Dan Siegel Event:

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BC Psychologist

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The British Columbia Psychological Association provides leadership for the advancement and promotion of the profession and science of psychology in the service of our membership and the people of British Columbia.

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DEAR COLLEAGUES,

Summer is upon us and this is the time we usually think about holidays and relaxation. This resilience issue is intended to invite us reflect on resilience and all the different ways it intersects our lives. The work we do with others is intended to help with their resilience. The good self-care we do for ourselves is to maintain our own resilience. I am also mindful of the resilience of our profession.

My clinical work is at Providence Health Care in Vancouver. I provide care to people who work in healthcare. For some reason, after 10 years of developing the work at the Centre for Practitioner Renewal, I continue to be surprised at how common it is that people who work in healthcare care less for themselves than they do for their own patients/clients. Just this morning I was seeing someone who works in the area of mental health. We were talking about how she is working to integrate the realisation that she had been serially sexually assaulted when she was younger. She expressed that she was frustrated with herself that it was taking more than a few weeks to integrate this revelation. I asked her what she would say to someone whom she was treating and said what she had just told me. Naturally, she described having a great sense of compassion for that person. Even though she is skilled in the area of mental health, somehow, compassion for herself was less than her compassion for others.

It is my hope that we can recognise the essential importance of the compassion we have for others and equally foster that compassion for ourselves. If we are able to be as compassionate towards ourselves as we are towards others, then our profession will truly become a place for sustainability.

In my letter to you in the Spring, 2015 edition of the BC Psychologist, I wrote that I have become the Canadian representative to the Committee of State Leaders (State, Provincial and Territorial Leadership). This committee is organising a forum as part of the American Psychological Association (APA) convention in Toronto. At the APA convention, the topic of the forum is: Protecting, Defending, (and Enhancing) the Psychology License.

While the forum is mostly American, I have been able to have some influence to have Canadian content included. Several American psychologists will be talking about the maintenance and protection of our profession across the US. On the same panel, I have asked Dr. Karen Cohen, Executive Director of CPA, to talk about how we manage to sustain our profession here in Canada.

This month, I participated in the Council of Professional Associations of Psychologists meeting (the semi-annual meeting of the Presidents and Executive Directors of the provincial and territorial psychological associations). While attending those meetings, I learned about 2 developments across the country that may be of interest to you.

The Ontario Psychological Association (OPA) submitted a request to their Minister of Health to expand the scope of practice of psychologists to include prescribing privileges for those who have the requisite training. Several jurisdictions across the US are also at various levels in the application process.

Another association (I will not name that province because this discussion is only in the very initial stages) reported that their government is considering extending privileges to psychologists to be included in the provincial health system. Recognising that to include access to psychological care under the provincial healthcare system, would benefit the province. Increasing access to psychological services to all healthcare recipients would contribute to lower sick time and increased productivity making for a richer economy. Of course this would also alter the relationship between psychologists and the institutions where they currently work.

Especially with this edition about resilience, I invite you to take the time to reflect on resilience and the different places and ways it occurs in your life. I invite you to appreciate the resilience you help create in those for whom you provide care. I invite you reflect on your own resilience and the compassion you have for yourself. I also invite you reflect on the resilience of our profession. I wish you all a very good summer.

Kind regards,

Douglas Cave, MSW, RSW, Ph.D.,
R Psych, MA, AMP, MCFP
President of the BC Psychological Association
Letter from the Executive Director

RICK GAMBREL, B. COMM., LLB.
The Executive Director of the BCPA. Mr. Gambrel has a Bachelor of Commerce in Finance and a Law Degree from UBC. Prior to working at BCPA, he was a trial lawyer for over 30 years, as well as Managing Partner of a number of law firms. He is Past President of both the Trial Lawyers Association of BC and of White Rock Concerts, one of Canada’s leading classical music presenters. Contact: rick.gambrel@psychologists.bc.ca

AS WE APPROACH A NEW MEMBERSHIP YEAR, I can report that the past year has been a very productive one for BCPA. The Association is doing more every year to advance psychology and the psychological well-being of British Columbians.

Some of the accomplishments by BCPA over the past year include:

- BCPA membership is the largest in the association’s history;
- Promoting 10 free public talks during February 2015—Psychology Month and two more talks in June 2015;
- As the most active psychological association in Canada during Psychology Month, BCPA garnered unprecedented media coverage in print, radio and television for psychologists;
- Submissions to government advocating for a greater role for psychologists in healthcare, with respect to children and youth and community care;
- Submissions to the BC Supreme Court Rules Committee to protect the privacy of your clients’ records;
- The Piece of Mind art exhibit in May 2015, connecting art and psychology and featuring the work of 30 accomplished BC artists, resulting in further media coverage for BCPA and psychologists;
- Like never before, listening to our members by way of our annual member survey and numerous focus groups with members and prospective members;
- Advocating to employers and unions for greater annual coverage limits ($2,000 per year) for psychological services covered by extended health plans;
- BCPA leadership serving on national psychology bodies. I am the BCPA delegate to the Council of Professional Associations of Psychologists (CPAP) and one of 5 members of the governing body for the national professional liability insurance plan brokered by BMS;
- BCPA’s endorsed professional liability insurance plans (brokered by BMS or Johnston Meier) offer better coverage than ever before and for the lowest rates available to psychologists;
- Engaging employers and unions at the CMHA Bottom Line Mental Health Conference and the Health Sciences Association (HSA) conference;
- At the HSA convention, BCPA Advocacy Committee member Dr. Kelly Price worked to pass a resolution supporting psychologists working in provincial autism clinics;
- Presenting 5 quality continuing professional development workshops
- Presenting 10 ethics salons, serving over 100 of our members in 4 locations around the province;
- Offering our BCPA online forum so that you can converse with, and learn from, your colleagues

BCPA is on a solid organizational and financial footing to be able to serve our members and to advocate for the profession and for good psychological care for British Columbians. And we have plans to do even more in the coming year, thanks to the good work of our members, board, committees and staff.

