Race Matters

How Counsellors Support Positive Racial and Ethnic Identity Development

Necessary Knowledge for Working with First Peoples
Being Atypical in a Typical World
Making Sense of Suicide: Robin Williams...
When “We” Becomes “Them”
Cultivating Presence in the Therapeutic Relationship
Mystery of the Missing Link Between Father and Son
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Renewing and strengthening our organization for today and for the future.

A great deal more failure is the result of an excess of caution than of bold experimentation with new ideas. (J. Oswald Sanders)

In every organization, as for every individual, taking time to pause and engage in careful consideration of intent, action and results, brings opportunities to creatively re-invent those parts of ourselves that have ceased to fit us, and to strengthen and refine those parts that can lead us toward the future we have imagined for ourselves.

However, we can neither take stock, nor imagine that future without you.

To deliver on our stewardship promise, we must engage in sustained conversations throughout our organization in order to chart a path forward together that best recognizes and celebrates the richness of our differences. The diversity of our now 3,000 strong membership means that it takes time to understand each other and thus ourselves. Only by creating space for conversations can we successfully discover and define our common vision and goals.

To that end, we are initiating two conversation and input spaces to gather your thoughts, comments and creative imaginings about services and supports for BCACC as it moves forward. In January, we will be launching a forum under Google Hangouts which will be hosted by Dr. David Paterson, Executive Vice-President, inviting people to gather together – virtually – to discuss issues of common interest. And, we will invite you to participate in an “e-suggestion box” by sending your comments through a link on the member portal. Please watch our weekly broadcast early in January for details on both of these options.

With your help and ongoing input and support we can lay the foundation that will sustain and enhance the counselling profession in BC for the future. We look forward to your energy, your passion, your wit and your wisdom, as we combine our efforts and engage in the exciting conversations that will take us where we want and need to be.

We wish everyone a wonderful holiday season, with times of rest, celebration and vision for the New Year.

Respectfully,

Duncan Shields - President
Carolyn Fast - Executive Director

BC Association of Clinical Counsellors
Enhancing Mental Health All Across Our Province
The Medicine Wheel is part of the ceremonial and cultural practices of many First Peoples* of North America. One learns how to use the Wheel through observation, practice, and by listening. When one begins to use the Wheel, they must ask questions to confirm that they are on the right track. Hansen notes “that [First Peoples’] ceremonies can be, and are being, misused by people who have not learned the cultural teachings that are required in order to conduct them properly.”

The Wheel is circular because there is no beginning and no end; it is a continuous life process that is never-ending. All my [Dr. Acoose] years of research have taken me to many places, but arriving at an understanding of how to follow ceremony and feeling proud that I have been able to sustain life and live in culture has been by far the most important. Building Medicine Wheels with criminalized Aboriginal women is a recipe for goodness, faith, hope, and for living prison-free as reintegrated human beings. Medicine Wheels are our balance.

Over the course of time, the women and I built Medicine Wheels according to the different trials and tribulations of our lives. This part of the article aims to explain the theory that is the Medicine Wheel. I begin by first providing historical context to the concept: What part the Medicine Wheel has played in traditional Aboriginal, (specifically, to me, Cree), culture, what it has been used for, and how it can be used today. I then give further details on how the Medicine Wheel is meant to work and what its process entails. I conclude by discussing why the Medicine Wheel is a particularly good tool for helping criminalized Aboriginal women in their healing journeys.

Medicine Wheel: Historical Context

The Medicine Wheel is a very old tool that First People have used over the years as a means of healing from the past. There are different types of Wheels put together by a variety of First People such as the Cree, Saulteaux, and Sioux. And, of course there are many other tribes throughout North America that practice the teachings of the Medicine Wheel. Throughout their lives, the Medicine Wheel helps individuals come to grips with, reflect on, and deal with the problems they face in the past, present and future. According to Michael Hart, the Medicine Wheel “has been utilized to explain and address issues, including racism, the impact of the Residential Schools, healing, education, and research.” Medicine Wheels can be conducted scientifically and through quantitative research methods, and there are really no boundaries as to how they can be used.

Until recently, due to colonization efforts, everything that First People knew about tradition and ceremony had to go underground. Many First People would continue to practice their traditions and customs but would do so in secrecy. Ultimately, due to this long-lasting restriction,
many of the traditions and customs of Aboriginal People would be lost, including many languages. Fortunately, the Medicine Wheel and its holistic view of the universe have survived to this day. A great amount of knowledge can be uncovered using Medicine Wheels; they have been known to track not only life cycles of people, but also of animals, plants, stars/astronomy, and environmental issues.

First People have a rich and vibrant culture. Most First People live by the laws of the land, honour Mother Earth, and understand that the environment is essential to daily life. As stated in Education is our Buffalo, “The cultures of Aboriginal people are holistic; that is, they are totally integrated in their connection to Mother Earth” (p. 26). In other words, First People are of the belief that all things, whether animate or inanimate, have a place in the world. This significance has been vital to the sustenance of First People, and to how they relate to Mother Earth. As Elder Danny Musqua explained:

We have a beautiful tradition and a holistic view of the universe that makes us who we are. In our circle, we need the old and the young, the old teach the young to keep the tradition alive. Nothing really dies out in a circle.

things might get old and wear out but they renew again, generation after generation. That is what the circle is about.\textsuperscript{xi}

It is said that working together in a holistic manner will bring First People closer together. The Medicine Wheel, as a holistic tool, makes this possible.

THE MEDICINE WHEEL EXPLAINED

The Medicine Wheel has been used for healing purposes for generations. As Michael Hart explains, “The Medicine Wheel is an ancient symbol of the universe used to help people understand things or ideas which often cannot be seen physically.”\textsuperscript{vii} The Medicine Wheel can be expressed in many ways, and there is no right or wrong. The idea behind the process is to have people work through the Wheel from birth to wherever they find themselves at the present time. The Medicine Wheel can be used to assist an individual in his or her own self-reflection. According to Hart, “traditional ceremonial leaders explain that every person has their own Medicine Wheel since it can reflect each person’s own life.”\textsuperscript{viii} In this sense, the Medicine Wheel is like a snowflake where no two are the same. It is a unique and beautiful thing.

Most First People will know and understand the significance of using Circles/Medicine Wheels and their connectedness to the land and its people. It is also said that working with Elders within the Medicine Wheel is vital to the restoration of life. According to Joan Sanderson:

The Elders shared wise counsel, advice, and guidance about maintaining harmony and balance in families and the community. They provided a continuity of worldview; they also lent wisdom to daily life and brought order to chaos. Elders were the reminders of heritage and survival and strength.\textsuperscript{ix}

The Wheel is like a journey of life that you can take to explore your lineage and to access knowledge from past First Peoples who have lived on this Earth for many moons. Because many Elders are profoundly spiritual people, they carry the great lessons of the Medicine Wheel. As such, they are the backbone within the Wheel, and it is through them that balance can and will be reached.

WORKING THE WHEEL

Working the Medicine Wheel is done to grasp life in new ways. It is about being innovative, honest, and willing to take the good with the bad. There is no right or wrong way to work and/or
The process of healing is not easy. The past comes close to the heart and makes life hard to live; however, the Medicine Wheel might help a person see new options or possibilities for herself. By helping someone put a whole new perspective on life, the Medicine Wheel assists that person in releasing stress and makes it possible for them to let go of pain and misery. As a result, it might also help people understand who they really are, and where they want to go in life. The Medicine Wheel teaches us that it is important to know who you are, where you are going, and what you need to do in order to stay in balance.

The Wheel is merely another way to log your life from birth to becoming old. Like journal writing, poetry, or storytelling, the Wheel is a tool that can help people to see and understand their pasts so that they may grasp what went wrong and why. It is a means of exploring mi-no-pimatisiwin (living the good life) and attaining revelations. In The Sacred Tree, it is said that, “the Medicine Wheel teaches us that the four elements, each so distinctive and powerful, are all part of the physical world. All must be respected equally for their gift of life.” If working through the Medicine Wheel is followed and done according to who you are as an individual, it has the potential to grow into powerful gifts of life.

The concept of four is significant to the Medicine Wheel. The Wheel has four sections that follow the four directions: North, East, South, and West. In those sections, for example, there are also four seasons, four animals and four colours that signify the four races of people, which are all part of the life cycle. As a rule you would start the Wheel in the North from birth, where you would have received an ‘Indian’ name. Then you would continue on towards the East, South, West, and back to the North and continue the life cycle until death, and beyond. However, due to the colonial changes of our society some people might start the Wheel process somewhere past the East or closer to the North. Wherever the process begins it will continue onwards in a circular motion.

**BUILDING A MEDICINE WHEEL AND FORMING A SHARING CIRCLE WITH CRIMINALIZED ABORIGINAL WOMEN**

Criminalized Aboriginal women have suffered much indignation throughout their lives. They have experienced physical and cultural destructions that have left them helpless and lost. They exist in a world that is lonely and empty, and they lack the opportunities that non-Indigenous are given. Many Aboriginal women suffer trauma, which leads to despair. The Aboriginal Healing Foundation argues that:

For Aboriginal women, European economic and cultural expansion was especially destructive. Their value as equal partners in Tribal society was undermined completely. The Aboriginal inmates in Kingston Prison for Women described the result this way: “The critical difference is racism. We are born to it and spend our lives facing it. Racism lies at the root of our life experiences. The effects are violence: Violence against us, and in turn our own violence.”

Whether they are in or out of prison, criminalized Aboriginal women have shown remarkable abilities of survival. The significance of the Medicine Wheel for criminalized Aboriginal women is that it can become an important part of their healing journeys because it is a great outlet for them to explore who they are, how they can heal, and where they are going. It is a simple tool that can assist them to empower their shattered lives.

**Rebuilding Lives:**

With the breakdown and disorganization of communities, Aboriginal women have been impacted through their loss of role, loss of pride, and loss of dignity. Living life in the Wheel can help them restore and rebuild their lives. While the healing journey is not easy, it represents an essential part of how any criminalized Aboriginal women will stay prison-free. The building of the Medicine Wheel as such is not difficult; the hard part comes with having to rehash and remember the hurts of the past.

The Medicine Wheel brings wholeness, restitution, and serenity to the disorder of living in an unkind society. It gives breadth to our lives and fills the holes and the suffering that have led to the criminalization of so many Aboriginal women. Through both the teachings and the knowledge transition that the Medicine Wheel brings, Aboriginal women will not only build common ground, but they will prosper and grow.

As we know, the Wheel is a sacred tool used in the healing journey. It nourishes body, mind, and soul. It is used to bring back balance, hope, and reciprocity. And it is used to show how First People have made their way since being colonized and being put into Residential Schools. The Medicine Wheel can help us see things that we might have difficulty seeing for ourselves. Because all people have the ability and capacity to grow, learning about the Medicine Wheel can help a person find the connection that her life has or had, and where and why she might have gone astray.

**Sharing Circles:**

In addition to constructing individual Medicine Wheels, there were a total of four Sharing Circles. Before each Circle, we first enjoyed a meal together. At each Circle, during our meal, we discussed and reached consensus on how the Circle would proceed. The meals would set the pace for the Circles, and whatever emotions and/or topics that came up during the meal determined how we would proceed during the Circle. As the host of each Circle, I would open with a Smudging Ceremony. Each woman was given a turn to express her thoughts, feelings, and stories during all of the Circles.

