How parents’ attitudes towards their babies, starting preconception, can influence their baby’s development and that of future generations.
**Contents**

<table>
<thead>
<tr>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Note from the Editor</td>
<td>3</td>
</tr>
<tr>
<td>Editorial Feedback</td>
<td>4</td>
</tr>
<tr>
<td>Thinking it Through: Bowen Family Systems Therapy with Family</td>
<td>5</td>
</tr>
<tr>
<td>Preservation Service Clients</td>
<td></td>
</tr>
<tr>
<td>Alex Angioli offers us a brief overview of some key components of</td>
<td></td>
</tr>
<tr>
<td>Bowen Family Systems Therapy and its incredible value as a</td>
<td></td>
</tr>
<tr>
<td>foundation for working with challenging family dynamics.</td>
<td></td>
</tr>
<tr>
<td>Pre- and Perinatal Psychology and Health</td>
<td>7</td>
</tr>
<tr>
<td>Myrna Martin provides us with a brief review of current research for</td>
<td></td>
</tr>
<tr>
<td>best practices in pre- and perinatal health as well as a solid</td>
<td></td>
</tr>
<tr>
<td>checklist for parents to consult before conception and after birth</td>
<td></td>
</tr>
<tr>
<td>to ensure they are doing their best for their baby’s psychological</td>
<td></td>
</tr>
<tr>
<td>and physical wellbeing.</td>
<td></td>
</tr>
<tr>
<td>Collaborative Divorce: How Therapists can Help Families Navigate</td>
<td>10</td>
</tr>
<tr>
<td>the World of Separation and Divorce</td>
<td></td>
</tr>
<tr>
<td>Lindsey MacInnes and Abby Petterson share the basics of the</td>
<td></td>
</tr>
<tr>
<td>structure and benefits of collaborative divorce and how to</td>
<td></td>
</tr>
<tr>
<td>determine if your clients would be a good fit.</td>
<td></td>
</tr>
<tr>
<td>Chronic Grief Therapy</td>
<td>12</td>
</tr>
<tr>
<td>Glynis Sherwood provides us with a detailed exploration of the</td>
<td></td>
</tr>
<tr>
<td>theory and clinical application of an approach to chronic grief</td>
<td></td>
</tr>
<tr>
<td>that is generating significant results.</td>
<td></td>
</tr>
<tr>
<td>An exploration of Therapeutic Practice as Sacred Engagement</td>
<td>16</td>
</tr>
<tr>
<td>Colin James Sanders shares a brief synopsis of a key aspect of</td>
<td></td>
</tr>
<tr>
<td>his doctoral thesis and explores theories from around the world</td>
<td></td>
</tr>
<tr>
<td>as they pertain to the consideration of the practice of therapy</td>
<td></td>
</tr>
<tr>
<td>as a sacred act.</td>
<td></td>
</tr>
<tr>
<td>Making mindfulness work: How to use Buddhist tools effectively in</td>
<td>19</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td></td>
</tr>
<tr>
<td>Informed by 20 years of personal practice and professional</td>
<td></td>
</tr>
<tr>
<td>training and experience, Amita O’Toole shares her perspective on</td>
<td></td>
</tr>
<tr>
<td>how we can safely use mindfulness in our therapeutic practices.</td>
<td></td>
</tr>
<tr>
<td>Wednesday Date Day at Cypress</td>
<td>21</td>
</tr>
<tr>
<td>Dr. Jennifer Montgomery reminds us of the importance of</td>
<td></td>
</tr>
<tr>
<td>prioritizing quality time as a couple and gives us an example of</td>
<td></td>
</tr>
<tr>
<td>how she meets many needs with one action and encourages her</td>
<td></td>
</tr>
<tr>
<td>clients to do the same.</td>
<td></td>
</tr>
<tr>
<td>Technology in the Play Room: A Healing Experience</td>
<td>22</td>
</tr>
<tr>
<td>Johanna Simmons displays courage, dedication and innovation in</td>
<td></td>
</tr>
<tr>
<td>her novel approach to working with a young client suffering</td>
<td></td>
</tr>
<tr>
<td>from complicated attachment to her adoptive parents.</td>
<td></td>
</tr>
<tr>
<td>Exploring the Grief Process in Addiction</td>
<td>24</td>
</tr>
<tr>
<td>Mary E. Duddy briefly explores some questions and considerations</td>
<td></td>
</tr>
<tr>
<td>on the topic of grief in addiction recovery.</td>
<td></td>
</tr>
<tr>
<td>Communication Problems and Solutions in a Nutshell</td>
<td>26</td>
</tr>
<tr>
<td>SAVI®, the System for Analyzing Verbal Interaction, has been a</td>
<td></td>
</tr>
<tr>
<td>powerful tool in the personal and professional lives of Dr.’s</td>
<td></td>
</tr>
<tr>
<td>Claudia Byram and Ian Macnaughton. In this article they share the</td>
<td></td>
</tr>
<tr>
<td>history and basic principles of SAVI® with us.</td>
<td></td>
</tr>
<tr>
<td>Boys Groups: Increasing Social and Emotional Literacy</td>
<td>28</td>
</tr>
<tr>
<td>Sherry Bezanson presents current literature on best practices for</td>
<td></td>
</tr>
<tr>
<td>the prevention and treatment of emotional and behavioural</td>
<td></td>
</tr>
<tr>
<td>challenges in boys.</td>
<td></td>
</tr>
</tbody>
</table>

**Community Pages**  

[The Authors' references for articles published in this issue of Insights Into Clinical Counselling are available online at http://bc-counsellors.org/iicc-magazine.]
Happy Spring to you, and Happy Anniversary BCACC!

From the humble beginnings of the BCACC in 1988, when a handful of counsellors with a shared vision began meeting in each other’s living rooms, our association has grown to 2600+ members strong and is now celebrating its 25th year in existence.

On behalf of BCACC members throughout BC, I would like to acknowledge those founding members and express our continuing gratitude for your foresight and commitment to creating an organization that continues to honour your founding principle:

Regulating the professional practice of Clinical Counsellors in the province of British Columbia.

What I find particularly inspiring about the BCACC is how committed our members are to the dual purposes of working together to support each other, through supervision, collaboration and education, and to ensuring that the members of our local and provincial communities have access to the resources and support they need in order to find solutions to the many challenges that life naturally brings to our doorstep.

I don’t know about you, but it seems to me that just as I start to feel confident that I’ve got this whole life and relationships thing figured out; that the rest of my days will surely only be smooth sailing from here, I instead wake up to find that my little skiff has run headlong into a storm I didn’t even see coming. And I am yet again reminded of one of great truths of life: The only constant in life is change.

The trick to life seems to be in how each of us navigates our own personal and societal storms. It is clear that successful navigation ultimately requires each of us to have a good solid foundation; a tool kit filled with the basics that allow us to demonstrate empathy and compassion for ourselves and to trust ourselves to find reasonable and respectful solutions to whatever problem may present itself.

Our clients come to us looking for a tool kit like this as well; something that allows them to navigate their own storms with dignity and grace. We Registered Clinical Counsellors provide them with a solid framework and the tools they need to be able to do just that.

In similar fashion, the BCACC is a very key tool in our counsellor tool kits; allowing us to feel a part of something solid, supportive and ethical. It provides us with a respectful and caring backbone for all aspects of professional practice, just like any healthy family should.

And so, I doff my chapeau to the founding members of BCACC and to the many members who have come to call the BCACC home. Thank you for everything you’ve done, and continue to do, to make our counselling community and our province a better place for us all.

Michelle Morand
Editor
Happy 25th Anniversary BCACC!
Hello Michelle, hope you are well. I read your ‘note from the editor’ in the December 2012 edition of Insights. The e-mails you received from readers regarding the article on Sex Addicts led me to re-read the article.

I don’t know what issues the responders were concerned about, however, in my opinion the authors presented a very good article. I happen to agree with them. I have worked with clients who thought they were sex addicts, but in reality they were not. I think that sexuality and sexual behavior may at times be misunderstood by some counsellors.

This article was refreshing to read. Actually, I somewhat detest labeling of any kind. I think that many clients are often mislabelled by someone and treated accordingly. I have worked with some clients for whom this became very dangerous emotionally and physically. In my practice I tend to observe the behaviors that clients exhibit and then work with the client to deal with the issues that these behaviors present. I hope that we will receive more articles like the one on Sex Addicts.

An interesting person to follow in the area of sexuality is Marty Klein. Anyways, I just wanted to share my thoughts with you about the article. By the way, I am a former school teacher, school counsellor, and in private practice for over 20 years for a total of 30+ years of counseling. I have taught at elementary, secondary and university level for many years. Take care. Frank Groenewold

www.drfrank.ca

And, another piece of feedback on the article pertaining to Sex Addiction:

Dear Michelle,

I recently read the article in the August 2012 edition of Insights into Clinical Counselling, entitled, “Sex addiction epidemic? No, it’s the Getting Caught Syndrome.”

In this article, the authors make the rather extraordinary claim that “Society’s ongoing pathologizing of sexuality is rooted in a sex-negative Christianized culture, the influence of which cannot be underestimated. Understanding these cultural roots is [sic] essential to freeing ourselves from its unhealthy grasp.”

If we are to understand these “cultural roots,” then I would just like to point out to readers that not even the Bible makes such an absurd claim that Christianity has the type of societal influence, negative or otherwise, that these authors assert. In fact, the Bible has a polar opposite perspective, citing no less than four times (John 12:31; 14:30; 16:11; 2 Corinthians 4:4) that the devil is the chief influence, going as far as calling Satan the “god/ruler/prince of this world” (depending of course, on the translation). Is there modern, relevant, secular evidence that fits with the Bible’s perspective? YES! Consider the following examples (American examples, in consideration of the authors’ considerable recognition as clinicians and educators in the United States):

• The United States Bill of Rights (1791) which states in Article the Third: “Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech,”

• Article 11 of The Treaty of Tripoli signed in 1797, states “…the Government of the United States of America is not, in any sense, founded on the Christian religion…”

• Thomas Jefferson wrote to the Danbury Baptists in 1802: “Believing with you that religion is a matter which lies solely between man and his God, that he owes account to none other for his faith or his worship, that the legislative powers of government reach actions only, and not opinions, I contemplate with sovereign reverence that act of the whole American people which declared that their legislature should “make no law respecting an establishment of religion, or prohibiting the free exercise thereof,” thus building a wall of separation between church and State.”

• The Civil Rights Act of 1964 states in Section 703:

(a) It shall be an unlawful employment practice for an employer—
(1) to fail or refuse to hire or to discharge any individual, or otherwise to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual’s race, color, religion, sex, or national origin.

There are lots of other legal and historical examples in both the United States and Canada that further delineate a church and state distinction, but these examples are significant, because they are relevant to the “birth” if you will, of the United States as a separate and autonomous country, distinguishing it from the laws and practices of the European countries that many American settlers originated from.

I agree wholeheartedly with the authors’ concluding sentiment, that the “sex-addiction approach to human sexuality is simplistic, dishonest and disease mongering.” But it is no less dishonest to describe Christianity as a predominant influence in modern-day North American society, or that it endorses a “sex-addiction” approach (since no Biblical scripture even comes close to upporting the notion). Thus, the whole argument that Christianity is “sex-negative,” or “highly suspicious and even antagonistic towards human sexuality,” essentially dissolves, and the authors’ underlying intentions of providing a convenient and understandable hypothesis for the complex issues related to sexualized dysfunction are exposed. As a litmus test, try exchanging the term “Christianized” with another term that reflects an individual group based on racial, social, or religious identification (e.g., “Judaized,”); does the “empirical” flavor of the article change?

Kevin G. Lefebvre, MA, RCC

And this note came to me from Suzanne, the author of an article on her personal experience with Dissociative Disorder as outlined in our Winter 2012 edition.

Hi Michelle

I just wanted to tell you that on December 12th I had an appointment my therapist and she had just received her copy of the Insights magazine. We were both impressed by how it looked.

On the afternoon of the 13th I received an e-mail from someone who lives on the Gulf Islands, who has been diagnosed with Dissociative Disorder. Her therapist had given her a copy of the article and she contacted me to thank me for letting her know she is not alone. I think I should forward this thanks to you also.

When I wrote the article I had hoped it would help therapist’s understand their clients and the condition a bit more, I never thought of a therapist giving a copy to their clients.

Thanks again

Suzy (Suzanne Venuta)
Family Preservation Services (FPS) and their efficacy with high anxiety families are seldom viewed from a Bowen Family Theory perspective.

Some years ago I was involved in planning, designing and implementing a FPS with families referred by the Ministry. At that time I attempted to introduce high risk, conflicted and highly anxious families to the principles of Bowen Family Systems and to doing work on themselves with the hope that they would quickly calm down and also gain perspectives they could carry forward beyond the planned period of intervention. Most of the families that are referred to such a program have some common presenting problems, the most prominent of which are child abuse or neglect, followed by spousal conflict.

