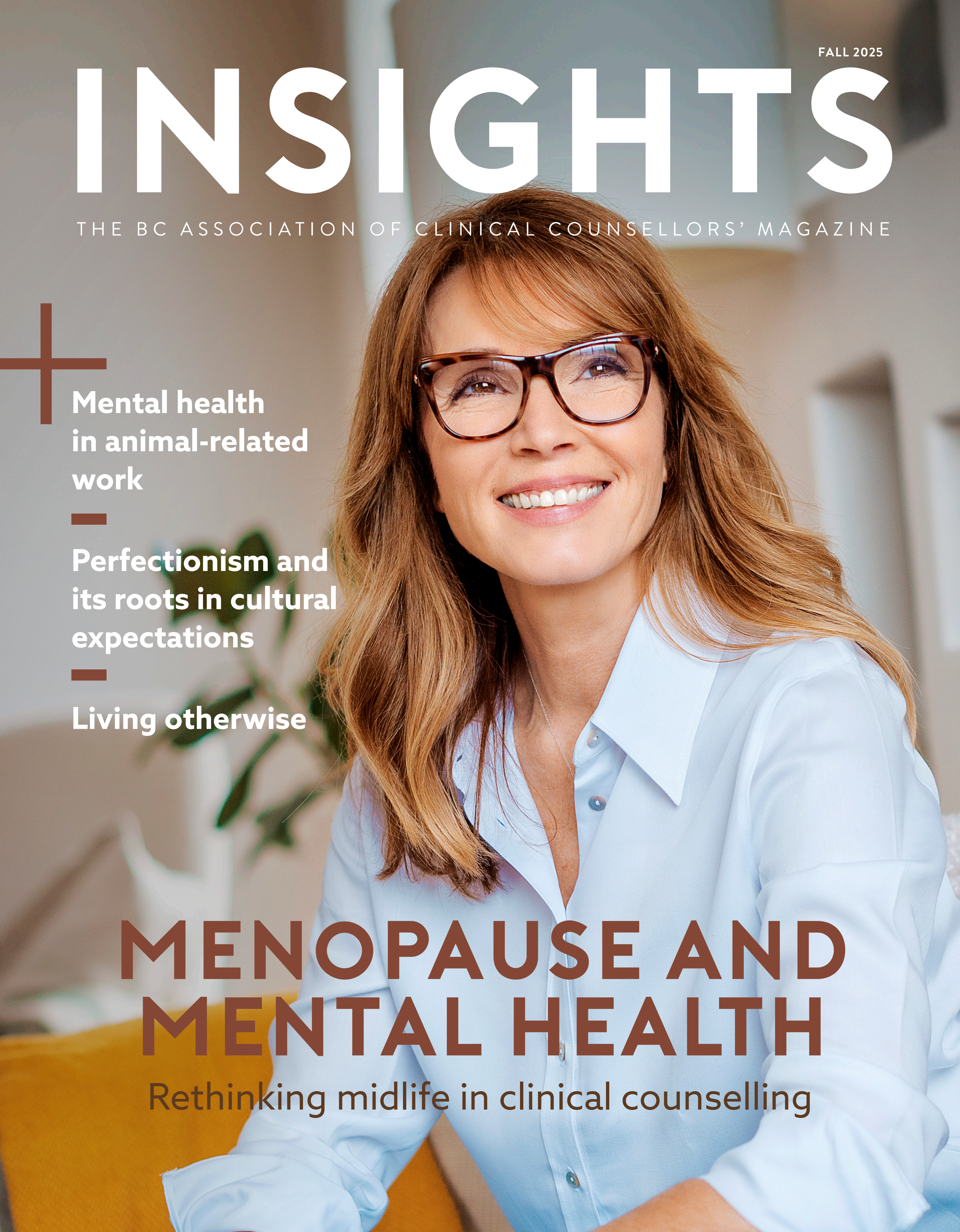
FALL 2025

INSIGHTS

THE BC ASSOCIATION OF CLINICAL COUNSELLORS' MAGAZINE



Mental health in animal-related work

Perfectionism and its roots in cultural expectations

Living otherwise

MENOPAUSE AND MENTAL HEALTH

Rethinking midlife in clinical counselling

CREATIVE INSURANCE SOLUTIONS

to better meet your needs

TO BETTER PROTECT THE MEMBERS OF THE BCACC WE ARE PLEASED TO PROVIDE THE FOLLOWING INSURANCE SUMMARY FOR 2025

- Professional Liability (Errors & Omissions) policies start at $100 annually for $3,000,000 or $5,000,000 option for $145 with higher limits available upon request.
- Commercial General Liability policies start at $60 annually for $3,000,000 or $5,000,000 option for $82 with higher limits available upon request.
- Coverage available for Student members starting at $63 annually.
- E-counselling coverage is included to cover remote therapy sessions offered in British Columbia and unregulated provinces. If you are practicing in a regulated province, please ensure you are aware of and comply with the relevant provincial rules and regulations.
- Policy pays the full cost of the legal defence up to the limit of liability selected. (Subject to sub-limits for the following: Abuse & Sexual Misconduct, Disciplinary Action, Penal Defence.)
- No deductible for any Professional Liability claim.
- No exclusion for Libel & Slander.
- Automatic Extended Reporting Period for any insured member who is no longer practicing for claims presented to them during a period of seven (7) years immediately following the end of the policy period with respect to an error, omissions or negligent act arising out of the insured services rendered.
- Legal Entity coverage includes up to three professionals on staff for no additional cost.
- Options available for clinics with more than three professionals. The additional cost for legal entities with up to 25 professionals is $100.
- Employment Practices Wrongful Act Liability $250,000 limit included. Higher limits available upon request.
- ARAG Legal Expense Insurance is included for members who have purchased Professional Liability. As of January 1, 2025, the policy provides a legal helpline, access to a legal document centre, legal document review, legal document drafting, and personal & business legal tax protection advice with a $50,000 limit of coverage and $250,000 aggregate.
- Enhanced ARAG Professional Legal Solutions available for $90.
- Security & Privacy Liability is included up to $100,000 per member subject to a shared limit of $3,000,000 for all insured members.
- Cyber Liability which includes Social Engineering Fraud coverage available and starting at $201.
- Commercial Property coverage available starting at $255.
- Accidental Death & Dismemberment coverage available starting at$15.
- Coverage available for inactive members.

MITCHELL&ABBOTT
INSURANCE BROKERS

NAVACORD®

Mitchell & Abbott is a full-service brokerage firm that has been delivering tailored insurance solutions for businesses, professionals, and individuals for over 100 years. With a client-first approach, we offer a wide range of products, including commercial, personal, and specialty coverages. Our expertise spans industries such as healthcare, professional services, construction, manufacturing, and hospitality.

Known for personalized service, competitive pricing, and strong industry partnerships, we also provide exclusive insurance programs tailored to meet specific industry needs.

For any questions, please contact one of our team members at:

800-463-5208
bcacc@mitchellabbottgrp.com

A COMPLETE PROGRAM SUMMARY IS AVAILABLE ON THE BCACC AND MITCHELL & ABBOTT GROUP WEBSITES.

CONTENTS FALL 2025

FEATURES

IN EVERY ISSUE

INSIGHTS
THE BC ASSOCIATION OF CLINICAL COUNSELLORS' MAGAZINE

The Insights team would like to thank the writers and interviewees who contributed to this issue of our magazine:

Meghan Hodgson, Annette Jalbert, Eleonora Joensuu, Manjot Mann, Miriam Pai-Spering, Laney Rosensweig, Liz Sinclair Kruth, Dave Vass, Jacqueline Wilson

BCACC is dedicated to enhancing mental health all across British Columbia. We are committed to providing safe, effective clinical counselling to all and to building the profession through accountable, well-resourced, and supported counsellors.

BCACC
109-1034 Johnson Street
Victoria, BC V8V3N7
Tel: 250-595-4448
Fax: 250-595-2926
Toll Free in Canada: 1-800-909-6303
communications@bcacc.ca
bcacc.ca

In the spirit of reconciliation, BCACC acknowledges and respects the First Nations, Metis, and Inuit Peoples upon whose traditional territories we work and live throughout Canada.

Insights is published on behalf of BCACC by
Page One Publishing
580 Ardersier Road
Victoria, BC V8Z 1C7
Tel: 250-595-7243
pageonepublishing.ca

Contributing Agency: Getty Images

Insights is published four times a year. To submit article proposals, contact the editor, Carolyn Camilleri, at ccamilleri@pageonepublishing.ca.

Find more information about submitting article proposals at bcacc.ca/insights-magazine/

Printed in Canada by Mitchell Press.

BOOKENDING THE DAY

The practice that brought me back to myself

BY ANNETTE JALBERT, RCC

There was a season where burnout didn't just knock — it camped out on my doorstep. As an RCC, multipreneur, and someone holding space for both clients and family, I found myself pouring from a cup that was bone dry. I knew something had to shift — not just in how I worked but in how I lived.

I knew taking a *self first approach* (I have grown to fall in love with this term) was something that I needed, desired, and craved, but I had no real idea what that meant or how it could even look at first. I started studying personal growth, telling myself it was for my clients but knowing deep inside it was really about me. Studying breathwork, meditation, gratitude, and awareness started to unlock many somatic tendencies that I carried and believed were just part of who I was — in my DNA!

It was through this process I began bookending my days — building intentional routines that gently opened and closed each day in alignment with what mattered to me most. Starting in chaos and ending in a crash was not my desire, and this method of intentionality in my day started feeling really good (inside of my central nervous system). It wasn't a productivity hack or another thing on my to-do list. It was a lifeline — and it's one I now share often with clients and colleagues alike.

MORNING: COMING INTO SELF BEFORE RESPONDING TO THE WORLD

The mornings used to start with a jolt — phone alarms, quick scans of emails, and a mental checklist already running before my feet hit the floor. Now my mornings begin inward. A few minutes of journalling and gratitude. A short meditation or breathwork practice. An inspirational YouTube or podcast that reminds me of possibility. A pause to ask: How do I want to feel today? Not: What do I need to get done? What intentions set my day?

Dr. Rangan Chatterjee talks about the power of "The 3 M's" — mindfulness, movement, and mindset — as anchors to start the day.[1] This trifecta has become a quiet guidepost for me: a short stretch, a reflection on what I'm grateful for, and something uplifting to set the tone. It's

not about doing it perfectly. It's about beginning intentionally.

Authors like Hal Elrod (*The Miracle Morning*) and James Clear (*Atomic Habits*) have written at length about how our mornings shape our identity and our days.[2,3] But for me, it wasn't just about optimization. It was about returning to myself before I offered myself to others. As counsellors, we carry so much. We hold space all day long. The morning is when I hold space for me.

EVENING: DIGESTING THE DAY, NOT JUST ENDING IT

The evenings are where the real exhale happens. Before I rest, I reflect. What conversations felt aligned? Where did I notice tension in my body or in my boundaries? What am I proud of? What do I need to let go of before I close my eyes?

A simple practice of writing down three things I'm grateful for from this day — no matter how small — has become a non-negotiable. And in the spirit of what

PRACTICAL STEPS FOR STARTING YOUR OWN BOOKENDS

If you're curious about creating your own routines, here are a few gentle entry points:

- ✦ Pick one time of day to begin with — morning or evening — and choose a 10-minute practice you can stick with.
- ✦ Use the "3 M's" — mindfulness, movement, mindset — as a guide. Maybe it's a short walk, a journal prompt, daily gratitude, or even sitting silently with your coffee before anyone else wakes up.
- ✦ End your day with a check-in: What felt good? What felt hard? What do you want to carry forward — or leave behind?
- ✦ Give yourself grace — this isn't another productivity tool. It's a way to connect with your inner world, so you can show up more fully in your outer one.

✦ LEARN MORE

Annette Jalbert, RCC, has founded a monthly mentorship for women called GROW^2 Mentorship and created a Deliberately Designed Life Planner. Both of these tools have been created to support the opportunity to create time and space for you, the resource that matters most. *www.deliberatelydesignedlife.com*

Gabor Maté reminds us, emotional health comes from acknowledging and feeling what's present.[4,5] My evening routine is a chance to do just that. It's not always tidy or poetic. But it's real.

I believe it's in this reflection that we begin to truly process our day. And when we process regularly, we build resilience — we don't let the pressure accumulate, unspoken and unnoticed, until it finally overflows.

THE DANCE BETWEEN ROLES: PERSONAL MEETS PROFESSIONAL

Here's the honest truth: I don't live in compartments. I'm not one person as a clinician and another at home. I bring me to every space I step into — and I know my clients do, too. So when I began to see how much these small, personal routines supported my own grounding, I started to share them in sessions. Not as prescriptions but as invitations.

This is where I see the real correlation and coexisting — not just between our roles but within ourselves. We are both caregiver and cared for. We are both holding space and needing space. And when we practise small daily rituals that honour that duality, we bring more authenticity, compassion, and clarity into all of our interactions — personal and professional alike.

Bookending your day isn't about perfection. It's about intention. It's about choosing to meet the day and yourself on purpose, no matter what that day holds.

FINAL THOUGHTS

Bookending my days didn't change my schedule — it changed me. Once I felt peace, not feeling it became very uncomfortable. It helped me rebuild after burnout. It gave me the space to hear my own voice before I listened to anyone else's. And it reminded me that resilience isn't built in the big, dramatic moments — it's built in the quiet ones. The ones we choose every day.

I wrote this article not because I get it right all of the time, but because I want others to know that it is okay to admit when we struggle. If I can help even one person find calm inside of chaos then it is worth the share.