We are drafting further submissions to government, reaching out to more psychologists around BC through our member focus groups, continuing to meet with employers and unions to advocate for more coverage for psychological services, and getting ready to reveal plans for another strong lineup of professional development workshops and ethics salons. And we will of course continue to produce this fine publication, the BC Psychologist.

I encourage you to join your colleagues and either renew your BCPA membership, or become a BCPA member. There is of course greater strength in numbers, and a strong partnership between the members, the Board, and the staff will continue to benefit the profession and the psychological health of all British Columbians. ▶️
BCPA News & Events

• membership renewal

Please renew your 2015 – 2016 BCPA membership online at www.psychologists.bc.ca or complete the renewal form (page 23 & 24) and send it back to BCPA with a cheque before August 31st, 2015.

• upcoming workshop & agm

NEW DIRECTIONS IN THE TREATMENT OF COMPLEX TRAUMA: MINDFULNESS, AFFECT REGULATION & EMOTIONAL PROCESSING WORKSHOP
*in conjunction with the BCPA Annual General Meeting (The BCPA AGM will take place during Lunch break.)
Presented by Dr. John Briere
9:00AM – 4:00PM Friday November 27th, 2015
@ University Golf Club (5185 University Blvd)

Please see page 25 & 26 or visit BCPA website at psychologists.bc.ca for more information and registration.

• submit articles

WANT TO WRITE FOR US? We are always looking for writers for the BC Psychologist or the BCPA blog. The theme for the upcoming Fall 2015 issue is: Collaboration. For further details, contact us at: communications@psychologists.bc.ca

WE PUBLISH NOTICES regarding retirement, awards, and deaths of members. Please keep us informed about your career and life milestones. If you want a notice to be included in the publication (approximately 100 words) contact us at: info@psychologists.bc.ca

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• piece of mind award

IN PARTNERSHIP WITH THE HEALTH DESIGN LAB AT EMILY CARR UNIVERSITY OF ART AND DESIGN

The BCPA Piece of Mind Award in Health Design for Innovation in the Field of Psychological Health and Well Being goes to Kevan D’Agostino for Together. (http://www.kevandagostino.com/#/togethersystem/)

Kevan D’Agostino is a communication designer who focuses on brand development, print design, and anything collaborative for the greater good. His experience in both marketing and graphic design has shaped his ability to not only converse on a personal level, but through an aesthetic that helps relay a message in a clear and effective way.

Together is an interactive system that brings light, laughter and positivity to a time that can be uncertain and overwhelming. By combining two well-known methods of Alzheimer’s care, play therapy and reminiscence therapy, Together combines curated photographs and media to create personalized and meaningful activities for families and residents to engage in together. Kevan D’Agostino received his award at the Piece of Mind exhibit opening night ceremony.
Piece of Mind 2015 Featured Artists:

IN ALPHABETICAL ORDER BY LAST NAME:

1. Magdalena Anthony — *Wisdom*
2. Miki Aurora — *Clifftop Eyes*
3. Marquerita Bilac — *The Puzzle*
4. Wren Bruce — *Caged*
5. Ashley Bulthuis — *The Decline*
6. Frances Cabahug — *Lanterns*
7. Evelyn Chan — *Dangerous Games*
8. Nichola Clark — *The Eye of the Storm*
9. Lino Conti — *The Hope Abides*
10. Stephanie Drake — *Bloom*
11. GJ Gillespie — *Kingdom Within*
12. Collage Art Group — *Peonie’s World*
13. Kirsten Hatfield — *Maelstrom*
14. Corinn Howes — *Nebula*
15. Yu-Ching (Isabelle) Hsu — *Recollection*
16. Jordy Johnson — *Lucky Lives*
17. Jacqueline Karista — *conscious of the unconscious*
18. Iori Kokotailo — *Godsplosion (The One That Got Away)*
19. Patrick Maquirang — *Runaway Thinking*
20. Melissa Peacock — *In The Weeds*
21. Courtney Powell — *Dazed*
22. Katie Prasad — *5 Stages of Grief: Anger*
23. Stephanie Semchuk (Gypsy Eyes) — *Dancing Souls*
24. Dave Stevens — *Arbutus Resilience*
25. Marilynn Tebbit — *Pink Dance*
26. Jose Urbay — *The Lake of the Hopeful Souls*
27. Natasha Vukovic — *Resilience*
28. Karyn Wang — *Your Mind is a Battleground*
29. Pongsakorn Yananissorn — *Sculpture of Dirt*

PRIZE RECIPIENTS:

Jordy Johnson (Non-student Artist) — *Lucky Lives*
Pongsakorn Yananissorn (Student Artist) — *Sculpture of Dirt*

IN PARTNERSHIP WITH

[BCPA logo]

[VPIL logo]
Reflections on Psychology Month Talks 2015

MS. BEVERLY KORT, R. PSYCH.
The Community Engagement Committee Member of the BC Psychological Association. www.iamlistening.ca

This year we had our most successful Psychology Month, with ten talks around the city and a corresponding sharp increase in media interest. We helped promote psychologists who were already making presentations during the month of February as well as hosted five original talks in partnership with the Vancouver Public Library.