Often, one of the spouses is also ill, either emotionally or physically. So we may identify three distinct categories of clinical dysfunction among families referred to an intensive preservation program: Marital conflict; Illness in a spouse; Impairment of a child (via abuse or neglect).

The emotional systems way to understand these complex situations is to conceive of the patient, or the organism, as the entire family, rather than the individual. There is an important difference between systemic and individual models of behavior.

For example, when a family presents that a seven-year-old is unruly and unmanageable, we see that unruliness as an expression of the anxiety in the family system.
The 8 key concepts of Bowen Family Systems:
There are 8 key concepts of Bowen Family Systems. They are:
1. Differentiation
2. Triangles
3. Nuclear family emotional process
4. Family projection process
5. Multigenerational transmission
6. Sibling position
7. Emotional cutoff
8. Societal emotional process

Please note: In an effort to provide you with a solid appreciation for the value of this process with challenging families in this brief article, I will focus mostly on Differentiation and Triangles for the remainder of this article.

The most basic concept in Bowen theory is that human beings exist in emotional systems, the most common unit of which is the family, particularly the nuclear family. The structure of the family is less important from this perspective than the flow of emotionality among related persons.

Relatedness begins to happen by virtue of spending time with people, so that anyone who is in contact with any emotional system becomes, on some level, related to it. This is an important point for Family Preservation therapists.

The FPS therapist will be challenged to enable one or more members of the family to improve their differentiation from the emotional system, while keeping a close watch on his or her own reactivity to the anxiety of the system.

This brings us to the first of the theoretical concepts of Bowen Systems thinking, and that is Differentiation, which may be defined as the degree to which a person is able to distinguish between their emotional process and their intellectual process. This distinction also implies the ability to take action based on reasoned reflection rather than on an automatic response to a situation or a person.

The emotional system operates in all persons and reacts automatically. A high level of Differentiation in a person denotes a greater ability to reflect on the emotional process. Lower levels of Differentiation result in greater reactivity and less ability to make reasoned decisions.

Better Differentiation means that an individual’s chronic level of anxiety will be lower, so that when stressors arise there is less likelihood that that symptoms will erupt and more likelihood that an adaptive resolution of the anxiety will be achieved.

In high-anxiety individuals, on the other hand, stressors impact the anxiety so that the emotional process takes over and there is less ability to reflect coupled with greater reactivity.

The FPS therapist needs to be aware of the ways in which the emotional system works.

In a nuclear family system, emotions flow along predictable channels and the family anxiety gets channeled into, and bound in, certain characteristic ways. This is known as the nuclear family emotional process and can present in a variety of patterns. However, the most basic patterns are found in the operation of the emotional laws of Triangles, which form whenever two people draw in a third to alleviate the anxiety arising out of their own relationship.

In couples therapy, for example, the presence of a neutral therapist usually allows the system to calm down because the triangle stabilizes. However, when an unstable couple triangles in a third member, such as a child, to absorb the anxiety of their relationship dyad, symptoms are likely to emerge.

When a child is ‘triangled’ by an anxious dyad and focused upon, as in the case of many client families in FPS, emotional or behavioral symptoms frequently develop in the child who is subsequently presented as the Identified Patient. A child who is the recipient of consistent focus is more likely to develop symptoms than one whose family system alternates other means of binding anxiety, such as marital conflict, extramarital affairs, or substance use/abuse. The triangling of a child and focusing upon him/her are the two main mechanisms whereby family projection operates.

The Process of Therapy:
Because all FPS clients are referred through the Ministry, there is some consistency in that child impairment is almost always a part of the clinical picture. Since child impairment is produced either by abuse or neglect or a combination of the two, we know that child focus and the projection process are at work and that they operate through triangles in the nuclear family emotional process. Thus, in the vast majority of FPS cases, we need to assess the particular kinds of projections that are being enacted and the ways in which focus is directed at the impaired child.

In an actual case, “A”, a 23-year-old mother of two girls, “B” (1 1/2yrs) and “N” (4 yrs), called the Ministry asking that her eldest daughter be put into care because of what she thought was unmanageable, aggressive, and defiant behavior.

When we went into the family, we found an intensive projection process at work. Mother blamed her children and especially the eldest for her current difficulties in life. “A” ascribed to “N” a degree of maliciousness and intentionality far beyond the capabilities of a 4-year-old.

The father of the children, “W”, was a drug addict with several convictions for armed robbery and several suicide attempts. The parents were separated with virtually no contact. “A” told a Counsellor that she saw “W” in “N”. “Every time I look at her, I see him,” she stated.

“A” also stated she saw herself in “N”. This aspect of the projection was corroborated by the mother of “A”, who told “A” that “N” was just like she was at her age.
Insights into Clinical Counselling
This is what parents need to know and understand: That how they are with their baby, starting preconception, can influence their baby's development and also that of future generations.

By Myrna Martin, MN, RCC, RCST®, Contributing Writer

It has been nearly a century since pre-and perinatal psychology was introduced by Otto Rank (top left in photo below), a student and colleague of Sigmund Freud. His slim book, The Trauma of Birth, was a gift to his mentor and friend in 1924. This birthday surprise detailed how Rank thought that difficulty during birth could affect the psyche of the person being born in such a way that it would affect them the rest of their lives.

While first warmly received by Freud, it was ultimately rejected and the relationship between teacher and student was forever affected. Since then, this pattern of considering that babies have experiences that have lifelong implications has taken similar course in the world. A small cohort of practitioners took on the thread that these early life experiences were deeply meaningful. Even so, it was not until the 1960s after the publication of research articles about attachment theory and how caregivers and babies interact, that the vital importance of this early bond received scientific support. This research detailed how the style of attachment between mother and baby could have lifelong and multi-generational implications.

The 1990s were considered The Decade of the Brain, and many government dollars supported scientific research into embryology, neurology and related fields, especially the human genome project. It was thought that humans had over 100,000 genes that could be mapped and therefore disease and health could be easily tracked and hopefully manipulated for the greater good.

However only 25,000 genes were discovered and research turned to looking at how the environment influenced gene expression. This field of study is called “epigenetics,” and explores how the environment and genetics interact. The nature/nurture discussion has taken a new, scientifically supported, twist since the era of the “epigenome” was born.

These days, researchers, scientists, therapists, medical doctors and other professionals realize that, while the genes tell the body what to do and how to develop, electrochemical information in many forms coming from the thoughts, feelings and experiences that a person has, influence how the genes we are born with will function.

In addition, chemicals in the environment around a human will influence how the genes express themselves. Experiences that grandparents have will influence their grandchildren’s life, as these epigenetic changes can be multigenerational. Geneticists can now track a variety of diseases through the generations. Professionals can also track how experiences influence the baby in utero, especially high levels of stress.

This is what parents need to know and understand:
That how they are with their baby, starting preconception, can influence their baby’s development and also that of future generations.

Mothers, fathers, and families can look at this paradigm and take away what many mothers have asked me for over and over: An instruction manual for being with babies and children that will help them help their children find happiness in the world.
Every mother (parent) I meet wants the best for their child. Those of us supporting human development can outline best practices that parents can consider, and also offer support if life experiences have been difficult.

Life is unpredictable and mostly not in our control but we can do our best to positively influence the outcome. Below is a list of points to consider when we want to give babies an optimal early life:

• Ancestral lineage: Are people securely attached and what chronic diseases are present?
• Dad and Mom “consciously” prepare for baby;
• Lovemaking is tender and intentional;
• Conception and implantation are easy;
• Uterus is healthy and baby is growing in a good spot;
• Mother and father lead healthy lives, with mild to occasionally moderate stress;
• Excellent, regular prenatal care;
• Birth is optimal: Natural with no interventions;
• Baby is not separated from the mother, has lots of skin to skin, does the “self-attachment sequence” and successfully breastfeeds;
• Neonatal period is relaxed and uneventful. Baby is completely breastfed until at least 6 months.

Rarely does any person or family have this optimal constellation of factors for human development. However, the good news is that we can influence how pregnancy, birth, and the early years play out. Here are some things that parents can do:

• If a woman is considering getting pregnant she can most positively influence healthy gene selection by preparing at least three months in advance. Bruce Lipton and other cellular biologists show that what a woman experiences then can create an environment that influences which genes are selected, especially if she can avoid high stress or experiences of fear or loss. Babies conceived during wartime or famine have an entirely different experience from those conceived in time of plenty. Women can take vitamins (eg. Folic Acid), and eat healthy foods, especially fish oils and other foods that positively influence neurological development.

• Potential parents can examine how attuned they are to their own emotions and how comfortable they are expressing these emotions with people they love and trust. Parents...
can begin to practice talking about their feelings with each other more to increase their own comfort levels with emotional expression. Parents who can do this with ease and help their children express and understand their emotions are one of the best predictors of children’s happiness and ability to self-regulate feelings.

• Partners can create a loving and conscious atmosphere for conception. Most of us know that not all babies are planned, and even when planning, it can be stressful to conceive if there are patterns of infertility.

• Parents can also influence their baby’s development through communication with the baby in utero. This concept can be a stretch for some parents, but research has shown that babies can experience their parents’ intentions, and communication, even if they don’t understand the words. These babies exhibit enhanced visual, auditory, linguistic, and motor development. In general, they sleep better, are more alert, confident, and content than infants who were not stimulated (who did not receive this level of communication in utero). Births in the families where there is prenatal communication are shown to have less intervention and the babies are bigger and stronger.

It is not what happened to us as children, but how we have come to terms with it that will influence our subsequent parenting skills and approach.
Sue and Charles first came to us after 5 years of litigation. They had spent all of their savings and energy battling with each other over a parenting schedule for their son, Peter. Recently, a judge had created an order, setting out a parenting schedule that neither parent was happy with, and that was not in the best interest of their child. They both realized that after 5 years in court, they had not accomplished anything, other than create an increasingly toxic environment for themselves and for Peter.

What is Collaborative Divorce?

Collaborative Divorce is an innovative approach to separation and divorce that helps protect the long-term interests of the family. The practice of Collaborative law is based on the tenent of “do no harm” and allows clients to be active participants in the process.

Collaborative divorce allows couples to dissolve their marriage with dignity, prioritize the needs of the children, work cooperatively and maintain control of the separation process. It is a no-court approach that has lawyers, therapists and financial planners working together as a team.

The centerpiece of collaborative practice is the Participation Agreement (Zack, 2012). This document sets out the agreement of the parties to proceed without going to court. It also ensures a commitment to full disclosure, cooperative and respectful negotiations and to protect the needs of the children. The roles of the various professionals are also outlined. On the Vancouver team, specially trained therapists work as “Divorce Coaches” and “Child Specialists” alongside Collaborative Family Lawyers. These therapists play an important role in helping families navigate the complicated and emotion-ridden world of separation and divorce.

Why Collaborative Divorce?

Peter was only 10 years old and had spent half of his life caught in between his parents. He described himself as having a lot of anxiety and difficulty sleeping, particularly when separated from his Mom. Peter disclosed that he couldn’t remember a time where there wasn’t a high amount of conflict between his parents. He was unhappy with his current schedule and described his relationship with his Dad as being uncomfortable and tense. Peter was feeling hopeless that the situation between his parents was ever going to change. In an act of desperation he approached his school principal, begging her to intervene.

Divorce and Separation is an issue facing many Canadian families, with approximately 4 out of 10 marriages ending in divorce. The majority of divorces (59%) occur among couples who were married less than 15 years. It is often in these earlier years that couples are having children, illustrating how often families with young children are splitting up. According to Statistics Canada, almost 30% of children born in 1984 experienced their parents’ divorce by the age of 15.

The discussion of divorce and its impact on children is not a new one, in fact studies from the 1970s onwards have consistently outlined the increased risk that divorce has on children, including both externalizing (e.g. aggression) and internalizing symptoms (e.g. depression, anxiety).

Research has shown it is not divorce itself that harms children, but the manner in which the divorce unfolds. High levels of conflict and distress in separation and divorce are the most destructive elements for children (Hetherington & Kelly, 2002), highlighting the need for a process that helps support both parents and children through a challenging time by reducing friction and stress. In 1989, Mechanic and Hansell found that family conflict had more direct effects on child well-being than divorce or parental death.
Knowing that many children will experience divorce, and the impact (particularly where conflict exists) that this transition can have on them, therapists are increasingly aware of the importance of engaging with families in a process that can reduce conflict and give all family members the tools and abilities to navigate through this difficult transition with the greatest level of respect and consideration for all concerned.

In looking at the research of child outcomes, one major protective factor identified is reduced and/or encapsulated conflict separations, and the development of cooperative co-parenting styles (Kelly, 2012). This is where the expertise and support of a specialized therapist can potentially change the trajectory of the family and work to both prevent and reduce risk to the child.

