What does it Mean to Communicate Clearly?

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Welcome to our Summer edition of Insights Into Clinical Counselling for 2014.

Would you agree that counsellors typically engage in the study and profession of counselling out of a desire to both understand their own life experiences and to help others facing similar crises in their lives?

I believe that most of the 2900+ Registered Clinical Counsellors across BC have walked their own talk in facing their pasts, learning from their life experiences, and making meaning from those events. They have worked hard to change their own harmful behaviours, which in and of itself takes great courage and is worthy of admiration.

Additionally, they have been inspired by their own healing, and by the potential for growth that they know exists in every human being, to commit their professional lives to making the healing process as safe and as beneficial as it can possibly be.

As a result of their personal experiences as counselling clients our members have the ability to look their clients in the eye and say with absolute confidence: Recovery is possible. You can leave this old pattern – whatever it may be – behind you for good and step free. You can create a life that truly honours and respects you and your values.

I know that in my experience as a client, having a support person who didn’t just talk about change but had embraced it and manifested it in his/her own life, was truly motivating.

Hope: The ability for a person to allow for the possibility that things can change; that our efforts can produce desired changes in our lives, changes that stick and that transform us at our core.

Our job as counsellors is not just to instill a feeling of hope in our clients; although that is a fundamental piece of the puzzle. Our job additionally, is to ensure that hope becomes securely anchored to our clients’ confidence in their ability to change the things that they find stressful in their lives. This is where our own unique journey and the tools we have accumulated as counsellors and as clients come into play.

Counselling is truly an art form. It is inspired by our life experience and our education, yes, and...it is the free expression of our innate talents that truly separate each of us from our peers and provide something unique to our clients. This too takes courage – to express your true self with grace and confidence, not only in the privacy of your home but in your professional life and the world at large.

I personally have benefitted from many different forms of counselling, each form adding a piece to the puzzle that is my unique life experience and providing me with my own eclectic little tool kit for life.

And professionally, I love the fact that there are almost 3000 of you RCCs out there that I can confidently refer clients to if my approach isn’t what they are looking for.

I know that you have the education required to provide quality support to my clients and that you share a code of ethics that will provide a safe environment for sharing and growth. I know that you are committed to providing your clients with the tools they need to find a solid foundation within themselves and that makes me hopeful for our clients, for our Province and for the world at large.

Thank you, for all you do.
By Sharon L. Acoose, PhD, and John E. Charlton DMin, RCC, Contributing Writers

**NECESSARY KNOWLEDGE FOR WORKING WITH FIRST PEOPLES**

HDI is designed to measure the economic, educational, and health status of a population. However, after drawing upon raw census data, Carrie Bourassa observes that Canada’s First Peoples exhibit poorer health and socioeconomic status than those of their non-indigenous counterparts.4

While the professional literature has begun to take into account First Peoples worldviews regarding mental illness and healing, such inclusivity is a relatively recent accomplishment. It has only been within the last quarter century that the American Psychiatric Association has placed an emphasis on investigating and incorporating such information within its publications.5 It took the American Psychological Association (APA) until 2002 to ensure that First Peoples will receive appropriate services by approving a set of Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists.6 Yet, misinformation and stereotyping is still problematic within both professional and mainstream literature/media.

James Waldram is critical of the tendency to present a utopian account of the health status of First Peoples prior to European contact.7 Worse, “research into Indigenous health has been largely focused on non-Indigenous, rather than Indigenous, notions of health.”8 At the non-academic end of the spectrum, Debra Merskin draws attention to the fact that the media broadcasts a continual and stereotypical theme, (i.e., sport team representations: Redskins, Braves, Indians, etc.), pertaining to First Peoples and their culture.9 No matter the intention, such practice is problematic because it is, in the end, a misuse of sacred cultural symbols and practices that function to perpetuate racist stereotypes.10, 11

As mental health professionals do not live in a vacuum, “counselling of Indigenous patients from mainstream perspectives may perpetuate oppression.”12

**FIRST PEOPLE AND RESILIENCY**

In the U.S., African-American psychologists have drawn upon...
constructionism as a culturally relevant paradigm in order to go beyond Eurocentric models for use among people of colour. First Peoples, and concerned counselling professionals who work with and advocate for First Peoples, would be wise to similarly utilize constructionism in order to develop models that build upon the necessary cultural and historical experiences of those with whom they work. Constructionists view knowledge not as a given, but as constructed. Knowledge is developed and shared through social interaction and individual learning. Who interacts with whom and who knows what coevolve. Constructionism inherently allows for intentional capacity building and, thus, promotes resilience-based approaches. Building resilience has been shown to be effective for improving health.

To this end, when we think about resilience, Michael Ungar offers the following, ecologically focused, definition:

In the context of exposure to significant adversity, whether psychological, environmental, or both, resilience is both the capacity of individuals to navigate their way to health-sustaining resources, including opportunities to experience feelings of well-being, and a condition of the individual family, community and culture to provide these health resources and experiences in culturally meaningful ways.

We would like to outline several key elements that counselling practitioners must consider in order to promote the psychological well-being of First Peoples as they construct models that go beyond Eurocentrism and colonization.

While it would be erroneous to assert that First Peoples are cross-culturally homogeneous, there are constants that cross cultures. Indigenous cultures, throughout the world, understand ‘wellness’ holistically. First Peoples make sense of the world through the concept of the Four Directions, the combination of the: Physical; Mental; Emotional; and Spiritual realms. Illness is the result of an imbalance among these realms. Traditional healing practices are designed to restore balance within these four realms. Treatment typically revolves around storytelling, sharing circles, sweat lodges, and vision quests. Importantly, Elders are also utilized. Unfortunately, not only have dominant approaches to mental illness rarely given any consideration to cultural factors when undertaking diagnosis, current Health Canada policies, that by law must allow First Peoples access to traditional healers, make the approval process, to secure funding, so difficult that some have considered it another attempt at colonization; this time through health care.

Counselling professionals who work with First Peoples need to be cognizant of the following:

Identity/Self: First Peoples embrace a holistic identity whose substance goes beyond one’s relationship to community, so as to enfold the environment and one’s ancestors as well. In this way, the identity of First Peoples can be seen as truly community-centred. Herman Michell notes that Indigenous Peoples “have a long-standing connection, relationship, and occupancy of a particular geographical land base from which their unique cultures and languages developed.” For Gregory Cajete, “Indigenous means being so completely identified with a place that you reflect its soul.” For First Peoples, identity of self encompasses geographical, physical, emotional and spiritual planes of existence.

As Indigenous University of Ottawa medical student James Makokis states, “We can go to university to learn, but how we help people lies in the foundation of ceremony, language and culture.”

Historical Trauma: First Peoples suffer not only from the proximal traumas of emotional, physical, sexual and family violence/abuse but also from intergenerational trauma inherited from shared experiences of colonization. Specific Canadian examples would be the 60’s Scoop and the Residential School system.

Culturally Specific Mental Health and Well-Being Practices: First Peoples have traditional psychological systems and healing practices, often based in spirituality, ceremony and ritual. These endeavours serve to restore imbalance.

Cultural Mistrust: Professional counsellors must be cognizant of the mistrust many First Peoples feel toward Western (i.e., colonized) services. Cultural mistrust is particularly tricky when mental health professionals are the product of the culture of the colonizers via the training/certification they must receive within the colonial education system.

Empowerment: Professional counsellors must intentionally do everything they can to equip First Peoples with the necessary tools to elucidate and develop evidence-based culturally relevant mental health constructs and paradigms that are community specific. The academy, as a microcosm of society, has a dual role here. First, universities can influence the development of a social justice advocacy agenda, which is not the same as cultural competency, in students and professional counsellors. Secondly, the academy can actively recruit First Peoples into leadership positions.

THE TWO WORLDS OF FIRST PEOPLES EXISTENCE

First Peoples are, to varying degrees, accustomed to traveling back-and-forth between cultures. The Tsawwassen People - of southwestern British Columbia, Canada - have gone so far as to codify this understanding within their Declaration of Tsawwassen Identity and Nationhood. There are pertinent implications for professional counsellors here.

As First Peoples are, generally, comfortable with at least the notion of concurrent dual treatment protocols, the question really is then, for non-Indigenous counsellors: Are you as well? As previously discussed, we do not live in a cultural vacuum. In order to address this potentially insidious issue, it has been noted that the task of the counsellor is “to improve your awareness, knowledge, and skills about who you are if you are to work with clients different from you.”
Updates, Myths, and Things to Think About

By Clive Perraton Mountford, PhD, RCC, BCACC Ethics and Standards Consultant, Contributing Writer

Take reflective counsellors who face challenging issues, add a consultant who is fond of “difficult questions,” mix in a legal advisor who loves a puzzle. What do we get?

Fascinating conversation… And, eventually, answers which can be surprising, pose more challenges, and sometimes point to difficulties and depths needing exploration.

Try these:
• Post-secondary institutions are moving to electronic data storage. This will apply to counselling departments.
I have a concern: Is the scanned version of a signed document entirely and always equivalent to the signed document itself?
• Suppose I have a client with HIV/AIDS whom I believe is engaging in unsafe sex without warning his partners.
This needs reporting. However, the client has a history of violence, and I believe him to be disturbed. I fear what he will do upon learning that confidentiality has been broken.

Section 18(1)(k) of the Personal Information Protection Act appears to protect a clinician who breaks confidentiality in such a case, but it also requires that notice of disclosure be mailed to the client.

Can this really be right?
• I have good reason to believe that my client is intending to kill him/herself. Am I legally required to report my client to the police?
• Is it true that clinical records must be kept for seven years and should then be destroyed?
• Can a counsellor or a counselling agency put a “no subpoena” clause into an agreement with a client and expect it to mean anything in practice?

I am sure that one of my clients is abusing his dog. He does not wish to talk about it, and I believe the abuse is serious. If this was a child, I would have a legal duty to report, and I know I would be legally protected in doing so. Does this duty and protection extend to animals?

An ex-client has engaged a lawyer to pursue an insurance claim on her behalf. The lawyer has sent me a request to release my clinical records and a release form signed by my ex-client. However, I saw this client for couples counselling with her then partner. I have no consent from him. What should I do?

Is it possible to put an enforceable non-competition clause in the contract between an agency and an employed counsellor which will disallow separate private practice within a certain distance of the agency? If so, what kind of distance might be specified?

Is there any law pertaining to the supervisor/supervisee relationship applicable within BC?

Suppose that an experienced counsellor agrees to provide a practicum opportunity and supervision for a trainee counsellor: What, if any, legal liabilities might that counsellor be opening him/herself up to? What, if any, new legal obligations might they have in consequence of this arrangement?

Were you checking your understanding as you read the questions? How many do you think you got “right”?

Let’s get organized
The common thread is that each of these questions involves legal matters, and I either lacked total confidence in my understanding or could not find clear, or clearly up-to-date, guidance. Therefore, I sought legal input.

Additional shared threads mean these questions form groups:
• Electronic data storage and record retention policy both involve records. How records are handled is part of what might be called the “nuts-and-bolts” of running a practice.
• No-subpoena clauses may at first seem quite a different issue, but they, too, affect how a counsellor or an agency runs a practice.