I used an eagle feather as a talking device so that when one of the women held the feather, she would be the only one allowed to speak, and no one would be permitted to interrupt her until she was done. If any of the women were menstruating, they were not allowed to hold the eagle feather due to the fact that this is when a woman is at her most powerful, and we do...
not wish to disrespect the feather. Although no time limit for the Sharing Circles was set, each lasted approximately two and a half to three hours. An offering of tobacco is a show of respect, dignity, and honour. I did not need to offer cloth because I deemed the tobacco offering to be sufficient.

It was a new beginning for two of the women because neither had had any previous dealings with Elders, except for when they were incarcerated. It was technically not their way, but they were willing to learn. These Sharing Circles were powerful beyond my imagination. I had no idea where this research would take me, and I had no idea how the Sharing Circles would turn out—if at all. I felt deeply honoured to sit in the Circles with these women. The experience was fierce! I have learned so much in the Aboriginal world since my [Dr. Acoose] sobriety, and this research process has given me the ability to be confident and to fear nothing. In the last Sharing Circle, one of the women broke down in tears and said that she did not want this process to end.

The power of these Circles was more powerful than even I could have imagined. The Circles gave these women breadth and the drive to continue living a good life. The magic in the Circles can only be seen by participation. It is difficult explaining the power and the feelings. These women cried openly, laughed out loud and surrendered to their hurt souls and prayed to find their spirits within the Circles. It is a miracle.

**CONCLUSION**

While First People have found their voice, this is a relatively recent turn of events. We still live in a culture where stereotyping not only persists, but also functions—no matter what the justification—to perpetuate racism. If othering is a process that dehumanizes, intentionally seeking to know the other should, we hope, foster a process toward social cohesion. It is for this reason that we began this exploration with a brief background intended to help mainstream counselling professionals, and by extension others, be able to intentionally begin to understand how Aboriginal worldviews may differ from those of mainstream—hierarchical and individualistic—Canada.

This second article of our two-part submission (we refer readers to our previous article, Necessary Knowledge for Working with First Peoples, that appeared within the August 2014 issue of IICC) offers an examination pertaining to the building, and utilization, of a Medicine Wheel in conjunction with forming a Sharing Circle. As Dr. Sharon Acoose noted, “the experience was [and we argue will be in other instances] fierce!” We would like to propose that this is but one example of how Aboriginal knowledge can be helpful to the mainstream, if the mainstream cares to intentionally listen and understand.

Indigenous or not, whether by choice or not, we all live in community. Given this, an ‘appropriate’ way of seeking to understand ourselves, and others, is through the lens of structural and normative frameworks that call for the development of “human capabilities to the fullest.”xii For this to happen, mental health professionals need to be self-aware of both their strengths and weaknesses, and able to meet their clients where they are. Many mental health professional bodies, in fact have gone so far as to, have this written into their Code of Ethics.

A note of caution is needed. If Braithwaite is correct, and we believe he is, about our understanding ourselves, and others, through the lens of structural and normative frameworks, meeting clients where they are at, while knowing where we, the mental health professional, is at, is essential as this allows therapists to bring themselves and their client(s) into the overlap between Indigenous and non-Indigenous ways of being and knowing that will foster intercultural and interdisciplinary dialogue.xiii

Donald Fixico,xiv Distinguished Foundation Professor of History at Arizona State University, has observed that the wars fought between the Indigenous peoples of North America and the Euro-Americans were more than just over land, they were wars of the mind. Today, mainstream culture still thinks in a linear fashion, which is different from the circular fashion of Indigenous peoples. These two continue to be at odds when both are not realized, “as by one not knowing the other.” This neglect presumes there is only one correct way of thought, the linear way, which implicitly compounds the long-term national problem of geographic dislocation and the negative aspects of alcohol (and other substances) once they were systematically introduced into Indigenous populations through trade; as the “large ripple” of colonization continues to manifest itself in new and unanticipated ways into 2014.

If counsellor and client are able to maneuver into the overlap between Indigenous and non-Indigenous ways of being and knowing, then Indigenous methodologies will prove themselves cross-cultural healing enterprises. The Medicine Wheel provides the road map; a Sharing Circle provides support, understanding, encouragement and possibly other ways to interpret one’s Medicine Wheel. Together, both serve to help the individual find and understand him or herself. This paper is but one example of the promise that the emergence of Indigenous philosophy within the mainstream holds.

* We will use the terms Aboriginal and First People interchangeably in order to be inclusive of Canada’s First Nations, Métis and Inuit populations; and by extension, other Indigenous Peoples, global-wide, as well.

**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@charltonpublishing.com
While I have been exposed to hundreds of psychological, social, and educational theories and have worked surrounded by school psychologists, educators, social workers, and clinicians, I never really learn a theory until I’ve described it to a young person or parent. The other day was no different. I was sitting across from a young girl’s mother, who was rightly unaware of psychological-ese, desperately wishing to know what’s happening with her child. This provided me the opportunity to explain intelligence quotient (and its counterpart: Adaptive Functioning) in an easy-to-understand, socially just, and, most importantly, useful manner.

“Linda*, I’ve asked you to come to my office today because we’ve just received your daughter’s testing back from the psychologist,” I begin. “There are two pieces that we now need to understand together, so that we can better understand Sarah’s behavior and emotional needs.”

Linda responded, “I didn’t really understand why he was asking me all of those questions. He didn’t really explain. I saw the results but I don’t get what he means.” She refers of the interviewing she participated in with the psychologist many weeks ago. “It’s the same thing with the hospital years ago. I have that 20-page report but I don’t get a word of it!”

Now, I’m not a psychologist but as a counsellor and instructor I deal with psychological concepts throughout my day. And I’m often the one left with the task of interpreting psychological concepts and articulating them in a language so that the parents I communicate with can fully comprehend what their child has just experienced – whether it is psychological-educational, adaptive, or symptomatology testing.

I start by explaining a little about the reasons for doing psychological-educational testing:

• To understand children’s strengths and limitations;
• Notice any major concerns;
• Decipher any gaps;
• Attempt to interpret their understanding of the world; and
• To learn ways to adapt the teaching and learning process to create as much success as we can for children.

Then I go on to explain a little about the reasons for doing adaptive functioning testing:

• To understand at what age a child is functioning;
• To adapt our strategies for interaction and building life skills, and more.

As a group we decided to have Linda complete adaptive functioning testing because her daughter’s IQ scores led to more questions than answers. With Linda, I share that Sarah is scoring at the top percentile of two of the areas of IQ but the bottom percentile of the other two areas. Complicating things further, her functioning scores lead us to believe she’s at an eight-year olds’ abilities, not her chronological age of 16. As I explain this to Linda, her face continues to be blank; I see no body language indicating comprehension or meaning. I’m stuck for a moment but then get an idea. I pull out my portable whiteboard, quite useful in situations such as these. “Linda, I’m going to draw something to help us understand what’s happening for Sarah.”

“Here,” drawing two lines to create three sections of the bell curve, and then pointing to the middle bigger section, “is where most of the population exists in their IQ and functioning.” I share some examples: A typical distribution of scores from math class test; height across a population, and so on. I worry that I’m getting my psychometric statistical explanations incorrect, but I figure it’ll do.

“Then I go on to explain a little about the what the bell curve is.”

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I pause and worry about my words. “On the other hand, people with severe mental challenges would be placed on this side of the bell curve.” I point to the opposite side of the spectrum.

Likewise, I go on to say that those people with severe developmental disabilities, and so on would be placed there too. She seems to understand the concept but I want to take it one step further. She and I have spent a long time working together to help meet the needs of her daughter and she’s very frustrated because nothing seems to work for their family.

I rack my brain for ideas, and then it occurs to me. “You see, the mainstream world is set up for people like you and me. Our workplaces, our schools, and other institutions are all built on the premise of the majority of the population’s functioning.”

“Oh,” she says.

“Yes, our knowledge of how we teach our children, how we build our schools, even how we intervene with people who are struggling are all based on meeting the majority of people’s needs. Our society isn’t quite set up for people on either sides of the spectrum. Don’t get me wrong, some people find an environment to thrive, but for the most part they struggle. We assume people are part of the majority until proven otherwise.” And then I add, “It’s totally unfair.”

“I want to connect it further. “Do you remember when Sarah was at school in early elementary school and they put her in seclusion for not talking in class when asked to respond to something and then she began to act out when pushed further?”

“Yes,” she says, “that was awful, she was there for a few days.”

“And do you remember when she was told to sit outside in the hallway until she was ready to participate?”

“Oh yes, she was so angry, and they kept putting her out there.”

“Well, with the information here, the psychologists who have interpreted the reports say that Sarah is functioning more like someone with Asperger’s IQ but with a developmental age of much younger. Can you see how she would have a hard time in school, with friends, etc.?”

“Gosh yes, that’s exactly how we’ve felt over the years talking with the school, with counsellors, with the hospital staff.”

I continue, “Yes, everyone up until now has assumed Sarah won’t do something, when really she can’t do something. When we expect kids to do something they quite literally cannot do, we set them up for failure.”

“Yes!” she proclaims.

“So now, what we have to do is set up an environment that meets her needs. Just like society has set up an environment for you and I to thrive, we need to do this for Sarah.”

And with that, we had a plan.

“I never really learn a theory before. And that, I believe, is what theory is for. "Names have been changed to maintain client confidentiality.

“People with severe mental challenges would be placed on this side of the bell curve.”

“Over here,... is where people who have very gifted abilities occupy.”

Biography
Carys Cragg MA, RCC, is a Registered Clinical Counsellor and Instructor at the University of Victoria and Douglas College’s schools of Child & Youth Care. Her writing can be found in Insights into Clinical Counselling, Canadian School Counsellor, Cognica, Perspectives, and the International Journal of Children’s Spirituality, amongst others. She can be contacted at carys.cragg@gmail.com.
Robin Williams’ suicide on August 11, 2014 was met with shock, grief, and confusion among fans and the general public. Like other unexpected celebrity deaths (such as the drug-related deaths of Philip Seymour Hoffman, Cory Monteith, Amy Winehouse, and Heath Ledger), news of the actor-comedian’s death sparked a flood of tributes, analyses, and speculation in print and online media. Represented within this content are distinctive discourses by which the general public makes sense of suicide. These discourses – constellations of language, meanings, and practices that offer particular understandings of human concerns – include explicit or implicit assumptions about the nature of suicide. Although dominant discourses often become taken for granted as “truths,” they are historically situated and socially constructed.

Narratives and conversations are sense-making practices that are shaped by discourses. Counsellors and clients each bring their own discursive lenses to the conversations of therapy. Discourses serve to position people: Each discourse opens up certain possibilities (e.g., for relating and responding) and closes off others. In conversations about suicide, even the most collaborative counsellors can “freeze” within a particular discourse – that is, foreclose on a singular set of meanings that can narrow their options for being helpful with a client.

In this article, I attempt to “make the familiar strange” by inviting you to examine how we socially construct suicide and to consider how other possible understandings might add nuance and richness to our responses.

