WINTER 2025

INSIGHTS

THE BC ASSOCIATION OF CLINICAL COUNSELLORS' MAGAZINE

When strength and resilience conceal burnout

The messy truth about supervision

ADHD Joy: Beyond the single story

UNMASKING IN SCHOOLS

Supporting neurodivergent students through authentic expression

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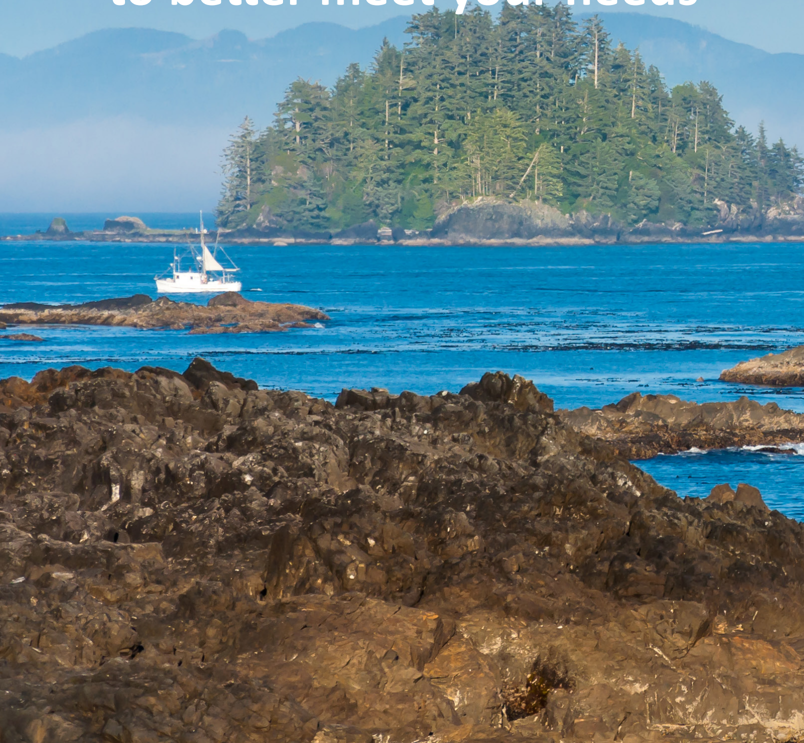
to better meet your needs



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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:

Sherina Chandra, Stacy Finch, Ciara Harte, Kara Ko, Roma Palmer, Kinga Robinson, Elnaz Shariatpanahi, Jennifer Westcott

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.

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AI AND CLINICAL PRACTICE

Ethical Considerations and Implications for Mental Health Professionals

IN THE RAPIDLY evolving landscape of mental health care, the integration of AI presents profound opportunities and significant ethical challenges. AI stands to revolutionize therapeutic services, including psychotherapy/clinical counselling. However, the adoption of AI into therapeutic service provision necessitates careful consideration of ethical principles, regulatory compliance, and professional responsibilities.

To provide clinical counsellors with a framework for integrating AI into their practices, BCACC published *AI and Clinical Practice: Ethical Considerations and Implications for Mental Health Professionals* earlier this year and made it available to download at bcacc.ca/ai-clinical-practice/. The first of their kind in Canada, these guidelines aim to support professionals in leveraging the benefits of AI while addressing ethical, legal, and operational challenges and promoting best practices that align with values of transparency, fairness, accountability, confidentiality, and privacy.

The successful integration of AI into mental health service provision depends upon the collective commitment to ethical practice, ongoing and continuous professional development, and client-centred care.

The new guidelines were authored by Candice Alder, MEd, RCC, an AI ethicist certified in IEEE's CertifAIed ethical assessment method for emerging AI systems, an IEEE Standards Association working group participant, and a research group member with the Centre for AI and Digital Policy. RCCs may know Alder from her BCACC Conference workshop Ethical AI: Navigating the Intersection of Innovation and Responsibility. Her excellent article *Beyond Human Limits*, about AI's potential to transform counselling outcomes, was published in the Spring 2024 issue of *Insights* magazine (bcacc.ca/insights-magazine/).

A NEW SPACE FOR CONNECTION: COMMUNITIES OF PRACTICE

ON DECEMBER 5, BCACC unveiled its refreshed Communities of Practice (CoP) — a dedicated space designed to help RCCs deepen their clinical work through shared dialogue, insight, and connection. Unlike the broad-ranging RCC Connect Facebook group, the CoP offers focused, practice-enhancing conversations centred on clinical themes.

Discussions span best practices, cultural humility, ethical considerations, and emerging research, always within the boundaries of professional confidentiality. Organized into three streams — Practice-Focused, Modality-Focused, and Client/Regional — the CoP invites members to join communities aligned with their expertise and interests.

Access the CoP by logging into the member portal and selecting eConnect → Communities/Discussion Groups.

WHAT IS SELF-CARE, REALLY

BY KARA KO, RCC, AND ROMA PALMER, RCC

ACCORDING TO RESEARCH self-care means different things to different people.[1,2] While the concept of self-care varies for each individual, its importance in maintaining mental and physical well-being cannot be overstated. But what is realistic for each of us to access in order to feel recharged and like we have the bandwidth to do what we need (and want!) to do each day?

Humans require fundamental elements — adequate rest, hydration, nutrition, and physical activity — to function at their best. However, what constitutes "enough" can differ from culture to culture, by geographic location, and individual circumstances. For example, self-care practices in collectivist cultures might focus on family and community connections, whereas individualistic cultures may prioritize personal downtime or hobbies.

In caregiving populations, self-care becomes more complex. A 2024 study by Gonzalo-Ciria et al. found that caregiving responsibilities often lead to a decline in self-care, particularly among women and younger caregivers.[3] This demographic is at increased risk for burnout and physical health issues because of the constant balancing act between caregiving, work, and personal responsibilities.

RECOGNIZING LIMITS

At the core of effective self-care is self-awareness. Knowing one's limits — and respecting them — requires 100 per cent honesty and the ability to reflect.

It means learning to recognize limits and understanding the support systems needed to thrive. For some, this could mean finding respite care, learning about community resources, or setting boundaries with loved ones. For others, it could mean re-evaluating commitments at work or with family or scaling back social obligations. It could involve delegating or outsourcing.

PRACTICAL STRATEGIES

Self-care is also about identifying what genuinely recharges and sustains. This might include creative outlets, spiritual practices, physical movement, or time with loved ones. It should feel realistic and attainable, not like another item on a to-do list. What can realistically be managed or with a slight shift?

Here are some examples of practical self-care strategies:

- Micro-practices: Taking small, manageable steps to integrate self-care into daily life, such as a five-minute breathing exercise or a quick walk around the block versus making a huge lifestyle change right away.
- Boundary-setting: Learning to say no without guilt and prioritizing tasks that align with your values.
- Community care: Leveraging support from friends, family, or professional networks to share burdens and responsibilities.

Self-care is both a personal and universal concept, shaped by individual needs and cultural influences. By understanding what self-care means for each individual and addressing barriers like guilt or societal expectations, a sustainable self-care practice can be created that enhances overall well-being.

Kara Ko, MSc, RCC, has a private practice supporting parents and adults with neurodiversity, learning styles, and interpersonal/cross-cultural relationships. She also helps colleagues build safe, inclusive therapeutic practices. Roma Palmer, MA, RCC, works with youth and adults in her private practice in the areas of anxiety, depression, trauma, and chronic illness. Mindfulness and community are key values that inform her work. Kara and Roma are co-founders of West Coast Counsellor Education, working to empower counselling professionals with effective tools for practice.

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RENEW YOUR MEMBERSHIP FOR 2026

AS THE PROFESSION PREPARES for regulation under a college, maintaining your membership with BCACC is more important than ever. The Association continues to strengthen the profession through educational offerings, affordable insurance, brand visibility, and opportunities for connection. Our advocacy efforts have led to major achievements, including RCCs' inclusion as health-care providers under Veterans Affairs Canada, the elimination of GST from RCC services, and increases to RCC compensation rates within the Crime Victim Assistance Program and ICBC.

With more than 10,000 members, our collective voice holds significant influence among policymakers and mental-health stakeholders.

BCACC is your connection to everything you need to know as clinical counselling/psychotherapy moves toward regulation under a college. We are committed to keeping you informed with timely updates, clarity, and resources to help you prepare for the transition.

Memberships expire on December 31, 2025, and renewals are now open. Renew early to maintain uninterrupted access to benefits and essential regulatory information. Simply log in to your member account and select the "Membership Renewal" tab to complete your renewal quickly and easily.

We look forward to supporting you in 2026 and continuing our work together on behalf of the profession.

REGIONAL ROADSHOW 2026

Implementing Effective Trauma Intervention

BCACC IS BRINGING an important educational event to your backyard in 2026. This highly anticipated, two-day workshop is a deep dive into a single relevant topic with a second day focused on bringing a regional lens to the topic.

Beyond the Wound: Implementing Effective Trauma Interventions with Dr. Carissa Muth, PsyD, RPsych, centres on Dr. Muth's innovative, integrative approach to trauma treatment. She begins by grounding participants in the neuroscience of trauma, highlighting current theories on PTSD and Complex PTSD and how these mechanisms shape symptoms, behaviour, and therapeutic readiness. From there, she addresses trauma assessment and differential diagnosis — often overlooked but critical to determining effective intervention.

Participants will learn to match evidence-based methods to each client rather than relying on a single approach. The workshop concludes with a flexible, staged treatment model integrating narrative therapy, CBT, DBT skills, and positive psychology, offering RCCs a clear, adaptable framework for meaningful change.

About the presenter:
Carissa Muth, PsyD, RPsych (AB & BC) is the clinical director of Sunshine Coast Health Centre and Georgia Strait Women's Centre inpatient mental health treatment facilities. In addition to teaching, training, and supervising counselling students, Dr. Muth designs and oversees program development at SCHC and GSWC. Her previous experience includes more than 10 years in private practice providing formal assessments and treatments to adults and adolescents. She specialized in addictions, depression, anxiety, and trauma. Her research to date has focused on the intersection between attachment theory and addictions, primarily on the role of family relationships in the recovery process. Dr. Muth has presented at conferences across the country, educating professionals on current research and methods for treating complex cases. ■

WHY THIS WORKSHOP IS DIFFERENT — AND ESSENTIAL FOR RCCS

- **Start with the brain:** Learn the neuroscience behind PTSD and Complex PTSD.
- **Assess:** Gain practical tools for trauma assessment and differential diagnosis so you can confidently identify what you're treating.
- **Match the intervention to the person:** Move beyond one-size-fits-all therapy and learn to pair evidence-based methods to specific trauma presentations.
- **Use a staged, integrated model:** Walk away with a flexible treatment roadmap for meaningful, sustained client progress.

