President's Message

Thanks and Farewell from the CCPA National President

As this edition of COGNICA marks my final message as CCPA National President, my communique to all of you is two-fold: (i) recognizing our 2017 CCPA Professional Champion, Mary Walsh; and (ii) bidding farewell as your 2015—2017 CCPA National President and "passing the baton" to your incoming 2017—2019 CCPA National President, John Driscoll.

2017 CCPA Professional Champion Award

It is my distinct pleasure to inform you that Mary Walsh is the third recipient of the CCPA Professional Champion Award. Previous recipients were Justice and Senator Murray Sinclair (2014) and LGen Romeo Dallaire (2016). This Award was created to honour and promote the stellar work of individuals in Canada who have played exemplary roles in enhancing the lives of others through championing the role of counselling and psychotherapy in its many forms in enhancing the mental health and well-being of people.

As many of you know, Mary Walsh is an accomplished actress, comedian and political satirist for the past 20+ years. Ms. Walsh has appeared on *This Hour Has 22 Minutes* and *CODCO*. Born in St. John's, Newfoundland, Ms. Walsh is the recipient of more than 30 Gemini Awards, recipient of the Order of Canada – Member of the Order of Canada (2000), recipient of the Governor General's Performing Arts Awards for Lifetime Artistic Achievement (2012) and recipient of honorary degrees from Memorial University of Newfoundland and Trent University. Mary has publicly shared her previous struggles with addictions (alcoholism) and continues to be a mental health advocate in Canada – being a featured speaker at the 2010 Breakfast of Champions – presented by the St. Joseph's Health Care Foundation and the Canadian Mental Health Association; serving as 2015-2016 Honorary President of the Canadian Psychological Association (CPA); and being one of the faces of Bell's "Let's Talk" initiative dedicated to mental health.

Thank you Mary for your valuable work as a Canadian mental health champion and advocate!

Farewell and "Passing the Baton"

It is hard to believe that the 2015—2017 CCPA National Board of Directors and I have reached the end of our two year term of office. Reflecting on the past two years, it is most apparent that the collective wisdom, teamwork and dedication by each and every Board member was fully realized in terms of their advocacy and outreach for CCPA members across a multitude of CCPA policy decisions and related initiatives. Here is a snapshot of key highlights from the 2015—2017 CCPA National Board of Directors:

CCPA is a national leader and champion of the counselling and psychotherapy profession in Canada

- ✓ Continued our membership growth with more than 5,900 members[1] across Canada - with CCPA representation in each province/territory.

[1] As of March 2017.

- ✓ Continued our outreach to emergency management response centers[2] who coordinate disaster psychosocial response and psychological recovery – notably, CCPA is a member organization of the BC Disaster Psychosocial (DPS) Council with CCPA members who volunteer their time to assist citizens and communities in BC who are affected by disasters and related emergencies. Furthermore, CCPA attended and was one of the sponsors for the March 2016 International DPS Conference held in Vancouver, BC.

- ✓ Engaged in grassroots advocacy and media relations as a means of enhancing the profile of CCPA and its members. Thank you to all CCPA members who connected with their provincial/territorial and federal elected officials. Also, thank you to all of our designated spokespersons who engaged in media relations for the suite of special days that we celebrate as an Association! For example, this included, but was not limited to, Canadian School Counselling Week and Canada Career Week.

  From 2015—2017, the CCPA Board of Directors focused on relationship building with national Indigenous (First Nations, Métis and Inuit) organizations which resulted in meetings in Fall/Winter 2015, Spring 2016, Fall 2016 and Winter 2017 to discuss CCPA and identify areas of mutual interest with regards to Indigenous-specific mental health issues and needs.

  A special CCPA issues paper on Indigenous mental health was prepared by select members of CCPA for subsequent circulation to Members of Parliament (MPs), Senators and leaders of the national Indigenous organizations in Canada - https://www.ccpa-accp.ca/wp-content/uploads/2016/10/Issue-Paper-2-EN.pdf.

- ✓ Obtained recognition of the Canadian Certified Counsellor (CCC) designation by the BC First Nations Health Authority in regards to authorized mental health service providers for First Nations people and communities in BC.

- ✓ Enhanced our Association's regional, national and international partnerships to promote the sharing of expertise and support wherever possible – this included, but was not limited to, CCPA's collaboration with the American Counseling Association (ACA) for the 2016 CCPA/ACA Conference in Montreal, Quebec; CCPA's launch of the inaugural CCPA Global Partnerships Standing Committee that sought to assist the CCPA Board in promoting national and international engagement with similar professional counselling and psychotherapy associations and related organizational bodies; and representation of select CCPA members' continued outreach and advocacy at international roundtables on counselling – e.g., International Association for Counselling (IAC). In fall 2015, CCPA was bestowed an inaugural Patron membership designation by the IAC Executive Council based on CCPA's leadership in international counselling.

- ✓ Engaged in regional counsellor regulation task groups/committees across Canada - in particular, BC (FACT[3]-BC), Alberta (FACT-Alberta), Saskatchewan (FACT-SK), Manitoba (FACT-Manitoba), Newfoundland and Labrador (FACT-NL), Prince Edward Island and New Brunswick. There has been rapid mobilization exhibited by various CCPA members in their given provinces/territories – members who are volunteering their knowledge, skills, abilities and time to ensure that CCPA is proactively involved with counsellor/psychotherapist regulation. This has been in the form of creating a provincial CCPA "caucus." CCPA caucuses in provinces such as

[2] Organizations that coordinate disaster psychosocial response and critical incident stress management services for communities.