**Role of the Therapist in Collaborative Divorce:**

Charles and Sue were hoping to create a parenting plan that they were both happy with and Peter was hoping to be able to spend more of his time with his Mother. They also needed to come to agreements on financial issues, including child support and division of child expenses. The relationship between Charles and Sue was very adversarial, with widely differing opinions on what was best for Peter. It was immediately apparent that both parents and their son needed specialized support to change the trajectory they had been on for the previous 5 years.

Divorce Coaches and/or Child Specialists are experienced Mental Health professionals with specific training in collaborative practice, family law, family mediation, conflict resolution and child development.

The Divorce Coach and/or Child Specialist roles present something of a paradigm shift from standard models of therapy. The work ends up being an integration between therapy and coaching and is more goal and education oriented than standard therapeutic interventions. Therapists have to navigate emotion in the room carefully, as using interventions that enhance emotion can be counterproductive in a high conflict situation (Gamache, 2003).

Collaborative Divorce is fast paced and involves working in acute, high conflict situations. Therapists working in the field have to be highly skilled in conflict management, mediation and well-versed in principles of family law and child development.

Each member of the couple will often have their own divorce coach, whose role is to provide emotional support, teach communication skills, discuss parenting concerns and to help ensure that needs, concerns and feelings are understood and contained (Gamache, 2003).

In cases where children are involved, a Child Specialist will be brought in as a neutral party, focusing on the child’s needs and well-being. The Child Specialist provides a safe place for the child to share their experience and will often report back to the team and parents. This role often includes working with the parents to create a parenting plan and schedule.

Charles and Sue each selected a Divorce Coach and Peter was matched with a Child Specialist. Both parents retained Collaborative Lawyers and began the discussions on topics including finances and child support. While the coaches worked with the parents to improve communication and begin to create a plan, the Child Specialist met with Peter to get a sense of how he was doing. The Child Specialist immediately noted the high level of distress that Peter was in and went back to the team to convey the importance of change.

In consultation with the Divorce Coaches, the Child Specialist made specific recommendations of what the parents could do to improve their relationships with their son and ways that he could be disengaged from the 5-year tug of war.

Throughout the entire process, the Coaches were updating Sue and Charles’ lawyers and preparing the two for their legal and financial meetings. If there were any roadblocks in the sessions with the Lawyers, Sue and Charles were sent back to the Coaches to continue to work on their communication.

Through the next several months the team worked with various parts of the family and in the end a temporary parenting plan was created that all three parties were happy with. Peter learned different strategies to help manage his anxiety and to communicate more effectively with his Dad. He also learned that he did not have to take sides with either parent; that he could be in relationship with both of them despite their different perspectives. Sue and Charles realized how much their own actions had put their son in the middle, and with their coaches learned strategies to keep their conflict away from their son.

**Which Clients Make Good Candidates for a Collaborative Process?**

There is a common misconception that clients who are interested in the Collaborative process have to be going through an amicable split or one of little or no conflict.

I’ll often have clients call who say “I’m interested in Collaborative Divorce but my ex and I aren’t collaborative.” While Collaborative Divorce does work well with low conflict separations, it is often the high conflict separations that can benefit the most from the process.
Chronic Grief Therapy:
A Lifeline Back to Health, Hope and Happiness

By Glynis Sherwood MEd, RCC, CCC, Contributing Writer

<table>
<thead>
<tr>
<th>Common denominator is that people grieve in direct proportion to the meaning the loss has for them.</th>
<th>Most individuals going through ‘normal’ grief don’t require counselling to complete these grief recovery tasks. Healing tends to happen organically over time, especially with good support.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feelings of intense pain are common in normal grief, and can last from days to months. Although every person grieves in their own unique way, grief has some common features including temporary preoccupation with the loss, sadness, fear, loneliness and disorientation. Most people recover from this intense pain over time, though memories of loss remain as permanent features of one’s psychological landscape.</td>
<td>According to grief and trauma professionals, chronic grief is characterized by the lack of resolution or the intensification of acute grief symptoms such as disbelief, shock, anxiety or depression after more than six months to a year since the loss.</td>
</tr>
<tr>
<td>Normal vs. Chronic Grief? What’s the Difference?</td>
<td>Chronic grief is distinguished from ‘normal’ grief by feelings of hopelessness, loss of meaning and/or belief systems, intense pre-occupation and longing for a lost loved one or situation, apathy, a lingering sense of disbelief about the loss, avoidance of situations or thoughts that are reminders of the loss, and sometimes, distressing, intrusive thoughts related to the loss that are reminiscent of trauma symptoms. Left untreated, chronic grief can lead to severe clinical depression, substance abuse and suicidal ideation.</td>
</tr>
<tr>
<td>Grief is a normal and necessary, though painful, response to losing someone or something we love and treasure. Normal grief involves acute feelings of psychological pain in response to the loss of a loved one through death, the end of a relationship, termination of a job, or declining health.</td>
<td>How well we cope with grief will determine our emotional resilience and ability to rebound from the pain of loss. According to William Worden (1992), there are four main tasks of healthy grief recovery:</td>
</tr>
<tr>
<td>Grief can also stem from socially unrecognized or “disenfranchised” losses such as early miscarriage, loss of a same sex partner, death of a friend, addiction, caregiver grief due to chronic or terminal illness of a loved one, exiting a cult or being shunned by an authoritarian religious community, crime victimization, estrangement from one’s family of origin, and childhood abuse. The</td>
<td>1. Accepting the reality of the loss; 2. Working through the pain and complexity of grief; 3. Adjusting to an environment in which the important person, place, activity, relationship, etc. is missing; 4. Moving away from grief and longing for what is lost, and finding a place for it in our memories as we move on with life.</td>
</tr>
</tbody>
</table>

People grieve in direct proportion to the meaning the loss has for them.
been impacted by unexpected and/or traumatic loss, such as sudden death, protracted fatal illness, violence or catastrophic injury.

People who have a history of mental health concerns, substance abuse, childhood abuse, neglect or trauma are more vulnerable to chronic grief. Other risk factors include a poor sense of self-efficacy, low self worth, a high degree of dependency on the relationship or situation, perception that the loss was preventable, absence of social support, current stressors and secondary losses (e.g. money, social status).

It has also been my experience that people who go through socially un-recognized grief can be at greater risk of chronic grief, as they feel isolated and stigmatized for ‘inappropriate’ grief. At any rate, the higher the degree of risk factors, the higher the need for individual therapy. And in the case of traumatic loss there is often a longer recovery trajectory.

Psychotherapy is particularly critical for recovery from chronic grief, and requires specific counselling approaches designed to treat grief, emotional and cognitive distress and trauma symptoms. Complicated grief has come to be understood as an Attachment Disorder, due to intense separation pain and anxiety stemming from the loss of an important person or object.

Those suffering from complicated grief must learn to grieve the loss of important attachment figures in a healthier way. This involves acquiring the skill of being able to move towards or turn away from grief at will; skills that are present in healthy griever.

The experience of overcoming chronic grief also entails learning to manage internal emotional reactivity and coping with other people’s reactions to the loss, which may range from being distant to overbearing. Healing requires reforming one’s identity in the face of the loss and, sometimes, increasing life management skills, such as learning how to cook or drive (Jordan, 2011).

Existentially, healthy grief is a process of reconstructing meaning that occurs after our client’s world view and belief systems have been disturbed or violated by their loss. An important task of psychotherapy is to help our clients to rebuild meaning in a way that incorporates the loss in a constructive manner.

**Treatment Interventions**


The tasks of therapy and the role of the therapist shift according to the developmental needs of each phase. With regards to the type of counselling required and sequencing, according to Jordan, prolonged grief therapy should proceed as follows:

- **Step 1 – Crisis Therapy**, which corresponds to the “Reactive” phase of grief;
- **Step 2 – Grief Therapy**, which can overlap with the “Reactive” phase, once the crisis has been resolved, and targets the “Reflective” and “Integrative” phases; and
- **Step 3 – Traditional Therapy**, which occurs during the “Reintegration” phase of grief.

The therapeutic modalities Jordan recommends include Trauma Reduction Techniques, Cognitive Behavioral Therapy, Narrative Therapy, Psychodynamic Therapy, Family Therapy, Complicated Grief Therapy and traditional Grief Therapy.

Peer and/or facilitated support groups can also play a central role in recovery.

As noted, the job of the complicated grief counsellor shifts according to the stage of therapy, and includes the following multiple, overlapping and reoccurring roles:

1. We bear witness to the client’s exploration and expression of emotion, beliefs and experience of loss.
2. We are the psycho-educational coach; teaching the client about normal human responses to loss.
3. We are the life skills coach; helping the client identify what supports they need and how to ask for help from others. This includes teaching progressive desensitization skills to reduce avoidance of loss, or containment skills to prevent flooding and overwhelm from loss thoughts, feelings or memories.
4. We are the client’s confidante.
5. We serve as a transitional attachment figure.
6. We are the psychotherapist; linking loss to other life issues, for example, earlier childhood loss, trauma or injuries leading to negative beliefs, expectations, feelings or moods. The therapist can also help the client overcome narcissistic perspectives, such as “I hurt more than you,” that can drive others away. In this way, therapy becomes an opportunity to revisit, rework and heal old wounds.
7. And we can serve as the client’s spiritual companion, helping the client use their grief for personal growth and transformation.

**Therapeutic Strategies**

Psychotherapy of chronic grief draws from a variety of counselling approaches, depending on the stage of therapy, presence of trauma, nature of the loss and client personality factors. A main challenge is assisting the client to overcome avoiding or becoming overwhelmed by the loss. Both avoidance and flooding defenses need to be minimized for healthy grieving to occur.

Complicating factors for successful chronic grief therapy include active substance abuse and/or pre-existing mental health problems. In my
experience as a certified addiction counsellor, any addictive behavior – which in effect masks, represses, distorts or numbs healthy emotional expression and working through affective distress - must stop for therapy to be effective. Specific treatment strategies for mental health concerns (e.g. depression, bi-polar disorder) may need to be incorporated into the overall treatment plan.

Methodology

John Jordan (2011) writes that core treatment tactics for recovery from chronic grief may include:

1. Trauma Reduction Techniques:
   a. Cognitive Therapy: Evaluates negative beliefs associated with trauma, e.g. “I’m a bad person.”
   b. Relaxation Techniques: Teaches diaphragm breathing and uses guided imagery or hypnosis to reduce nervous system arousal.

2. Dosing Techniques: Designed to assist the client to achieve more control over when and how much to experience their grief. By learning to choose when to ‘dose’ themselves or to pull back from grief, clients come to accept the reality of their loss while overcoming trauma symptoms, negative beliefs and distressing emotions. This skill acquisition makes the grieving process more conscious and voluntary, and builds psychological resilience.
   a. Prolonged Exposure Therapy: Combines exposure to traumatic stimuli, which is described in detail, recorded, and listened to at home;
   b. Meaning Reconstruction: Uses journaling to write about the traumatic event in detail, repeating the writing four to six times over a two-week period;
   c. Writing Letters: To or from deceased and/or an empathic ‘imagined’ friend who knows what the client needs to heal;
   d. Restorative Retelling: Recalling the traumatic loss scene and then retelling

The incident in a more bearable way that does not preclude the loss;

3. Complicated Grief Therapy: A 16 session program developed by Dr. Kathryn Shear, MD to treat prolonged bereavement. Using the dosing technique of having the client retell the story of the death several times, the therapist points out shifts in the narrative, clarifying signs of strength and working through negative beliefs.

4. Rituals: New rituals or traditions of commemorating loss are built alongside old rituals to help the client move into their new post-loss identity, while continuing to process their grief in a healthy manner.

Complicated Grief Assessment Strategies

When conducting the initial evaluation of a client who presents with symptoms of complicated grief it’s important to conduct a detailed assessment as this will guide the timing and specifics of treatment interventions. Important assessment questions address how much:

a. The client is having trouble accepting the loss;
   b. Grief is interfering in the client’s life;
   c. The client is experiencing intrusive images or thoughts of the loss that really trouble them;
   d. The client is avoiding things they used to do/enjoy before the loss;
   e. The client is feeling cut off or distant from others; especially family or friends;
   f. The client is having intense feelings of loneliness when in the company of people they are close to;
   g. The client is either avoiding thinking about the loss, or is overwhelmed by memories, images, thoughts or emotions;
   h. Trauma symptoms may be interfering in the client’s daily life and grief recovery.

It’s also important to assess for the client’s ability to see reality as it is, their coping style (a balance between avoidant and confrontational is healthiest), a history of loss, trauma or mental health concerns, what the loss means to the client, the presence of additional stressors, quality of social support, and the griever’s expectations for therapy and recovery.

