SPRING 2026

INSIGHTS

THE BC ASSOCIATION OF CLINICAL COUNSELLORS' MAGAZINE

Recognizing and supporting neurodivergent mothers

Counselling first-generation postpartum moms with grandmothers in mind

PARENTING STYLES

A look at how culture can affect parenting

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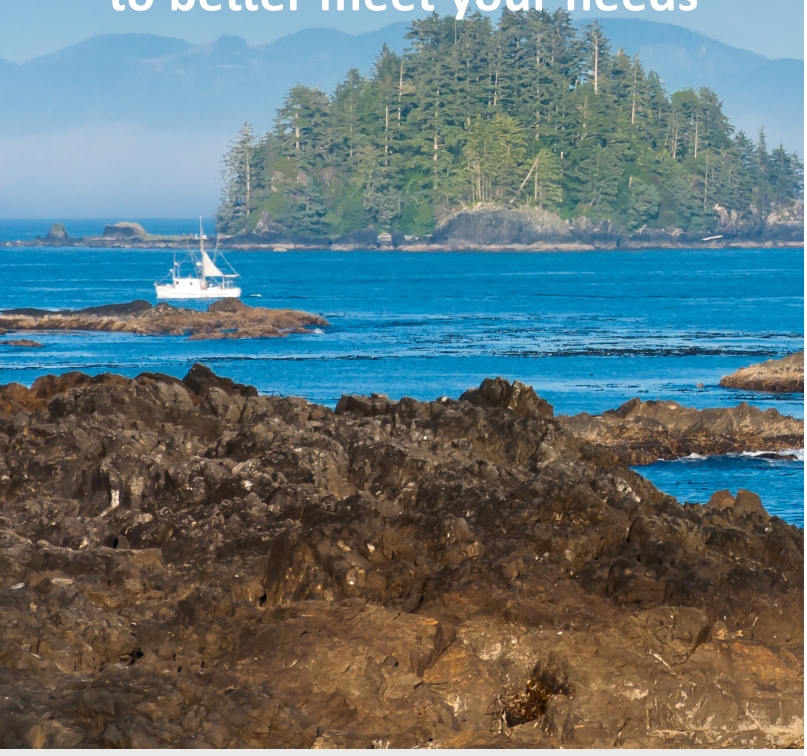
to better meet your needs



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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:

Kelsey Ashe, Nishi Banipal, Celine Cluff, Nicola Doughty, Nicole Hutchinson, Theresa Jackson, Salima Kerai, Martina Nova, Gurleen Dhial Sangha, Ruth Skutezky

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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REGIONAL ROADSHOW 2026

PROFESSIONAL development can feel disconnected from the complex realities you navigate daily. BCACC's Regional Roadshows are designed to counter that disconnection by combining recognized expertise with region-specific workshops, meaningful peer connection, and direct access to decision-makers who shape mental health services in your community.

The first Regional Roadshow of 2026 took place in Kelowna, April 10 and 11, and was well attended. Next up is June 5 and 6 in Victoria, September 18 and 19 in Prince George, and October 2 and 3 in Burnaby.

DAY ONE ACROSS ALL LOCATIONS:

Beyond the Wound: Implementing Effective Trauma Interventions with Dr. Carissa Muth, PsyD, RPsych

The impact of trauma is pervasive, multifaceted, varied, and often lasts a lifetime, which creates complexity for assessors and treatment providers. In this workshop, Dr. Muth provides a foundation based on the neuroscience of trauma and an overview of assessing trauma, including differential diagnoses. Rather than defaulting to a single treatment method, Dr. Muth guides participants in matching evidence-based treatment methods with trauma presentations. This staged approach to addressing trauma includes the integration of therapeutic methods such as narrative therapy, CBT, DBT, and positive psychology.

DAY TWO IN VICTORIA:

Beyond the Surface: Understanding the Intersections of Trauma, Adverse Events, and Opioid Harms in B.C. with Dr. Carissa Muth, PsyD, RPsych

An overview of the neuropsychological factors involved in trauma and addiction, highlighting the numerous contributing components in the development and treatment of substance use.

DAY TWO IN PRINCE GEORGE:
Responding to Trauma Through an Indigenous Lens with Maura Gowans, MSW, RSW

Indigenous frameworks to create safety for Indigenous clients, while considering the seven generations before and the seven generations to come. Intergenerational trauma and where it comes from and how it shows up in the body. Strength-based practices, land-based healing, and effective communication.

DAY TWO IN BURNABY:
Uprooted but Unbroken: Deepening our Clinical Connection with Displaced Families with Dr. Zuhra Teja, RPsych

Weaving together clinical research with lived experiences of displacement, from war and persecution to resettlement. A trauma-informed, rights-based, and culturally responsive lens to deepen clinical practice by examining assumptions, strengthening work with interpreters, and fostering emotional safety, dignity, resilience, and hope.

Each Regional Roadshow includes a **Stakeholder Roundtable Discussion**, where you can join an honest dialogue with your community of RCCs, government officials, service partners, and health authority representatives.

All locations finish Day One with an **Evening Social Reception** where you can connect with fellow RCCs and deepen professional relationships.

Find all the details, including registration, at https://conference.bcacc.ca.

About this issue's theme:

PARENTING BABIES AND CHILDREN

BY NICOLA DOUGHY, RCC
INSIGHTS EDITORIAL ADVISORY COMMITTEE

PARENTING sits at the intersection of identity, culture, self- and co-regulation, and relationship. For counsellors, it is an ever-evolving clinical landscape that calls for both depth and nuance. This issue of *Insights* explores the complex realities of working with parents, children, and families across developmental stages and cultural contexts, inviting counsellors to reflect on how personal, relational, and systemic factors shape the parent-child experience. From the unique challenges of ADHD in motherhood to the intricate ways parenting styles are informed by cross-cultural practices, these articles highlight the importance of understanding clients in the full scope of their lives.

Together, these articles invite you to consider approaching parenthood not as a singular experience, but as a layered, contextual process.

Turning attention to the early stages of the parenting journey, one article examines the role of pre-baby counselling and proactive postpartum wellness planning as a meaningful opportunity for prevention, preparation, and resilience. Another offers insight into how dysregulation and family dynamics can influence a child's behaviour, an essential lens for practitioners supporting emotional and relational development. This issue also deepens the conversation around intergenerational and cultural influences, particularly in work with first-generation postpartum mothers, where honouring heritage and family roles can be a source of strength in clinical considerations.

Together, these articles invite you to consider approaching parenthood not as a singular experience, but as a layered, contextual process through curiosity, cultural humility, and thoughtful intervention.

Communities of Practice

CONNECT, REFLECT, GROW

LAST DECEMBER, BCACC launched a refreshed, revitalized Communities of Practice (CoP) — a dedicated space designed to support RCCs in meaningful professional connection.

"In a field that can be challenging in many ways, Communities of Practice offer clinicians a place to engage deeply with their work," says Jane Beaumont, MC, RCC-ACS, CAE, BCACC's Director of Clinical Practice. "They foster thoughtful clinical discussion informed by current research, emerging evidence, and best practices, creating space for shared learning and strengthening both professional confidence and the quality of care we provide."

While it may feel similar to the RCC Connect Facebook group, the CoP is distinct in its focus: it is dedicated to clinical conversations and professional growth. Discussions are general in nature, client confidentiality is always upheld, and case-specific details are reserved for supervisory settings. Three key streams are available: practice-focused groups, modality-focused groups, and client and regional groups.

