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# The Canadian Counselling and Psychotherapy Association's quarterly newsletter – Printable Version

## This Issue

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*President's Message*

## What's on the Horizon for CCPA

Greetings!

As I am writing this message to you, summer hasn't completely slipped away, but by the time you read the fall edition of Cognica, Alberta will be at its most golden. The aspens will have turned a dazzling sunburst shade and the golden colours of the wheat fields will span for miles across the landscape. It is at this beautiful time of the year that I welcome back our members to another year with CCPA.

What is on CCPA's horizon as summer draws to a close? A number of trends that will shape the profession's future have been taking form for many years and continue to evolve. CCPA's Executive and Board are at work on a number of projects. Let me draw your attention to some of the Board's major initiatives over the next months.

As **the** national association for counselling and psychotherapy, CCPA has been instrumental in setting professional and ethical standards for the counselling/psychotherapy profession. This coming spring, a new ethics case book will be available authored by researchers and counsellor educators from across the nation. In the same format as the previous edition, a number of new issues are addressed including: certification of career counsellors, culturally-infused counselling, counsellor isolation in private practice, secondary trauma and compassion fatigue, and working with clients using electronic platforms.

The Association already has a solid counsellor certification program (the Canadian Certified Counsellor or CCC). As the regulation of counsellors and psychotherapists continues to occur, there will be a growing need for our members to obtain clinical supervision in order to meet the criteria for more direct client contact hours than was required in their programs. However, most graduates of counselling programs do not receive training in supervision. Therefore, CCPA has developed the Canadian Certified Counsellor-Supervisor (CCC-S) program to address this gap. There are basic qualifications needed to apply for supervision as a specialty adjunct to CCC with four potential pathways to obtain certification (see the CCPA website). Once again an online course will be offered through the University of Ottawa in January 2014 (http://www.ccpa-accp.ca/en/counsellingsupervision/). Plans are in the making to have a French version of the course available too. Meanwhile, webinars are being developed to support the CCC-S program and the requirement for Continuing Education Credits (CECs) in this area for those holding the certificate. David Paré from the University of Ottawa will be presenting two webinars: Creating Counsellor Reflective Communities (October 23rd) and Micro-practices of Reflective Supervision (November 20th). More webinars focused on supervision are being developed in addition to a textbook on supervision to be published in 2015.

CCPA strives to promote recognition of professional counsellors and psychotherapists to the public and the media. To this end, CCPA has engaged a media specialist to assist the association in responding to current events in a timely way through press releases. Taking this step has led to increased opportunities for interviews in the public domain. Beth Robinson, CCPA Director for Nova Scotia, has been interviewed twice in

the past few weeks on two topics: CCPA's response to the tragic events in Quebec, Labrador, Alberta, Manitoba, and Ontario and the improvement of youth mental health services in Nova Scotia.

Our Directors often speak of the issues and challenges faced by those living in the North. Nearly three years ago, CCPA made the decision to support directors in British Columbia/Yukon, Alberta/NWT, Saskatchewan, Manitoba/Nunavut, Ontario, Quebec, and Newfoundland/ Labrador in reaching out to our northern members and their colleagues. Once again, the National Board is supporting the Northern Initiative to offer two webinars this fall exclusively to northern practitioners. Each webinar will be offered twice as was done last year: Professional Ethics in Small Communities: Confidentiality in Rural & Northern Settings by Judy Malone and Bill Thomas and Cultural Competence in Northern Counselling: Residential Schools Trauma, Intergenerational Trauma, Colonization, & Historic Trauma by Lloyd Robertson and Mark Kelly.

Research has an important role to play in the delivery of high-quality counselling services and with this in mind; CCPA undertook a pilot study last year. CCPA's Inaugural Research Conference was held in February 2013 at the University of Ottawa. The conference format included a keynote address, followed by a poster session, and concurrent workshops. Delegates thought the program was a success and students were especially appreciative of the feedback received from researchers. The conference has caught the interest of several university programs and their students. CCPA is currently working with a team in New Brunswick to plan the next research conference.