Preliminary studies of the efficacy of Complicated Grief Therapy are extremely hopeful as they show that the recovery rate is twice that of regular grief counselling (Shear, 2010). These findings suggest that proficiency in chronic grief therapy methods is an essential skillset that therapists must acquire in order to help their clients regain their psychological wellbeing.

Biography

Glynis Sherwood, MEd, RCC, CCC, is a Counselling Therapist specializing in recovery from longstanding Grief, Anxiety, Depression and Addictive Behaviors. She lives in Vancouver, Canada and can be reached at: 778-837-0616 or by email at Glynis@GlynisSherwood.com. Visit www.GlynisSherwood.com to download her free eBook: Stop the Struggle - 5 Steps to Breaking Free from Long Standing Emotional Pain, and read her Blog, “Recovery Matters.”
An exploration of Therapeutic Practice as Sacred Engagement

By Colin James Sanders, MA, RCC, PhD (Candidate), Contributing Writer

What I love is always the unexpected in a problem, the moment of spirit, certain enlightenments on a question, a certain ambiguity in the response.

In this brief article I offer a brief synopsis of the theories of those who have influenced and inspired my perspective on the practice of therapy as a sacred act, a form of bearing witness.

The sacred, in practice, remains inseparable from the political, for me. The influences I explore in this article, by way of enhancing this concept are: The Family Centre in Lower Hut, New Zealand (Waldegrave, Tamasese, Tuhaka, Campbell, 2003) Noillag Byrne and Imelda McCarthy (2007) and The Fifth Province Associates in Dublin, Ireland; and the co-founder of narrative therapy, Michael White. This brief article ends with an appreciation of philosopher Emmanuel Levinas (2001).

In 1991 I first encountered the work of The Family Centre, from Lower Hut, New Zealand. Attending their Vancouver event, I was profoundly encouraged with the ways in which this culturally diverse association of therapists and researchers envisioned a “just therapy”: A therapy concerned with social justice, and the social factors that often culminate in deleterious experiences for families and communities (Waldegrave, Tamasese, Tuhaka, Campbell 2003).

Continuing to assist me in my therapeutic and organizational practices are the trilogy of ideas The Family Centre describe as guiding their work, namely: Belonging; The sacred; and Liberation.

The Family Centre describes their “just therapy” trinity of guiding concepts in the following way:

“...we have chosen three primary concepts that characterize our Just Therapy approach. When assessing the quality of our work, we measure it against the interrelationship of these three concepts. The first is belonging, which refers to the essence of our identity; who we are, our cultured and gendered histories, and our ancestry. The second is sacredness, which refers to the deepest respect for humanity, its qualities and the environment. The third is liberation, which refers to freedom, wholeness and justice. We are interested in the interdependence of these concepts, not one without another” (2003, p.75, emphasis in original).

Relating to the concept of the sacred, The Family Centre further describes their understanding of spirituality within their practice in this way:

“Another metaphor we often use is that of spirituality. By spirituality, we are not referring to Christian institutionalism, but to something more akin to the sacredness of life or ‘soul’ as in soul music” (2003, p.75).

The Family Centre further notes: “We view the process of therapy as sacred. People come, often in a very vulnerable state, and share some of their deepest and most painful experiences. For us, these stories are gifts that are worthy of honour” (2003, p.6). A “just therapy” pays close attention to the social context of a person’s relationships, being particularly aware of socio-cultural and socio-economic influences and factors, while bearing witness to the lived experience of individuals, families, and communities.

Imelda McCarthy and Noillag Byrne’s ideas and related practices have also contributed to an understanding of the practice of therapy as a sacred encounter, or, as Noillag Byrne speaks of such an engagement and encounter, as a form of communion (Byrne cited by McCarthy, 2004, p.7).

McCarthy writes, “When we listen to the storied lives of our clients we are constantly challenged to place our ‘selves,’ our stories and our constructs at risk so that we can be open to receive their gift of soul baring” (2004, p.2). The therapeutic encounter, viewed in such a way, entails bearing witness to the stories being narrated.

McCarthy and Byrne utilize the metaphor of the mythical Irish “Fifth Province” to enable them within their work: The fifth province is a therapeutic approach that provides a systemic analysis from a dialectical vantage point. In a fifth province application, the movement of hope and despair is held in dramatic tension. They are not oppositions to be overcome, a hierarchy to be reversed or an unfolding synthesis. Rather they are discursive identities with an immeasurable hiatus, which seek reconciliation with each other, not evaluation (Byrne and McCarthy, in Flaskas, McCarthy & Sheehan, 2007).

Within therapeutic conversation, holding “hope and despair” simultaneously, dialectically, without considering them to be in opposition, requires considerable diligence and a commitment to being open-hearted and open-minded. Engaging in such a way also requires a belief that those who are suffering possess the resolve, resources, know-how and wisdom to address struggles and dissolve the dilemmas within the context of their relationships with others, and with the social context of their lived experience.

McCarthy envisions such conversations as being, in a sense, “portal[s] to the spiritual” (2004, p.4), and a way of engaging in conversation that opens a space for an ethical posture entailing “a dis-position of openness, acceptance, curiosity, enquiry and love.”
McCarthy writes of “listening with the heart…” noting, “Even Wittgenstein has said that speaking is only part of a much larger activity” (2004, p.6). Finally, McCarthy notes Thich Nhat Hahn (1999), proposing that “…if we can stay in the present, in the here and now or the ‘now here’ as I like to call it, then our awareness, energy and being become fresh and available in our inter-viewing, inter-acting and our ‘inter-being’” (Thich Nhat Hahn, 1999).

Michael White, co-founder along with David Epston of what has become known as “narrative therapy” (White and Epston, 1990) is not often referenced within therapy literature relating to the sacred, yet, perhaps not surprising for a person who read widely and thought relationally, a thread of reflections regarding the sacred does flow through White’s thinking, his practice, and his narrative therapy ideas. As Michael himself once remarked, “I guess I’ve always been more interested in reading outside the boundaries of the profession rather than inside” (White, 1995, p.12), and amongst the places this “reading outside the boundaries” took White we find Victor Turner on rite and ritual, Van Gennep on rites of passage, and Gaston Bachelard on reverie and imagination (White and Epston, 1990).

Not surprisingly, given the attention to cultural and related connections, from an ethnological perspective, White had an appreciation regarding the deep interconnections between spirituality and identity, noting, “…in joining in narrative conversations with Indigenous Australians, the categories of identity that are invariably privileged are those of kinship and spirituality” (1997, p.231), whereas predominant psychological identity that are invariably privileged are those of kinship and community, a social context that I often view as constructs within Western traditions often privilege the spirituality” (1997, p.231), whereas predominant psychological constructs within Western traditions often privilege the individual, and individualism, over kinship associations, family, and community, a social context that I often view as promoting of disconnection, and disillusionment, and despair.

White remarked, “The notion of spirituality does interest me” (White, 2000, p.131), adding, …we need to be reclaiming these sorts of terms in the interpretation of what we are doing – love, passion, compassion, reverence, respect, commitment, and so on. Not because love and passion are enough, but because these terms are emblematic of certain popular discourses; because they are associated with discursive fields that are constituted of alternative rules about what counts as legitimate knowledge, about who is authorized to speak of these knowledges and about how these knowledges might be expressed (White, 2000, pp.129-130).

White’s Foucaultian proposal aligns with the idea that local knowledge (Geertz, 1973), and formerly subjugated knowledge may become resurrected, revived, and brought forth, and can become honoured and witnessed as being viable alternatives to normative and prescriptive ways of being, and becoming. White’s articulation that “we need to be reclaiming these sorts of terms” finds affinity with Kenneth Gergen’s thought, namely that:

“…practices which are nourished by discourses of spirit, love and God need to be begin to find legitimacy” (Gergen, 1998, cited in McCarthy, 2004, p.9).

Accordingly, White connects his thoughts regarding spirituality to ethics, “I take this use of the word ‘spirit’ to here refer to ‘ethos’…”, continuing, “…and while I am prepared to acknowledge the contribution that I make to this, I am keenly aware of the extent to which this ethos is shaped by the sentiments that people bring with them into these circles” (White, 2000, p.168).

This co-created, co-constructed experience within the therapeutic engagement is relational, dialogical, and allows for a sharing within community.

White expands upon “…some accounts of spirituality that I can join with”, remarking: One of these accounts represents a spirituality that is expressed in the knowing action that we take in contributing to the regarding of life. This is a consciousness or, if you like, a spirituality that is expressed in the maintenance of curiosity, in the face of indifference, about what it is that usually passes unnoticed; in attending to what it is that exists in people’s lives that is otherwise subject to inattention, and in initiatives taken to rescue the extraordinary from the ordinary (White, 2000, p.1).

This perspective on the performance of therapy as entailing a sacred and political practice does not involve any rigid adherence to a particular code of morality; rather, this perspective remains open to dialogue, and to beginning to comprehend the perspectives of others, without condemnation or the attachment of blame.

As Kenneth Gergen has written, “It is not enough for the scholarly community to smugly view religious traditions as havens of mythology. If scholarly work is to make a significant contribution to the culture that sustains it, open dialogue is imperative” (2009).

Philosopher Emmanuel Levinas speaks of “being-for-the-other” (2001, p.106), an ethic requiring having responsibility toward the other. Levinas furthered the work of Martin Buber, whose text, I and Thou, Levinas has called “a fundamental book” (2001, p.72).

Levinas writes:
“My interest [is] in the intersubjective relation, my principle theme…” (2001, p.106). Levinas proposes that, “…human sociality is not at all a missed coincidence, but a superior excellence,” stating, “I call love peace…Peace is sociality; it is to attend to the other” (2001, p.113).

In summary:
In this brief article, I have described some of concepts that resonate for me in regards to therapeutic practice as a form of sacred engagement with suffering others. I chose to end with a few words on Levinas, but could easily have started this reflection with his ideas, as well. Levinas’ appreciation for the sacred face of the other runs throughout my own work, as does the practice of being hospitable to others and engaged within a sphere of assuming responsibility within relationships and inter-relationships of any sort.

Biography
Colin James Sanders, MA, RCC, PhD (Candidate) is B.C. Director for the Master’s in Counselling Programs with City University of Seattle, Vancouver, B.C. This reflection is a vastly distilled synopsis of a chapter from the dissertation Colin is currently writing, entitled, Narrative Poetics: Being an Architect of Language.
Making mindfulness work

How to use Buddhist tools effectively in psychotherapy

By Anita O’Toole, MA, RCC, Contributing Writer

The Buddhist practice of mindfulness seems pretty simple, safe and easy to teach to clients. We become aware of our own experience, and then ‘observe’ or ‘listen to’ that experience, from moment to moment, so that the awareness becomes deeper and more subtle. Easy, right?

As a Buddhist psychotherapist I believe the benefits of mindfulness for many clients are beyond question. Indeed, these benefits are increasingly well-documented (particularly by Kabat-Zinn et al). The potential pitfalls, however, are not yet widely understood.

It is my intention, in writing this article, to outline the broader context of mindfulness and in doing so increase its appropriate and effective use as a psychotherapeutic tool.

Difficult to grasp, dangerous to grasp wrongly:
“The teaching is as difficult to grasp, and as dangerous to grasp wrongly, as the poisonous water snake.”

The Buddha

Although on the surface it would seem that we can learn the technique of mindfulness well enough to teach it to clients after attending a short course, in reality it can be difficult to guide students safely through the practice.

Though simple to learn, mindfulness is a strong practice. If directed wrongly, the negative consequences for those we seek to help can be significant. This is one reason why Buddhist monks are traditionally ordained for ten years before they begin teaching.

Having experienced a number of Buddhist groups, and watched the growth in the popularity of mindfulness in therapy over the last few years, it is clear to me that both therapists and Buddhists need to ensure a maturity and balance in their own practice of mindfulness, before teaching others.

Buddhism and psychotherapy:
The interaction between psychotherapy and Buddhism has by no means always been fruitful. Freud was dismissive of any spiritual significance of the ‘oceanic feeling’ that a colleague had reported after meditating. He saw religion as a genetic response to early feelings of helplessness.

Freud’s perspective has since been shared by many in the psychoanalytic tradition. Alexander for example, in his 1961 paper entitled Buddhistic Training as an Artificial Catatonia, described Buddhist meditation as a “libidinal, narcissistic turning inward, a sort of artificial schizophrenia.”

Jung was more attentive to the possibilities of the mystic traditions of the East, and saw reasons for Western psychotherapy to take such traditions seriously:

“The psychotherapist who is seriously concerned with the question of the aim of this therapy cannot remain unmoved when he sees the end towards which the Eastern method of psychic ‘healing’ – i.e., ‘making whole’ – is striving. As we know, this question has occupied the most adventurous minds of the East for more than two thousand years, and in this respect, methods and philosophical doctrines have been developed which simply put all Western attempts along those lines into the shade.”