To access the CoP, RCCs can log in to the member portal, select eConnect, and choose Communities/Discussion Groups.

PATHOLOGICAL DEMAND AVOIDANCE

PATHOLOGICAL demand avoidance (PDA) wasn't something Kelsey Ashe, RCC-ACS, went looking for — it found her when her own child was struggling deeply to just be a two-year-old toddler. While PDA is often considered a profile of autism, Ashe says it tends to show up very differently from non-PDA autism and is perhaps better understood as a cousin of autism or ADHD.

"Treatment approaches even within the neurodivergent world don't often work for PDA families," says Ashe. "That sent me into a serious personal and professional deep dive, because families deserve to be believed, understood, and supported."

Knowing how misunderstood and alone families can feel, Ashe turned that experience into a passion for supporting PDA families.

WHAT DOES PDA LOOK LIKE?

Generally, we understand PDAers as those who experience everyday demands as threats, triggering intense stress responses. PDAers are creative, wise, deep, and sensitive with a strong drive for autonomy and justice. They are pressure-sensitive to internal, external, and invisible demands. When they are able to feel safe enough, their beautiful insides can shine — however, accessing safety can be very difficult as they are deeply sensitive. This can be such a gift when supported and a significant factor of disability when compromised.

When we are interacting with PDAers, we are often interacting with their nervous system responses as opposed to their beautiful shiny insides. Common signs include:

- Extreme resistance to everyday demands, including external, internal, and invisible demands, as well as demands on one's mind and identity and even things the PDAer wants.
- Rapid escalation and mood swings when feeling controlled and pressured.
- Creative use of negotiation, distraction, humour, or role-play to avoid demands.
- Sudden shutdowns or explosive meltdowns that seem out of proportion but are actually expressions of internal distress.
- A drive for autonomy over self and time to the extent that it can override biological functions such as hunger, thirst, sleep, and toileting.

When PDA is missed, they are often labelled oppositional, manipulative, or "too anxious." Supports then become more controlling, which increases fear and nervous system collapse. Over time, this can lead to burnout, trauma, family breakdown, and deep shame in the child. Misunderstanding PDA can actively cause harm.

WHERE DOES TRAUMA WORK FIT IN?

Trauma work teaches us to listen to the nervous system. It's fundamentally a bottom-up approach that recognizes how cumulative stress and trauma shape the nervous system over time and understands that honouring internal signals is essential to sustainable healing. These principles are not optional when it comes to PDA — they are foundational.

Supporting PDA requires deeply attuned, trauma-informed approaches that prioritize safety and relationship over performance or compliance. We need to trust the stories we hear and recognize that just because someone can do something does not mean it is in their best interest. Even the idea of "can" is quite complicated. Healing is not always about pushing through; it often involves softening, slowing down, and being with what is present. Deeply honouring and attuning to where that person is in that specific moment.

DOES PDA SHOW UP IN ADULTS?

Yes, absolutely. PDA doesn't disappear in adulthood; it more often becomes highly masked or adapted to. Many adults with PDA have learned, often at great personal cost, how to override their nervous system to function in a world built on compliance and expectation or how to create a lifestyle that accommodates their needs. It can show up as chronic burnout, cycles of over-functioning followed by collapse, intense reactions to perceived demands, and a deep aversion to authority or externally imposed rules. PDA in adults can also look powerful, with many PDAers become advocates, disruptors, entrepreneurs, and moral compass-holders.

If you want to learn more about PDA, check out the courses and presentations for counsellors at https://healingspaces.podia.com/upcoming-events-courses.

Kelsey Ashe, MACP, MAL,RCC-ACS, is the trauma-wise, neuro-affirming Clinical Director at Healing Spaces. She is also a neurodivergent person and parent of two brilliant neurodivergent children.

BCACC'S NEW APPLIED ETHICS COURSE

Today's mental health professionals regularly encounter nuanced situations involving boundaries, informed consent, confidentiality, and culturally responsive care — areas where clear guidance and confident decision-making are critical. To support mental health professionals in navigating the ethical complexities of modern clinical practice, BCACC has launched a new course: Applied Ethics in Psychotherapy and Counselling.

"Ethical practice is at the core of safe, effective psychotherapy and clinical counselling," says BCACC CEO Michael Radano. "This course was created to provide clinicians with practical, relevant support they can immediately apply in their day-to-day work."

The 13-module course was developed in collaboration with Dr. Simon Nuttgens, RCC, an experienced counsellor educator and ethics scholar, and is delivered in a flexible, asynchronous format. Through expert-led content, participants engage with real-world case studies, reflective exercises, and interactive quizzes designed to deepen both understanding and application of ethical principles.

Find more information and the registration link via the BCACC members portal: https://members.bcacc.ca.

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. Are you a BCACC member? One of the many perks of membership is 50% off all e-Connect courses!
Find the full eConnect catalogue at https://members.bcacc.ca.

CHILDREN AND SCREENS

Helping parents teach healthy tech habits

BY CELINE CLUFF, RCC, AND SALIMA KERAI

Screen time continues to be a trending topic with parents and caretakers. This article is meant to shed light on how the research on screen time is developing and changing, so clinical counsellors can better educate, advise, and guide their clients on screen use with young children.

Much of what intrigues people when it comes to screens is the existing research base on screen time and how it affects the behaviour of children. Until recently, there was scant guidance in the literature with respect to teaching young children healthy tech habits and embracing a new school of thought: that screens are here to stay. The guidelines that do exist (e.g., no more than one hour per day for children under five years) have recently been criticized for being inadequate because they fail to consider the context and content of screen use.

For example, if a child spent one hour of screen time on their device for school, that uses up all of their screen time. A 15-minute family WhatsApp chat also eats into a child's daily screen time. By focusing excessively on quantity over quality, we fail to address the purpose for which screen time is being used.

The Canadian Paediatric Society acknowledges that setting firm time limits for young children might not be realistic.[1] And while it is wonderful to be deeply invested in the upbringing and care of children, caretakers must also be mindful of self-care. If there is a gap in childcare services, respite sometimes only comes in the form of screen time.

Perhaps it is time to reframe the narrative to ask how we can help children thrive in a world of screens. The American Academy of Pediatrics points out that newer guidelines are shifting the focus from "what" is on the screen to "who" is consuming the media alongside the child. Treating an episode or a video like a picture book by commenting on what is being watched, parents and caretakers can promote the learning of new words in younger children.[2] Hence, prioritizing educational and interactive screen use over passive screen use can mark a good starting point for establishing healthy screen habits.

Dr. Shimi Kang, the award-winning Harvard-trained psychiatrist, researcher, author, and speaker, once compared learning how to use technology responsibly to learning how to use fire. Dr. Kang says that when fire was new and exciting, it was also dangerous and posed risks. It took humans time to learn how to control it and hone its benefits.[3] When we think about the advent of technological devices, it is hard not to draw a parallel.

One of the reasons children are so captivated by screens is that they offer a seemingly never-ending stream of pleasing, attention-grabbing subject matter. Like fast food, some forms of media are designed and created to be convenient and easily obtained. Dr. Kang suggests approaching media consumption like junk food and limiting the bad media we consume without eradicating it from our tech diet.[4] Examining when, how, and for what purpose screentime is used plays a role in forming a healthy tech diet.