They help to shape the practice. They are a nuts-and-bolts, or perhaps “infrastructure,” kind of matter. So, too, are non-competition clauses.

Deciding whether to offer supervision as part of one’s counselling practice, and whether to take a supervisee into one’s counselling practice, also affect the shape of a counselling practice and the kind of “infrastructure” required.

Thus a nuts-and-bolts and infrastructure thread links this group of questions.

Are there other over-arching categories visible within the questions received?

Another good question—one I am beginning to think about. Most of the other enquiries received seem to belong either to a relating to my client group or when things go wrong. But that is discussion for another day.

Looking back, looking forward
If you follow Ethics and Standards Broadcasts—the ones Marci Zoretich mails out—you may have noticed the arrival of an updated How Private Is Private by George K. Bryce and
an updated Summary by George and me.

The updated Commentary and Summary deal with a counsellor’s “duties to report and protection when reporting.” They are in part a response to some of those information sharing questions. The HIV/AIDS question, the suicide question, and the dog question are discussed in both. But the question involving couples counselling is not.

I want to explore information sharing questions in light of the work George Bryce and I have recently done and discuss our journey and findings with members. However, I cannot out the federal Personal Information and Electronic Documents Act. This was looking good. But I wondered whether it actually applied in BC. “Ask George Bryce,” I advised myself.

Good move. It doesn’t. BC has the Electronics Statute Act. And, as yet, BCACC has no legal commentary. George, therefore, provided guidance by email. Here is a very brief summary:

- An on-line, electronically signed document is, in practice, equivalent to a paper document signed with a pen so long as the document is safely stored and properly retrieved when needed.
- If a client originally signed a paper document, and that document was then scanned, and the paper version was destroyed, rules governing electronic copies of paper documents would then apply.
- Those rules entail that a scanned document and signature should be acceptable before a court or administrative tribunal so long as there is continuity in the scanning, storage, and retrieval processes that have protected the integrity of that copy.

In other words, electronic documents and electronically stored documents are as acceptable as paper documents given demonstrable continuity.

However, there is a different kind of wrinkle here. Paper documents locked in a filing cabinet in the office of a University Counselling Service are tolerably secure. How well do electronically stored documents on computers serviced by technicians and accessible to various parties protect client confidentiality?

It will depend on many factors. I am uneasy about the avalanching computerisation of what should be confidential records in education and in health and social care. I doubt all those factors can be controlled.

How long should I keep ‘em?

Two BCACC documents discuss the length of time that a counsellor should keep clinical records. Both recommend seven years …because that period covers the standard six year limitation period for most causes of action, plus an additional year between the date a statement of claim is filed and the date it must be served on the defendant.

We are also reminded that The law allows minors (those under age nineteen) to sue their health care providers for damages after they reach the age of majority if their parents have not already sued on their behalf. Therefore, the seven year retention period would not start running until the minor’s 19th birthday.

But the times may be a-changing. A new Limitations Act came into force in BC, in June 2013, aligning BC’s limitation periods with those of most other provinces.

There will now be:
- A two year limitation period for most civil action instead of six
- An “ultimate” limitation period of fifteen years instead of thirty

Additionally and importantly, there is no limitation if:
- A Claimant is suing a Defendant for harm caused by a sexual assault

Confused yet? In addition to the above, and possibly in response to it, the College of Physicians and Surgeons of BC have recently adopted a sixteen year retention rule for medical records. What should counsellors do: follow the Physicians, continue with the seven year plan, or do something entirely different?

There may be need for discussion within BCACC because the answer is not immediately clear. For now, as we each ponder our individual “records retention policy”, the following is probably relevant:

- Brad Ackles of Mitchell & Abbott assures me that an insurance claim against a member has never been made more than two years beyond the end of counselling. Remember that the primary purpose of records is arguably to provide against insurance claims and complaints.
- George Bryce proposes that in most cases a three year retention rule would be adequate.
- In other cases, and particularly if a matter falls outside limitation, it is not clear that records should be destroyed at all.
- Unless we are seriously malpracticing, or utterly convinced of our invulnerability, we cannot...
Anxiety in Young Children: Differences in Ability to Recognize Facial Expressions

By Alisa C. Bridger, MA, RCC, Lynn D. Miller, PhD, R Psych & Vanessa E. Waechtler, MA, RCC, Contributing Writers

Anxiety has been identified as the most commonly occurring mental health disorder across the lifespan. While young children suffer from high rates of anxiety disorders, Kendall¹ estimates that fewer than 20% of those children receive intervention. Albano et al² note these children “suffer for the most part in silence and are not easily identified as problematic.” Perhaps another barrier to effective intervention is the belief by parents, teachers, and even counselling professionals that young children will outgrow their worries, fears, or shyness.

The lack of intervention is problematic. Separation Anxiety Disorder (SAD) is associated with “an acute and early onset...often occurring after a major stressor such as the start of school.”³ Often these children do not receive a diagnosis or treatment, despite our current knowledge that Cognitive Behavioural Therapy (CBT) is effective in treating anxiety in youngsters, and that, if left untreated, SAD has been shown to have significant deleterious outcomes.³ Research by Turner et al⁴ indicates that an early onset pattern of anxiety, inhibition, and shyness may be a developmental vulnerability to more mental health disorders. Schwartz et al.⁶ suggest that a new focused interest on young children who display extreme levels of shyness may be informative of future anxiety development.

Current research in anxiety prevention and early intervention has largely been conducted with older children and adults. Specifically, evidence based programs (predominantly CBT), often include a component that addresses social skills training and support.⁵ A particular aspect of the social skills training is based on research that identifies anxious children and youth as less able to read social cues than their non-anxious peers.⁶ One of the stated goals of these treatment programs is to train adolescents to recognize subtle emotional cues accurately in others in order to help reduce their anxiety symptoms.⁷

Research regarding this ability of emotion recognition in others has not yet been extended to young children with anxiety symptoms. Although the ability to recognize facial emotion is present at 3-years of age, scant research has been devoted to studying the development of this ability. Piaget’s theory of cognitive development offers a theoretical perspective to address emotion recognition development. Flavell⁹ notes, “Piaget (1928) believes that the major vehicle for the developmental decline of...cognitive egocentrism is social interaction, especially with peers.”

Regarding facial affect recognition, if a child negotiates this stage poorly, or fails to interact socially with competence, shyness may result. Shy children will have less practice and fewer interactions with their peers, leading to fewer opportunities to recognize facial affect, possibly influencing their progress through this stage of social development. Shyness inhibits interaction, thus limiting pro-social activity and normative daily social interaction. Infrequent spontaneous social interactions cause shy children to have fewer repeated experiences of typical facial affect recognition, leading to less skill acquisition. Piaget’s theory suggests that increased exposure to a stimulus (direct instruction) increases assimilation of that concept (social skill acquisition).¹⁰

The concept that shy children may be interacting with their peers less frequently, and have less practice identifying others’ emotions via facial expressions, has a two pronged implication. Reduced practice in reading others’ social cues may influence not only the accuracy of the child’s recognition of the emotion, but it may also influence the time required for the child to determine what she believes the other individual is feeling.

Sonneville et al¹¹ note that limited data exists regarding the speed of facial emotion processing. The authors concluded in their preliminary study that, as with ability to recognize positive affect, the speed of recognition of positive affect increases and develops earlier than that of recognition of negative affect. Other research¹² shows although there is not a significant increase in accuracy of recognition of facial affect between the ages of 7 to 10, there is a significant increase in speed of recognition. The findings¹³ that speed of emotion recognition increases similarly to emotion accuracy, with accuracy improving before speed and both speed and accuracy increasing over time, supports Piaget’s developmental model and the need for practice and training to improve accuracy and speed of recognizing facial expressions in others.

This study advances the literature supporting social skills training programs for young children by examining whether shy kindergarten children (as identified by teachers and parents) differed from non-shy controls in their speed and accuracy of identifying emotions in photographs.
Shy children will have less practice and fewer interactions with their peers, leading to fewer opportunities to recognize facial affect.
Overview of Bipolar Disorder:

By Sana Gaitonde, MSc, RCC, PhD Candidate, Contributing Writer

Bipolar Disorder (BD), commonly known as manic-depression is a serious mental illness in which individuals experience unusual shifts in mood, energy, and activity level. It is often a recurring condition involving ups and down in mood characterized by manic, hypomanic and depressive episode. Bipolar can have debilitating effects in lives of people affected by this condition. It can affect many different areas of one’s life causing significant distress in one’s daily functioning. The purpose of this paper is to review relevant literature of epidemiology, etiology, course and diagnostic features, and treatment issues on bipolar disorder.

**Diagnosis**

Bipolar disorder (BD) can be a life-long disorder characterized by disturbances in mood and behaviour with recurring manic or hypomanic episodes and major depressive episodes. It can cause significant interference with one’s thoughts and behaviours. Further, it can severely impact one’s social functioning, relationship with friends, family, employers and others. According to Diagnostic and Statistical Manual-IV-Text Revision bipolar disorder can be categorized in four subtypes: bipolar I, bipolar II, cyclothymia, and bipolar disorder not otherwise specified.

- Bipolar I is categorized by at least one manic episode and possibly intervening major depressive episode.
- Bipolar II is characterized by episodes of major depression and hypomania.
- Cyclothymic disorder is characterized by episodes of hypomania and symptoms of depression that do not meet the complete diagnostic criteria of major depressive episode.
- The clinical syndrome that do not meet the exact criteria of bipolar I, bipolar II or cyclothymic disorder fall in the category of bipolar disorder nos.

During manic episodes, a person experiences elevated and expansive mood, decreased need for sleep, increased goal directed activities, flight of ideas, increased involvement in pleasurable activities (sometimes with painful consequences), increased energy, and distractibility.

Hypomania is defined by similar symptoms of manic episode but with fewer symptoms and shorter duration. Phases of depression in bipolar disorder are defined by criteria for major depressive episode such as feeling sad, not enjoying pleasurable activities, insomnia or hypersomnia, fluctuations in weight, decreased energy, decreased concentration, hopelessness, thoughts of suicide. One of the challenges has been to distinguish the diagnosis of bipolar disorder and borderline personality disorder as they share several symptoms and related impairments.

**Epidemiology**

Mood and affective disorders are considered to be one of the most prevalent psychiatric disorders in the United States. In 2004, World Health Organization ranked bipolar disorder as the 12th most common moderately to severely disabling condition in the...
The incidence of mood disorders among various races has been inconclusive due to conflicting results and certain methodological problems in data. The NCS and ECA study report no gender difference in the prevalence of bipolar. There is variability in the age of onset reported by many studies. One study reports the age of onset for bipolar I as 18.2 years and bipolar II as 20.3 years. Another study estimates the mean age of onset as 30 years of age.

According to one study, African Americans who presented with mania or manic episode have a higher likelihood of being misdiagnosed with schizophrenia instead of bipolar disorder. Emigration has been suggested as a risk factor of bipolar illness.

Etiology

There are many theories that attempt to explain the etiology of bipolar disorder. Evidence from twin studies, adoption studies, and family studies suggests heritable and genetic factors for bipolar disorder. Biochemical and pharmacological studies implicate various neurotransmitters, enzyme, neuropeptide, as well as immune system playing a role in the bipolar diagnosis. Some theories also suggest the significance of stressful life events in emergence of Bipolar Disorder.