[3] "FACT" stands for Federation of Associations for Counselling Therapists.

British Columbia and Alberta are providing opportunities for CCPA members to work with designated representatives from CCPA National Office and the CCPA Executive to update one another on key developments in the provincial/territorial counsellor regulation discussions. This collaborative team-based approach provides a mechanism for CCPA members to utilize a group decision-making process to ensure that we effectively represent CCPA members' interests in the provincial/territorial counsellor/psychotherapist regulation discussions. Thank you to all of you who are involved in these important discussions!

- ✓ Engaged in various advocacy, outreach and policy discussions to support timely, accessible and effective mental health service delivery provided by counsellors and psychotherapists at the regional and national levels. For more information about CCPA's advocacy endeavours, please visit https://www.ccpa-accp.ca/social-media/.

- ✓ Launched the inaugural "CCPA Leaders of Tomorrow Forum" in November 2015 which saw 11 CCPA members selected to partake in a two day CCPA leadership workshop in Ottawa, Ontario to learn about the various facets of CCPA, participate in media training, hear presentations from a panel of leaders in the field, learn about their personal leadership styles and develop action plans for future volunteer engagement with CCPA over the coming year.

- ✓ Continued our national clinical supervisory competency development and online training in the theories and practice in clinical supervision.

- ✓ Continued our advocacy for the recognition and inclusion of CCCs as qualified mental health service providers by Health Canada's First Nations Inuit Health Branch.

CCPA is a conduit for professional development and membership service delivery

- ✓ Launched our Association's revised set of CCPA *Standards of Practice* and the CCPA *Ethics Casebook* – furthering our commitment to high ethical standards and practices in the counselling/psychotherapy profession in Canada.

- ✓ Continued the coordination and hosting of a diverse range of professional development webinars that can be accessed by CCPA members to support continued learning and development in counselling/psychotherapy.

- ✓ Launched unlimited bilingual telephone legal advice services to all certified members through Marsh Canada, CCPA's liability insurance provider.

- ✓ Collaborated with emergency service organizations such as the First Nations' Emergency Services Society (FNESS) in advancing a pilot project to support professional development opportunities to CCPA members in the area of Indigenous-specific critical incident stress management (CISM).

- ✓ Coordinated Indigenous cultural safety professional development opportunities for the CCPA Board of Directors and National Office to guide and inform continued relationship building with regional and national Indigenous organizations across Canada.

- ✓ Advanced an Indigenous Continuing Education Credit (CEC) Initiative which will involve developing pathways to assess and grant CECs for certified members who partake in Indigenous teaching practices, healing ceremonies and/or community engaged scholarship.

- ✓ Developed three new CCPA awards – Student Representative Award, Humanitarian Award and Unsung Heroes Award.

- ✓ Coordinated the 2016 CCPA Research Conference in St. Albert, Alberta in October 2016 which included a special evening presentation by mental health champion and former Summer and Winter Games Olympian, Clara Hughes.

- ✓ Launched a CCPA clinical supervision textbook and a handbook on counselling and psychotherapy in Canada.

- ✓ Sponsored two continuing education sessions in Nova Scotia in October 2016 at Halifax and Greenwood. Approximately 60 participants learned about the supports and transitioning opportunities available to military families across Canada. This initiative is a collaboration between CCPA, the CCPA School Counsellors Chapter and our partners at the Military Family Services/Canadian Forces Morale and Welfare Services Department of National Defence/Government of Canada and the Vanier Institute.

- ✓ Launched a pilot regional professional development workshop initiative in British Columbia (fall 2016) to strengthen networks and build awareness about CCPA with a particular focus on outreach and advocacy in northern and interior regions of BC.

CCPA continues its sound fiscal management of the Association's finances

- ✓ Demonstrated in the 2015/2016 *CCPA Financial Report* (https://www.ccpa-accp.ca/wp-content/uploads/2016/04/FinancialReport_15-16.pdf) that on behalf of the CCPA membership, the CCPA Board of Directors and National Office have and continue to utilize a conservative stance and ensure sound fiscal management of the Association's finances constructing annual balanced operating budgets recognizing how factors such as counsellor/psychotherapist regulation, normal growth patterns and retention rates can impact and influence CCPA revenue projections.

CCPA utilizes modern business practices that aid in organizational continuous improvement

- ✓ Continued to utilize risk management reporting to aid in effective board decision-making and due diligence in policy development on behalf of CCPA members.

- ✓ Engaged in quality assurance and related continuous improvement of CCPA programs and services ensuring that our national programs are timely and relevant for the current and emerging counselling and psychotherapy landscape. Notably, select members of CCPA are engaged in rejuvenating CCPA's counsellor education accreditation program (CACEP) to support quality standards for accrediting master's level counselling programs in Canada.

To the incoming 2017—2019 CCPA National Board of Directors: I look forward to continuing the valuable work of CCPA and its dedication to the enhancement of the counselling and psychotherapy profession in Canada under the leadership of John Driscoll, 2017—2019 CCPA National President. It has and continues to be a privilege working alongside John. His ongoing commitment to counsellor regulation across Canada and being on the forefront of current and emerging trends in counselling and

psychotherapy at the regional, national and international levels to support member services and related initiatives is most evident.