We talked to the four Psychologists who volunteered to give presentations specifically hosted by BCPA and Psychology Month to find out more about how the experience was for them.

• Dr. Tina Wang & Dr. Pam Narang
  Cross Cultural Parenting
  Collaborative Problem-Solving Parenting

• Dr. Patrick Myers
  How to Cultivate a More Passionate Life

• Dr. Larissa Mead-Wescott
  Building a Better Brain

All the psychologists used this opportunity as a motivator to put together material they felt very passionate about and have wanted to share with the public but had not had the resources to organize and promote themselves.

LARISSA: “It was a very gratifying professional activity and worth the disruption in your schedule to pull the talk together.”

PATRICK: “Psychology is more than sitting face to face with a client... We need to share the wealth in as many ways as possible.”

TINA: “I am interested in making psychology/psychologists appear more accessible, more approachable, more ‘mainstream’ to the general public... raising public awareness.”

PAM: “I would recommend it, especially if there is a topic that you are interested in and find yourself repeatedly going back to it in your own practice.”

They all expressed the sense of accomplishment from impacting people on a larger scale, the opportunity to interact with an interested and enthusiastic audience, and the satisfaction of putting psychological health and psychologists more in the public domain.

The increased media interest was facilitated by Peak Communications and resulted in very well attended events. They really helped us put Psychology Month on the map this year and was also a boost for the Psychologists, as they were all invited to do interviews.

TINA: “...learned a lot about the importance of partnering with media to help shape the image of psychologists as well-trained approachable professionals.”

LARISSA: “It is also a nice way to get a little press — if people are looking to develop a niche or get a certain specialty into public awareness.”

Now is the time to start thinking about Psychology Month 2016. We encourage you to volunteer for next year’s Psychology Month Talks.

If you would like to present a topic but feel unsure or insecure about how to do it, BCPA will provide you with the names of “veteran” speakers who will help coach you through the process.

We want to thank all the Psychologists who gave talks this year and look forward to promoting even more of you next year!

Dr. Tina Wang
Works P/T at BC Children’s Child Psychiatry unit and P/T in her private practice with a general focus with children, adolescents, families, and adults.

Dr. Pam Narang
Works in the Child Psychiatry Inpatient program at BC Childrens Hospital and as a Clinical Instructor with the UBC Department of Psychiatry.

Dr Patrick Myers
Works with an EAP and has a private practice with a general focus with adults

Dr. Larissa Mead-Wescott
Has a Private Practice in Clinical Neurology (North Shore Neuropsychology), specializing in assessment and working with individuals age 14 to elderly with any sort of neurological or cognitive issues. She also works P/T with Lifemark Health Centre for head-injured workers.

BC PSYCHOLOGIST 9
RESILIENCE AMONG HEALTHCARE PROVIDERS (HCP) IS OF GROWING INTEREST.

Psychologists are included among HCP who sometimes suffer the effects of waning resilience as a result of exposure to serial suffering. Compassion fatigue (Figley, 1995) is an increasingly well known term among HCP who are exposed to serial suffering. Related to burnout (Maslach, 1993), vicarious trauma (McCann & Pearlman, 1990) and secondary traumatic stress (Stamm, 1995), compassion fatigue is about the preoccupation with an individual or trauma that results in the inability to continue to care for others. This inability to care for others may also impact the ability of a HCP to care for themselves.

For the last 10 years, my clinical work has been to address these and other concerns with HCP. The Centre for Practitioner Renewal (CPR) (www.practitionerrenewal.ca) was created at Providence Health Care to support healthcare workers. We developed guiding questions which shaped our work. Those questions are:

- How do we sustain health care providers in the workplace?
- What is the effect of being in the presence of suffering?
- What would be considered reparative, healing or restore resilience for health care providers?

When we started our work, we thought the work would largely be about addressing primary and secondary traumatic stress. Indeed we see and work with that. However, I now recognise that resilience is effected by traumatic stresses from patients, but a significant amount of that which erodes our resilience is difficult collegial interactions and relationships. From my work at CPR, I see that the relationships we develop especially with colleagues either sustains or erodes our resilience.

To that end, the CPR motto is ‘efficiency through relationship’. Healthcare is generally based on a business model of efficiency (Porter & Lee, 2013). The business model of efficiency is about moving the maximal number of people through the system as fast and efficiently as possible. A business efficiency model may be how healthcare functions, but the work of health care providers is about relationship. Ten years of clinical experience has shown that relationship is sacrificed to action and efficiency in the usual type of business model.

When I speak about relationship, it is framed as relationship with self, others and Other. In other words relationship is framed as, my relationship with myself; my relationship with other people; and my relationship with something beyond myself and others that brings me meaning in my life. This last concept of a relationship with ‘Other’ is different for each of us. For some, this means a relationship with a religion or spirituality. For others, it may mean a relationship with nature, or the universe.

The work of the CPR is about building, repairing, and sustaining relationships in the workplace. Civility is a key quality of this building, repairing and sustaining. A civil environment promotes the process of caring and optimizes the task of functioning. A civil environment includes balancing task and process in the relationships with self, others and Other.

