in all humans, its value has often been lost by clients who feel handcuffed by stress and anxiety.

During mindfulness-based activities, when the flow of imagery is brought forth in a therapeutic context, the overworked analytical mind — in this case, the struggling first responder — experiences moments of rest and symptomatic relief, which form the foundation of rebuilding their everyday reality.

Under the expressive-therapy modality, the first responder naturally externalizes the intrusive thoughts and feelings in a context that counters the social projections of psychological disease, ailment, or sickness. The first responder learns to be present with their trauma in a way that allows them to trust personal intuition, which has often been hijacked by the analytical thought process. The expressive pathway provides a greater balance between the analytical and emotional mind, thereby promoting greater openness and tolerance for the unpredictable nature of work and life; this aspect of therapy is especially important for first responders, because returning to work involves witnessing future traumatic events in an unpredictable fashion.

The test for all mental-health professionals lies in translating the value of our service in a way that entices first responders into a novel therapeutic experience.

Expressive therapies allow the first responder to digest previous memories in a way that cultivates personal growth and healing rather than reliving trauma within a closed loop of personal suffering. This experience has the power to dissolve the anxiety that underlies hyperarousal, which has been working to reinforce the lasting effects of psychological trauma. Through regular access to therapy, the layers of vicarious trauma can start to release their grip, leading to inner growth and greater emotional resilience. Some expressive-based clinicians refer to the process as “manifesting sanity,” whereby the restoration of self allows one to be present with their emotional pain and find creative ways to work with the survivability of their personal suffering.

Expressive therapies hold the potential of not only absorbing the effects of vicarious trauma, but also leading struggling first responders toward reclaiming healthy emotional lives. The expressive process can reduce symptoms consistent with post-traumatic stress disorder, while also addressing other related psychological challenges, including depression and anxiety.

Moving forward, the test for all mental-health professionals lies in translating the value of our service in a way that entices first responders into a novel therapeutic experience. While this process involves a level of vulnerability unfamiliar to most, the emotional crises facing countless first responders across Canada warrants counsellors and first responders alike to move beyond their comfort zone.

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Many spouses and partners say they feel like they are the third wheel in a relationship, with the object of the other’s infidelity being an advanced collection of pixels.
IN THE EARLY 1970s, a computerized game called “Pong” was introduced and quickly became a fad. Using a simplistic joystick control, Pong allowed users to deflect a small pixelated “ball” back and forth, either with an opponent or against the computer itself. At the time, the technology was incredible — everyone had to have one.

But while the popularity of Pong was predictably short-lived, it had opened the minds of consumers and electronics companies. It also opened the door to an industry that has not only shown incredible staying power, but also an ability to evolve and integrate the latest technology. In fact, the video game industry is where most new technology is introduced, whether it is within the programming of a new game or a new console or computer.

Today’s games are available in endless variety across countless genres, ranging from Massive Multi-player Online Role-Playing Games (MMORPG), to digitized game shows, card games, and first-person shooter games. Users can build cities, race expensive cars, create magical worlds, commit consequence-free virtual crimes, and battle against mythical creatures.

One wonders how Pong players, astounded by the technology of the time, would even fathom today’s video-game industry.

GAMER PROFILE

Video games are not just the stuff of childhood and adolescence. According to a recent review by Big Fish Games, the average age of video-game users is 35. And with many of the top-selling games built around concepts of assassination, crime, war, and fighting, it is not a surprise many of those who use video games
do not see them as being just for kids.

Nor are the players strictly male: while 75 per cent of those employed in the gaming industry are male and the stereotypical gamer is male, 48 per cent of females play games, compared to 50 per cent of males.

Despite all this, most of the negative attention garnered by video games is regarding their effect on the developing brains of younger users. Video games have been blamed for school shootings, sexual violence, apathy and malaise, poor social skills and learning outcomes, and even health problems.

The American Psychological Association established a task force to investigate these alarming allegations and after much time, effort, and money, concluded that the data is inconclusive. Most of the studies were methodologically flawed and the outcomes were inconsistent.

Peer-reviewed research has found consistent associations between gaming and a variety of mental-health conditions, including depression, anxiety, ADHD, and addictive behaviour. While ethical research is limited in its ability to determine whether gaming is a causative variable or simply correlated with these conditions, many counsellors are seeing an increase in client cases where video-game use is either a peripheral or central consideration.

Addictive video gaming, in particular, is worth exploring further, especially as there is likely a considerable overlap between addictive behaviour and other presenting problems.

**ADDICTIVE GAMING BEHAVIOUR**

So how can a professional (or parent or partner) know the difference between typical gaming behaviour and addictive gaming behaviour? While the same question can be asked with any addictive behaviour, it might be more difficult to recognize with video-game playing.

I use a very broad definition of addiction: the inability to reduce or stop a behaviour despite its negative consequences in one or more areas of the individual’s life. This is intentionally broad because I believe addictive behaviour, like many other behaviours, is most accurately graded on a spectrum or continuum rather than in a categorical way.

Like all other disorders in the DSM, regardless of how many symptoms are displayed, unless those symptoms cause significant impairment in functioning in occupational, educational, or relational areas, the individual technically does not meet the diagnostic criteria for a disorder. This tells us the disorder is caused by the behaviour and is not the cause of the behaviour; the condition or conditions are the cause, while the disorder is the effect.

This means a single person with an advanced educational degree, a successful high-income home-based job, and no baseline desire for a relationship may game for upwards of 10 hours a day and not be considered to have a disorder. Because this behaviour is not causing impairment or negative consequences, it is arguable whether this behaviour needs to change or not.

However, it also means individuals who only game for an hour or two a
day may meet the criteria because of the severity of consequences. If the consequences are continually negative and occur as a direct result of the behaviour, then the absolute amount of time spent on the behaviour is irrelevant; what is relevant is the individual’s inability to reduce or stop the behaviour.

Of course, the individual engaging in the behaviour is not always the best source for assessing negative consequences. Addicted individuals often see their behaviour as reasonable and not out of the ordinary. It’s always possible to find someone worse off who can serve as a standard example of “true addiction.”