CCPA has also turned its attention to the internationalisation of counselling as a profession. Last year, a chapter was authored by Roberta Neault, Blythe Shepard, Krista Benes, and Sareena Hopkins to provide information about the status of counselling in Canada. The chapter appears in Counseling around the World: An International Handbook, published by the American Counseling Association. Lorna Martin, Michel Turcotte, Laurent Matte, and Blythe Shepard recently published an article on the Counselling and Psychotherapy Profession in Canada: Regulatory Processes and Current Status in the *British Journal of Guidance and Counselling*.

As our visibility increases on the world stage, CCPA has developed a partnership with the International Association for Counselling (IAC). The IAC has played a significant role in the development of counselling services in many parts of the world and has consultative status with the United Nations, ECOSOC, UNICEF, UNESCO, ILO, and the Council of Europe. CCPA will be partnering with the association to host the IAC Conference 2014, taking place May 3-7, 2014 in Victoria, BC followed by the annual CCPA conference, May 7-9, 2014. Delegates can receive a discounted rate when registering for both conferences. The Call for Presentations for both conferences ends soon (October 21st), so hurry; you won't want to miss out on this special conference!

Plan ahead and apply for one of CCPA's travel awards. CCPA provides six (6) $500 awards in support of members who wish to attend the CCPA Annual conference. Members from all CCPA regions are invited to apply, but must attend the conference to receive the award. CCPA also provides four (4) $500 awards in support of student members who wish to attend the CCPA Annual conference. Marsh, the CCPA Professional Liability Insurance Broker of Choice, provides two $500 awards to student members demonstrating academic excellence.

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Speaking of awards, the CCPA National Awards Program offers an opportunity to recognize and applaud colleagues for their contributions to the profession. This year CCPA will be accepting nominations for the following awards:

- The CCPA Counsellor Leadership Award
- The CCPA Research or Professional Article Award
- The CCPA Doctoral Dissertation Award
- The CCPA Master's Thesis Award
- The CCPA Counselling Book Award

Take this opportunity to applaud colleagues who have made a positive and lasting impact on the practice of counselling and psychotherapy! Remember nominations must be received by CCPA no later than midnight of December 15, 2013. Then come celebrate with us in Victoria!

As Henry Ford stated, "Coming together is a beginning; keeping together is progress; working together is success." In closing I would like to take this opportunity to thank all of our 4,900+ members who have helped our association grow and to meet its goal of enhancing the counselling profession in Canada. It is through our members who contribute their time and talents that CCPA continues to be the voice of our profession in Canada. Thank you for your continued support.

Blythe Shepard, PhD, CCC
President

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## CCPA had a Presence at the International Association for Counselling Conference in Istanbul – *Blythe Shepard*

The 2013 International Association for Counselling (IAC) Conference and the 12th Turkish National Congress of Psychological Counselling and Guidance took place at the Bogazici University in Istanbul, Turkey September 8-11. IAC has consultative status with the United Nations, ECOSOC, UNICEF, UNESCO, ILO, and the Council of Europe. Its mission is to promote the well-being of peoples worldwide by advancing relevant counselling practice, research and policy. Four past presidents were in attendance: Bill Borgen (Past President of IAC), David Patterson (Executive Council of IAC), Ron Lehr (Executive Council of IAC), and Lorna Martin as well as myself.

Lorna Martin and I were invited to participate in a panel discussion, International Counsellors and Counselling in the 21st Century: Reflections and the Role of IAC. Other panelists included Tuncay Ergene (President, Turkish Association of Psychological Counselling and Guidance), Carmen Galea (President, Malta Association for the Counselling Profession), Amanda Hawkins (President, British Association of Counselling and Psychotherapy), Seamus Sheedy (Irish Association for Counselling and Psychotherapy), and Cirecie West-Olatunji (President, American Counselling Association) with Dione Mifsud (President, International Association for Counselling) as Chair. We shared our views on the challenges that counsellors and the counselling profession

face in the 21st century while highlighting cultural considerations and implications for counselling practice and training around the world.

The International Association for Counselling (IAC), in partnership with the Canadian Counselling and Psychotherapy Association (CCPA), will be holding their next conference in Victoria, BC from May 3 to 7, 2014 with more details ON PAGE 8.