THE EVOLUTION OF KNOWLEDGE-SHARING

After the invention of the television, people gradually replaced listening to the radio with watching TV. Now that streaming is replacing cable television, we are seeing the string of evolution

TAKEAWAYS

- When teaching young children healthy tech habits, start with good role modelling.
- Use concrete, straightforward language when negotiating with younger children about how much screen time is granted (i.e., number of episodes, use of a timer).
- Switch up passive viewing with interactive, education-based tech activities.
- Talk to older kids about the importance of a healthy "tech diet" — it's not just about how much you are consuming, but what.

continue. This evolution not only represents a shift in how media is consumed, but also how knowledge is shared. Nowadays, culturally relevant skills and crafts might be self-taught with YouTube videos. However, it does not always provide the same level of guidance as someone teaching someone else a skill in person.

Today, there are many examples of interactive, educational, and play-based screen time activities that can serve as a conduit for passing down knowledge and stories and teaching creative writing skills. A great example is Digital Storytelling, whereby someone creates a digital story about a subject, adds visual and audio elements, and shares it with a broader community.[5]

The evolving digital landscape has gradually made it easier and more convenient to choose which knowledge to obtain, how to obtain it, and when. During COVID, when schools were closed, digital screen use was the only means to impart school-based education. And while knowledge acquisition is generally considered a good thing, when online platforms are relied upon heavily, it can also lead to endless scrolling. Another potential flip side is having to fact-check content, depending on which knowledge-sharing platform is used.

Instead of worrying about how much screen time is too much, perhaps the question should be, for what purpose are people using screens? Teaching children how to interact mindfully with technology by focusing on the caretaker-child relationship should be at the forefront.

The most advocated approach is to set boundaries and limits for screen use. This requires concise messaging, prior negotiation about time limits, or an agreement on a concrete number of episodes. In addition, trying tech-based activities that don't involve passive screen use can be a fun alternative. These activities require children and caretakers to work together to be creative and problem-solve. For example: bug or plant safaris, which involve using an app to take pictures of insects or plants in nature to identify them.

By recognizing the importance of mindful screen use, caregivers can help children develop healthy tech habits that will serve them well into the future. ■

Celine Cluff, PhD, is a Registered Clinical Counsellor in Kelowna. Salima Kerai, PhD, works at Centre for Global Child Health, The Hospital for Sick Children, Toronto.

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THE UNIQUE CHALLENGES OF ADHD IN MOTHERHOOD

BY MARTINA NOVA, RCC

When I first became a mother, I assumed that the hard parts would be the ones everyone talks about: the lack of sleep, demands of caregiving, invisible weight of planning, and remembering things no one else sees. What I didn't expect was how deeply attention differences and nervous system regulation would shape my postpartum experience.

I come to this topic from a few different places. In my work, I support new parents as they navigate identity shifts, nervous system regulation, and the emotional realities of early motherhood. I am the author of *Same Page Parenting*, a book designed to help couples have thoughtful, practical conversations before and after becoming parents, and I created *The Therapy Journal*, a guided resource used by clients and clinicians to support reflection and emotional processing. I am also a mother to two little humans, and I am living with ADHD myself. That lived experience has shaped how I understand my work in ways textbooks never could.

In my clinical work and in my own journey, I've watched ADHD weave itself through the mundane and hard tasks of parenting, turning what might feel like small struggles into persistent stress generators that wear on identity, confidence, and connection.

This article explores how ADHD shows up for mothers and parents, why it's often overlooked in perinatal care, and what we can do to support neurodivergent parents.

WHAT ADHD IS AND WHAT IT ISN'T

ADHD isn't laziness. It isn't lack of effort. It's not something you can fix with visual reminders or breathing exercises alone. At its core, ADHD is a neurodevelopmental condition that affects how the brain manages attention, motivation, and emotion. A neurodevelopmental condition is a difference in how the brain develops and functions from early life. ADHD falls into the same category as autism spectrum disorder, learning disorders, and some processing differences. ADHD is not

something that develops later because of stress or life events; it is present from childhood, even if it isn't recognized until adulthood.

While some people imagine ADHD as the image we learned in childhood (i.e., the restless, disruptive boy in class), many adults, especially women, have presentations that look very different. They are quietly overwhelmed, highly sensitive internally, and managing complexity with relentless effort that no one sees. Since ADHD includes variations in executive functioning and dopamine pathways, routine tasks, planning, and transitions demand more from the brain than they do for someone without ADHD. For mothers who are juggling everyone else's needs, that difference can become painfully visible.

WHY PERINATAL CARE OFTEN MISSES ADHD

Most perinatal care systems don't screen for or discuss ADHD. When a parent says, "I can't keep track of anything," they're often told to "practise breathing strategies" or "sleep when the baby sleeps." While well intended, these suggestions overlook how neurodivergent brains struggle with unstructured tasks and regulation under stress.

Anxiety calls for coping strategies and cognitive reframing. ADHD calls for understanding the brain's wiring, compassion, nervous system regulation, and building systems that work with that wiring. When professionals miss this distinction, parents are left feeling invalidated, overwhelmed, and unsupported.

Many of the mothers I work with describe similar experiences. One client told me she felt like she was "failing at basic life" after her second baby. She couldn't keep up with appointments, misplaced important paperwork, and felt constantly on edge. Her doctor assumed she was anxious and suggested more self-care. But when we explored her history, it became clear she had struggled with attention and organization long before parenthood. Once we reframed her challenges through an ADHD lens and focused on nervous system regulation instead of willpower, her shame eased almost immediately. Her struggles hadn't changed overnight, but her understanding of them did.

ADHD THROUGH PREGNANCY AND POSTPARTUM

We rarely talk about how vulnerable this period is for neurodivergent parents. The postpartum brain is already adjusting to massive biological, emotional, and identity shifts. When ADHD is layered on top of that, even highly capable mothers can feel as though they are suddenly unable to function. Tasks that once felt manageable feel chaotic. Decision fatigue increases. The ability to prioritize and plan weakens. Without understanding why this is happening, many mothers assume they are simply not cut out for parenting, when in reality, they are experiencing a predictable neurobiological response to hormonal and environmental change.

Hormonal shifts fundamentally affect ADHD. During pregnancy, sustained estrogen can support dopamine activity. Some neurodivergent mothers notice a surprising improvement in focus. After birth, estrogen and progesterone take sharp hormonal dives. For someone whose nervous system already struggles with dopamine regulation, this drop can amplify emotional sensitivity, dysregulation, and overwhelm in ways that look like anxiety or mood symptoms but are rooted in biology as much as psychology.

When you add sleep deprivation, constant touch and responsiveness, and unstructured days, what was manageable before birth can feel magnified into something unmoored. In postpartum, inattentive-type ADHD may show up as dissociation, disconnection, spacing out, or being easily distracted. Hyperactive or combined types may experience irritability, restlessness, or overwhelm. Emotional reactivity can look like crying or snapping then spiralling into guilt or self-blame. Understanding this pattern matters because it changes language and expectations. When we know symptoms aren't efforts to "try harder," we can offer compassionate tools that meet the brain where it actually is.

One more piece often missing from these conversations is how strongly ADHD runs in families. Research consistently shows that ADHD is highly hereditary, as genetically influenced as traits like eye or hair colour. This means that many mothers with ADHD are also parenting children who are neurodivergent. When both parent and child have sensitive, easily overwhelmed nervous systems, dysregulation can bounce back and forth between them. A child's big feelings can activate a parent's stress response, and an overstimulated parent can unintentionally escalate a child's distress. Understanding this cycle helps explain why parenting with ADHD can feel so intense and why tending to our own nervous system is essential. When

> When shame is met with curiosity instead of criticism, nervous systems slowly learn that mistakes do not equal unlovability.

parents learn to regulate first, they become the calm nervous system their child can borrow.