For more information please visit →

SAVE THE DATE:

- **KELOWNA:** April 10 and 11, 2026 — Dr. Carissa Muth, PsyD, RPsych
  Day 1: Beyond the Wound: Implementing Effective Trauma Interventions
  Day 2: From Disruption to Dialogue: Strengthening Relationships After Adverse Events
- **VICTORIA:** June 5 and 6, 2026 — Dr. Carissa Muth, PsyD, RPsych
  Day 1: Beyond the Wound: Implementing Effective Trauma Interventions
  Day 2: Beyond the Surface: Understanding the Intersections of Trauma, Adverse Events, and Opioid Harms in BC
- **PRINCE GEORGE:** Sept 18 and 19, 2026 — Dr. Carissa Muth, PsyD, RPsych and Maura Gowans, MSW, RSW
  Day 1: Beyond the Wound: Implementing Effective Trauma Interventions
  Day 2: Through an Indigenous Lens
- **BURNABY:** Oct 2 and 3, 2026 — Dr. Carissa Muth, PsyD, RPsych and Dr. Zuhra Teja, RPsych
  Day 1: Beyond the Wound: Implementing Effective Trauma Interventions
  Day 2: Uprooted but Unbroken: Deepening our Clinical Connection with Displaced Families

ADHD JOY

Moving Beyond the Single Story

BY CIARA HARTE, RCC

I've always been fascinated by stories. Long before I was a therapist, I was a storyteller, if only in the safety of my mind. I spun worlds together with my hands on paper, my mind in the sky, and my focus anywhere but where adults expected it to be. Years later, in my early twenties, I was given an ADHD diagnosis; but before this diagnostic label, I was given a different set of labels by my peers. Sensitive. Forgetful. Awkward. Lazy. The list went on and over the years, I flipped through the files of my stored knowledge to try and understand more about myself — to try and understand the story of this life as told by those observing me.

After years of working with ADHD'ers, I learned I was not alone. It is well documented that ADHD'ers receive substantially increased levels of criticism,[1] with one estimation that by the age of 10, a child with ADHD could receive up to 20,000 corrective or negative comments in school alone.[2] As the years passed, client after client repeated the same stories, authored by their peers, teachers, families, and society as a whole. Following diagnosis, stories once defined by words like sensitive, loud, and lazy quickly were replaced with others — emotional dysregulation, impulsivity, executive dysfunction, amongst others. Doctors, psychiatrists, and other clinicians became the new authors of our stories.

While these stories often define the ADHD experience, the reality is that no story is unbiased, and the prevailing cultural story of ADHD is no exception. It is critical to understand that the vantage point from which stories are told is based on power, and whenever doctors, psychiatrists, and therapists are given a monopoly on the truth of ADHD, our clients are once again robbed of an ability to author their own story.[3]

EMOTIONAL DYSREGULATION

You're so sensitive. You're too much. You cry a lot. You're dramatic. You're kind of intense. The stories ring familiar as clients tell them to me over and over and over again. Sitting across from them, I nod in shared understanding — I've received these labels, too. This experience seems to be repeated in every neurodivergent memoir or experiential account I've ever come across. In her book, self-advocate Marian Shembari writes: "Unlike the princess and the pea, our sensitivities are seen not as a sign of sophistication but as a burden to the people around us. We're ignored, punished, or teased when we speak up, so we eventually learn to endure our pain, turning the abuse on ourselves. I must be weak, we think. I must be broken."[4]

The medical model weaves the threads of these social labels into psychological jargon. "ADHD is a disorder of self-regulation," writes the Centre for ADHD Awareness Canada (CADDAC) in bolded text. "People with ADHD become frustrated, overwhelmed, and angry more easily; they are also less able to express these emotions in acceptable ways. They are often more irritable and moody."[5] Even experts seem to agree. Dr. Russell Barkley, a

clinical neuropsychologist who focused his career on ADHD, says "ADHD is not a mood disorder. It's a failure-to-regulate mood disorder."[6]

I try to find myself and my clients in words like disorder of self-regulation. I think of the members of the ADHD support group I co-facilitate, who told us that after particularly emotional sessions, they meet outside for a group hug before leaving — the person being hugged in the middle depends on who feels they need it the most that night. I think of the thoughtful space they hold for each other while witnessing the spectrum of each other's humanity. Or of the participants who've told us how their sensitive sensory systems light up with joy listening to their favourite song on repeat, again and again. The music brings a sensory joy that is hard to describe in words, but collectively we've tried: it's like a treat you could take a bite out of. Tangible and real. A sensory pleasure. A gift.

Sensitive can be a loaded word for us. It is a label with roots often deeply embedded in our histories; and yet, we remind our group participants that sensitive does not mean bad. "If we were talking about a metal detector, sensitive would be good. Or a bomb-sniffing dog. You want a good instrument to be sensitive. Why is it bad to be very skilled at sniffing out the emotional bombs in the environment?" asks Dr. Devon Price, an autistic psychologist and self-advocate.[7] "Sensitivity, despite being a sign of attentiveness and discernment, is frowned upon when you're good at detecting things people would rather you not see."[8]

Unlike the princess and the pea, our sensitivities are seen not as a sign of sophistication but as a burden to the people around us.

IMPULSE CONTROL

"I'm sorry I'm rambling" is one of the most uttered phrases in my office. "Sorry, I got really excited there, did I interrupt you?" is another. "Sorry, I didn't mean to cut you off." Always sorry. Loud. Annoying. Weird. Bossy. Selfish. Distracted. The stories add up like a shameful pile of dirty laundry tucked in a corner, followed quickly by the need to apologize for the mess. The DSM might throw impulsive on top of the pile like a dirty sock.

"Some people with ADHD may make decisions overly quickly or act rashly. They may have difficulty waiting, interrupt others, and make spontaneous decisions," explains CADDAC.[9] HealthLinkBC adds that impulsivity in ADHD is highly likely and can include engaging in "reckless, risky, or antisocial activities without thinking about the consequences."[10] Impulsive people can be impatient and have temper outbursts, they say, and ADHD'ers are often impulsive.

As I take in this pile of dirty laundry, I can't help but notice it's not the full story. My mind drifts, again, to my clients and my groups. How when we are together the conversation bounces around the room, building in a crescendo of ideas and harmonizing voices. How laughter erupts like a volcano in a room full of ADHD'ers who aren't afraid to take up space. The way we randomly burst into song or take breaks to joyously stim. How we self-manage turn-taking without shame or apology for the unique way we speak.

The way we do things is different, and being different can be a beautiful thing. Disability advocate Micha Frazer-Carroll explains how impulsivity shapes her creativity: "Being neurodivergent, I'm quite chaotic when I create, jumping back and forth between different areas and sections… when collaging, it's a strength to bring together seemingly unrelated images to form new narratives." She goes on to say that navigating the medical and pathology model of understanding the world flattens us by expecting a "formulaic package of a legible story," but that the freedom of our creativity offers a new way of understanding ourselves and the world.[11]

In our group, we introduce the concept of a "weaver" communication style. This concept was introduced on the blog Neuroclastic.com and highlights how some of us take the scenic route in our communication, complete with analogies, tangents, and side context.

While these communicators may be distractable or described as talkative, they are effusive storytellers.[12] Impulsive or not, I believe the speed with which our minds move is fascinating. Our storytelling seems to depart from the regimented structure of a traditional narrative arc, moving instead through fragments, layers, and context: as a result, we carve out space for multiple viewpoints and a more complex reality.[13] When given the accommodation and safety to be who we are, ADHD'ers are dreamers.

THE DANGER OF A SINGLE STORY

No matter the story, whether authored by ourselves, peers, family, or professionals, it is undeniable that the details we include matter. One of my professors in graduate school, Jacqueline, stressed the importance of asking questions and listening as if there are other stories to be told. She reiterated to us that what we shine a light on, we will find, and to be aware of the power we hold as therapists in shaping narratives.

The problem with labels like emotional dysregulation and impulsivity is not that they are inaccurate but that they are incomplete: like a map of a coastline that tells us nothing of a beach, the smell of the breeze, the feeling of sand passing through our fingers.[14, 15] The picture of ADHD is so often painted in one way, even by name alone: hyperactive, inattentive, deficit, disorder.

It is not my intention to share the story of ADHD with rose-coloured glasses, to diminish the struggles or make light of suffering. My hope has only ever been to widen the lens through which we view it. In exclusively seeking stories of pain, suffering, and impairment, that is all we will ever see and we cannot act upon what we cannot see.[16]

If the prevailing stories that are told about ADHD depend on power and privilege, it is our job as therapists to always listen as if there are other stories to be told. Sensitive and impulsive, sure, and also the creativity of our resistance, the wisdom in our survival, the depth and darkness of our humour, the joy of an active sensory system. All these stories are there in your clients, just waiting to be told. ■

Ciara Harte, RCC, is a counsellor and co-founder of Unmasking YYJ, providing ADHD group therapy and advocacy. She is passionate about intersectional care, the healing power of storytelling, and community building.

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UNMASKING IN SCHOOLS

Supporting Neurodivergent Students Through Authentic Expression

BY STACY FINCH, RCC

Sarah, a grade 7 student, sits perfectly still during morning announcements, hands folded, eyes forward. Her teacher sees a model student, a pleasure to teach. What they don't see is Sarah's exhausting internal monologue: Don't stim. Don't fidget. Remember to nod at the right moments. Why is everyone laughing? I should laugh, too. By lunch, Sarah is mentally drained from performing neurotypically, and by evening, she melts down at home where it's finally safe to be herself.

This is masking: the daily performance many neurodivergent students feel compelled to maintain in schools. Each morning begins with donning what one 15-year-old student called, "my second skin," suppressing natural ways of moving, speaking, or reacting to blend into neurotypical environments.

For RCCs, understanding masking isn't just about recognizing behaviour; it's about seeing the profound courage and exhaustion behind a child's attempt to belong. Masking involves hiding authentic self-expression to avoid stigma, bullying, or punishment. While it can serve as survival, research increasingly shows devastating costs.

Neurodivergent girls report higher camouflaging rates than boys, placing them at heightened risk for anxiety and depression.[1] Students describe emotional distress, school avoidance, and self-harm linked to school stress.[2] These effects persist into higher education, where diversity rhetoric often masks ableist practices.[3]

As RCCs, we're uniquely positioned to support individual students while challenging systems that make masking feel necessary for survival.

UNDERSTANDING MASKING: WHAT IT REALLY LOOKS LIKE

Marcus, an autistic grade 4 student, absolutely lights up talking about trains. At home, he shares fascinating facts about locomotives and their history, the physics behind how they work, and he can tell you exactly which train lines run

through every major North American city. His enthusiasm is infectious when he talks about his passion.

At school, however, Marcus learned through painful experience that talking about trains makes other kids walk away or worse, mock him for being "obsessed." Teachers redirect him towards "more appropriate" topics. He forces himself to ask about hockey, a sport he finds boring and overwhelming, because that's what gets him tentatively included in playground conversations. He practises looking interested, nodding at the right moments, even though inside he's thinking about train schedules.