According to one study the approximate lifetime risk of bipolar disorder among monozygotic co-twins is 40–70%, first-degree relative is 5-10%, and unrelated persons is 0.5-1.5%. The meta-analysis conducted by this study suggests that family studies are consistent in showing the increased risk of bipolar disorder among the first degree relatives especially with the early age of onset. There is no adequate evidence of the estimated risk among second-degree relatives. Further, it estimates the occurrence of bipolar disorder among monozygotic twins is 50%. However, it suggests that three studies underestimate the concordance of monozygotic twins and the true concordance may likely be closer to 60%.

An adoption study conducted by Mendlewicz & Rainer (1977) focused on biological and adoptive parents of 29 bipolar adoptees and 22 normal adoptees and the biological parents of 31 bipolar non-adoptees, There was an increased risk of mood disorder, 18% increased risk in biological parents and 7% increased risk in adoptive parents who could meet the diagnostic criteria of mood disorder.

Neurotransmitters such as norepinephrine, dopamine, glutamate, and GABA have been implicated in bipolar disorder to certain degree. Brain dopamine pathways have been implicated with the core bipolar symptoms including depression and mania. Psycho-stimulants that increase dopamine activity have been known to produce mania like effects. Amphetamine produces similar effects even in non-bipolar subjects.

The depression in bipolar responds to a dopaminergic antagonist, implicating an association between depression and the dopamine neurotransmitter. It has been reported that symptoms of depression and mania can be replicated using pharmacological
manic symptoms. Further, neurotransmitters such as serotonin and norepinephrine have been linked to symptoms of mania and depression in bipolar disorder. Low levels of serotonin have been suggested as the predisposing factor for mood disorder. Also, too much norepinephrine is suggested in symptoms of mania and too little norepinephrine is implicated in depression.\textsuperscript{29}

Another study conducted by Johnson et al (2008)\textsuperscript{8} focused on goal attainment life events and negative life events as predictors of mania and depression. It was suggested that there is an increase in goal attainment life events during the manic phases of bipolar disorder but not the depressive phases. On the other hand, negative life events have been suggested to be a predictor for depressive symptoms but not for mania symptoms.

**Course**

Bipolar is thought to be a chronic and recurrent condition that persists throughout a person’s life span. However there is some evidence that there is an age factor that plays a role as one study suggests highest rates of bipolar disorder in the ages 18 to 29\textsuperscript{5} or age 25 to 34.\textsuperscript{10}

Johnson and Roberts (1995)\textsuperscript{9} studied three major biological theories with attention to the implication for investigations of how life events affect the course of bipolar disorder. Severe negative life events have been associated with four times the risk of relapse.

According to one study negative life events such has major losses are directly associated and may predict the course of depression episodes within bipolar. Other factors such has sleep disturbance caused by negative life events can, however, predict mania within bipolar.\textsuperscript{8}

The systematic enhancement program of bipolar disorder (STEP-BD) was designed to understand the long term outcome of patients with bipolar disorder receiving STEP-BD treatment. In this study, within a two year follow-up period, 58.5% of the participants achieved recovery and 48.5% of participants experienced recurrence. Further, 70% of the recurrence was depressive in nature with the ratio of 2:5:1 between depressive episode and manic, mixed or hypomanic episodes.\textsuperscript{19}

Another study was conducted on 71 euthymic bipolar patients in remission and 61 healthy controls to understand the clinical predictors of functional impairment. It was reported that among their sample, 60% of the patients diagnosed with bipolar disorder experienced functional impairment in comparison with 13% of the healthy controls. Four major clinical factors as predictor by this study that contributed to the functional impairment were: subclinical depressive symptoms; previous mixed episodes; previous hospitalizations; and older age.\textsuperscript{24}

**Treatment**

Bipolar Disorder can be one of the most debilitating mental health conditions. It does not only negatively affect the quality of life and mortality of the person diagnosed with this disorder but it can significantly impact their family and loved ones who struggle in caring for the patient and coping with their mood episodes. Pharmacological treatment such as mood stabilizers can offer some relief but have to be taken consistently and for life. Psychotherapy can help with understanding and managing one’s depressive and manic episodes.

In 2000, 64 leading experts came together to revise the recommended regimen of medication for Bipolar Disorder. Mood stabilizers such as Lithium and Valproic acid have been recommended as the first line of treatment for treatment and prevention of mania. If first line of treatment fails, Carbamazepine and Lamotrigine are recommended as the second line of treatment. Olanzapine and Risperidone have been used more commonly as a first line of treatment for psychotic depression in addition to mania. Mood stabilizers may also be used for mild depression however Bupropion and Venlafaxine are indicated as a first line of treatment for severe depression.\textsuperscript{16} Lithium has certain limitations as it is associated with toxicity at certain doses. The most common side effects of Lithium that have been reported are gastrointestinal irritation, tremor, cognitive dulling, and with long-term treatment renal, thyroid, and cardiovascular side effects may occur.\textsuperscript{18}

Psychotherapy can help with managing the depression and manic symptoms. The goals of psychotherapy are to reduce distress and the risk of future episodes and also improve functioning between episodes. Common psychotherapeutic interventions include cognitive behaviour therapy, interpersonal therapy and social rhythm therapy.\textsuperscript{4} Interpersonal therapy and social rhythm therapy have shown some evidence for efficacy in bipolar disorder II symptoms.\textsuperscript{14}
Bipolar is characterized by ups and downs in the mood and affect. These ups and downs in the mood can at times cause significant impairment to one’s daily functioning including the relationships, interpersonal lives, and professional lives. Bipolar has been ranked as 12th most common debilitating condition in the world at any age.13

According to one study, the lifetime prevalence of affective disorders has been estimated at 8.3%.23 Another study estimated the lifetime prevalence of bipolar disorder I as 1.0% and 1.1% for bipolar II, while 2.4% of the population falls under the sub threshold of bipolar disorder.12

There is unclear data on the prevalence of bipolar disorder among different races and the mean age has been reported in one study as 18.2 years for bipolar I12 and 30 years by another.6

Various etiology-based studies have suggested that genetic factors, neurotransmitters and psychosocial factors play an important role in bipolar disorder. The lifetime risk of bipolar disorder among monozygotic twins is estimated as 40-70% and 0.5-1.5% for unrelated persons. A meta-analysis on twin studies estimated the occurrence of bipolar among monozygotic twins as close to 60%.3 Family studies and twin studies implicate the role of genetics in the diagnosis of bipolar disorder. Neurotransmitters such as dopamine, serotonin and GABA also appear to play a role.17 Another study has discussed the role of negative life events as predictive of depression and goal attainment life events as a predictor of mania.8

Lithium has been widely accepted as the first line treatment for managing bipolar disorder, especially the symptoms of mania. Mood stabilizers may be used for depression.16 Lithium comes with significant side effects due to its toxicity.

Psychotherapy can help with reducing distress and improving functioning between episodes. Therapeutic interventions such as cognitive behavioural therapy, interpersonal therapy, and social rhythm therapy have also shown some evidence of efficacy.14

Therapeutic interventions focused on family therapy have also gained some support. It focuses on providing support and education to the family so they can respond to the early symptoms of family members diagnosed with bipolar disorder. This intervention is also focused on psycho-education and providing family members and patients with effective coping responses.22

There is very limited research on the prevalence and occurrence of bipolar disorder across cultures. More research is needed in this area. There is also a clear need for more research on the early diagnosis of and intervention for bipolar. As genetics seem to play such a big role with the occurrence of bipolar disorder, it may be challenging to have more early preventative and intervention measures. Further research on pharmacological treatments with fewer side effects may also helpful.

Discussion
This paper has discussed several research findings on bipolar disorder and its epidemiology, etiology, course, diagnosis, and treatment method.

Biography
Sana Gaitonde, MSc, RCC is currently working on her doctorate degree in clinical psychology and has recently completed her externships at a private practice in Washington DC area. She has worked for a few years as a mental health clinician with children and adolescents in the lower mainland (Surrey, BC) and has written on the challenges and pitfalls of relying solely on DSM manual for diagnoses, as well as the challenges faced by parents raising transgendered youth. Her doctoral area of research is working with suicidal and non-suicidal self-injury. She can be reached at sana31@gmail.com.
Communication

Every moment of every day we communicate with others. Even when we think we are not communicating, we are. Consider the last time you chose not to attend a function, whether it was with family or friends. If you did not clearly communicate why you were not there, there may have been speculation as to your absence. Suggestions abounding that you were sick, or wanted to avoid seeing someone; maybe you were tired from overwork, or had a scheduling conflict.

Regardless of whether or not any of these reasons were true, it is okay to be honest and share who you are, what is happening in your life, and how life circumstances are impacting you in a way that is true to you without sharing too much. We can learn to take the risk to share who we are and our decisions with others. In this way, others can offer us support if we need it and together we can learn to build healthier stronger relationships.

This article explains clear communication, the benefits, and offers steps to begin to improve your communication skills.

Understanding Clear Communication

When we clearly communicate, we are truly able to connect with others. This is true with colleagues at work and with those we hold close to our hearts.

Clear communication means we share who we are, whether it is our perspective or our innermost thoughts and feelings, in a genuine way. In other words, we take a risk. Allow ourselves to be vulnerable and to be seen for who we are.

When we fear exposing our true selves, miscommunication can occur – even if this is not our intention. Miscommunication can sever relationships; misunderstandings pull us apart rather than draw us together.

It is Easy to Miscommunicate

Communication requires drawing together several different pieces of information that enable us to share our intentions, or what we desire to share, with another.

Messages offered through body language, tone of voice and facial expression may collide with the words chosen. This leaves the receiver of the message deciphering a confusing collision of verbal and nonverbal cues, which can easily lead to a misinterpretation of the message.

To muck up the matter even more, we also pick up on underlying emotions that may or may not be connected to the message meant for us. For example, if someone is having a bad day and their body language may reflect that, yet the underlying emotion is discordant. As a result of confusing verbal, nonverbal, and emotional undertones, the receiver can spiral down painful pathways of interpretations of feared thoughts and beliefs. To follow through with the above example, we may begin to doubt our value or worth as we are haunted with questions such as, “What did I do to upset them?”

Without enough information, we begin to evaluate the situation based on our understanding which is bound by our experiences. This can impact our relationships and unfortunately lead us to feel more distant rather than connected.

Components of Communication

When we communicate, there are various components that come into play. In the book Reaching Out: Interpersonal effectiveness and Self-Actualization, David W. Johnson notes these pieces are:

1. Person A: Someone with a message to convey.
2. The Behaviours: The medium through which the message is delivered.
3. Person B: The receiver of the message.

Person A

Individuals we interact with have their own personality, personal experiences, values and beliefs that shape who they are and their way of interacting with others in the world. When they desire to connect with others they begin their communication with an intention, or what they desire to say.

Based on the family they grew up in, the community they lived in, groups of
What Does It Mean To Communicate Clearly
friends, etc. they have an understanding of how to communicate. Essentially, they have their own cultural background and way of encoding their message. All of this is hidden from the person they are speaking with. This means, the other person has to infer what the intention is based on what is perceived through behaviours.