The use of mindfulness in psychotherapy has grown in recent years and is now in mainstream use in some parts of the Western psychotherapeutic world. For example, it is taught in mainstream hospitals in the UK to sufferers of chronic pain.

The dangers of divorcing mindfulness from Buddhism:
Mindfulness is a central practice in the Buddhist tradition. Its use in psychotherapy has tended to play down this association, however. This allows us to make use of the technique while avoiding clients’ (and therapists’) potentially negative associations with religion in general. It also allows us to avoid projections of mystic exoticism that can get in the way of engaging with the technique.

No belief in Buddhist ideas is required to practice mindfulness. Often, the breath is used as an object of attention for this deepening of awareness. The breath is always with us, and it can help us to understand what state we are in at any moment.

According to Buddhaghosa (who in 5th century CE wrote a guide on meditation that is still regarded as an authority on the topic), mindfulness of breathing (Anapanasati) is one of the few meditation techniques suitable for all character types. It therefore seems appropriate for the therapeutic community to make use of this technique.

Mindfulness, however, has traditionally been practiced with the wider Buddhist theoretical framework. While separating it out can be beneficial, it is helpful to understand that context in order to avoid certain pitfalls that can, at the very least, render mindfulness practice impotent, and at worst harm our clients.

Mindfulness practice essentially strengthens our minds. It increases our mental energy and focus. If that energy and focus is used to cultivate poorly chosen states of mind, we can run into problems. But how does this happen?

One common factor is using mindfulness as an avoidance technique. When
people are suffering (as they usually are when they arrive in therapy rooms or Buddhist groups) there is a strong tendency for them to want to avoid their painful experience. If taught and/or practiced without skill, mindfulness can facilitate this. This ‘spiritual bypassing’ (as Welwood terms it) is the exact opposite of the road to healing.

Another factor is misunderstanding one’s meditation experiences. Mindfulness practice can lead to strong experiences, as what was unconscious bleeds through into consciousness. Without such a framework, and without a properly qualified teacher to guide the student to a correct understanding of such ideas, meditation experiences can be terrifying, and can lead to people feeling like they are losing control of their minds, or entering a different reality. They can also lead people to feel liberated, even confusing relatively minor insights with full and perfect enlightenment.

Unfortunately, psychotherapeutic training alone does not equip us to tell the difference between a client’s meditation experience that, while strong, is normal and of genuine worth, and an experience that may be the early stages of a psychotic episode.

For therapists wishing to teach mindfulness techniques to clients, I will therefore briefly present some ideas that may be of benefit as a context for mindfulness practice.

The Buddhist context:
In the Buddhist tradition, meditation is part of a ‘threefold path.’

The first aspect of this path is ethics, the second meditation, and the third wisdom. A meditation practice that is uninformed by ethics and un-tempered by wisdom can lead the practitioner to do real damage (both to themselves and to others) without even realizing it. I have seen this happen many times in spiritual groups. And I regularly treat clients who have been on the receiving end of such people.

The threefold path is one of several traditional formulations used to describe the Buddhist path to awakening. Note that the image of the ‘path’ is common in Buddhism but it can be confusing. This is not a linear path—each aspect feeds into the next, and supports the others.

1. Ethics
Since there are many schools of thought concerning ethical living, I will briefly summarize the Buddhist position.

Buddhism does not see things in terms of good and evil, but in terms of ‘skillful’ and ‘unskillful.’ This highlights the training approach to ethics – ethical action is a skill to be developed and practiced. Mindfulness practice is used firstly to give the mind enough clarity to be able to observe which mental/emotional state is at play at any one time and secondly to strengthen our ability to maintain the skillful ones.

Although there is certainly weight given to physical acts, from a Buddhist perspective, ethics is seen mostly in terms of the intention behind an action. Actions motivated by love, generosity and clarity of mind are considered ethical. Actions motivated by hatred, greed or delusion are not.

Since we are habitual beings, it is possible to use ethics as a practice for deepening and broadening our positive mental and emotional states, and undermining negative ones. Meditation is used to support ethical practice, and vice versa.

2. Meditation
Technically, ‘samadhi’ (translated as ‘meditation’) is not the practice of meditation per se but a particular stage in meditation where certain ‘super-conscious’ states are developed and deepened. Since this will be of limited interest to therapists, however, I will use this section to outline the wider Buddhist meditation framework, within which mindfulness practice sits.

There are two broad categories of Buddhist meditation practice: Those designed to develop ‘tranquility’ (samatha); and those designed to develop ‘insight’ (vipassana). Mindfulness can fall into either of these, depending on the meditation object.

Another important Buddhist meditation practice that has so far received little attention in Western psychotherapeutic circles is the metta bhavana, or ‘cultivation of universal loving-kindness.’

The metta practice can act as a useful counterbalance to mindfulness practice. I use it a great deal in my work with clients, particularly where there are issues around low self-esteem, depression and existential alienation. Though there is not room to discuss the practice here, it would be fruitful for the psychotherapeutic community to explore the potentials of this practice.

3. Wisdom
For Buddhism, the wisdom that is learned from others is seen as the lowest level of wisdom. It is helpful to a point, but by no means the end of the path. Wisdom is not a matter of intellectual knowledge, but of seeing directly. This is what insight meditation is designed to bring about. But insight into what?

From a Buddhist perspective, impermanence – the fact that all things change, coupled with our inability to accept this fact – is seen as the cause of our suffering. Insight into this truth is viewed as what makes the end of suffering possible, since our perspective then shifts until it is in harmony with how things actually are, rather than how we want them to be.

These are often important themes in a therapeutic context. Insight is not always preceded by tranquility. Often it is preceded by life events. Clients arrive in therapy either because something has changed (a death, end of a marriage, etc.) or because they want it to.

As a tranquility practice, mindfulness can help clients identify the impact of insight in their own experience and then assimilate this into their lives. However, it can also magnify the reality of change, which can be terrifying if the therapist is not in a position to ‘hold the boundaries’ of that experience for the client.

If we, as therapists, can hold those boundaries; if we can help clients to interpret and integrate overwhelming
Wednesday Date Day at Cypress

By Dr. Jennifer Montgomery, Contributing Writer

Therapy comes in many forms. One of my favorites is skiing, especially my Wednesday Date Day at Cypress Mountain with my husband. It addresses all of the components of what we would recommend to our clients: Benefits for mental health, physical health, marital health and even spiritual health.

My husband and I have season passes for Cypress, which are very reasonably priced. We are both self employed with flexibility in our schedules, so we set aside every Wednesday during the ski season for our ski date.

What I love about skiing is getting out of the dreary weather that the Lower Mainland boasts. Up on the mountain it is generally brighter, dryer and sports spectacular views. Just being outside, which normally we don't get enough of in our winters, offers freshness to my spirit and clears my mind – not to mention the extra zap of Vitamin D!

Of course exercise is good for all of us. I try and recommend to others to choose a form of exercise that they actually enjoy, not one to endure. For me skiing is not only fun, but also a good workout. It also pushes me in the off season to train in the gym and ensure my body is ready to go for the next season.

I am a big proponent of marital health. It is not something that just happens, but something that all couples should be intentional about. Whether it is a healthy sex life, having fun together, or simply just time carved out to be together; marital health is extremely important as a foundation for all other areas of our lives.

During ski season, nothing else interferes in our Wednesday Date Day. Even if the snow conditions at Cypress aren’t the best, we still go. It is a nice drive up there from White Rock (after rush hour), do some skiing, and end our date with lunch in the bar. We also plan our return home just ahead of the afternoon rush hour in order to end our day well. This quality time set aside weekly is something we both look forward to.

Spirituality, whatever that means to you, certainly seems to occur in nature’s most beautiful settings. I certainly see the mountains as one of those beautiful settings. The trees, the snow, and fresh air combined with spectacular views of the city and the ocean capture all that is good; good for the soul.

Last but not least, we have convinced a good number of our close friends to also purchase a season pass. Now and again our schedules work out that we can ski together. This is definitely another bonus and adds to everyone’s mental health!!

Dr. Jennifer Montgomery practices in White Rock and can be reached at 604.244.6969
www.doctorjen.org
Despite her above-average intelligence, a lack of friends, difficulty with transitions, odd eating behaviours, using negative language when referring to herself and overall poor self-image, I knew that I was seeing a child with attachment issues (Perry, 2001).

This was affirmed by her parents’ statements that Jessica was always pushing them away, either with her negative behaviour or with her language. Jessica’s parents felt that they always had to be engaged with her, because as far as Jessica was concerned they could never spend enough time with her.

After nine months of weekly appointments, a few, small, positive changes in Jessica’s behaviours outside of the playroom were reported. She had begun to have some positive interactions with the children at the daycare she attended and was using her words more to express herself instead of getting angry and physical. She was interested in partaking in activities that she had resisted before.

Does technology have a place in a play therapy session? With a little innovation and thinking outside of the box, technology can be used to reach resistant clients.

Resistance occurs when further exploration into play themes or material becomes too threatening or intense, which can be frightening for children. I use a non-directive, child-centred expressive play therapy approach guided by the principles of Adlerian psychology and fully believe in the body’s innate wisdom to move toward healing, but what does one do when the client gets stuck in such a way?

When a client of mine reached this plateau, I discovered that technology could provide an avenue for her move on and continue her healing.

Jessica* is an eight-year-old girl who had been adopted from Romania at one year of age. She had experienced several interruptions in her bonding experience during this first year and was showing me, through her play, the chaos of her early life. From the behaviours she displayed (tantrums, the need for control, the inability to accept any praise or encouragement, poor performance at school in spite of her above-average intelligence, a lack of friends, difficulty with transitions, odd eating behaviours, using negative language when referring to herself and overall poor self-image), I knew that I was seeing a child with attachment issues (Perry, 2001).

This was affirmed by her parents’ statements that Jessica was always pushing them away, either with her negative behaviour or with her language. Jessica’s parents felt that they always had to be engaged with her, because as far as Jessica was concerned they could never spend enough time with her.

After nine months of weekly appointments, a few, small, positive changes in Jessica’s behaviours outside of the playroom were reported. She had begun to have some positive interactions with the children at the daycare she attended and was using her words more to express herself instead of getting angry and physical. She was interested in partaking in activities that she had resisted before.

In the playroom, Jessica always wanted to engage me in parallel play. She directed what I did as she self-directed her own play. On occasion she would ask that we trade places. Parallel play indicated there was wounding from
her pre-adoption experience (Perry, 2012). This, as well as other reported and observed behaviours, placed Jessica at a young age, far below her chronological age of eight (Perry, 2009). According to Dr. Perry’s (2009) neurodevelopment theory, the brain has four distinct regions: the brainstem, diencephalon, limbic system and cortex.

The brain develops sequentially from the bottom up and the normal development of the brain is dependent on the normal development of the previous part of the brain. Each of the brain’s four regions has a function and each has its own timetable for development. This is significant as we can use a child’s behaviour to help us identify their developmental age.

This theory and the work of Daniel Hughes (2006) informed my next step: Jessica needed to have experiences that allowed her to develop in the areas where development had been disrupted. She also needed to be able to begin to make sense of her pre-adoption experiences.

The goal, in collaboration with her parents, was to begin to put the negative pre-adoption experiences in a new framework and separate these from her experiences with her loving adoptive family. This, along with continued, consistent and nurturing experiences with her adoptive family, would encourage development.

I knew that I could not use Hughes’s (2006) didactic model for therapy, as Jessica wanted her parents nowhere near the playroom during our sessions. Additionally, any direct talk of her pre-adoption experiences would not be possible with Jessica. Therefore, my challenge was to find a way to do this work in an indirect and unobtrusive way.

Jessica and her parents were aware that I had adopted two children internationally. I strongly felt that this shared experience was invaluable in relating to and understanding Jessica’s behaviours, as well as in empathizing with and relating to her parents. I wanted to be able to draw on this common experience with Jessica but she was not open to engaging in any conversation about her pre-adoption experiences. The question became, “How do I do this?” all the while remaining aware of transference and counter-transference issues.

I decided to integrate technology and play therapy. The last 15 minutes of each play session was dedicated to closing activities, which included a story. I thought that I would write a story paralleling my eldest daughter’s adoption story to share with Jessica at this time. I chose my eldest for my story as her adoption experience and its effects were very close to Jessica’s.

I divided the story into six “chapters” and put it together in a Power Point slideshow to be projected onto the wall. I called this a Stor-e-Book. At story time I asked Jessica if she would like to watch a slide show and listen. She jumped in to fill in the details of the story that she already knew: those parts of the story that were common in both Stor-e-Books.

The strength of using technology with Jessica was that it was a way to make the very personal more impersonal, and for her to be detached and safe from the content but engaged in the process. I was in control of the content and how much of the story she got each time.

Jessica was in control of watching the slides, how long she wanted to view each slide and when to finish the Stor-e-Book if she wanted to (which she never did). I used illustrations that were very generic, as I still wanted to maintain a certain distance. It was important that each chapter ended in a place that allowed for closure.