To CCPA CEO Barbara MacCallum and the CCPA National Office: Thank you for the opportunity to collaborate and seamlessly integrate strategic policy and operational decision-making on behalf of the Association. The depth and breadth of knowledge, skills and abilities that you and the National Office staff "bring to the table" facilitated opportunities to advance forward thinking and creative initiatives to support our diverse membership now and in the future.

To the departing CCPA National Board Directors (Tracy Duffy – CCPA Newfoundland and Labrador Regional Director, Kiraz Johannsen – CCPA Quebec Anglophone Regional Director, Ricardo Pickering – CCPA British Columbia and Yukon Regional Director and Blythe Shepard, CCPA Past President): Thank you very much for your leadership, particularly in the form of outreach and advocacy on behalf of your respective CCPA members. Your commitment to the CCPA membership and your voices at the board table were most appreciated. I extend my best to you in your future endeavours!

In closing, thank you to all CCPA members for your ongoing commitment to and involvement with the Association.

I hope to see many of you at the 2017 CCPA Annual Conference in St. John's, Newfoundland.

Thank you/Merci/Meegwetch!
Natasha Caverley, PhD, CCC
2015—2017 CCPA National President

President-Elect Message

Dear CCPA Members,

These days, the topic of "wellness" figures prominently in our lives. In our workplaces, we see and read the wellness posters, the emails listing hints, the contests and other activities for staff. For counsellors/ psychotherapists working as school counsellors in a school settings or counsellors/psychotherapists who work in post-secondary settings, a norm is to mention wellness along with all the other services and related resources provided for students in counselling or wellness centres. Private practitioners know very well, how important wellness is for their clients and often mutually develop goals with them that include wellness activities. We are familiar with the many versions of the Wellness Wheel. One description is noted in our most recent *Issues Paper*, " Call to Action: Urgent need for improved Indigenous mental health services in Canada" While many Indigenous communities may hold their own teachings about mental health, the Medicine Wheel is widely recognized as it is a healing and teaching tool that conceptualizes Indigenous views on wellness through a holistic approach. The circle represents the wholeness and cyclical nature of life. Each dimension (physical, mental, emotional, and spiritual) carries its own teachings and while these directions have different meanings and expressions for different communities, some of the principles are universal (Graham & Stamler, 2010; Svenson & Lafontaine, 2003). We know it is essential to take care of ourselves, to work at being well. It is important to be conscious of what you eat, to take time to exercise, to socialize, to be active in your family, and to contribute to the well-being of co-workers at your workplace. ***We all know this and we do our best to put it into practice.***

In fact, the Entry to Practice Competencies, based on the *Task Group for Counsellors Regulation Competency Profile (2007), Task Group for Counsellor Regulation in British Columbia* that is utilized in our CCPA publication, Supervision on Counselling and Psychotherapy: A Handbook for Canadian Certified Supervisors and Applicants, in *Section VI: Professional Practice* notes that the supervisee, *maintains health care and a level of health necessary for responsible counselling and maintains wellness practices in the context of professional performance.* **It is a competency and ethical practice for our profession**. This competency is also listed in the Ontario, Quebec, and nationally validated, competency profiles, which can be found on *Compass Centre for Examination Development* on the CCPA website: *http://www.compassexams.ca/en/self-assessment/* .

Sometimes, though, with all of the planning and all the guidelines, as good as they are, they cannot replace discovering a certain quality of wellness, often uniquely valuable to each of us, which enters our daily lives in surprising ways. Recognizing wellness sometimes just has to hit you in the face, so to speak. For me, I often see that when I take the time to pay attention and to listen to the people around me, it helps me to realize how they make their decisions to be well.

Recently, I was speaking with a manager of student life at a Canadian college. We were talking about counsellors/psychotherapists and the many workshops and sessions they put on for students at their campuses. It is work that contributes to and supports many students in their wellness choices. Counsellors/psychotherapists do a great job at this type of work. This manager was saying though, that while these are valuable activities, they sometimes do not reach out to the whole student population. She suggested that counsellors/psychotherapists need to get out around the campus and interact with students during student activities. She suggested that the counsellor/psychotherapist could find a space in those activities, to engage with students, to build relationships, to listen to what students are saying, and to create opportunities to support student wellness through these exchanges. Many counsellors/psychotherapists do this already and she believes it often is a more effective way to meet students than in your office or in the classroom, or during a workshop or presentation. While it is necessary and valuable to do the classroom and student centre tasks, I think she made an excellent point. As I listened to her, I found myself becoming enthused to use more of this type of grassroots approach to reach out to students to create wellness opportunities.

In my private practice, I previously worked with a client who was having a difficult time in the workplace. She had a lot on her mind and she felt it was affecting her work. She was worried about what co-workers and her supervisor, even her partner, were thinking. In conversations with me, she was attempting to gain insight and understanding of this situation. Near the end of our sessions, she had made a number of decisions about how she would proceed. I was impressed to hear that one of her decisions was to stay on as chair of a working group at her office. She was a leader on the committee but had found it difficult to reconcile how she could remain in that position with all that had happened. In spite of this, she decided to stay, to continue in a leadership role, and to enjoy the fact that she really did want to be on that working group. I knew then, that she was doing well. She had made a decision for her own personal and professional wellness.