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## Common Questions About CCPA's Certification Pathways – *Monika Gal*

September 2013 marks a landmark moment in CCPA's certification program. The certification requirements were re-organized into the "Pathways to Certification" and separate application pathways were created for recent graduates and experienced practitioners. The clarification is especially important for experienced practitioners because they can now clearly determine their certification requirements and application procedure as distinct from those of recent graduates. I've written about these updates in previous editions of Cognica; please consult the Summer 2013 edition for detailed information regarding the updates. The current requirements have also been updated on CCPA's website, under the "Membership" and then "Certification" tabs. Please take a look and send your thoughts to certification@ccpa-accp.ca.

Just before the certification updates and requirements came into effect, I presented a free webinar presentation on the Pathways to Certification. The presentation reviewed the upcoming certification requirements and application procedure and was attended mainly by practitioners interested in applying for certification, as well as representatives from counselling programs. Due to the positive feedback received, CCPA will be regularly offering these free webinar presentations in both English and French. If you are interested in applying for certification, please join in! You can find information on these webinars at http://www.ccpa-accp.ca/en/freewebinars/.

A number of wonderful questions were raised by the participants of the webinar. I'll take a moment to answer some frequently asked questions that may be useful information to other certification applicants:

**Q: I haven't graduated yet from my Masters degree in counselling. Could I qualify for the "C.C.C.-Qualifying" title while I finish this course?**
A: No. The C.C.C.-Qualifying title is only available to practitioners who have satisfied all of the education requirements. This includes completing all of the required coursework and having the Masters degree in counselling conferred. An applicant's training is not considered to be complete until they have been awarded their degree.

However, if the applicant has successfully completed all of the program's coursework and the senate has reviewed the program completion with a set date for the conferral of the degree, the applicant may still be able to apply for certification. To do so, the applicant should ensure that his or her transcript indicates that the grade and credit were awarded to all courses required for certification, and in addition provide a letter from the counselling program's director or University Registrar confirming that

the applicant has successfully completed the program requirements and indicate the date on which the degree will be awarded.

For example, if Jane Doe successfully completed all courses required for her program by the end of the Fall semester in December 2012, but is waiting to have her degree conferred at the June 2013 graduation ceremony, she can still apply for the Canadian Certified Counsellor title if she provides her transcript where the grade and credit were awarded to all courses required for certification as well as a letter from the University Registrar confirming that Jane will have her degree conferred at the Spring convocation ceremony.

However, if John Smith successfully completed all the courses required for certification by the end of the Fall semester in December 2012 but is still working on completing his thesis, he cannot apply for the Canadian Certified Counsellor title because his program is incomplete and he could not yet provide the required letter confirming that the program is completed and identify the date on which the degree would be conferred.

**Q: I'm likely missing a required course. Can I obtain the "C.C.C.-Qualifying" title while I finish this course?**

A: No. The C.C.C.-Qualifying title is only available to practitioners who have satisfied all of the education requirements. This includes completing all of the required coursework and having the Masters degree in counselling conferred. If a required course is missing, the applicant must finish his or her course of study and confer his or her degree before he or she qualifies for certification.

**Q: I think my application satisfies the coursework requirements, but my program didn't have a practicum requirement. Which pathway should I use to apply for certification?**

A: A practicum course is a required course to qualify for certification. The majority of counselling programs which align with CCPA requirements have had a counselling practicum course as a mandatory part of their program since 2002/2003. Unless the program was completed before this time, the applicant must have completed some a practicum course as part of his or her program in order to be eligible for certification. If a practicum course was not a part of the program structure, most likely the program will have other gaps aligning with the certification requirements. For example, the program may not have a course in Counselling Theories or the scope of practice may not be in counselling and psychotherapy. Applicants lacking a counselling practicum course should consider submitting a Certification Pre-Evaluation Application instead, which is a cost-effective way to have the application reviewed by the Registrar and identify gaps in obtaining Certification.