Other more objective ways of assessing the effect of the behaviour might include questions such as:

- Is gaming often a source of contention between the individual and others?
- How much time does the individual spend thinking and talking about gaming when not actually gaming?
- Has the amount of time spent gaming increased?
- How does the individual respond when prevented from gaming?
- Does gaming contribute to financial difficulties?
- Does gaming take time away from more important activities?
- Does the individual have a poor sense of how much time is spent gaming?

While not an exhaustive question list, these points are mostly objective. Either they do or don’t spend three hours; it is not a matter of opinion. What is up for discussion is the impact of those three hours.

It is easy to vilify time-consuming and costly pursuits, but there are many other activities that drain money and time and impact relationships but are seen as healthy: exercise, practicing an instrument, or working. The activity itself is irrelevant — what is relevant is the impact.

**IMPACT ON RELATIONSHIPS SPECIFICALLY**

One of the common presenting issues clinical counsellors assist clients with is the impact of infidelity on relationships. The betrayal of trust, feelings of violation, and questioning of beliefs can lead to long-lasting trauma. It may sound melodramatic, but addictive behaviour can have an equally devastating impact, particularly if there is an element of secrecy involved (and there usually is). Many spouses and partners say they feel like they are the third wheel in a relationship, with the object of the other’s infidelity being an advanced collection of pixels, and when a partner is gaming addictively, it is very difficult for the non-gaming partner to feel a sense of connection.

In order to take gaming addiction seriously, it is helpful to see the parallel with other addictive behaviours. Consider the following statement:

“My husband never pays any attention to me anymore. He’s always talking about this game or that upgrade or making plans with his online friends to go raid a castle or something. I’ve asked him to cut back and spend more time with me, and he always says he will, but the games always seem to pull him back in. I don’t think he can stop.”

To some, this may seem like the quintessential nag, a killjoy who doesn’t understand her husband is just having some harmless fun with his friends. However, what if we make a few vocabulary changes:

“My husband never pays any attention to me anymore. He always seems to have a beer or glass of wine in his hand, or he’s making plans with his
work friends to get together and have more beer and wine. I’ve asked him to cut back and spend more time with me, and he always says he will, but the alcohol always seems to pull him back in. I don’t think he can stop.”

If a person expressed this concern about her husband’s drinking, a series of follow-up questions would be automatically forthcoming with due attention paid to the issue.

When it comes to gaming, however, it is tempting to dismiss the concern as parallel to a disagreement about which TV shows to watch on a Friday night.

If someone approached a counsellor seeking help for living with or helping a spouse or partner who experienced depression, anxiety, ADHD, or any other mental-health condition, it would not even be a question as to how the presenting client would be impacted by his or her partner’s struggles.

Remember then, much research has shown a clear link between excessive gaming and these very same mental-health problems. It is a logical leap to make that if a person has concerns about his or her partner’s gaming, they are just as likely dealing with a partner’s mental-health struggle.

WHAT TO DO
In the Narcotics Anonymous recovery program, one of the maxims is “a drug is a drug is a drug.” The intention is to underscore that heroin is no different from marijuana, cocaine, ecstasy, or any other drug. This doesn’t mean that the chemical makeup and chemical effects are identical, as many have falsely assumed; it means that the process of becoming addicted to any drug is the same across all drugs.

When working with behavioural addictions, such as spending, eating, Netflix, or video games, it can be a beneficial reminder to rephrase this statement as “addiction is addiction is addiction.” This means that if an individual is seeking help for addiction to alcohol, pornography, sugar, or Pokemon, the underlying driving forces are essentially the same: the felt need to escape one’s present circumstances.

While the impetus behind addiction is fairly consistent, approaches to treatment must be tailored to each individual’s unique needs, abilities, and situation. This is especially vital when the object of addiction is not something the individual can simply eliminate from their life, like drugs or alcohol. If a person is addicted to online pornography but must use the internet daily for work, it will be necessary to develop a workaround. Similarly, behavioural addictions to eating or spending also require a way to manage behaviour rather than eliminate it entirely. One way of approaching this is to use the Three Circles approach.*

The outer circle consists of behaviours that are healthy and positive.

The middle circle consists of behaviours that are questionably healthy, that increase the chances of pushing boundaries, or that have unclear consequences. Additionally, the middle circle may include circumstances or emotional states that increase the likelihood of addictive behaviour.

Finally, the inner circle refers to behaviours that are inarguably unacceptable. As individuals work through their addictive behaviour patterns and cycles, it becomes increasingly apparent which behaviours belong in which circles.

An example using addictive gaming with an adult male is illustrative (see right). Note the circle with the most

*The model used here is a modification of the Three Circles approach advocated by Sex Addicts Anonymous.
items is the middle circle: there is a large grey area between responsible, healthy behaviour and irresponsible, harmful behaviour.

The most critical element for ongoing recovery is how well the individual navigates through that fog. As individuals become more self-aware and more aware of their surroundings and circumstances, the middle circle will often expand and contract.

The Three Circles approach is dynamic, in that it is an ongoing and continually edited treatment plan. It does not penalize inner-circle behaviour but seeks to understand the middle-circle circumstances and/or choices that led down that path. Clinical experience has demonstrated that the degree to which an individual resists moving something from the middle circle to the inner circle is the degree to which the addictive behaviour is difficult to reduce or eliminate.

For example, Tom has acknowledged that he plays his favourite game far too much and that it has had a negative impact on his relationship with Tammy. She feels isolated and alone and has repeatedly expressed frustration with Tom’s unwillingness to reduce the amount of time he spends gaming. Following an ultimatum that Tom must choose between his avatar and Tammy, Tom has sought help.

After an assessment of the addiction’s severity, Tom and his counsellor complete the Three Circles inventory. Included in Tom’s middle circle is the item “playing on lunch break at work.” Tom labels this middle-circle behaviour because it “isn’t hurting anyone” and he isn’t missing work or falling short in his responsibilities. The counsellor asks how often Tom’s lunchtime playing overlaps into working hours. Tom says this occasionally happens but is rare. They decide to leave this behaviour in the middle circle for the time being.