The Behaviours

When a message is encoded, the receiver of the message works with a combination of the observed behaviours and the underlying emotion picked up in the interactions1. These observed behaviours can include body language, tone of voice, facial expression, and words chosen.

Person B

The receiver of the message observes the behaviours and based on his/her own personality, personal experiences, values, and beliefs he/she interprets the behaviours. Essentially, the receiver employs his/her own unique way of decoding the message sent.

Based on Johnson’s perspective, communication draws upon several different pieces of information that we offer to the receiver of our message. The challenge is that each of us, based on who we are and our life experiences, learns different ways of piecing together this information. In other words, we all develop our own way to encode and decode messages.

Clear Communication

Clear communication occurs when our behaviours and feelings are congruent with the intention of the message we are attempting to convey. This means that there is no need to follow the cliché read between the lines. In a sense, it means we allow ourselves to be open, genuine, and even vulnerable if we choose.

When we take the risk to truly allow others to see us for who we are, we allow ourselves to connect2 and this means we meet one of the basic emotional needs in life: Belonging.

Basic Emotional Needs

In life, we have basic emotional needs. When these needs are met, we truly feel that everything will work out in the end.

This statement does not imply that we get what we want or that we even get what we need. Rather, it reflects that no matter what happens in life, no matter what life throws at us:
- We feel we have the skills to allow ourselves to connect with, express, and release the emotions we need to;
- We trust that as we connect with the emotions involved in the situation we will be able to make sense of it;
- And believe that by working in this way we discover what we need to do in order to be able to move forward within the circumstances of our lives.

In other words, by working with our emotions3, our sixth sense, we are working to meet our basic emotional needs in life.

So what are these Basic Emotional Needs?

Drawing from Maslow’s Hierarchy of Needs and combining it with the basic needs outlined by Rosenbloom, Williams, and Watkins in Life After Trauma, Second Edition: A Workbook for Healing, we come up with the following list of basic emotional needs:
- Safety
- Trust
- Control
- Intimacy
- Value
- Belonging.

Our confidence in our ability to meet these needs builds over time through our successful interactions with others. Examples of how people demonstrate these needs through their interactions with us are as follows:
- Safety: People protect us and those we care about from harm or demonstrate righteous indignation when we were/are harmed;
- Trust: They encourage us and those we care about to trust our instincts. They interact with us, and those we care about, in a way that allows us to trust them;
- Control: They allow us and those we care about to govern our own lives and respect our wishes. They respectfully and clearly communicate their opposition when we or those we care about make requests of them that they are not able or willing to meet;
- Intimacy: They are receptive when we, or those we care about, are vulnerable with them and they allow themselves to be vulnerable with us and those we care about;
- Value: They treat us and those we care about, with decency and respect and demonstrate that we and those we care about have worth;
- Belonging: They include us and those we care about in their groups.

When others communicate clearly with us, and those we care about, we begin to develop a strong sense of who we are and feel capable and confident as we navigate life.

This is a key reason why clear communication is so important.

Building the Skills for Clear Communication

Working towards clear communication in your relationships requires being present in the moment to prevent emotions from past experiences clouding current interactions.

Before communicating with someone else, check out how you feel.

If you can identify, “Yeah, I get that I enjoy hanging out with this person, but I feel crappy due to the frustrating interaction today,” it may be that you need to work through the icky stuff from your day or simply need to communicate clearly what you are experiencing so the other will not have to read between the lines.

To address the icky stuff from the day, take a moment and write down on paper or on your smart phone:
- What happened;
- The emotions it prompted;
- Connect with the emotion to discover what specific needs prompted the emotion;
- Figure out a way to address what happened:
  - i.e. Is it something that reminded you of something else which means you need to sort it through on your own and resolve the past concern;
  - Or is it isolated to the situation which means learning how to improve communication within the relationship;
  - Take steps to empower yourself in the acknowledged past, or present, situation.

To communicate clearly with the other person, be honest.

For example, let them know you are happy to see them, but something that happened that day is still sitting pretty heavy with you. If you do not want the
Introduction

Most people who know me know that I am very passionate about premarital counselling. It was the main motivation for my Master’s thesis, starting private practice, and many of my professional goals surround making this service more appealing and accessible for couples. I think it’s one of the most powerful ways couples can prepare themselves for what lies ahead.

Problem

The problem, as is the case for many types of counselling services, is that it is difficult to connect the service with those who may benefit from it. And more often than not, it seems that it takes being faced with serious consequences or problems before people look to counsellors or other professionals for help.

So premarital counselling is a tough sell. Couples are often at their peak happiness, for a lack of a better term, when they get engaged, with all of the excitement surrounding planning the fairy tale wedding. Why fix it if it isn’t broken? I remain convinced that premarital counselling can play a vital role in building strong couples, and in turn, strong families.

You would be amazed to hear about the things many couples fail to discuss at length prior to the commitment of marriage is made. Where do we want to live? Do we both want to have children? What are our parenting values and styles? Do we want the same things out of life? And some couples rush in – so in love with the idea of marriage and getting to plan a wedding, that they fail to ask themselves and their partners the hard questions. Many people have entirely different views of how a marriage should be, but they don’t discover this until much further down the road.

Do couples today feel more pressured to walk down the aisle? Has increased social media, like Facebook, made it all so in your face, that people feel left out if they don’t have a picture-perfect wedding as well? Are we so consumer-driven that we have lost sight, as a culture, of what marriage is really about?

I would like to think that things are getting better in this department. But the average Canadian Wedding, according to a recent survey conducted by Wedding Bells magazine (2012), is now around $34,000. And little, if any of that money, is devoted to ensuring that couples understand the importance of the step that they are taking and their expectations.

The good news is that Canadians are waiting longer to get married – between 1972 and 2008, the average age at first marriage increased from 22.5 to 29.1 for women and from 24.9 to 31.1 for men (Statistics Canada, 2008a). People are likely putting their career first, dating more people, and focusing on themselves before deciding to settle down. In my opinion, the early 20s are an important developmental stage, necessary to determine what you are looking for in a partner, among other things.

Nonetheless, some couples do seem to suddenly feel that they are “at that age”, and there is an ensuing rush to the altar and to start a family, without taking a closer look at their expectations about marriage, and whether the individuals in the couple want the same things in the long run. It is my belief that leading up to engagement and the wedding, couples would benefit greatly from using this time for self-reflection and really immersing themselves in what they are signing up for. This is especially needed in this age of high divorce rates. As of 2008, 43% of Canadian marriages were expected to end in divorce (Statistics Canada, 2008b).

So what’s so great about premarital counselling? It has many benefits, but I am only touching on a few here.

Benefit # 1: Its focus on prevention.

In premarital counselling, the focus is not on what has already or is currently going wrong in the relationship, but on preventing damaging conflict in the first place. So although there will inevitably be conflict in every relationship, and I believe that this is, to a certain extent, a healthy part of...
Abandonment and Engulfment Fears

By Sherry Bezanson, MEd, RCC, RRP, Contributing Writer

The continuum of abandonment and engulfment represent the range of normal anxieties in any relationship. What is not normal is when the fear of one or the other adversely governs our behaviour. Both arise in all of us—most of us have one pattern as a more dominant concern than the other, depending on what we learned in our family of origin. Abandonment fears feel frightening and painful and can trigger a sense of impending loss and unworthiness. Engulfment fears alternatively, trigger a sense of invasion and causes retreat and protectiveness and, just like a prisoner in a high turret, the person walls him/herself off from pursuit.

When these fears become so intense as to affect our judgment and behaviour, they become problematic for us. If love was full and timely as children, we may not identify much with either end of this continuum. However, if a child felt either smothered or neglected, the pattern can continue into adulthood. On the abandonment end of the spectrum is the pursuer. On the engulfment end is the distancer. Like any continuum, both ends are extreme and yet related. One cannot be a pursuer without a distancer, and one cannot distance without the advancement of a pursuer. It is part of the same intimacy dance.

In adults, the distancer construes giving and receiving as controlling or obligating, while the pursuer over-gives and usually takes better care of the distancer than of themselves. The distancer often maintains secrets or a secret life and may become angry and defensive at being questioned. In turn the pursuer has poor boundaries and poor protective mechanisms and often tolerates abuse, unhappiness or infidelity. The pursuer, in an attempt to get closer, walks on eggshells, and is always compromising his/her values to appease the distancer.

When either fear is triggered a person runs to whatever has become the “comfortable” behaviour pattern. Does it feel comfortable? No, it feels terrorizing, but it is part of an acquired behaviour pattern. Although it may be tempting to disown what is happening in this dynamic, the suffering and pain are not due to what the other person in the relationship is doing, it is coming from within and it is a phantom fear from childhood.

When attachment needs have not been met in early childhood, fears from our past can get activated in intimate relationships because the original injury was never
acknowledged, restored or forgiven. Because these fears are not rational we have little ability to talk ourselves, or someone else, out of them. We also can’t blame another for our own fears on this continuum, as they are cellular reflexes. The sense of either being abandoned or engulfed feels very real when activated. However, in reality, an adult cannot be abandoned, only left; one cannot be engulfed, only crowded.

A mature response to these fears is to develop the capacity to commit to another in relationship without being immobilized by the fear of abandonment if someone pulls too far away, or by the fear of engulfment if someone gets too close.

**Steps for Working With Abandonment and Engulfment Fears**

In relationship counselling, it is important for couples to feel compassion for their spouse or partner, and encourage each to work to create change within themselves. Part of this process can be accomplished through a mindful approach; reminding partners to be in the present, rather than in the past. The solution lies in finding ways to motivate each partner to take a step back and to be open to recognizing that they are engaging in old behaviours.

To become aware of one’s reactions brings a sense of power over the intensity of their feelings. When we fear engulfment we believe that closeness takes something away from us. In reality, the way to deal with this fear of losing pieces of oneself is, paradoxically, by freely giving of oneself. By encouraging clients to make a self-disclosure, admit vulnerability, or show a feeling we help them to see that the fear of losing something through engulfment can be replaced by the freedom and empowerment of voluntarily letting go of control.

The fear of abandonment is the deep fear of being left alone. Thus, encouraging the pursuer to sit in the unsure feelings of anxiety that arise from feeling disconnected to the love source is a necessary piece of healing. The pursuer can face the fears and find a calming space to breathe deeply and recognize that the world isn’t going to end.
Insights into Clinical Counselling - August 2014

Non-Conformists Unite!
Nonlinear People in a Linear World

By Ted Leavitt MSc, RCC, Contributing Writer

The Value of Going Around in Circles

As a part of my diverse private practice, I often have the opportunity to give lectures to various community groups on a wide range of subjects. Because my own interests are diverse, these lectures usually borrow from many different concepts and fields in order to educate the audience. I usually warn the audience at the beginning that when I am teaching I speak in concentric circles working my way around the perimeter of the concept, introducing several concepts that may at first appear to be unrelated, and then gradually narrowing in on the main point. In this way, they have the proper context for the final, parsimonious concept that I want them to walk away with.