Discourse Analysis and “Truth Effects”

We engage with our world via discourses and the varying assumptions, perspectives, and actions or practices that come with them. We rarely select our discursive repertoires intentionally; rather, culturally dominant discourses come to seem “obvious” and uncontestable. Within discursive “reality tunnels,” certain interpretations and responses are logical, and others are rendered illogical or simply invisible.

Discourse analysis1,2 is a qualitative approach concerned with language and its role in the construction of social and psychological life. Discursive approaches are not interested in proving a discourse true or false; rather, they seek to draw attention to the construction and effects of cultural truths.

In what follows, I am not trying to disprove dominant models of suicide, nor am I attempting to advocate for the wholesale adoption of an alternative theory. I do believe, however, that any single discourse will be unable to adequately describe a complex human phenomenon such as suicide. I will not speculate on the causes of Robin Williams’ death; rather, I will attempt to show that the media invoke discourses in ways that shape (and are shaped by) consensual social meanings around suicide. If new information surfaces about the “facts” of Williams’ death after the time of this writing (late August), a discourse analyst would continue to focus not on the truth, but on the truth effects – how what “counts” as true shapes possibilities for action and understanding.

Why Did He Do It? Meaning-Making in the Media

A dominant discourse, found in a majority of articles on Williams’ death, is that of “mental health problems” such as depression, addiction, and anxiety: For instance, Williams’ publicist released a statement indicating that Williams had been “battling severe depression.16 Most articles stopped short of making a direct causative link between Williams’ mental illness and his suicide (an exception: “It’s not Williams’ fault he felt the only cure for his depression was the one that is, to be frank, guaranteed to work”). However, citing mental health issues leads readers to infer that these issues must be significant in interpreting Williams’ actions. Addiction is included in the mix of problems that are listed (despite Williams’ wife, Susan Schneider, stating that his “ sobriety was intact” at the time of his death), contributing to a portrait of chronic torment rather than situational despair.

A second prominent account, which emerged some days after the news of Williams’ death, focused on the disclosure that he had recently been diagnosed with Parkinson’s disease. This detail was treated as explanatory for a number of reasons. One commentator writes: “The Parkinson’s diagnosis does add much needed context to the narrative of depression and suicide. Who among us ‒ drunk or sober ‒ is above the full power of a devastating diagnosis?” In this claim, Parkinson’s is treated as the final straw added to a pre-existing burden of depression and addiction.

A statement from the National Parkinson Foundation (NPF) reverses the explanatory order: “According to a recent study conducted by NPF, more than half of those with the disease suffer from clinical depression, which is part of the disease process itself.” This claim invokes scientific discourse to underscore its legitimacy, and implies that suicide is a tragic sequela of the disease. Depression is framed as a medical issue, presumably beyond the patient’s agency. It is likely not a coincidence that this statement from the NPF reinforces the necessity and urgency of investing in Parkinson’s research and support. Finally, a newly-emerging and controversial
"It's not Williams' fault he felt the only cure for his depression was the one... guaranteed to work."

"His anxiety"

"It's addiction"

"Romantic loss"

"...financial struggles"

"Williams' latest sitcom being cancelled"

"Act of protest or resistance"

"He had recently been diagnosed with Parkinson's disease"

"The people who say wise things for a living are very often in more pain than the average..."

"...a sin against God"

"Romantic loss"

"It's not Williams' fault he felt the only cure for his depression was the one... guaranteed to work."
account at the time of this writing was that of Williams’ suicide as a “side effect” of drugs used to treat Parkinson’s.

Another explanatory repertoire suggested that Williams’ suicide was linked to aspects of his personality, such as wisdom (e.g., “the people who say wise things for a living are very often in more pain than average”) or sense of humour (e.g., “Robin Williams and why funny people kill themselves”). In the majority of content on Williams’ death, the dominant discourse of suicide as the result of internal pathology is recognizable. In other words, suicide is considered a symptom of a problem or sickness (e.g., depression) inside the person. Even in articles that mention external stressors such as financial struggles or Williams’ latest sitcom being cancelled, these factors tend to be presented as triggers of a pre-existing vulnerability – not as reasons or causes in themselves.

One of the most widely-viewed images in the immediate wake of Williams’ death was also the most controversial: The Academy of Motion Picture Arts and Sciences tweeted a still from Disney’s Aladdin with the quote “Genie, you’re free” (Robin Williams provided the voice of Aladdin’s Genie). This tweet, initially described as moving and evocative, prompted backlash from commentators (including suicide-prevention groups) who argued that it inappropriately glorified suicide as a loving liberation.

That the Genie tweet was widely embraced suggests that it tapped into an already-prevalent discourse of death as “resting in peace,” and suicide as a form of death that can qualify as a release (presumably from pain or suffering). Suicide as an escape from unmanageable (physical) pain underlies the practice of doctor-assisted suicide, which is increasingly considered a reasonable choice in the face of debilitating terminal illness.

The backlash against the Genie image, however, suggests that the notion of death as a merciful release continues to be contested in the context of self-accomplished suicides. The chief medical officer at the American Foundation for Suicide Prevention (AFSP) emphasized that “suicide should never be presented as an option,” and that the mental health concerns that underlie suicide are treatable. The AFSP was also concerned about a possible “contagion effect,” implying again that vulnerable, at-risk people must be protected from exposure to external “triggers” against which they are assumed to have little control.

Suicide as Internal Pathology

In his book Suicide: Foucault, History and Truth, Ian Marsh traces the social evolution of self-accomplished death – from the honour-related voluntary deaths of Ancient Greece and Rome, through self-murder as a sin against God and a crime against the State, to the early nineteenth-century shift towards treating suicidality as a medical condition. As searches for the specific anatomical origins of suicide proved fruitless, academic and clinical thought shifted to unseen pathological processes – destructive inner “passions” that could overcome susceptible patients’ rationality and drive them to end their lives. It was in this era that suicide came to be incontrovertibly associated with mental illness; circumstances such as financial ruin or romantic loss were rendered secondary to underlying pathology. This understanding of suicide as a “tragedy … caused primarily by pathological processes internal to the individual that require expert diagnosis and management” remains dominant today, and is clearly recognizable in media responses to Robin Williams’ death.

As suicide became understood as a tragic consequence of mental illness, public responses to suicide deaths became less shaming or punitive and more compassionate – doubtless a welcome change. However, the construction of suicide as a scientific, medical phenomenon rendered it mysterious to family and friends and, often, to the “patients” themselves. Suicide became cast as a frightening and unpredictable force that must be expertly treated; suicidal people required protection from malign forces that might overtake their “true” selves. Certainly, many people experience suicidal impulses in this way – whether framed as metaphorical “demons” or biochemical aberrations (exemplified by narratives such as the autobiography How I Stayed Alive When My Brain Was Trying to Kill Me) but it is debatable whether this is the “natural” phenomenology of suicide, or a looping effect whereby people come to self-interpret via the language and logic of dominant discourses. In any case, attributing suicidal urges to a malevolent, non-self-entity such as “depression” alleviates the blameworthiness of suicide, but can also render people uncertain, helpless, and dependent on “expert” intervention when suicidal thoughts arise.

What is Left out of the Pathology Discourse?

The pathology discourse of suicide has proven useful in many ways. It provides a “common enemy” that need not be synonymous with the person; it can offer some comfort to bereaved friends and family by...
a sense of purposelessness, emptiness, Durkheim argued, people experience in this state of normless anomie, understandings of what is valuable; in the absence of agreed-upon their place. Striving is rendered futile meanings have not yet arisen to take when a society's shared values and Anomic suicide was thought to arise anomic, egotistic, fatalistic, and altruistic. of the discipline of sociology, wrote that destroy the human spirit. Religious and philosophical traditions have long offered explanations of the meaning of suffering. It has been seen as a purifying trial; humankind’s natural condition through which we must stoically persevere; or a lesson that behoves us to extend mercy to others in the future. However, in secularised modernity, suffering has become extraneous and unnecessary. Suffering becomes not a spiritual purification, but an unpleasant symptom to be erased through medical and technological intervention. Advertisements and news of scientific advances promise us that suffering is avoidable or curable; indeed, much suicide-prevention discourse advances this same notion. For those whose suffering persists despite multiple efforts at “treatment,” the perceived meaninglessness of their suffering (reinforced by its alleged curability) might exacerbate their hopelessness.

Broadening our Repertoire of Responses

“Addictions, suicide, depression – these are not medical problems, they’re existential problems. They’re existential problems that occur because we’ve created societies that do almost nothing to enhance the human spirit.” – Ken Low

Most typically, calls to action around suicide seek to “decrease stigma” and “increase awareness.” These injunctions, interpreted critically, often amount to an invitation to inspect emotional states through the dominant lens of “mental health” – to monitor oneself and others for potential “warning signs of suicide” and to dutifully seek professional (medical/psychological) help if any “risk factors” are perceived (cf. the very broad range of “symptoms” – from back pain to traffic violations – that have been read as possible precursors of suicide). Media commentaries also frequently include calls for increased funding for mental health services – presumably increasing the reach and omnipresence of therapeutic mental health discourse.

While few would take issue with efforts to reduce shaming, we – as policymakers, counsellors, or laypeople – can choose to supplement these dominant responses with generative possibilities drawn from alternative discourses. At the policy and public health level, we can broaden the scope of our prevention strategies to recognize the political and sociocultural forces that underlie despair, hopelessness, and suicide – for instance, in Indigenous communities, decolonization might be a central practice of suicide prevention. Jennifer White and her colleagues, in their fascinating studies of suicide prevention programs among young people, caution against the narrowing of meanings to a single “correct” understanding of suicide. They instead encourage educators to critically and honestly navigate with students the many contradictions and complexities of suicide and its “prevention.”

Martin Seligman, the researcher who would go on to champion the positive psychology movement, wrote a chapter in 1990 entitled “Why is there so much depression today? The waxing of the individual and the waning of the commons.” In Seligman’s opinion, the rise of consumerism and preoccupation with one’s own comfort and wellbeing has led to profound, widespread dissatisfaction. He urges a re-evaluation of our individualist values and a return to concern for the common good. Over twenty years later, I am not sure that we have heeded this call. As we teach our children “mental health literacy,” socializing them to manage their emotions in sanctioned ways, we might also consider how we are teaching them to navigate existential questions about their place in their community and world, about life’s purpose, and about the nature of suffering.

Because inner-pathology understandings of suicide imply that suicidal people need to be protected from their own destructive impulses, counsellors often feel pulled into risk-managing ways of practice around suicide. Indeed, institutional policies might mandate this style of approach – for instance, counsellors may be required to impose a “no-suicide contract” upon any clients who talk of wanting to end their life. I do not have space to explore these issues here, but I invite counsell-
I’m not sure of the specific time I realized I had become a “them”. Perhaps it was in a consultation group after having missed numerous meetings due to illness; or maybe when I had no more clients, no more relevant issues to bring to the group because of the illness…

Throughout my counselling career, I have participated in a number of ongoing peer consultation and facilitated supervision groups. Of course, the clients were the main topic of discussion—how to be better counsellors with “these people” who sought us out or were referred/mandated to us. And yes, it’s true, we are encouraged to “do our own work,” “sit in the other chair” in order to be better therapists. But what happens when dealing with our own chronic mental/physical health issues becomes our work, instead of what we were called and trained to do? When “we” become “them?”