THE WEIGHT OF SHAME AND OLD STORIES

Many adults with ADHD were never identified in childhood. Instead, they received messages like, "You are careless," "Why can't you just focus," or "You always forget." These messages are shaming and make us feel like we're not doing enough. And so, when a parent with undiagnosed ADHD forgets a lunch bag or form, it doesn't feel like a small slip, it feels like that old wound reopening.

Shame lives in the narrative that something is fundamentally wrong. Clinically, we know shame isn't the same as guilt. Guilt says, "I did something wrong." Shame says, "There's something wrong with me." And shame thrives in silence and invisibility. Helping parents recognize this pattern is foundational to change. When shame is met with curiosity instead of criticism, nervous systems slowly learn that mistakes do not equal unlovability.

REGULATION COMES FIRST

For many parents with ADHD, what looks like distraction or poor follow-through is often something deeper: nervous system dysregulation. When the body is living in a constant state of pressure, urgency, or perceived threat, the brain shifts into survival mode. In that state, focus, memory, emotional control, and decision-making become more difficult. This is why the most important starting point for ADHD support is not productivity tips, it's regulation.

ADHDers are especially vulnerable to chronic dysregulation, which can create a frantic crash cycle where everything feels overwhelming or impossible to keep up with. Even simple tasks — emails, chores, and daily transitions — can feel enormous and register as threats rather than manageable parts of life.

Regulation happens from the bottom up, beginning with the body and nervous system. The first step is learning to notice — we need to recognize what dysregulation feels like inside us. For some, it may show up as a racing heart, tight shoulders, shallow breathing, or a knot in the stomach. For others, it looks like mental fog, rushing, irritability, or a sense of inner pressure. Developing this awareness is foundational, and when we can pause and say, "My body is dysregulated right now," we have the opportunity to respond instead of react.

From there, simple, back-to-basics practices help signal safety to the nervous system: slowing movement, deep breathing, tapping, rocking, stretching, or pressing hands into the thighs. These small sensory actions interrupt the stress response and begin to bring the body back into balance. Only once the body feels steadier can we work with thoughts and beliefs. After that, we can begin to shift habits and behaviour. Too often, parents are encouraged to skip straight to trying harder. Without regulation first, those efforts rarely stick, and burnout follows.

> Good intentions alone are not enough if we do not understand how ADHD actually functions in real life.

A helpful way to think about regulation is in three layers:

1. **Body regulation:** Noticing physical sensations, grounding, movement, and sensory input to bring the nervous system back into a zone where choice is possible.
2. **Thought regulation:** Once the body is calmer, we can notice the inner critic, name thoughts that escalate stress, and gently reframe them from a place of safety rather than urgency.
3. **Behaviour regulation:** With a steadier nervous system and clearer thinking, we can build routines and structures that support daily life.

In practical terms, regulation might look like small shifts in daily life. When they realize their heart is racing, a parent might put cold water on their wrists before responding to a tantrum. They might stretch their shoulders before opening emails. They might set a single visual cue on the kitchen counter instead of trying to remember 10 things. These are not productivity hacks — they are nervous system supports. When parents learn to work with their brains instead of fighting them, everyday life becomes gentler and more sustainable.

WHAT CAN WE DO AS CLINICIANS?

Supporting ADHD parents and mothers requires more than empathy. It requires informed, trauma-aware, neurodiversity-affirming care and psychoeducation. Good intentions alone are not enough if we do not understand how ADHD actually functions in real life.

First, we need training. Perinatal mental health training helps clinicians understand how pregnancy, birth, and postpartum impact mood, attachment, and identity. ADHD-specific training helps us understand executive functioning, emotional regulation, and neurobiology. These two areas must be integrated, not treated separately. A clinician can be excellent at treating postpartum anxiety and still miss ADHD entirely if they have never been taught how differently it can present in

adults, especially in women. Ongoing professional development in both fields is essential if we want to offer accurate and effective care.

Second, we need to read, listen, and stay curious. ADHD research is evolving rapidly. Neurodivergent voices are telling us what works and what harms. We owe it to our clients to stay informed rather than relying on outdated stereotypes or one-size-fits-all strategies. Curiosity means asking open questions, being willing to rethink our assumptions, and remembering that lived experience is a form of expertise.

Third, we must screen and ask better questions. When a postpartum client struggles with forgetfulness, overwhelm, or emotional reactivity, ADHD should be part of the differential not an afterthought. Better questions might include: have you always had trouble with organization and follow-through? Did these challenges exist before pregnancy? Do you feel overwhelmed by routine tasks even when your mood is stable? Do you often start things but struggle to finish them? Asking about childhood patterns, school experiences, and executive functioning can help clinicians see beyond postpartum anxiety and recognize that ADHD has been present all along.

Fourth, we need to normalize support. Visual schedules, reminders, shared calendars, lists, alarms, and routines are accessibility tools. We would never shame someone for wearing glasses, so we should not shame someone for using scaffolding that helps their brain function. Part of our role is helping parents let go of the idea that needing systems means they are failing. Instead, we can reframe supports as smart, compassionate accommodations that make family life more sustainable.

Finally, we need to work with the nervous system. Bottom-up regulation, parts work, trauma-informed care, and relational repair are essential for ADHD parents. This also means teaching co-regulation skills, helping partners understand ADHD dynamics, and supporting parents to slow down before problem-solving. When shame decreases and safety increases, behaviour changes naturally. Effective clinical work with ADHD mothers is not about fixing them — it is about helping them understand their wiring and building lives that fit who they already are.

THE OPPORTUNITY AHEAD

Motherhood asks every parent to adapt, grow, and stretch. For mothers with ADHD, that stretching happens on terrain that is often invisible to the outside world. With the right understanding, tools, and support, neurodivergent parents can move from surviving to thriving. When clinicians and communities recognize ADHD not as a flaw but as a different way of being, we create space for mothers to show up as they truly are — capable, creative, and deeply devoted. When we shift our lens from fixing deficits to supporting difference with insight and compassion, we help not just individual parents, but entire family systems breathe, connect, and flourish in their own quirky way. ■

Martina Nova is a Registered Clinical Counsellor, author, and mother of two who specializes in trauma, ADHD, motherhood, attachment wounds, and people-pleasing.

EARLY CONVERSATIONS, LASTING IMPACT

Helping new parents have the best possible start

BY RUTH SKUTEZKY, RCC

Much of our work as counsellors, especially with couples, happens in times of rupture — when the relationship is strained, ultimatums have been made, or there is an urgency for things to be different. Partners can arrive in counselling as adversaries, not teammates, a world apart with little belief that repair is possible. This work is deeply important, and it remains central to our profession whether you work with individuals, couples, or families.

Alongside crisis response, therapy can also function as a space for preparation, reflection, and early support, particularly during major life transitions — like the great leap from couplehood to parenthood. I've seen the beauty of this change, as clients stretch and grow, navigating who they want to be as parents. It is also a time that comes with complex challenges that can wreak havoc on relationships.