She always looked forward to viewing the Stor-e-Book and would ask at the beginning of each session if she would be seeing my daughter’s Stor-e-Book today. She was given a choice as to when in the session she wanted to watch the Stor-e-Book.

In my daughter’s adoption Stor-e-Book, I was able to demonstrate how memories formed while my daughter was in the pre-verbal stage were responsible for her mistaken beliefs. These implicit memories can be evoked by smell, sight, sound or body sensations. When they are recalled, the reaction can be highly visceral and initiate the “fight or flight” response. (Levine, 1997, Eldene, 2011.).

For this reason I referred to this in my daughter’s Stor-e-Book as “body memory.” I spoke of how my daughter’s body memory changed over the course of the years, and how even now, as an adult, her old body memory still comes sneaking back at times. The Stor-e-Book showed the messages that the body memory gave my daughter and how skewed they were from fact.

From Jessica’s reaction and interest in the adoption Stor-e-Book, I sensed that hearing more stories about others’ adoption experiences was important to her. I still knew that she would not accept these stories in book form. So, I scanned and made a power point slide show of the book called The Red Blanket (Thomas, 2004), which she watched the next week.

At the end of this story Jessica asked, “You have another daughter, don’t you?” I replied that I did and I asked if she would like me to write my second daughter’s Stor-e-Book for her. She said that she would.

I related this second story to her in much the same way: using language that was now familiar to her and repeating themes that she had seen in the first Stor-e-Book. She jumped in to fill in the details of the story that she already knew: those parts of the story that were common in both Stor-e-Books.

She was noticing the shared experiences of my two children: two different children, two different experiences yet with common themes. Furthermore she could see the similarities in a published story that had been written by another adoptive parent. “How would I love to see her notice these same commonalities with her own story!” was my thought at this time.
## Exploring the Grief Process in Addiction

By Mary E. Duddy, BScN., MA, RCC, Contributing Writer

In this article I will explore the grieving process as it applies to addiction and seek to address the question: Do we grieve from addiction? And if so, how?

I struggled with the noun that I would use for the person who is addicted to substances. Addict seemed very harsh, habitué sounded softer, but it is not well known. The article is about addiction therefore I decided to presume that readers would know that I was talking about persons who were addicts and not use the word unless it was relevant to what I stating.

Addiction can be a complicated grieving process. The person grieves for the things that the addiction took and then they must grieve the loss of the substance when they are in recovery.

In preparing this paper I spoke with several people who referred to themselves as addicts in order to get an idea of how they see addiction in relation to grieving. I asked what they felt they had lost when they realized they were addicts and began the journey of healing.

Some of the answers that came back to me were things like lifestyle, escape, responsibility, numbness, safety, control, awareness, choice. Some also felt they had been looking for a culture because they did not think they had one. They believed that a culture would give some grounding. Some felt that they were unfilling their expected role in the family and when they moved through their addiction they lost that role, only to discover another one.

Addiction is defined in Stedman’s Concise Medical Dictionary as “Habitual psychological and physiological dependence on a substance or practice that is beyond voluntary control” (Dirckx, 1997, p.13).

Humans maintain survival by attending to their environment. We are aware of input that is “novel and alien in the environment” (Fagan & Shepherd, 1970, p.41). This is awareness.

In human beings, awareness develops where novelty and complexity of transaction are greatest, and the most possibilities (for good or ill) exist. Awareness seems to facilitate maximum efficiency by concentrating all the organism’s abilities on the most complex, possibility-loaded situations (p.41).

In other words there is a complex transaction that occurs between the environment and the individual that allows for optimum functioning. If awareness does not develop during an interaction, then something will go wrong or will malfunction. If an individual is not using “awareness” (p.41), then addiction can occur.

“Voluntary control,” (Dirckx, 1997) is a measure of “awareness” (Fagan & Shepherd, 1970).

Erikson (1950) says that with the advent of adolescence “all sameness and continuities relied on earlier are more or less questioned again” (p. 261). This questioning puts the individual into a situation where an important transaction may occur. The novel and complex possibilities are presented to the adolescent individual and they can be “good or evil” (Fagan & Shepherd, p.41, 1970). The individual picks the transaction of using addictive substances because this appears to have the most possibilities. The individual is aware they are choosing to use an addictive substance.

Once an individual becomes dependent, the ability to choose becomes compromised. The individual has blocked awareness and lost touch with their environment. Situations are presented and the individual picks what he considers the one with the most possibilities.

At this time there is voluntary control, however this will change as dependence occurs.

Once the individual has lost awareness then they have lost the capacity to focus on that which is important for survival. The person loses the ability to focus on life maintenance and will not be able to see what is missing from and needed in their life. An example of this would be the ability to make choices for survival (Fagan & Shepherd, 1970).

Kübler-Ross (2005) sees denial as helping the individual move through the stress of grieving a loss. This is not about denying the addiction. This is a symbolic denial (p.8). As they move through recovery it is important for them to be protected by numbness to the knowledge that they are an addict. During this time they will ask questions and tell their story helping to deny the pain of their addiction. In time, the numbness fades.

Awareness during/with denial will happen when the individual pays attention to their circumstances and sees them as being dysfunctional. The individual sees their responsibility for this loss of choice. They must learn to live with the loss of the substance, while never forgetting that they are an addict (p.10).

Resentment and anger are related in that they feed on each other.
An introduction to SA VI® — the System for Analyzing Verbal Interaction. SA VI®, pronounced “savvy,” is a system for analyzing talk; the verbal interactions between people.

SA VI® emerged in the 1960’s, in an exciting university climate. The field of group dynamics was still young, the focus on education was growing, and theorists like Kurt Lewin and Ludwig von Bertalanffy had put out important new ways of thinking: Field theory and general systems theory.

Two graduate students at Temple University, Yvonne Agazarian and Anita Simon, were part of this world of ideas, and sparked around their shared interests. Both wanted to able to describe, in specific observable ways, how any particular ‘system’ is working, so that this description could be linked to outcome measures. They wanted to be able to link how people behaved to notions like productivity, satisfaction of members, efficiency, cohesion, etc.

The output of this collaboration was SA VI®. SA VI® began life as a research tool based in information theory. It was a way of tracking the potential of groups to process information and to solve problems. Its authors thought that if such a system was based in theory, rather than judgments about ‘good’ or ‘bad’ behavior, it could be very helpful in researching the actual effects of different communication behaviors or patterns and in relating these effects to the goal of the setting.

What the authors did not anticipate was how useful this observation tool would be for clinicians and their clients in recognizing and changing painful, frustrating and unproductive patterns in everyday life.

We, the authors of this article, both stumbled across SA VI® several years ago, and have been intrigued with it ever since. Claudia was a graduate student in 1975, and became so curious about SA VI® that she apprenticed herself to its authors as a ‘go-fer’ in research, and has never looked back. She uses SA VI® in her clinical and consultation practice and is a senior SA VI® trainer.

Ian says SA VI® has become an effective tool in his personal relationships as well as in his counseling and coaching practice. He finds it is easier to notice the patterns of language that actually impede the flow of helpful, connected communication when he uses SA VI®. Clients like SA VI® too, as it makes it is easy for them to identify patterns in themselves and to know what to ask, or say, differently to gain the results they want.

Ian recalls a conversation with a friend: “We got into an opinion debate around the effectiveness of various counseling methods. It was going nowhere until I asked for examples, his experience, and information on the research that had shaped his opinion. He quickly moved to giving me factual information I lost the desire to “debate and prove” and became curious. We connected around the topic very differently and we both learned something helpful.”

A Bit about SA VI®
SA VI® categorizes the way we talk, distinguishing, for example, Opinions from Questions from Sarcasm from

Red row behaviours introduce noise (for example, Attacks, Complaints, Gossip, Discounts)

Yellow row behaviours are neutral (e.g., Facts, fact Questions, Proposals)

Green row behaviours give evidence that the speaker heard what others said (e.g., Paraphrasing, Answering Questions, Building)
When communication is organized this way, SAVI® allows us to make informed judgments about the effects we can expect different kinds of communications to have. It also provides practical guidelines for intervening in unproductive conversations.

As counsellors, talk is our major tool and it is useful to have an objective way of understanding it. Here are two examples. These people are talking about different things, but have the same communication problem - the same SAVI® pattern! See if you can spot it.

A. Let’s get down to business here on our budget. Income this side, expenses the other.
B. Ok, but don’t you think we need to look at goals first? That’s what the budget is for after all.
A. Sure, goals matter, but if we don’t know what we have coming in and going out now, we won’t know where we are starting...
B. I know our income and outgoing matters, but if we start there...

Here’s another one...
A. You did say you would do the dishes.
B. I know, but I just don’t have time to do it now.
A. Ok, but when will you? I don’t want to stand around looking dirty dishes.
B. I know you want me to, but I have other priorities right now. I’ll get to it.
A. Of course, but...

Sound familiar? If you ask these people what the problem is, they might say the other person is stubborn, or that the problem is the budget, or that “she never listens to me.” An observer might say competing agendas are the problem, or that no one is listening.

So what does SAVI® say? SAVI® sees the difficulty as coming not from motivation or agenda or personality (though our ideas about that may be correct), but from the “noise” the speakers are inadvertently putting into the challenge to communicate with each other.

The particular kind of noise deadlocking these conversations is called “Yes-But,” a Red row behaviour. Yes-But statements carry a token agreement, the “yes” followed by a difference, the “but.” As listeners we naturally orient to the “but” so the differences stand out to us most and any possible similarities are lost. Stress goes up, frustration rises and trouble is on the horizon.

Content can be conveyed using many different kinds of behaviour — the same information can be expressed in the form of a question, a proposal, a joke, a put-down, and so forth. What the listener hears, and how effectively the information will be used, depends on the behaviour used. We all know this intuitively; SAVI® organizes what we know so that we can track and teach it. Using SAVI®, we can understand why the message received by a listener is quite different from the message that the speaker meant to send, and see what to do to get the conversation back on track.

SAVI® provides a way of thinking about and describing communication that enables us to:
• Understand and explain what’s happening in any given conversation;
• Predict what is likely to happen next;
• Try to change the course of those events, if you wish;

The SAVI® Paradigm
Thus the SAVI® approach to the challenge of understanding communication is different from the way many of us are used to thinking about what we say and what others say to us. Some of its characteristics are:
• A focus on behavior. SAVI® is not concerned with a person’s level of maturity, intentions, psychological diagnosis, character or personality. It focuses squarely on behaviours and their contribution to the communication process; information that is available to any observer.
• Attention to both words and tone. SAVI® examines not only what was said but how it was said. Voice tone (the “music” of the communication) is as important as the words we speak, and SAVI® always takes this factor into account.

• A nonjudgmental approach. In SAVI® terms, there are no good behaviours or bad behaviours. If you’re thinking SAVI®, you’re in the position of a researcher or detective – you are collecting data about the effects of what was just said, without judging or personalizing it.

• A pragmatic analysis. SAVI® categorizes communication behaviours in very practical terms, examining whether they tend to facilitate or hinder information transfer. The behaviour you use profoundly influences what your listener hears, how likely they are to take in that information, and what feelings they’re likely to have about what you’re saying. In studying SAVI®, you learn why (and when) certain behaviours work better than others for getting your message across.

Learning the model increases your awareness of communication behavior as it is happening, provides new strategies to move communication toward the desired goal and allows for simple, structured practice.

The SAVI® model has assisted therapists, coaches, organizational consultants and clients to achieve more satisfying and productive conversations. It is easy to share with clients and can be used right away, reinforcing confidence and promoting hope that disagreements can be navigated and more effective relationships can occur, whatever the goal of the conversation.

The website www.SAVIcommunications.com outlines the basics of the model and, in our opinion as practitioners, is worth exploring.

SAVI® is a registered trademark of Yvonne Agazarian and Anita Simon

Biographies
Claudia Byram, Ph.D., has brought SAVI® both in his psychotherapy practice and in his work with Family Businesses. He has extensive experience as a Family Systems Consultant and Coach and has been both a clinical supervisor and an instructor.
Finally, it’s time for boys to be nurtured in ways that work for them. For at least fifteen years, perhaps more, girls in Canada have been able to band together in communities to talk about body image, body changes and troubles with friends. It seems natural that girls meet this way and share their realities with their peers, led by an emotionally healthy female. But is it natural and necessary for boys to engage in this same kind of process to increase their social and emotional skills? The research on boys says a resounding: “Yes!”

There is growing evidence indicating that all over North America, boys are socially and emotionally disengaged. They are rapidly falling behind girls and under-achieving in the regular areas of success – academics, motivation and self-efficacy. In order to turn this around, boys not only need educational settings suitable for their learning styles, but also opportunities to explore environments that model healthy emotional relating.