This isn't simply fitting in. Masking involves suppressing natural neurological expression. It includes hiding stimming behaviours that provide regulation, forcing uncomfortable eye contact, copying peers' interactions without understanding meaning, or avoiding special interests that bring joy.[4]

Radulski distinguishes between masking, concealing visible traits, and camouflaging, which includes broader assimilation to neurotypical norms.[5] These distinctions matter because they reflect both internal processes and external performances students navigate daily. McKinney et al. identify three interconnected components:[6]

- Masking: Suppressing neurodivergent traits to appear neurotypical. One student described this as "putting my real self in a box and sitting on the lid all day."
- Compensation: Developing workarounds for social challenges. Students rehearse scripts for conversations, practice facial expressions, or imitate gestures they don't understand.
- Assimilation: Adopting others' behaviours and interests at the expense of authentic identity. This intensifies during adolescence when belonging feels critical.

These strategies evolve over time. Elementary students rely on compliance and copying. By secondary school, many students engage in exhausting self-

monitoring that can lead to identity confusion. Schools often become environments where neurodivergent students learn to survive rather than thrive.[7] "I learned in grade 3 that stimming got me in trouble," shared Maya, now an adult reflecting in therapy. "The teacher would stop lessons to ask me to put my hands still. Everyone stared. I learned it was safer to dig my nails into my palms under my desk. At least that pain was invisible."

This illustrates a crucial truth: masking isn't choice, it's survival. When authentic expression meets discipline or rejection, masking becomes necessary. Students learn that stimming might be discouraged, communication differences misunderstood, and emotional expression labelled disruptive. Schools can inadvertently create cultures valuing compliance over authenticity. Behavioural IEP goals emphasizing "appropriate" behaviour, quiet hands policies, and eye contact expectations send messages about acceptable ways of being. Students mask for varied reasons: safety from bullying, adult approval, or compliance with expectations.

THE INTERSECTIONAL REALITY

Aisha, a Somali Canadian student, navigates multiple expectations. She masks her ADHD traits while code-switching between languages and cultural norms. At school, she suppresses natural movement, moderates her voice to avoid stereotypes, and monitors emotional expression. These intersecting pressures create layered masking, a complex performance that leaves students estranged from their identity.[8]

Girls often report higher camouflaging rates, but Pearson and Rose caution against framing masking as simply a female presentation.[9] Instead, masking reflects social exclusion and trauma that begins when children learn authenticity carries risk.

Masking intensifies for students with multiple marginalized identities. A transgender autistic student masks both neurodivergent traits and gender expression. A Black ADHD student manages racial stereotyping and neurotypical expectations simultaneously. These create compounded masking with exponentially higher costs.[10,11]

Jordan, a Black autistic teenager, learned early that his natural enthusiasm was often misinterpreted as "aggressive" while his need for movement was viewed as "defiant" or "disruptive."

Students mask for varied reasons: safety from bullying, adult approval, or compliance with expectations.

He developed elaborate strategies to appear calm and compliant, even when overwhelmed by sensory input or social demands. Jordan learned to keep his voice monotone, his body perfectly still, and his face neutral, essentially becoming invisible to avoid negative attention. By high school, Jordan was experiencing daily panic attacks but was afraid to seek help, because asking for support might confirm the negative stereotypes he'd spent years trying to avoid.

IMMEDIATE AND LONG-TERM IMPACT

The costs extend far beyond exhaustion. Sustained masking links to chronic anxiety, depression, and "autistic burnout," profound exhaustion from trait suppression.[12] School environments can worsen these challenges. Fielding et al. found students experiencing school distress reported attendance difficulties, self-harm, and persistent emotional struggles.[13] These students feel misunderstood by systems meant to support them.

Jamie, age 16, described: "It's like having two full-time jobs, being a student and being normal. By home time, I have nothing left. I can't even decide what I want for dinner because I've used all my energy pretending to be someone else." Masking consumes mental energy otherwise available for learning and connection. Students monitoring behaviour constantly have reduced capacity for academics or authentic relationships. Identity development suffers; students become uncertain about genuine preferences, delaying self-formation into adulthood. "I spent so long pretending to like what friends liked that I don't know what I actually enjoy," shared one adult client. "I feel like I'm meeting myself for the first time at 35."

THE RIPPLE EFFECTS

Effects persist into adulthood. Adults who masked extensively report workplace burnout, relationship difficulties, and fractured identity. Long-term suppression hinders self-advocacy and fulfillment.[14] Emma, now in her late twenties, was the "perfect student" throughout school. She never caused trouble, always followed rules, excelled academically, and received glowing report cards. Teachers loved her because she was quiet, compliant, and seemed to need no support. What no one saw was her nightly meltdowns at home, her growing anxiety about social situations, her constant mental exhaustion from monitoring every facial expression and body movement, and her increasing

disconnection from her own thoughts and feelings. Years later in therapy, Emma described feeling like "a ghost in my own life, present in every classroom and social situation but never really there, never really me."

THE RCC'S ROLE: CREATING SAFE SPACES

RCCs create unique therapeutic spaces where students can safely unmask. In schools, this includes confidential counselling where students explore authentic selves and peer groups connecting neurodivergent students with similar experiences. To truly build rapport and gain trust, while also understanding a child or youth's lived reality, authenticity check-ins are key. Including questions such as "How much of yourself did you get to be today? What parts stayed hidden?" validate students' complex experiences and the cognitive and emotional labour of masking.

COLLABORATION AND SYSTEMS CHANGE

Effective support requires collaboration with educational teams. Recognizing distress signs is critical: attendance changes, emotional volatility, withdrawal from activities, and unexplained physical symptoms can all be signals.[15] Understanding these through a masking lens enables appropriate responses addressing root causes. RCCs can advise on classroom strategies to reduce masking pressure such as flexible participation, sensory accommodations, and trauma-informed approaches recognizing masking as environmental response rather than defiance. RCCs can also advocate for policy changes, IEP modifications, and institutional practices reducing conformity pressure while promoting neurodivergent acceptance.

PRACTICAL NEUROAFFIRMING STRATEGIES

❋ **In Schools:** Create reliable safe spaces where students can step away from overwhelming situations without penalties. Establish "safe adult" lists so students know which staff they can approach authentically. This requires training multiple staff who understand neurodivergence and respond supportively.

Integrate neurodiversity education into classroom discussions, normalizing differences through diverse books, visuals representing neurotypes, and activities modelling various communication styles.

For students experiencing distress, implement flexibility around attendance, routines, and schedules, providing crucial regulation space.[16]

❋ **Therapeutic Approaches:** Working with children requires coordination between school and community RCCs

5 PRACTICAL STRATEGIES FOR RCCS

1. **Invite the student to map safe spaces and people.**
   Co-create a "safe adult list" and "safe place" in school where the student feels comfortable unmasking. Let them lead this process to preserve agency.
2. **Implement brief mask breaks or sensory pauses.**
   Suggest to schools that students might step out (with permission) when feeling overwhelmed: quiet corners, sensory tools, or short breaks outside class.
3. **Use narrative check-ins.**
   In counselling, ask clients: What do you genuinely like? What feels "you" vs. what feels like you put that on for others? Helps in reclaiming authentic preferences.
4. **Advocate for student clients or as parent advocates.**
   RCCs can support student/parent clients by attending IEP meetings, writing letters, or partnering with teachers to ensure systems are aware of masking pressures.
5. **Embed intersectional sensitivity and cultural responsiveness.**
   Ensure race, gender, sexuality, and culture are part of the conversation when exploring masking. Strategy fits but adaptation matters (e.g., respecting cultural norms, understanding layered identities).

ensuring consistent support. Help students differentiate between chosen masking, strategic navigation feeling empowering, versus imposed masking in unsafe environments.

For adults understanding lifelong patterns, focus on "archaeological work," excavating authentic preferences from years of performance. Narrative approaches help separate genuine identity from masking-shaped personas.

❋ **Systemic Change:** Supporting unmasking requires addressing environmental factors making masking necessary. Critically examine behavioural IEP goals, advocate for trauma-informed practices, and promote policies reducing conformity pressure.

Consider cultural responsiveness, recognizing how intersecting identities shape masking experiences.[17] For LGBTQ+ autistic youth facing high victimization rates, targeted interventions, including mentorship, peer advocacy, and anti-discrimination training, become essential.[18]

❋ **Supporting Families and Adults:** With families, RCCs provide neurodivergence education, affirming parenting strategies, and advocacy guidance for creating environments where children can express themselves safely. In private practice, RCCs support adults reclaiming suppressed identity aspects. This involves identity reconstruction, burnout recovery, and learning authentic navigation while maintaining necessary connections.

ETHICAL CONSIDERATIONS

❋ **Balancing Authenticity and Safety:** Supporting unmasking requires careful navigation. Not all environments are safe for complete authenticity. Some students may increase vulnerability by revealing themselves fully.

Unmasking should be student-led, respecting autonomy while providing guidance about consequences and safety strategies.[19] This requires assessing environmental safety, building self-advocacy skills, and working systemically toward safer spaces.

❋ **Understanding Privilege:** Students' experiences are shaped by intersecting identities: gender, race, sexuality, socioeconomic status. Privilege determines who can safely unmask and when. Students with strong support or progressive schools may have safer opportunities than peers without these protections.

RCCs can acknowledge these realities while expanding safe spaces for all students, recognizing masking as a response to systemic pressures rather than individual choice.

❋ **Clinical Recognition:** RCCs can recognize subtle camouflaging appearing as quiet compliance or perfect behaviour. Conversely, disruptive behaviours sometimes serve as coping strategies for overwhelming environments. Ethical practice requires interpreting behaviours through systemic understanding rather than deficit models.

A VISION FOR CHANGE

Picture classrooms where stimming is understood as self-regulation, special interests celebrated as expertise, different communication styles valued, and students can request breaks without penalties. This isn't utopian, it's necessary transformation towards environments where neurodivergent students thrive rather than survive.

As RCCs, we're positioned to lead

this change. Combining individual support with systemic advocacy creates environments where students don't choose between belonging and authenticity.[20] This requires ongoing learning about masking's drivers, implementing intersectionality-responsive strategies, and recognizing authenticity support as systemic imperative. Research shows identity-congruent support and peer mentorship serve as protective factors during transitions,[21] while gaps persist between inclusive rhetoric and lived experience even in higher education.[22]

Sustained masking links to chronic anxiety, depression, and "autistic burnout," profound exhaustion from trait suppression.

Working with schools, we can establish "masking breaks," designated times and spaces when students can regulate in sensory-friendly environments without academic penalty. We can advocate for neurodiversity clubs where students connect authentically with peers who understand their experiences. We can train staff to recognize signs of masking fatigue — the glazed look, the sudden behavioural changes, the physical exhaustion — and respond supportively rather than punitively.