What if we began to view counselling as a place where preparatory conversations can unfold in the lead up to a known stressor — a time when excitement can be high and a couple is more open and flexible? From what I've seen in my practice, clients tend to be very motivated to learn more about each other's perspectives, hopes, and fears during these windows, as they look ahead to the future as a team, feeling united and hopeful.

THE TRANSITION INTO PARENTHOOD

Becoming a parent is widely acknowledged as a major life change, with common warnings such as: "You'll never sleep again!" or "Say goodbye to your freedom!" Parenthood can test our limits, including the love that we have for our partner. Most of us imagine that having a baby will bring us closer together. But the truth is, a new baby can shake the foundation of even the most connected

relationships. John and Julie Gottman's research showed 67 per cent of couples describing a decline in relationship satisfaction after their baby arrived.[1]

Relational impacts are often underestimated. Becoming a new parent is one of the hardest tasks a couple will face and for good reasons: new identities and hormonal changes, relentless sleep deprivation, next to no time for yourself, isolation, and dealing with the new stress of life with a baby. There are so many unknowns, and these issues add up and become a perfect storm for resentment, disconnection, miscommunication, and even doubting the relationship or questioning the decision to become a parent.

COMPLEXITIES OF PERINATAL MENTAL HEALTH AND MATRESCENCE

Perinatal is a term used to describe pregnancy and one year following birth, and perinatal mental health is complex because it involves so many layers of change at once. To say that pregnancy is physically and emotionally taxing would be an understatement. When someone gives birth, they experience the greatest hormonal change of their life, with estrogen and progesterone dropping significantly, and oxytocin and prolactin spiking to facilitate bonding and milk production.

Psychologically, new parents are adjusting to shifts in identity, routine, time, and autonomy, to name a few. For many who identify as mothers, the concept of "matrescence" captures this experience.

The term was coined by anthropologist Dana Raphael and describes a developmental phase marking the transition from womanhood to motherhood that begins in pregnancy and may last a lifetime.[2]

> A new baby can shake the foundation of even the most connected relationships.

Author Lucy Jones, in her book *Matrescence*, describes the impact well: "We still barely acknowledge the psychological and physiological significance of becoming a mother: how it affects the brain, the endocrine system, cognition, immunity, the psyche, the microbiome, the sense of self."[3]

Here are few statistics worth acknowledging:

- Women are more likely to develop depression and anxiety during the first year after childbirth than at any other time in their life.[4]
- Approximately 1 in 5 women and 1 in 10 men will experience a perinatal mood and anxiety disorder.[5]
- This risk is 5 times higher in high-risk pregnancies.[6]
- Perinatal women are at 2 times greater risk for OCD onset than the general population.[7]

Consensus among perinatal clinicians is that these estimates are likely low. Due to the nature of the symptoms and limitations with screening, distressed parents tend to underreport. This is compounded by the associated shame, stigma, and even parental fears about having their capacities to care for their baby questioned. As a result, many new mothers experiencing symptoms describe feeling very alone and worry that something may be "wrong" with them.

These estimates further fail to capture the experiences of parents from marginalized communities, who are frequently underrepresented or excluded

in perinatal mental health research and who face additional barriers due to a lack of culturally responsive and accessible community support.

Partners also can experience parallel shifts and emotional reorganization, sometimes with less societal or cultural acknowledgment.

And we know that dads and partners can struggle with symptoms of depression, anxiety, OCD, PTSD, and more.

We should also acknowledge here that there are many pathways to building a family, including surrogacy, adoption, donor sperm or egg, etc. This highlights that everyone's journey is unique, and as therapists, we want to remain curious about what someone has gone through to become a parent.

PRENATAL EDUCATION FOR COUPLES

Many expectant parents seek prenatal education, which can be invaluable for understanding pregnancy, labour, and delivery. Programs such as those offered by local organizations Brood and It's Ready, Babe have broadened these offerings to include deeper conversations about informed consent, medical interventions, and diverse birth experiences, as well as infant care. These are wonderful additions to support new parents.

However, what often receives less attention is the relationship friction that can emerge after welcoming a new baby. This goes back to the question: what might it be like for couples to have space to reflect on these changes before they are living them? Rather than feeling caught off guard amid exhaustion and emotional volatility, pre-baby counselling can invite important conversations ahead of time. Then, when couples are in this stressful, sleep-deprived period, making a hundred decisions a day while learning on the job, they are revisiting conversations previously explored, not questioning the future of their relationship when conflict catches them off guard.

POSTPARTUM DISSONANCE AND ACCUMULATED RESENTMENT

Postpartum dissonance is an all-encompassing term that many birthing people and any new parent can experience. Simply put, it is the experience of postpartum not matching with what was pictured. This dissonance is often accompanied by feelings of disappointment, confusion, anger, or regret — in other words: "This isn't what I signed up for" — a sentiment that can become especially intense if there is also a sense of being alone in the struggle.

Often, these overlapping issues and emotional experiences can lead to feelings of resentment which accumulate during a very vulnerable time. Many postpartum challenges are perceived as relational, because in the absence of a strong support system, the simplest narratives become riddled with blame — "This is hard, and I feel like it's my fault" or "That was hard... and you weren't there for me when I needed you." When this blame towards self or others accumulates, it becomes more difficult for couples to recover.

Some interesting correlations worth mentioning: maternal depression is the greatest predictor of paternal depression; and women who are more supported by their partner do better (less severe mental health symptoms, faster resolution of PMADs, increased relationship satisfaction).

For many, the arrival of a baby can reveal individual differences in coping styles, responses to stress, and needs.

WHY THIS TIME CAN FEEL SO HARD FOR COUPLES

Some of the challenges I see couples experience during postpartum, which can unfold for many years that follow, include:

- Feeling judged for how they are managing, accomplishing, or adjusting
- Assumptions made but not discussed about roles and responsibilities
- Navigating boundaries with family and extended support systems
- Feelings of loneliness or disconnection
- Grief for aspects of pre-baby self
- Feeling pressured to meet parenting ideals or that things "should" be different
- Lingering feelings about how their partner showed up

Sleep deprivation and less time for self can make it much harder to "fight fair" or use humour, diplomacy, and compromise (e.g., in the middle of the night with a crying baby).

When conflict feels unexpected, couples may question themselves or their relationship, rather than recognizing the broader context.

COUNSELLING AS A SPACE FOR PREPARATION AND REFLECTION

For any counsellor who works with adults in their reproductive years, the topic of family planning and the transition to parenthood will eventually show up in your caseload. Some couples seek counselling specifically because they are expecting a baby; others may already be in therapy when they begin to build their family. In either case, you can help them explore how this transition intersects with identity, relationship patterns, and support systems.