Two weeks later, Tom receives a written warning about playing his game during work, which leads to a heated argument with Tammy. The counsellor suggests playing on lunch break is more risky for Tom than he believes. Tom denies this, saying he will be more careful. In further discussion, Tom begrudgingly agrees that when he plays his game at lunch, he has repeatedly gone on to play during working hours. When he does not play at lunch, he has never gone on to play during working hours.

This is the point at which Tom must decide how serious he is about changing his addictive behaviour. If Tom stubbornly insists this behaviour is fine and he’s just going to try harder, he will likely continue down the path he has already been on, grow increasingly frustrated that the consequences continue, and possibly give up on the idea of changing. If Tom moves this behaviour into the inner circle, he greatly reduces his chances of accidentally gaming during working hours.

While many individuals struggling with addiction would grind to a halt at this point, over the next few months, Tom recognizes the small decisions he is making that continue to put him in harm’s way. As he moves these behaviours and situations from the middle circle into the inner circle, he finds it easier and easier to manage his addictive impulses, building trust with Tammy and his employer and building confidence within himself.

To return to an earlier point, if the object of Tom’s addictive behaviour was a substance or dangerous activity, it would be more readily accepted as a clinical issue and treated with the respect and attention it deserves.

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THE AVERAGE AGE OF VIDEO GAME USERS IS 35. AND WITH MANY OF THE TOP-SELLING GAMES BUILT AROUND CONCEPTS OF ASSASSINATION, CRIME, WAR, AND FIGHTING, IT IS NOT A SURPRISE MANY OF THOSE WHO USE VIDEO GAMES DO NOT SEE THEM AS BEING JUST FOR KIDS. Because addictive video gaming can be equally harmful mentally and emotionally, and in some cases, even physically, it is clearly time to recognize it for what it is and treat it as such. After all, addiction is addiction.
I'm feeling really triggered after that client: what's going on for me?

I dread meeting with this client: what should I do?

I don't feel like I'm getting anywhere with this client: what could I try instead?

Who do I call for help?
GETTING SUPPORT

Recognizing when you and your practice would benefit from outside consultation

BY SARAH PATRICK, RCC

- I’m feeling really triggered after that client: what’s going on for me?
- I dread meeting with this client: what should I do?
- I don’t feel like I’m getting anywhere with this client: what could I try instead?

These are all common and valid questions facing new and experienced counsellors. Who hasn’t had a time when they felt triggered in a session and thought, “What was that about?” Other signs we may be struggling with a client or situation include feeling lost and unsure of where we are in the process or what the next steps should be. Maybe we know where we want to go but are not sure how to get there. Or perhaps we just want the reassurance that we’ve followed the right steps.

Having a second pair of eyes on the situation — someone knowledgeable and experienced — can be beneficial, educational, and a boost to our professional confidence.

Counsellors often work in isolation, and unless we seek opportunities to connect with others in the profession, we may miss out on even casual discussions about new research and procedural changes that bring new perspectives to our work. It is helpful to speak with others who might have different resources or can recommend training we hadn’t come across. And sometimes, it goes deeper than resources and processes, and we need help recognizing a trigger we must move past in order to continue work with a client.

Burnout, the effects of vicarious trauma, and the weight of our own issues can eventually erode our motivation and diminish our skills, making it harder to provide quality care. The question of how to give the best service to clients while taking care of ourselves is at the forefront of every counsellor’s mind.

Considering our profession, it is ironic many of us hesitate to seek help for ourselves.

Having a second pair of eyes on the situation — someone knowledgeable and experienced — can be beneficial, educational, and a boost to our professional confidence.
WHAT STOPS US?
Counsellors may hesitate to seek consultation for a number of reasons, ranging from not being sure when it is needed or if the situation warrants it, to not knowing how to find help or what steps to take once we do.

It can be hard to admit we need help. Even something as simple as checking on procedures can make us feel uncomfortable, as if we don't know our jobs. When a client session triggers a reaction in us, it is often very confusing and difficult to recognize. And not connecting well with clients or feeling a lack of empathy or even hardened can make us feel downright shameful.

Pride can be a piece of it. After all, we are counsellors and we aren’t supposed to have problems or need help, right? It makes us feel vulnerable, especially if we are worried about looking incompetent or fear how others will view our struggles.

Not being sure where to access clinical consultation or how to choose the right consultant creates other challenges, especially if we have heard stories from colleagues about ineffective and problematic consultation.

Then there is the cost. It can be expensive to get consultation and for some of us, that may be the biggest barrier of all, especially if we are new to the profession.

However, not taking the steps means missing out on the benefits and professional growth that can only come from working with a well-trained, experienced consultant. And ultimately, our clients may also miss out, too.

THE BENEFITS OF CONSULTATION
Clinical consultation and supervision are commonly accepted as beneficial to the field by counsellors and researchers alike. It allows us an opportunity to examine our own reactions to clients and client issues, and it supports us in resolving whatever has come up for us so we can proceed with our clients. Consultation provides support, particularly for novice counsellors, in developing a sense of professional identity. And from an ethical perspective, it helps us maintain our skills in line with current recommendations. New ethical dilemmas are brought forward continually, and it can be intimidating to be stuck in an ethical dilemma without support.

Encouragement from those who are more experienced helps us to hone our skills, such as problem solving, creativity, emotional awareness, and confidence. In addition to supporting growth, getting support also provides some protective factors. Research statistics show a range of 21 to 67 per cent burnout in the mental-health field. This is clearly an area we need to have good skills to navigate.

But clinical consultation is not only beneficial for the counsellor; it also has benefits for clients. Research has shown that consultation positively affects the working alliance between the counsellor
WHERE DO YOU FIND CLINICAL CONSULTANTS?
David Stewart, an instructor at City University, advises his students to find a consultant, someone they can rely on to help if they get in trouble or, hopefully, prevent trouble.

There are many aspects of consultation that are based on preference — there is no right or wrong — and having a say in the relationship makes you feel more in control.

In a sense, consultation allows counsellors to understand what it feels like on the other side of a counselling relationship, particularly the vulnerability. It also allows for modelling of a safe, trusting relationship, where appropriate boundaries are maintained, something some counsellors struggle to impose for fear of damaging the therapeutic relationship. Consultation also allows for a demonstration and discussion of self-care, which we all need to pay attention to.