In our therapeutic work, we hold space for the profound grief that often comes with recognizing years of suppressed authenticity. We celebrate seemingly small but significant moments of unmasking; when a client first stims freely in our office, shares a passionate special interest without apology, or admits they actually hate something they've pretended to enjoy for years. We help families understand that their "easy" child might be working incredibly hard behind the scenes to appear that way.

In neurodivergent-affirming practice, authenticity isn't a risk; it's a fundamental right. Students deserve environments where they can learn and grow without exhausting daily performance. As RCCs, we hold power to make this reality through individual counselling, family support, professional education, and systemic advocacy. We can create lasting change, allowing neurodivergent students to bring their authentic selves to their educational journey... and thrive.

The path requires challenging assumptions about normalcy while advocating for environments honouring neurological diversity as natural variation. Most importantly, it requires centring neurodivergent voices as we work towards futures where masking becomes choice rather than survival necessity and authentic belonging becomes the norm. When we get this right, we don't change individual lives — we transform entire school cultures. We create ripple effects that benefit all students, not just neurodivergent ones. We model what true inclusion looks like: not just tolerating difference but celebrating it as essential to our shared humanity. ■

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BEHIND THE FAÇADE

When strength and resilience conceal burnout

BY SHERINA CHANDRA, RCC

They were the one everyone relied on — calm in crisis, steady under pressure. Life had taught them early that falling apart wasn't an option; strength was survival. Over time, resilience became their identity — the quiet composure others admired. But what began as strength slowly turned into expectation. They barely noticed when their coffee turned cold or their laughter felt practised. The world saw resilience; beneath it, exhaustion quietly took root...

Their story is not unique.

In life, most people will experience trauma or adversity — sometimes in small doses, sometimes at overwhelming extremes. These experiences shape mental health and influence many parts of one's identity and way of living. In response, people learn to adapt, overcome, and improvise. They spring back, finding ways to grow rather than falter in the face of hardship and begin to move through daily life with a deep sense of empowerment and inner strength.

> Resilience has shifted from an admirable quality to an expectation in today's world.

THE POWER OF RESILIENCE AND STRENGTH

According to researchers Steven Southwick and Dennie Charney, resilience is "the ability to weather and recover from adversity."[1] In other words, it's to bend without breaking. Similarly, the American Psychological Association identifies resilience as "the process of adapting well in the face of adversity, trauma, tragedy, threats, or significant sources of stress."[2] Psychologically, resilience refers to how many people can maintain their mental health — or experience only temporary struggles — even when faced with significant emotional or physical challenges.[3] In positive psychology, resilience is a protective factor supporting emotional balance and personal growth. It helps people develop adaptive coping strategies, manage stress more effectively, and sustain a sense of optimism and hope, even when life feels overwhelming.[4]

At its core, resilience reflects persistence, resourcefulness, and hope — traits we often associate with strength and mental toughness. However, resilience has shifted from an admirable quality to an expectation in today's world. People are often praised for "staying strong" or "pushing through," rarely considering the personal cost of doing so.

UNDERSTANDING ADAPTIVE RESILIENCE AND TOXIC RESILIENCE

True resilience allows space for rest, reflection, and support, and adaptive or positive resilience is defined as the ability to maintain or regain well-being despite significant adversity, often leading to personal growth or "resilient reintegration."[5] This process reflects recovery and strengthening one's inner resources, wisdom, and sense of purpose through challenge and disruption. However, strength is equated with stoicism and productivity in many professional and cultural contexts. People may internalize the belief that vulnerability is a weakness, leading them to maintain an image of strength long after their energy and emotional resources are depleted.

Toxic resilience refers to an unhealthy form of persistence in which employees continue performing under extreme stress, burnout, and dissatisfaction rather than seeking help or setting limits. While resilience is generally viewed as a strength, in high-pressure work cultures, it can become counterproductive, leading to emotional exhaustion, declining performance, and poor well-being. In *Worrying Workplace Trend: Toxic Resilience*, Ibrahim Yikilmaz emphasizes that this toxic version of resilience emerges when individuals believe their worth depends on enduring hardship without complaint, ultimately harming

employee health and organizational sustainability.[6]

Resilience helps people recover from hardship and strengthens their sense of purpose, confidence, and connection with others — key elements of long-term well-being. When resilience becomes rigid, it no longer protects — it conceals. Individuals may appear calm and competent while inwardly struggling with fatigue, irritability, or self-doubt. This marks the beginning of burnout hidden behind the mask of strength.

THE SHADOW SIDE OF STRENGTH: WHEN RESILIENCE MASKS BURNOUT

At this point, once a source of empowerment, resilience begins to turn against the individual. When the expectation to stay strong becomes constant, individuals may begin to suppress vulnerability and push beyond their limits. When resilience is defined as returning to a previous level of functioning, it can encourage individuals to sustain unmanageable workloads or emotional suppression rather than change course. Over time, this "stuck" resilience can reinforce exhaustion and burnout.[7] In these moments, resilience shifts from an adaptive process to a performance — a mask that hides distress rather than reflects genuine well-being. What once protected becomes concealing, leading to burnout disguised as composure and quiet exhaustion behind the façade of capability.

Growing research shows that resilience does not always protect people from burnout — sometimes it can hide it. In *The Dark Side of Resilience and Burnout: A Moderation-Mediation Model*, authors describe a "dark side" of resilience, where people keep going under heavy stress and push through exhaustion instead of noticing it.[8] In their study of ambulance workers, certain personality traits like diligence, boldness, and perfectionism combined with resilience to keep people performing well, even as burnout quietly developed underneath. In these cases, resilience helped them appear calm and capable while running on empty inside. This finding reveals a vital paradox: resilience can help people cope but also delay awareness of their fatigue. When being strong becomes an expectation rather than a support, resilience can shift from protecting a person to silently contributing to burnout.

THE HIDDEN SIGNS OF BURNOUT

Burnout has long been recognized as a psychological syndrome that develops as a response to chronic emotional and interpersonal stressors.[9] It is characterized by three interrelated dimensions: emotional exhaustion, depersonalization or cynicism, and a diminished sense of personal accomplishment. In 1974, Herbert Freudenberger and John York were among the first to describe burnout as "the high cost of high achievement," observing that it most often affects those passionate, dedicated, and driven by purpose.[10]

> The symptoms of burnout often remain unnoticed or are misinterpreted as everyday stress.

The symptoms of burnout often remain unnoticed or are misinterpreted as everyday stress. Physically, people may experience ongoing fatigue, disrupted sleep, headaches, and tension.[11] Cognitively, burnout contributes to forgetfulness, poor concentration, and what some describe as "mental fog."[12] Emotionally, it can manifest as irritability, anxiety, sadness, or emotional numbness.[13] Behaviourally, burnout leads to withdrawal, reduced empathy, and neglect of self-care routines.[14]

Individuals who pride themselves on being resilient are often the same people at risk of burnout. They overextend themselves, believing they can handle anything, and suppress early warning signs such as fatigue or irritability. As Freudenberger and York noted, these individuals "put a great deal of themselves into their work," feeling pressure from within and others to continually give more.[15] In 2021, Christina Maslach and Michael P. Leiter expanded on this, describing burnout not as personal weakness but as a mismatch between one's energy, values, and environment.[16] Over time, this imbalance drains vitality, even as individuals appear outwardly composed.

Because these symptoms develop

gradually, they are often considered temporary or unavoidable. People who wear resilience as a mask may tell themselves, "I just need to push through this busy time," without realizing they are already beyond their capacity. The ability to appear in control becomes part of the problem — it hides the distress from others and oneself.

WHO IS MOST AT RISK

Personality factors further contribute to this risk. High-achievers, perfectionists, and those with low self-efficacy or high self-criticism are more prone to burnout.[17] Such individuals often hold themselves to impossible standards and see rest as indulgent. Structural and cultural pressures amplify these tendencies, including organizational overwork, systemic inequities, and societal ideals of productivity. In many settings, resilience is celebrated while rest or vulnerability is discouraged, making the mask of strength even more challenging to remove.

Burnout spans across demographics — women managing family and home demands, Gen Z and millennials striving under constant pressure to achieve, those with Type A or perfectionistic traits, and individuals in demanding professions. Research suggests that burnout disproportionately affects individuals in helping and service-oriented professions such as education, health care, and social services.[18, 19] People in these fields invest emotionally in their work and derive meaning from caring for others. The same empathy and responsibility that make them effective also make them vulnerable to depletion.

Burnout is highly prevalent among health care professionals, with significant emotional exhaustion reported across multiple roles. In a U.S. national survey of 5,445 physicians, doctors scored significantly higher in resilience than the general workforce. However, burnout remained widespread — even among the most resilient physicians — showing that resilience alone cannot offset the impact of systemic stressors in health care. The study highlights the need for broader organizational and structural changes to reduce burnout and improve physician well-being effectively.[20]

In the 2022 National Health Service workforce survey in the U.K., 34 per cent of staff reported feeling burned out and 37 per cent found their work emotionally exhausting, with particularly high rates among ambulance workers. Studies indicate that up to 72 per cent of physicians and 51 per cent of nurses experience emotional exhaustion, reflecting the intense psychological toll of health care work as staff often push through demanding conditions without sufficient recovery.[21]

Research among Canadian paramedics found that higher resilience was linked to fewer symptoms of mental disorders. Nevertheless, other studies, such as the R2MR program with Calgary police officers, showed no lasting improvement in well-being.[22] This suggests that when resilience becomes an expectation rather than a support, it can push individuals to endure chronic stress instead of addressing it. Over time, this persistent endurance can evolve into burnout, where strength and perseverance begin to work against the individual.[23]

Although higher resilience is generally linked to positive outcomes, research suggests that excessive resilience can lead to maladaptive behaviours in occupational settings and overused strengths may become weaknesses, meaning individuals can sometimes be "too resilient" for their own benefit.[24]

True resilience involves awareness, rest, and connection, not just endurance.

THE COST OF CONCEALING BURNOUT

When burnout remains hidden, the consequences are far-reaching. Prolonged exhaustion erodes empathy, creativity, and motivation, leading to emotional detachment and cynicism.[25] Physical health deteriorates as stress impacts the immune system and contributes to chronic conditions.[26] Psychologically, individuals experience a loss of purpose and meaning, questioning their competence and value.

The longer resilience is used to cover distress, the more disconnection it creates — from one's body, emotions, and relationships. Over time, the mask of strength becomes isolating. What once symbolized pride and perseverance becomes a barrier to genuine connection and healing.

HOW REGISTERED CLINICAL COUNSELLORS CAN SUPPORT CLIENTS BEHIND THE MASK

RCCs are uniquely positioned to help clients recognize when resilience has become overextended. Many high-functioning, self-reliant individuals maintain composure even as emotional fatigue builds, making their distress difficult to detect. Counsellors can attune to subtle cues such as discrepancies between words and affect, persistent tiredness, or guilt about resting.