Being physically active is an important part of wellness and so I do some walking, basic exercises, lawn bowl and occasionally curl. On the ice this past winter, I was speaking with a friend who lives in a co-op condominium unit. He was telling me a bit about their last co-op member meeting. Near his home, an excellent boardwalk provides a great view of the ocean as you walk. He told me that he is a great walker, and that at the last meeting, he encouraged other members of the co-op to join him or to consider walking on the boardwalk. He told me that to encourage them - he reminded them that this is Canada's 150th Anniversary (http://canada.pch.gc.ca/eng/1468262573081). He suggested that they consider walking around the boardwalk 150 times in a month or whatever fit their schedule. I thought: what a great idea, what a good friend and co-op member, inviting others to be well. What an innovative way to help himself, and others, be well.

I realize that everyone knows this, as you live it day-to-day in your personal and professional lives, but I find that unique reminders, invitations by others, insights provided by others, innovations by others, are of refreshing value for all of us.

In the summer season, you all know you should take some time for yourself, your family, your friends, your partner, and to enjoy life. It is a time to be well.

My wish for all of you, and the people you help every day, is to “Be well!”

Sincerely,

John Driscoll

President-Elect, CCPA

NOTEBOOK ON ETHICS, STANDARDS OF PRACTICE AND LEGAL ISSUES FOR COUNSELLORS AND PSYCHOTHERAPISTS

Dr. Glenn Sheppard

Access to Information and Protection of Privacy Acts: Two Cases Involving Their Application to Students in Public Schools

As most readers know, in our society our right to certain information as well as to protection of our privacy is regulated by provisions in legal statues established by both the Federal and Provincial governments. For example, the Federal statue, enacted on July 1, 2004, has the title *Personal Information Protection and Electronic Documents Act (PIPEDA).* It applies to all Federal government departments and agencies and to all commercial activity in Canada. This means that it applies to those counsellors and other such practitioners in private practice but not to those who work in public educational institutions such as public schools. All of these statues provide for a commissioner or an adjudicator to adjudicate specific matters referred to them involving access and privacy rights covered by the legislation.

School counsellors and school psychologists as well as other educational personnel maybe unsure as to how such provincial statutory provisions could apply to access to information about school-age students and to their privacy protection. I believe that the following two decisions, one from British Columbia and the other from Newfoundland and Labrador, are informative in how those provisions can apply to student rights.

Case I: Victoria School District No. 61 (BC), 2012 BCIPC9

Sometime in 2012 students from a school in the Victoria School District were uncomfortable with the behaviour of a bus driver while they were travelling with him on a school trip. After the trip eight of these students, both boys and girls, met with their school counsellor to express their concerns about the driver. The counsellor then prepared a letter that described the behaviour that made them feel uncomfortable. Following this disclosure by the counsellor, the bus driver was disciplined by his employer, a local private bus company.

Subsequently the bus driver made a request to the Board of Education of the School District for copies of all the records relating to the complaint against him as well the names of all student complainants and their contact information plus the names of their parents. He alleged that the complaints were false and had damaged his reputation. The school district authorities provided him with the entire record of the complaints by the students. This included a copy of the letter prepared by the school counsellor that included information shared by the students about their concerns over the driver's behaviour and six pages of handwritten notes prepared by the counsellor during interviews with the eight students. It included the first names of six of the students.

The school district refused to disclose the students' full names and related information because it believed that such a disclosure would violate the students' privacy rights as per *Section 22* of the *BC Freedom of Information and Protection of Privacy Act (FIPPA).* It also denied access to the requested information by invoking *Section 19* of the *FIPPA* believing that such a disclosure might endanger the personal safety of the students.

The bus driver took the refusal to disclose the requested information to Jay Fedorak, the FIPPA adjudicator. As part of his consideration of this application to him by the driver, the adjudicator outlined the following three questions he believed he needed to answer:

1. *Whether the School District must withhold the names of the students to protect personal privacy under s.22(1) of FIPPA.*

2. *Whether the School District may withhold the names of the students to protect their personal safety under s.19(1)(a) of FIPPA.*

3. *Whether the School District must withhold the names of the students to protect the business interests of a third party under s.21(1) of FIPPA.*

During his review of these matters he became aware that the school counsellor had promised to maintain the students' confidentiality. He concluded that the fact that personal information was supplied in confidence was relevant to consideration under s. 22(2)(f) of FIPPA. Having considered the whole matter the Adjudicator reached the following conclusion:

I have found that the students' names on the requested records constitute the educational history of the students. Consequently, disclosure is presumed to be an unreasonable invasion of their privacy. I find that none of the relevant circumstances rebut the presumption that disclosure would be an unreasonable invasion of privacy. I find that the fact that the students' supplied their information in confidence favours withholding the information. Therefore, I find that s.22(1) of FIPPA applies to the students' names and School District must continue to withhold them.

Mr. Fedorak also concluded that given this decision on Question I there was no need for him to address Questions 2 and 3.

Case 2: Newfoundland and Labrador (Education) (Re, 2006 NLIPC)

In 2006, Mr. Philip Wall, Information and Privacy Commissioner in Newfoundland and Labrador had to deal with an application made under the *Access to Information and Protection of Privacy Act (ATIPPA)* For access to private information following a denial of a request for access.

The application for access involved a 14 year old boy. This boy had been diagnosed with a number of disorders. In 2005, two consultants from the Division of Student Support Services in the Department of Education, conducted a private interview with this boy and also with his two parents. In the Commissioner's Report he states that some members of the community were interviewed as well. It is unclear in the Report who these individuals were but it is reasonable to assume that were members who knew this boy. At least one of the consultants was a psychologist with experience in conducting student assessments and both had some responsibility for recommending the allocation of resources for students with special needs.