To get the most out of consultation, consider a directive as opposed to an unstructured plan that includes regularly scheduled meetings. Objectives can be set and agreed upon at the beginning and should be re-evaluated throughout. To ensure consistency, consider creating a contract outlining the services being provided, a schedule, responsibilities, evaluation procedures, and financial compensation.

Most of all, recognize that consultation is worthwhile and valuable to us personally and professionally, as well as to our clients because it makes us better counsellors.

Members can call the BCACC office for access to a list of available consultants organized by region as well as information about areas of specialty if specific assistance is wanted.

Stewart adds that because getting consultation under some circumstances may be scary or uncomfortable, you may want to ask people you already know and trust.

If nothing else, ask the people you went to school with or people whose opinion you value. Sometimes they can make referrals.

“Networking is a really big piece of that and goes a long way toward the safety aspect,” says Stewart.

REFERENCES
Clinical Supervision

A QUESTION OF DEFINITION

By Carolyn Camilleri

In B.C., the term “clinical supervision” has become a catchall for any activity where a more experienced counsellor provides guidance to another counsellor. As a result, there may be some confusion about the role of a supervisor.

Dr. David Stewart, former BCACC president and a clinical supervisor for more than 35 years, teaches clinical supervision at City University of Seattle. He reveals some important distinctions in terminology.

“Clinical supervision is about understanding what’s going on for the clinician, what’s going on for the client they’re working with, and how to help the clinician be more effective with the client given the circumstances.”

A counsellor’s first experience with clinical supervision may be at university.

“In order to graduate with a Master’s degree in social work, counselling, psychology, or clinical psychology, you have to have clinical supervision,” says Stewart. “That’s the field standard.”

Clinical supervision may also be a requirement for entry into an association, such as the BCACC, or as a condition of employment at an agency. Contrast this with administrative supervision.

“Administrative supervision is making sure you did the things you were supposed to do,” says Stewart. “It’s ticking off boxes.”

Dr. Glen Grigg, RCC, says this distinction between administrative supervision — when do you get your holidays, what are your office hours, and what forms have to be filled in — and clinical supervision is key.

While administrative supervision is a workplace function, clinical supervision is more like mentoring.

“Clinical supervision is usually taken to be an ongoing relationship in which the supervisee receives feedback, support, education, and opportunities for guided reflection all concerning the differential use of self in counselling and psychotherapy,” he says.

Where it gets confusing is between clinical supervision and clinical consultation. In addition to being clinical supervisors, Stewart and Grigg are clinical consultants, and they both stress the differences between the roles.

“Consultation is a different relationship,” says Grigg, who took completely separate courses in supervision and consultation at Walden University. “Consultation is focused on the sharing of skills and problem-solving capacity relative to a particular case. The two processes are quite different. A consultant does not take responsibility for decisions, only for sharing expertise.”

That responsibility is especially important to note.

“If somebody were looking for a clinical supervisor, they would be, in effect, putting themselves under the auspices of whoever it is they were being supervised by, and that person would now assume legal liability for everything this person was doing, which, outside of being in a graduate program, is unusual,” says Stewart.

Grigg concurrs and points out that this legal responsibility goes beyond cases covered in supervision, because the supervisor is contributing to the supervisee’s decision-making process. If there is a problem — for example, if a client complains that harm was done — while the supervisor doesn’t have all the responsibility, they need to know they are going to have to step up and take their share of it.

When a supervisor is working for an agency or university with practicum students, then the agency or university also shares the liability. The problem is when supervision is offered independently by counsellors in private
practice and whether there is an awareness of the liability inherent in the role. Liability is discussed in course work; however, Stewart says, “The majority of people who do clinical supervision have never had a course in it.”

Currently in B.C., clinical supervisors are not required to take courses before using the title, nor are there official requirements. Members of the BCACC who wish to be listed as clinical supervisors must meet certain qualifications, depending on the type of supervision they want to provide (go to bc-counsellors.org/member-info/eligibility/).

And while the clinical supervision course is part of the MA program at City University where Stewart teaches it, it is not a requirement for graduate students at CityU or at other universities.

Qualifications for clinical supervision aside, much of what is thought of as clinical supervision in B.C. is actually clinical consultation, which bears no legal liability or responsibility. Even more common is peer consultation, whether that means casual discussions with colleagues or at counsellor support groups.

“Typically, a person in private practice wouldn’t be looking for a clinical supervisor; they would be looking for clinical consultation or peer consultation in an area they want to learn or if they have a case where they don’t know what to do,” says Stewart.*

“I think clinical consultation is far more useful, because you have to work relationally with the person,” says Stewart. “You give them the respect of understanding what they’re trying to do and you try to help them accomplish that, as well as overseeing and looking out for the safety of the client.”

**BECOMING A SUPERVISOR OR CONSULTANT**

Currently, there are no courses in consultation in B.C., but if you are interested in becoming either a supervisor or a consultant, both Grigg and Stewart recommend taking a supervision course.

“There are models of clinical supervision that organize how you approach it,” says Stewart. “It’s a starting point in order to get clear on what the work is.”

Moreover, it requires a different skillset than counselling.

“Being a good clinician does not mean you’ll be a good clinical supervisor,” says Stewart. While the goal of good clinical work is to be effective with clients, he explains, the job of a clinical supervisor is quite different.

“You are working in a triangular relationship where you never see the client, but you’re responsible for the outcome with the client,” he says. “You’re trying to help the clinician do what they need to do to help the client.”

In other words, clinical supervision is an influencing relationship, not a direct relationship like counselling.

Some associations, such as the CCPA and AAMFT, provide clinical supervision training and certification. Clinical supervision courses are also available at City University, Trinity Western University, and the Justice Institute of British Columbia.

For qualified private-practice counsellors, adding clinical consultation represents a potential source of business and a new way to make a difference in the profession.

And understanding the difference between supervision and consultation will hopefully encourage more counsellors to seek guidance when they need it.

David Stewart, PhD, is a former BCACC president. He has been a clinician, supervisor, and trainer/educator in Victoria since 1975.