I was abruptly introduced to this process by a car accident—three of them, in fact, over 5 years. Taking a little time off to heal after the first one, I was still looking ahead, impatient to get back to work. I pushed on, accepting the emotional and physical pain as something to live with while continuing to do therapy with clients. However, the cumulative effects of pain continued to decrease my effectiveness and abilities, which I was still able to deny. Finally, one well-meaning employer asked me to take time off to recover from the 5 years of effects—what a shock to have the consequences of my denial revealed to me! A miasma of feelings of shame, hurt, outrage, and fear enveloped me. For a while. Just a while. But I began to plan going back to work, accepting that this “sick leave” was merely a bump on the road, a temporary set-back to my continuing on with my career. So this calm acceptance saw me through the summer of the “time-off” when everyone else is in “time-off” vacation mode anyway.

Then came September, when life seems to start up again. I was struck by the fact that I was NOT getting better and able to get to work. This sick leave thing looked like it was going to stretch on longer that I had planned. I shrugged that off, and continued to go to my consultation groups—when I wasn’t too ill. I still paid rent on my office, kept a website going, my work phone number and voice mail were still current. But sick leave turned into short-term disability, and I was still unable to get back to work. I had to change the message on my voice mail (but continued to keep paying for it). I began to feel a bit defensive when asked when I was planning to be back to work, as well as when comments about clients with chronic issues hit too close to home. I felt I had nothing to offer, client-wise, to the consulting groups. The sympathy and care were still there (we ARE therapists, after all), but not the collegiality. I felt the beginnings of “them-ness”. I was becoming one of “those” clients with chronic mental/physical illness.

I had worked with clients with chronic illness. I listened to their descriptions of the endless medical procedures, the hoops they had to jump through for disability monies, the lack of understanding of friends and family members, the pain they suffered on a daily basis; I heard their feelings of worthlessness, abandonment, fear, anger, betrayal, loss, depression… I acknowledged their grief, confusion, and loss of status among colleagues and friends, their sadness over the changes to family life, and the consequences for their kids, how they changed the word “invalid” to “inVALid” as a way of attaching some humour to their experience. I encouraged them in researching what they could about their particular illness, and ways to survive and manage the illness, as opposed to being a victim. And now, I identified with “them.”

The “them” concept emerged during a consulting group for workers in health fields, when one of the attendees was struggling with what we all could see was workplace stress and burn-out. She was afraid of taking any time off, as she had heard a colleague deride another person who had taken a stress leave as “joining the ranks of THEM”. It was almost like the Victorians, drawing their skirts aside to avoid coming in contact with filth. We discussed her worry over the possible perceptions that she wasn’t able to “handle” the work, that she didn’t have “the right stuff.” She also admitted a concern about what her being gone would mean for the work load on all the others, as well as her chances for future promotions.

This person’s experience sounded too familiar. I realized times I had unfairly judged colleagues who needed to take a longer time off because of mental/physical illness, or who were dealing with a chronic condition, and that I had heard others do the same. Stigma is alive and kicking in our ranks.
And by-products of this are fear and denial, which push people into working that much harder and longer in order to prove they can “handle it,” and ignoring or denying symptoms of long term distress. These feelings and actions were part of my repertoire, as well.

One of the hardest things to admit, as a former “we”, is that even though I know all the theories and perspectives, explanations, encouragements, these cognitive assets still don’t prevent me from feeling and experiencing the same things as a “them.” For example, I know how much my counselling position gives me a sense of worth and capability and the many reasons why. I know that the loss of this due to the chronic illness has to be grieved, and how destabilizing it can be, which can then trigger anxiety. I know that one of the big issues with chronic illness is the lack of control over outcomes (i.e. cure), episodes, relapses, social life, etc., and the resultant powerlessness and helplessness. Knowing all of this doesn’t stop me from having to feel the loss; it doesn’t stop me from trying to find something I can be “good” at again.

One of the low points I experienced was when my friends doubted how I was communicating to medical personnel and specialists because I wasn’t getting better, and they wanted to come with me. While I appreciated the support, I was devastated, because I had been thinking at least I can be good at managing my own medical team. I understand they were also feeling powerless and wanted to “make it better” for me. But again, this cognitive awareness did not preclude having to “work through” the issues with friends.

Powerlessness and dependency were concepts to be challenged but also accepted, I encouraged my clients. As a client myself, medication and remedies amplified my helplessness. Trying one medication after another, seeking relief and hopefully a cure, researching and listening to others’ suggestions—all of this demanded more energy I didn’t have, and introduced me to the roller coaster of hope and despair, as well as the dilemma of weighing the side effects against the therapeutic benefits. One medication helped the pain, but likely triggered another chronic illness. Another robbed me of my ability to concentrate, but did alleviate anxiety and sleeplessness.

Pursuing health led me down many useless and expensive paths. Who could relate to this? The “them.”

Another difficulty I have encountered having been a “we” is losing the status I enjoyed as a counsellor. I took pride in my website, as well as in the competence it demonstrated. When it became financially necessary to close down the website and let go of my business phone, I lost the tangible and public evidence for my position. The new business cards, brochures, and letterhead ordered before the accidents were packed away, almost as if that person ceased to exist.

When I had encountered clients with chronic illness before, one area we would spend considerable time on had to do with the forms, tests, all kinds of medical evidence needed for claims for sick leave or disability. They related the usually frustrating and demeaning process of having to prove they were unable to work, to provide evidence in the face of doubt and minimization. While I could reflect and empathize with the struggles, it didn’t impact me: Until I became a “them.”

Over the course of 5 years, I had to document the pain (both physical and mental), submit to tests and interviews with myriad specialists, and generally prove to the auto insurer that I didn’t have much value left, for which I should be reimbursed. I now personally understood the demoralizing process my clients had reported. Furthermore, my having to engineer three appeals for Long Term Disability came to symbolize a fight for validation of my personhood apart from what I “did” before.

Even though these all have been hard lessons learned, for those of you secretly relating to the struggle against becoming a “them” in whatever way that might mean, this is a journey that involves facing doubts and fears, breaking through denial, being more honest (and realistic) about limitations and gentle and compassionate with the self that can learn and grow, just like any human, be they “we” or “them.” As one “them” writes, “There’s something intimate about sharing with others the various ways our bodies have broken down and no longer work properly. It means letting people see the man (or woman) behind the curtain, with all their human frailties showing. It means letting them see behind the social facade we all keep. I can’t help but think that there’s a stigma attached to having chronic illness(es), that having health problems is a sign of weakness in our moral fiber, somehow.”

From sickmomma.blogspot.ca/2012/07

The following quote gives me a hopeful perspective: “Health is…not just the absence of disease or infirmity… It is accepting the fact that life has problems, and that one works responsibly and courageously toward a solution or modification of those problems. Health is not an end in itself….”. Eagle Ridge Hospital credo, Port Moody, BC.

Biography

Booble Kirby has lived life as a counsellor for 26 years, mother for 23 years, wife for 29 years, university instructor for 10 years, a disabled person for 2 years—all roles which have taught and continue to teach her about the weaknesses and strengths of being human.
## Race Matters:
How Counsellors Support Positive Racial And Ethnic Identity Development

By Lisa Gunderson, PhD, RCC, Contributing Writer

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<th>Research has supported the advantages of a positive racial and ethnic identity (REI) in adults and youth for decades. Recently, researchers reported that racialized middle and high school youths, who were positive about their ethnic and racial identity, had fewer problems with drugs, alcohol, negative behaviour, and depression while doing better in school, and having better self-esteem and social interactions.²</th>
<th>sense of REI and is it salient to you?</th>
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<tbody>
<tr>
<td>Step 1: Ready to Support?</td>
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<td>Engaging in support requires the counsellor to first check the self. Three quick hints that counsellors may need additional training or continuing education in this area include not knowing or feeling comfortable with their own REI. Second, subscribing to the &quot;colourblind&quot; ideology (&quot;race and ethnicity do not matter&quot;) despite the overwhelming literature to the contrary. Third, not engaging in cultural formulation with all clients and not considering how REI may impact their presenting symptoms.</td>
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<td>Step 2: How Do I Support?</td>
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<td>If you do not have adequate experience or training in dealing with REI issues, or you live in a homogenous area, seek out training, consultation, and supervision by alternative means (e.g., webinars, phone, or Skype). Five additional ways to support individual clients and families include:</td>
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<td>1. Having a list of therapists who specialize in racial and ethnic issues in your area or surrounding area for referral, consult, and supervision;</td>
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<td>2. Having a list of multicultural resources including books, websites, and links for clients;</td>
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<td>3. Maintaining your continuing education and professional development training on counselling racialized clients; and</td>
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<td>4. Becoming active in your local, provincial, and national mental health associations by joining or starting committees that are dedicated to racialized populations, issues and/or professionals.</td>
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<td>5. If you are working with youth, review the findings from the Ethnic and Racial Identity in the 21st Century Study Group³. Also, the American Psychological Association (<a href="http://www.apa.org">www.apa.org</a>) does a very good job in addressing racialized and other minoritized groups. At the homepage, go to public interest, and then click on the Office of Ethnic Minority Affairs.</td>
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Insights into Clinical Counselling - December 2014

Let’s take a look at a sub-group of parents who provide an excellent example of the necessity of a positive REI. As transracial adoption grows, parents have a myriad of questions on how to support their children in positive REI development. Below are questions that were posed by parents of transracially-adopted children and some of my responses. The questions and responses have been edited and were originally published by Adoptive Families Association of British Columbia in Focus on Adoption (www.bcadoption.com).

The first six questions include my response. The last six questions are for you to review and consider your response. Then, you can e-mail me directly and I will send you my response. I would be happy to respond to your answer(s) as well.

Q. Why do you advise against the idea of being colour blind? What is the alternative, and how can I talk to my child about it?

A. Generally, when people say, “we don’t see colour or colour doesn’t matter” they are coming from a good space in their heart (i.e., I will not judge or treat you differently because of your race). Often, dominant members in a culture adhere most to the “colourblind” ideology. This ideology is one of the earliest stages of White Racial Identity and cultural competency models. Here are 3 reasons against the idea:

1) Colourblindness or any other “blindness” (e.g., persons with disabilities or gender) is factually incorrect and illogical. All of us have a “colour” and it matters. Acknowledging race does not make you “racist” it makes you a realist who lives in a multicultural society.

2) Mounds of research have led psychologists and other social scientists to reject the colourblind ideology. Children are hard-wired to categorize difference and learn to stereotype based on race, even when parents don’t discuss race.

3) For most persons (not all), skin colour is an identifiable marker for race (e.g., people of African descent). All racialized groups have faced discrimination and group members still fight and die because of “skin colour.” We dishonour and pay a disservice to that history and current events by saying we don’t notice or it doesn’t matter. Further, we miss the opportunity to recognize current racial discrimination and to become needed allies. Consistently, over 50% of police reported hate crimes were motivated by race/ethnicity, with Black populations being the most targeted.4

Instead, speak to your child about “racial equity” or fairness (for small children). The goal is to not ignore, but to acknowledge that differences exist, honour those differences, and not judge them.

Q. I am raising an adopted child of a different race, in a community that is not very racially diverse. How do I help my child to be confident about himself and form a strong racial identity?