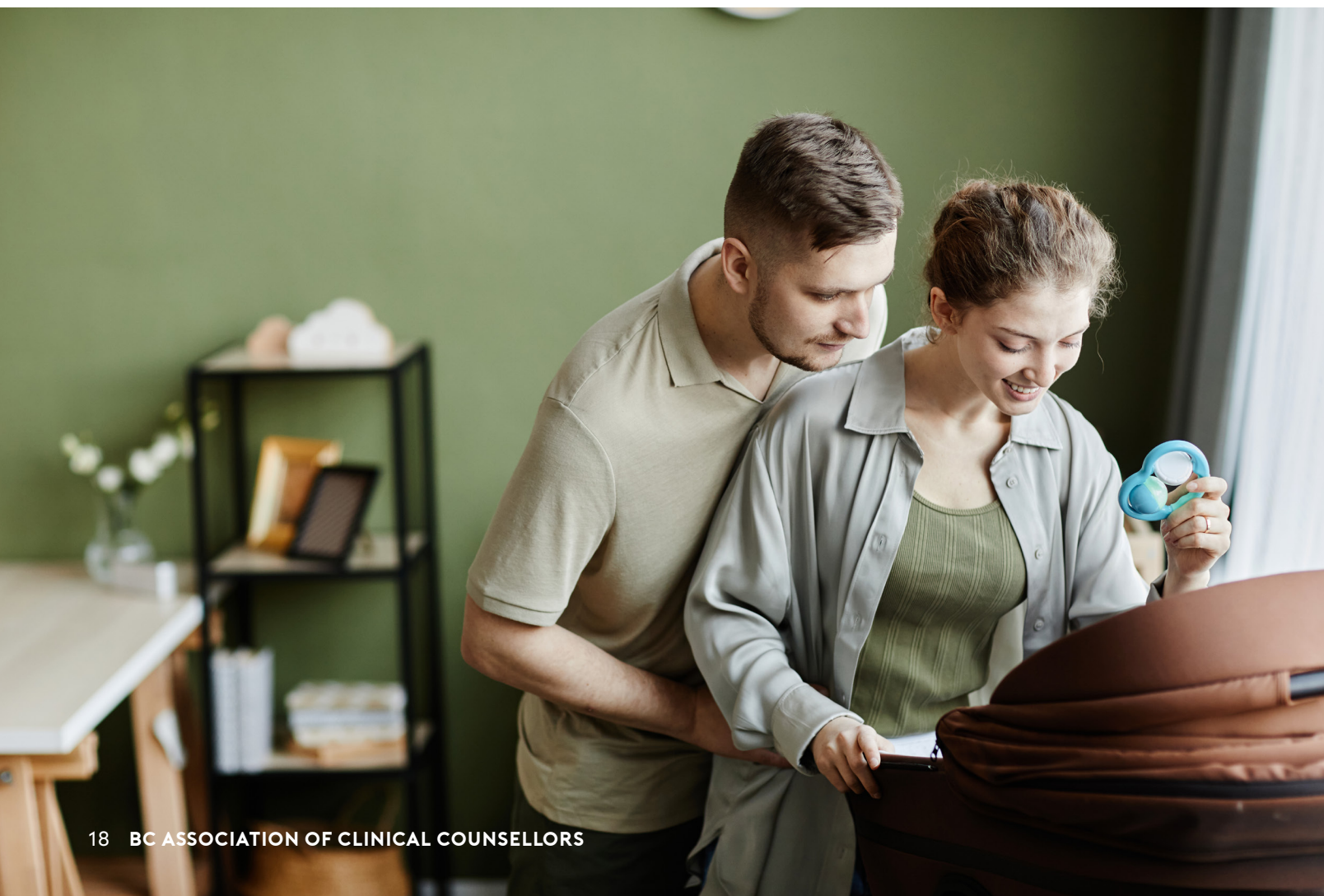
> You can help them explore how this transition intersects with identity, relationship patterns, and support systems.

Counselling before the arrival of a baby can be a space for reflection — an opportunity for couples to slow down and become more aware of how they approach stress, change, and uncertainty, as well as what they are picturing their life could look like with a baby.

One of the most powerful impacts we can have with these clients is to normalize support, especially for those who do not have reliable or consistent family available. Many new parents value independence or self-sufficiency and struggle with the idea of accepting help. A therapist's office may offer a place to explore these beliefs and make room for alternative narratives, such as those that frame support as protective rather than a reflection of their competency as new parents.

If you are interested in this type of therapy, some of the many approaches you could consider implementing into sessions include:

- Exploring differences in expectations, fears, and hopes
- Highlighting strengths and building a culture of appreciation within the



relationship

- Teaching couples communication skills, with a focus on repair strategies
- Providing much-needed education about perinatal mood and anxiety disorders and symptoms, including when to seek further psychiatric consultation
- Naming the occurrence of intrusive or "scary" thoughts, to minimize shame
- Discussing the idea of the "Good Enough Parent" and introducing self-compassion
- Talking about some of the physiological changes to expect, and how the context of postpartum can impact perception, including how we view our partner
- Dispelling myths around "bouncing back" for the birthing person postpartum and normalizing that adjustments take time
- Encouraging bio-psycho-social support following birth, including involving other professionals as needed (i.e., lactation consultants, sleep consultants, nutritionists, naturopaths, physiotherapists, primary care providers, etc.)
- Mapping out community and social support and clarifying what would be considered helpful from family and friends
- Creating a postpartum wellness plan so the couple feels more prepared

When integrating some of the above approaches, counselling becomes less about preparing couples to "get it right" and more about helping them understand what they may encounter, encouraging self-compassion, while offering tools to help them reconnect when things feel hard.

If you aren't sure where to start, here are some questions for expectant parents to invite deeper exploration:

- What is your typical response to stress or overwhelm?
- How do you usually let one another know when you are struggling?
- To what degree do you tend to avoid issues?
- Do you tend to allow frustrations to stack up until they become too much?
- What are you most looking forward to about life with a baby?
- What do you feel more uncertain or apprehensive about?
- What does self-care mean to you, and how might this look postpartum?
- Who has been supportive to you in the past, and what made that feel helpful?

From here, all sorts of meaningful conversations can unfold, including those around hopes, dreams, fears, values, beliefs, and expectations.

FINAL THOUGHTS

Expanding counselling as an offering during the transition to parenthood invites us to work a little further upstream. When we connect with couples during this stage, they enter parenthood with greater understanding of themselves, each other, and the systems around them and with more skills and readiness to handle what comes their way.

When I reflect on our shared profession, the idea of helping to positively change the trajectory of a relationship and a family, even slightly, brings me a sense of meaning and hope for the future. Of course, it will be the clients showing up and doing the work, but we can serve as guides, helping to point them in the right direction and reminding them of why it matters.

If you are looking for additional resources to support your clients as they enter parenthood, we welcome you to reach out to our clinic at *info@illuminate-online.com.* ■

Ruth Skutezky, RCC, PMH-C, is the co-founder of Illuminate Counselling, a group practice specializing in reproductive mental health and relationship support. With a foundation in couples counselling and advanced training in perinatal mental health, Ruth's approach is rooted in commitment to helping her clients feel seen, supported, and empowered from preconception to parenthood.

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OTHER RESOURCES

Books

- *And Baby Makes Three: The Six-step Plan For Preserving Marital Intimacy And Rekindling Romance After Baby Arrives* by John and Julie Gottman
- *Motherkind: A New Way to Thrive in a World of Endless Expectations* by Zoe Blaskey
- *Good Moms Have Scary Thoughts: A Healing Guide to the Secret Fears of New Mothers* by Karen Kleiman
- *The Art of Holding in Therapy: An Essential Intervention for Postpartum Depression and Anxiety* by Karen Kleiman

Digital Resources From Illuminate Counselling

- Postpartum Wellness Plan
- Postpartum Depression & Anxiety Workbook
- Conversation Starters Before Having a Baby
- Babyproof your Relationship (online course)
- New Parents Relationship SOS (online course)

LISTENING BEHIND THE BEHAVIOUR

Considering trauma and family systems in child symptomology

BY NICOLE HUTCHINSON, RCC

Many would agree that the discomfort of emotional dysregulation and the associated behaviours often provide the impetus to seek therapeutic support. I have found this to be especially true in my work with children and adolescents, where parents consistently reach out in search of greater understanding and meaningful change for the sake of their family's wellness and perhaps their own sense of sanity. Their children's presentations are described as defiance, aggression, irritability, unable to sleep/sleep too much, stomach aches or headaches, extreme fear, issues with eating, self-harm, etc.