**Q: I completed less than the required 150 hours of direct client counselling during my practicum, but I have enough hours if I include my work experience. How can I document this?**

A: If the practicum hours are insufficient to obtain certification (150 for graduates after September 2013 and 120 hours for applicant who graduated before September 2013), the applicant might still qualify for certification if the number of hours of direct client contact they completed is no less than 40 hours less than the requirement. For example, if John Smith graduated in June 2011 and completed 80 hours or more of direct client counselling, he may still be eligible for the C.C.C.-Qualifying title. John would need to document a specific number of post-graduate hours of supervision in order to obtain the C.C.C. title. The Registrar would specify the number of hours in the evaluation of John's file. If John has been accumulating supervision hours since graduation, he could submit these hours in order to satisfy the requirements. If John has not been accumulating supervision hours since graduation, he might be granted the C.C.C.-Q title for a one-year period while he completed the required hours of supervision.

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## Navigating the DSM-V – *By Michael H. Hejazi*

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) has been in print since May 22nd, 2013. The timing of the release seemed altogether poignant to readers of this newsletter given the ongoing regulation of the counselling and psychotherapy professions process taking place in Ontario. With governmental regulation of the profession there will be new and additional expectations to standardize practices, communicate systematically, and evaluate data in accordance with statistical guidelines for third party payers and public-accountability purposes. It seems useful to determine to what extent professionals who work as counsellors and psychotherapists should be expected to know about and work with the changes found in the new edition. It would take far too much space and time to describe and compare all the individual changes found in the revised fifth edition of the DSM in comparison to the earlier fourth. Moreover, such a discussion would be unnecessarily descriptive. Rather, to introduce readers to the changes that they will encounter in their work, and provide a road map with which clinicians can navigate and make sense of the overall revisions, this article aims to elaborate on the new awareness about the contextual nature of distress, the adoption of a dimensional approach over an axial approach, and the usage of disease specifiers in the DSM-5. In most, if not all other ways the DSM-5 is similar to the DSM-IV.

Diagnostics have always played a role in therapy. Counsellors and psychotherapists work through realized and emphasized distinctions between the mind and body within all their casework. By working through their various methods and diagnostic determination formulation processes therapists provoke new ways of understanding and theorizing about the experiences of individuals and groups. Thereby a diagnosis appears to have an important role in the curative process, through naming, hypothesizing, treating, and communicating meanings associated with symptoms and experiences. For example, what is described as 'Binge-Eating Disorder, 307.51' is known to be different in certain important ways from 'Dissociative Identity Disorder, 300.14'.The intention described by the authors of the DSM-5 is an aspiration to move away from speculating. Readers may apprehensively expect a systematic rigidity to go hand in hand with such a program. Surprisingly the very same manual makes a series of marked turns toward contextualizing information and experiences, expressed as an appreciation for the fluidities between illness nomenclatures, cultural experiences of adversity, and the apparent clustering of symptoms over syndromes. People involved in the profession have worked hard to ensure that the authors of the DSM recognize that ultimately all diagnoses are conventionally composed. The new edition contains meta-awareness about cultural influences, which should be encouraging for therapists interested in a phenomenological approach to clinical framing. A person may be diagnosed in the DSM-5 framework as having a primary diagnosis of Binge-Eating Disorder, as a principal clinical concern, and secondary Dissociative Identity Disorder that is partial and not altogether pervasive, but clinically significant.

Any positive or negative outcome concerning the therapeutic problem-solving gaze given in the DSM-5 must be unintentional and only later ascribed through practices. The authors of the DSM-5 intended to streamline psychiatry into step with other medical disciplines. For example, by replacing the phrase 'general medical condition' with 'another medical condition' the DSM-5 has opened the possibility for clinicians to reach principle diagnoses and multiple diagnoses from among the same symptoms, and to ascribe specifications to diagnoses, effectively creating new and expanded taxonomies of psychopathology variety. All diagnostic categories allow for unspecified identification of clinical presentations that are characteristic of a given disorder type. This added diagnostic flexibility, the new possibility of ranking, and the reorganization of the book into three parts: an introduction with instructions, a classification of mental illnesses, and new areas of study and development, the

DSM-5 aims at prospective generalizability and universality. The DSM-5 goes to new lengths to achieve international applicability and standardization with the International Classification of Diseases (ICD); the new DSM edition gives a full numerical listing of diagnostic codes for both ICD 9 and the anticipated ICD 10. The elimination of the multiaxial system is another major change to DSM-V from the preceding version. The axial system had been in effect since DSM-3, implemented in an effort to give attention to the whole pathological state of some clinical case-types. For example Axes IV (Psychosocial and Environmental Problems) was used to note environmental stressors and factors that may have influenced the etiology of some pathology, or been brought about by it. As such the consideration of causation has been incorporated into the primary process of diagnostic interpretation.