Whether you're a clinical counsellor, a coach, or someone navigating multiple roles, your well-being is not a luxury. It's the foundation of your work, your life, your impact. May your days begin and end with you. ■

Annette Jalbert, RCC, is based in Northern British Columbia and has more than 15 years of experience supporting individuals through life transitions, emotional wellness, and burnout recovery. She is the founder of Deliberately Designed Life, a platform she created after her own deeply personal experience with burnout. Her clinical work emphasizes practical, evidence-informed strategies for sustainable well-being, including the power of intentional routines like bookending the day. As both a clinician and entrepreneur, she is committed to helping others foster clarity, resilience, and alignment in both their personal and professional lives.

REFERENCES

1. Clear, J. (2018). *Atomic Habits: An easy & proven way to build good habits & break bad ones*. Avery.

2. Elrod, H. (2012). *The Miracle Morning: The not-so-obvious secret guaranteed to transform your life (before 8AM)*. Hal Elrod International.

3. Chatterjee, R. (2019). *Feel Better in 5: Your daily plan to feel great for life*. Penguin Life.

4. Maté, G. (2003). *When the Body Says No: The cost of hidden stress*. Knopf Canada.

5. Maté, G. (2022). *The Myth of Normal: Trauma, illness & healing in a toxic culture*. Knopf Canada.

VETERANS AFFAIRS CANADA

Recognizes Registered Clinical Counsellors

Veterans Affairs Canada (VAC) has officially approved Registered Clinical Counsellors (RCCs) as eligible health service providers — a milestone that expands access to specialized mental health care for Canada's veterans.

With more than 9,000 RCCs practising in British Columbia, this decision reflects the growing recognition of the profession's expertise. It also represents years of advocacy by BCACC to increase access and reduce wait times for veterans seeking care.

WHO IS ELIGIBLE?

To register as a VAC provider, counsellors must:

→ Be RCCs in good standing with BCACC, holding unrestricted registration.
→ Have at least five years of clinical counselling experience.
→ Specialize in one or more of the following: PTSD, anxiety, depression, adjustment and bipolar disorders, chronic pain, addiction, life and transition skills, or individual and family counselling.

HOW TO REGISTER

RCCs can apply through the Medavie Blue Cross website under the Health Professionals section. The portal includes information on registration, ePay enrolment, direct deposit, benefit grids, and claims submissions.

Questions can be directed to Medavie Blue Cross Provider Inquiry at 1-888-261-4033.

SUPPORTING THOSE WHO SERVED

The inclusion of RCCs in VAC's provider network is an important recognition of the profession's contributions and a meaningful investment in veterans' well-being. By joining VAC's roster, qualified RCCs can provide timely, trauma-informed, and specialized care to those who have served Canada — ensuring they receive the support they deserve. ■

BIG CHANGES AHEAD FOR PSYCHOTHERAPY REGULATION IN B.C.

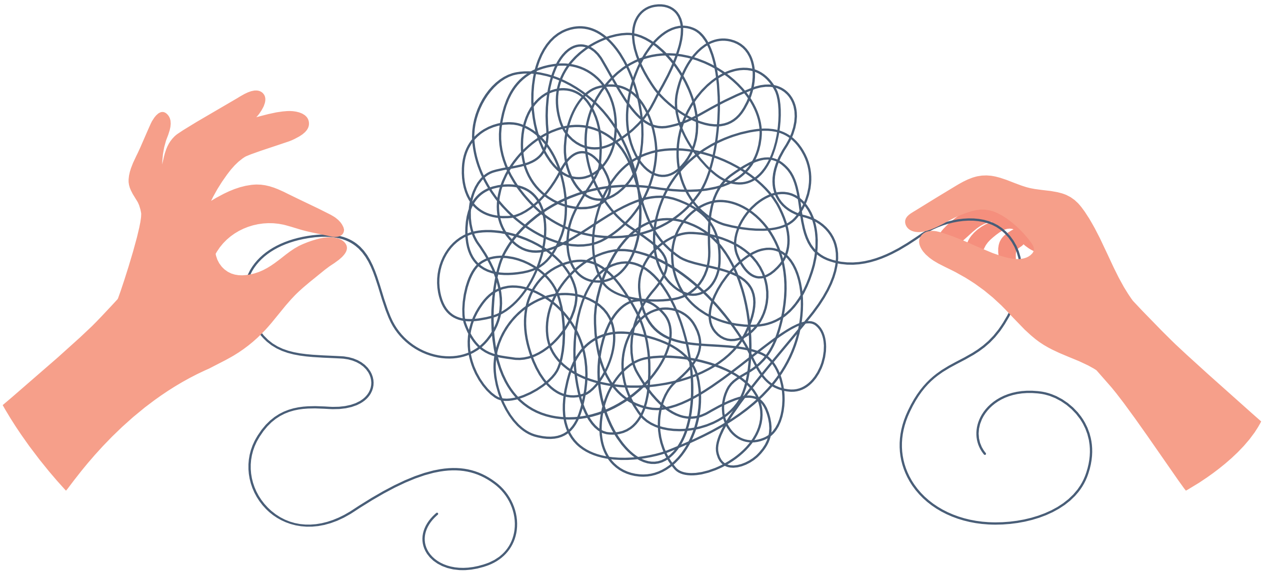
The B.C. government has confirmed two major developments that will shape the regulation of psychotherapy in the province. First, the *Health Professions and Occupations Act* (HPOA) will officially replace the *Health Professions Act* (HPA) on April 1, 2026. This modernized framework is designed to strengthen public safety, enhance accountability, improve cultural safety, and increase trust in the health system.

Second, beginning November 29, 2027, the profession of psychotherapy will be formally regulated under the College of Health and Care Professionals of BC (CHCPBC). Regulatory colleges like the CHCPBC are responsible for enforcing legislation, setting professional standards, and ensuring practitioners provide safe and effective care.

This update follows the government's July 16 release of revised regulations aligning health professions with the upcoming HPOA. These regulations define each college's responsibilities, reserved titles, scopes of practice, and limits or conditions of care.

The BCACC hosted an online town hall on July 24, 2025 for members to learn more about this information and have their questions answered. Members can watch the recording for more details and next steps, available in the member portal under "Breaking News."

PERFECTIONISM
and its roots in cultural expectations



BY MANJOT MANN, RCC

I am perfect, at least on paper. I got married in my early 20s, had a child before 30. I have a good job and a master's degree. I live in a respectable neighbourhood and drive a nice car. In theory, I've checked all the boxes and met the societal and cultural expectations handed to me as a South Asian woman, but I also haven't.

If I were perfect, I would be a doctor or lawyer. If I were perfect, I'd have at least two if not three children. I would have subscribed to the life expected of me: childbearing and childrearing and having an education I could put on a figurative mantel but never actually need to use. Instead, as a therapist and writer, I take apart my life and share my findings with the world. I write about the sharp edges in my world: the nausea I feel around being a disappointment to my parents, all the ways I try to prove my worth by doing everything for everyone, the balancing act of having a career but not letting that outshine motherhood. I am a scientist studying myself and sharing my findings. I am unpalatable and imperfect and it's exhilarating and heavy at the same time.

I chose a career that doesn't always make sense to my parents or grandparents' generation. I long to describe my work in adequate-enough words that all children of immigrants can take home to their parents and grandparents and say "See, this is what I do." Instead, the gut-wrenching work of holding a mirror to someone's soul while they unpack the wonder and grief of who they are remains a mystery to that generation. I talk for a living. I explain for a living. I help for a living. It explains everything and nothing.

Like many eldest daughters, I was taught to be perfect from a young age.

I learned to be compliant and a people pleaser and have become a master at putting aside my needs. I know how to be emotionally digestible.

Nine years ago, my aunt passed away. She was ill on and off for years and her death left a stillness in our lives. Our family kept moving, never fully acknowledging the monstrous grief but learning to walk on eggshells around it. Then my grandfather passed away, and again, we became mute in the face of loss. Years later, when someone asked me how we dealt with those losses, it hit me — we never did. Grief calls for a vulnerability incongruent with perfectionism. As a child raised to be palatable and obedient, there is no space in me for the deep wells of loss and sorrow brought on by death. I am too perfect to grieve.

HOLDING UP A MIRROR FOR OTHERS

As a therapist, I mostly work with South Asian women. Who better to hold up a mirror than someone who looks just like you? Working with my community has taught me how similar we all are. Regardless of age or life circumstance, we always find ourselves circling back to the same thing — perfectionism. I hear the same story echoed from different women: I did everything that was asked of me and somewhere along the way I lost myself. Perfectionism is a parasite. Over the years, it scrapes at all of our wants and needs until we are nothing more than a vessel for others. When a client comes to therapy to battle against perfectionism, it's usually because they have realized that perfectionism felt like their identity, but in reality, it was a life raft on choppy, unforgiving seas.

Healing perfectionism so deeply rooted in cultural expectations takes time and a large dose of self-compassion. Most people don't realize that perfectionism isn't who they are but rather who they were taught to be to survive. The realization happens in therapy as we start examining their story. I often ask clients to reflect on how perfectionism helped them survive. Did it get them through a tough childhood with a critical parent? Did it help them feel loved in a troubled marriage? Did it make them feel worthy in their relationships? The reason isn't as important as the compassion. Can you see the reason you had to be perfect? Can you forgive yourself for doing what you had to in order to survive? Can we thank the perfectionist part of ourselves?

> **Perfectionism is a parasite. Over the years, it scrapes at all of our wants and needs until we are nothing more than a vessel for others.**

Self-compassion is what unravels the self-loathing and guilt that often take root next to the need to be perfect. Understanding the societal, cultural, and gender expectations that bring each client to their reckoning is an important part of the healing journey. The story didn't begin when you acted on your perfectionism; the story began when expectations were unknowingly handed to you and you had no choice but to react.

Perfectionism and its roots in cultural expectations is something most of us can relate to on some level. Proximity is important here. The healing process also requires the healer to reflect on their own experiences. I can only hold up a mirror because someone held one up for me. It's important that we bring the compassion and empathy that comes with doing our own inner work. What expectations have been placed on you? How have you made peace with the person you are versus the person you were expected to be? You can't help someone heal if you haven't healed these parts of yourself first.

Healing is a long road. Sometimes we can stop and smell the flowers along the way. Other days, we are focused on just getting to the next destination. Perfectionism creeps in when I least expect it. When I overextend myself as a mother. When I constantly try to outdo myself as a wife. When I am too available as a daughter, sister, or friend. Perfectionism never really leaves us but as we heal, the roots become less deep over time. They don't hold us as tightly, forcing us to react in certain ways. Instead, they are a gentle nudge, reminding us of who we once were and the less perfect, more authentic version we are trying to be. ■

Manjot Mann, RCC, supports South Asian women as they heal from trauma, set boundaries, and find strength in their own stories.

RECOMMENDED READING

- ✻ *How to Be the Love You Seek: Break Cycles, Find Peace and Heal Your Relationships* by Nicole LePera
- ✻ *A Radical Awakening: Turn Pain into Power, Embrace Your Truth, Live Free* by Shefali Tsabury
- ✻ *Fierce Self Compassion: How Women Can Harness Kindness To Speak Up. Claim Their Power and Thrive* by Kristen Neff

MENOPAUSE AND MENTAL HEALTH

Rethinking midlife in clinical counselling

BY MIRIAM PAI-SPERING, RCC

When I was 44, I experienced a sudden change in sleep and mood. With three young children, I was used to poor sleep quality, but that summer, I stopped sleeping altogether. The lack of sleep impacted my memory and ability to think, and my mood swung from anxiety to uncharacteristic anger. I had never experienced any serious mental or physical health issues, and aside from pandemic fatigue and a demanding job, life felt fairly normal. Yet, I was struggling, and the instability began to impact my marriage, parenting, and work.

Remembering my mother's erratic moods in her late 40s, I brought up my sleep and mood changes and irregular, heavy periods with my family doctor and asked whether hormones could be involved. The concern was dismissed: I was "too young" for menopause. Instead, I was prescribed a benzodiazepine for anxiety and a sedative for sleep.

After several weeks with no improvement and worsening mood symptoms, including panic attacks, I was given olanzapine, an antipsychotic, and Xanax, a fast-acting tranquilizer. The rapid pharmacological escalation and lack of diagnostic clarity led to further destabilization. How could I have gone from high functioning to feeling like a wreck within weeks? A trusted friend — also a therapist — noted the mismatch between symptoms and treatment trajectory and encouraged further investigation.

My own literature review revealed that hormone level fluctuations can precede menopause by as much as a decade, often manifesting in mood symptoms. Fast-forward four months of waiting for an appointment at a Vancouver menopause clinic, comprehensive hormone testing confirmed I was in perimenopause — a term I had never heard before. Within a week of initiating therapy with natural progesterone, my sleep quality improved, mood stabilized, and cognitive clarity returned. It was like a curtain had lifted. I felt more energetic and capable than I had in months. Most importantly, I was met with a model of care that validated and normalized my symptoms and provided information and holistic care.

WHERE WE ARE WITH MENOPAUSE EDUCATION

My experience highlights a significant gap in public and clinical understanding of menopause and raises important issues for clinical counselling as well. Even though each person's experience is unique, there are several commonalities across my story and those I hear from friends and clients.

First, there appears to be a striking lack of information and knowledge about perimenopause and menopause in general and in family practitioners in particular. Even though menopause is "having a moment,"[1] according to the Canadian Menopause Society, menopause education is not yet consistently integrated across residency programs in family

medicine. Many primary care physicians have little experience with menopause, and the belief that menopause is something that women (in this article equated with biological females) must simply endure is still widespread.[2] As a result, symptoms might be minimized or treated superficially while the underlying cause is disregarded.

Second, according to a national research report from the Menopause Foundation of Canada, one in two women felt unprepared for menopause and four in 10 felt alone during this time.[3] Many women are ashamed or embarrassed to talk about their symptoms.