Incivility among colleagues hurts morale and the bottom line (Porath and Pearson, 2013). Porath and Pearson note that incivility is expensive, and few organizations recognize or take action to curtail it. They note that civility is often brought on by thoughtlessness rather than malice. They go on to explain that those who are the targets of incivility often end up punishing both their offenders by means of other uncivil acts and the organization or system in which they work. However, most targets of uncivil behaviour hide or bury their feelings rather than considering revenge. We know that hiding or burying difficult feelings predicates an unhappy future. Like vicarious traumatic stress, Porath and Pearson furthermore note that simply witnessing incivility has negative consequences. They describe the results of a survey of 800 managers and employees in 17 industries who have been on the receiving end of incivility. The results of their survey showed the following:
• 48% intentionally decreased their work effort
• 47% intentionally decreased the time spent at work
• 38% intentionally decreased the quality of their work
• 80% lost work time worrying about the incident
• 63% lost work time avoiding the offender
• 78% said that their commitment to the organization declined
• 12% said they left their jobs because of their uncivil treatment
• 25% admitted to taking their frustration out on customers

ENGENDERING RESILIENCE AND ENHANCING RELATIONSHIPS
Herman (1992) provided a model of trauma treatment that is elegant in its simplicity, but complex in its application. Herman provided a 3-stage model of trauma treatment that 10 years of clinical experience has been shown to be as effective for resilience of HCP as it is for the treatment of Posttraumatic Stress Disorder. The 3-stage model from Herman is:
• Safety
• Remembering/Mourning
• Reconnection

Herman’s model is not step-wise, rather it is a back-and-forth approach. The model begins with safety. Creating a ‘safe enough’ environment, a ‘safe enough’ inner experience and ‘safe enough’ relationships before moving into the work of unpacking the past and mourning it. Before taking each step into remembering and mourning may mean returning to re-establish safety. The cycle between safety and remembering/mourning continues until the remembering and mourning is complete. Reconnection is about returning to the connections and relationships in the world.

While providing care to healthcare workers regarding resilience, it is the same process. Creating safety is different for each of us. However safety includes considerations about the environment, inner experience and relationships. Over the years of treating HCP, I have been struck by the tendency of HCP to accept difficult emotions in their own patients, but evidencing a pattern of suppressing difficult emotions in themselves. By this I mean, if the basic elements of emotions are mad, sad and glad, then HCP focus on the absence or presence of glad, but avoid mad and sad altogether. It is not the only one, but being able to express mad (in a constructive way) and sad may be a metric of safety.

Once safety is created, remembering/mourning may begin. Returning regularly to safety is necessary to proceed through remembering/mourning. Remembering is about recalling, experience and working through the memory of that experience. Remembering, in the present sense, is about mindfulness. Mindfulness about how someone wants to respond in an intentional manner rather just reacting. Mourning is about grieving and having that grief witnessed.

Reconnection is about returning to relationships. Self, others and Other is the way we conceptualise relationships in the work we do at CPR. Reconnection to self includes acknowledging difficult and uncomfortable feelings, creating and maintaining boundaries in an intentional way, and self-compassion. Reconnection to others includes both at work and out of work relationships. During times of waning resilience, isolation is common. Reconnecting with important people and establishing new and meaningful relationships is included here. Reconnection with Other is less straightforward than the other types of relationships. Meaning-giving relationships cannot be forced. Those connections can only be discovered through openness and exploration. Waning resilience may impede the felt sense of flexibility to explore meaningful relationships. When resilience has increased, there may be more energy available to explore meaning. This last type of meaning-making relationship is likely a life-long exploration.

CONCLUSION
Being a HCP taxes resilience. As psychologists, we are HCP. While being in the presence of suffering on a regular basis may erode our sustainability, maintaining relationships may inoculate us from the ill effects of our work. As with other HCP, having meaningful relationships with ourselves, other people and something that brings us meaning in our lives are some of the features that can help protect our resilience.

While this article focuses on individual experiences regarding resilience, I am also mindful of resilience from a systems perspective. With an eye to systems, I reflect on the systems in which we interact and relationships among those systems. While relationships we create on an individual basis may enhance or erode our individual resilience, I reflect on the impact of relationships our profession creates. As a profession that has advanced training in relationship development, it often gives me pause to consider how our profession may develop relationships that will enhance the resilience of our profession.
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References


You’re **TOUGHER** than You Think You Are!

MIKE WEBSTER, ED. D., R. PSYCH.

Dr. Webster has practiced as a police psychologist for over 35 years. He specializes in Crisis Management and works with law enforcement agencies both domestically and internationally. He has consulted on a number of high profile crises including Waco Texas, Jordan Montana, Lima Peru, and Gustafsen Lake British Columbia.

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**IT’S MY IMPRESSION THAT THE TERM “RESILIENCE” IS OFTEN USED IN A SUPERFICIAL MANNER,** without much real understanding. You may be aware that the phenomenon of resilience has been defined in a variety of ways, and all seem to agree that it involves the ability to “bounce back” from adversity, and includes the ability to “bend but not break” under extreme stress. Of these definitions, the one that stands out and serves to guide training in psychology is the view of resilience as a set of processes that enables “…good outcomes in spite of serious threats...” (Masten, 2001, p. 228). It is our skill at facing challenges and persevering in the face of relentless demands. Resilient individuals have the ability to forge positive outcomes even when they have been thrown off (mental) balance. They have a set of coping skills that serve them well in the face of oppressive events. For example, you may be aware that the literature in this area indicates that following a traumatic exposure most people (80–90%) will recover quickly and without ongoing professional assistance, and only a small percentage will require long-term help (Bonnano, 2004; Westphal, Bonnano, & Bartone, 2008). Considering the idea that resilience is the rule rather than the exception, it is not a sign of exceptional strength of character in a unique individual, but a fundamental aspect of normal coping; it is “ordinary magic” (Masten, 2001).