These difficulties effect the family dynamics, encouraging the stress response, and may potentially influence violence or neglect. The parent often feels powerless and seeks a "fix" through counselling. However, when a counsellor focuses solely on managing behaviours, the outcome is often temporary, frequently resulting in a recurrence of difficulties and leaving families feeling frustrated by the short-lived effect of their therapeutic investment. This is in part related to the neurodevelopmental aspects of symptomology that are often unaddressed with cognitive regulation approaches.

Parents and caregivers are primary influencers of a child's neurological and psychosocial development with their overall wellness being a determining factor of outcomes.[1] I propose that clinicians listen behind the behaviours of children, considering a neurodevelopmental and family systems approach. This involves assessing the child and other household members, including presentations from previous generations, to influence the symptomology via comprehensive, family-based treatment.

EXPLORING BEYOND THE BASICS

One advantage of not having the privilege to diagnose is that it encourages us, as clinicians, to remain genuinely curious about our clients' lived experiences and the contextual factors shaping them. This requires us to listen more openly,

explore more deeply, and allow the client's unique narrative to guide our understanding and approach, rather than the generally prescribed interventions for diagnoses. When a child client presents with symptomology of any psychological disorder, I ask the following question: Why these specific presentations for this specific child from this specific social environment?[2] Open-minded explorations into symptomology and associated neurodevelopment have uncovered various explanations for why the child has specific perceptions of continued experiences and associated presentations within family relationships and outside social contexts such as school.

The following case study is used with the explicit permission of the clients, and names have been changed to protect confidentiality.

J, a 38-year-old cisgender woman, contacted me about P, her 10-year-old foster-adopted son. P had been diagnosed with severe attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), and possible conduct disorder. Further evaluation was negative for fetal alcohol spectrum disorder and positive for a near-total lack of executive functioning and a learning disorder in written expression. The school environment was not assessed as P was home-educated.

P's symptoms of ADHD presented in early development, and symptoms of ODD presented around age eight. P was highly impulsive and occasionally physically violent towards his family and friends. He slept poorly and was reported to have started small fires. When P was physically injured such as in falls, he did not approach J for soothing and rarely cried secondary to the experience.

An exploration of the birth-family history revealed:

- Alcohol and methamphetamine exposure during the prenatal period.
- Apprehension into the foster care system at five months after abandonment. His birth mother had inconsistent housing, and P was her fifth child out of her care.

P's early medical report included low weight gain, frequent ear infections, and extreme gastroesophageal reflux disease.

A genealogical exploration of the adoptive home included the following significant findings:

- Maternal great-grandfather with PTSD secondary to World War WII.
- Maternal grandmother with PTSD secondary to witnessed intimate partner violence, witnessed and experienced child maltreatment, early emotional and physical neglect, and IPV in her first marriage, with persistent anxiety and depression managed with pharmaceuticals. She has been divorced three times.
- Adoptive mother with disorganized attachment, paternal abandonment, and untreated anxiety and depression. Child of divorce from first father and also first stepfather. Frequent moves in the first five years of life.
- Paternal great-grandfather with PTSD secondary to World War II.
- Paternal grandfather had a compulsive work ethic and was often angry with violent outbursts.
- Paternal grandparents' divorce.
- Adopted father is an adoptee with untreated anxious-ambivalent attachment secondary to perceived rejection and abandonment from his birth mother. As mentioned, he is a child of divorce within his adoptive family.

Environmental presentations included:

- Low social support.
- Low socioeconomic status.
- Chaotic home environment with three additional siblings.
- High reactivity in J and in the adopted father.
- A generally authoritative parenting style with authoritarian components, such as minimal child-agency and strict rules on obedience.

J and her partner had a persistent sense of inability to influence and cope with P's behaviours, despite extensive training as foster parents. They feared their other children were at risk and how P's behavioural presentations may evolve through adolescence.

IF MAMA AIN'T HEALTHY, THEN NOBODY'S HEALTHY

It has been widely recognized that maternal health has a significant impact

on the neonate and infant, and global governing bodies have established numerous programs to support women during the pregnancy and postpartum periods. Outcomes demonstrate a positive shift in maternal and neonatal nutrition and maternal mental health and increased effectiveness in attachment, with an extended hope for a decrease in early life adversity for children.[3] Yet childhood adversity continues to occur at an alarming rate.

I have noticed in my collaboration with clinicians as well as in my own experience as a parent seeking medical and counselling support for my child, that caregiver wellness is often neglected in the assessment of school-aged children or adolescents. This is despite the recognition in our field that a high percentage of adult clients' presentations directly relate to early-life stressors and adversities, often secondary to their caregivers' mental health and associated responses.

Before seeing a child or adolescent, I meet with, ideally, both caregivers. The discussion provides verbal and non-verbal information on their states of wellness. I explore what their life is like now and during their development, highlighting the presence of emotional, verbal, physical, and/or sexual abuse, as appropriate, given the level of rapport. This, along with a genogram, assesses for patterns of adversity, health challenges, or substance use and can portray genetic and epigenetic effects that may be considered in how their child is presenting.

Additionally, as parental presentations are assessed, I consider the child's neurobiological reception and decoding of the subtle and not-so-subtle information parents display in their tone, body language, and vocabulary. This detailed exploration provides insight into the roots of the child's symptomatology. Moreover, assessing early life stressors from gestation through age eight offers critical insight into a child's exposure to adversity and how these experiences may have shaped neural development, as well as influenced the child's evolving perceptions of what is considered normal.[4,5]

I suggested to J that we incorporate a family therapy approach to address her son's behaviours.[6] I met with individuals and pairs rather than the entire family, while retaining the overall focus on the whole family relationship as the "client." With attachment trauma spanning both parents and P, attachment healing for the three of them was a main goal. Unfortunately, J's partner resisted therapy.

I've found that caregivers may express resistance when they perceive that the focus is shifting away from the child and onto them. Not only may they wish not to "dig up" their past, but the associated vulnerability of accounting for their own contributions towards the child's behaviours can feel overwhelming. I gently explore this through a stance of unconditional positive regard. I have also found that thoughtful, intentional self-disclosure can be a meaningful tool in supporting caregivers as they reflect and consider alternative perspectives. We have all been children, and many of us are parents who know how difficult raising the next generation can be, particularly if we hold unhealed experiences.

Parents and caregivers are primary influencers of a child's neurological and psychosocial development.

J demonstrated a desire to address her emotional and mental health. As such, the beginning of treatment focused on J and included psychoeducation of P's neurodevelopment with explanations for the adaptive use of his behaviours.[7] We explored attunement and how P was likely picking up J's anxiety, which activated his hypervigilance and "fight" within his nervous system. In this context, P expressed increased comfort with disharmony at home, rather than the uncertainties of calm, which were unfamiliar to him.[8]

A collaborative approach was maintained between J, the pediatrician, and me, and it was mutually agreed that P could benefit from a psychostimulant. J reported a decline in P's reactivity, impulsivity, and violence immediately. P's increased consistency and flexibility contributed to a calmer, more predictable home environment, influencing a more reliable sense of safety for the whole family. A clinician might have chosen to terminate at this point, as the child's behaviours had become manageable. However, I believe there is immense value in continuing to address the root concern, which in this case was attachment trauma in three of six family members.