Glen Grigg, PhD, RCC, is a counsellor and consultant in Vancouver, as well as the Chair of FACTBC and the BCACC Chair of Legislative Review.

*The BCACC strongly encourages Registered Clinical Counsellors to seek clinical consultation regularly.

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**NOT COUNSELLING FOR COUNSELLORS**

Whether you are talking about clinical supervision or clinical consultation, neither are the same as counselling.

“Supervision is about a client and helping a clinician get a good outcome with a client,” says David Stewart. “Counselling is about personal development.”

While there are personal development aspects to supervision, especially for students, good supervision stays on one side of that line. Crossing the line brings up areas that are tricky to navigate, says Stewart.

“You come up to the line sometimes, and you may say, ‘From what you’re telling me, I can see you’re really overwhelmed at this particular point on this particular case, and from things you’ve said, there may be some personal history there, so my recommendation is that you check it out with somebody you would trust to work on that with.’”

The concern with supervision and consultation is making sure the counsellor is able to carry on with the client. And if they aren’t, the supervisor or consultant may need to help with reassigning the case. “That’s coming up to the line, but it’s not crossing the line,” says Stewart.
I’m sure this thought has occurred to you in your practice: “It amazes me how much this person has lived through, and they’re still trying to move forward!” We hear stories of endurance, pain, and survival, and we may even remark on the cost our clients pay socially, emotionally, and mentally for their coping efforts.

In my practice, when a client comes in with issues related to chronic illness or pain management, I expect to see symptoms associated with the diagnosed illness and a related amount of co-morbid anxiety and depression. But it’s significant to me that almost all of my ill clients have histories of post-traumatic stress disorder (PTSD). My clients with “chronic” diagnoses carry weighty emotional burdens, usually for years. Eventually in therapy, they begin to understand that their illness connects to their histories.

THE SCIENCE BEHIND IT
Science — psychoneuroimmunology — shows clear, complex neural and physiological connections between psychological processes and the body’s nervous and immune systems. We see that PTSD is actually a precursor for the development of chronic illness.

When a person experiences any stressful event, a cascade of changes occurs in the neuroendocrine, cellular, tissue, and organ systems. While these changes are necessary to rally resources to aid survival, the secondary effects of this process are silent and can be insidious.

In a healthy stress response, the body acts with rapid activation of multiple neuroendocrine pathways, including the hypothalamic-pituitary-adrenal (HPA) axis and the sympathetic nervous system (SNS). These changes act on the body rapidly to make resources available for the fight-flight response. Once the stressor concludes, the glucocorticoid hormone cortisol defines the end stage of the HPA axis. Secreting from the adrenal cortex, cortisol enters circulation and serves as negative feedback on the hypothalamus, ensuring the stress response ends; it is the “off switch” allowing the body to return to full homeostasis over the next couple of hours.

In PTSD, however, there are both measurable and subjective differences in the stress reaction: the brain appears to respond unusually. It has been suggested this may be a fault in the neurocircuitry, and that the brain experiences detrimental change in three crucial regions involved in stress response: an exaggerated amygdala response leading to an intensification of fear associations and responses; deficits in frontal lobe functioning, which mediates suppression of attention to the traumatic event; and deficits in hippocampal functioning, which provides appreciation for contexts of safety.

Together, these changes significantly impede the trauma-extinction response. When brain systems defect, the
traumatic event is exaggerated and remains unprocessed, continuing to invade the present.3

This is precisely how PTSD is unique: the repeated reactivation of the traumatic memory in flashbacks with the associated stress response recreating subjective feelings of terror. The nervous system manifests both physiological reactivation and psychological distress. This means large amounts of stress hormones continue to be secreted in the body long after the danger has actually passed.4

LONG-TERM CONSEQUENCES
Another mechanism unique to the stress of PTSD regards the hormone cortisol itself. Research has found that cortisol levels are distinctly low in people with PTSD.5 Since cortisol has a protective effect against PTSD,6 clients with PTSD are physiologically unable to adequately inhibit the stress response with the “all clear” message. When the end stage does not produce effect, a state of fight-flight mobilization persists over time.7 This means individuals with PTSD have a heightened experience of the terror of the event, repeated flashbacks with accompanying terror, and a deficient stress-extinction response.

As physiological reactivation repeatedly occurs, intense stress exposure disrupts the individual’s internal psychophysiology by progressively sensitizing and “kindling” it to trigger in the process.8 Over time, PTSD sufferers have an ever-diminishing capacity for stress-extinction responses, or any stress responses, and an ever-increasing risk of progressive escalation of reactivity.9

In fact, some suggest a history of abuse may “tune” the nervous system to be cautious and prepared for defensive fight-flight behaviours, even when real danger does not exist.10 When stress hormones continue to secrete, they are subjectively experienced as anxiety, defensiveness, and terror. PTSD sufferers grow to be frightened of associations with the original trauma and then, over time, of their own reactions to those associations: sensory information that once provided useful factual input becomes unsafe. As the layers of experience build and associations of stress, trauma, and bodily responses compound, the individual’s ability to accurately pick up and interpret information from environmental cues can become overwhelmingly confusing, frightening, and traumatic.11

Thereafter, PTSD sufferers remain dysregulated; they may alternate periods of overactivity with periods of exhaustion as their bodies suffer the effects of traumatic hyperarousal of the SNS activity can be reduced using trauma-focused and relaxation-focused treatments in tandem: EMDR, hypnosis, progressive relaxation, guided imagery, meditation exercises, and breathing exercises.
nervous system. This dysregulation has been demonstrated in research. Deficits in vagal regulation are present in perpetrators of violent abuse and are related to a variety of psychiatric disorders such as PTSD, generalized anxiety disorder, and depression. It has also been shown that victims of abuse have state-regulation difficulties with a bias toward states that are defensive of threats.

In the midst of unrelenting stress, PTSD sufferers develop coping mechanisms in order to approximate calm regulation. As we know, these coping mechanisms can either be adaptive or can worsen their physiological vulnerability. For example, victims of abuse may cope with overwhelming feelings of threat by paying excessive attention to internal sensory stimuli and by distorting environmental cues. They are sensitized to reminders of subtle traumatic memories and become reactive to minor associations. This creates an escalating cycle of distress and defensiveness, predisposing an individual to negative affective appraisal and increasingly depressed mood.