Despite this warning, it is obvious to me as the class proceeds that there are people who are having a hard time hanging in there. As I go around and around in circles, their eyes glaze over. After the class, I send out e-mails asking for feedback and there are always people who would have preferred that I get to the point sooner. However, the majority of the people expressed that nobody has ever explained the concept in such a way before, and that the way that I did it made perfect sense to them.

What is the difference between these two groups of people? I believe it comes down to one thing, the ability to happily walk in a straight line. What I am referring to is the separation of people into two groups: linear and nonlinear.

Linear vs. Nonlinear People:

Linear people prefer to move through life in a stepwise progression. They begin step one with step ten in mind but only proceed to step two when step one is completed. When step two is completed, they then proceed to step three and so on.

The nonlinear person has a vague idea that there is something resembling a step 10 and because of this, knows that there must be a step one. However, it is unclear what that step may be. In addition to this lack of clarity about the beginning, the middle appears to be a total mystery.

However, beyond the lack of clarity regarding the middle portion of the process, there is an underlying feeling for the nonlinear person that they should know and that, because they don’t know, there is something wrong or deficient with them that needs to be corrected. This underlying guilt is the product of a very successful program of belief-building known as culturization, which is the process of influencing an individual’s values and beliefs by exposure to a particular culture over time.

It Just Is

Culturization is effective when people who resist the influence of culture either feel guilt or shame for doing so. Another sign is when others attempt to make them feel that way. This indicates that the values and beliefs that have been decided upon by the larger culture have worked their way into the bedrock of the individual’s core beliefs.

We know we have reached a core belief when we can no longer explain the origin of belief. For example, when I ask people why it is wrong to bully someone else, they will usually answer that the strong should not take advantage of the weak. This leads to a series of questions beginning with the word “why.” The answer, invariably, comes down to: “It just is.” This is how we know we have arrived at a core belief. Core beliefs seem to ‘just be.’ They have been instilled in us for such a long period of time that we cannot even determine their origin.

How do we know that such a value is merely a belief and not a universal, moral absolute? Because there are entire cultures that do not share that belief. There are cultures wherein the above-mentioned line of questioning would be to explore the acceptance of bullying, even by the bullied. “Why is it OK for the caste system to persist? Why is it OK for the strong to dominate the weak?” The answer is the same: “It just is.”

It is this same process that gives nonlinear people the frame of reference that their way of being and existing is fundamentally wrong. Society has placed a high value on productivity and views it as achievable only through linear means. When I say that society has placed a high value on this characteristic, I do not just refer to its utility value, or its usefulness, but to its moral value. We believe, generally speaking, that to be productive is proper, good, and even, dare we say, righteous.

Who Says?

One of the wonderful traits that is a product of my ADHD (Attention Deficit Hyperactivity Disorder) is the tendency to read multiple books at once, often not completely finishing any of
them. This is a decidedly nonlinear way of learning. Obviously, when studying for an exam in university, a linear approach is more useful. However, despite the fact that I am not in university, not studying, and have no utility obligation to read one book at a time or even to finish any particular book, I feel guilty putting down one book and starting another before I have completed the first.

Why do I feel guilty? Who decreed that books must be read in sequence instead of concurrently? Who commanded that we must finish what we start? What great moral calamity will arise if I read three books at the same time and don’t finish any of them?

I’m sure as some people read this, they may have trouble relating. We may not only be touching upon their core beliefs that place a high utility and moral value on being linear, we are actually describing their very nature. For these individuals, cultureization is not necessary. Cultureization, as it currently exists, actually arises from their nature.

Nonlinear individuals must try not to resent this fact; it ‘just is’ how our society has developed. In other cultures, being nonlinear may be highly valued. In those cultures, the visionary, forward-looking, big-picture-seeing individual has great utility value.

A Wee Double Standard

In fact, within our own culture, despite the micro-level obsession with linearity, there is a macro-level admiration for nonlinear people. The entertainment industry is home to some of the most eclectic, frenetic, unpredictable and constantly evolving individuals in this world. They are also among the most admired, obsessed-over, and sought-after people on the planet. Perhaps this arises from nonlinear individuals living out their nonlinear nature by proxy through these privileged few who appear to have cast off the chains of a linear culture.

While those in the entertainment industry are admired, celebrated, and well-paid, some are far from a paragon of personal emotional stability. They are the living billboard of the maxim that money can buy neither love nor happiness. So how do we explain this paradox? Perhaps the cause of this instability is the attempt to super-impose the linear expectations of the business side of the industry onto the nonlinear individuals around which that business is built.

The Nonlinear Person and Mental Health

On a scale that many more of us can relate to, I believe that many of the anxiety, aggression, addiction, and depression problems that we work with on a daily basis as counsellors arise from this same mismatch between linear and nonlinear natures. For example, many couples who seek counselling regarding communication problems have difficulty seeing the point of view of the other, simply because one is linear and the other is nonlinear.

Relationship problems do not necessarily arise due to the presence of both linear and nonlinear natures, but of the inability or unwillingness of one or both of these natures to understand or accommodate the other.

For example, a common relationship complaint is that one person does not spend enough time with the other. While the offending party recognizes the affect that this has on the other person, they cannot seem to find it within themselves to spend the time that the other person desires. If they do find it within themselves, it often feels forced and disingenuous to both parties. This leads one or both of the people to conclude that they do not care for the other. While sometimes this may be the case, it is not the rule, but rather the exception.

The rule is likely that the nonlinear person, who feels at home on the go, cannot feel comfortable or calm when they are not. It is not a personal attack, targeted at the other partner. It is an unwillingness to spend time or a lack of desire or care for the other person. It is simply that the nonlinear individual needs nearly constant activity or wandering around in order to feel at peace.

In our culture we pathologize this behavior, referring to it as hyperactivity, or a deficit in attentional ability. However, perhaps it is simply a mismatch between a person’s nature and the expectations of the linear society. The mismatch is not with the linear individual but with the expectations of the linear individual.

Both linear and nonlinear approaches are required in order for a relationship to succeed. If both parties are obsessively task oriented, it may be difficult for them to make decisions. Somebody has to take a risk. Somebody has to see the big picture. However, once the big picture has been seen and the risk has been taken, somebody needs to nail down all of the details and make sure that everything is in order.

Imagine, for a moment, that we asked the nonlinear and linear individuals to switch roles. While this would be difficult for the nonlinear person, it would also be very familiar as this is their usual experience in society. However, for the linear person, it may seem...
Have you ever worked with a client who was the loved one of an addict – perhaps without even knowing it?

Often, the loved ones of people struggling with addiction feel so badly about their situations that they don’t talk about what’s going on – not even with their therapists!

As a 2001 alumnus of the Adler School of Professional Psychology in Vancouver, I have been an Addictions Therapist in private practice for more than 20 years, after having worked as an addictions counsellor in Vancouver’s low-income Downtown Eastside (DTES) for 16 years. Although I do still see clients in my practice who are struggling with addictions of various kinds (such as mind-altering substances, smoking, gambling, eating disorders, compulsive overspending, internet and porn addiction, video gaming, and codependency, to name but a few), I now work primarily with people who are the loved ones of those addicts – because there continue to be too few resources for them, and they often suffer just as much as the addicts they so dearly love.

Loved ones generally don’t understand why the addicts in their lives keep using the addiction. “Why can’t they just stop?” they often ask me with great frustration. They also don’t understand why they continue to treat the addicts in ways that are not helpful and even disrespectful, toward both the addicted person and themselves. To me, the most important concept they need to recognize is that if nothing changes, nothing changes. In other words, if a loved one is going to continue to ‘rescue’ a person with an addiction, what incentive does that addict have to stop using?

As time went on and I saw more and more loved ones in my practice, I began to wonder why a practicing addict who was continually being enabled and not being held accountable for bad behaviour would ever choose to change what he or she was doing. And as I started to pose that question to his/her loved ones in our counselling sessions, I could see the light bulb gradually coming on.

As the loved ones decided to make their own healthy choices and set appropriate, self-respecting boundaries, the ripple effect was that the addict almost always decided to make some healthier changes as well.

**Addiction and Adlerian Tools**

Although I would consider myself to be an ‘eclectic’ therapist, not following any one teaching or format, I do find that Adlerian tools work quite well in addiction counselling. One of my favourite Adlerian tools to use with clients is called private logic. We each have our own inner private logic, and we are for the most part unconsciously ruled by it when we either take action or choose to remain passive. Most of the time we don’t understand our own private logic, much less someone else’s. I believe that my job as a therapist is to help people to understand themselves as deeply as possible. Teaching the concept of private logic is a major first step toward the essential self-awareness from which change can occur.

I also love the Adlerian idea of Encouragement, Encouragement, Encouragement. In every session with every
As my clients learned about the 4 goals of misbehaviour and made the necessary changes, we once again found that their addicted loved ones often settled down and chose differently as well. I knew I was onto something important.

The Significance of Social Interest

But I also knew that I couldn’t see every loved one who was reaching out to me for help – and, as at least a part-time Adlerian, my sense of social interest (in short, how we contribute to the world) made it impossible for me to simply rest on my laurels. I decided to write a book outlining what I had learned so that other loved ones living elsewhere in the world could try following the techniques that I was now teaching my clients.

In 2010, I published my first book, Loving an Addict, Loving Yourself: The Top 10 Survival Tips for Loving Someone with an Addiction, which went on to win several International and USA Book Awards. In my book, I present quite a different way of looking at addiction, as well as the tried-and-true strategies I’ve found for ending the enabling that invariably keeps the addiction going.

Two years later, in 2012, I published Loving an Addict, Loving Yourself: The Workbook. This comprehensive, award-winning workbook accompanies the first book by assisting loved ones to go deeper into themselves to look at how their own codependency and people-pleasing began, and how to change these behaviours so that they can finally learn to deal with the very conflict they’ve been trying so hard to avoid -- and increase their own self-respect in the process.

I believe that it’s vitally important for counsellors – whether working in the addictions field or not – to know how to most effectively help the loved ones of those with addictions. Aside from 12-step programs like Al-Anon and Codependents Anonymous, a number of progressive treatments centers that have incorporated family components, and a smattering of “Affected Others” sharing groups that have recently sprung up across Canada and the US, resources for this population continue to be sorely lacking -- and they need help equally as much as the addicts they love.

In my opinion, the best way to win the “war on drugs” is to assist the loved ones to stop enabling the addicts. If nothing changes, nothing changes – and if people with addictions continue to be rescued and enabled, why would they willingly change anything?