Many therapists will rightly discern a tension in the larger profession, when that which is defined as a mental health problem is further medicalized, the role of counselling, talk therapy, and meaning making becomes more tentative. Counsellors and psychotherapists work through the distinctions between mind and body; thereby provoking new ways of understanding and theorizing. The DSM-5 troubles therapists because the diagnostic and statistical purposive aspects of the manual have been read to infer certain actual groupings between diseases, composing syndrome clusters, and suggested treatments; however, the DSM-5 does no such thing. The DSM-5 should not be confused for a theoretical or treatment guideline. The purpose of the book is to be practical, a reference tool. As such the diagnostic book must be accessible to members of the broader community. The DSM-5 introduces an added dimensional aspect in case formulation. By eliminating the multi-axial system the DSM-5 has opened the way for phenomenological approaches to a topographic layering of clinical presentations and description. For example, following the DSM-IV 'Outline for Cultural Formulation and Cultural-Bound Syndromes', where an approach was sketched to examine the way that culture was impactful upon a presenting clinical episode, the DSM-5 introduces an actual and comprehensive formulation whereby the clinician is aware of their own role in meaning-making and disease classification identification. In credit to the authors of the DSM-5, in no other field of science is any system of classification as hotly debated and provocative as the one in the professional disciplines of psychology, mental health, and counselling.

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## Outcomes Monitoring and Canadian Psychotherapists - *By Terra Kowalyk, Gabriela Ionita and Marilyn Fitzpatrick*

How do we know when we are effective as psychotherapists? Do we wait for clients to tell us they are doing better? Do we use clinical judgment? Many professions have objective measures that evaluate success. For example, educators can point to the grades of students, physicians to symptom improvement, and courtroom lawyers to judicial decisions. Psychotherapists typically deal with ambiguous data and have a proud tradition of developing and refining clinical judgment to assess progress. In 2011, the CPA Task Force on Evidence-Based Practice of Psychological Treatments underlined the continuing importance of clinical judgment to evidence-based practice (EBP), "practitioners are required to exercise their professional judgment when providing treatment". However, the CPA's definition of EBP also includes the idea of progress monitoring (PM) and feedback. The Task Force called for "the monitoring and evaluation of services provided to clients throughout treatment".

The developing emphasis on PM can be traced to emerging evidence that clinical judgment is skewed toward what we want to see. As clinicians, it is normal to want all our clients to benefit. However, clinicians are not skilled at identifying deteriorating clients. Hanson, Lambert and Forman looked at outcome rates of over 6,000 patients across a variety of settings, and found an average deterioration rate of 8.2%, from 3.2% to 14.1%. When comparing clinical judgment to a systematic outcome (PM) measure, Hannan and colleagues found that the empirical method correctly predicted 100% of clients who were reliably worse or deteriorated at termination; 86% were identified by only the third session. In comparison, clinicians using their subjective clinical judgment predicted that only 3 out of 550 clients would deteriorate at termination, and only 1 of these predictions was accurate. A further study by Hatfield, McCullough, Franz, and Krieger found that only 32% of therapists recorded patient deterioration in their case notes in situations where clients reported symptom worsening.

Not only do clinicians systematically fail to identify client deterioration, they tend to overestimate client improvement. Walfish, McAlister, O'Donnell, and Lambert asked 129 clinicians to rate their ability to help clients compared to other psychotherapists, and the extent to which they believe their clients improve, remain the same, or deteriorate. On average, clinicians viewed their skills to be at the 80th percentile (no respondents' self-rating was below the 50th percentile). The majority believed that 77% of their clients improved as a result of their treatment and 3.66% deteriorated; almost half indicated that none of their clients regressed. These numbers defy statistical possibility. In the face of such positive self-assessment bias, the need for empirical outcome measurement is clear.