As Daniel C. McFarland and Fay Hlubocky note, burnout often develops gradually in people who continue to perform despite exhaustion, using resilience as a form of self-protection.[27] By gently exploring these patterns, counsellors can help clients understand that true resilience includes balance, rest, and vulnerability. Integrating mindfulness and compassion-focused approaches can further support clients in restoring authenticity and reconnecting with their values and sense of purpose.

RCCs can help by gently exploring beliefs about strength and self-worth, distinguishing between authentic resilience (adaptive recovery) and performative resilience (image maintenance). Psychoeducation about burnout can normalize experiences and reduce shame.[28, 29, 30]

Lastly, compassion-focused therapy (CFT), alongside approaches such as mindfulness-based stress reduction and narrative therapy, provides a structured framework for helping clients reconnect with their emotional and physical limits.

Some clients may appear highly resilient, consistently taking on extra responsibilities and pushing through fatigue, but this outward strength can mask hidden burnout driven by an overactive threat system.[31] In these cases, resilience is not purely adaptive; it reflects threat-based reliance, where clients overperform to avoid perceived threats such as failure, judgment, or rejection. They suppress vulnerability and ignore personal limits, maintaining the appearance of competence while internally experiencing chronic stress and self-criticism.[32] RCCs can use CFT to help clients recognize these patterns

and activate the soothing system through practices such as self-soothing, compassionate imagery, and mindfulness. For example, an RCC might guide a client through a compassionate imagery exercise, where the client visualizes a supportive figure offering understanding and kindness, helping them internalize self-compassion and reduce threat-driven coping.[33]

By cultivating self-compassion and a compassionate self-identity, clients can acknowledge their hidden burnout, regulate emotions more effectively, and develop sustainable resilience.[34] Counsellors can support this process by encouraging clients to set boundaries, re-evaluate perfectionistic standards, and integrate rest as a resilience strategy, which helps prevent relapse and promotes long-term well-being. Modelling balance, authenticity, and self-compassion in their practice allows RCCs to demonstrate that true resilience includes vulnerability, rest, and self-care. When clients feel permission to unmask, they can rebuild a sustainable sense of strength grounded in self-compassion rather than mere endurance, fostering emotional balance and authentic resilience.

REDEFINING STRENGTH

Unmasking resilience does not mean abandoning it — it means redefining what strength truly is. True resilience involves awareness, rest, and connection, not just endurance. It invites people to acknowledge limits and care for themselves as part of their ongoing capacity to care for others.

Continuing with the client story from the beginning of this article… through sessions with their RCC, they began pausing to savour a warm cup of coffee and letting their laughter be spontaneous rather than performed. They realized that the resilience they had relied on to push through burnout could coexist with self-compassion and care, and that true strength was sustaining both themselves and their capacity to show up for their work and others. ■

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DON'T GO IT ALONE

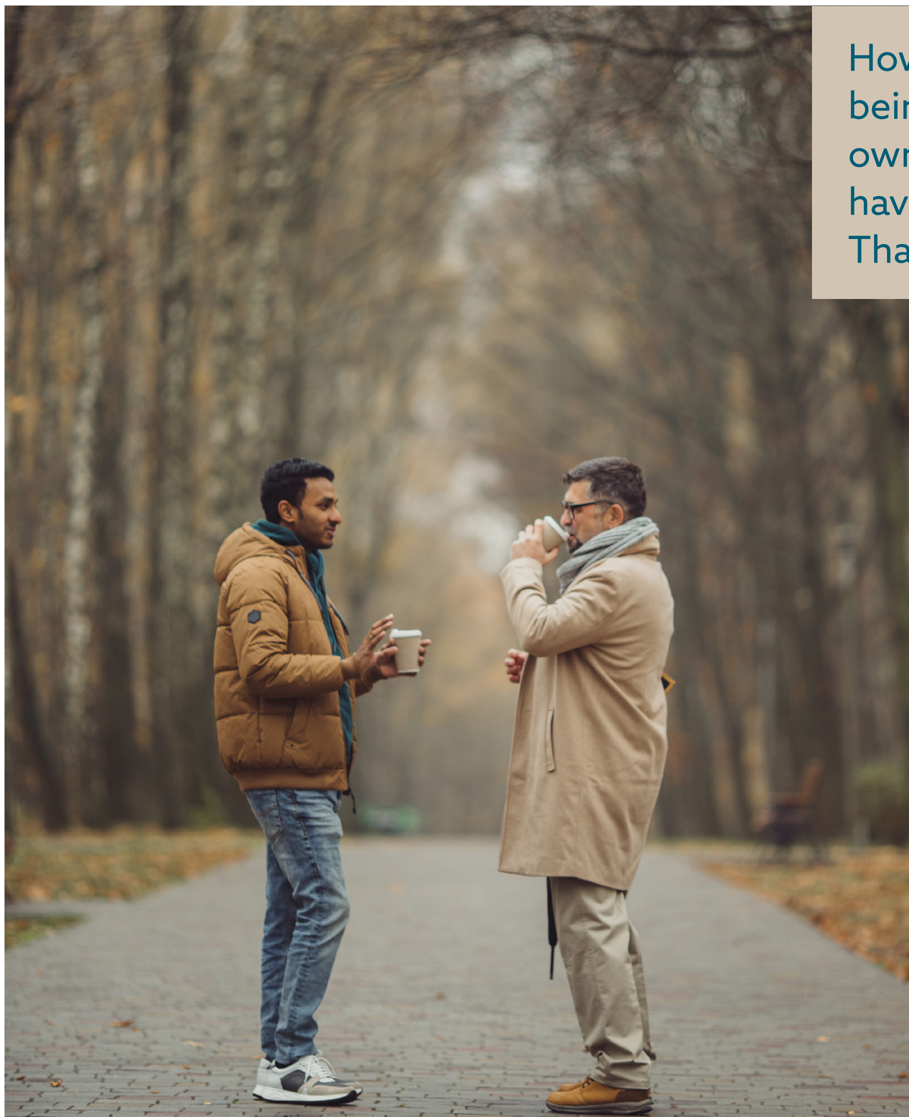
The messy truth about supervision and why I believe in it

BY JENNIFER WESTCOTT, RCC-ACS

When I look back on my career, there is one thread that runs through every chapter: supervision. It has been my anchor and my frustration. My lifeline and my puzzle. It has lifted me up, and at times, made me question everything.

From my very first training sessions to my work now, supervision has never been simple. It has been debated, defined, and redefined. Some days it felt like a gift. Other days it felt like a burden. Yet no matter how I experienced it, supervision kept showing up. I remember being a new therapist, unsure of myself, and clinging to supervision like oxygen. Later, I remember being the one in the supervisor's chair, realizing the weight of holding someone else's uncertainty. It was confusing then. It is still confusing now.

And yet, after more than 25 years, I can say this with certainty: supervision is one of the most important and most misunderstood parts of our work. It is messy. It is inconsistent. It asks us to sit in discomfort. But it is also the very thing that has allowed me to keep going when I wanted to stop.



How safe can people feel being vulnerable about their own struggles if they fear you have the power to fire them? That tension haunted me.

A PATCHWORK OF SUPERVISION STYLES

It was confusing from the start. Each teacher I trained under spoke passionately about their model as if it were the only true way. Every model seemed to contradict the others.

My first training was with a trauma therapist who insisted that supervision should never include administrative responsibility. If you were in charge of hiring and firing, then it wasn't "true" supervision.

Not long after, another teacher told me the exact opposite. If you weren't the hiring or firing type, then it wasn't supervision at all — it was consultation. So, there I was, fresh and eager and completely confused. Every supervision role I embodied included some element of administrative responsibility. Did that mean I wasn't really doing supervision? Or worse, that I was doing it wrong? And yet, I understood what my first teacher meant. How safe can people feel being vulnerable about their own struggles if they fear you have the power to fire them? That tension haunted me.

My next training was focused on healing the healer. We sat in circles on the floor, processed our emotions, and witnessed each other's raw material. It was beautiful. I felt connected, seen, and even healed at times. But I still left wondering what to do with my clients in the next session.

Then I tried to emulate formal supervisors I had admired. These sessions felt like exams. I came armed with carefully considered questions, rehearsed so they would sound just right. Competent enough to show I knew what I was doing, but humble enough to let the supervisor shine. The supervisor handed down their answers. It was hierarchical. They knew more than I did. I usually left feeling inadequate, worried about imposter syndrome, and unsure how to integrate their advice into my own style.

Later, I trained in art therapy supervision. That was deeply meaningful, too. The creative exercises unlocked insights words couldn't. But even that wasn't the whole picture.

I realized that each approach held a piece of the puzzle. None alone was enough. And maybe there isn't one "whole thing."

THE SHOCK OF STEPPING OUT OF UNIVERSITY

One of the most vulnerable stages of being a therapist is the very beginning. I still remember the mix of pride and panic when I walked out of grad school with my degree. My shelves were lined with textbooks. My notes were filled with models and theories. My head was bursting with acronyms like CBT, DBT, and EFT. But then came the real clients.

Nothing prepared me for the silence in the room after someone shared their deepest pain. Textbooks don't teach you what to do when a client bursts into tears before you even say hello. They don't prepare you for the way trauma lingers in the air. They don't explain the weight of being the first person someone has ever trusted. No manual shows what it feels like to carry stories home at the end of the day.

Fresh out of university, supervision becomes essential. New therapists often think they're supposed to have all the answers. In truth, the work isn't about answers. It is about being present. It is about listening deeply. It is about trusting the process even when it feels messy and uncertain.

I've supervised many new graduates. I see the same wide-eyed panic I once had. They ask: Am I doing this right? What if I make it worse? How do I know when to push and when to sit in silence? The surprises never stop coming. Clients don't follow scripts. Sessions rarely look like roleplays in training. And that is okay. Supervision, mentorship, and community help bridge the gap. They remind us that stumbling is part of learning. They remind us that therapy isn't about perfection. The most powerful lesson for me has been this: clients don't need textbook-perfect interventions. They need us. Human. Flawed. Caring. Willing to sit with them in the unknown.

THE GOOD, THE BAD, AND THE DEEPLY PERSONAL

Over the years, I've had supervision that saved me and supervision that made me question everything. The good supervision was like oxygen. It kept me in the field when I wanted to quit.

I'll never forget David, a supervisor who truly saw me. One day I shared that I had a conflict with a colleague. He gently said, "I've noticed you seem okay to conflict with women, but you rarely speak up with men. What do you think that's about?"

That one question hooked me. It showed me how supervision could weave together my work with clients and my own history.

And then there was the supervision that didn't fit for me. The kind that made me secretly look forward to my supervisor's vacation so I could breathe again. I remember being told I had to present cases succinctly and always know the precise question I wanted answered. That assumed I already knew what I needed, which I often did not. Those sessions chipped away at my confidence until I dreaded them.

WHAT EVEN IS SUPERVISION?

Explaining supervision outside of the therapy world is its own challenge. When friends ask, I usually say, "It's like supervision but more. It includes the therapist as a person, because our personhood is the main tool we use." That line is almost always met with blank stares.