In the long term, poor coping strategies may result in devastating consequences: substance abuse, eating disorders, relationships fraught with violence and conflict, illness, and even suicide.

By the time we see our PTSD clients, they may have been in a state of dysregulated stress and trauma reactions for years. This, in the long term, “wreaks havoc with their health.”

**A CLEAR CONNECTION**

When a body undergoes repeated cycles of stress responses, the immune system weakens to the point of dysfunction. This has been called the “kindling theory”—prolonged stimulation of HPA axis exceeds threshold limits, resulting in persistent hypersensitivity and a low tolerance to stress. Changes in how neurons fire actually start to change the chemistry and functioning of the brain. That is, “neurons that fire together wire together”—chronic stress responses create neuroplastic changes that perpetuate these conditions, resulting in “upregulation” of the sensitivity of the brain.

PTSD is one of the predisposing factors to development of this distorted state of upregulation. Evidence from developmental neuroscience suggests that early experiences can program the development of regulatory systems that are involved in the later development of illness. Exposure to trauma increases the risk of developing chronic fatigue syndrome (CFS) between three and eight times, depending on the type. Emotional neglect and sexual abuse during childhood were the stressors most strongly associated with CFS.

And multiple traumas have a cumulative effect on physical health. For each additional type of childhood trauma experience, the risk of developing CFS increased by 77 per cent.

The cumulative effect of stress and the corresponding wear and tear on the body has been called “allostatic load.” The role of allostatic load has come to be seen as an important risk for coronary arterial disease, fibromyalgia, irritable bowel syndrome, chronic fatigue, obesity, and many other health conditions. The majority of multiple-sclerosis patients in one study reported previous traumas, including sexual abuse, physical, and psychological violence, and complicated bereavement. Another study shows individuals with PTSD as having the highest likelihood of developing chronic illness conditions and non-traumatized individuals had the lowest. Further study demonstrated that the relationship between PTSD and chronic medical conditions was explained by the number of lifetime trauma experiences.

It is usual for my clients with autoimmune disease to experience uncommon stress before a disease onset or flare-up. Remarkably, autoimmune diseases account for one third of common diseases in the US, below cancer and cardiovascular disease, affecting five to eight per cent of the population and rising. These diseases disproportionately afflict women and are among the leading causes of disability and death for young and middle-aged women.

**APPROACHES TO HEALING**

As counsellors, it is imperative we recognize our clients’ stress levels. Multiple stresses, multiple losses, traumas, poor coping skills, and adverse childhood events produce a physiological system that is vulnerable and primed for illness. The part we play as counsellors is in assisting clients to regulate their stress responses and reduce the stressors. Studies of effects of psychotherapy treatment...
for clients with illness suggest it is essential PTSD symptoms are treated effectively and without delay to reduce associated psychological symptoms and to reduce the psychological stress burden associated with the neurological conditions of clients with illness.

In order to reverse immunological sensitivity, emotional and physical detoxification is necessary. Van der Kolk outlines “top down” and “bottom up” strategies to deal with the dysregulation of PTSD, and the same applies to chronic illness.30

“Top down” involves strengthening the brain’s capacity to monitor the body’s sensations and coping. This is best accomplished with mindfulness practice, which also increases awareness of internal cues and sometimes reconnects them with their bodies. However, it can be difficult and frightening at first and must be combined with relaxation and trauma-focused interventions to help the client emotionally regulate.

“Bottom up” strategies involve de-escalating the overactive nervous system. I reduce the SNS activity of my clients using trauma-focused and relaxation-focused treatments in tandem: EMDR, hypnosis, progressive relaxation, guided imagery, meditation exercises, and breathing exercises.

Approaching healing in chronically ill clients, and indeed working with clients who struggle with serious diagnoses, takes time and can be a delicate endeavour. The work involves not only acknowledging and mediating self-regulation needs, but also shifting the often-entrenched cognitive stance that accompanies years of defensiveness and isolation. While addressing physiological needs, we must interweave continual encouragement for the client to change maladaptive attitudes and beliefs, shift negativity and accept positive coping skills, build resources, and adopt new wellness and social support behaviours.

Megan Hughes, RCC, is a member of the International Society for Traumatic Stress Studies and Psychoneuroimmunology Research Society. She works with general issues across ages, focusing on PTSD, chronic illness and pain.


REFERENCES


TREATMENT OF CHRONIC DISEASE CONSUMES 67% OF ALL DIRECT HEALTH CARE COSTS, AND COSTS THE CANADIAN ECONOMY $190 BILLION ANNUALLY—$68 BILLION IS ATTRIBUTED TO TREATMENT AND THE REMAINDER TO LOST PRODUCTIVITY.*


INSIGHTS MAGAZINE 29
STARTING A PRACTICE

The all-important business plan

BY CONSTANCE LYNN HUMMEL, RCC

Starting a private practice is exciting, but it can also be overwhelming and even intimidating. Too often, people dive in without thinking it through, only to panic later and decide private practice isn’t for them. But really, they may have just needed a better plan.

The most important thing to remember when you are starting a private practice is that it is a small business. If you’ve never run your own business before, you’re most likely going to need some guidance and training to make the process a smooth one. After all, the skills you need to be a good counsellor are different than the skills you need as a business owner.

So where do you start? With a step many counsellors skip to their peril: an intentional business plan. A business plan is the foundation from which your practice can grow, and it needs to be the first thing you do — before you get an

Having a solid plan will save you time, money, and stress, and it will give you confidence and help to avoid or manage roadblocks along your path to success.
office, pick your business name, or set up a website. Having a solid plan will save you time, money, and stress, and it will give you confidence and help to avoid or manage roadblocks along your path to success.

Here are some aspects of a business plan to consider.

**YOUR VISION:** It’s important to have a really clear sense of what you want to create before you try to create it. Think of it like baking a cake — you don’t throw a bunch of ingredients in a bowl and hope it turns into a cake. You need to decide what kind of cake you want and get specific ingredients. That doesn’t mean you can’t add things along the way, but it gives you a starting point. Ask yourself these questions:

1) **Who are your clients?** “People with problems” is not specific enough as an answer. You need clarity around who you are trying to help, what they feel their issues are, and the type of services they want and need. If you can give people what they’re searching for, it’s much simpler than trying to convince them they need what you’re offering. This clarity will help inform your branding, choose your location, and determine your marketing approach.