A. This is incredibly challenging. Forming a strong racial and ethnic identity is a daily process that requires both internal and external exposure from others like themselves. My first response is one that many people do not like – move. Children need others who look like them and they need access to communities who honour their heritage. You became a racialized family when you adopted your child. Now, you have the responsibility to create an inclusive environment for your child. This has long-term psychological consequences for your child. Ask yourself why must you stay?

If moving to a more diverse environment is truly not an option (vs. an inconvenience – longer commute), then develop real friendships with other racialized families, join racialized organizations, conduct a racial audit of your home, put your child in the most diverse school you can find, find big brother/sister or mentor of the same
race or ethnicity, start to build a support group or attend a support group for transracial youth & travel to diverse spaces often. Then, I would encourage your child to move out of your community when they are of age and to a more diverse space.

Q. I’d like to develop relationships with people who share my child’s culture of origin, but I don’t know how to do it in a genuine way.

A. You must become part of the community. Find an active association and get truly involved (look at event sponsors). Attend community events, afterschool activities, and cultural celebrations consistently. Attending events allows you to connect with people who are trying to connect to, or maintain, their own ethnic heritage. Once you are seen consistently, trust will begin to develop.

At your child’s school, make play dates with a diverse group of children and get to know their parents. Reconsider the places in your daily life if they do not have people who share your child’s culture of origin (e.g., schools, places of worship (if applicable), hair salon etc.).

Broaden your circle of friends and start to engage in activities where you can meet people (e.g., local recreation centers or meet up groups). If you live near a college or university, take a relevant course or look at student union groups (many will allow community members to join). Become mentally prepared - this can’t be just for your child. You must want an integrated life as well. If you initially feel uncomfortable, that is okay, stick with it. Remember, your child is watching your cues.

Q. We have European ancestry, but think of ourselves as Canadian. We’ve lived here for generations and don’t feel rituals, traditions, behavioural traits, dress, religious traits, etc. distinguish your ethnic cultural piece (e.g., Euro-Canadian, Chinese Canadian, or African-Canadian).

When you are part of the dominant culture, these pieces may appear normal but you are swimming in your culture all the time. A great book to begin the conversation with your children is “We All Have a Heritage”. The danger in simply calling yourself Canadian is that Canadian may be interpreted as being white. Canadians come in all races and ethnicities, you must acknowledge your own.

Q. Is there a typical process to a youth forming a strong racial and ethnic identity?

A. Based from work in the U.S., there are racial identity models for African (commonly referred to as Black), Asian, Latino, Native American and Bi/Multi-racial descendent persons who are living in a racialized environment, as well as, European (referred to as White) models based on the dominant society. Each of the models describes a theory on racial identity formation. There are no specific times or ages attributed to these models. At a minimum, try to understand your racial identity stage before or while helping your child.

Q. Why would my child (11 years) completely reject anything to do with his birth country, culture or racial group?

A. Rejection is a behavior that underlies other emotions (i.e., anger, fear and sadness). According to the models, racialized individuals attempt to identify with White society and some become ashamed or embarrassed by ethnic markers which leads to “estrangement, and rejection of racial/ethnic heritage…fragmentation of ethnic identity becomes noticeable”.

Depending on age of adoption and history, the rejection could be due to trauma or connections to negative experiences that happened in his birth country. He may think that acknowledging and understanding his birth culture or racial group will cause hurt, rejection, or dishonour to you and the family. Perhaps, others of his race and/or culture are not being positively regarded within his community. Further, if he lives in a dominant White area and the majority of his peers are White, he may feel he has to assimilate or he perceives he won’t be (1) “truly Canadian”, or (2) accepted by his White peers. Finally, he could be rejected or feeling disconnected or uncomfortable with others who are racially or ethnically similar.

If your child is bi/multi-racial, this may be his choice right now in terms of the fluidity of his identity. However, COMPLETE rejection might indicate a deeper wound that may be helped with appropriate multicultural counselling.
This article explores the power and the value of therapeutic presence in client-therapist relationships. It is my desire to increase awareness of the concept, practice and research on therapeutic presence, and to develop further ideas to improve a therapist’s quality of presence.

Psychotherapy is more than just a conversation between therapist and client—it is an encounter between two people with a shared goal of improving the client’s life circumstances and offering new ways of thinking and living.

While client goals may vary from learning better communication skills to personal growth and development, research suggests that the quality of therapist-client relationship is one of the main factors contributing to positive therapeutic outcome.1

So, what does the therapist offer to clients to best promote an effective outcome? Much of counsellors’ training in this area focuses on skills and techniques. However, studies suggest that the quality of the counsellor’s presence in the therapeutic relationship is the primary element in a foundation for change.2

**Therapeutic Presence:**

The word presence comes from the Latin praesentia meaning “being felt as present” by another. Presence is the way a therapist shows up with a client, the unseen, unspoken connection between the two. Therapeutic presence is not simply a skill, but a quality, or a way of being with another. This quality of being is based on the therapist’s ability to bring herself into the room with the client “bearing witness to the truth of another’s experience.”3 (p. 146).

What does presence look like? First, presence is a process that involves the therapist being open and attuned to the client in the moment; listening with her/his whole being. Second, the therapist is in contact with the surrounding spaciousness—while paying attention to the details there is also a sense of the fullness of experience. Third, the therapist feels grounded and centered within herself/himself. Fourth, the therapist’s presence is guided by the intention of being of service to the client’s healing journey.4

In summary, “the therapist must be able to fully encounter the client’s experience while maintaining the ability to observe his or her reactions and experiences and to act thoughtfully based on the confluence of these aspects of the relationship”5 (p. 178).

Therapeutic presence enables the therapist, through attunement, to connect with the client where he or she is. Attunement first occurs in early nuanced exchanges between mother and baby that create neurobiological changes in both parties. Depending on the caregiver being fully present, the infant is regulated in the moment and also learns to self-regulate.

Research has now documented that infants respond to particular prosody (patterns of stress and intonation in speech), facial expression, movements, and even to “unseen”, but felt, caregivers’ moods. It is easy to notice that an upset mother will often have trouble calming an upset baby, whereas a regulated caregiver has a soothing effect on a distressed baby. Consequently, co-regulation occurs when (any) two people are well-attuned.6

Studies report that when two people are in physical proximity they begin to shape the electrical activity of each other’s brain. Also, “other nonverbal signals, including facial expression, tone of voice, gestures, and timing of response, have direct impact” and “it is in this manner that the emotional state of the sender directly shapes that of the receiver.”7 (p. 277).

The attunement learned in infancy activates the brain to feel the other and be present with another; it is advantageous that the therapist and client develop it in their therapeutic relationship. Geller suggests: “Therapeutic presence can be...
Therapeutic presence, and I suggest phenomenological and improve their quality of presence with clients? Mindfulness teaching presence. So how can trainees and therapists develop programs have yet to offer a systematic approach for been only minimally explored and counselling psychology Despite the clear benefits of therapeutic presence, the topic has Development of Therapeutic Presence:

Therapists both seem to feel more energized after sessions where they felt fully present as well as feel more available for the next client. Thus, this quality of presence may also help prevent burnout, as therapists do not carry the residual anguish from the people they see.

With presence, therapists learn to become more aware of their own bodily responses to the client’s experience, which inform how they may best be helped. Their internal resonance to the client’s experience interacts with their professional knowledge and out of that emerges a response right for the unique needs of the particular client seeking help.

**Development of Therapeutic Presence:**

Despite the clear benefits of therapeutic presence, the topic has been only minimally explored and counselling psychology programs have yet to offer a systematic approach for teaching presence. So how can trainees and therapists develop and improve their quality of presence with clients? Mindfulness practice has been commonly cited as a means to developing therapeutic presence, and I suggest phenomenological reflection can help improve the quality of their presence.

Mindfulness practice was adapted from ancient Buddhist texts and is now used in the psychotherapeutic world. The practice focuses one’s attention on the moment-to-moment experience and its various and ever-changing intertwined physical sensations and mental events. As Sakyong Mipham says: “Total mindfulness means being completely in tune with what is occurring in the moment. The practice develops the ability to relax in a state of receptivity and availability without being carried away by concerns, judgments or preconceptions. Maintaining receptivity opens one to the vulnerable moments, which allow connection with the essence of another. Thus therapist and client connect through their shared humanity.

Mindfulness not only increases a person’s capacity to be present but also regulate one’s moods and increases positive affect. A simple momentary shift from mindless reaction to mindful recognition can reduce the power of a stress reaction and its hold over people. Once a person has stepped out of automatic pilot mode and identification with the stress reaction, she or he has a choice in how to skillfully respond to the experience in the moment. Mindfulness’ self-regulatory component and orientation toward “curiosity, openness and acceptance,” helps the therapist develop therapeutic presence.

Along with mindfulness practice, phenomenological reflection can improve the quality of presence of trainees and therapists. The purpose of phenomenological reflection is to gain insight into a lived experience. By reflecting on the experience of therapeutic presence (or its absence) with a client one becomes aware of all the aspects of that lived experience—both what helped the therapist to be present and what hindered that ability.

Van Manen talks about four elements of reflection: Lived Space; Lived Body; Lived Time; and Lived Other.

1. Lived Space is felt space, or the way one experiences day-to-day existence, the landscape in which one moves. For instance, as an overwhelmed client walks into a therapist’s office, both the client and the therapist may feel overwhelmed by feelings of powerlessness; this is how one becomes the space one inhabits in the moment.

2. Lived Body, or physical presence, reveals something about how one responds to the critical gaze of a client. A therapist’s body or gaze may respond in telling ways; lived body reflection increases self-awareness of bodily sensations/reactions.

3. Lived Time is subjective time as opposed to clock time. Does the therapist-client encounter seem to be speeding up or slowing down?

4. Lived Other is the relationship one maintains with others. How does the therapist attune to, or receive, the other? For example, during an encounter with a particularly anxious client, a therapist may or may not be able to maintain his centre.

By reflecting on these four elements a therapist is able to examine subtle, often unnoticed interactions and improve his overall ability to be present with clients. That is, phenomenological reflection, or inquiry, helps bring to light, details of the client-therapist encounter making explicit whether the interaction was beneficial and providing insight for improvement; thus the reflection can result in a more attuned therapist. Mindfulness practice and phenomenological reflections complement one another in developing and improving therapeutic presence.

**Practice of Therapeutic Presence:**

My desire to write this article was inspired by the possibility of deepening connection and healing in the therapeutic relationship. Mindfulness and phenomenological reflection are the two areas I suggest therapists explore training, and practice, in order to cultivate presence. Both develop the four categories of presence described by Geller.
of a situation, or the totality of sensation) I usually recall the session or following a session to embody particular narratives. Valuable phenomenological reflections that can be used while in development can increase my sense of presence and includes the awareness of one’s self in the moment, maintaining openness and receptivity and having a sense of spaciousness and expanded awareness and perception. Mindfulness is a simple practice that involves learning to develop focus and concentration.