When therapists ask, I often say, "Supervision can feel personal because it is. We are the tool. Our history, our wounds, our strengths, they show up in the room. So, getting feedback on that can feel very personal."

Even as I say it, I sometimes wonder: am I overthinking this?

> The most powerful lesson for me has been this: clients don't need textbook-perfect interventions. They need us. Human. Flawed. Caring.

MY OWN MISSTEPS

As a supervisor, I've made mistakes. I've avoided performance issues because I valued safety and vulnerability. I didn't know how to balance accountability with compassion. Could I hold both at once? In those moments, I felt like I was failing. It required a maturity I feared I might never have.

Working in a large mental health clinic reassured me somewhat. I listened to other supervisors debate what supervision actually is. They struggled, too. Performance, personal material, client needs, safety, how do you hold all of it together? No one had the answer.

My mom used to say, "If there was one answer, there would be one book, and we'd all have it." That phrase has become my compass. Supervision doesn't come with one book. That realization gave me permission to find my own way.

THE "SHOULDS" THAT NEVER END

Supervision has often felt like a dark room filled with "shoulds." With some supervisees, our sessions never even touched on clients. With others, we started with a case question and ended up in childhood memories. Meanwhile, in my head, a little voice whispered: Is this helpful? Is this what supervision is supposed to be?

Part of me envied colleagues who ran EMDR or DBT consult groups. Their boundaries were clear. Their scope defined. Meanwhile, I floated among therapists practising many modalities, some I wasn't even trained in.

Maybe supervision isn't about the "shoulds." Maybe it's about what I believe. About what I've seen help.

THE UNHELPFUL MESSAGES

Supervision can be powerful, but it can also wound. Over the years, I've received and even spoken messages that left me feeling small, confused, or alone. These were not said with malice. Often, they came from overworked supervisors trying to do their best. But they still shaped how I saw myself as a therapist. Over the years, I've been under-supervised, cancelled on, and left to figure things out alone. Along the way, I've heard, and sometimes said, some very unhelpful things:

"If you don't hear from me, it means you're doing well."

"Just tell me what you need, and I'll provide it."

"Do we really need to meet every week?"

"Don't you have consult groups for this?"

"I'll let you know if I think you need help."

"Keep personal stuff out. That's for EFAP, not supervision."

"Didn't we cover this last time?"

"I'm not a therapist, but I can still supervise your cases."

Looking back, I cringe at how normal these messages once felt. They created an environment where silence was mistaken for safety, where needing help looked like weakness, and where the human side of therapy was often brushed aside. The truth is these messages didn't make me stronger — they made me question myself more deeply.

Supervision should never leave us feeling like we are alone in the work. It should remind us that we are held, supported, and human.

Supervision should never leave us feeling like we are alone in the work. It should remind us that we are held, supported, and human.

WHAT I ASPIRE TO

After years of both giving and receiving supervision, I've come to believe that the best supervision doesn't come from rules or rigid models. It comes from relationship. From trust. From love.

Here's what I hope to embody as a supervisor:

- ✦ Supervision is first and foremost a trust-based relationship. Safety comes before cognition.
- ✦ Therapists deserve to be witnessed. They sit in pain every day. They need space to unload and be held.
- ✦ Supervision is a right, not a privilege. It should be prioritized not cancelled.
- ✦ Supervision is needed at every developmental stage not just for beginners.
- ✦ Supervision serves two purposes equally: support the client and support the therapist. One cannot exist without the other.
- ✦ Well-supported therapists do better therapy. That includes processing their own material.
- ✦ Supervision is co-created. It adapts to the supervisee's needs, session by session.
- ✦ When supervisees leave, I want them to feel capable, competent, and more in love with who they are. Not a clone of me.
- ✦ Fear is part of the job. For supervisors and supervisees alike. Growth requires it.

These are not goals I meet perfectly. They are guideposts. When I fall short, they bring me back to what matters.

At its best, supervision is not about fixing therapists — it is about reminding them of their humanity. When we feel safe, witnessed, and trusted, we become more capable of creating that same safety for our clients. That is the supervision I hope to give, and the supervision I believe our profession deserves.

WHY COMMUNITY MATTERS IN A CLOSED-DOOR PROFESSION

One of the hardest realities about being a therapist is how isolating it can be. Unlike other professions, much of our work happens behind closed doors. We hold people's deepest stories, but we do it in silence. We carry the weight,

yet we rarely share it in real time with colleagues.

That silence can be dangerous. It breeds self-doubt, burnout, and loneliness. It can make us question whether we are good enough, or whether anyone else struggles the way we do. Community softens that weight. When therapists gather, whether in supervision, peer consultation, or spaces like Therapist Sanctuary, something shifts. We realize our inner voices are not unique. Our imposter syndrome is not a solitary burden. The fears we hold are mirrored by others.

In my experience, the simple act of being witnessed by another therapist is healing. Not because they fix it, but because they nod and say, "me too." That moment of shared humanity lightens the load.

This is why I believe community is not optional in therapy. It is essential. If we want to sustain this work, we need to hold one another. To laugh, to cry, to vent, and to wonder out loud together. Without community, the risk of burnout rises. With community, the possibility of thriving returns. ■

Jennifer Westcott, MA, RCC-ACS, is a clinical supervisor, clinical hypnotherapist, and artist. She provides online, telephone, and in-person counselling from her Cranbrook-based practice, Holistic Healing Counselling. She also provides consultation and supervision to therapists.

WHY I BUILT THERAPIST SANCTUARY

In 2022 I burned out. Fully. Three months off. I built myself a little reading nook in my supply closet with a rocking chair and candles, and I asked myself: if I love this work so much, why am I so bottomed out?

The answer was supervision. Or rather, the lack of supervision that nourished me. So, I created Therapist Sanctuary. A space where therapists could be cared for the way they deserve with practical tools and modelled interventions; honest conversations about our inner worlds not just techniques; community, laughter, tears, and the messy middle; and client voices reminding us of what really helps. A sanctuary, by definition, is a place of refuge. That's what I needed, and that's what I hope this can be for others, too.

Because in the end, supervision is messy. It's uncertain. And it's also the thing that keeps us in the work when we want to run. I still don't have one perfect model to offer. What I have is love for therapists, a belief in their strength and humanity, and a deep conviction that they deserve spaces where they can be vulnerable, messy, and still belong.

If that sounds like what you've been missing, you're not alone. You can find out more at therapistsanctuary.com.

A QUIET CRISIS

Women in Trades and Mental Health

BY ELNAZ SHARIATPANAHI, RCC

As an RCC, I have had the honour of working closely with tradeswomen and listened to stories, stories that highlight a quiet crisis, one marked by strength, silence, and survival.

Making up only about five per cent of the on-site trades workforce in Canada,[1] women in skilled trades often navigate their workspaces in isolation and are frequently exposed to environments that are not built for their inclusion, physically, culturally, or emotionally. This isolation contributes to a host of mental health challenges, including anxiety, depression, substance use, and trauma-related symptoms.

But these women should not have to navigate these systems alone. Mental health professionals can and must be part of the solution.

THE LANDSCAPE OF TRADES: GENDER DISPARITY AND MENTAL HEALTH RISKS

In Canada and across much of the world, the trades remain heavily male-dominated. Women entering these fields are often pioneers, trailblazers who must continuously prove themselves in order to be accepted.

According to Galarneau, Durand-Moreau, and Cherry in their 2024 article "Reported harassment and mental ill-health in a Canadian prospective cohort of women and men in welding and electrical trades," women in trades are significantly more likely than their male counterparts to experience harassment, discrimination, and job insecurity.[2] This gender-based mistreatment does not happen in isolation. It is often coupled with physical safety concerns, a lack of adequate facilities (such as restrooms or changing rooms), and limited access to properly fitted personal protective equipment (PPE).[3]

WOMEN ARE NEEDED IN THE TRADES

According to *Douglas* magazine, as British Columbia's growing population needs more housing and commercial buildings, the province also needs more skilled trades — and that means more women working in the trades.

"In fact, the BC Construction Association predicts that 6,000 construction jobs will be unfilled by 2032, due to labour shortages and retirements. 'We need everyone on deck,' says Rory Kulmala, CEO at the Vancouver Island Construction Association. 'We need women to work in the industry. We need skilled trades.'"

To accommodate that demand, a number of organizations and businesses in B.C. are working to attract, train, and retain women in the skilled trades with the aim of changing the culture and making workplaces more inclusive.

Source: Moneo, S. (2023). Power Tools. Douglas magazine, August/September 2023. https://www.douglasmagazine.com/power-tools/

Women may also face intense pressure to outperform in order to "prove" their worth. One of my clients told me during a session: "I cannot afford to be average. If I show weakness, they think I do not belong."

This constant demand to exceed expectations comes at a cost. Long shifts of 10 to 12 hours combined with physical strain and emotional isolation create perfect conditions for burnout and psychological distress.

CLIENT REFLECTIONS: THE HUMAN COST OF ISOLATION AND HARASSMENT

Therapy rooms are often the first spaces where tradeswomen feel safe enough to tell the truth. Several of my clients have described working in toxic environments where harassment is normalized and speaking out is punished.

One client shared: "I was the only woman on site. When they made comments, I just swallowed it. It did not feel safe to speak."

Another client was transferred after standing up for a colleague: "I did the right thing, but it cost me. I lost the only person who had my back, and now I feel like a target."

These women are not alone. The Centre for Innovation in Campus Mental Health highlights that such experiences often lead to depression, anxiety, and in some cases, post-traumatic stress disorder (PTSD).[4] The emotional toll is further compounded by a lack of mentorship, few female colleagues, and a prevailing "toughness" culture that discourages vulnerability.

SUBSTANCE USE: COPING MECHANISM OR SURVIVAL STRATEGY?

For some tradeswomen, emotional suppression becomes a survival strategy. In an effort to get through the day and deal with trauma, many turn to substances. In my clinical work, I have observed increased use of alcohol, cannabis, and stimulants among this population not for recreation but for emotional management.

One client stated: "It is easier to drink after work than to sit with everything that happened. I do not have the energy to process it."

According to RE-MIND, this coping strategy is not uncommon.[5] The lack of mental health support in trades coupled with stigma leads many women to self-medicate rather than seek professional help. These patterns, when unaddressed, can evolve into long-term substance use disorders and more severe psychological harm.

BARRIERS TO SEEKING MENTAL HEALTH SUPPORT

Despite the need, many tradeswomen hesitate to access mental health services. Several factors contribute to this:

1. Stigma around mental health in the trades sector
2. Lack of gender-specific services
3. Scheduling barriers due to shift work
4. Distrust of professionals who may not understand the trades environment

One client told me: "I tried talking to someone before, but they did not get it. I felt judged, like I was too angry or too emotional." This quote underscores a vital truth: tradeswomen need practitioners who understand their

world, who validate their experiences without asking them to shrink, simplify, or sanitize their pain.