The focus of this article is on the impact of menopause on mental health. More than 10 million women in Canada (1.5 million in B.C.) are over the age of 40 and are experiencing this normal life phase;[4] between 30 and 40 per cent of them report new onset or worsening mood swings, anxiety, or depression.[5] Even though menopause affects almost half the world's population, women in this phase are neither publicly nor clinically well supported.

Clinical counsellors can help women by recognizing, validating, and normalizing their experience. They can support emotional regulation and processing, address life stressors, and encourage women to talk about their symptoms openly, empowering them to advocate for themselves. But first, let's talk about what menopause is.

DEFINING MENOPAUSE AND PERIMENOPAUSE

Menopause is defined as the permanent cessation of menstruation due to the depletion of ovarian follicle reserves. It is diagnosed retroactively after 12 consecutive months without a menstrual period. The average age of menopause in Canada is 51 years but, importantly, age of onset ranges from 45 to 55 years.

As menopause sets in, many women report hot flashes (or flushes), night sweats, difficulty sleeping, joint pain,

Menopause education is not yet consistently integrated across residency programs in family medicine.

and brain fog. These changes are largely attributed to declining levels of estrogen and progesterone.

Perimenopause is the transitional phase leading up to menopause. It can begin as early as age 35, but on average, it starts in the mid-40s and ends in the early 50s and lasts from two to 10 years or more. During this stage, a drop in progesterone can disrupt estrogen balance, often resulting in irregular periods, heavy bleeding, breast tenderness, weight gain, and mood swings.

Whereas menopause is marked by declining hormone levels, perimenopause is a hormonal rollercoaster during which hormone levels fluctuate significantly, leading to symptoms that are utterly unpredictable in onset, severity, and type. During this phase, estrogen levels are sometimes lower but more often higher than premenopausal levels; progesterone levels are also random but often fall relative to estrogen.[6] Whereas follicle-stimulating hormone generally declines, it can also be high in a last-ditch attempt to stimulate the ovaries. These hormonal fluctuations lead to irregular periods, and because estrogen and progesterone also play important roles in cardiovascular health, bone health, memory, and cognition, can also cause a host of other symptoms, some of which affect mental health.

BEYOND IRREGULAR PERIODS AND HOT FLASHES

When we think of menopause, we typically associate it with menstrual periods that are irregular or have stopped, hot flashes, and night sweats. Indeed, hot flashes and night sweats are experienced by 62 per cent and 55 per cent of menopausal women in Canada, respectively, and 84 per cent and 77 per cent of women are aware that these can occur.[7]

Fewer than 50 per cent of women in Canada associate symptoms such as depression, anxiety, sexual arousal issues, joint pain, or incontinence with menopause. Other lesser-known symptoms include increased risk of urinary tract infections, altered sense of smell, memory loss or "brain fog," dry mouth or bad breath, skin and hair issues, and issues related to or contributing to sexual health. All of these symptoms have the potential to be severe and to impact quality of life, work productivity, and long-term health. In fact, it is estimated that up to 10 per cent of women in Canada quit their jobs because their menopause symptoms impact their ability to function at work.[8] It is easy to imagine how such wide-ranging physiological and psychological changes can affect a client's body image, and by extension, their sense of identity and self-esteem.[9]

For an overview of all medical symptoms, why they happen, and what can be done, I refer you to Louise Newson's *Definitive Guide to the Perimenopause & Menopause*[10] and Jen Gunter's *Menopause Manifesto*.[11]

Fewer than 50% of women in Canada associate symptoms such as depression, anxiety, sexual arousal issues, joint pain, or incontinence with menopause.

MENOPAUSE AND MENTAL HEALTH: MOOD, SLEEP, AND COGNITION

As clinical counsellors, we frequently work with women in midlife who present with mood swings, anxiety, and depression, often in conjunction with fatigue and cognitive symptoms. Despite their high prevalence, these symptoms remain among the overlooked symptoms of perimenopause and menopause, and their underlying mechanisms are not well understood.[12]

The etiology of mood disorders is complex and involves many factors. A growing understanding of the role of hormones in mental health has led to recognizing the importance of neuroendocrine changes as one of these contributing factors. In their clinical guideline on mood, sleep, and cognition during menopause, the Society of Obstetricians and Gynaecologists of Canada (SOGC) states that perimenopause is a particularly vulnerable time window to develop depressive symptoms and major depressive episodes, even in women with no history of depression.[13] The guideline is less specific about anxiety or mood swings, even though these symptoms are reported by more women than depression.[14] One reason for this might be the lack of research on anxiety in the context of women's health.[15] Another is the heterogeneity and symptom overlap of anxiety disorders, which seem harder to define clinically than depression. Whether the menopausal transition is a window of particular vulnerability for new-onset anxiety is therefore still unclear.

Let's look at what happens in the brain when estrogen and progesterone levels are fluctuating, as during perimenopause, or low, as during menopause and postmenopause. Traditionally associated with sexual and reproductive functions, these two hormones also greatly modulate brain structure (e.g., volume) and function (e.g., brain metabolism, connectivity, plasticity). Two of the areas impacted by structural and functional changes during the menopause transition are the hippocampus (responsible for memory processes) and the amygdala (involved in emotional processing),[16,17] explaining symptoms related to memory and emotion regulation.

At the cellular level, estrogen and progesterone can influence serotonin, an important neurotransmitter in the brain that regulates mood, the sleep-wake cycle, memory, and executive functioning (e.g., planning, decision-making, cognitive control). During the menopause transition, low estrogen levels may lead to a decrease in serotonergic activity, thereby increasing the likelihood of mood symptoms[18] as well as of the type of executive and memory problems often described as brain fog.

Similarly, progesterone modulates the activity of brain receptors for the neurotransmitter GABA and increases this system's antianxiety and antidepressant responses. Congruent with this, a progesterone drop may reduce the calming, anxiety-reducing, and sleep-promoting effects of GABA and make the brain more reactive to cortisol (a hormone released during stress).[19] This negative dynamic can further exacerbate sleep disturbances, fatigue, irritability, and mood problems.[20]

Taken together, fluctuating or low hormone levels are a critical contributor to the cognitive and mood symptoms of menopause transition. An important point that can help normalize the experience is that menopause effects on brain functioning are typically temporary; they disappear once menopause is over,[21] possibly because of the brain's capacity to adapt to changes in hormone levels. Moreover, lifestyle factors such as nutrition and exercise modulate the impact of hormones and can be an important discussion in counselling.

Whereas medical treatment of mood symptoms in menopause still focuses on prescribing antidepressants, the SOGC guideline[22] also mentions strong evidence that hormone therapy can have antidepressant effects similar in magnitude, especially in perimenopause. Large-scale studies are being conducted to explore whether replacing and

rebalancing hormones during this period can also be neuroprotective (e.g., prevent dementia later in life).[23] Our focus in clinical counselling is not on medical treatment, but we can ask questions that might help our clients seek information and empower them to advocate for the best treatment for them.

41% of women in Canada respond that their menopause symptoms impact their relationship with their partner in a negative way.

THE HIDDEN IMPACT OF MENOPAUSE ON RELATIONSHIPS

When asked about how menopause affects different areas of their lives, 41 per cent of women in Canada respond that their menopause symptoms impact their relationship with their partner in a negative way.[24] The scientific literature largely focuses on sexual function, frequency, and experience in midlife couples — and this is indeed a big topic for counselling. Reduced libido and vaginal dryness are two common symptoms of perimenopause or menopause and in conjunction with age-related hormonal changes for men[25] (notably, a decline in testosterone), they can significantly impact intimacy. If not normalized and discussed, lack of intimacy and sex can lead to feelings of frustration and rejection and ultimately to disconnectedness and loneliness.

However, menopause can profoundly affect relationships beyond sexual symptoms. Mood swings, anxiety, and depression may impact self-esteem and how women feel about themselves at work, as mothers, relationship partners, etc. as well as about those around them. Midlife is also a time of role and identity shifts caused by growing children, aging parents, and career changes. Not much is known about the impact of menopause symptoms on the social and emotional health of relationships and vice versa — how relationship satisfaction affects the severity of menopausal symptoms.

As a therapist specializing in relationship counselling, I frequently hear both partners in relationships portray menopause as a problem women "have to take care of"; yet it is the shared responsibility of the couple and requires a growth mindset in both partners to better understand this period and support each other. Given the ongoing stigma about menopause, however, open conversations with an intimate partner can be difficult. In counselling, we can start a conversation with an inquiry into the understanding of menopause.

The 2019 MATE survey[26] on men's perceptions and attitudes revealed that men most frequently associated hot flashes, mood swings, and low libido with menopause, and 77 per cent said they felt impacted by their partner's symptoms (e.g., contributed to trouble sleeping, emotional strain on the relationship, reduced frequency of sex). Men did not associate menopause with other symptoms such as fatigue, weight gain, irregular periods, and forgetfulness. Interestingly, 74 per cent of men said they felt their partner was coping with symptoms fairly well — a response that contrasts with how men perceive the impact on themselves and with how women experience menopause. Clearly, menopause transition is a tough time for women and their partners. Clinical counsellors can look at this through a systemic lens, de-pathologizing the woman's (or couple's) experience and supporting their shared knowledge, perspective taking, empathy, and positive support for each other.

Many sources present practical advice,[27] for instance, stepping away from conflict and revisiting difficult conversations when both partners feel rested and resourced, expressing positivity and feelings of affection — especially when self-confidence and self-esteem are impacted by symptoms, fine-tuning relational and communication skills around needs, and discussing physical closeness and intimacy in the context of sexual challenges. Partners can even be encouraged to make lifestyle changes together, creating new connection rituals.

COUNSELLING CLIENTS DURING MIDLIFE

In summary, this article explores the often-overlooked psychological and relational impact of perimenopause and menopause, emphasizing the vital role of clinical counsellors in supporting clients through midlife. Clinical counsellors are encouraged to normalize clients' experiences, provide psychoeducation, address identity and relationship changes, and empower women to seek integrated, informed care. I conclude with a non-exhaustive list of ideas for counselling midlife clients and their partners.

- **Build your own knowledge base:** Stay informed about perimenopause and menopause through evidence-based resources and continuing education. Consider including questions about hormonal transitions in intake assessments for clients over age 35.
- **Take a holistic approach:** Explore the full range of factors influencing midlife mental health, including sleep quality, nutrition, physical activity, work stress, caregiving roles, and relationship stress.
- **Adopt a relational and systemic lens:** Help clients and their partners develop empathy for each other's experience and normalize the challenges of midlife transitions. As appropriate, invite partners or family members into sessions to facilitate open communication, shared understanding, and mutual support. Co-create strategies for maintaining connection, emotional safety, and intimacy.
- **Promote self-awareness and self-trust:** Prompt clients to listen to and tune in with their bodies and trust their own experience; suggest they track symptoms and emotional experiences using journals or menopause-specific tracking apps.
- **Encourage self-care:** Help clients take care of themselves to identify and prioritize practices that are restorative and enhance well-being, whether that's exercise, healthy food, mindfulness, creative expression, connecting with friends, or stillness.
- **Support informed advocacy:** Encourage clients to seek reliable information about menopause and use that information to leverage appropriate care from their physician. Where possible and appropriate, collaborate with other health-care providers to support holistic care. ■

Miriam Pai-Spering, PhD, RCC, is a neuroscientist turned therapist. She works at the Vancouver Couple and Family Institute and offers emotion-focused therapy to couples and individuals with a particular focus on supporting clients of all genders through (mid)life transitions.

REFERENCES

1. Canadian Menopause Society. Retrieved: June 19, 2025. https://www.canadianmenopausesociety.org

2. Menopause Foundation of Canada. Retrieved: June 19, 2025. The silence and the stigma: Menopause in Canada. https://menopausefoundationcanada.ca/menopause-in-canada-report/

3. Menopause Foundation of Canada, 2025.

4. Statistics Canada. Population Estimates on July 1st, 2024, by age and sex. Retrieved: June 19, 2025. https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1710000501&pickMembers%5B0%5D=1.11&pickMembers%5B1%5D=2.3&cubeTimeFrame.startYear=2024&cubeTimeFrame.endYear=2024&referencePeriods=20240101%2C20240101

5. Menopause Foundation of Canada, 2025.

6. Prior, J.C. (1998). Perimenopause: the complex endocrinology of the menopausal transition. *Endocrine Reviews*, 19, 397-428.

7. Menopause Foundation of Canada, 2025.

8. Menopause Foundation of Canada, 2025.

9. Vincent, C., Bodnaruc, A.M., Prud'homme, D., Olson, V., & Giroux, I. (2023). Associations between menopause and body image: A systematic review. *Womens Health*, 19, 17455057231209536.

10. Newson, L. (2023). T*he Definitive Guide to the Perimenopause & Menopause*. London, UK: Yellowkite.

11. Gunter, J. (2021). *The Menopause Manifesto: Own your health with facts and feminism*. New York: Penguin Random House.

12. Fidecicchi, T., et al. (2024). Neuroendocrine mechanisms of mood disorders during menopause transition: a narrative review and future perspectives. *Maturitas*, 188, 108087.

13. Shea, A.K., Wolfman, W., Fortier, M., & Soares, C. (2021). Guideline No. 422c: Menopause: mood, sleep, and cognition. *Journal of Obstetrics and Gynaecology Canada*, 43(11), 1316-1323.

14. Menopause Foundation of Canada, 2025.

15. Soares, C.N. (2013). Anxiety and the menopausal transition: managing your expectations. *Menopause*, 20, 481-482.

16. Duarte-Guterman, P., Yagi, S., Chow, C., & Galea, L.A.M. (2015). Hippocampal learning, memory, and neurogenesis: effects of sex and estrogens across the lifespan in adults. *Hormones and Behavior*, 74, 37-52.