There are hundreds of techniques, practices and systems of meditation. I usually begin my practice with feeling my state of being, a simple internal check in. I allow myself to notice what is occurring in the moment and then bring my awareness to the sensations of my body breathing. Noticing the conscious and subconscious mental gossip, recognizing that the attention has swerved from the physical presence of the body and returning to the breath, I breathe in and out of my lungs. Often one must slow down to a point the mind finds uncomfortable in order to locate awareness in the body. Slowing to a pace where one can observe the sensations underlying one’s thought process takes a lot of practice. This process results in being in tune with one’s inner world while being open and receptive to another’s. Also, using the body, feelings, and mind to increase concentration and seeing sense perceptions as invitations into further mindfulness can open doorways into a larger environmental awareness.

Phenomenological Reflection Following a Therapeutic Session:

Phenomenological reflection builds on the previous categories of presence and includes the awareness of one’s intention of being with a client while reflecting on therapist-client interactions. The practice of phenomenological reflection processes lived experience. In the Somatic Transformation training developed by Sharon Stanley, I learned many valuable phenomenological reflections that can be used while in session or following a session to embody particular narratives.

While attending to the body-felt sense (the bodily awareness of a situation, or the totality of sensation) I usually recall the uncomfortable parts of a session and reflect on how I managed those feelings in the moment. This is how I work through those feelings while I am reflecting as they still linger from the past interaction. This process allows for new information and insights to come to light and informs the next meeting with that client.

New learning is available whenever I take the time to slow down and reflect. This tends to increase my sense of competence as well as lead to personal and professional growth. This kind of phenomenological reflection is also helpful in my processing unfinished residue of the suffering from clients I see in my daily practice.

Preparation Prior to Seeing a Client and for Maintaining Presence in the Session:

Geller describes steps to cultivating therapeutic presence prior to seeing a client, or for cultivating the conditions for presence to emerge in therapy sessions, as follows:

- Pause – take a moment to stop what you are doing;
- Relax into this moment by taking a deep breath;
- Empty yourself of judgments, thoughts, distractions, agendas, preconceptions;
- Sense your inner body, bring awareness to your physical and emotional body;
- Expand sensory awareness outwards (seeing, listening, touching, sensing what is around you);
- Notice what is true in this moment, notice the relationship between what is within you (internal environment) and around you (external environment);
- Center and ground (in yourself and your body);
- Extend and make contact (with client, or other)

This particular practice enhances the qualities of presence through pausing, clearing space and grounding oneself in the moment.

Cultivating and sustaining therapeutic presence requires internal training and an ongoing commitment to personal and professional growth. The practice of therapeutic presence involves fully attending to the experience of yourself and your client, while maintaining the same openness, curiosity, acceptance and love as in an ideal caregiver and infant bond. When this presence is offered, the therapeutic relationship grows into a deep connection that can result in a positive outcome. The ability to be present can be cultivated in students as well as in therapists. As I mentioned earlier, research shows that therapeutic presence brings about “greater well-being, emotional regulation, decreased anxiety, reduced burn-out, enhanced internal and external connections, and heightened vitality.” Therefore, integrating mindfulness and phenomenological reflection practices into both academic settings and continuing education for therapists would deepen therapists’ quality of presence and thus enhance the client-therapist relationship itself.

Biography

Maria Stella, PhD, RCC is a therapist in private practice (Origins Counselling Services) specializing in issues related to loss, trauma, change and transition. She is an associate faculty member at City University (Master in Counselling and Master in Education Counselling). Feel free to contact her at maria@mariaostella.com.
Mystery of the Missing Link Between Father and Son

By June Wong, MA, RCC, Contributing Writer

My client had been trying to describe to me a bond that he felt was missing between him and his twelve year old son that he attributed to his absence during the first four years of his son’s life. Three years ago when we worked together, I thought I understood what he was talking about. But recently when his family got referred to work with me again, we did an experiential exercise where I got to see the dynamics between him and his son play out in front of me. Through that exercise, I gained a deeper understanding of what that missing bond is.

My client has two sons, five and twelve years old. I worked with him and his family three years ago shortly after he and his ex-wife separated. The objective at the time of intervention was to provide counselling support to the eldest son to cope with his parents’ separation and support the father in addressing his oldest son’s behavioural issues.

When the father described to me, in pain, how he felt that something was missing between him and his elder son because he was physically absent in his son’s life at birth due to extenuating factors, we tried to explore what that missing ingredient may be so that we may perhaps reconstruct that for him and his son. We worked hard during the time that was allotted to us and by the time we closed our file, we still had not found the answer. Three years later, his family got re-referred to my agency for counselling service and we were, once again, confronted with the same question.

In our first meeting, the father tells me that his biggest concern is the fact that his elder son seems to hold the same mistakes despite his father’s multiple attempts to address the issues.

My client tells me that he is certain that his elder son is old enough to understand his expectations but that he would selectively carry them out which leads my client to think that his son is ‘defiant’ and ‘stubborn’. I, on the other hand, from an attachment point of view, view his elder son’s behaviours as manifestations of his jealousy towards his younger brother and his maladaptive ways of coping with his family’s separation.

For months, the father and I had ongoing discussions on how to parent his eldest son differently to help change his son’s behaviours. We were not able to reach any consensus because while I believe that his son is displaying act-out behaviours due to unmet needs, his father is convinced that his son misbehaved due to malicious intent.

One day, my client could not find a babysitter for his children when he came to my office for an individual counselling session. He brought both his boys to my office and they waited in the waiting area while I met with him. I took that as an opportunity to do some work with my client and his sons and suggested my idea to my client towards the end of our session. Upon hearing my idea, my client broke into hysterical laughter.

Earlier in the session, my client had told me that the night before, he and his sons sat on a loveseat at home watching TV together, with his elder son beside him and his younger son on his lap. An idea came to me as I thought about the need of the twelve year-old boy, who did not get to enjoy sitting on his father’s lap when he was younger, due to his father’s absence in his life. I wondered how he had felt in the past five years when he saw his younger brother repeatedly enjoy the closeness to their father that he did not have as a child.

As a counsellor, I believe that one needs to pass through every developmental stage successfully (regardless of which developmental theory one chooses to believe) in order to develop into a mature, healthy, and functioning adult.

The twelve year-old, in my view, as confirmed by incidents shared by my client, seems to be stuck at age five in some areas, which is when his father first came to live with him and his mother. I decided to try something to see if I could help this child reclaim what I suspect was missing from his childhood.

I suggested to my client that I would like to invite both his sons into the room and have them sit on the loveseat with him (we have a loveseat in our counselling room, too), just like they would normally at home. I would like to see what their natural seating arrangement is like and then get the two boys to switch places to see how they may react.

At that, my client broke into hysterical laughter and told me that he was pretty sure that his elder son would not sit on his lap, given his age and gender.

He asked me, “June, I don’t think my elder son will sit on my lap, you wanna bet? What do you think [he will do]?”

I smiled and told him that I do not know what to expect and could only hope that his son would sit on his lap.

However, should his son choose not to, that may suggest that he does not need that from his father and that could be a good thing, too. I checked again with my client’s comfort level with my suggestion and received a positive response. I then went to the waiting area and brought the two boys into the room.

I got them to join their father on the loveseat like they would normally do at home. The little one naturally climbed onto his father’s lap, with the assistance of his elder brother, and the elder son comfortably sat himself beside his father. After they were all seated, I asked every family member
how they felt about their seating arrangement. All reported that they felt ‘fine’ and ‘good’.

Next, I challenged the elder son who I have established a therapeutic relationship with three years ago by telling him that I would like to get him and his little brother to go out of their comfort zone a little because that is when you may have the biggest growth. Both boys consented. I asked the two boys to switch places with each other and they could not stop giggling as they, without a moment’s hesitation, followed my instructions. I should have taken a picture of the scene but I did not have my camera with me at the time. It was a rather heart-warming picture, with the son’s long legs dangling over his father’s longer legs.

I proceeded to interview each family member again and asked them how they felt about the new seating arrangement, starting with the little one, who kept on shaking his head but did not say a word.

His father encouraged him to speak his mind and at last, he helped his younger son by suggesting to him, “Do you feel that your brother has taken your spot?” The little one nodded.

Next, I asked the twelve year old boy how he felt about sitting on his father’s lap. I was expecting him to say something to the effect of awkward or uncomfortable, and to my surprise, he answered “I feel comfortable, but I do not think this is comfortable for my dad.” I asked him why, and he answered that he was ‘big’ and ‘heavy’. I then asked his father how he felt about having his older son sit on his lap.

His father answered, “He is heavy.”

I thanked everyone for their participation and told them to take their time in re-arranging themselves, should they feel the need to. I observed that the twelve-year-old took his time in getting off his father’s lap. When he finally did take the seat beside his father, his father asked him whether he felt entitled to sit on his father’s lap.

Without hesitation, the elder son answered, “no.”
If there is one thing most clinicians have in common, it is the knowledge that the therapeutic relationship is at the heart of what we do.
Without a sound therapeutic relationship, none of our modalities would be effective, while, with one, everything we do has the potential to help our clients live a more satisfying life. We also know that empathy is the foundation of the therapeutic relationship. Empathy is explicitly taught as a value in most counseling programs, along with reflective listening skills that help us to relate to our clients.

We integrate the value of empathy and practice the skills until they become second nature, and then comes the day we experience an empathic break in clinical practice. We just were not able to connect and whatever the reason, we suddenly know from personal experience what we have been taught: Empathy is the foundation of what we do.

So what is this Thing Called Empathy?

The concept has its origins in the work of German philosophers of aesthetics who suggested that we find art and nature beautiful by feeling into it. The word did not exist in English until early in the 20th century when an English psychologist translated the German Einfühlung (“feeling into”) by going back to the ancient Greek empatheia (en = “in” + pathos = “feeling”).1 The Oxford dictionary now defines it simply as the “ability to understand and share the feelings of another.” Empathy is the ability to feel into the other’s subjective experience.

How do we Develop this All-Important Ability?

Carl Rogers2 said that our empathy increases with our experience as therapists and that is no doubt true, as we are exposed to the suffering of others and we must find a way to relate to it if we are to continue to work in this field. Yet empathy is something more than a professional value and skill. Following Rogers’ lead, we have to acknowledge that being empathic says something about who we are as a person, not just how we practice therapy. Developing empathy requires that we pay attention to how we develop as a person. Depth psychology has something to say about this that may be of interest to all clinicians.

Vicarious Introspection

Heinz Kohut is known as the founder of Psychoanalytic Self Psychology. From this theoretical perspective, the life course is understood in terms of the development and maintenance of a coherent sense of self. Kohut’s theory was largely developed through his clinical practice, by working with the transferences that occur in the therapeutic relationship. He was concerned primarily with the client’s subjective experience of it. Empathy in the therapist was thus a necessity, if he or she was to respond appropriately.3

Kohut’s first major contribution to the psychoanalytic literature was a 1959 paper on empathy. In it, he argued that “thoughts, wishes, feelings and fantasies” are real and that we can observe them in the “inner world . . . through introspection in ourselves, and through empathy (vicarious introspection) in others.”4 In other words, we can know something about the other’s inner world by paying attention to our own inner world. We can vicariously know what the other is feeling. The theoretical underpinnings of this notion were developed by another psychoanalytic theorist, C.G. Jung.

Jung is perhaps best known today in the field of psychology for his theory of personality typology. Many of us have taken the Myers-Briggs Type Indicator (MBTI) or other similar personality inventories based on Jung’s theory. It assumes that we orient consciously to reality through the processes of sensation, thinking, feeling and intuition, and that each of these functions, as Jung called them, can be extraverted or introverted.