**Progress Monitoring Measures**

In psychotherapy, the focus is increasingly shifting to PM systems. The clinical utility of these systems has repeatedly been demonstrated to improve practice. For example, after the implementation of a

tracking system, a centre for family services found that cancellation and no-show rates dropped by 40% and 25%, respectively, and the number of clients in long-term treatment who experienced little or no improvement fell by 80%. In one year, the centre saved nearly half a million dollars, money used to hire additional staff and provide more services. Another community health and counseling organization experienced similar reductions in cancellations and no-shows, and the average length of therapy decreased by 59%. A recent meta-analysis of outcome monitoring studies indicated that the effects of providing feedback on deteriorating patients were the greatest across all patient groups; effectively those who were most at-risk were identified most effectively.

Overington and Ionita have provided an overview of PM instruments in areas such as domains assessed, target population, administration, cost, and training. The three main domains generally assessed are: 1) symptoms, 2) well-being, and 3) functionality. Different instruments have various strengths and features. For example, some instruments aid in diagnosis; others are used to facilitate discussion around therapy progress. In terms of administration and scoring, most are available in paper and computer versions and the shortest take as little as 2-minutes for clients to complete. Computer versions can be completed by clients on their own tablets in the waiting room and the results calculated and forwarded automatically to the therapist's inbox in time for the session.

The data from PM measures can also provide a means for evaluation at various levels including the organization, practitioners, and the clients; a term known as benchmarking. At the organizational level, PM measures can be used to compare the quality of services provided by each organization. They can also provide clinicians a useful comparison with other practitioners to see where their clinical skills excel and where they need improvement. Clients can also be examined to see how they fare in regards to a benchmark created by the particular measure.

**PM Usage in Canada**

The McGill Psychotherapy Process Research Group (MPPRG) has been studying the use of PM measures in Canada. In 2012, Ionita conducted a nationwide survey of PM measure utilization. Of the 1668 clinician-respondents, 1124 had not heard of PM measures, 242 knew of - but had never used - them, 101 clinicians had used them in the past, and only 201 clinicians (12%) were currently using a measure to track client progress in therapy. Across the provinces, there was a range of utilization from 4.8% to 24%. In other words, even in the province with the highest utilization rates, only one in four psychotherapists currently use some form of PM measure to track client change.

Ionita also examined the barriers to PM utilization. Canadian practitioners who were not using PM indicated that their top three barriers to utilization were: 1) lack of training on the measures, 2) limited access to training on the measures, and 3) limited knowledge about the measures. One clinician who overcame her reluctance to use the measures told us, "I was noticing how the same fears and questions I had were being shared all the time by people using it all over the world. So I started thinking, 'okay it's

not a problem with me, it's normal to have those doubts' and reading through how people dealt with and learned how to overcome the barriers... Like everyone does I suppose, we put up barriers when we are coming against something new but it's just because it's new." We all want to help each client; PM measures can provide an objective measurement to help to make this a reality.

**Surmounting the Barriers**

Since the biggest barriers to using PM measures appear to be lack of knowledge and training, the MPPRG is currently developing an online tool to help clinicians access information, explore their doubts, and choose a PM measure suitable to their practice. It will include information from journal articles, video interviews with psychologists, testimonials from fellow clinicians, and interactive activities that provide an experiential understanding of what PM measures have to offer. We anticipate bringing you news and links to this tool in 2014. Watch for it in Cognica.

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## Trauma, Dissociation, and the Journey to Soul Healing - *By Trish Karin Stewart*

*All of our problems, personal and societal, are due to a loss of soul. Soul gets lost in our everyday lives whenever we try to force ourselves to fit some norm of health and correctness. … I want to be the person, who lives from the core of my heart, with the creativity that allows the soul to blossom in its own colors and shapes.*

- Thomas Moore

The research project "Trauma, Dissociation, and the Journey to Soul Healing" is a narrative inquiry into soul pain caused by traumatic experiences and the effects of soul-loss retrieval as a way of recovery from long term trauma and dissociation. Particular interest is placed on soul-loss retrieval's ability to restore wholeness and power balance in a person's life. The qualitative methodology of Narrative Inquiry was chosen for this research project because "our species thinks in metaphors and learns through stories". In addition to the conventional research analysis, therapeutic art was used to discern the researchers more intuitive and subconscious interpretations of the research material.