Research shows that boys begin to disconnect from their emotions at the age of three or four when they are told by adults, often their parents, to “be a big boy,” that “big boys don’t cry,” and by all means, “don’t be a sissy,” etc. This results in boys learning to disassociate from their feelings and shut down to their true nature. This male code of stoicism that creates boys’ wounds also forbids them to acknowledge or deal with them.

While girls tend to do this at twelve to thirteen years and turn it in on themselves with depression and self-hurting behaviors, boys, who disengage further at adolescence, turn it outward and hurt others with anger and acting out behaviors.

Boys need to be motivated to learn how to channel their energy and risk-taking behaviors in ways that are disciplined, have integrity and are morally appropriate. Boys need access to safe places, emotionally challenging experiences and caring adults on a daily basis.

Boys often find their need for nurturing to be at odds with the cultural expectations for males to be tough, grown up, and independent. Popular culture encourages boys to be independent, but in practice too much independence often encourages counter-dependence, where a boy denies his natural need to lean on others from time to time.

In the male-cultural myth, dependency on others is often equated with being vulnerable which itself is confused with being weak.

Boys need to learn that the opposite is actually true: When one is being emotionally vulnerable it is really a sign of strength rather than a weakness. However, in Western culture, boys are encouraged to deny their feelings of vulnerability, such as tenderness, fear, anxiety, uncertainty, sadness, and grief. Boys feel they have only one acceptable “male” feeling they can openly express - one they perceive actually enhances their masculinity, anger.

Boys who are sensitive are often teased by tougher or more self-confident boys and then react against other boys who are considered weak or immature. They punish the sensitive or more dependent boys with the very punishment they themselves dread: Shame.

In reviewing male media images the main identity story involves “partying, pimping, playing people and slacking.” It’s a story in which those with the most power too often have the wrong kind of power: They are bullies, narcissistic athletes, “dogs” or “players.” Too often power is defined as control in these media images. These images saturate boys from an early age in a variety of forms including cartoons, World Wrestling, My Space, and video games. These images encourage boys to ignore their feelings and needs, and offer a dangerously false sense of power.

The slacker image takes the pressure off boys who feel they don’t measure up to be the super hero. It helps them make fun of the pumped up hyper-masculine jocks. They learn to be funny and endearing. In this way they can defy ambition and authority figures that demand more than some boys can give.

In addition, for years now, a significantly large number of boys are being diagnosed and medicated to control their behaviour. Psychologist Leonard Sax in his book Boys Adrift, states that many cases of inappropriately diagnosed ADHD are actually Nature Deficit Disorder. He suggests that boys spend too much time indoors, playing video games, instead of interfacing with nature.

In fact, research indicates that putting boys in nature in all kinds of weather, where they can get their hands dirty and feel and smell real “stuff” (trees, sap, dirt, plants, etc) is helpful in treating ADHD, obesity, and depression.

Boys who have been deprived of time outdoors often have trouble grasping simple concepts – such as how to hook up a garden hose, dig a hole, or hammer a nail, etc. There’s a whole generation of youth who have not spent time in the backyard, woods, or in tool shed. Instead these precious
learning and connecting opportunities have been replaced by indirect learning through computers.

Researchers suggest that all boys fit somewhere on the spectrum of distractibility, impulsivity, and hyperactivity. They are more physically restless and impulsive, making boys “look” ADHD. In addition, there are many assertions that boys are struggling academically due to the feminization of school settings: Female teachers; expectations of sitting and stillness; and academic processes that favour female development but fail boys. Cognitive skills such as reading, writing and verbal ability develop more slowly in boys.

Research indicates that in order for boys to be successful, they need to develop and increase their emotional IQ. It appears that boys, beginning at a young age, are systematically steered away from emotional understanding and toward silence and solitude.

Increasing boys’ emotional literacy isn’t an attempt to turn boys into girls; both genders will benefit from boys exploring their emotional lives. A boy’s world is full of contradictions and often caregivers are at a loss regarding how to best help sort them through. A boy longs for connection at the same time as he feels the need to pull away. This struggle steers boys away from their inner world and creates the emotional miseducation of boys. Boys are left to manage conflict, adversity, and change in their lives with limited emotional tools.

Boys groups can be a powerful tool to combat these concerns. They build emotional literacy by:
• Identifying and naming emotions;
• Recognizing the emotional content in speech, facial expressions, and body language;
• Understanding the situations or reactions that produce emotional states, such as the link between loss and sadness, threats to pride or self-esteem, and fear.

In boys groups, assisting boys in identifying their feelings, developing a safe place to begin to learn how to share those feelings, and learning assertive ways to communicate their needs is fostered. Also helping boys mediate power relations with their peers, girls, and adults is vital to healthy emotional growth. Boys groups increase confidence and help boys learn to express themselves. The groups can provide boys with a safe place and with exposure to a healthy lifestyle for those who have had little guidance growing up.

Reaching boys in group settings is, ideally, a preventative strategy. It is important to reach pre-adolescent boys prior to symptomology; before resistance and disengagement occur. However, boys groups can also be useful for youth who are already experiencing behavioral problems that put them at risk. Teaching boys skills such as dealing with conflict and confrontation, anger management, respect, goal setting, increased decision-making habits, how to identify their feelings, and the use of some self-soothing techniques can lessen the possibility of further disconnection and acting out.

Boys’ well-being groups enhance skills and confidence in themselves and their futures, their character, and their connections to others where they feel supported and empowered. Check to see if this model of supporting boy’s development has reached your community or a city near you. In addition, there are training models available if you are interested in being on the ground floor of supporting boys’ well being.

Sherry Bezanson, BSW, M. Ed, RCC
sbezanson@uniserve.com
After completing this second Stor-e-Book, I ventured to ask her if she would like me to write a Stor-e-Book about her. She said, “Yes!!” I had already attained permission from her parents to do this and now got permission from Jessica to get pictures and details from her parents. I wanted to make the Stor-e-Book as accurate as possible.

The following week, I arrived at the office with the first chapter of Jessica’s Stor-e-Book. She was very excited when we read it and was thrilled when she saw pictures of herself and her parents in the Stor-e-Book.

When I read to her about how her body memory started to give her inaccurate messages very early in her life, she commented to me, “My body memory is very old.” This was the first time since reading all the Stor-e-Books that she related herself to any part of the story or that she ever directly disclosed anything about herself.

The play in her sessions was starting to show different themes, themes of nurturance, tenderness, safety and adoption.

At home, Jessica’s parents were noticing that she was starting to relax, take some risks and was even beginning to allow them into her very guarded, private world, albeit only very briefly. Was she testing out a new reality?

In the following session Jessica was very anxious to get to her Stor-e-Book, asking to shorten the playtime so that she could view it. Jessica listened and was very focused. While we were reading the part where she first met her adoptive parents, I read things like, “The mommy looked at Jessica with such love in her eyes,” or “You could tell by the smiles on mommy, daddy and Jessica’s faces that this was a happy family.” She paused at these slides and studied the expressions on everyone’s faces. Was she starting to believe that she was truly loved? Was she beginning to trust?

According to Perry and Hambrick (2008), repetitive experiences are needed for traumatized children to be able to trust and bond. These include “positive, nurturing interactions with trustworthy peers, teachers and caregivers … Other examples are dance, music, or massage.

I believe that Jessica is receiving this nurturing interaction indirectly through the Stor-e-Books. In them, she repeatedly hears that loving parents rock, sing, read, and play with their children. Meanwhile, at home, Jessica’s parents continue doing all of these things with her.

Her parents are aware that new neuropathways need to be formed and that repeated, consistent, nurturing experiences are necessary for this (Perry & Hambrick, 2008). Her early, inaccurate body memory needs to be reshaped in order for Jessica to acknowledge and take in positive experiences, and to be able to trust that her adoptive parents will not abandon her.

At the time of writing this article, I have only read two of the seven chapters of Jessica’s Stor-e-Book to her. My intent is to burn a DVD with the Stor-e-Book on it for her to take home to watch with her parents. It is my hope that this DVD will be viewed often by Jessica and her parents and will inspire many other healing interactions.

This section of this article is Reprinted from Play Therapy magazine with expressed permission of the Association for Play Therapy © 2012.

Update:

Since the publication of my initial work with Jessica there have been a few interesting developments that offer increased support for this approach in our therapeutic support of children.

Jessica continued to be very interested in listening to her Stor-e-Book at the end of each play session. Her play began to have consistent themes around nurturing and interaction, for example: Mommy and baby animals interacting and having loving dialogues together. Something was shifting.

Meanwhile, Jessica’s parents were anticipating some predictable, anxious behaviours. Jessica was about to start a new school year and historically she had difficulties with transitions. As the first week of the new school year came and passed, her parents were happy to report that the year began without incident.

A couple of weeks later Jessica’s parents went to their first parent-teacher interview and the teacher told Jessica’s parents that she had yet to see the child that they were describing to her. Jessica was actively participating in class, getting her work done and was cooperative. Meanwhile at home Jessica was getting her homework done without her parents having to remind her, cleaning her room regularly, cleaning out her hamster cage and was parting with old toys that she no longer needed.

There was one more chapter of Jessica’s Stor-e-Book to read but Jessica and her parents went on a two-week family holiday. The timing of this holiday could not have been better planned as now Jessica could experience firsthand the love, attention and nurturance from her parents that had been described in the first six chapters of her Stor-e-Book.

The family had a great holiday with very little incident. Once back home, Jessica continued to be more cooperative.
and easy going. She was not arguing with her parents and was able to accept the boundaries that they were setting. As we know, the healing journey does not necessarily follow a linear path and in the last three weeks Jessica has been showing many of her old behaviours. However, Jessica and her parents both experienced a harmonious time where bonds were strengthened; they had opportunity to experience their relationship differently.

According to Hughes (2006) the stress of integrating new experiences of self and relationships with others is great and cannot be constantly maintained. Jessica’s parents will continue to experience the roller coaster of emotions and behaviours.

My experience has shown, that as time goes on, the ride smoothens out, the ups and downs are less intense and the duration of the ups increase as the downs decrease. The journey for Jessica and her parents continues.

Exploring the Grief Process in Addiction

Continued from page 24

The individual blames circumstances for their addiction. Without awareness they are unable to see that the problem is theirs alone and that they have the ability to interrupt the addictive behaviour. The inability to perceive how they can interrupt this behaviour will result in blaming others.

Awareness allows them to perceive their anger; to realize that it exists (Fagan & Shepherd, 1970). Not all addicts see resentment as part of their grieving (interview CB). As with any other grieving, there are individual differences.

This person knows that there are choices to make; one clearly being the choice to relapse. The relapse is a retreat, to go back and then climb out of the dark to a shining place of recovery (interview with DS). This is what we call ‘bargaining.’ They go back to the substance to have the novel and complex transaction that was experienced before. The act of coming out of the dark is exercising choice.

Bargaining helps them move from feelings of helplessness to control as they decide to move into relapse and then out of it. They wonder if they will ever be the same and will they abuse again. There is awareness when they choose to relapse; the individual chooses relapse and recovery as being the greatest option (Fagan & Shepherd, 1970, p.41).

How do we look at depression separately in the grieving process of addiction? This is sadness experienced over a loss. Kübler-Ross (2005) asks the question “is the situation ...actually depressing?” (p. 21). Yes it is. Depression during the recovery of an addict is part of the healing. The individual is adapting to life without substances. They are replacing an old role for a new one that they have chosen. There is an awareness that life is different now and it is up to them to keep it happening. To an addict in recovery, the decision may be frightening and overwhelming.

Depression is nature’s way of protecting them from emotions that they cannot handle. It is a withdrawal until they can be concerned about events again. Awareness is happening when the individual reaches depression because they are aware that there is something missing, something sad in the environment/organism dyad.

Awareness is evident at the end of this process. The person keeps landing on their feet, but their legs are getting tired and sometimes they land on their butt (interview with DS). The individual is paying attention to what has happened to them, where they have come from and what they lost. Awareness is the acknowledgement that there is an addiction and they are an addict. Now they can concentrate on the possibilities of recovery. Acknowledgement is the stage where the addict is aware that they have moved through the stages of grieving and sees them as the stages of their recovery (interview CB).

Kübler-Ross (2005) says that “there is not a typical response to loss as there is no typical loss” (p.7). Additionally, addiction is not a typical loss and because all addicts are as “individual as their lives” their responses will naturally differ (p.7). Using the framework of grieving, an addict can move more easily through their healing process and the world at large, becoming aware of what they are feeling and learning to identify and meet their needs. This will enable them to begin to deal with their life and most importantly, trust themselves to navigate its ups and downs on their own (Fagan & Shepherd, 1970).

Biography

Johanna Simmons is a Registered Clinical Counsellor and a certified parenting educator, practicing in West Vancouver, British Columbia who specializes in child and family therapy. She has worked with children in different settings: as a classroom teacher, a special education teacher and now as a play therapist. Visit simmonscounselling.ca or email johanna@simmonscounselling.ca for more information about her practice.