Contemporary Jungian-oriented therapists work with the resulting, eight-function model of consciousness. Feeling, for example, can be either extraverted or introverted, and whether we use extraverted feeling or introverted feeling, or both, has a lot to do with our capacity for empathy. But first, a few words about the theory.

Jung’s Theory of Typology

For consciousness to be fully developed, we have to be able to perceive that something ‘is’, in order to think about what it is, to evaluate whether it matters to us, and to have some hunch about where it might have come from and where it might be going. This is how Jung described sensation, thinking, feeling and intuition.5 Each of these four functions can be deployed through two basic attitudes of consciousness: Extraversion and Introversion. Extraverted feeling, for example, “seeks to connect with the feelings of others,” while introverted feeling “is mainly concerned with the values that matter most to oneself.”6

We live in an extraverted society where we are expected to pay attention to what is going on around us, especially if we live in cities. This comes easily if we are extraverted, that is, if we are interested in the outer world. People with an introverted personality, who are more interested in what is going on inside themselves, are receiving a lot of attention lately because the inner world is less understood than the outer, and so are they.7

Jung said that with extraversion, psychic energy turns outward toward the object, while with introversion it turns inward toward the subject.8 Personality development for him meant, in part, that we develop the capacity for both extraversion and introversion so that we can respond appropriately to whatever situation we find ourselves in. It also means developing sensation, thinking, feeling and intuition so they are available when we need them. When Jung formulated his theory almost a century ago, he assumed that most of us would go through life with just one function well developed; we now believe it is more a matter of the relative development of the eight functions. The theory assumes that all eight ways of consciously orienting to reality are available to us and can potentially be developed.
**Extraverted Feeling**

There is little doubt that empathy requires us to develop extraverted feeling. We all have feelings about people, events, ideas or situations in the outer world. These feelings are the content of the feeling function that according to Jung, is “a process that imparts to the content a definite value in the sense of acceptance or rejection (‘like’ or ‘dislike’).” The feeling function can evaluate any psychic content, but as a practical matter, feelings are typically the content of the feeling function.

With well-developed extraverted feeling, we are able to relate in the appropriate way to outer objects because we have an “adequate evaluation” of them and are “capable of evaluating their positive and negative sides appropriately.”

In other words, we can relate to what the other is feeling.

It is perhaps easier to explain how an extraverted thinker functions (it is certainly easier for this extraverted thinker). He or she is drawn to the thoughts of others and thinks about them (although it is also possible to think about feelings, as I am doing here). Jung described thinking as “the psychological function which, following its own laws, brings the contents of ideation into conceptual connection with one another.” Extraverted thinking can occur in conversation with another individual, while reading a book or attending a lecture, or through reflection on the ideas or beliefs that are extant in a society.

The extraverted feeler, by comparison, is drawn to and evaluates the feelings of others, both in individuals and between them, and in collective expressions of values – what we call culture. It has been suggested by Marie Louise von Franz (left) and James Hillman, respectively, that extraverted feeling can be a bit conventional and conversely that it can be highly differentiated. They were among Jung’s most important interpreters and both had relatively undeveloped extraverted feeling. They agreed that extraverted feelers tend to be well adapted, perhaps because their empathy gives them the lay of the land.

Empathy would seem to rely heavily on extraverted feeling, and yet they are not the same thing. Extraverted feeling goes beyond empathy in that it comes into play whenever we relate to outer objects, not just when we relate to the feelings of others. It is necessary for empathy but not sufficient; we cannot ignore the other functions or the need for introversion.

**Some Challenges**

Jung said that with empathy we assimilate the other, that is, we draw the other into our subjective sphere of interest. For this to happen in a way that supports a therapeutic relationship, extraverted feeling must be relatively well developed. The feeling function must be differentiated from the other functions, which implies that they must also be relatively well differentiated. And feelings must be sorted out from sensations, thoughts and intuitions. Unfortunately, having feelings is no indication that the feeling function is well differentiated.

Affect and emotion is a sure indication that we have been overtaken by something beyond the rational process of feeling. The line between feelings and affect is blurred and one could say that when feelings are strong enough they become affect. Emotion is deeper still. Something beyond the feelings or affect of which we are conscious has come in at this point.

Depth psychology points to the intrusion of unconscious processes to explain the emotionality we experience at these times. When the emotion is disproportionate to the situation we are in the grip of something that has undone conscious processes. Jung called the unconscious psychic contents that overtake us in these moments “complexes,” and he was fond of saying that we don’t have complexes, they have us.

It is easy to see how emotion can undo our attempts to be empathic. Extraverted feeling is not sufficient to bring the other into our sphere of subjective interest if discordant contents come our way and trigger something deeper in us. Insight is required, and that involves the functions of thinking and sensation (what is going on here, what are the facts) and perhaps even intuition, a hunch that something is wrong.

Extraverted feeling can actually betray us if we are not aware of exactly how it functions in us. If we rely too heavily on our feeling function, there is a good chance our thinking function will be “inferior” in the sense that it lags behind the development of other functions. The risk of relying too heavily on any one function is that the other functions will become “archaic” as the psychic energy that nature has bestowed on them passes to the unconscious.

One of the most difficult challenges in identifying our own typology, much less anyone else’s, is that the behaviours we observe that are associated with a particular function (for example, empathy and extraverted feeling) may actually reveal a function that is inferior. When extraverted feeling was still relatively undeveloped in this writer, for example, it often took the form of feeling into and then appropriating the other’s feeling as my own. It is possible to feel and to say ‘yes, I can really relate to that’ and in doing so, to rob the other of their experience in a way that is contrary to the spirit of empathy.

When introverted feeling is the superior function, that is, the function we use most readily, extraverted feeling can have a shadow quality that leads to a degree of paranoia about what the other is feeling. Ideally, we have both extraverted and introverted feeling available. Following Jung, James Hillman suggests that really well developed feeling involves both extraverted and introverted feeling working together to create harmony between what is assimilated from the other and one’s own subjective values.

The key to understanding where extraverted feeling fits in a person’s typology is to map the hierarchy of all eight functions. Despite the difficulties, it is important to know as much as
A Therapeutic Approach to Working with Trauma and Dysregulation: The Example of Eating Disorders and Substance Use Disorders

By Ron Manley, PhD, RPsych, and Carrie DeJong, MC, RCC, Contributing Writers

As therapists we see clients with a range of psychological concerns in our consulting rooms and what most of them have in common is a significant degree of activation in the nervous system, often as a result of trauma. Clients with eating disorders (EDs) and substance use disorders (SUDs) tend to exemplify this dysregulation. These disorders are generally regarded by mental health professionals as among the most challenging to treat, in part as relapse is common and treatment may be lengthy. In this paper we use EDs and SUDs as examples of working with a dysregulated nervous system where a client has an inability to manage this activation in a healthy manner. We view treatment as providing a context in which clients may develop an “earned, secure” attachment, as well as opportunities to engage in self-directed neuroplasticity aimed at building self-regulation.

The Theory and the Neuroscience

As a species we have a limited repertoire in dealing with predators. Scanning the environment for safety or threat, a process Porges terms “neuroception,” has enabled us to survive. Faced with threat we can flee, fight, or resort to tonic immobility, although Taylor et al. have added the “tend or befriend” response for females. This repertoire of responses to threat is enacted through a huge mobilization of energy in the sympathetic nervous system, which is normally discharged or released when the threat has passed. However, if fight/flight are prevented or are socially inappropriate, a chronic state of activation may develop. Tonic immobility may result if neither flight, nor flight, are possible - a behavioural option which, while likely conferring an evolutionary advantage, again loads the system with a high level of undischarged activation.

We are witnessing tremendous integration between fields as diverse as developmental psychology, psychiatry, the neurosciences, the contemplative traditions, and traumatology. Allan Schore refers to an “ongoing paradigm shift” where attachment theory has become the “dominant model” of human development. He speaks to the results of the so-called “decade of the brain” which underscore the critical importance of how the brain itself is sculpted as a result of early environmental social input. He also talks about the shift in psychology from cognition to emotion as well as highlighting the “critical concept of self-regulation.” We would add that this therapeutic shift includes an emphasis on sensation (or what has been termed the “felt sense”) and its role in the nervous system.

Brain development is experience dependent. There is little doubt that the shaping of brain structure and function occurs in the context of our early attachment relationships and that, as a result, we develop “working models” or templates for how relationships with others will be enacted. According to Schore and others, the primary caretaker’s (usually the mother) right brain is utilized by the baby’s right brain as a template for the development of self-regulation. The capacity for what Fonagy and colleagues term “mentalization” and its role in the development of a sense of self (and intersubjectivity), is likely also a function of this early process of brain growth and sculpting in social interaction. We have a high sensitivity to early conditions, whatever those conditions happened to be. The development of enhanced self-regulation in therapy is predicated upon this concept of using another’s regulated nervous system as a template.

The concept of the “triune” brain is important. From a phylogenetic perspective, the first part of the brain to develop was the “reptilian” brain, a part of which is the brainstem. The next was the limbic system which includes the amygdala, hippocampus, and hypothalamus. In terms of trauma, this area of the brain, largely responsible for emotionality, has been described as “survival central.” The last to develop is our neocortex which is responsible for cognitive processing. Each of these brain regions suggests a different level and type of information processing, including what occurs in psychotherapy. For our purposes here we make the point that the effects of activation or trauma can result in “bottom-up hijacking” such that the lower brain centres and trauma symptoms may become less amenable to cognitive attempts to downregulate or control these symptoms.

Eating Disorders, Substance Use Disorders, and Trauma

Anorexia nervosa is an ED characterized in general by significant caloric restriction leading to marked weight loss. Individuals with bulimia nervosa may often be of a statistically normal weight but engage in repeated and frequent episodes of binge eating and purging. Binge eating disorder is similar to bulimia in that there are repeated episodes of binge eating but there is no purging. Approximately half of the individuals with restricting anorexia nervosa develop binge eating and purging. Both SUDs and EDs are said to have the highest mortality rates of any psychiatric disorder.

There is a great deal of research, including meta-analyses, aimed at understanding the relationship...
between SUDs and EDs, the degree of comorbidity, how SUDs may differ across ED subtypes, and how we might account for this etiologically. Explanations for the comorbidity between SUDs and EDs have included problems with affect regulation and prior trauma. However, the clinical reality is that our clients present for treatment with clear “activation” in their nervous system, even those without an obvious history of trauma or PTSD.

The dysregulation of the nervous system in clients with EDs and or SUDs is evidenced through the behaviours they use in attempts to manage this dysregulation and activation. For example, substance abuse, binge eating, purging, and marked caloric restriction, while often regarded as “coping” behaviours, also are signposts of this autonomic nervous system dysregulation. These behaviours may be a result of and contribute to the affective dysregulation these clients tend to experience.

**What is Trauma?**

Most attempts to define trauma have been based on ways of classifying traumatic events and efforts to quantify the severity of these events. The term “complex trauma” is often used to refer to early relational trauma. We also hear the terms “small t” and “big T” trauma, however, the approach here considers trauma to be in the nervous system rather than in the event itself. As Levine puts it, “the organism’s response to a threatening event is more important than the event that caused it.” This is a concept that requires a shift in thinking and carries with it significant implications for psychotherapy.