17. Rehbein, E., Hornung, J., Sundström Poromaa, I., & Derntl, B. (2021). Shaping of the female human brain by sex hormones: a review. *Neuroendocrinology*, 111, 183-206.

18. Bendis, P.C., Zimmerman, S., Onisiforou, A., Zanos, P., Georgiou, P. (2024). The impact of estradiol on serotonin, glutamate, and dopamine systems. *Frontiers in Neuroscience*, 18, 1348551.

19. Fidecicchi et al., 2024.

20. Podcast on progesterone and mental health. Retrieved: June 25, 2025. https://www.drlouisenewson.co.uk/podcasts/natural-progesterone-what-mental-health-benefits-can-it-bring (June 25, 2025)

21. Gunter, 2021.

22. Shea et al., 2021.

23. Gravelsins, L.L., & Galea, L.A.M. (2025). One size does not fit all: how type of menopause and hormone therapy matters for brain health. *British Journal of Psychiatry*, 9, 1-14.

24. Menopause Foundation of Canada, 2025.

25. Fiacco, S., Walther, A., & Ehlert, U. (2019). Steroid secretion in healthy aging. *Psychoneuroendocrinology*, 105, 64-78.

26. Parish, S.J., et al. (2019). The MATE survey: men's perceptions and attitudes towards menopause and their role in partners' menopausal transition. *Menopause*, 26, 1110-1116.

27. Very Well Health: Best ways to support a partner during menopause. Retrieved: June 25, 2025. https://www.verywellhealth.com/supporting-your-partner-during-menopause-2322673

LIVING OTHERWISE

Honouring the Work of Queer Family Building

BY ELEONORA JOENSUU, RCC

Isolation. Loneliness. Fear. Rage. Disempowered. Ignored. Othered.

These are not generally the first descriptors one would associate with the decision to build a family, yet these are not uncommon experiences for 2SLGBTQ+ folks in the family-building process.

There is no one way to make a family, and queer and trans families have long traditions of creating family that push against traditional, heterosexual, cisgendered nuclear family models. To build queer families — whether by trying to conceive children, building queer kin networks, creating chosen family, adopting, co-parenting children or animals — is therefore an act of "swimming upstream" against stigma, system-based barriers, discrimination, and erasure.[1] In the myriad ways to build family, my focus here is primarily on queer families who want to conceive children.

While challenging the concept of the traditional nuclear family has increased visibility and acceptance of queer families, the experience of queer family building continues to be marked by heteronormative, cisnormative, and patriarchal norms and barriers. For example, queer conception cannot be equated with the issue of "infertility," yet infertility treatments developed for heterosexual couples are the standard clinical practice when 2SLGBTQ+ clients access reproductive services.[2] Furthermore, research has shown that the 2SLGBTQ+ individuals face inequitable access to health care, quality of care, and satisfaction of care in the Canadian health-care system,[3] thereby demonstrating the urgent need for tailored reproductive care that understands the individual and systemic realities of queer communities.

As counsellors, we can play a meaningful role in offering such care. However, affirming and competent practice is more than a Pride flag on your website, more than inclusive language — it is practices that are responsive to the specific and unique history and experiences of queer and trans identities and family-building process. My hope here is to share some of those with you. I am a queer, cisgender, white settler and I have recently become a parent. As counsellors, we are called to keep the human experience at the centre, and so I intentionally share some of my experiences here with this aim in mind. However, this discussion is a small sliver of wider reproductive oppressions where racism, capitalism, ableism, white supremacy, and homophobia shape family building and the

Affirming and competent practice is more than a Pride flag on your website.

politics of reproduction and fertility care. The experiences I share and speak from are limited by my social location, and I invite readers to continue thinking about reproductive justice — in other words, the ways that race, identity, economic and social context impact family building, fertility, and reproductive outcomes.[4]

THE ASSISTED REPRODUCTION PROCESS AND GATEKEEPING

Family building for queer and trans people typically, though not always, requires involving someone other than those who are planning to raise the children, whether this is through donor gametes and Assisted Reproduction Technology (ART), adoption, or surrogacy. Consequently, queer people are often required to bring significant intention to family building, alongside financial, physical, and emotional resources. This intentionality can be experienced differently in the psychological journey.

For some, this intentionality can be supportive of mental, physical, emotional, and spiritual well-being as clients can actively plan and prepare.[5] However, this intentionality can also be a source of grief in its reminder of otherness. This may be a feeling of "but it's so annoying not to be able to accidentally make a baby!"[6] or a more sustained sadness that "we are not like others." There is an invitation here to attend to a client's relationship to this common requirement to involve others, whether this is known others or strangers.

Intentionality and resilience are easily framed as positive attributes, but often beneath the surface lives grief — grief that one did not have any other choice available to them and that building family demanded perseverance, resilience, and parenting decisions long before any bodies were involved.

At the institutional level, the common need to involve others means that queer intended parents are very likely to interface with systems and institutions that may not understand their unique needs and lived experiences. Yet they must engage in these invalidating processes and structures to build their family. Sharma astutely writes that "Our health system often demands queer and trans people take the care we are given without complaint, even if it is violent, inadequate, or just plain wrong, often at great personal and/or financial cost."[7]

One example of such a demand is the counselling session that intended parents are often required to attend before using donor gametes. While the *Assisted Human Reproduction Act* and the related Safety of Sperm and Ova Regulation that govern the use of gametes in Canada at the federal level do not mandate psychological counselling before using gametes, the Canadian Fertility and Andrology Society recommends counselling as a best practice.[8] Accordingly, many fertility clinics require a counselling session resulting in a written report on the intended parents before any procedures involving donor gametes.

As queer people who have faced significant gatekeeping at the hands of professionals and institutions, this counselling session takes on a different meaning: it operates as an extension of these often discriminatory institutional practices. In addition to being a costly session, many intended parents are given minimal information about the details of

the report being written about them and the criteria on which it is based and are offered few choices in who they can see for this session.

While the decision to and experience of using donor gametes is worthy of counselling support, the experience of this "required" session was far from supportive. In fact, this session is often experienced as out of touch with queer family-building realities, invalidating, disempowering, and at times, re-traumatizing.

If you are supporting queer clients who will be using donor gametes, you can play an important role in preparing your clients for this common requirement and in supporting them to process the experience afterwards. Recognize the survival strategies that this counselling requirement demands of queer people: the need to "apply a veneer of 'normalcy' and 'respectability' to our lives and bodies to achieve a form of conditional acceptance inside a system that wasn't designed for us."[9] Exploring ways clients can access agency and autonomy in a system that undermines it, such as boundary-setting and self-advocacy,[10] as well as advocating for culturally attuned reproductive care, are significant efforts to challenge historical and ongoing discrimination and gatekeeping.

UNHOUSING THE OPPRESSOR

Considering or deciding to have children as a queer person is a process that can be filled with many voices — one of these being the socialized and internalized messages about whether queer people should be parents. The history of criminalizing and pathologizing homosexuality meant that the "fitness" of 2SLGBTQ+ people as parents and caregivers was not even a question that could be asked — it was assumed they were not and could, in fact, be a "danger" to children.

While the history of the social and legal developments that have led to queer people accessing inclusive and diverse pathways to family building is beyond my scope, it's important to note this history, as the social biases they seeded continue to circulate and be reinforced in the dominant culture and media. We don't need to look far to see evidence of this as we witness anti-queer and anti-trans calls to ban queer books and curriculum from schools, Pride month reigniting debates about whether it is "appropriate" for children to attend, and drag queen library events for children becoming sites of protest.

> **Queer intended parents are very likely to interface with systems and institutions that may not understand their unique needs.**

Within this context, the queer family-building journey involves grief — grief as normative concepts of family are deconstructed, grief that the love we share with our partners is not enough to spontaneously create new life, grief as we navigate the reactions of homophobic others to our family building plans, grief as we wonder how the world will receive our children-with-queer-parents.[11] Intended queer parents often face these voices both externally and internally.

These voices can be particularly loud at challenging intersections of the family-building process, such as when conception attempts are unsuccessful ("Perhaps it's a sign that it isn't meant to be"). Even at what are meant to be joyful moments, like announcing a pregnancy or years later as a parent, queer families deal with questions like, "Who is the 'real' mom?" or worries about how the child will fare "without a mom/dad." As Zisman writes, "One of the hardest realities of queer family building is that we don't get to put oppression on hold. Heterosexism, cissexism, homophobia, and transphobia shape the happy times, the confusing times, and the times of loss and pain."[12] This is perhaps one of the most significant pieces clinicians can recognize: there are few straightforward moments in queer family building.

It is important to understand and create space and process for these experiences and the complex emotional terrain they form. Naming historical and social structures that give rise to these

narratives — hetero- and cis-normativity, ableism, patriarchal family models — can offer clients an opportunity to be seen in their unique experiences. It also serves to challenge the idea that the problem is "within" clients. This is particularly important in a family-building process involving medical procedures where there is an extraordinary focus on individual bodies and assessments of how well they are functioning.

Lastly, witnessing the injustice — it shouldn't be this way — implements into the therapy space what feminist psychoanalyst Jessica Benjamin refers to as the "moral third" — an acknowledgment confirming that events and their resulting harms are real, as well as acknowledging that those experiencing them are worthy of being heard. While witnessing is not a substitute for political change, Benjamin argues that it creates the condition where such change is possible by naming injustice and raising awareness of human interdependence and the shared responsibility we carry for one another.[13]

THE ISOLATION OF DIFFERENCE AND UNSEEN LABOURS

Deciding to try for a family as a queer couple and navigating the fertility industry was for me an experience of otherness and persistent coming out. I was exhausted by having to come out at every step of the process. I did not see myself, my relationship, or my hoped-for family reflected back to me in materials, support groups, forms we filled out, prenatal classes we attended, care providers we encountered. I feared microaggressions if I spoke up for my needs, and I carried tension at each appointment, wondering if professionals would ask if my wife was my sister or friend when she attended with me.

Similarly, my wife speaks of her experiences as a female non-birthing parent and being unable to find support for or representation of her unique position. In a gendered, biological essentialist system, "mom" is assumed to mean "birthing parent" and "dad" is assumed to be "non-birthing parent" — neither match my wife's gender identity, sexual orientation, or her role as a queer parent. She wasn't seen in her identity and experiences yet was highly visible in her "not fitting." As Zisman names, there is a paradox of visibility in the queer family-building experience: "You are at once erased, not easily found on forms, in doctor's offices, in books. But you are also hyper-visible, surveilled, questioned, too present, too seen."[14] Each of these experiences increased the sense of isolation and loneliness in an already difficult and

RESOURCES FOR COUNSELLORS AND CLIENTS

Books

- *Conceivable: A guide to making 2SLGBTQ+ family* by Laine Halpern Zisman
- Baby Making for Everybody: Family Building and Fertility for LGBTQ+ and Solo Parents by Marea Goodman and Ray Rachlin
- *The Queer Parent: Everything You Need to Know from Gay to Ze* by Lotte Jeffs and Stu Oakley

Online Resources

- PregnantTogether: Virtual community supporting queer folks and solo parents from preconception through parenting. Free and paid support groups, online resources, events and workshops. pregnanttogether.com
- Postpartum Support International: Helpline, virtual support groups, peer mentors, support coordinators for LGBTQIA+ folks who are expecting, adopting, or parenting. https://postpartum.net/get-help/queer-parents/
- Donor Conception Canada: Free support groups (virtual and in-person) and resource lists for folks exploring donor conception and parenting donor-conceived children. https://dccanada.org/
- Social Media Rainbow and Queer Family Groups: For safety reasons, I won't name these groups publicly but know that multiple groups exist in B.C. They are large, active communities of queer families of all kinds, supporting one another.

Supporting clients to connect to queer conception/parenting community and queer providers can be powerful.

taxing process.

In a counselling context, research has shown that queer clients often choose therapists from within their own queer communities.[15] The preference of queer clients for queer counsellors is directly shaped by the history of marginalization and oppression as clients seek to connect with others similar to themselves and to avoid rejection and stigmatization.[16] As an intended queer parent, I felt this same desire, particularly around such a vulnerable time in my life; I was active in looking for queer conception supports, and then later, queer pregnancy and parenting supports. I chased every passing mention of "Oh I think there is a group…", only to discover they were on hold because of lack of funding, or they were a hetero-focused group that was "queer welcoming," meaning I'd likely be keenly aware of my otherness. Once pregnant, I called the handful of midwifery practices with queer midwives, asking them to take me on as a patient despite being out of their catchment area. I was turned away and nervously hoped care providers in my area would be able to translate the Pride flag on their websites into culturally attuned care.

Accordingly, supporting clients to connect to queer conception/parenting community and queer providers can be powerful, as can offering community connection opportunities through your own practice. Research has shown that community-based strategies that create connection to others with similar experiences, such as 2SLGBTQ+ specific peer support groups, are some of the most effective coping strategies through the family building process.[17]

Similarly, counsellors can make a significant contribution through resource networking. The fertility and reproduction industry are overwhelming to navigate and hetero- and cis-normative in structure; therefore, knowing the resources available for queer and trans parents in your community is an immense step toward meaningful care. If your clients are needing services that you cannot provide yourself, ensure you have a robust referral network you have vetted for 2SLGBTQ+ competency.

THE INVITATION OF QUEERING FAMILY

Lastly, I invite counsellors to celebrate radical family building with their queer clients and within society at large. As Goodman and Rachlin remind us, queer people have been figuring out how to build families and parents for generations within systems that don't support them;[18] recognizing, celebrating, and lifting up all the ways queer families come together is important.