An interesting question then is: what specifically makes up resilience? Much of the data used to answer this question comes from the study of those who have been exposed to combat and who were held as prisoners of war. These studies, in their efforts to lay resilience bare, have ranged from the examination of our biology (e.g., Lester, McBride, Bliese, & Adler, 2011) to the influence of the social context (e.g., Bliese & Britt, 2001). The latter has received a great deal of attention, as it was recognized early on that resilience is fueled largely by relationships — namely, their number and quality, whether real or perceived. The richness of social support and resources available to victims of traumatic exposures play a central role in the effectiveness of resilience. The data noted above asserts that the concept of resilience is best regarded as including resilient families, resilient communities, and resilient organizations.

As there is much interest in the individual characteristics of resilience, here are a few of these individual characteristics gleaned from the literature (cited above):

**The ability to regulate emotion.**
This refers to the ability to stay calm under pressure; the ability to defuse emotion and clear one’s head enough to prevent oneself from feeling overwhelmed. This skill is thought to be the most important in the context of resilience. When we are in charge of our own emotions, we interact with others more effectively, make better decisions, use better judgement, and are better problem solvers. Accurate and flexible thinking leads to emotional control.

**The ability to analyze problems.**
This refers to the ability to examine a problem and accurately determine its cause. Research shows that what we think about stressful events will affect how we feel about them and what we do about them.

**The ability to be cognitively flexible.**
This refers to the ability to reframe a stressful experience and find some benefit in it. This is the skill of adjusting one’s perspective and being able to use an alternative view to adapt to changing demands and transitional stressors.

**The ability to make meaning out of one’s traumatic experience; to develop a “survivor’s mission”.**
This refers to the ability to use one’s faith, spirituality, or values as a map to guide them through the healing process. This is sometimes referred to as the ability to make a “gift” out of one’s experience for others; to share one’s story.
The ability to maintain realistic optimism. This refers to the ability to believe that “this too shall pass”. This type of optimism is not mindless. It is not about disregarding challenges and forcing a positive outlook. It is about seeing things as they are and believing that all problems can be met and mastered.

I have emphasized, above, some of the cognitive characteristics of resilience. Because the use of resilience is so contextually influenced, I will close by emphasizing the importance of resilience-engendering organizations.

It has been noted by some that PTSD is on the rise in the military and paramilitary (i.e. police) worlds. It is my belief that this may be related to the failure to nurture these individuals’ natural resilience. In order for these organizations to provide a fertile ground which supports the development of resilience, they need to address organizational issues such as harassment, sexual harassment, intimidation, bullying, high stress levels, poor leadership, lack of unit cohesion, poor morale, tasks out of check with resources, and the corporate culture.

Recently an American military mental health team (Ballenger-Browning & Johnson, 2010) suggested that high unit cohesion and competent leadership resulting in confidence, good morale and mission acceptance contributed to resilience. Those soldiers who were sent to battle with strangers were more likely to suffer mental injuries, while those who were in the company of unit members they had trained with, knew well, trusted, had pride in, and depended upon were more likely to demonstrate resilience. The team of researchers emphasized that what allows soldiers to cope well with the demands of war, including the spectre of death and injury, is, more than anything else, their loyalty to their comrades. It is again apparent that the core of resilience is camaraderie.

In my opinion, post traumatic responses decrease, and resilience increases, when military and paramilitary organizations are genuinely motivated to live by their “mission, vision, and values” statements. It is remarkable what genuinely motivated leaders can do for the health of the membership. Leaders who have a deep emotional bond with their “troops”, who understand the concept that they don’t eat until the “troops” have eaten, and don’t sleep until the “troops” have slept, are not unlike a preventive elixir. With an attitude like this at the top of an organization, camaraderie, unit cohesion, and health will inevitably flourish.

REFERENCES
the issue of childhood sexual abuse (CSA) in Canada remains relevant, as recent statistics indicate that thousands of children and youth experience sexual victimization every year. The most recent epidemiological examination of this issue in Canada revealed that 13,600 new cases of sexual abuse of children and youth under 18 years of age were reported in 2008 (Ogrodnik, 2008). In fact, this study identified that children and youth under the age of 18 were 1.5 times more likely to experience sexual assault than young adults aged 18 to 24 (Ogrodnik, 2008). Findings suggest that sexual assault against children and youth under the age of 18 tends to be non-violent in nature, and typically involves sexual interference, sexual touching and sexual exploitation (Ogrodnik, 2008), although violent sexual assaults do occur where physical injury is sustained in concert with sexual assault. Certainly there is robust research to suggest that psychological injury can be sustained regardless of the degree of sexual assault that is perpetrated (Finkelhor, 1990).

As is the case in the United States, Canadian statistics indicate that female children and youth under age 18 experience sexual perpetration at rates five times greater than their male peers or young adult females aged 18–24 (Ogrodnik, 2008). This finding illuminates the significant risk young female children face regarding their potential to be sexually victimized. Though beyond the scope of the present article, it should be noted that male children and youth, including those over the age of 18, remain more vulnerable to experiences of physical assault compared to their female counterparts.

Findings such as these continue to support the fact that CSA continues to be experienced by thousands of Canadian children and youth. There is lengthy and robust research which highlights the deleterious impact of CSA on emotional development and psychological well-being. For example, research has shown that CSA is related to posttraumatic symptoms and self-injurious tendencies (Chaplo, Modrowski, Bennett, & Kerig, 2015), eating pathology and emotion regulation (Moulton et al., 2015), and negative personality traits such as sensitivity, anger, and anxiety (Sudbrak et al., 2015). These are but a few examples of the severe and longstanding impact CSA can have on developing children and youth.