HOW RCCS CAN SUPPORT TRADESWOMEN FACING THESE CHALLENGES

As RCCs, we are in a unique position to support, validate, and advocate for tradeswomen. Here are several ways we can make a meaningful difference:

→ **Create a Trauma-Informed and Nonjudgmental Space**
Tradeswomen often carry layers of trauma, some related to gender-based violence, others from workplace accidents or chronic emotional suppression. A trauma-informed approach means listening without pathologizing, validating their pain, and helping them reconnect to their resilience.

→ **Normalize Emotional Expression**
In a work culture that often equates emotional openness with weakness, many tradeswomen have internalized the message that they must suppress feelings. As RCCs, we can model emotional acceptance and offer language that helps clients express what they may have long buried.

→ **Understand Their Work Context**
Be curious and ask questions to explore the nature of their work: the hours, the environment, the people. This shows respect and allows us to tailor interventions to their lived experience. It also helps to understand trade-specific stressors, including certification exams, physical exhaustion, or on-site politics.

→ **Support with Substance Use Without Shame**
When clients use substances to cope, our goal is not to moralize but to understand the function of the behaviour. Many clients feel ashamed before they even walk into the room. Helping them explore their substance use with curiosity and with no judgment can lead to healthier, sustainable coping tools.

→ **Promote Connection and Peer Support**
Tradeswomen often feel alone. Encourage clients to connect with others in their field, such as through women's trade associations, unions, or mentorship programs. Peer connection can break cycles of shame and self-doubt.

→ **Advocate Beyond the Therapy Room**
Where appropriate, we can advocate systemic changes, from employer education to community programming. We must use our voices not just for healing but for prevention and equity.

Tradeswomen need practitioners who understand their world, who validate their experiences without asking them to shrink, simplify, or sanitize their pain.

A SHIFT TOWARD RESILIENCE AND EMPOWERMENT

Despite the challenges, tradeswomen show immense resilience. Several clients have begun redefining what strength means not as stoicism, but as the ability to speak up, seek help, and protect their well-being.

One client recently shared: "For the first time, I am not trying to prove anything. I am just trying to take care of myself." This is the heart of our work as RCCs — not to fix, but to walk alongside clients as they reclaim their agency and rebuild their lives on their own terms.

Tradeswomen deserve more than endurance. They deserve recognition, support, and mental health care that sees them fully. As RCCs, our role is not only to treat symptoms but to challenge systems, cultivate trust, and empower women to live with strength that is sustainable, not self-sacrificing.

To fellow RCCs: Let us continue learning. Let us listen deeply. Let us show up in ways that honour both the wounds and the wisdom our clients carry. Together, we can create a future where tradeswomen are not just surviving, but where they are thriving. ■

Elnaz Shariatpanahi is an RCC working in the areas of substance use, trauma, and mental health, particularly with individuals in the construction industry, both Red Seal workers and apprentices. Her practice focuses on creating trauma-informed spaces where tradespeople can heal, express emotion safely, and reclaim resilience through connection and empowerment.

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KINDNESS, COMPASSION, AND CURIOSITY

Relating to all parts in a person's system with Internal Family Systems

AN INTERVIEW WITH KINGA ROBINSON, RCC

Internal Family Systems (IFS) was developed by Richard C. Schwartz through his work with clients. Schwartz was a family systems therapist who noticed, while working with a client, that they reported hearing "parts" and "voices" that were arguing in their mind. When Schwartz pressed the client to notice these voices, the client was able to distinguish one part/voice from another, which resulted in them feeling less overwhelmed.

Through curiosity and exploration, Schwartz discovered that these parts had wants, fears, beliefs, and distinct views of the world, and more so, they had polarizations and alliances with other parts within an individual's system. In addition to parts, Schwartz discovered there was also a "Self" — an innate indestructible core of wisdom, compassion, and calm within every person — and that a respectful relationship between the parts and the Self, in which the Self was established as a benevolent leader within the system, could result in the experience of having balance within a person's system in a way that allows a person to move through challenging experiences more smoothly and with more compassion and kindness towards themselves.

Schwartz began to use family systems therapy on the internal system of a person, as opposed to focusing on their external world (e.g., their physical family or relationships) and discovered this was helpful for his clients. This initial exploration was the foundational framework upon which the IFS model was built. Since the 1980s, IFS has grown by leaps and bounds.

"The original intent of IFS is to support clients to become Self-led, which means that their parts feel loved by the Self and trust the Self's leadership. This relationship with the Self can bring a great measure of inner peace along with the ability to relate to life's challenges and to other people with clarity, calm, confidence, courage, and compassion."[1]

This intent continues to be the primary focus of an IFS therapist's work with their clients.

How did you come across IFS?
I came across IFS through reading the book *The Body Keeps the Score* by Bessel Van Der Kolk, which led me towards reading *Introduction to the Internal Family*

Systems Model by Richard Schwartz, which was lent to me by a fellow therapist. After reading this book, I was hooked. I quickly and deeply fell in love with the IFS model because it related to all parts in a person's system with kindness and compassion and curiosity. It was not a model that spoke for pushing against what showed up in one's system or about getting over/past/rid of difficult or challenging experiences. Rather, it was a model for leaning in and being curious with whatever part shows up, getting to understand it more fully, and trusting that it and all the other parts in the system are doing the very best that they can, in the only way they know how, in full support of that person.

Also, I loved the concept that there is a Self in each of us that is all knowing, indestructible, compassionate, calm, wise, and caring as this concept anchored the spiritual beliefs I have always carried. This way of seeing the world brings peace, calm, and hopefulness to my system in a way like few other things.

Did you know right away that you wanted to learn more?

True to the IFS lens, I would say parts of me did know right way that I wanted to learn more and take a deep dive into IFS as fast as possible, while other parts of me wanted to slow down and allow space and time for the model to integrate into my system. As it turned out, the six-month mandatory break between being able to register for another IFS training and the lottery system of being accepted into a training allowed for both needs to be met within my system. I was granted time between each training experience to process and integrate the model and do deep dives during the training and through the peer support and consultation groups. It was a beautiful balance that worked out as I feel it was meant to.

What was that training like for Level 1?

I decided to take the Level 1 IFS training after I talked with an IFS therapist and they walked me through the various options. At the time, I was not sure about wanting to go beyond the Level 1 but I wanted to pursue training that would allow me to continue to grow in the model and would allow certification, should that become an interest in the future. It took me three attempts to be selected for the Level 1 training, as it ran on a lottery system.

The cohort I was in was led by Paul Ginter (lead trainer) and Madeleine Warren (assistant trainer) and a handful of amazing program assistants. The training was unlike any other training I had ever been in. It was both didactic and experiential in nature and allowed for ample practice of the model in small groups where we were all in the role of the client, observer, and a therapist (with a program assistant). The container in which the training was held was safe, supportive, encouraging, culturally diverse, and very respectful of every trainee's uniqueness and level of knowledge about the model. I felt seen, heard, and validated and learned a great deal about the exceptionality of the model through the open, respectful, kind, and caring training approach. Level 1 training was a healing experience for me. It felt like I had landed in the place I was meant to be and was practising a model that supported the healing of others in a respectful, compassionate way. It was an absolute gift.

> **The Level 1 training was a healing experience for me. It felt like I had finally landed in the place I was meant to be.**

Were you able to use Level 1 training with clients right away?

I was able to implement the model with clients right away through utilizing parts language and by inviting clients to consider trying something new that might initially come off as different in its approach. I found that clients were often willing, kind, and open to the idea and played along with the experiential practices we attempted in our sessions. They were surprised by the outcome and learning that was gained through suspending their "analytical part" and leaning in to what naturally and automatically emerged from their systems. I asked clients to trust the inner voice they heard in their minds and what they noticed it saying, then to follow whatever thread emerged with curiosity, openness, and kindness.

To a great degree, IFS therapy is an experiential practice that is hard to put into words. To the analytical parts of us, perhaps, it lands as "woo woo," but the felt experience and the internal shift that this therapeutic approach can foster is undeniable.

Were IFS Levels 2 and 3 a natural progression?

Because the Level 1 training was so internally powerful for me, I decided to take things slow and practised the model as consistently as I could to make certain that it did not lose its momentum within me, or in my work with clients, before I committed to a Level 2 training. Getting accepted to a Level 2 training took more time than it did to get into a Level 1 training — the lottery system of the trainings at the time was a real challenge

LEARN MORE ABOUT INTERNAL FAMILY SYSTEMS

Find information about the IFS model and gain access to training and additional learning and educational resources at these two websites:

- Internal Family Systems Institute (https://ifs-institute.com/)
- Internal Family Systems Counselling Association (https://ifsca.ca/)

— but the training itself was equally as impactful and settling for my system as my Level 1 training.

After my Level 2 experience, going for a Level 3 training was a no brainer — I was in and fully committed. When the opportunity for a Level 3 training arose, I took it. Every one of my IFS trainings to date have been a true gift to my soul. It was not only the success with my clients that inspired my ongoing training but it was also my confidence in the model and who I had become. Once one sees the world in a way that lands with them as who they are as a human, they cannot unsee it.

Which client concerns do you most commonly use IFS?

I use IFS to support clients with understanding their internal experiences better, be this an experience of anxiety, stress, depression, overwhelm, exhaustion, care-taking depletion, grief and loss, negative self-talk, or addictive/hyper-focused processes.

Are there any circumstances where IFS should NOT be used?

I will give answering this a try in a way that makes sense to my parts. For a more accurate answer to this question and not just my personal experience, please refer to journal articles or other reputable resources for information.

I believe that the IFS model casts a wide net of what concerns and circumstances it can support, but it does come down to the education, experience, and comfort of the practitioner applying the model and the demographic of clients they are choosing to work with.

I also believe that clients interested in short-term solution-focused therapy or a therapeutic approach that is primarily focused on providing psychoeducation may benefit less from the model due to the experiential element attached to this model. Establishing a safe container in the therapy session where parts of the client feel safe to engage in the IFS process may take time, and even then, it could take time to build the trust of the protectors in the client's system to allow access to the exiles and then to support the exiles to unburden. Not to say that this cannot happen fast in some systems, but it can take time in other systems. It all depends on the uniqueness of each person's individual system.

Is IFS a standalone modality or can it be used with other counselling techniques?

Though it can be executed as a singular modality, IFS therapists often have training in multiple modalities. For example, a trauma therapist may have training in EMDR, somatic experiencing, and IFS. I have training in emotion focused therapy, Gottman therapy, and IFS. IFS offers a lens through which to understand one's own internal system and the systems of others, so it lends itself well to working in conjunction with other models.

Where can RCCs learn more about IFS? Is supervision available?

If therapists are interested in exploring the IFS model, I would direct them to the Internal Family Systems Institute and to Internal Family Systems Counselling Association websites (see left). Books I recommend are *Introduction to the Internal Family Systems Model* by Richard Schwartz, *Internal Family Systems Therapy* (second edition) by Richard Schwartz and Martha Sweezy, *Somatic Internal Family Systems Therapy* by Susan McConnell, and *Transcending Trauma* by Frank G Anderson.