As Sharma notes, "Family can be a site of both liberation and oppression."[19] As counsellors, we are called to hold the both/and of this statement and support our clients as they navigate this multiplicity. Recognize and name the significant labour of creating such a radical family space, while opening yourself to the invitation of queer culture: "Queer theory and queer experiences teach us to live otherwise." [20] What might be possible when we decide to queer family? ■

Eleonora Joensuu (she/her), PhD, RCC, is a private practice clinician and CityU faculty member. Her PhD in Philosophy of Education researched disgust and she remains fascinated by the full spectrum of human emotional experience and its wisdoms. www.crescentcc.ca

REFERENCES

1 Kirubarajan A, Barker LC, Leung S, Ross LE, Zaheer J, Park B, Abramovich A, Yudin MH, Lam JSH. LGBTQ2S+ childbearing individuals and perinatal mental health: A systematic review. *BJOG*. 2022 Sep;129(10):1630-1643. doi: 10.1111/1471-0528.17103. Epub 2022 Feb 8. PMID: 35048502.

2 Monseur, B. (2024, Oct 31). Queering reproduction - LGBTQ+ family building [Video]. YouTube. https://www.youtube.com/watch?v=wRyoo5QP3cg&t=2700s

3 Comeau, D., Johnson, C., Bouhamdani, N. (2023). Review of current 2SLGBTQ+ inequities in the Canadian health care system. *Front Public Health*, 18(11).

4 Ross, L. J., & Solinger, R. (2017). *Reproductive justice: An introduction* (1st ed.). University of California Press.

5 Rachlin, R., & Goodman, M. (2024). *Baby making for everybody: Family building and fertility for LGBTQ+ and solo parents*. Balance Books.

6 Rachlin & Goodman, 2024.

7 Sharma, Z. (2021). *The care we dream of: Liberatory and transformative approaches to LGBTQ+ health*. Arsenal Pulp Press. p. 47.

8 Canadian Fertility and Andrology Society (2023). *Assisted Human Reproduction Counselling Practice Guidelines*. https://cfas.ca/_Library/Guidelines/CSIG-Counselling-Practice-Guidelines_Revised-September-2023.pdf

9 Sharma, 2021, p. 47.

10 Kirubarajan et al., 2022.

11 Zisman, L. H. (2025). *Conceivable: A guide to making 2SLGBTQ+ family*. Fernwood Publishing.

12 Zisman, 2025.

13 Benjamin, J. (2015). *Acknowledging the other's suffering: A psychoanalytic approach to trauma in Israel/Palestine*. Tikkun, Duke University Press, 30(3), 15–16.

14 Zisman, 2025.

15 Kessler, L. E., & Waehler, C. A. (2005). Addressing multiple relationships between clients and therapists in lesbian, gay, bisexual, and transgender communities. *Professional Psychology: Research and Practice*, 36(1), 66–72. https://doi.org/10.1037/0735-7028.36.1.66

16 Graham, S. R., & Liddle, B. J. (2009). Multiple relationships encountered by lesbian and bisexual psychotherapists: How close is too close? *Professional Psychology: Research and Practice*, 40(1), 15–21. https://doi.org/10.1037/a0013904

17 Kirubarajan et al., 2022.

18 Rachlin & Goodman, 2024.

19 Sharma, 2021, p. 228.

20 Zisman, 2025.

MORAL DISTRESS and a few other mental health culprits

A day in the life of a veterinarian, animal rescuer, or animal advocate

BY LIZ SINCLAIR KRUTH, RCC

One Saturday afternoon while I was working as an emergency room veterinarian, a client arrived with his small, shaggy dog named Bob, who had been bitten by another dog. Bob's eye was ruptured and needed to be removed; however, his owner could not afford the surgery which would cost around a thousand dollars. The ER practice where I worked had a strict "no free vet care" policy. Bob shyly looked up at me with his one good eye, in obvious pain and afraid of what was going on around him, and he gave me a lick and tried to snuggle into my arms.

For the first time in seven years, I called my boss to plead the case, but he was out of the country with no phone access. I called my husband to see if we could afford the bill ourselves, but we had just gotten married and money was tight. The staff at the clinic reminded me, "You can't save them all, Liz." With nowhere left to turn, and the emergency room packed with other patients, I set aside my compassion and my ethics and took Bob's life. Soon after, I found myself unable to cope with the emotional strain I felt when faced with cases like these on a daily basis. Distraught and without support, I made my decision to leave the profession.

This article is dedicated to the veterinarians, animal rescuers, and animal advocates who deal with emotionally and morally distressing situations. This article is also dedicated to Bob, and all the other ones lost too soon and for no good reason.

VETERINARY MENTAL HEALTH: HIGHER RISK OF SUICIDE

Over recent years, awareness of mental health issues has become a growing concern within the veterinary profession.[1] Stigma around accessing therapy is particularly prevalent for people who work in the medical field, although some progress has been made in recent years.[2, 3, 4, 5] Unfortunately, there is little corresponding discussion in counselling psychology literature about how to understand, counsel, or access veterinarians or other animal-related workers to provide the mental health support that they are seeking.

Several studies and systematic reviews from the U.S. and U.K. show that veterinarians have a significantly increased risk of suicide compared to the general population.[6, 7] In fact, a 2010 review found suicide risk among veterinarians to be as high as three times that of the general population.[8] In response to these alarming findings and the growing awareness of mental health issues, a profession-wide plea was issued for more research into the risk factors associated with suicide.[9] Subsequently, the Center for Disease Control and Prevention conducted a study of suicide risk factors among U.S. veterinarians.[10] The survey collected data from 10,254 currently employed veterinarians and found both female and male veterinarians to be two to three times more likely to experience serious psychological distress based on the Kessler-6 psychological distress scale.[11] Veterinarians also reported higher levels of depressive episodes and suicide ideation than the general population.[12]

It is worth noting that the number of suicide attempts by veterinarians were lower than the general population, although overall suicide rates are higher, likely due to veterinarians' access to and knowledge of medications resulting in more fatal suicide attempts.[13, 14]

Veterinarians also reported higher levels of depressive episodes and suicide ideation than the general population.

In another recent U.S. study, mental health measures of veterinary support staff were also found to be low, suggesting that veterinary technicians/nurses are also suffering.[15] It is reasonable to consider that animal rescuers, shelter workers, and other animal advocates would have similar and sometimes heightened distress experiences.

WHY IS THE SUICIDE RISK HIGHER?

One model for understanding suicide risk amongst different professions outlines four discrete factors as main contributors. These four factors include demographics, internal occupational stress, psychiatric morbidity, and opportunity factors.[16]

The first factor is the demographic of people who tend to work in professions that might predispose them to suicide risk.[17] For example, a review of suicidal behaviour in veterinarians found that young and female veterinarians are at highest risk for suicidal thoughts, mental health problems, and job dissatisfaction.[18]

The second factor, internal occupational stress, includes stresses due to the nature of the work such as long hours, poor work-life balance, dependence on clients for livelihood, decisions about treatments due to client's financial resources, and issues around euthanasia.[19, 20] A veterinarian's view of and experience with euthanasia as part of their work may also influence their attitudes towards suicide.[21]

The third factor, psychiatric morbidity, highlights the psychiatric profiles of people attracted to the profession in question.[22] Veterinarians are selected based in part on very high academic performance and have been shown to have a tendency towards perfectionism. Perfectionism concurrently entails higher levels of anxiety, fear of failure, and unrealistic performance expectations, which are traits linked to higher risks of suicide.[23]

The fourth factor thought to be linked to suicide risk is opportunity factors. Opportunity factors describe the access an individual has to lethal means of suicide, such as lethal drugs and knowledge in the medical professions.[24]

Some potential protective factors are found within the profession, including positive clinical outcomes, pride in the work, good relationships with colleagues, and intellectual growth and challenge.

MORAL DISTRESS AND OTHER CULPRITS

Years after I left vet-med and was doing my MA in counselling, I came across the term "moral distress." My struggles as a veterinarian finally started to make sense to me. Moral distress can be described as the feeling experienced when one is prevented from taking the ethical course of action. In the scenario with Bob, it is clear that the ethically correct position is to do the surgery. However, due to the financial constraints of the owner, a set of inflexible hospital policies, and my own sense of reservation about my role as a professional, I felt my only option was to perform an unethical euthanasia.

Morally distressing situations tend to be systematic and recurring, and it has been shown that if unaddressed, can lead to an accumulation of reactive distress or moral residue.[25, 26] Moral residue may worsen the experience of moral distress and can lead to a breaking point. When seeing a veterinarian as a counselling client, it is important that moral distress be considered as a potential underlying cause for or contributor to many presenting problems such as compassion fatigue, work-related psychological distress, depression, anxiety, and/or suicidal thoughts.

As a therapist who often works with veterinarians and animal-related clients, the most common issues I see are moral distress, vicarious trauma, compassion fatigue, and burn out. I see a lot of burn out, which I think is often a compilation of all the other issues. It's also important to recognize that moral issues often underlie all of these presenting complaints, even if they aren't obvious at the outset. Veterinary and animal-related people will often think of their burn out as depression and push themselves to do more (when what is needed is to disengage and do less).

A whole host of other animal-related people are also at risk for mental health struggles. Shelter staff and animal rescuers face daily exposure to trauma and an endless list of animals in need. They often operate with few resources and little structural or institutional support and rarely have health benefits.

Then there are the vegetarians and vegans as animal advocates. Whether you eat animal products or not, most people agree that animals should not be abused. However, billions of farm animals suffer through institutionalized mistreatment and violence such as extreme confinement, depravation of normal behaviours, pain, fear, and distress. Being aware of these forms of normalized violence and exploitation but being relatively powerless to stop them is moral distress on a massive global scale. Psychologist Clare Mann has coined the term "vystopia" to capture this experience.[27]

Dr. Casey Taft, a professor of psychiatry at Boston University School of Medicine, adds another layer of depth. As a specialist in PTSD and intimate partner violence and a vegan advocate, he says, "When one experiences trauma and abuse, they are more likely to be sensitive to trauma experienced by others and fight for justice for those oppressed."[28]

That's a lot to unpack at your next session!

WHAT TO KNOW AS A THERAPIST

When discussing moral distress with a client or in our own case conceptualization, it is crucial to distinguish the difference between moral distress and an ethical dilemma.[29] An ethical dilemma is where there two or more defensible positions exist that one can work through by following ethical principles and arrive at an outcome. This is compared to a situation of moral distress, wherein the individual knows the right course of action but is constrained from taking it or forced to act contrary to it. Instead, conversations around moral distress are more likely to focus on identifying institutional issues around policy and social justice, including identifying who holds accountability and responsibility for actions taken. In fact, to avoid simply acclimatizing people to unethical systems, it is crucially important that counsellors do not exclusively work to eliminate the symptoms of moral distress without changing the underlying problematic structure.[30, 31, 32]

RESOURCES

For Vets:

- CVMA Mental Health Awareness page: "Who Ya Gonna Call: Helpline, Phone Numbers and Websites". List of Mental Health Resources for Veterinarians.
- Veterinary Hope foundation: Free peer support groups facilitated by a mental health professional. https://veterinaryhope.org/
- Off the Beaten Path: Canadian Veterinary CE with a mental health focus. https://www.offthebeatenpathvetretreats.com/

For therapists:

- University of Tennessee Veterinary Social Work post graduate certificate program: https://vetsocialwork.tennessee.edu/

Thus, counselling should aim at three levels — personal, team, and institutional — for moral distress to be properly addressed.[33, 34] For example, mental health promotion and personal counselling can be paired with team meetings to discuss morally distressing cases with input from all involved, and a summary sent

to policy makers to provide feedback for improving the system.[35, 26]

Implementing wellness programs in clinics is one way to promote personal well-being, reduce stigma towards mental health care services, and address workplace culture to better promote well-being. However, there are identified barriers to implementing wellness programs in veterinary medicine. Many clinics are small businesses, and it can be difficult to find the time and financial resources for wellness programs. Also, a lack of measurable outcomes in the literature can make it difficult to make evidence-based decisions (although a veterinary-specific assessment tool has recently been validated).

PERSON-CENTRED APPROACH FOR MORAL DISTRESS

In this world of techniques, sound bites, and tools (many of which I use with clients, too), I work hard to stay focused on the Rogerian tenets of authentic self, unconditional positive regard, and accurate empathy. I find when I do that, the counselling takes care of itself.

Person-centred therapy (PCT) could be considered an appropriate approach for working with veterinarians experiencing moral distress for several reasons. First, veterinarians are trained as decision makers, so a counselling approach that recognizes the client's resources and strengths would be empowering for this population. Also, some veterinary colleges have curriculum geared towards creating client-centred care, which is a medical approach to care similar in principle to PCT. Subsequently, PCT is likely to make sense to and work within the cognitive framework of many veterinarians. Veterinarians are highly evidence-based thinkers, so they are likely to respect PCT, which is one of the most well-established and researched therapeutic approaches.

Moral distress is a personal experience based on personal values and ethics, and one person will experience moral distress in a given situation whereas another may not. PCT respects and accepts the perspective of clients without judgment, which is particularly helpful for moral distress. PCT also fits with social justice approaches that focus on institutional change,[37] which is a necessary component of addressing moral distress.

EDUCATION

A study of ICU nursing staff has shown that workshops that discuss and promote solutions for moral distress have significant benefit.[38] There are three avenues from which education on moral distress can be approached.

First, education and introduction of the concept of moral distress can be incorporated into veterinary curriculum. This can help introduce the concept to future veterinarians who can act as ambassadors to the professions. This is likely the first step towards navigating policy and social changes that target the underlying causes of moral distress.

For example, changing hospital policy to refuse convenience euthanasia and lobbying for legal changes to the status of animals.

Education on moral distress could also be introduced into counselling psychology curriculum. Since awareness and research on moral distress in various professions is gaining significant momentum, introducing the topic into counselling curriculum would help facilitate the development of counsellors who can adequately recognize and address this problem in clinical situation.