The effects of trauma on the brain are a result of brain development being so experience-dependent. In the case of relational trauma at an early age, we need to consider these effects and how the client’s established procedures (what we often call the “default”) for relating to the world constitute adaptations that were necessary in terms of early developmental survival and the preservation of their relationships with early attachment figures.

We use “activation” to refer to autonomic nervous system hyper- or hypoarousal, that is, arousal that is above or below the individual’s “window of tolerance.” Kindling of the limbic system was originally observed by animal researchers, and is a phenomenon whereby low level electrical stimulation of limbic system structures leads to sensitization of “limbic neuronal circuits and lower neuronal firing thresholds.” Kindling has been considered as a model for the development of PTSD. Once thought to be permanent, Post and colleagues discovered that this kindling could be “quenched.” We view kindling in part as a more severe and chronic form of activation.

The work of Porges has been highly influential in traumatology. His polyvagal theory outlines two anatomically different parasympathetic branches of the vagus nerve. The dorsal-vagal branch is unmyelinated and tends to be responsible for hypoarousal and shutting down in the face of threat. The other, myelinated vagus or ventral-vagal complex is involved in the face, eyes and larynx. The latter Porges calls the “smart” vagus or “social engagement system.”

We find that considering the capacity of the client for social engagement (for example, voice prosody) and the state of the vagus to be a useful heuristic in assessment and treatment.

**Overview of the Somatic Psychotherapies**

An emphasis on the role of the body in psychotherapy is often traced to the work of Wilhelm Reich, Alexander Lowen, and even aspects of Gestalt therapy. However, we locate its more recent appearance to Ron Kurtz’s Hakomi. Lisbeth Marcher and her colleagues of the Bodynamic Institute have developed a “somatic developmental psychology” that correlates a child’s psychological development with learned voluntary control of various muscle groups. Peter Levine pioneered the “Somatic Experiencing” school of therapy, and Pat Ogden and colleagues have developed “Sensorimotor Psychotherapy.” Self Regulation Therapy has been developed by Lynn Zettl and Ed Josephs of the Canadian Foundation for Trauma Research and Education (CFTRE).

The Trauma Resiliency Model, developed by Elaine Miller-Karas and Laurie Leitch also has similarities to these other approaches. These all overlap significantly with one another yet there are differences as well.

**A Somatically-Informed Clinical Approach**

It is evident that if we are to help our clients discharge activation in their nervous system we will need a clinical approach that accesses this activation somatically. Our work with clients, including those with EDs or SUDs, is multifaceted and includes elements of cognitive-behavioural, psychodynamic, emotion-focused, mindfulness, and feminist approaches, as well as somatic psychotherapy. We outline the latter here as this approach is likely less familiar to therapists. Treatment for trauma needs to be considered as a sequence of three stages: Establishing safety; Dealing with traumatic content and memories; and lastly, Helping the client to integrate these learnings and shifts into broader areas of their life.9,11

Attunement in psychotherapy goes beyond what has traditionally been termed the therapeutic “alliance” or “rapport.” The neurobiological model for attunement may well be the connection between the infant and caretaker’s right brain. Similarly, the client accesses the therapist’s nervous system as a template from which to further develop their own capacity for self-regulation. It is essential that therapists learn to sense into and be aware of their own somatic responses. This capacity is part of what has been termed “evolved embodiment” and “somatic competency.” The clinical applications of work in mindfulness have been significant contributions and we view this state as essential to...
good therapeutic attunement. However, we do not regard it as sufficient as mindfulness alone may not facilitate discharge of activation.

The essential skill is the capacity to track sensation moment to moment in the therapy session. That is, encouraging clients to notice the attending sensations when they experience activation and to follow these sensations. There are several reasons for this, including that sensation may be considered the “language” of the reptilian brain. We work with clients to further develop their capacity to recognize and name sensation in the here and now. Helping a client with an ED to notice and track sensation may need to be developed slowly due to their discomfort with being in the body. Activation is generally correlated with the client’s recounting their personal narrative, which is used mainly as a vehicle to access the activation and to contain it. Talk therapies that do not limit the narrative content in a session run the risk of leaving a client in a state of high activation or at worst may inadvertently re-traumatize the client.

Limiting or titrating the degree of activation in a session is important as it enables the client to remain within the “window of tolerance.” This window is typically very narrow for traumatized clients: that is, the more kindled the nervous system the more likely that relatively low amounts of stress will push them into hyper- or hypoarousal. Clients will generally quickly default to old, established procedures (such as the ED or SUD) as these have become “grooved in” from overuse. The therapist, by enabling the client to remain within this band of optimal arousal in the session, can facilitate the laying down of new pathways.

This is a process which may encompass “self-directed neuroplasticity,” - deliberately choosing activities and making choices that allow for new pathways to begin to develop. This is the old neurological adage: “What fires together wires together.” In colloquial terms, it is using our mind to change our brain (the contemplative traditions being an example).

The therapist works with the client to identify or create resources, which are real or imagined areas of the client’s life with which they can connect that function to settle the activation in the nervous system by promoting discharge. Behaviours such as trembling, laughing, crying, shaking, and yawning may be an indication that some of the activation associated with truncated fight/flight or tonic immobility has been discharged. Therapy sessions constitute working with discrete “problem” areas, using content to elicit and titrate activation, and then resourcing the client to facilitate discharge. We work with dissociation in a similar manner, and often provide psychoeducation about how dissociation has likely developed as an adaptive capacity for the client.

Limitations

Although some research on somatically-oriented psychotherapy is beginning to emerge, it is important to note that this process of working in therapy has yet to be the subject of randomized, controlled experimental outcome research and there is a necessity for this. However, Courtois and Ford indicate that “Although such interventions have not been as extensively tested in scientific studies…they currently have a broad clinical consensus and are widely recognized by clinicians as critical in working with this population” (ie. trauma). It would be of empirical interest to determine whether discharge of activation associated with any client narrative content would result in a lessening of ED or SUD behaviours.

Summary and Conclusions

We hope to have encouraged a sense of curiosity and excitement in recent discoveries in neuroscience and traumatology, and the implications of these discoveries for working more directly with the activation that our clients bring to therapy. These advances direct us as care providers to consider our client’s nervous system and to conceptualize their presenting concerns less in terms of disorders and diagnoses and more in the context of functional adaptations to significant
Race Matters

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How Would You Respond to These Parents?

1. My adopted child (5 years) struggles with his visual difference in the family and says he hates his dark skin.

2. What do I do when my child tells me he/she doesn’t want to attend cultural events or to stop putting on those movies that I purposefully choose to try to make sure his/her culture/ethnicity is represented?

3. How important are role models in the formation of a youth’s racial identity?

4. We have no personal experience with racism. How do we prepare and support our adopted child for the discrimination that is sure to be directed at her because of her dark skin?

5. How do I explain the reasons for discrimination and the mistreatment of people belonging to his racial group and other minority groups?

6. My young child is commenting on skin colour loudly, in public, using very blunt terms (“That person has really brown skin!”). What should I say and how should I teach her to speak?

While the following discussion focused on REI, the suggestions are applicable to counsellors working with other minoritized groups (e.g., women, GLBT, persons with disabilities, immigrants). Thank you for supporting your clients and their families in racial and ethnic identity development.

Biography

Lisa Gunderson works with individuals, families, educational, and organizational institutions in Canada and the United States focusing on minoritized issues and racialized populations. She has received numerous awards for her work and teaching in the past 17 years. Based in Victoria, Dr. G. is available for training, in-person consultation with therapists, and counselling for individuals and families dealing with minoritized issues. Her PhD is in clinical psychology from the University of Southern California (visit www.oneloveconsulting.com or email Dr.Gonelove@gmail.com).

Making Sense of Suicide

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measure of health to be well adjusted to a profoundly sick society.” The oppressed and privileged alike can be susceptible to society’s various sicknesses. Ultimately, we may need to build a better world before people stop feeling compelled to escape it.

Biography
Karen H. Ross is a doctoral student in Counselling Psychology at the University of Calgary and a former Registered Clinical Counsellor. Her research explores how different discourses of “mental health” – such as those found in public health campaigns, institutional policies, and popular culture – shape options for problem-solving and identity construction, particularly among young people. She can be reached at khross@ucalgary.ca.

Working with Trauma and Dysregulation

autonomic nervous system activation and kindling.

The approach outlined here offers therapists an additional way of utilizing an understanding of the nervous system as a powerful tool in their work with clients. Rather than needing to relive overwhelming life experiences in order to work through them, therapists now have a way of helping clients to renegotiate their relationship to these unsettling experiences in the here and now.

Biographies
Dr. Manley is a registered psychologist in private practice in Vancouver, and he has worked in the area of eating disorders for almost three decades. His interests include human potential, generally, and a range of psychological concerns including trauma recovery. He conducts trainings and workshops in a number of areas, including the development of the capacity for enhanced self-regulation and its neuroscience underpinnings, and he offers supervision of therapists and trainees. He may be reached through his website at www.dronmanley.com.

Carrie DeJong (RCC) is a clinical counsellor with extensive experience in the fields of trauma and addiction having worked in both child trauma treatment and adult residential addiction treatment. Carrie is now in private practice focusing her passion on helping clients navigate the challenging work of addressing trauma and addiction issues. For more information please visit www.carriejong.com.

 Mysteries of the Missing Link...

 unearth some clues to the missing bond between my client and his son and as a result, led us to have more material to work with to complete an unfinished counselling goal and unfinished business for my client.

And through creating something that was supposed to have happened but did not happen in this twelve-year-olds life, I believe will have a positive chain effect on his relationship with himself, his brother, and his father.

Biography
June Wong is a graduate from the Counselling Psychology Program at City University of Seattle in Vancouver. She is currently working as a Family Counsellor at Family Services of Greater Vancouver. Please contact her at jwong@fsgv.ca should you have any questions or feedback about her article.

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Biographies
Gail Lyons has a private practice in Analytical (Jungian) Psychotherapy in Vancouver. She trained extensively with the Ontario Association of Jungian Analysts and provides therapy and consultation for other therapists who are interested in depth psychology. She can be reached at 604-266-7438 or g Lyons17@gmail.com. For more information, please see www.vancouver-jungian.com.

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Membership Update

BCACC will publish lists of membership registration changes in each issue BCACC News. This issue contains updates to our membership register between May 1 and August 31, 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

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

We have recently updated our library. For a complete listing of all Resource Library holdings in Head Office, visit the Member Portal (https://bc-counsellors.secure.force.com) and click on Resource Library Holdings

BC Association Of Clinical Counsellors
Member Orientation Workshops

2015 Workshops
February 2015 – Region 2
April 2015 – Region 3
May 2015 – Region 4
September 2015 – Region 1
November 2015 – 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, including 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.

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

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You can also change your contact information online anytime: Log into your Member Portal – https://bc-counsellors.secure.force.com

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Subscriptions

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To All Our Readers, Registered Clinical Counsellors, Clients and Supporters, Our Best Wishes for a Wonderful Holiday Season and a Happy and Healthy New Year!

BCACC and the Insights into Clinical Counselling Magazine Team