In 2006, the boy's mother requested access to a copy of the interview notes made by the consultants during the interviews both with their son and with her and her husband. In response to this request the notes from the interview with both parents were provided to the mother. However, the Department of Education denied access to the notes of the interview with her son claiming that doing so would be an unreasonable invasion

of his privacy. Following this denial, the Department received another request for these notes but this second request came in a letter signed by the boy. In response a letter was sent to the boy's mother instead of to the boy and it said the following:

"Department is denying the request in that I am of the view that this request is not for the benefit of (name of son) and I maintain that disclosure would constitute an unreasonable invasion of his privacy. Access has again been refused in accordance with Section 65(d) of the *Access to Information and Protection of Privacy Act (the Act)* which states:"

> *A right or power of an individual given in this Act may be exercised by the parent or guardian of a minor where, in the opinion of the head of the pubic body concerned, the exercise of the right or power by the parent or guardian would not constitute an unreasonable invasion of the minor's privacy:*

In considering the question of just who the actual applicant was for the requested information in the second request signed by the boy, the Commissioner concluded that the mother was the applicant for the purposes of his review. With respect to his decision regarding the mother's request of access to her son's interview information he relied on two prior decisions on similar requests. He quoted from a decision by the Ontario Privacy Commissioner when a father was denied personal information about his 14-year-old son. In that case, the Commissioner said the following:

I have carefully reviewed the representations provided to me in conjunction with the records at issue. While the father has argued that he requires his son's personal information to determine whether the various government agencies acted with their statutory mandates, ***he has failed to convince me that he is exercising such a right of access on behalf of his son. Rather, my conclusion is that the father, while acting in good faith, is seeking this information to meet his personal objectives and not those of his son. I also find, based on the sensitive nature of the materials contained in the records, that the release of the son's personal information would not serve the best interests of the child.***

Mr. Walls also quoted from another similar case dealt with by BC Privacy Commissioner in which he said:

I acknowledge that concern, but note that s. 3(a) speaks of the exercise by a parent or guardian of the right to have access to a record where that right is exercises "on behalf of" someone who is under 19 years of age. As my predecessor said in Order No. 53-1995. Where an applicant is not truly acting "on behalf" of an individual described in s. 3 of the Regulation, the access request is to be treated as an ordinary, arm's-length request under the Act, by one individual for another's personal information….

After considering the facts of the case before him and being informed by these prior decisions Mr. Walls reached the following conclusion:

After a thorough analysis of the responsive record, all material provided to me by the mother and the Department and the decisions of my counterparts in other jurisdictions, I concluded that the circumstances of this case warranted a decision in favour of the son's privacy. In my opinion, the mother was acting on her own behalf in attempting to gain access to this information. I do not

> *believe that her request for this information is in the best interest of the son and, as such, her request does not outweigh the son's right to have his personal information protected. I have concluded, therefore, that the entire record must not be released to the mother, as per section 65(d) and 30(1) of the ATIPPA.*

Based on these two decisions and, the cases reviewed by the Commissioner we can readily conclude that parents and guardians do not have an unfettered right of access to private personal information of their children who are minors. It appears that the onus is on the parent requesting access to demonstrate that a request is in interest." Of course, this places significant responsibility on all public bodies, including all schools, to exercise discretion when addressing the privacy rights of a minor.

Self-Care: It's an Imperative, Not an Indulgence

Beth Robinson

Counsellors are givers. Their caring, compassionate, and empathic nature is readily evident as they focus their energies on assisting clients in the quest for healing and growth. Unfortunately, the daily living stories of counsellors often are reminiscent of the tales we have all heard of professional carpenters, painters, plumbers, and electricians. Lore has it that these high demand tradespeople are so busy tending to the building and renovation requests of others that their own homes are the last to receive needed attention. Not uncommonly, a similar scenario applies to counsellors and self-care.

Rather ironically, helping professionals, who regularly promote self-care in the lives of their clients, are renowned for neglecting their own need for balanced living. They log long work days, fail to take regular breaks, complete tasks while eating lunch, and say yes to work-related requests even when their schedules are already packed full. Work trails them home and blurs personal-professional life boundaries. Care of the self takes a definite back seat to caring for others.

Counsellors can be generous to a fault, allowing the demands of clients and others in their lives to trump their own right to time devoted to physical and mental recharging. Missed opportunities for healthful eating, good sleep hygiene, and an active lifestyle can contribute to sluggishness and less than optimal performance. Failure to devote leisure time to connection at the intrapersonal, interpersonal, and spiritual levels precludes opportunity for rejuvenation, rekindling, and renewal. And putting off one's own personal growth pursuits, the kind that fire up passion and purpose, stifles the human drive to be generative and creative.

Charles Figley (1995, 1999, 2002a, 2002b), a globally renowned traumatologist, has researched and written extensively in the areas of vicarious or secondary trauma, compassion fatigue, and burnout. He suggests that the very qualities that permit helping professionals to connect empathically with clients also increase the risk for psychological distress arising out of intimate journeys into the realm of client suffering. Dr. Figley asserts that the toll exacted by deep caring is inescapable, but the deleterious effects can be mitigated by appropriate self-care. In other words, counsellor self-care can be the antidote to the hazards of professional helping.