> Up to 25 per cent of veterinarians now seek counselling support, compared to 13 per cent only seven years ago.

Also, introducing curriculum can set the groundwork to start discussions between stakeholder professions on how to address the root causes for moral distress. For example, collaborations could lead to counsellors designing and leading workshops that can be adapted for working with various professionals such as veterinarians, rescuers, and animal advocates, as well as medical professionals, such as nurses and physicians.

LOOKING TO THE FUTURE

As an early adopter of veterinary mental health, I've seen a lot of positive progress in my 10 years of practice. The Canadian Veterinary Medical Association recently added a resource page to list veterinary-related therapists,[39] and many of us meet occasionally as an informal consult group — there are more than one of us! Up to 25 per cent of veterinarians now seek counselling support, compared to 13 per cent only seven years ago.[40] The University of Tennessee now offers a Veterinary Social Work post-graduate certificate program, and they even have a conference on veterinary mental health every two years. I identify myself as a vegan/vegetarian-friendly therapist on my website and if I search for other vegan therapists online, I actually get some results! ■

Liz Sinclair Kruth, RCC, RP, DVM, MSc, is a veterinarian turned private practice therapist in Brentwood Bay. She and her family are vegan and run a very small animal rescue organization. She loves animals and people alike.

REFERENCES

1. Larkin, M. Finding the calm amid the chaos: When it's not the patient who needs a wellness check, but the veterinarian. *JAVMA News*, 2013; 243(10),1368-75.http://dx.doi.org/10.2460/javma.243.10.1368

2. Bartram, D., & Baldwin, D. Veterinary surgeons and suicide: A structured review of possible influences on increased risk. *Veterinary Record*, 2010;166(13), 388-97. http://dx.doi.org/10.1136/vr.b4794

3. Nett, R., Witte, T., Holzbauer,. . . Funk, R. Risk factors for suicide, attitudes toward mental illness, and practice-related stressor among US veterinarians. *JAVMA*, 2015; 247(8), 945-955.http://dx.doi.org/10.2460/javma.247.8.945

4. Sartorius N. Stigma and mental health. *Lancet*, 2007;370(9590), 810– 811. http://dx.doi.org/10.1016/S0140-6736(07)61245-8

5. Larkin, M. (2024, Jan 22). Veterinary Profession Heading in Right Direction. *AVMA News*. https://www.avma.org/news/veterinary-profession-heading-right-direction-mental-health

6. Blair A., & Hayes H. Mortality patterns among United States veterinarians, 1947–1977— an expanded study. *International Journal of Epidemiology*, 1982; 11(4), 391–397.http://doi.org/10.1093/ije/11.4.391

7. Miller J., & Beaumont J. Suicide, cancer, and other causes of death among California veterinarians, 1960–1992. *American Journal of Industrial Medicine*, 1995; 27(1):37–49. http://dx.doi.org/10.1002/wajim.4700270105

8. Platt, B., Hawton, K., Simkin, S., & Mellanby, R. Systematic review of the prevalence of suicide in veterinary surgeons. *Occupational Medicine*, 2010; 60(6), 436-446. http://dx.doi.org/10.1093/occmed/kqq044

9. Larkin, 2013.

10. Nett et al., 2015.

11. Nett et al., 2015.

12. Nett et al., 2015.

13. Nett et al., 2015.

14. Morgan, S., & Yoder, L. H. A concept analysis of person-centered care. *Journal of Holistic Nursing*, 2012;30(1), 6-15. http://dx.doi.org/10.1177/089801011141289

15. Foster, S., Maples, E. (2014). Occupational Stress in Veterinary Support Staff. *Journal of Veterinary Medical Education*, 2014; 41(1), 102-110. http://dx.doi.org/10.3138/jvme.0713-103R

16. Stack, S. Occupation and suicide. *Social Science Quarterly*, 2001; 82(2), 384-396. http://dx.doi.org/10.1111/0038-4941.00030

17. Stack, 2001.

18. Platt et al., 2010.

19. Platt et al., 2010.

20. Stack. 2001.

21. Platt et al., 2010.

22. Stack, 2001.

23. O'Connor, R. The relations between perfectionism and suicidality: A systematic review. *Suicide and Life Threatening Behavior*, 2007; 37(6), 698-714. http://dx.doi.org/10.1521/suli.2007.37.6.698

24. Stack. 2001.

25. Epstein, E., & Delgado, S. Understanding and addressing moral distress. *Online Journal of Issues in Nursing*, 2010; 15(3), 1. http://dx.doi.org/10.3912/OJIN.Vol15No03Man01

26. Epstein, E., & Hamric, A. Moral Distress, Moral Residue, and the Crescendo Effect. *Journal of Clinical Ethics*, 2009; 20(4), 330.

27. Mann, Clare (2018). Vystopia. Communicate31.

28. Taft, Casey (2016). *Motivational Methods for Vegan Advocacy*. Vegan Publishers.

29. Epstein & Delgado, 2010.

30. Epstein & Hamric, 2009.

31. Howe, E. G. Fourteen important concepts regarding moral distress. *Journal of Clinical Ethics*, 2017; 28(1), 3-14.

32. Musto, L., Rodney, P., Vanderheide, R. Toward interventions to address moral distress. *Nursing Ethics*, 2015;22(1), 91-102. http://dx.doi.org/10.1177/0969733014534879

33. Bartram, D., Sinclair, J., & Baldwin, D. Interventions with potential to improve the mental health and wellbeing of UK veterinary surgeons. *Veterinary Record*, 2010; 166(17), 518-23. http://dx.doi.org/10.1136/vr.b4796.

34. Epstein & Hamric. 2009.

35. Bartram et al., 2010.

36. Epstein & Hamric, 2009.

37. Buhin, L., & Vera, E. Preventing racism and promoting social justice: Person-centered and environment-centered interventions. *The Journal of Primary Prevention*, 2009;30(1), 43-60.

38. Beumer, C. Innovative solutions: the effect of a workshop on reducing the experience of moral distress in an intensive care unit setting. *Dimensions of Critical Care Nursing*, 2008; 27(6), 263-267. http://dx.doi.org/10.1097/01.DCC.0000338871.77658.0

39. Larkin, 2024.

40. Larkin, 2024.

SELF-DIAGNOSIS

A TikTok Fairytale

BY MEGHAN HODGSON, RCC

I'm chasing my cousin around my grandmother's bedroom. She's older, taller, smarter, and to my four-year-old brain, the coolest of cool. She has several inches on me, so when she stops, I slam headfirst into her back.

"What do you want to be when you grow up?"

Without hesitation, I disclose my aspirations for mermaid-hood. It was the 90s, and I was riding the waves of *The Little Mermaid*'s re-release.

"Humans can't be mermaids. Pick something else," she instructs. Today, I learn that flipping my proverbial fins won't get me far.

Instead, I become a Registered Clinical Counsellor. When no one's looking, I brush my hair with a fork. I cultivate cute little rituals to stay human in a dehumanizing world. Every afternoon, I embark on my pilgrimage for coffee. I snuggle an earbud into each ear, and wiggle awake two rosy feet dangling from hypermobile ankles. Screentime safeguards me against bottomless small talk. I order the same drink from the same baristas, then gravitate to the café's farthest corner.

While I wait for my triple-shot vanilla oat milk latte, I scroll through Instagram, flipping between my personal and professional accounts. Each algorithm represents a different part of me, on-the-clock-Meghan and off-the-clock-Megs. At first glance, they appear — and sound

— radically different. One is filled with soft-spoken psychoeducation, aesthetic infographics— "very mindful, very demure." The other is infused with dark humour, expressive arts, and a skiff of existential dread.

In fine therapist form, I psychoanalyze myself and read between the lines. A vignette forms. I see a digital meeting of the selves, grappling with my everyday challenges, familiar fears, and finding hope within them. I see what soothes me, a digital care web. Each feed, a different flavour of online mutual aid, ranging from #ADHDhacks, hot takes from lived experience, disability justice advocacy, and brilliant autistic comedians.

Rinse and repeat.

Today, it's more of the same until my phone shows me something new. The University of British Columbia (UBC) just released a study examining the role of social media in influencing personal and public perceptions of neurodevelopmental disabilities, specifically attention deficit hyperactivity disorder (ADHD).[1] No amount of latte art can lighten the load of scholarship from prominent research institutions. My nose feels a bit prickly imagining my self-identified neurodivergent clients reading the results, challenging their sense of self all over again.

PERSPECTIVES ON SCHOLARSHIP

On the surface, it's harmless and credible scholarship. In isolation, there is minimal harm in exploring how ADHD-related TikTok content may shape young adults' perceptions of the neurodevelopmental condition, with a specific focus on self-diagnosis and content-sharing practices. Moreover, its methodology simply asked undergraduate students to assess the diagnostic accuracy of selected TikTok videos using a 1–5 Likert scale. Their evaluations were then compared to ratings by two psychologists with specialized training in ADHD diagnosis using the fifth-edition, text-revised *Diagnostic and Statistical Manual of Mental Disorders* criteria.[2] The results demonstrated significant discrepancies between student and expert ratings. In line with prior scholarship, they emphasize the importance of addressing potential misinformation to support accurate diagnosis, effective treatment, and appropriate resource access for those with ADHD.[3]

Infusing disability justice and decolonizing care work is a humbling process.

Sadly, I sense well-intended and true care, which isn't always present in Western research. In my limited — and arguably, underqualified — opinion, Karasavva et al.'s study reads as thoughtful and deliberate in its execution. However, we already know these diagnostic frameworks are rooted in colonial constructs, and frequently, they appear neutral, all while reinforcing systems of oppression.[4] Regardless of a researcher's intended impact, in my opinion, corporate stakeholders and western institutions could potentially weaponize studies like these which may then silence and discredit disabled voices, especially self-identified ones.[5]

We needn't look far for examples from the American Psychological Association (APA).[6,7] With each edition of the DSM, in my view, the APA rebrands itself, sweeping centuries of egregious behaviour into their archive's darkest corners.[8, 9]

In late 2024, the APA released an article raising the infodemic alarm.[10] Truly provocative statistics are cited that reinforce the author's concerns. According to their primary source, 100 per cent of the ADHD-related content in their "analysis" of 500 TikTok videos was "misleading," and 91 per cent of the content creators lacked "medical training." [11]

However, as a care worker, what I actually consider concerning is their choice of primary source, PlushCare. Within a couple clicks, I circumvent their psychoeducational infographics and find it's a paid subscription service to a virtual

The ways we embrace our self-identified clients shape the future of our profession, and how we reconcile with our past.

telehealth clinic, owned privately in the United States. They advertise drop-ins, diagnostic assessments, and online Ozempic prescriptions.[12]

Western psychology's investigation into these "potential" harms is what remains to be seen.[13] When we look at where the research grants go, we see their priorities. Dr. Jennifer Mullan, author of *Decolonizing Therapy*, reminds us that ″we cannot heal what we deny. We cannot liberate what we pathologize," but we can choose denial and continue to pathologize.[14]

Perhaps, it's not the crip* community who's at risk but the institutions built to contain them.[15] When disabled "untrained" Tiktokers monetize shared lived experience and personalized hot takes, who loses influence? From the lack of research and news coverage, we can reasonably assume that the vast majority of neurodivergent social media users aren't resorting to conspiratorial cocktails because their Adderall prescription expired. Yet, it's common for fear-mongering blogs and legitimate research institutions to cite deathly COVID conspiracies — like drinking bleach — as grounds for challenging disabled identities.[16]

Fairytales, folklore, and children's literature can tell us what many disabled folks already know.[17] We never narrate our lived experience — even when we're the main character.[18] The luckier ones — me included — sometimes can co-author our life stories should we fight the right people at the right times. Even then, luckiness and more success in the ring just point to privilege.

Albeit anecdotally, I have never encountered accounts of people, across the entire spectrum of disabled to abled bodies, confusing the function of Facebook with Google scholar. Freedom of expression and digital connection are core functions of social media. When disabled people are bullied online, the world reminds us of free speech. If Western psychology was truly concerned with disabled lives, especially those of queer, trans, Black, brown, and people of colour, studying social media's influence on self-diagnosing neurodivergence wouldn't be the priority. Instead, they would study the perpetrators of oppression.

NEUROAFFIRMING CARE WORK

Care work doesn't have to be synonymous with Western psychology.[19] The healing professions are an ecosystem that weaves in all sorts of arts, science, culture, and healing practices. However, infusing disability justice and decolonizing care work is a humbling process that requires deep, embodied accountability. It requires healers, especially white ones, to reckon with their roots alongside their profession.[20, 21]

Our standards of practice are only as

** Crip is a term reclaimed by some in the disabled community to express pride in disability identity.*

strong as those upholding them, so we must take care of one another. We can be anti-pathology, even anti-psychiatry, without internalized ableism sneaking into our sessions.[22] Now more than ever, the ways we embrace our self-identified clients shape the future of our profession, and how we reconcile with our past. Let curiosity, compassion, and humility guide us through the deconstruction of racist, ableist systems, so we can show up whole-heartedly with clients, regardless of any biases against social media and self-diagnosis.[23, 24]

This is a gentle reminder that when a client is exploring self-diagnosis and disabled identities, they are not demanding clinical judgment from you.[25] Receiving disclosures of suspected neurodivergence in therapy sessions are signs that you are a safe person in an unsafe world.

When disability is expressed, trust that no clinical paradigm is strong enough to override their personal experience.[26, 27] Allow clients to reclaim their stories without policing their language. When care workers actively challenge or disengage with their client's disabled identities, it becomes disability erasure.[28, 29] It's internalized ableism through label avoidance.[30, 31]

In neuroaffirming care work, we become a part of their world, rather than dragging them into ours. We learn to use their language, rather than centring ours.