Given the extensive literature documenting negative outcomes among survivors of CSA, it is surprising that a substantial group of victimized children do not develop PTSD or other psychiatric disorders (Finkelhor, 1990). One conceptual model that explains how individuals can not only withstand the negative effects of trauma, but actually thrive following a traumatic experience, is Posttraumatic Growth (PTG; Tedeschi & Calhoun, 2004). This model postulates that following a traumatic event, and given a certain number of factors, a traumatized individual can experience growth and development.
in specific ways. These include developing a greater appreciation for life in general, having more meaningful interpersonal relationships, having greater awareness of, and reevaluating, one’s personal strengths, and having enhanced spiritual beliefs. According to Tedeschi and Calhoun (2004), effective social support following a traumatic event is crucial. Support from a social network that facilitates the exploration of the meaning of what occurred, and the development of narrative understanding of the reasons behind the traumatic event, is supportive of growth. An overall ability to cognitively engage and productively ruminate about the traumatic experience in a way that enhances the development of meaning and new understanding is also key. This model does not suggest that traumatized individuals will not experience distress following a traumatic event. Rather, it suggests that as the distress is processed the individual can be changed in a positive fashion that would not have occurred if the traumatic event had not been experienced, at least partially, through the mechanisms described above.

As it pertains to children, Kilmer (2006) has identified unique characteristics that are proposed to be necessary for growth experiences to occur. These include: the child’s beliefs, characteristics and functioning prior to the traumatic event; the responsiveness of caregivers after the traumatic event occurs; the severity of traumatic exposure; the presence and depth of relationships and support; the appraisals, ruminations and cognitive processing of the child post-trauma; available cognitive resources, and; what is called ‘self-system functioning’. The interaction between the above variables determines the potential for children to experience PTG.

McElheran and colleagues (2012) suggest that several components needed to be incorporated into Kilmer’s PTG model when working with children and adolescent survivors of CSA. In particular, the child’s attachment style needs to be considered. Attachment dynamics between children and their primary caregivers influence variables such as psychological well-being, affect management, and the ability to access support from family and friends (Mercer, 2006), which in turn affect the child’s ability to make sense of the traumatic event. Attachment systems may also determine how a caregiver might respond to the child after a traumatic event, which is an important component of PTG among children (McElheran et al., 2012; Kilmer, 2006). There is a dearth of research on attachment style and PTG among children and adolescents, and future studies should examine the impact of attachment systems on PTG following sexual abuse.

Another important variable to highlight in PTG is family cohesion, which would encompass the family’s ability to form and maintain safe and trusting relationships in supporting the child. McClure and colleagues (2008) sampled 177 university women who had experienced CSA, and found that family characteristics accounted for 13–22% of variance in outcomes associated with well-being. Specifically, family cohesion was a significant predictor of positive social functioning and greater resiliency (McClure et al., 2008).

**CLINICAL IMPLICATIONS**

Studies have consistently shown that family support is a critical factor in a child’s well-being following CSA (Marriot et al., 2014; McClure et al., 2008). It is also an important component of Kilmer’s (2006) PTG model. Attachment style between child and caregiver would not only influence a child’s ability to access support, but would also likely influence several factors of the PTG model, such as self-efficacy and emotion regulation.

Given the influence of attachment dynamics on caregiver response and the child’s sense of family support, providers treating childhood trauma symptoms would likely include relational techniques that bolster attachment by building secure and trusting relationships (Greenberg & Watson, 2006). Attachment-based therapeutic approaches for children may also foster new attachment formations, thus impacting several determinants of PTG by enhancing relationships and social support, improving self-efficacy, and helping the child face and manage distress (Homeyer & Morrison, 2008; Kilmer, 2006). In addition to working with children, strategies to educate and work with parents around attachment would also be crucial. For example, parent-only interventions such as psychoeducational groups, parenting training, or even individual treatment for parents may have a positive impact on the child’s outcome to the extent that they foster positive attachment.

In addition to considering the caregiver-child attachment formation in promoting PTG, it may also be necessary to focus on the family environment in general. Research has demonstrated the importance of family cohesion in promoting well-being in the aftermath of sexual abuse (Foster, 2014; Marriot et al., 2014; McClure et al., 2008), which suggests that providers could include a family-based approach in addition to individual therapy. Specific interventions aimed at teaching family members to support each other, communicate safely, and appropriately nurture the child can potentially help the CSA survivor overcome the devastating effect of CSA by improving the capacity to trust and engage in healthy social relationships (Foster, 2014; McClure et al., 2008).
When used in treatment, other components of the PTG model could also enhance outcomes. For instance, the model highlights not only family support, but social support in schools and communities as well (McElheran et al., 2012), suggesting the need for school and community-based workshops and programs targeting CSA (Barron et al., 2015). Children and adolescents presenting with a history of sexual abuse may benefit from peer-led support groups, which would increase social support and encourage healthy interpersonal relationships. In addition, clinicians that are able to engage clients in effective rumination and cognitive processing of the traumatic event could also facilitate PTG (McElheran et al., 2012).

Mental health treatment providers are often tasked with the challenge of working with children, adolescents, and families with a history of CSA. While certainly accepting, addressing, and working through the numerous associated negative outcomes is crucial, providers also have the ability to enhance certain factors that may help the survivor make sense of the trauma and thrive. Components of the PTG model can inform best clinical practices among providers working with children and adolescents to improve well-being and quality of life.