However, when self-care is a practice that counsellors encourage in clients, friends, and family members, but deny to themselves, the costs can be high. Psychological depletion and disengagement can result in diminished or impaired performance. The rewards of professional helping may no longer be apparent and disillusionment may set in. Judgment may become clouded and self-monitoring may not be undertaken consistently and effectively. Ultimately, inattention to self-care can lead to client harm, ethics complaints, and/or litigation.

Although the message appears quite simple–practice self-care on a regular basis–it can feel uncomfortably indulgent to counsellors to focus on themselves. This is why it is crucial to consider self-care a professional and ethical imperative. Counsellors engage in self-care not only to ensure their own well-being, but to safeguard the well-being of their clients. The mantra *What I for myself I do for others* may offer counsellors, in a palatable manner, the self-permission to invest in themselves.

Self-care should be planned for and scheduled just like all other professional responsibilities. Adherence is facilitated when dedicated time for self is a part of each day. And just as the goal is balanced living, so too should the self-care plan offer a balance of mental and physical health-promoting activities.

You are encouraged to reflect on the current status of your own self-care practices. Do you have a plan that addresses the six domains in the diagram below? If not, there is no time like the present to make positive changes in your personal and professional life. Remember: self-care is an imperative, not an indulgence!

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CJCP EDITOR'S UPDATE

It is my pleasure to announce new appointments to the editorial board of the *Canadian Journal of Counselling and Psychotherapy* (CJCP). We are joined by four renowned individuals in our field, listed in alphabetical order: Richard Balkin, Samuel T. Gladding, Jeffrey Kottler, and Donald Meichenbaum. These appointments are just one of several initiatives we are taking at CJCP to further promote our Journal's reputation in the counselling and psychotherapy field and to highlight the work of our authors.

Yours best,
Kevin Alderson
Editor in Chief, *Canadian Journal of Counselling and Psychotherapy*

Complicated Grief Therapy: A Lifeline Back to Health, Hope and Happiness

Glynnis Sherwood

Complicated grief, also known as prolonged, chronic, or traumatic grief, is a serious road block to mental health and happiness. This article provides an overview of chronic grief therapies as a unique and crucial approach to helping clients recover from 'the pain that won't go away.' My research for the article draws heavily on the work of John R. Jordan, PhD, a clinical psychologist and grief counselor who specializes in working with survivors of suicide, and provides training for mental health professionals worldwide. Dr. Jordan has authored numerous publications, training programs and manuals in the bereavement field, and was the recipient of the Association for Death Education and Counseling Research Recognition Award in 2006.

Normal vs. Chronic Grief? What's the Difference?

Grief is a normal and necessary, though painful, response to losing someone or something we love and treasure. Normal grief involves acute feelings of psychological pain in response to the loss of a loved one through death, the end of a relationship, termination of a job, or declining health. Grief can also stem from socially unrecognized or "disenfranchised" losses such as early miscarriage, loss of a same sex partner, death of a friend, addiction, caregiver grief due to chronic or terminal illness of a loved one, exiting a cult or being shunned by an authoritarian religious community, crime victimization, estrangement from one's family of origin, and childhood abuse. The common denominator is that people grieve in direct proportion to the meaning the loss has for them.

Feelings of intense pain are common in normal grief, and can last from days to months. Although every person grieves in their own unique way, grief has some common features including temporary preoccupation with the loss, sadness, fear, loneliness and disorientation. Most people recover from this intense pain over time, though memories of loss remain as permanent features of one's psychological landscape.

Normal grieving involves a repeated fluctuation between a loss orientation, where a person moves towards grief, and a restoration orientation, in which grief is compartmentalized, and includes features of healthy avoidance. According to this framework, healthy grieving tends to be more voluntary, mindful and chosen (Jordan, 2011).

How well we cope with grief will determine our emotional resilience and ability to rebound from the pain of loss. According to William Worden (1992), **there are four main tasks of healthy grief recovery:**

1. Accepting the reality of the loss;
2. Working through the pain and complexity of grief;
3. Adjusting to an environment in which the important person, place, activity, relationship, etc. is missing;
4. Moving away from grief and longing for what is lost, and finding a place for it in our memories as we move on with life

Most individuals going through ‘normal’ grief don’t require counselling to complete these grief recovery tasks. Healing tends to happen organically over time, especially with good support. However, many mental health professionals acknowledge that adequate familial and social support systems can be lacking for grievers, especially after the first few months following the loss. They also often agree that people experiencing healthy grief can still receive valuable help, understanding and normalization of grief emotions by engaging in counselling.

Grief counselling ceases to be an option that can enhance the natural healing process and instead becomes an essential lifeline in situations where the grief is chronic. Chronic grief is characterized by the lack of resolution or the intensification of acute grief symptoms such as disbelief, shock, anxiety or depression after more than six months to a year since the loss.[1]

Chronic grief is distinguished from ‘normal’ grief by feelings of hopelessness, loss of meaning and/or belief systems, intense pre-occupation and longing for a lost loved one or situation, apathy, a lingering sense of disbelief about the loss, avoidance of situations or thoughts that are reminders of the loss, and sometimes, distressing, intrusive thoughts related to the loss that are reminiscent of trauma symptoms. Left untreated, chronic grief can lead to severe clinical depression, substance abuse and at worst, suicidal ideation.