BACK TO GROUP AND LIFE

I choke on my coffee, snapping me out of my self-righteous inner monologue, and realize I'm late for group. Divergent Collective is my baby. It's a passion project I cradled forever and launched this year. On paper, Divergent Collective is seasonal group therapy. In essence, it's a messy little crip-care web I wove myself. It's ethically messy, like me, and many of the participants — all neurodivergent disabled folks. I arrive with minutes to spare — a participant offers to hold my bag of books while I unlock the door. Compulsively, my healer-ego wants to decline their help because part of me still claws onto therapeutic martyrdom. Fortunately, I get over myself and the threshold of the door.

We don't break bread, but we share MadeGood cookies and swap stories of success and survival. They say sweet things and share wisdom Western studies can't capture. Social media is more than a social network for disabled communities — it's where we process the mixed messages we receive from doctors, pain from past employers, and fears about our futures.

When my day is done, I arrive home to belligerent cats who accuse me of animal abuse. Our relational rupture is repaired once their bowl is refilled with kibble. They seem safe and happy. I hope each participant in my Divergent Collective group arrives home safe and happy, too. My youngest parts — my mermaid parts — still yearn for a Disnified world, one where I could guarantee clients happy endings. Instead, my best bedtime story is simply knowing that Western psychology — at least as it stands today — can't win without every healer on their side. ■

Meghan Hodgson is a multidivergent Registered Clinical Counsellor at Hidden Gems Counselling, specializing in neurodevelopmental neurodivergence and disability justice in therapy.

REFERENCES

1. Karasavva V, Miller C, Groves N, Montiel A, Canu W, Mikami A (2025). A double-edged hashtag: Evaluation of #ADHD-related TikTok content and its associations with perceptions of ADHD. PLoS ONE 20(3): e0319335. https://doi.org/10.1371/journal.pone.0319335

2. Karasavva et al., 2025.

3. Karasavva et al., 2025.

4. Mullan, J. (2023). *Decolonizing therapy: Oppression, historical trauma, and politicizing your practice*. North Atlantic Books.

5. Mullan, 2023.

6. Piepzna-Samarasinha, L. L. (2018). *Care work: Dreaming disability justice*. Arsenal Pulp Press.

7. Silberman, S. (2015). *NeuroTribes: The legacy of autism and the future of neurodiversity*. Avery.

8. Mullan, 2023.

9. Silberman, 2015.

10. Abrams, Z. (2024, July 01). How to reverse the alarming trend of health misinformation. *American Psychological Association*. https://www.apa.org/monitor/2024/07/ending-health-misinformation

11. PlushCare. (n.d.). TikTok mental health misinformation: A growing concern. PlushCare. https://plushcare.com/blog/tiktok-mental-health

12. PlushCare, 2025.

13. PlushCare, 2025.

14. Mullan, 2023.

15. Chapman, R. (2023). *Empire of normality: Neurodivergence and capitalism*. Pluto Press.

16. Abrams, Z. (2024, November 06). Addressing misinformation about mental health with patients. *American Psychological Association*. https://www.apa.org/topics/journalism-facts/misinformation-mental-health

17. Leduc, A. (2020). *Disfigured: On fairy tales, disability, and making space*. Coach House Books.

18. Hodkinson, A., & Park, J. (2017). 'Telling tales': An investigation into the representation of disability in classic children's fairy tales. *Educationalfutures*, 8(2), 48–66. https://educationstudies.org.uk/journal/ef-vol-8-2-2017/

19. Piepzna-Samarasinha, 2018.

20. Mullan, 2023.

21. Piepzna-Samarasinha, 2018.

22. Andrews EE, Forber-Pratt AJ, Mona LR, Lund EM, Pilarski CR, Balter R. #SaytheWord: A disability culture commentary on the erasure of "disability". *Rehabil Psychol*. 2019 May;64(2):111-118. doi: 10.1037/rep0000258. Epub 2019 Feb 14. PMID: 30762412.

23. Mullan, 2023.

24. Piepzna-Samarasinha, 2018.

25. Andrews et al., 2019.

26. Andrews et al., 2019.

27. Andrews et al., 2019.

28. Piepzna-Samarasinha, 2018.

29. Piepzna-Samarasinha, 2018.

30. Andrews et al., 2019.

31. Cameron, Julia J., "Developing the Label Avoidance Measure of Stigma: A preliminary psychometric review" (2021). Graduate Student Theses, Dissertations, & Professional Papers. 11751. https://scholarworks.umt.edu/etd/11751

ABSURDISM AND THE *Myth of Sisyphus*

How one counsellor finds solace in the midst of chaos and existential angst

BY DAVID VASS, RCC

Throughout the day, I often shake my head in disbelief — whether it be while stuck in traffic, dealing with a housing crisis, or reading about politics. These moments evoke anger, frustration, or numbness, making me say, “This is absurd” and “This should not be!” I imagine many share these feelings, especially about the lack of accountability in a growth-driven world. As someone who values justice and fairness, these developments feel unacceptable. In the interest of being the best I can be for my clients, I have found solace, perspective, and resolve in Albert Camus’ absurdism via his philosophical work, the Myth of Sisyphus.[1]

STUCK IN PROTEST

The Human Drama and Existential Angst

It is that divorce between the mind that desires and the world that disappoints, my nostalgia for unity, this fragmented universe and the contradiction that binds them together. (Camus, 1942, p.50)

Camus suggests that much of our suffering stems from our desire for the world to conform to our expectations, which it never does. Efforts to reduce disappointment through structures, guidelines, and consensus are futile because many factors of human experience are beyond control. This creates existential angst — a tension between our need for meaning in a chaotic, indifferent world.[2] The digital age only exacerbates this strain, where instant gratification blurs the lines between wants and needs, making even minor delays feel intolerable as we become accustomed to immediate satisfaction and expect the world to cater to our desires at a moment's notice.

We Suffer as a Result of Unconscious Living

We get into the habit of living before acquiring the habit of thinking. In that race which hastens us towards death, the body maintains its irreparable lead. (Camus, 1942, p.8)

Camus highlights how routine autopilot can take over as we focus on maintaining basic needs like food, shelter, and security. In today's uncertain world, this tunnel vision can lead to reactive behaviours stemming from a "forgiveness over permission" mindset. Slowing down and accepting accountability can trigger fears of missing out or being overwhelmed in a frenzied environment. Although this rat-race is often tolerated, its profound psychological suffering can become unbearable.[3]

GETTING UNSTUCK BY RESPONDING TO REALITY

Becoming Conscious

The return to consciousness, the escape from everyday sleep represent the first steps of absurd freedom. (Camus, 1942, p.59)

The rise of awareness around our absurd situation is what Camus highlights as the emergence of liberation. We become cognizant of the drama and our role in creating this cosmic tension through our constant strivings. Pockets of momentary satisfactions may be glimpsed amidst a flooding of unmet desires.

> Embracing absurdism doesn't mean losing hope or resigning yourself to despair.

Reflect, Question, and Consider

In psychology as in logic, there are truths but no truth. (Camus, 1942, p.19)

The next step is to then recognize the personalized nature of suffering. Nothing is inherently "absurd," only my evaluation of it makes it so based on my values, beliefs, and expectations. Camus states that one who embodies the absurd does not get lost in their reactive evaluations but reflects on the lens that creates their perceptions and considers the situation calmly.[4]

Acceptance and Re-engagement

The absurd [person]... recognizes the struggle, does not absolutely scorn reason, and admits the irrational. (Camus, 1942, p.37)

Camus' overarching gesture in his thesis is an invitation for us to find ways to reconcile our moral differences and proceed through life with dignity. This embrace with life, of course, can be exceedingly difficult at times, as it requires our illusions to collapse. Thus, it requires immense courage,[5] as well as creative discipline to focus on the areas and experiences in life that we value.[6]

Conclusion

It is not surprising that much of history's profound existential literature emerges from humanity's darkest times. Embracing absurdism doesn't mean losing hope or resigning yourself to despair. Instead, it involves letting go of fantasies rooted in the expectation of future meaning and confronting the irrational nature of existence. From this empowered stance, one no longer passively allows life to dictate to them but actively participates in its absurdities, shaping their response with what's available.

The key question becomes whether one can accept reality as it is — rather than as they wish it to be — and still find meaningful engagement.

Acceptance doesn't mean abandoning criticism or disapproval. Like Sisyphus, the goal is to develop patience and fortitude to carry one's burdens, recognizing their uniqueness. With conscious awareness, one can find humour or levity amidst the struggle — though remembering this is not always easy. ■

Dave Vass, MC, RCC, has a private practice on Commercial Drive, Vancouver, specializing in helping people with Type-C Personalities live with more fulfillment and freedom.

REFERENCES

1. Camus, A. (1942). *The myth of Sisyphus and other essays*. Vintage International.

2. Gunjan, K. (2023). Absurdism unveiled: The intersection of the absurd and modern realities. *International Journal of English Literature and Social Sciences*.

3. Fredrickson, J. (2015). *The lies we tell ourselves*. Insight Books.

4. Camus, 1942.

5. Frederickson 2015.

6. Dwyer, C. (2024). Absurdism and coping: A follow-up on "It is what it is". *Psychology Today*.

ACCELERATED RESOLUTION THERAPY

Helping clients rapidly resolve symptoms of trauma and other mental health issues

Accelerated Resolution Therapy (ART) was developed in 2008 by Laney Rosenzweig, MS, LMFT. As a mental health clinician, Laney was trained and proficient in multiple treatment modalities, including EMDR. She quickly appreciated the therapeutic value of eye movements but also recognized the need to modify how they are used and integrated with other techniques. She created treatment protocols that are directive, standardized, and easy to apply to different conditions. The genesis of ART involved integrating elements from different therapies in a unique and more effective way.

Jacqueline Wilson, RCC, is a B.C.-based clinical counsellor who has been using ART since 2023 to help clients reprocess difficult memories, restore emotional equilibrium, and foster resilience. Both Jacqueline and Laney are interviewed here, along with supplemental information from acceleratedresolutiontherapy.com.

WAS ART DEVELOPED TO ADDRESS A PARTICULAR DISORDER OR ISSUE?

ART was originally researched at the University of South Florida to treat psychological symptoms related to trauma and PTSD. It is a unique, evidence-based psychotherapy that helps clients rapidly resolve symptoms of trauma and other mental health issues by replacing distressing images with positive ones of their choosing — often within a single session.

Recognized by the American Psychological Association's Division 12, ART combines the power of calming eye movements with elements from therapies like Gestalt, psychodynamic therapy, and guided imagery to enhance effectiveness and speed. This approach allows clients to process trauma without needing to verbalize painful details, making it less emotionally taxing. ART has been shown to effectively treat a wide range of conditions, including PTSD, anxiety, depression, OCD, phobias, grief, and even reading difficulties linked to dyslexia.

HOW DOES ART WORK?

ART integrates techniques from traditional psychotherapies to reprogram how distressing memories are stored in the brain, reducing or eliminating the emotional and physical reactions they trigger. Using rapid eye movements, the parasympathetic nervous system is activated, which allows the client to process distressing memories leading to desensitization. The ART protocol then goes beyond desensitizing and works to introduce positive images which are believed to be beneficial.

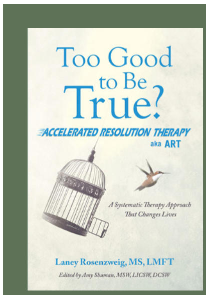
By eliminating sensations and negative images, the triggers are gone. ART enables quick and lasting relief from long-standing symptoms. Its structured and directive approach, validated by scientific research from the University of South Florida, combines proven therapeutic practices with safe, effective methods to achieve rapid recovery.

ARE THERE ANY CIRCUMSTANCES WHERE YOU WOULD NOT RECOMMEND ART?

Laney's response: If someone is not comfortable with this eye movement therapy, I would not proceed, although, the eye movements are very calming and may alleviate anxiety at the beginning of the session.

IF AN RCC HAS A CLIENT THEY BELIEVE WOULD BENEFIT FROM ART, HOW CAN THEY ASSESS IT? WHERE OR TO WHOM SHOULD THEY REFER THE CLIENT?

Laney's response: The majority of clients with a trauma history benefit from ART if they can move their eyes comfortably, are able to hold a thought, are motivated to change, and are willing to possibly experience negative emotions as they process their memories. ART-trained therapists can be found on the therapist



In Laney Rosenzweig's book, *Too Good To Be True? Accelerated Resolution Therapy: A Systematic Therapy That Changes Lives* (Archway Publishing, 2022), she weaves information about the therapy with her own story. In straightforward language, she explains how the therapy has helped people from all walks of life in all sorts of situations make astonishing changes. Some have said, "It's too good to be true," but clients will tell you that it has helped them overcome trauma often after only one session. With ART therapy, the onus of change is squarely on the client's shoulders, where it should be. Clinicians don't have to do the heavy lifting. This alleviates compassion fatigue, so clinicians can leave a therapy session feeling as light as the client.

Source for the introductory paragraphs: Accelerated Resolution Therapy acceleratedresolutiontherapy.com directory at Accelerated Resolution Therapy: acceleratedresolutiontherapy.com/therapist-directory.

ARE THERE OTHER MODALITIES THAT ART WORKS WELL WITH AND ANY THAT DO NOT?

Laney's response: ART is its own complete modality. It takes an hour and needs no other modality. Many ART clinicians are trained in other modalities. The ART protocol has elements of Gestalt, mindfulness, acceptance, guided imagery, metaphors, and somatic therapies.

HOW DID YOU COME ACROSS ART? WHAT DREW YOU TO TRY IT AND TAKE THE TRAINING?