Biography

For over 20 years in her private practice in Vancouver, BC, Candace Plattor, MA has helped both addicted clients and their loved ones understand addictive behaviours and make healthier life choices. She also provides clinical supervision for therapists working with addicts and their loved ones, and writes a blog called Psyched on the Vancouver Observer website. An author and Registered Clinical Counsellor, Candace earned her MA in Counselling Psychology at the Adler School of Professional Psychology in Vancouver. For more information about her, please visit her website at www.candaceplattor.com.
Using the Feelings Key™ in Counselling

By Bruce Wagner, MC, RCC, Contributing Writer

| It is neither possible nor desirable to engage in the counselling process without addressing the reality of emotions. Many counsellors use ‘feeling lists’ to assist themselves and their clients as they explore the emotional realm. Regrettably, most of these tools lack research and design. Nonprofessional feeling lists can lead to frustration on the part of practitioner and client alike. Several years ago, a colleague and I were discussing this issue when we decided to spend an afternoon rectifying the situation. We were amazed to see how intricate, time-consuming, and rewarding the project turned out to be. After a considerable development period, we dubbed the results of our efforts the “Feelings Catalog™”. At the time, we had a desire to emphasize choice and responsibility in the area of affect. The Feelings Catalog™ integrated well with various counselling modalities and client types. We had success with the tool in our own practices and over time, we taught interested practitioners, interns, employees, and graduate students how to use the Feelings Catalog™ as a therapy aide. After several years of research and experience – “unlocking hearts” – the Feelings Catalog™ received its first major revision re-launching under the name “Feelings Key™.” | It is helpful to consider the range and relationship of emotional abilities we assume/hope our clients normally possess. We call this hierarchy of practical feeling skills the Ladder of Affective Capacities™ or LAC. It begins with Recognizing emotions. Unsurprisingly, some clients are so out-of-touch with their feelings, they may not even know that they are experiencing emotions. This awareness deficit may be due to many reasons including defensive reaction (avoiding intense feelings); emotional dissociation; lower emotional intelligence; over-focus on the rational-cognitive; cultural background; gender stereotypes; and/or family-of-origin issues and strictures, and so forth. Such clients may acknowledge physiological sensations (e.g. tightness in chest, lump in throat, sweaty hands) but not verbally connect them to specific feelings or mood states. For others, these basic ‘body signals’ are the only evidence that they possess any emotions whatsoever. Following Recognition, clients consciously or unconsciously move up the Ladder of Affective Capacities™ to Identifying feelings. This can be difficult as a limited emotional vocabulary is often a defining characteristic of persons seeking mental health services. It can also be a drawback of some Cognitive-Behavioural based counselling methods. Clinical experience has demonstrated that without the ability to differentiate and specifically name each pertinent feeling, most clients are unable to move to higher levels of LAC. The beauty of the Feelings Key™ is that it makes Identifying feelings a straightforward process thus eliminating guessing for client and therapist alike. Once the identification process has begun, the therapist can work more confidently with his or her client to gain Understanding of a given feeling or emotion set. This may include knowing the components of a feeling including the origins; triggers; frequency; duration; intensity; and related or clustered feelings that may accompany a primary feeling. Clients can increase understanding of an emotion or feeling set by describing an image or picture that a given term evokes for them. Full emotional integration goes beyond Recognition, Identification, and Understanding to include Acceptance, Responding, Regulating, and Appraising. Regrettably, how these processes combine and work with various therapeutic modalities (e.g. the Emotional Management Protocol™) exceeds the scope of this article. Traditional ‘feelings lists’ often present a jumble of words. These kinds of collections tend to overwhelm and frustrate. Some attempt a semblance of order by alphabetizing (see sample below). | Such efforts are marginal improvements at best. This is because the words generally have nothing to do with each other. This type of ‘indexing system’ might be helpful for a client who has already identified an appropriate term for his or her feeling. The format is unhelpful when the client cannot readily specify his/her experienced emotions. Closely related to word-based lists are visual collections made up of pictograms or emoticons. Whether working with youths or adults, I have found these kinds of tools to be of limited benefit. In addition to absence of organization, |
the drawings are often of poor quality or even silly to the point of insult. They may be helpful for people who are doing well, but those experiencing emotional pain do not need their feelings trivialized.

The Feelings Key™ was developed in a clinical setting by professional therapists. It was designed to help clients rapidly pinpoint the specific emotions they have experienced in the past, are presently experiencing, or hope to experience. This is accomplished by applying the “Funneling Technique™” to a carefully selected group of words. While clients are always encouraged to use their own vocabulary, for those who struggle, the current Feelings Key™ provides over 500 emotional descriptors covering the gamut of human emotion.

To be included in the Feelings Key™ emotional words or terms had to pass a number of tests. For example, they could not be difficult or obscure. To be sure, many therapists know what it means to feel tenebrous, morose, diffident, concupiscent, or ebullient. The average client does not. Further, while foreign words can be incredibly descriptive, most laypersons are unaware of what terms such as ennui, angst, weldshmertz, schadenfreude, verklempt, and gezellig mean.

Still further, slang or colloquial terms are excluded from the Feelings Key™. This is not to say that feeling descriptors such as gobsmacked, pissed, bigtoe, shagadelic, or lousy are always unhelpful.
Introduction

This study aimed to investigate the relationship between shyness and the ability to recognize facial expressions in young children. The extant literature suggests that behavioural inhibition may lead to anxiety disorder development. Research further indicates that older children who suffer from social anxiety are less able to identify facial expressions accurately in others. Our study suggests that shyness is related to the ability to recognize facial affect, and appears to support the hypothesis that facial affect recognition would be less accurate and take longer for anxious children.

The participants in this study were 118 kindergarten students from nine classes in four schools in a large suburban school district in Western Canada. Participating students individually completed the Pictures of Facial Affect (PFA) assessment with the researcher at the school site.

Method

Participants

The participants were 118 kindergarten students from nine classes in four schools in a large suburban school district in Western Canada. Participating students individually completed the Pictures of Facial Affect (PFA) assessment with the researcher at the school site.

Measures

Thirty-six slides from the Pictures of Facial Affect (PFA) developed by Ekman and Friesen13 were presented to the children via a computer and the children were timed reviewing them. The 36 slides were composed of six different individuals, three males and three females, each demonstrating six basic emotions, (happiness, anger, fear, sadness, disgust, and surprise).

Procedures

Parents rated their child on a 5-point Likert scale as ‘much more shy or fearful than other children of the same age.’ Teachers identified the 5 most and 5 least shy students in their class.

All students individually completed the Pictures of Facial Affect (PFA) assessment with the researcher at the school site.

The assessment was timed from start to finish.

Results

Shy and Not-shy Groups

The study design created a forced choice category for the teachers as the request was to name the top and bottom 5 students showing shy symptoms. Parental rating of shyness was determined with scores of 4 or 5 (‘often or always shy’). Scores of 1 (‘not at all shy’) were classified as not-shy, with a score of 2 or 3 belonging to the middle group. Despite allowing two scores (‘always’ and ‘often’) to form the shy group, and utilizing the one extreme score of ‘never’ to form the not-shy group, there remained almost twice as many children in the not-shy (20.3%) teacher-identified group as in the shy parent groups (10.9%).

There was a relatively low degree of parent and teacher agreement about which students were shy. Therefore, all data was analyzed for both the parent and teacher identified shy and not-shy children separately. For all results, significance levels were determined at the p < .05 level, and trends were reported at the p < .10 level.

Accuracy of Emotion Recognition

The accuracy of the children’s recognition of each facial expression was also recorded. Unanimously across the groups, happiness was the most accurately (93-99%) identified emotion. The least accurately identified emotion was disgust (40-51%) for all groups, except the parent-identified shy children, who were least accurate in identifying fear (38.3%).

After happiness, anger was the second most accurately recognized emotion. Finally, surprise, sadness, fear, and disgust were not significantly different from each other in accuracy of recognition.

Main Effect of Group Assignment as Shy or Not-shy

For children identified as shy or not-shy by parents, there was a significant difference with not-shy children being more accurate than their shy peers in identifying sadness. For children identified as shy or not-shy by their teacher, there were no significant findings, but a trend of not-shy children being more accurate than their shy peers was experienced in all cases.

Discussion

This study found that children identified as shy took a significantly longer amount of time to label the expression they saw on an individual’s face. There was also a trend for the shy children in this study to be less accurate in their recognition of facial expressions.

Shy children identified by their parents were significantly less accurate in their ability to recognize sadness than the not-shy children. Several trends emerged between the shy and not-shy groups, whether identified by teacher or parents. The trends were consistently in the direction of the shy children being less accurate in their identification of emotions. For all groups there was a difference in overall recognition of emotion (p < .10) and for accuracy of recognition of sadness specifically.

The extant literature suggests that behavioural inhibition demonstrated in young children may lead to shyness, which may lead to anxiety disorder development. Research further indicates that older children who suffer from social anxiety are less able to identify facial expressions accurately in others. Our study suggests that shyness is related to the ability to recognize facial affect, and appears to support the hypothesis that facial affect recognition would be less accurate and take longer for anxious children.

Sonneville14 found that “accurate interpretation of facial information is a prerequisite for successful nonverbal communication, but speed of processing is equally crucial.”

Conclusion

This study confirms that children identified as shy have significantly lower accuracy in recognizing facial expressions than their not-shy peers. The findings highlight the importance of early identification of shy children and the need for targeted interventions to improve their social skills and emotional recognition.

References


and his colleagues began examining a construct he termed Behavioural Inhibition, defined as a state of being quiet, vigilant, and restrained while assessing an unfamiliar situation. His longitudinal research of behaviourally inhibited toddlers led to the observation that “about 40% of the original groups of inhibited children (at 21 months old) became less inhibited at 5½ years, while less than 10% of the uninhibited children became more inhibited”. The researchers believed this reduced inhibition was a reflection of societal values, and socialization experiences.

This theory may have some relevance to the findings of the current study that produced a much smaller shy parent-identified group (14) than the not-shy group (26). The allusion to a societal judgment against shyness may be an indication that parents are hesitant to label their children as shy and resulted in the much smaller shy parent-identified group (14) than the not-shy group (26). Kagan has noted the biological basis for shyness. Shyness serves a protective function, and is not inherently problematic.

This study may encourage clinicians to encourage parents, classroom teachers, and school counsellors to provide support for young children, with or without an anxiety diagnosis. Early awareness of poorer facial cue recognition may lead to early intervention, which may increase the opportunity for shy children to engage with their peers, and through this practice, reduce the level of anxiety around interpreting the emotions of others in social interactions.

**Limitations**

Approximately thirty years ago a researcher named Kagan and his colleagues began examining a construct he termed Approximate thirty years ago a researcher named Kagan and his colleagues began examining a construct he termed Behavioural Inhibition, defined as a state of being quiet, vigilant, and restrained while assessing an unfamiliar situation. His longitudinal research of behaviourally inhibited toddlers led to the observation that “about 40% of the original groups of inhibited children (at 21 months old) became less inhibited at 5½ years, while less than 10% of the uninhibited children became more inhibited”. The researchers believed this reduced inhibition was a reflection of societal values, and socialization experiences.

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This study may encourage clinicians to encourage parents, classroom teachers, and school counsellors to provide support for young children, with or without an anxiety diagnosis. Early awareness of poorer facial cue recognition may lead to early intervention, which may increase the opportunity for shy children to engage with their peers, and through this practice, reduce the level of anxiety around interpreting the emotions of others in social interactions.

**Biography**

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Ted Leavitt works in his private practice, Connectivity Counselling, full time, along with facilitating workshops, writing articles, and recording music. He specializes in attachment injuries, especially in the context of impulse control problems such as addiction, ADHD, anxiety, and aggressive behaviour. He can be reached at ted@connectivitycounselling.com and by phone or text at 604-825-1832.