2) **Who are you?** Your practice needs to reflect who you are as a person, how you want to work, and how you view change and healing. There is no one-size-fits-all approach because every counsellor is unique. Do you want to work part-time or full-time? From home or from an office? Is this your main business or a side business? Do you eventually want to expand and offer other services or products? Do you want to bring in associates at any point?

3) **Where do you see your practice in five years?** Building your practice so it fits your dream, or you risk outgrowing your practice instead of growing into it. Set goals and determine the steps you need to take to achieve them.

**LOGISTICS:** These are the “business basics” outlined in more detail on page 32: a web presence, a way to be contacted by clients, a way to get paid, and a place to work. You also need to decide how much to be paid: determining your rates means having an awareness of what other counsellors who offer similar services are charging. For guidelines, go to bc-counsellors.org/choose-a-counsellor/fee-schedule/. You should also assess your costs and determine your budget. Especially in the beginning, you will likely want to keep costs tightly controlled.

**LEGAL/ETHICAL:** This may include registering a business name, a GST account, getting a business licence, and getting insurance, among other things that may be specific to the way you work. Note that every municipality in the province may have different regulations for business licences. Failure to obtain a business licence may result in a fine or being shut down; ensure you check with your municipality to find out what you need. Even if you are working as an associate with someone else or running a business out of your own home, a licence and insurance need to be in place before you get started. You may also

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**Starting an online counselling practice**

Online counselling is becoming increasingly popular. While it has not been fully accepted across the profession, online counselling is clearly here to stay. However, there are specific considerations that need to be addressed before you can launch an online practice. Understanding privacy concerns, getting the appropriate insurance coverage, and managing intake forms and agreements are critical. A number of questions about online counselling are addressed in the article “Standard for the Use of Technology in Counselling” in the members section at bc-counsellors.org.

Some counsellors are choosing virtual telemedicine platforms, such as Livecare (livecare.ca) and Medeo (medeohealth.com), while others are investigating different ways to work online, depending on the type of services they offer and the clients they want to assist.

To learn more about launching an online practice or adding it to your existing practice, you may want to sign up for a course that can give appropriate guidance.

A number of courses are available including E-Therapy Essentials (etherapyessentials.com) and Therapy Online (therapyonline.ca).
want to establish relationships with a clinical supervisor or consultant, as well as within a supportive counselling community, such as the BCaCC.

**BRANDING:** This isn’t just a logo or a colour scheme. Your brand is the experience people have when they connect with you in person, online, and on the phone. It is the visual look of your website, office, business cards, and your head shot and also the tone of your voice in writing and in speech. Are you formal or casual? Take some time to determine how you want to represent yourself publicly as a professional. Keep in mind, too, the clients you want and ensure your branding is welcoming to them.

**MARKETING:** You need to have a basic marketing plan in place that addresses online and offline strategies for connecting with clients, colleagues, and the community. It generally takes at least three months to see returns from any marketing efforts so, ideally, you should start letting people know you are launching a private practice ahead of time. Considerations include directories, such as with BCaCC, potential referral sources, past and present colleagues, and any connections you have that may be a source of clients. A website and business cards are not enough; you will need to take an active role in marketing your business.

You may find that some aspects of your business plan need tweaking as you go along — and that’s okay. As you progress in your practice, you will learn new business skills, gather more tips and information, and make discoveries about yourself that influence and refine your plan. Your business plan is a guide of your own making, intended to serve as a map leading to your goals. And as with any journey, having some flexibility to allow for detours and diversions along the way is smart planning.

Constance Lynn Hummel, MA, RCC, is a psychotherapist and leadership coach in private practice. She is also a business strategist offering online and face-to-face programs in private-practice business training at The Business of Helping. www.thebusinessofhelping.com

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**Getting the Right Insurance**

Appropriate insurance coverage for your practice is critically important — and legally required. Part of that responsibility includes having a really solid understanding of how your insurance works and what it all means — and that means having a conversation with an insurance representative.

Brad Ackles, Vice President at Mitchell Abbott Group Insurance Brokers (mitchellandabbott.com), the official insurers for BCaCC members, says counsellors starting private practices need to be aware of the various forms of liability coverage, errors and omissions/professional liability versus commercial general liability.

“Counsellors also need to understand the contractual obligations they may have with landlords and anyone working on their behalf, including contract employees,” says Ackles. “They

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**BUSINESS BASICS**

**BY CONSTANCE LYNN HUMMEL, RCC**

“Where do I start?” is one of the most common questions I am asked in my role as a business coach and strategist. In most cases, the answer to that question is “It depends.” However, if you want to get your starter ducks in a row quickly, beyond your business plan (see page 30), here is a checklist of items you need to think about.
need to have discussions on the full range of services and modalities to be sure all their operations are covered properly."

Ackles adds that there are packages available if there is a need to insure one’s business contents and then separate coverages for the various liability options.

“Usually, the ‘packages’ have all the coverage improvements or upgrades,” he says. "It’s a matter of selecting the correct coverage for your particular situation."

In addition to being properly insured before you start taking clients, it is just as important to keep your coverage up to date as your practice grows and changes.

“An annual review is always advisable,” says Ackles. “But where we really need to have discussion is when anything operationally changes: have you rented commercial space? Have the services you provide changed? Are you using contracted employees?"

Because insurance is something we don’t think about every day — until we need it, that is — you may want to schedule periodic reviews and contact your insurance company if you have any questions or concerns.

Web Presence
In an ideal world, setting up a basic website is often a first step — but you don’t have to do so until you are ready. Too often, people spend a lot of money on a website they end up scrapping a few months later. You need time to think carefully about your practice, your vision, and your branding.

Instead, in the very early stages, set up a profile on one of the online counselling directories, so you can direct people there to learn more about you and your services. This gives you a legitimate web presence without a big investment of time and money. It also buys you the time you need until you are confident about your branding and ready to invest in your own website.