According to grief and trauma Psychologist John Jordan (2011), **prolonged grief is experienced by approximately 15% of all grieving people**, especially those who have been impacted by unexpected and/or traumatic loss, such as sudden death, protracted fatal illness, violence or catastrophic injury.

People who have a history of mental health concerns, substance abuse, childhood abuse, neglect or trauma are more vulnerable to chronic grief. Other risk factors include a poor sense of self-efficacy, low self worth, a high degree of dependency on the relationship or situation, perception that the loss was preventable, absence of social support, current stressors and secondary losses (e.g. money, social status). It has also been my experience that people who go through socially unrecognized grief can be at greater risk of chronic grief, as they feel isolated and stigmatized for ‘inappropriate’ grief. At any rate, the higher the degree of risk factors, the higher the need for individual therapy. And in the case of traumatic loss there is often a longer recovery trajectory.

Psychotherapy is particularly critical for recovery from chronic grief, and requires specific counselling approaches designed to treat grief, emotional and cognitive distress and trauma symptoms. **Complicated grief has come to be understood as an Attachment Disorder, due to intense separation pain and anxiety stemming from the loss of an important person or object.** Those suffering from complicated grief must learn to grieve the loss of important attachment figures in a healthier way. This involves acquiring the skill of being able to move towards or turn away from grief at will; skills that are present in healthy grievers. The experience of overcoming chronic grief also entails learning to manage internal emotional reactivity and coping with other people’s reactions to the loss, which may range from being distant to overbearing. Healing requires reforming one’s identity in the face of the loss and, sometimes, increasing life management skills, such as learning how to cook or drive (Jordan, *2011*).

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

Treatment Interventions

John Jordan (*2011*) identifies **four phases of prolonged grief recovery**:

1. Reactive;
2. Reflective;
3. Integrative; and
4. Reintegration

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

Step 1 – Crisis Therapy, which corresponds to the "Reactive" phase of grief;

Step 2 – Grief Therapy, which can overlap with the "Reactive" phase, once the crisis has been resolved, and targets the "Reflective" and "Integrative" phases; and

Step 3 – Traditional Therapy, which occurs during the "Reintegration" phase of grief

John R. Jordan, PhD, is a clinical psychologist and grief counselor who has specialized in working with survivors of suicide loss for many years in the Boston metropolitan area. He also regularly provides training for mental health professionals, clergy, and others throughout the United States, Canada, and Australia on working with individuals and families after suicide. He is a consultant for the Survivor Council of the American Foundation for Suicide Prevention and the Grief Support Services of the Samaritans of Boston. Dr. Jordan has authored numerous important publications in the bereavement field and was the recipient of the Association for Death Education and Counseling Research Recognition Award in 2006. He is also coauthor of two books in the suicide bereavement field: "After Suicide Loss: Coping with Your Grief "and "Grief after Suicide: Understanding the Consequences and Caring for the Survivors". With the sponsorship of the American Foundation for Suicide Prevention, he also authored the Foundation's Support Group Facilitator training program and manual for survivors and professionals who would like to facilitate self-help support groups. therapy.

The therapeutic modalities he recommends include Trauma Reduction Techniques, Cognitive Behavioral Therapy, Narrative Therapy, Psychodynamic Therapy, Family Therapy, Complicated Grief Therapy and traditional Grief Therapy. Peer and/or facilitated support groups can also play a central role in recovery.

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

1. We bear witness to the client's exploration and expression of emotion, beliefs and experience of loss.
2. We are the psycho-educational coach; teaching the client about normal human responses to loss.
3. We are the life skills coach; helping the client identify what supports they need and how to ask for help from others. This includes teaching progressive desensitization skills to reduce avoidance of loss, or containment skills to prevent flooding and overwhelm of loss thoughts, feelings or memories.
4. We are the client's confidante
5. We serve as a transitional attachment figure

6. We are the psychotherapist; linking loss to other life issues, for example, earlier childhood loss, trauma or injuries leading to negative beliefs, expectations, feelings or moods. The therapist can also help the client overcome narcissistic perspectives, such as "I hurt more than you," that can drive others away. In this way, therapy becomes an opportunity to revisit, rework and heal old wounds.
7. And we can serve as the client's spiritual companion, helping the client use their grief for personal growth and transformation.

Therapeutic Strategies

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

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

Methodology

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

1. **Trauma Reduction Techniques:** a. **Cognitive Therapy**: Evaluates negative beliefs associated with trauma, e.g. "I'm a bad person."b. **Relaxation Techniques**: Teaches diaphragm breathing and uses guided imagery or hypnosis to reduce nervous system arousal.
2. **Dosing Techniques**: Designed to assist the client to achieve more control over when and how much to experience their grief. By learning to choose when to 'dose' themselves or to pull back from grief, clients come to accept the reality of their loss while overcoming trauma symptoms, negative beliefs and distressing emotions. This skill acquisition makes the grieving process more conscious and voluntary, and builds psychological resilience.
3. **Prolonged Exposure Therapy**: Combines relaxation techniques with gradual exposure to traumatic stimuli, which is described in detail, recorded, and listened to at home;
4. **Meaning Reconstruction:** Uses journaling to write about the traumatic event in detail, repeating the writing four to six times over a two week period;
5. **Writing Letters**: To or from deceased and/or an empathic 'imagined' friend who knows what the client needs to heal;
6. **Restorative Retelling**: Recalling the traumatic loss scene and then retelling the incident in a more bearable way that does not preclude the loss;
7. **Alternate Ending**: Uses guided imagery to portray the worst case scenario, real or imagined, which is then transformed to the best case scenario, then reviewed;
8. **Activism:** Involvement in support groups and helping others in a way that is redemptive or meaning-making. For example, Compassionate Friends support groups for bereaved parents;
9. **Relational Repair:** Occurs at the end stage of therapy. Designed to mend ruptures in relationships, it can also be an opportunity to conclude unfinished business e.g. 'complete' a relationship with a person who died by suicide.