REFERENCES


**Numinous/Transformative Experiences as One Way to Building Resiliency**

**DARIA SHEWCHUK, PH.D., R. PSYCH.**

Dr. Daria Shewchuk is an educator and clinician in private practice, with a focus on treating individuals who have experienced trauma. She is passionate about her therapy work. She has provided counselling (first as a clinical social worker and later as a Psychologist) since 1972.

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**HOW CAN PSYCHOLOGY ADDRESS THE PROBLEMS OF SUFFERING?** What attitudes do we assume toward suffering? How do we make sense of the tragedies that our clients share with us? What helps people be resilient and face their life challenges without being crushed by them?

This paper explores one way which can help people not only cope with life's stresses, but enhance their capacity to bounce back and even thrive. Experience has shown that resilient people are more optimistic, adaptable, and independent. Likely due to adaptability and independence, they are also better at solving problems and have better levels of self-control.

This paper focuses on the healing potential of numinous/transformative experiences as one way of building resiliency. People who experience numinous/transformative experiences and process these experiences/integrate them often subsequently, identify themselves as more than just ego. They develop a larger view of themselves, and this usually results in cultivating a more resilient human being.

So what is a numinous/transformative experience? Dr. Lional Corbett (2011, 2012) speaks of it as a personal experience or “the sacred”. He notes that this can take novel forms- from a profound dream, to a waking vision, experiencing the 'beauty of nature', through creative means, as a synchronistic event, or any number of other means.

Rossi, (2004), notes that the:

> psychological qualities characteristic of the numinosum (fascination, mysteriousness, and tremendousness) in spiritual development described by Rudolph Otto (1923/1950) and the three facets of novelty, environmental enrichment, and physical exercise that neuroscience now finds characteristic of

the development of consciousness (memory, learning, etc.) via activity-dependent gene expression and brain plasticity to build a better brain in daily life. (p. 14)

Rossi and Rossi (2008) also write about how “numinous experiences of art, beauty, and truth are positive experiences precisely because they generate the “activity-dependent creative reconstruction of the mind-brain at the molecular-genomic, brain plasticity, and psychological levels” (p. 34).

Corbett notes that people have an inner ability to recognize numinosity, and that we recognize the sacred when we experience it. He, like Carl Jung, believes this ability is an inborn, innate tendency.

Rossi and Rossi note that neuroscientists are now documenting how some brain systems of memory and learning are better oriented to exploring future life possibilities rather than maintaining accurate records of the past. Rossi and Rossi state:

> This constructive future orientation to identity and self creation, which was pioneered by Carl Jung (1917/1953), Milton Erickson (1927/2008; Erickson & Rossi, 1973, 1989), and Rossi, (1972/2008; 1973a-c) was recently described as the ‘memory-prediction framework’ in the operation of the six layered human neocortex that accounts for the evolution of intelligence, creativity, and intelligent machines (Hawkins & Blakeslee, 2004). (In Rossi & Rossi, 2008, p. 27)

I expect that most of us have seen clients whose life turned around as a result of a transformational spiritual experience that made them realize that ‘if they don’t find some meaning in life, they may as well die.’

Jung (1958) wrote on the topic of meaning and spirituality, stating:

> The individual who is not anchored in God can offer no resistance on his own resources to the physical and moral blandishment of the world. For this he needs the evidence of inner transcendent experience which
alone can protect him from the otherwise inevitable submersion in the mass. (p. 34).

He also describes the “transcendent function” which arises from a union of conscious and unconscious contents. This often leads to an expanded sense of self.

Frankl (1984) wrote about how men who were interned in the concentration camps during World War II felt they had nothing to live for and died quickly. As I read Frankl’s book, I noted his many examples of numinous experiences among those interned. These experiences helped them survive (i.e., be more resilient). For example, Frankl (1984) stated “As the inner life of the prisoner tended to become more intense, he also experienced the beauty of art and nature as never before.” (p 59)

Frankl (1984) also wrote of needing to ground these numinous experiences into the day to day life, even at a concentration camp.

What was really needed was a fundamental change in our attitude toward life. We had to learn ourselves and, furthermore, we had to teach the despairing men, that it did not really matter what we expected from life, but rather what life expected from us. We needed to stop asking about the meaning of life, and instead to think of ourselves as those who were being questioned by life — daily and hourly. Our answer must consist, not in talk and mediation, but in right action and in right conduct. Life ultimately means taking the responsibility to find the right answer to its problems and to fulfill the tasks which it constantly sets for each individual. (p. 98)

Vasavada (1987), in his article on India and Jungian Psychology, speaks of the transcendent function. He wrote, “Transcending that level, rising to the level of spirit, the Light, the Self, dissolved the tension, because it begins to be seen from the standpoint of wholeness, the Self, where all is included in harmony.” (p.20)

In Miyuki’s (1995) article, “Buddhist Experience as Selbstverwirklichung” (Self-Realization), he talks about the self as embracing both the conscious and the unconscious and uses the term “self-centered” or “self-centric” to denote the ego functioning in the service of the self. Mykiui wrote, “In this manner the ego is replenished by assimilating the contents of the unconscious. The Ego, thus enriched and strengthened, can become stable enough to integrate even more unconscious material.” (p.173)

In helping clients contact their numinous experiences they can come to feel that there is a link with the infinite. I was struck by the miraculous changes in attitudes and desires that this experience can lead to. I was then further struck by what Vasavada (1987) refers to as the “torturous journey to individuation” (p. 21) and the client’s ability to accept and stay with this journey in the process developing even more humor, caring, and compassion for themselves. This was in stark contrast to clients who had no numinous experiences, who often led very chaotic lives, and had a hard, if not impossible, time attending sessions on a consistent basis, instead coming to therapy during times of crisis and projecting their problems onto others in extreme ways.