Supervision is available for IFS in Canada, the USA, and in various countries around the world. It is important to make sure the supervisor is qualified to provide the service the therapist is seeking and be vigilant about where and through what organization the supervisor received their training, as well as the years of experience they have working with the model and what they can offer you as a learning therapist (e.g., group supervision, individual supervision, credentials that qualify them to sign off on supervision hours that would be required for certification, etc.). All of these details can matter as supervision is an important personal and professional investment. ■

Kinga Robinson, RCC, started work in the mental health field as a youth counsellor at a youth recovery program. From there, she has worked in a variety of areas, including with women in a second stage recovery program, as an aftercare worker, as a transitions/program support counsellor at an adult treatment facility, and with families/individuals/couples referred through Child and Youth Mental Health and then by Child Protection through the Ministry of Child and Family Development. She now works solely in private practice.

REFERENCES

1. Schwartz, R, & Sweezy, M. (2020). *Internal Family Systems Therapy*, 2nd edition. Guildford Publications. p. 23.

RECORD KEEPING COURSE

Meeting a true need amongst our practitioners

When BCACC asks RCCs what they most want to learn about, record keeping comes up one of the most consistent training requests. This brand new course is our response to that request.

Course content has been built from the Ontario Association of Mental Health Professional's (OAMHP) existing curriculum and expanded with B.C.-specific content from experienced RCCs, who share the real complexities they face in record keeping. Each key topic includes video discussions that speak directly to ethical and legal expectations in B.C. The course has been designed to help practitioners feel informed, organized, and confident in managing client records responsibly.

TALKING ABOUT SEX WITH COUPLES

Presented by Suzanne Lasenza

Couple counsellors interested in bolstering their skills and any counsellor wishing to enter this field won't want to miss this lively, insightful workshop designed to equip counsellors to speak comfortably and therapeutically about sexual intimacy with clients.

Presenter Suzanne Iasenza is a practising psychologist and ASSECT Certified Sex Therapist who specializes in and writes on topics such as human sexuality, sex therapy for individuals and couples, and sexual orientation and gender identity. She teaches at the Ackerman Institute for the Family, Adelphi University's Derner Institute Postgraduate Program in Psychoanalysis, the Westchester Center for the Study of Psychoanalysis and Psychotherapy, the Family Institute of Westchester, and the Institute of Contemporary Psychotherapy in New York City, where she co-founded the Sex Therapy Training Program.

Workshop attendees will leave with wealth of valuable perspectives and tangible tools to support couples navigating complex relational dynamics.

ECONNECT: COURSES YOU CAN TAKE ANYTIME

BCACC's eConnect features a growing collection of engaging self-paced courses — all developed with counsellors' professional growth in mind. Best of all, you can sign up and take them anytime you wish and at your own pace. Just few current titles include:

- Elevate Your Practice: Understanding Eating Disorders
- Working with Refugee Clients
- Families, Family Breakdown and the Law (2-day recording)
- How to Set Up a Private Practice
- Building a Group Practice
- Working with Cultural Diversity in the Therapeutic Setting
- Transforming Problematic Caregiver Patterns
- Working with Parents in High-Conflict Divorce
- Staying Objective in Couples Counselling
- Unlocking the Power of Narrative Therapy
- Basic Group-Facilitation Skills

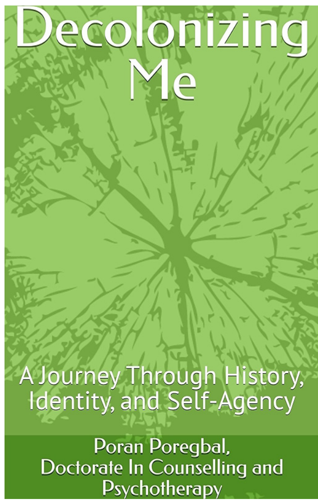
Find the full eConnect catalogue at learn.bcacc.ca/product-category/e-course/. ■

COMING SOON: CONFERENCE RECORDINGS ON ECONNECT

We are very pleased to announce that BCACC members will soon be able to purchase and stream select sessions from our conferences. It is a great opportunity to revisit powerful keynotes and presentations at your own pace.

Stay tuned for the release announcement in your MindFull newsletter and eConnect updates.

Read

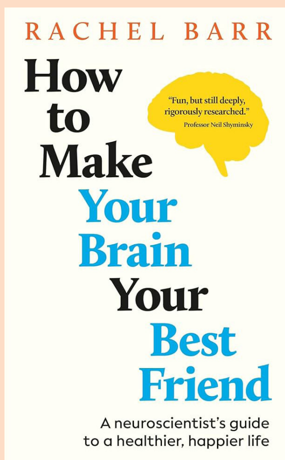


DECOLONIZING ME: A JOURNEY THROUGH HISTORY, IDENTITY, AND SELF-AGENCY

By Poran Poregbal, MA, RSW, RCC

In an era of global upheaval, where people are questioning inherited ideologies, structures, and traditions, the call to reclaim oneself is more urgent than ever. The process of decolonization, both personal and collective, requires that we break the silence, confront the distortions, and stand in the whole truth of who we are.

Decolonizing Me is a personal and psychological journey that reflects author Poran Poregbal's life's work on identity, trauma, and the lived experiences of Iranian people, particularly women. The narratives are woven from the threads of her lived experiences and her struggles echo through the lives of many racialized and marginalized individuals who grapple with the duality of visibility and erasure. *Decolonizing Me* invites readers to consider how we might all reclaim agency by telling our own stories, loudly, unapologetically, and without needing permission.



MAKE YOUR BRAIN YOUR BEST FRIEND: A NEUROSCIENTIST'S GUIDE TO A HEALTHIER, HAPPIER LIFE

By Rachel Barr

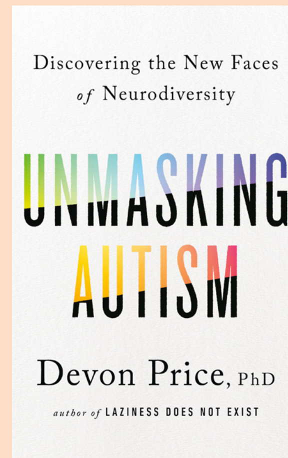
Your brain is the most remarkable thing in the known universe. Always trying to mend itself and protect you, it's in a constant state of flux — adapting, reconfiguring, finding new pathways — and it has an astonishing capacity for recovery. In *Make Your Brain Your Best Friend*, Quebec-based neuroscientist Rachel Barr shows us that because of the brain's near-infinite potential for neuroplastic change, it's never too late to carve out neural pathways to form new habits, new skills, and new ways of thinking. Whether you want to understand your brain from a neuroscience perspective or take refuge in a book that's like a warm hug for your mind, this is a delight-filled, evidence-based read.

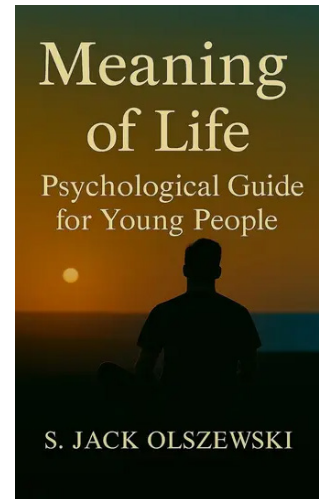
UNMASKING AUTISM: DISCOVERING THE NEW FACES OF NEURODIVERSITY

By Devon Price, PhD

In *Unmasking Autism*, Devon Price blends history, social science research, prescriptions, and personal profiles to tell a story of neurodivergence that is usually dominated by those on the outside looking in. Price lays the groundwork for unmasking and offers exercises that encourage self-expression, including celebrating special interests, cultivating Autistic relationships, reframing Autistic stereotypes, and rediscovering values.

This widely acclaimed book is a deep dive into the spectrum of Autistic experience and the phenomenon of masked Autism and provides individuals with the tools to safely uncover their true selves while broadening society's narrow understanding of neurodiversity.





MEANING OF LIFE: PSYCHOLOGICAL GUIDE FOR YOUNG PEOPLE

By Jack Olszewski, PhD, RCC

Meaning of Life: Psychological Guide for Young People is not a manual — it's a companion. It walks with the reader through self-discovery, emotional resilience, and authentic living. Each chapter explores key aspects of the human experience: identity, relationships, values, passions, and mental health.

Grounded in psychological insight, the guide speaks with empathy and hope. It acknowledges loneliness, change, and the quiet strength of gratitude and mindfulness. It offers tools and reflections to help young people thrive — not just survive. Above all, it affirms that meaning is found in everyday choices, relationships, passions, and courage. To every young person asking, "Why am I here?"— this book is for you. Your questions matter. Your life is worth exploring.

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L to R: Kevin McMullen, Mary Klovance, Shelly Dean, |Meg Kapil, Constance Lynn Hummel, Dr. Elder Roberta Price, David Stewart, Evangeline Willms Thiessen, Sarah Fraser (CRPO), Jane Goranson Coleman, David Hutton, Kathy Lauriente, Christopher Leckman

Back row: Marcy McCabe, Director of PR & Advocacy, Candice Alder, BCACC Board President, Michael Radano, CEO

Missing: Allan Wade, Janet White, Rhett-Lawson Mohajer

BCACC 2025 Award Winners

BCACC honoured our 2025 Award Winners at an evening event held Friday, September 19, 2025, in Vancouver. These 16 individuals were celebrated for their contributions to the Association, their communities, and their outstanding work in mental health.

✦ **Distinguished Lifetime Contributions to the Profession Award**

Allan Wade, PhD, RCC, CM

✦ **Humanitarian Award**

Dr. David Hutton

✦ **Honorary Membership Award**

Dr. Elder Roberta Price

✦ **BCACC Impact Award for Mental Health Organization**

College of Registered Psychotherapists of Ontario

✦ **Clinical Supervisors Award**

David Stewart, PhD, RCC-ACS

Dr. Evangeline Willms Thiessen, RCC-ACS

Janet White, RCC-ACS

✦ **Distinguished Professional Contributions to Applied Research Award**

Meg Kapil, PhD, RCC-ACS: Doing Well and Feeling Well: Investigating the Contributions of Two Stress Related Appraisals and Regulatory Practices on Student Success Outcomes

Rhett-Lawson Mohajer, PsyD, RP, RCC: The Psychoanalysis of Music Improvisation: A Phenomenological Qualitative Study

✦ **Practitioners Award**

Constance Lynn Hummel, RCC: The Business of Helping

Mary Klovance, RCC: The Neurodiversity Family Centre

Shelly Dean, PhD, RCC: Centre for Response-Based Practice

✦ **BCACC Volunteers Award**

Jane Goransen-Coleman: 1999 – 2025

Kevin McMullen: 2005 – 2025

Kathy Lauriente: 2002 - 2025

✦ **BCACC Student Member Award**

Christopher Leckman

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