**Non-Conformists Unite!**

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unbearable. Imagine if, as part of a university class, the students were required to read four books all at the same time and not finish any of them. Their ability to multitask and be incomplete would determine their grade in the class. Many would likely either shut down from the overwhelming expectations or do the best they could, which would inevitably be inadequate.

Many of the people that we work with lament that they should be somewhere by now, they should have accomplished something, that they have nothing, and are nothing. When asked who they are comparing themselves to, they often will cite a few examples of close friends or family members who were much “further along” at the same age or stage of life. It is at this point that I like to point out the discrepancy between linear and nonlinear ways of relating to the world.

Perhaps, I suggest, the problem is not their inability to function in the linear world that we live in, but the inability of that world to accommodate their nonlinear nature.

Experience tells me that there are plenty of nonlinear people out there in disguise. I believe this is why people are driven to behaviours that remove their inhibitions, such as drinking alcohol or using drugs. This may feel like the only way that they can be their true self. However, I assert that it is possible to be your true self and even the truest form of yourself without having to resort to these means.

Both linear and nonlinear alike must recognize that nonlinearity is a legitimate way of functioning and that productivity and linearity have a tenuous relationship. Linearists must surround themselves with, or at least expose themselves to, individuals who have managed to cast off society’s linear expectations without resenting those expectations. If these things happen, we nonlinear people may feel free, perhaps for the first time, to wander, wonder, and enjoy the journey without obsessing about getting to the destination on time.

**Biography**

Ted Leavitt works in his private practice, Connectivity Counselling, full time, along with facilitating workshops, writing articles, and recording music. He specializes in attachment injuries, especially in the context of impulse control problems such as addiction, ADHD, anxiety, and aggressive behaviour. He can be reached at ted@connectivitycounselling.com and by phone or text at 604-825-1832.

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Understanding of self and one’s family of origin; Lifestyle; Meaning; and Goals.

Premarital counselling can benefit those who seem sure that they have found the person they want to spend the rest of their life with and just want a relationship tune-up to nip in the bud any disagreements or discrepancies between what partners anticipate their marriage to be like.

It also can help to provide clarity to those who aren’t so sure. The process of exploration enhances clarity so that couples can make informed decisions about whether to commit or not. And if a couple decides during premarital counselling to go their separate ways, I certainly do not see that as a failure, but rather a courageous, responsible decision. It means they have realigned themselves with what they really want separately, and can venture forward with more confidence and understanding.

To bring this to life a bit, I’d like to share two brief vignettes as examples of the types of couples who could benefit from premarital counselling, although the possibilities are endless.

Example: Couple #1
HS (32) and CR (27) have been together for 8 years - they met through a friend in university. CR had been waiting a long time for a proposal, as many of her close friends became engaged and married. She too wanted to have a big wedding, settle down, and have children. After many years of dropping hints, finally she gave HS an ultimatum: “We either get married or I’m going to find somebody else.”

Within the year, they were engaged. HS, although he loves CR, feels pushed into the marriage and spending more money than he would have liked on the wedding. He wants to make her happy, and has always had trouble speaking up in the relationship, so remains silent about his concerns. He resents how it has all unfolded, and wonders if he’ll be trapped into a life that he did not sign up for with more ultimatums in the future.

CR is happy planning the wedding, although stressed and feels that HS is disconnected and is uninterested in the whole thing. She is hurt by this, and wonders whether they will ever have a 50/50 partnership where they are both doing the work. The wedding planning keeps them distracted enough so that they are not sharing their concerns with one another. They both wonder whether they have settled, but feel it is too late to bring up these issues with each other.

Example: Couple #2
TT (34) & MB (33) met online and had an instant connection on their first date. After three months of dating they have agreed that they would like to get married someday – and that this was it. They seem to like to do the same things, have so much fun together, and really click.

MB has never been in love before. She had boyfriends in the past, but none that she felt as strongly about as they did her. TT had dated a lot in the past, and has his heart broken a few times. He has finally moved on from his most recent relationship, ending one year prior, and is ready to settle down. MB would like to have kids in the near future, and is getting to the age where she feels as though she is running out of time. No wedding date has been set, nor has there been an official proposal, but it is on the horizon. There is much time left to consider the future, and is getting to the age where she feels as though she is running out of time. No wedding date has been set, nor has there been an official proposal, but it is on the horizon.

Premarital counselling can help both of these couples address their unique issues, by enhancing understanding of themselves, as well as what they and their partners are bringing into the relationship from their past. Also, by clarifying expectations about their marriage, the pair can move onto the same page. As a result, they can let go of any doubts that they had and really be excited about their marriage and their future. The couples can then venture forward, knowing that they have done their due diligence to enhance the resiliency of their relationship in the future.

So how can practitioners be a part of this movement towards prevention and normalizing premarital counselling? By being aware of the services that are available and by encouraging clients to make this investment in their future and normalizing it for them.
In addition, practitioners can adopt the mentality that there is plenty of work that can be done with any couple – even those that seem to be doing great can benefit from examining themselves and their relationship.

**Biography**

Ruth Skutezky is a Registered Clinical Counsellor with a private practice in North Vancouver, BC. She works with a diversity of individual issues, but her passion is working with couples, especially those about to enter times of transition, such as marriage or parenthood. She conducts premarital counselling as well as puts on educational talks in the community. For more information, please contact her at counsellorruth@gmail.com or visit her website: www.counsellorruth.com

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### What Does It Mean to Communicate Clearly

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past moment to interfere with the get-together, let the person you are meeting with know that you are happy to see them and state it will just take some time to shift gears, then ask them how they are doing or how their day went.

As they begin to talk, shift your focus from how you feel to the other person. This will help bring you into the present moment, rather than be caught up in the past.

Keep in mind that later, whether it is that evening or the next day, you will need to revisit what happened that evoked the disruptive emotions and figure out what happened. To do so, work with the writing activity above. In this way, you clear that emotional experience from clouding your mind and free yourself up to enjoy, or at least experience, the present.

**In the Shoes of the Receiver**

We are not always the ones talking when we connect with another. There are those moments when we are the receiver of another person’s communication. When we are in the shoes of the receiver, there are things we can do to help foster clear communication.

Remember, each of us have our own unique experiences that have fostered our understanding of body language, tone of voice, eye contact, word choice and so much more. To prevent any misunderstanding, we need to check in to see that our interpretation fits with what the other person is trying to say.

To illustrate this, consider a silly moment experienced with a group of friends. This may have been something that occurred in high school or something more recent like a silly misunderstanding that everyone found to be quite humorous.

With this group of friends, you can simply say one word that has come to represent that moment and everyone bursts out laughing. However, with a different group of people who do not have that same experience associated with the word, there will not be the same reaction.

When we are in the receiver’s shoes, we can work towards clear communication by sharing our thought process in response to the other person. We may start by stating, “When you say this, I think of such and such. Is that similar to what you are saying?” In this way, we are working towards clearly understanding what the other is truly trying to share and we move away from automatically assuming we come from the same background when in fact we do not.

**Summary**

Clear communication allows us to build our basic emotional needs. These in turn allow us to feel more solid in who we are and to trust that we are going to be okay no matter what life tosses our way.

The challenge is that clear communication means we need to be aware of all of the ways we may unintentionally miscommunicate (e.g. allow a cluttered busy day or major disappointments to cloud our communications with others), as well as actively work towards ensuring we are truly hearing what another is saying rather than making assumptions based on our own understandings of the behaviours and underlying emotions being communicated by another person.

You can discover what prevents you from being able to clearly communicate. You can feel solid and comfortable sharing who you are with others. The more you allow yourself to practice clear communication, the more opportunities you have to build your own basic needs.

**Caveat:**

Sometimes life throws us some distressing experiences. As a result of past painful moments, it can be challenging to allow ourselves to be seen for who we are. These past painful experiences have taught us that self-preservation means keeping ourselves safe, or hiding ourselves from additional potentially painful moments. We can heal from these past painful experiences.

To see if there may be past painful experiences clouding your ability to communicate clearly, see if you find yourself defaulting to encrypted ways of communicating (e.g. intentionally hiding yourself from others) despite wanting to clearly communicate.

Pay attention to your thoughts and feelings and notice if the fear of being seen is overwhelming and driving your behaviour.

These are examples of times when we may need to connect with a therapist, or someone who can help you repair past painful moments that overshadow the present. If there is judgment or fear about reaching out to see a therapist, consider re-wording “reaching out to a therapist” as “choosing to see a communication coach”. You can heal, learn and grow.

**Biography**

Natasha Barber is a clinical counsellor and dietitian who works with individuals and couples in Vancouver. Her passion is working with individuals who are trying to sort through their relationship with food, and thus their relationship with themselves. Her love of words is illustrated in her belief that words can either box us in or set us free. For more information, please contact her through her website natashabarber.ca, by phone 604-221-2373, or by email natashabarber@shaw.ca.
Using the Feelings Key™ in Counselling

But - as in areas such as sexuality - the counsellors’ job often includes an educational function. In the same way that counsellors, for the most part, eschew calling a penis a ‘weewee,’ the Feelings Key™ avoids slang. To illustrate the point, the word lousy -literally meaning “full of lice” - lacks affective precision for therapeutic purposes.

Similarly, while I may understand “bigtoe” as a very positive expression, it is probably unfamiliar to persons not living near the West Coast. Finally, the Feelings Key™ attempts to avoid many vague or duplicate terms such as coy, malaise, or complacent and complaisant.

When using the Feelings Key™ the client begins by choosing a Polarity—either negative or positive. This is not to suggest that the feelings flowing from the Negative Polarity are necessarily bad or inappropriate, merely that clients often experience them as difficult or unwanted.

Next the client chooses a Main Mood or MM. Moods can be defined as the internal feeling states that individual’s experience while affects, are what show on the outside. Thus, emotions may differ between what is presented externally through facial expression, tone, actions, etc… (i.e. affect) and what is going on inside (i.e. moods). The expression “laughing on the outside but crying on the inside” helps clarify the difference between affect (in this case laughing) and mood (sadness). MM’s include Angry, Happy, Sad, Anxious and so forth.

Clients continue to distill their emotions into more accurate language by moving from their Main Mood to Expressed Emotion (EE). Many clients find this level of precision to be sufficient (some other feelings lists achieve this kind of fidelity) but the Feelings Key™ allows for further refining through a final level of descriptors called Focused Feeling (FF). The FFs provide more feelings words having the potential of even greater exactitude as they are ranked by increasing intensity. For example, FFs under the Expressed Emotion “Annoyed” include over a dozen words ranging from the relatively benign Bothered and Perturbed…through Irritated and Aggravated…all the way to the more intense Exasperated.

The entire Funneling Technique™ from picked Polarity to Focused Feeling can be very rapid. This holds true even if a client starts with impaired emotional Recognition. Quickly pinpointing emotions is an essential strength of the Feelings Key™. Even so, it is amazing how therapeutically heuristic the actual process can be. Emotions are complex phenomena. Clients have feelings and ‘feelings about their feelings’. Clients rarely experience a single pure emotion. Guilt can be mixed with anger…fear with curiosity. It is this very jumble, in fact, that lies at the root of some client problems.

The Feelings Key™ makes an inexpensive and welcome addition to any counsellor’s toolbox. It is currently available as a full-colour double-sided worksheet or as a smartphone/tablet application for Android or Apple from Google Play or the Apps Store respectively.