A way you can be contacted
If people can’t reach you, it’s pretty hard for them to book with you. You need a designated email address for clients and a phone number you can be reached at. If you haven’t decided on your website domain, use a free service such as Gmail.

Other providers such as Hotmail or Yahoo are generally not seen as professional and may make clients question your credibility.

A way to accept payment and provide receipts
Before you take your first client, decide how you will accept payment. The simplest and fastest ways are cash, cheque, and e-transfer, followed by credit cards.

Designate a separate bank account for business purposes and only deposit business earnings there. You don’t want to mix your personal and business transactions or, trust me, you will be crying at tax time.

And speaking of taxes, educate yourself on how and when you need to collect and submit GST. In general, once you earn $30,000 in any 12-month period, you need to collect GST. For more information, including how to register for a GST account, go to cra-arc.gc.ca/gov/content/employment-business/small-business.

For receipts, create a simple computer-produced receipt that includes all your information properly presented. Handwritten receipts may be a problem if your client is claiming services through a benefits plan. Once you get your feet underneath you, there are various online services such as WaveApps.com, Squareup.com/ca, or Cliniko.com to assist you with managing invoices, payments, and receipts.

A place you can see clients
Generally, this means an office.* In the very beginning, if at all possible, avoid locking into a long-term contract. Within your first three to six months, you will be ironing out the kinks in your practice, and you may find you need something different than you originally thought.

An hourly rental is a low-overhead, low-commitment option. You may also want to consider renting office space from a colleague or even setting up an office in your home.

* Starting an online practice is a subject unto itself and may or may not be appropriate for your work. See page 31 for more about training and information for online practices.
“Exercise,” I tell my clients, “will really help you with your recovery.”

Most of the time I feel like the teacher in Charlie Brown: I am pretty sure all they hear after the word “exercise” is “waaa, waaa, waaa.” Occasionally, I get a positive response, especially if the client has experienced the benefits of exercise before. And sometimes, the client puts it into practice.

Exercise really can help clients — and it also helps counsellors. After all, counsellors are human beings who suffer from bouts of depression and anxiety, not to mention the pitfalls of vicarious trauma, stress, and burnout. Finding time for exercise reduces the impact of the work we love.

THE BENEFITS
In a study cited in Shawn Achor’s book, The Happiness Advantage, three groups of patients treated their depression with medication, exercise, or a combination of the two. Surprisingly, all three groups experienced similar improvements in their happiness levels early on. The groups were tested six months later to assess their relapse rate. Of those who had taken medication alone, 38 per cent had slipped back into depression. Those in the combination group did slightly better: 31 per cent had relapsed. The biggest shock came from the exercise group: their relapse rate was only nine per cent.1

Exercise is also effective in reducing anxiety, increasing self-esteem and confidence, and even increasing brainpower. It boosts our mood and enhances our work performance by improving motivation and feelings of mastery, reducing stress, and helping us get into flow — that “locked in” feeling of total engagement when we’re most productive.2

There’s more. Other benefits include gaining confidence, taking your mind off worries, getting more social interaction, and coping in a healthy way that is readily available almost anytime, anywhere.

Yes, anywhere. Going to the gym is not the only way to exercise. In fact, if going to the gym isn’t your thing, making yourself go may cause more stress. While running, lifting weights, playing sports, and other fitness activities certainly get your heart pumping, so can gardening, washing your car, walking the dog, and walking to work. Options like yoga and swimming offer the simultaneous benefits of exercise and relaxation. Combining exercise with outside time gives you the benefits of fresh air and vitamin D.

Any activity that gets you off the couch and moving can help improve your mood. Once you realize the importance of some form of movement every day, the ideas and opportunities will come to you.

Jeff Haden’s online article 10 Scientifically Proven Ways to Be Incredibly Happy3 is an excellent, well-researched, comprehensive resource — and exercise is in the #1 spot!

You may even want to pass it along to your clients, because once we have incorporated exercise into our own lives and are experiencing the benefits, it is a much easier sell to our clients.

EXERCISE CAN CHANGE YOUR BRAIN
Regular exercise releases feel-good brain chemicals (neurotransmitters, endorphins, and endocannabinoids), reduces immune system chemicals, and increases body temperature, which may have calming effects. A brief workout also releases the stress hormone norepinephrine, a chemical messenger in the brain, which scientists have long known plays a strong role in memory.4

According to a post by Gretchen Reynolds in the New York Times, research has found that our muscles produce a protein called PCG-1alpha during exercise. PCG-1alpha helps to break down kynurenine, a metabolite that accumulates in the body during stress and is known to contribute to depression and burnout. Less kynurenine, means less chance of burnout.5

REFERENCES
DID YOU KNOW?

Right now **ANYONE** in British Columbia can claim to be a counsellor. FACTBC thinks this needs to change.

**BRITISH COLUMBIANS DESERVE BETTER.**

Citizens need to be protected, services need to be accessible and counsellors need to be accountable. Associations like BCACC do all they can to ensure high standards and client safety, but can only do this for registered members. Only a regulatory college has the authority to regulate anyone claiming to be a counsellor whether they are an association member or not. A regulatory college of counselling therapists will serve the needs of British Columbians and ensure counsellors are qualified to help people in need.

**ABOUT US**
The Federation of Associations for Counselling Therapists in BC (FACTBC) is the unified provincial voice of our member associations as we pursue the development of a College of Counselling Therapists to protect British Columbians.

We are a society of 12 professional associations that collectively represents more than 5,000 counsellors and therapists practicing throughout British Columbia.

**OUR ADVOCACY**
We have been advocating for a regulatory college for years and recently asked counsellors across B.C. to help us by contacting their local MLAs directly. More than 200 supportive emails have been sent to MLAs throughout B.C. but we still do not have a firm commitment to make the regulatory college a reality.

**WANT TO GET INVOLVED?**
If you would like to advocate for increased public protection, accessibility, and accountability of mental health services, contact FACTBC Lobby Coordinator John Gawthrop (jcgawthrop@gmail.com).
Or if you want more information, check out our website (www.factbc.org).
WHY SHOULD YOU JOIN THE BCACC?

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

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

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

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

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