It is my experience that individuals who have numinous, spiritual experiences do thereafter identify themselves as more than just ego. They have had contact with the Self. This can lead to a strengthening of the ego. The ego can sometimes become more stable following these experiences, providing that the experiences are processed in a meaningful way for the client. The client is then able to integrate more unconscious, disturbing material. I am constantly amazed by the human ability to heal from profound trauma (and all that can accompany it), and the positive role that one’s Personal Spiritual experiences can play in the healing.

So how can we positively impact identity by helping clients see a bigger “I”, and therefore help them towards a more resilient self-creation? This is too large a topic to address here, so I refer the reader to Dr. Lionel Corbett’s (2011) book The Sacred Cauldron: Psychotherapy as a Spiritual Practice (2011). In this book, Corbett discusses the expression of the Sacred in Psychotherapy in our role as psychotherapists, as well as such related topics as suffering and the discovery of meaning in psychotherapy. See also Corbett’s writings on the healing effects of numinous experiences (Corbett, 2007, 2011, 2012).

In my case, it has become my practice to ask clients if they had ever had a spiritual experience such as dreams, visions, synchronistic events, and/or experiences within nature. I have noticed that just posing this question resulted in many of my clients accessing their numinous experiences and often some sort of transcendent experiences. Their attitude and outlook changed immediately, as they were able to speak from broader point of view.
Those who have not had numinous experiences prior to coming into therapy, in my experience, often develop an interest in existential questions and experience some numinous experience later (as they process their life experiences). In my opinion, there frequently seems to be some relationship between processing traumatic life experiences and in the process of working through them experiencing numinous/spiritual experiences.

In short, integrated numinous experiences (i.e., integration through the transcendent function) leads to the formation of a new self-concept that comes about from identifying oneself as a “spiritual being” or a “different being” who is “more” in some way. As discussed earlier, one becomes less identified with ego and therefore has a broader point of view about their problems, projecting fewer of these problems onto others. They become more resilient human beings.

It serves us and our clients well to be ever more prepared to be open to and, if appropriate, to make room for the numinous in the therapy room.

REFERENCES

FURTHER READINGS
Underpinning Theory

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- Techniques to restore adaptive, flexible boundaries
- The body’s role in maintaining dissociative parts
- Interventions to process and integrate implicit and explicit memories
- To identify and capitalize on pretraumatic resources
- Sensorimotor Sequencing for recalibrating the nervous system when working with traumatic memory

Kekuni Minton, PhD, is a founding trainer of SPI and former instructor at Naropa University in couples therapy, working with trauma, and psychotherapeutic techniques. His doctoral thesis focused on somatic relational therapy, and he has special interests in meditation and cultural trauma. Dr. Minton is co-author of Trauma and the Body: A Sensorimotor Approach to Psychotherapy with Dr. Pat Ogden, and has been in practice since 1989, integrating and creating cutting-edge psychological techniques for use in psychotherapy.

Rochelle Sharpe Lohrasbe, PhD, RCC, began her career in forensic psychiatric nursing, holds a PhD in child and youth care, and has more than 25 years’ clinical experience in treating the effects of traumatic stress and suboptimal attachment. She is an EMDRIA-approved consultant, has facilitated for the DNMS Institute, and has presented at several major conferences including EMDR Canada and ISSTD. In her private clinical practice, Dr. Sharpe Lohrasbe sees both children and adults who have experienced abuse, neglect, and other traumatic experiences.

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Friday November 27th, 2015 9:00AM – 4:00PM
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Continuing Education Credits: 6

The BCPA AGM will take place during Lunch break.

About the Workshop
Based on Dr. Briere’s newest research and writing (e.g., Principles of trauma therapy: A guide to symptoms, evaluation, and treatment, 2nd edition, DSM-5 update [2014, Sage]; Mindfulness-oriented interventions for trauma: Integrating contemplative practices [2015, Guilford]), this workshop will review new diagnostic and treatment developments in the field of complex trauma, and will describe an integrative treatment approach that employs a range of empirically-based interventions. Topics will include the use of mindfulness, titrated exposure, and metacognitive awareness in trauma treatment; clinical implications of the recently discovered “memory reconsolidation” effect; the primacy of affect regulation interventions for severe trauma effects; trigger management; the “pain paradox” as an overriding perspective; and working with trauma-related substance use/abuse.

Learning Objectives
Attendees will be able to
1. List the primary changes from DSM-IV to DSM-5 with regards to trauma
2. Define mindfulness and metacognitive awareness as they relate to psychotherapy
3. Outline the implications of memory reconsolidation for exposure-based interventions
4. List three contraindications of mindfulness training for trauma survivors
5. Describe the pain paradox as it relates to avoidance and symptom chronicity

About the Presenter – John Briere, Ph.D.
John Briere, Ph.D., is an Associate Professor of Psychiatry and Psychology, where he teaches and consults in the burn center, emergency services, and inpatient psychiatry at Los Angeles County + USC Medical Center, and Director of the USC Adolescent Trauma Training Center of the National Child Traumatic Stress Network. A past president of the International Society for Traumatic Stress Studies, he is recipient of the Award for Outstanding Contributions to the Science of Trauma Psychology from the American Psychological Association. He is author or co-author of over 120 articles and chapters, 15 books, and 9 trauma-related psychological tests. He teaches on trauma, assessment, therapy, and mindfulness internationally. His website address is johnbriere.com.

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