The Feelings Key™ avoids many terms. It suggests that the words happy and sad are ‘imprecise’ and ‘armed with a gun’. The Feelings Key™ longs to avoid many of these words and suggest that the feelings flowing from the Negative Polarity are necessarily bad or inappropriate.

Abandonment and Engulfment Fears

He/she then gets to see clearly that his/her fears are not actually of abandonment or engulfment; what is really being feared is the possibility of powerlessness in the face of these two opposite feelings. Encouraging clients to choose to work on the fear builds openness and resourcefulness. This naturally restores trust in their own capacity for self-nurturance and safety when people get too close or go too far away.

Engaging in authentic communication and developing compassion for one’s partner and oneself, when gripped by either of these fears, can begin to break the cycle. Victim-thinking keeps clients stuck. Encourage clients to admit their fears to each other and break the power of withholding. Encourage clients to be gentle and tolerant with themselves while they learn to rewrite their early programming. There will be backslides, and we can prepare clients to see these as a natural and healthy part of the process of change, and we can also help them see that, once the silence has been broken, they can begin to move forward.

For example, if one partner fears abandonment, have him/her practice letting the other go further away than he/she normally feels comfortable with. If the fear engulfment is triggered, have clients agree to give freely of their time and affection to the other. Repeat these exercises, increasing the distance or the closeness each time.

When clients can endure the stress and fear of choosing a different option outside of their normal response, you know that their relationship matters to them in a healthy way. The willingness to step toward intimacy, while at the same time experiencing and releasing old fears increases self-esteem and self-respect.

Biography

Bruce Wagner operates Ascent Counselling & Therapy in Abbotsford. He has directed an award winning assessment & counselling program, taught graduate students, presented at many conferences, published research in peer reviewed journals, and developed several tools and techniques for therapists.

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know in advance how long we might need records for.

My suggestion, for now, is that we each consider our client group and the possibility of needing records beyond the three-year limit. If it is a real possibility, turn records into electronic data so that they do not take up space, store them securely (I encrypt them), and keep them… for a long, long time.

Here is an interesting side note: While discussing records with Brad Ackles, I asked about audio or video recorded sessions. For insurance purposes, would it be sufficient for a counsellor to keep recordings of sessions rather than taking notes? It would. Of course, permission to record and to save the recordings would be required, but for those of us who are not naturally inclined to note-taking, that raises interesting possibilities.

Subpoenas and competition

I felt sure of the answer to the no-subpoenas question, but I checked the matter out hoping I was wrong. Why?

No-subpoena clauses would help protect client confidentiality and keep clinical work out of court in situations rife with acrimony and legal wrangling. They would be a blessing to counsellors working with children caught up in parent wars.

Morally, a case can be made for such clauses. Morally, a case can be made for extending a kind of Legal Privilege to counsellor-client communication and short-circuiting the whole issue. It would be interesting to take the so-called "Wigmore Criteria" — which are used as a test for Privilege—and demonstrate how thoroughly clinical counseling satisfies them.

However, we live in a "real" world, the courts are not receptive to counsellor-client Privilege, and they are most unlikely to be swayed by the "no-subpoena clause" in counsellors’ agreement with their clients. In summary, such clauses are a waste of time.

How about non-competition clauses? It surprised me, but the answer is similar. I was even more surprised to learn the answer was under my nose in the BCACC Legal Commentary Restricive Covenants in Shared Office Contracts. Somehow, the title did not suggest the content. Here is the relevant passage:

6.3 Avoid non-competition clauses As non-competition clauses may not be enforceable, but can be expensive to litigate, they should be avoided unless they are absolutely necessary. Employers should avoid including them, and employee counsellors should be wary of signing a contract that includes one.

Relevant discussion is also to be found in sections 4.4, 5.3, and 5.4.

Supervision

• There is no specific legislation pertaining to clinical supervision.
• There is no particular common law rule that would apply to it either.

This may, perhaps, change if some kind of regulation finds its way onto the books. But, for now, the law in no way speaks to clinical supervision as a particular activity.

Of course, if a supervisor is working under the auspices of a counsellor training program, for example within a university, there will be rules and requirements attached to that. They are for the supervisor, the student, and the institution to negotiate, agree, or reject among them. If a supervisor takes a supervisee into his/her clinical practice, the possible liabilities and obligations depend upon how it is done:

• If it is under the auspices of a training program, any rules and requirements negotiated with the training program will apply.
• If the supervisee is a fully qualified colleague, then the question to ask is whether the arrangement involves aspects of an employer-employee relationship. If it does, then vicarious liability might apply and there may be tax implications.

In addition, it may be important to know that if a client is judged to be “in fact” the client of the supervisor, then the common law can place primary responsibility on the supervisor for harm caused by the supervisee. Anyone working with a training program is well advised to ascertain the “chain of liability.” Anyone taking a colleague into his/her practice is well advised to be quite clear whose clients are whose.

George Bryce was also of the opinion that, except when a training institution places clear and particular obligations upon a supervisor, the law is unlikely to hold the supervisor responsible for anything more than:

• Providing appropriate supervision within the scope of the supervising counsellor’s own qualifications or competencies.
• Reporting irreconcilable concerns to a relevant authority.
• In the case of trainees, ensuring they are aware of any reasonably foreseeable risks to clients that might arise during counselling and how to avoid or minimize consequential harm.

Don’t those of us who supervise do that as routine practice however experienced the supervisee?

Here is one area of practice where the law gladdens my heart. Supervisors are sometimes spoken of as though responsible for the behaviour of their supervisees in the manner of a puppet-master and a puppet. But one cannot be responsible for what one does not have the power to do or to change. If I am not in the counselling room, then I have little power over what happens there. I can only supervise to the best of my ability and blow the whistle if I think there is a serious problem.

And if I am in the counselling room? Well, I don’t think I should be, but that is something for another day.

There is much more to say about supervision. Mitchell and Abbott Professional Indemnity covers it. The distinction between supervision and snsupervision is worth an article in itself.

Counsellors who work without a “professional friend” correlate disturbingly with counsellors who find themselves dealing with the Inquiry Committee. But I am at the end.

Next time, information sharing.

Biography

Clive Perraton Mountford, PhD, is BCACC’s Board appointed Ethics and Standards consultant. He is available most days to discuss matters pertaining to Ethics, Standards, and clinical practice with RCC’s. To contact him either email cpm@peraford.co or call Head Office for his current whereabouts and telephone number. Elsewhere in his professional life, Clive is a counselling therapist and supervisor in private practice, an applied ethicist, and a focusing teacher. He is active within several BCACC committees.
WORKING WITH FIRST PEOPLES

Abandonment and En-gulfment Fears

Not only must counsellors address their own potential prejudices, they must also actively work with First Peoples in order to provide complementary (traditional/Western) services. This may involve working alongside an Elder or shaman so that traditional medicine and psychotherapy are complementary and not competing. Finally, professional counsellors, and their Associations/Collages, must hold governments accountable for policies that while adhering to the letter-of-the-law subvert its spirit. How Health Canada currently regulates First Peoples access to traditional healers is but one example.36

Biographies
Dr. Sharon L. Acoose is a member of the Sakimay First Nation and Associate Professor, School of Indigenous Social Work, First Nations University of Canada.

Dr. John E. Charlton is a Registered Clinical Counsellor in private practice, editor-in-chief of the peer-reviewed journal Addiction, Recovery and Aftercare, and tri-author of the book Walking With Indigenous Philosophy: Justice and Addiction Recovery. Dr. Charlton has extensive experience counselling First Nation individuals in Ottawa and Vancouver’s lower eastside. You may reach Dr. Charlton at john@jcharltonpublishing.com
MEMBERSHIP UPDATE

BCACC will publish lists of membership registration changes in each issue BCACC News. This issue contains updates to our membership register between January 1 and April 30, 2014. All lists are arranged by Region and City. We will continue to post monthly updates via the Member Portal (https://bc-counsellors.secure.force.com).

Resource Library

We have recently updated our library. To borrow books, videos or DVDs, contact Carly at 1-800-909-6303 ext 0, or e-mail hoffice@bc-counsellors.org. For a complete listing of all Resource Library holdings in Head Office, visit the Member Portal (https://bc-counsellors.secure.force.com) and click on Resource Library Holdings.

BC Association Of Clinical Counsellors

Member Orientation Workshops

2014 Member Orientation Workshop Schedule
September 2014 – Region 1
November 2014 – Region 5

Why should I attend the Member Orientation Workshop? The Board of Directors expects all new RCCs to attend the workshop within two years of joining BCACC. Long-time RCCs are also welcome to attend.

The information that new members of BCACC receive in their Welcome Package offers resources to get them started. The MOW is a six-hour experiential orientation workshop designed to introduce new members to the Association’s structure, including member-support and regulatory functions, and a group ethics exercise. Further, attendees can be updated on the future direction of the counselling profession in B.C., and build community by meeting their colleagues.

Attendance is free of charge, but advance registration is required. All materials, together with refreshments and a light lunch, are provided. Upcoming dates and venues are broadcast from Head Office via e-mail.

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, drawing 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.

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

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 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
aina@bc-counsellors.org
or phone 1-800-909-6303 ext. 4.
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 via the Member Portal, and three times per year in Insights Into Clinical Counselling.

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Subscriptions

Subscriptions for Insights into Clinical Counselling are available at a cost of $21.00 (incl. GST) for three issues. Please contact BCACC Head Office for particulars.

Help us Keep in Touch

Head Office needs your current home and mailing addresses on file so we can send you your membership card and receipt, association announcements, letters of good standing, and Insights into Clinical Counselling Magazine – just to name a few!

If you are moving or if you have a new e-mail address, phone 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:
Log into your Member Portal – https://bc-counsellors.secure.force.com

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/iicc-magazine.

2015 Membership Renewal

Due January 1, 2015
Notices will be sent in November, and the application will be available via the Member Portal.
Please login to the Member Portal to ensure we have your current contact information (https://bc-counsellors.secure.force.com).

Upcoming Head Office Closures

Monday, September 1
Monday, October 13
Tuesday, November 11
December 22 – 26
January 1, 2015
The BCACC offers a warm welcome to Carolyn Fast who is joining our Association as Executive Director, starting September 2, 2014. Carolyn has worked in the non-profit sector in British Columbia and Ontario for the past 30 years, including work in co-operative housing, food banking, community economic development, domestic violence and most recently in housing readiness education. She has a strong commitment to providing needed services to the vulnerable, as well as helping to facilitate larger change in our society through her work.

Carolyn is currently completing a degree in the Master of Arts in Community Development Program in the School of Public Administration, University of Victoria. Her area of research for her master’s project is co-location of non-profits into “non-profit centres,” a burgeoning movement designed to achieve more efficient and effective service and innovation among non-profit partners.

Carolyn is the proud mother of a son, Ben, recently a graduate of the University of Victoria and currently a masters’ student at Royal Roads University.

Carolyn is very excited to begin work at the BCACC, providing support to so many who are doing essential mental health work in communities around the Province. She looks forward to meeting many of you in the months to come.

We’re looking forward to having Carolyn on board in September.