The inquiry investigated the lived experiences of soul loss caused by trauma and of soul healing, as narrated by four middle-aged women. They participated in soul-loss retrieval as part of the Trauma Recovery Certification Program, which was developed and taught by Dr. Jane A. Simington, owner of Taking Flight International. This approach to trauma processing was chosen because it is a pioneering blend of modern psychotherapeutic techniques with traditional North American aboriginal wisdom, and elements of ancient shamanic approaches, still practiced in many parts of the world. Jungian psychology, modern discoveries in trauma-induced brain physiology, and elements of contemporary clinical psychotherapeutic techniques are interwoven with aboriginal ceremonies and guided visualizations into soul loss retrieval.

Severe trauma is a very stressful situation that shatters our spiritual, psychological, and physical ability to make sense of the traumatic event and to grow beyond that experience. For a successful treatment and recovery from such an experience, all three elements have to be included in the healing process. Many modern clinical interventions address the physical and psychological symptoms of stress related disorders, such as anxiety, depression, phobias and PTSD, with pharmacological medications in addition to psychotherapeutic techniques. More spiritually-oriented methods such as the practice of mindfulness, meditation, energy transfer work, and clinical hypnosis have also been discovered to be helpful but of limited value, when applied without their original spiritual components.

We humans are inherently spiritual beings, hard-wired to the Divine energy, always searching for the Divine connection. Our Soul is the vessel that invites and holds the Divine energy. It is the seat of what Jung called the Higher Self, the God Within. If that vessel is weakened or diminished, our life force also

diminishes. Consequently, healing from trauma without inclusion of the spiritual component can be very time consuming and of limited value.

From a shamanically-inspired perspective, soul loss happens when traumatic events sever pieces from a person's soul and trap them in the time and space of that event. This leaves the person incomplete and vulnerable to further invasions. At the onset, dissociations are seen as the mind's attempt to flee from the stressful situation. Later, with the help of flashbacks and triggers, the conscious mind is reminded of the event in order to initiate healing and recovery.

The traumatic events experienced by the research participants made them feel unsafe and often caused them to retreat from active participation with their families, communities, and society-at-large. Their disconnectedness and isolation helped them to cope and to move on in life, but it also made them powerless, invisible, and voiceless. This caused them to feel lonely and become vulnerable to further abuse. Soul retrieval helped the research participants to revisit the traumas of their past within a safe and supportive environment. With the recovery of each little piece of their younger selves, they were able to reclaim their personal power, heal their souls, rebuild their self-confidence, and reshape their past memories. The research participants were able to reclaim the virtues and gifts that had been lost with every missing soul part—self- love and love for others, compassion, the ability to communicate, to laugh, and be happy. They believe that the quality of their lives within their private and professional circles has changed measurably in a positive way following soul retrieval.

Dr. Simington's integrative approach (2003, 2010) does not replace psychotherapy, but enriches it by adding a spiritual dimension to it that is older and predates what most of us understand as our organized, religious, and dogmatic foundation. This could position it as a healing approach that would make room for many faith orientations. It is important because the majority of North Americans consider themselves to be religious or spiritually oriented, and familiar with the concept of the soul.

Approaching healing through the dimension of the soul resonates with many people in Canada who live in a world that is multi-cultural and increasingly mobile. Canadian immigrants are possibly more familiar and comfortable with traditional shamanic techniques than with exclusively modern cognitive, or even arts-based, approaches. This intentional blending of the ancient and the modern can then raise our awareness and invite conversation about how different people understand and approach healing of the very particular traumas they may have experienced. For this to happen, there is a great need for skilled psychologists, psychotherapists, and counsellors who can introduce the philosophy of soul and the technique of soul healing into the therapeutic process. Many modern clinical health professionals could gain much by embracing soul as an element in the healing of body, mind, and spirit without having to change the foundation of their theoretical orientation.

*Karin Stewart is a recent graduate from St. Stephen's College with a Masters in Psychotherapy and Spirituality (MPS). She is a landed immigrant to Canada and a former refugee from Poland to Germany.*

*Karin specializes in her practice on issues related to traumatic experiences and also embraces holistic approaches to psychotherapy such as guided visualization, energy transfer work, and therapeutic art. Karin's complete thesis can be accessed at the St. Stephen's College in Edmonton.*