Jacqueline's response: I was introduced to ART through the recovery centre where I work in B.C., which is deeply committed to trauma-informed care and evidence-based modalities. During my initial ART basic training, I had a profound realization that I was carrying unresolved trauma from international military deployments to Haiti, Honduras, Bosnia, and Kabul and Kandahar in Afghanistan. With the support of a trained ART professional, I underwent the therapy myself and experienced significant healing. I was scheduled for five treatments and it only took three sessions. This transformative experience inspired me to pursue advanced and enhanced ART training, and I am now proud to serve as a certified ART Train-the-Trainer facilitator. ART has not only become a cornerstone of my professional practice — it has quite literally changed my life.

CAN YOU GIVE US SOME EXAMPLES OF SUCCESSES?

Jacqueline's response: Clients resolve their trauma often within one session. Early childhood traumas are often resolved within one session. Nightmares and/or insomnia lessen or disappear. A client who had not driven for four years due to several accidents left the appointment and asked their husband to sit in the passenger seat — she was driving home. Grief images transferred into positive imagery. I have conducted over 900 sessions and a handful have not been successful. Unsuccessful sessions are often related to secondary gains and the client's inability to let go of their pain and suffering.

Where can RCCs learn more?

Learn more at www.ARTworksNOW.com or www.AcceleratedResolutionTherapy.com. Laney Rosenzweig leads a free Zoom intro every 4th Wednesday at 6 p.m. Eastern. Go to the website and sign in on the tab on top of the webpage that says "free intro." Jacqueline Wilson offers training in ART through the ART website.

MORE ABOUT THE INTERVIEWEES

Laney Rosenzweig, MS, LMFT, is a U.S.-based licensed marriage and family therapist who has been in the mental health field since 1989. Laney is the founder and developer of Accelerated Resolution Therapy (ART) and the CEO of Rosenzweig Center for Rapid Recovery (RCRR), which trains clinicians in ART. ART has a treatment protocol that is directive, standardized, and easy to apply using eye movement therapy. Her introduction of voluntary image replacement (VIR), which guides clients to erase negative images from view in their mind, is a unique and powerful way to quickly eliminate triggers and eradicate symptoms.

Laney has travelled the globe training licensed mental health professionals in ART and has over 55 ART trainers. Yale University has also trained clinicians and is in the process of doing a study, as is the Mayo Clinic and the Canadian Military. She has facilitated PESI Continuing Education Seminars and other presentations and is available present to civilian and military groups who are seeking an alternative to longer, less effective treatments for trauma and other mental health problems. Learn more about ART from Laney's Ted-X talk, which you can link to from acceleratedresolutiontherapy.com.

Jacqueline Wilson, CD, MA, MACP, RCC, is a B.C.-based compassionate clinical counsellor who specializes in trauma recovery, supporting individuals affected by PTSD, intergenerational harm, racism, and systemic oppression. With masters in disaster management and counselling psychology — and years of military service that took her to conflict zones such as Haiti, Honduras, Bosnia, and Afghanistan — she brings a deep understanding of trauma and resilience to her work.

Jacqueline currently consults with addiction and healing centres near her home In Cobble Hill, where she provides therapeutic support to first responders, veterans, and marginalized individuals recovering from complex trauma. This includes the layered impact of prolonged exposure to distressing experiences such as systemic discrimination, childhood adversity, occupational trauma, and intergenerational harm. She recognizes how such trauma can profoundly alter one's sense of safety, identity, and connection.

Since being introduced to ART in 2023, Jacqueline has become a passionate advocate of its transformative potential. With clinical precision and empathetic care, she uses ART to help clients reprocess difficult memories, restore emotional equilibrium, and foster resilience. Her lived experience, cultural sensitivity, and unwavering dedication make her a trusted guide on the path to healing and renewed hope.

WORKSHOP SPOTLIGHT

Find these and many other workshops created and recorded especially for BCACC members at https://learn.bcacc.ca/product-category/e-course/.

APPROVED CLINICAL SUPERVISORS: WANT TO SEE THE 7 EYED MODEL OF SUPERVISION IN ACTION?

Join us on October 8, 2025, to move from theory to practice with an opportunity to try out the Seven-Eyed Model yourself. Enhancing Clinical Supervision with Process Models, with a focus on the Seven-Eyed Model is a highly interactive, two-hour session tailored exclusively for Approved Clinical Supervisors.

What the workshop offers:

- Live demonstration with a real supervisory case
- Small-group role plays for direct experience using the model
- Practical strategies to manage complex, emotionally charged supervisory challenges
- Insight into integrating process models

You'll have pre-workshop reading materials and an opportunity to submit your supervisory challenge so you can bring real scenarios to the learning process. You'll actively address real issues like countertransference and parallel process, gaining awareness and tools to handle the personal and interpersonal complexities of supervision. This session moves beyond simply knowing about the Seven-Eyed Model — it is focused on helping you apply it effectively.

About the presenter: David W. Stewart PhD, RCC-ACS has been working as a counsellor in Victoria for over 40 years and has gained a broad understanding of and experience with many diverse counselling and therapy models. Learn more about David at https://www.supervisionservices.ca

ETHICAL DECISION-MAKING IN PRACTICE: AN INTERACTIVE WORKSHOP THAT BRINGS ETHICS TO LIFE

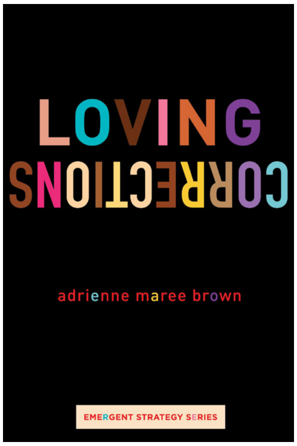
Ethical decision-making is central to our work, but for many, the guidelines and codes learned during graduate studies can fade into the background. This workshop on October 20 is designed to bring those tools back into focus, showing how the BCACC's Code of Ethical Conduct, Standards of Practice, and decision-making guidelines can support you in navigating real-world complexities. You'll join small group discussions, working through a nuanced ethical dilemma with your peers.

- **Active participation:** Step into lively discussions where your voice matters and your perspective shapes the process.
- **Collaborative exploration:** There are no easy answers: this is about navigating grey areas together and building confidence in your ethical process.
- **A fresh take on ethics:** Discover how engaging, and even fun, it can be to tackle ethical dilemmas with curious, like-minded colleagues.

About the presenters: Nina Sheere, MCP, RCC, ACS Candidate, has extensive experience working with concurrent disorders and trauma. In addition to her private practice serving teens, adults, and couples, Nina offers group therapy, consulting services, workshops, and trainings. Heather Scott, MCP, RCC, ACS Candidate, has advanced training in complex trauma, PTSD, and dissociation and engages in individual and group therapy with survivors of complex trauma. Both Nina and Heather teach Ethics in Counselling Psychology at Adler University. Learn more here: www.scottsheere.com

CHECK IT OUT IDEAS TO MOTIVATE AND INSPIRE

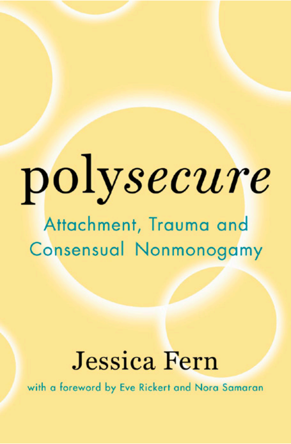
Read



LOVING CORRECTIONS

By Adrienne Maree Brown

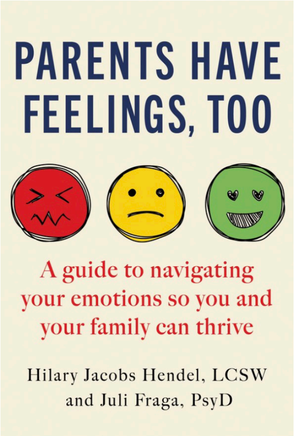
New York Times-bestselling author Adrienne Maree Brown knows we need each other more than ever and offers a practice for holding collective power, righting wrongs, and generating true belonging. These prescient, compassionate essays explore patterns we engage in that are rooted in limited thinking. Through a lens of "loving corrections" rather than mere critique, Brown helps us reimagine how to hold ourselves, our loved ones, and our communities accountable by setting clear boundaries, engaging in reflection, and nurturing honest relationships.



POLYSECURE: ATTACHMENT, TRAUMA AND CONSENSUAL NONMONOGAMY

By Jessica Fern

Attachment theory has entered the mainstream, but most discussions focus on how we can cultivate secure monogamous relationships. What if someone is striving for secure, happy attachments with more than one partner? Polyamorous psychotherapist Jessica Fern breaks new ground by extending attachment theory into the realm of consensual nonmonogamy. Using her nested model of attachment and trauma, she expands our understanding of how emotional experiences can influence our relationships. Then, she sets out six specific strategies to help people move towards secure attachments in multiple relationships.



PARENTS HAVE FEELINGS, TOO: A GUIDE TO NAVIGATING YOUR EMOTIONS SO YOU AND YOUR FAMILY CAN THRIVE

By Hilary Jacobs Hendel & Juli Fraga

In Parents *Have Feelings, Too*, psychotherapists Hilary Jacobs Hendel and Juli Fraga provide the tools parents need to understand and effectively work with their own feelings, breaking the chain of intergenerational trauma and passing along emotional intelligence to their children to create a generation of people with emotional regulation skills. It's an emotions playbook for family wellness.

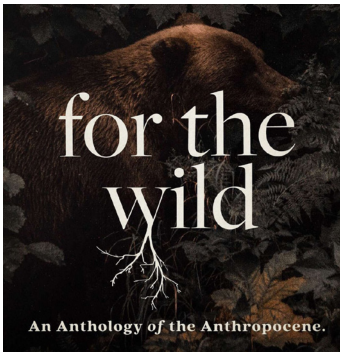
Listen

THE ANXIOUS GENERATION WITH JONATHAN HAIDT

What Now? with Trevor Noah

YouTube

Jonathan Haidt, noted social psychologist and author of *The Anxious Generation*, sits down with Trevor Noah to discuss how smartphones and social media are harming Gen Z — and really all of us. Haidt encourages claiming back third spaces, championing anti-fragility, and … maybe letting your kid go take a walk.



FOR THE WILD: AN ANTHOLOGY OF THE ANTHROPOCENE

forthewild.world/listen

For The Wild is a slow media organization dedicated to land-based protection, co-liberation, and intersectional storytelling. It is rooted in a paradigm shift away from human supremacy, endless growth, and consumerism. Their work highlights impactful stories and deeply felt meaning making as balms for these times.

BCACC Member Benefits

We are over 6,000 members strong and growing every day.
Become an RCC and access unparalleled value and recognition.

BC ACC
BC ASSOCIATION
of CLINICAL COUNSELLORS

The RCC designation is synonymous with professional accountability, labour mobility, and high ethical standards in the counselling profession. BCACC supports RCCs with an array of in-house benefits, such as our Find a Counsellor Tool, Approved Clinical Supervisor Program, member advertising rates, committees, events, professional development, EConnect, #RCCconnect, and cost-savings from our benefit partners.

With an average of 18,000 visitors per month, BCACC's Find a Counsellor search tool can help you connect to clients and grow your practice with ease and simplicity.

Learn more at bcacc.ca/counsellors

Jane

→ A free first month with at no cost.
jane.app

perkopolis

→ : Access over 5,000 exclusive perks, including Samsung, Westjet, Hellofresh, Cineplex, AVIS, and much more.
perkopolis.com

MITCHELL&ABBOTT INSURANCE BROKERS

→ Competitive professional and commercial liability insurance and access to legal advice.
mitchellandabbott.com

PESI®

→ Members enjoy exclusive discounts, up to 90%, on top-tier PESI Canada professional courses and bonus offers throughout the year.
pesicanada.ca

Bell

→ Save up to $1,600 on bring-your-own device and plan and device included offers
bell.ca

the EDGE Benefits™

→ A robust health and dental plan with available add-ons.
edgebenefits.com

ANYTIME FITNESS.

→ 10% off standard monthly dues and 50% off standard enrollment fee when joining Anytime Fitness gym.
Many locations across B.C.
anytimefitness.com

ENVISION
Your Virtual Learning Platform

→ Quality advanced continuing education for mental health clinicians. Get 15% off workshop registrations, excluding EMDR training.
envisionworkshops.com

adracare

→ 10% discount per month with month-to-month contract towards any subscription with a first month free OR 20% discount per month with an annual contract towards any subscription with a first month free.
adracare.com

MNP

→ Discounts on selected services from one of Canada's leading professional accounting services firms. MNP provides client-focused accounting, consulting, tax, and digital services..
mnp.ca

WAYPOINT INSURANCE

→A Mitchell and Abbott partner — preferred rating and custom solutions for residential and auto insurance, including short-term and home-based business
waypoint.ca

HALFMOON

→ 15% off products
shophalfmoon.ca

ODIN BOOKS

→ Exclusive 10% Discount (in-store & online). Access books, sensory tools, games, and resources to support mental health and inclusive education.
odinbooks.com

staples PREFERRED

→ Preferred pricing, dedicated account management, shipping, print, and marketing discounts
staplespreferred.ca/pcam

COAST hotels

→ 10% off the daily hotel rate at Coast Hotels across Canada
coasthotels.com

OXYGEN YOGA & FITNESS

→ 10% discount on the "Oxygen For Life" annual membership
oxygenyogaandfitness.com

B YOGA

→ 15% off products
byoganow.com

→ Get 20% off of the full-priced shoes until Dec 31, 2024.
ca.vessi.com

bcacc.ca/join/rcc

BCACC
BC ASSOCIATION
of CLINICAL COUNSELLORS

Would you like to reach over 10,000 members of BCACC?

Ask us about advertising opportunities.

Insights is a member-driven publication printed four times a year for our 10,000-plus mental health care professionals.

communications@bcacc.ca | T (250) 595-4448 | TF (800) 909-6303 | bcacc.ca