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

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

Complicated Grief Assessment Strategies

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

1. The client is having trouble accepting the loss;
2. Grief is interfering in the client's life;
3. The client is experiencing intrusive images or thoughts of the loss that really trouble them;
4. The client is avoiding things they used to do/enjoy before the loss;
5. The client is feeling cut off or distant from others; especially family or friends;
6. The client is having intense feelings of loneliness when in the company of people they are close to;
7. The client is either avoiding thinking about the loss, or is overwhelmed by memories, images, thoughts or emotions;
8. Trauma symptoms may be interfering in the client's daily life and grief recovery.

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

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

References

Jordan, J. (2011). *Traumatic Loss: New Understandings, New Directions*. CMI Education Institute. Eau Claire, WI.

Worden, W. (2009). *Grief Counseling and Grief Therapy*, 4th Edition, Springer Publishing, New York, NY.

Shear K, Frank E, Houck PR, Reynolds CF. (2005). *Treatment of Complicated Grief: A Randomized Controlled Trial*. Journal of the American Medical Association. 293(21): 2601-2608.

[1] This is a 'rule of thumb' amongst mental health clinicians. The Diagnostic and Statistical Manual of Mental Disorders (DSM V) published by the American Psychiatric Association in 2013 has included Persistent Complex Bereavement Disorder (PCBD) in the Emerging Measures and Models section, with a view toward including it in later revisions of the DSM.

The British Columbia Disaster Psychosocial (DPS) Volunteer Network

In 2001, the Disaster Psychosocial Program (DPS) was formed with a mandate to develop and provide psychosocial strategies. Working across emergency management systems, the DPS Program accomplishes its mission by collaborating with multiple partners, managing its volunteer network/resources to build provincial psychosocial service capacity, promoting system integration and by developing education and training strategies for leaders, front line workers, and the public.

The program develops and provides these strategies with a continuum of supportive services targeting both the public and responders affected by an emergency or disaster. These services are intended to empower people to help themselves and connect them to local resources, minimizing the long-term psychosocial effects of a disaster. The program also encourages community recovery by providing educational tools and resources to increase resiliency and healthy coping.

In September 2014, CCPA became an official member of the BC DPS Council which facilitates members like you to be called upon as local, community-based volunteers when the need arises. Furthermore, CCPA attended and was one of the sponsors for the spring 2016 International DPS Conference held in Vancouver, BC.

The DPS Services Volunteer Network is comprised of professional and paraprofessionals from:

- BC Association of Social Workers
- BC Psychological Association
- BC Association of Clinical Counsellors
- Canadian Counselling and Psychotherapy Association
- Police Victim Services of BC
- Canadian Association for Spiritual Care

DPS volunteers are engaged through the DPS Program by its program lead and coordinator.as well as guided and supported by the DPS Council. The DPS Council has representatives from each of the above

professional groups, as well as the Canadian Red Cross, Salvation Army, Emergency Social Services, and the First Nations Health Authority (FNHA).

If you are a BC CCPA Certified member (CCC) and are interested in volunteering with the Disaster Psychosocial program, please submit an application online. Please note that volunteers are screened to ensure they have the necessary credentials.

Through the Continuing Education Credits (CEC) Program, CCPA also recognizes members who engage in pro bono work in a professional counselling or psychotherapy capacity such as consultation, crisis counselling and disaster response.

For more information about the DPS Program, please visit the following website:

http://www.phsa.ca/our-services/programs-services/health-emergency-management-bc/disaster-psychosocial-program

CCPA 2017 AGM Notice

ATTENTION ALL CCPA MEMBERS
The Canadian Counselling and Psychotherapy Association will hold its Annual General Meeting on May 18, 2017, from 12:00 p.m. to 1:15 p.m. at the Sheraton Hotel Newfoundland at 115 Cavendish Square in St. John's, NL, A1C 3K2. Every member is invited.

AGENDA

Welcome

1. Acceptance of Agenda

Motion Required: To accept the agenda.

2. Minutes of May 2016 AGM

Motion Required: To accept the minutes of the May 2016 AGM as presented (as amended).

3. President's Report

Motion Required: To receive the President's report as presented.

4. Board of Directors 2017-2019

Motion Required: To accept the slate of Directors and Officers as presented.

Motion Required: To destroy the ballots received for the 2017 elections.

5. Financial Report 2016-2017

Motion Required: To receive the 2016-2017 audited financial statement as presented.

6. Approval of 2017-2018 Auditors

Motion Required: That van Berkom & Ritz LLP be selected as the Financial Auditors for 2017-2018.

7. By-Law Changes (see attached)

Motion Required: To amend the above noted sections of the by-laws.

8. Good Faith Motion

Motion Required: That all actions taken by the Executive and Board of Directors since the last Annual General Meeting were carried out in good faith.

9. Adjournment
Motion Required: To adjourn the meeting.