Biography

Mary E. Duddy has a private practice in Victoria BC specializing in Family and Mental Health issues and more recently Grief counselling. Her web site is www.mduddycounselling.ca and her email is mduddy@islandnet.com.
In treating such a family, the primary goal is to move the focus away from the children and onto the parent, to help the parent develop some self-reflection and some understanding of self-process.

One way this is done is by asking questions which require a self-reflective response. Due to the limited time that we have available, it is not always possible to achieve this as fully as would be desirable. However, self-reflection is only an intermediate step in the journey toward maturity, and one of the important aspects of taking a systemic view of intensive family work is to think of our intervention as only a small step in the family’s journey toward wholeness and maturity.

Our role, then, in the four-to-eight weeks we typically have with each family, is to provide some conceptual and behavioral tools to enable the development of the process of Differentiation in the most available member of the client family.

We see evidence that a further step in Differentiation has been achieved when a person begins to reflect on the emotional process in their family of origin and to make some connections with the present process.

This is just a brief overview of the concepts of Differentiation and Triangulation and the use of Bowen Family Systems Therapy to approach your work with families in difficult places. In my experience, the therapist’s ability to perceive the individual as a member of a larger family system and to approach their treatment with that broader perspective will help to pinpoint patterns and treatment approaches that can lead to healthy boundaries in individual family members and their way of relating to each other, and ultimately heal the family pattern.

Biography
Alex Angioli, MA Counselling Psychology, RCC, is in private practice in Chilliwack, BC, where he continues to do Family Therapy. www.fraservalleycounselling.com. He is a candidate for the D.Litt et Phil degree in Psychology. Reach Alex at 778-552-5293.

Another common misconception is that a separating couple must have children to engage in this model, when in fact, Collaborative Divorce can be a good fit for many different populations.

One important factor to screen for in any initial consultation is domestic violence. If violence or abuse exists then working in a Collaborative Forum could potentially put the couple at risk.

Potential Challenges for Therapists:

Divorce and Separation work comes with its challenges. Therapists end up being at the centre of very high conflict circumstances and have to navigate it in a way that models calm, grounded, conflict resolution.

Therapists work as a team (often consisting of two Coaches, one Child Specialist and two lawyers), which means that all members have to be goal setting with one another. If even one member of the team has a different perspective or goal the process can become that much more difficult.

The Child Specialist role can be tricky, in that children often look to their therapist as the conduit of change in their family.

Many children come into the process under duress and gain hope in the idea of somebody taking a stand on their behalf. While this can often be a very positive experience, it is also contingent on the parents’ willingness to hear what the child has to say and to make changes. This is where a solid Divorce Coaching team can work with the parents to incorporate the child’s needs in helpful and healthy ways.

Biographies
Lindsey MacInnes, MA, RCC, is the clinical director at Concordia Counselling services and provides counselling to individuals, couples and families. She is a Collaborative Divorce Coach and Child Specialist and a Charter Member of the BC Roster of Collaborative Professionals. Lindsey serves clients from her Vancouver and Coquitlam offices and can be reached at lindsey@concordiacounselling.ca

Abby Petterson, MA, RCC, CCC, the clinical director at AJ Petterson & Associates, provides counselling and psychotherapy to individuals, couples and families specializing in the areas of eating disorder treatment and separation and divorce. Abby is a trained Collaborative Divorce Coach and Child Specialist and is a Charter Member of the BC Roster of Collaborative Professionals. Abby serves clients in and around the Vancouver area from 2 office locations in Vancouver and West Vancouver. She can be reached at abby@pettersonandassociates.com.
Pre- and Perinatal Psychology and Health

Continued from page 9

These families also have more intense bonding and greater coherence. To create this outcome, parents can talk, read, play games through touch and sing to their unborn.

• Stress plays an important role in human development. If it is truly overwhelming or toxic stress, like that experienced during war, domestic violence, a huge workload at the office, or adverse circumstances the mother feels she has no control over, stress can program the baby’s nervous system so he or she is hard to settle, negatively affecting sleep, communication, eating and even motor and cognitive development. However, occasional moderate stress can support humans to be more resilient. Not all stress is bad! But women need to determine how much is too much for them and get the support they need. Therapies such as massage and other forms of bodywork, meditation and relaxation techniques are important resources here, as are exercise, walks in nature and anything that helps a mom feel better and more in charge of her environment.

• Parents (mothers in particular), can look at their own history and determine how they were parented. Research has shown that that we parent our own children in the same manner in which we were raised with up to 85% accuracy. The best way to prepare is to make sense of your history and address problems in the presence of a qualified counsellor. It is not what happened to us as children, but how we have come to terms with it that will influence our subsequent parenting skills and approach.

• Pregnant moms and their mates can seek out good prenatal care and select minimal intervention during birth. In addition, birth and postpartum doulas, or women who can help with the birth and the newborn, can really help the new family off to the best possible start. Research has shown that the presence of a doula can decrease the need for interventions and even increase the satisfaction of a couple’s relationship.

• If there has been a difficult birth or separation between mom and baby, then parents can use skin-to-skin practices and therapies to help repair and support bonding. This is effective even if the baby was adopted. Breastfeeding is also a best practice for optimal human development, but if that is not well established, parents can still support their children with lots of holding, skin-to-skin contact and other best health practices and play.

• Research now shows that the first 18 months of life in a human lays down the significant nerve pathways. The brain develops rapidly until age three when neurons not being used or stimulated will be pruned. Since a baby’s nervous system goes 10 times slower than an adults, parents and caregivers can slow down and provide appropriate enriching experiences through touch, music, rhythm and communication. Parents can talk with their babies. The connecting, attuned experience is vital for all aspects of the baby’s development!

• Moms and caregivers need to be encouraged to make themselves a priority. Babies will entrain with what a mom is feeling. If she is exhausted, anxious, depressed, lonely, or nutritionally drained her baby will feel it. There is truth to the saying “if mama’s not happy, no one’s happy.” If mom needs to go back to work, families can select educated and resilient care providers and help for the family to make the transition.

One of our greatest spiritual challenges is living in the real world, and at every turn on the life road, parents can feel blamed. Every parent wants the best for their child. Moms and Dads need to be encouraged, with the support of this current research to take time for themselves and their baby and to make use of the resources available to them in their extended family and community.

Parents need to connect with other families, find a balance between function and overwhelm and reach out for help if they need it.

We need a cultural shift around moms and babies, but until then, we can chart our course with these pre- and perinatal points in mind to support our clients and their families.

Myrna Martin, MN, RCC, RCST® can be reached at myrna@myrnamartin.net. www.myrnamartin.net

Making Mindfulness Work...

Continued from page 20

experiences, and help them to integrate new insights into their lives in a grounded and ethical way, we can be confident in using mindfulness techniques in our treatment.

Biography

Amita O’Toole is a Buddhist integrative psychotherapist. Her MA dissertation (for which she received a distinction) focused on Buddhism, psychotherapy and the treatment of depression. As well as her psychotherapy training, Amita is a Five Tibetan Yogas facilitator, trained by Dekyi-Lee Oldershaw, student of Zachoeje Rinpoche. She has been a practicing Buddhist for 20 years.
Membership Update

To find out which RCCs have joined, moved on, or changed status, visit the Membership Update online, posted monthly on BCACC’s website under “What’s New.”

Resource Library

To borrow books, videos or DVDs, contact Marci at 1-800-909-6303 ext 0, or e-mail hoffice@bc-counsellors.org.

We have recently updated our library. For a complete listing of all Resource Library holdings in Head Office, visit www.bc-counsellors.org/bcacc-resource-library-holdings.

BC Association Of Clinical Counsellors

Member Orientation Workshops

New members of the BCACC receive a Welcome Package containing a variety of information and resources to get them started. In addition to the Welcome Package, the Association offers a six-hour experiential orientation workshop which is held on the Lower Mainland and on Vancouver Island at various times of the year. The Board expects all new RCCs to attend the workshop within two years of joining the BCACC.

This event is designed to introduce new members to the Association’s structure, including member-support and regulatory functions, and to provide an update on the future direction of the counselling profession in B.C. Long-time RCCs are also welcome to attend. Attendance is free of charge, but advance registration is required. All materials, together with refreshments and a light lunch, are provided.

2012 Member Orientation Workshop Schedule

April 20 – Region 3
May 25 – Region 4
September 14 – Region 1
November 16 – Region 5

Details about upcoming workshops and venues are broadcast from Head Office via e-mail.

Note: there is an online version of the Member Orientation Workshop, for RCCs who are unable to attend a face-to-face version. The password for online access is available from Head Office.

Workshop Presenter: John Gawthrop, MA, RCC

John has a counselling background going back 30 years. He is Deputy Registrar of BCACC and is a past Chair of Ethics for the Association. He has conducted ethics investigations for BCACC since 1997 and is a certified regulatory investigator. In addition, John has delivered ethics training and consulting in academic and private sector settings since 1994. He designed the Orientation Workshop and drew from his knowledge of and history with the varied aspects of the Association in creating and/or editing the informational and experiential components of the day. The intent is to provide a well-paced and lively experience that will be of lasting relevance to new and current RCCs alike.

Insurance Information

The Mitchell and Abbott Group of Hamilton, Ontario, is BCACC’s Broker of Record for Professional Liability Insurance (Errors & Omissions) and Office Contents/Premises Liability Insurance for Members of BCACC. The annual Renewal date for your insurance policy is April 1st. For information contact Brad Ackles at:

The Mitchell and Abbott Group
Insurance Brokers Limited
2000 Garth Street, Suite #101
Hamilton, Ontario
L8V 5C4
Toll free 1-800-461-9462
or (905) 385-6383
Fax (905) 385-7905.
Or contact Brad by e-mail
BAckles@mitchellabbottgrp.com

HMR Employee Benefits Limited (formerly Pullen Insurance Agencies), Victoria, covers the BEN-I-FACTOR GROUP INSURANCE PROGRAM available to BCACC members. This program offers Dental Benefits, Extended Medical Benefits, Disability Insurance and Group Life Insurance. For information contact Pamela Lewis or Rick Reynolds at:

HMR Employee Benefits Limited
220-2186 Oak Bay Avenue
Victoria, BC V8R 1G3
Toll free 1-888-592-4614
or (250) 592-4614
or by Fax (250) 592-4953

If you have any concerns or complaints about BCACC’s insurance brokers or policies please contact Aina Adashynski in our Victoria Office at aina@bc-counsellors.org or phone 1-800-909-6303 ext. 4.
Upcoming Head Office Closures

Monday, May 20th
Monday, July 1st
Monday, August 5th
Monday, September 2nd

Two Teams of RCCs Striding for Mental Health!

BCACC is entering corporate teams in the Sun Run in Vancouver on Sunday, April 21st and the Times Colonist 10K in Victoria on Sunday, April 28th. Congratulations to our teams and thank you to Sun Run co-captains Jenny Hollingshead and Zoe Paris!

Important Notice to All Members Changing Membership Status

When you need to change your Membership status, particularly when going from Inactive to Active, (i.e., resuming practice as an RCC) please notify Head Office at once. It is also important that you contact Mitchell and Abbott Insurance to ensure that you have the proper professional liability coverage before commencing private practice. Inactive insurance only provides you with coverage for counselling you undertook prior to the onset of your inactive policy. Head Office verifies all changes in status with a letter of confirmation of the status change. Status changes are reported monthly to the Membership on the BCACC website.

Disclaimer!

Except where specifically indicated, the opinions expressed in Insights into Clinical Counselling are strictly those of the authors and do not necessarily reflect the opinions of the BC Association of Clinical Counsellors, its officers, directors, or staff.

The publication of any advertisement by the BC Association of Clinical Counsellors is not an endorsement of the advertiser, or of the products or services advertised. The BC Association of Clinical Counsellors is not responsible for any claims made in advertisements.

Advertisers may not, without prior consent, incorporate in a subsequent advertisement the fact that a product or service has been advertised in a publication of the BC Association of Clinical Counsellors.

Help us Keep in Touch

If you are moving or if you have a new e-mail or fax, please, let us know...

T (800) 909-6303
F(250) 595-2926
E hoffice@bc-counsellors.org

You can also change your contact information online anytime: www.members.bc-counsellors.org/members/improfile.aspx

Back Issues Online

Looking for an article you once read – or wrote – in an old issue of IICC?

You can find PDF copies dating back to Summer 1999 at: www.bc-counsellors.org/news.aspx.

Subscriptions

Subscriptions for Insights into Clinical Counselling are available at a cost of $20.00 plus tax for three issues. Please contact BCACC Head Office for particulars.
Over 2600 Registered Clinical Counsellors (RCCs) are Celebrating With You: 25 Years of Enhancing Mental Health and Well-Being All Across Our Province