A NOTE ON ATTUNEMENT

To attune means to "bring into harmony," with harmony meaning "to be in agreement with."[9,10] While attunement can offer beneficial connections between parent and child, I have observed the opposite to be true as well: attunement can contribute to maladaptive experiences, such as heightened anxiety, unproductive conflictual behaviours, and power struggles. In my experience, many parents misunderstand the profound influence their emotional state has on their children's subconscious awareness and the contribution this makes to the

arousal of the sympathetic nervous system of each of them. Psychoeducation and equipping parents with practical self-soothing tools are essential. The familiar flight attendant's instruction — "secure your own oxygen mask before assisting your child" — serves as a powerful metaphor, underscoring the importance of parental grounding practices, breathwork, and self-care as foundational supports for both parent and child.

A NOTE ON PARENTING STYLES

Parenting styles are a significant contributor to the developmental outcomes of their offspring. The authoritative style is widely considered the most effective, and authoritarian, permissive, and uninvolved styles are recognized as contributing factors in child symptomology.[11,12] This too requires a deeper exploration beneath the behaviours with the question: Why this parenting style with this parent in this family? I have found that integrating cultural considerations, particularly alongside genealogical perspectives, with the understanding of a child's neurological development, provides a foundational framework that meaningfully informs and guides treatment planning.

While J and her partner presented as more authoritative, they had private parenting training before the children were born that included first-time obedience as achievable and expected, a concept later contributing to power struggles. Additionally, J's partner was raised by an uninvolved, authoritarian father who also expected first-time obedience achieved using fear tactics. P's birth mother, who was likely uninvolved in her parenting approach, secondary to substance use, transient living, and other factors, contributed to early attachment trauma in P. A chaotic environment and lack of control, even in infancy, are associated with poorer developmental outcomes, and inadequate caregiving can condition an infant to later dissociate human interaction from comfort or relief.[13,14]

The cumulative effects of the parenting styles, attachment traumas, low socioeconomic status, and persistent anxiety with reactivity gave rise to continued chaos and poor attachment, despite training and support provided by social services for foster parents. P's nervous system was accustomed to chaos and appeared to implement protective measures such as impulsivity and aggression to gain perceived control over situations.

We eventually shifted sessions to include P, using attachment and somatic-based modalities with executive functioning support at home. Our family approach continued for nine months and included psychoeducation with J around her other three children's presentations. Termination occurred after the root causes of J's anxiety and depression had been integrated, and she and P exhibited a more secure attachment. Both J and her partner had released the concept of first-time obedience and practised a gentler way of training their children. P continued the psychostimulants under the care of his pediatrician. He generally demonstrated sustained calm, increased playfulness, and reduced impulsivity. Notably, there was also a slight improvement in the quality and organization of his written expression.

I was recently contacted by J, who reported feeling calm, grounded, and less reactive. She has strengthened her social connections in a women's yoga group, where she experiences a sense of authentic community. J also observed positive shifts in her partner, despite his not having received direct treatment.

Now 15 years old, P remains under the care of his pediatrician; however, he discontinued psychostimulant medication last year. While P may occasionally escalate, violence is rare and minimal. He continues to have mild symptomology of ADHD, and executive functioning tools continue to be effective in addressing this.

Both J and her partner are generally coping well with P's occasional challenging behaviours, and their overall family health has improved drastically. The family has increased healthy social connections, and J is considering returning to school for an advanced degree in social sciences.

CONCLUSION

Emotional dysregulation in children and adolescents rarely develops in isolation. Behaviours presenting as defiance, aggression, or pathology may reflect adaptive responses to early adversity, attachment trauma, and persistent relational stress. When clinicians move beyond the surface of symptomology and ask why these specific behaviours are occurring in this specific child, within this specific family and social context, a more coherent and sustainable treatment direction begins to emerge.

P's presentations could not be fully understood apart from his prenatal exposures, early neglect, attachment disruptions, and the intergenerational trauma present within his adoptive family system.

Many parents misunderstand the profound influence their emotional state has on their children's subconscious awareness.

Likewise, sustained progress was unlikely if intervention focused solely on behavioural modification. Integrating neurodevelopmental understanding with genealogical exploration, cultural considerations, caregiver wellness, and attachment-based intervention provided a more comprehensive framework for treatment.

This case further illustrates that caregivers are not peripheral to the therapeutic process but central to it.

When clinicians attend to caregiver regulation, insight, and attachment security, with collaborative relationships across disciplines, observable symptom reduction reflects not simply behavioural control, but relational and neurobiological reorganization.

Listening behind behaviours requires curiosity, restraint, and systemic awareness. When this stance is maintained, intervention extends beyond immediate symptom relief and begins to interrupt patterns of intergenerational trauma and dysregulation. In doing so, family-based treatment offers the potential not only for behavioural change, but also for greater stability, connection, and enduring health within the family. ■

Nicole Hutchinson, RCC, is a trauma specialist with over 20 years of experience journeying alongside children, youth, and their families. She finds immense satisfaction in seeing people thriving within the restoration of their families and the societies they impact. Nicole lives and works in Victoria, B.C.

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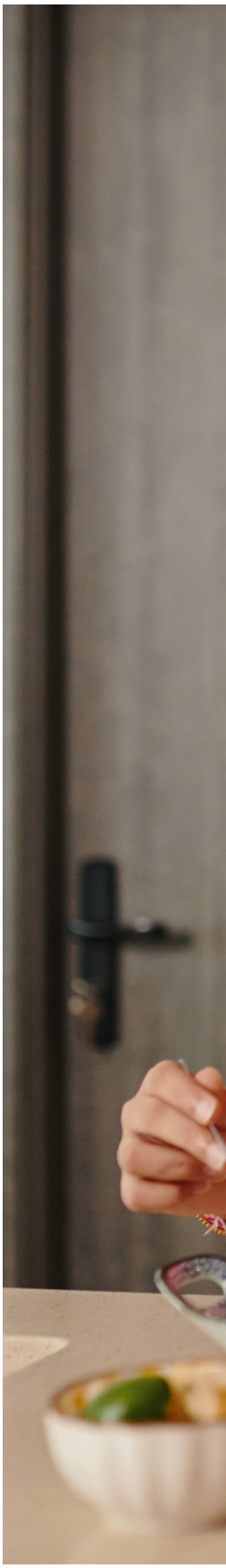
CULTURE AND PARENTING

The relationship between parenting styles and cross-cultural practices

BY GURLEEN DHIAL SANGHA, RCC



The concept of culture does not appear to be fixed or static; rather, it is dynamic and fluid.[1] There are many layers to cultures and worldviews that can vary from one geographical area to another and even from one residential location to another. There are subcultures within cultures, and mentalities differ within families. There is no right or wrong way of living, as culture is how human beings navigate the world.

Culture is integral to human survival.[2] Culture informs socialization as individuals learn how to behave within that culture, what is considered inappropriate and to understand traditions, specific values, and meanings.[3] Two broad categories of culture we commonly encounter are individualistic and collectivist.

INDIVIDUALISTIC AND COLLECTIVIST CULTURES

Societies can be individualistic, collectivist, or somewhere in between. Collectivist cultures tend to value relatedness, strong belonging, duty, harmony, advice from others, and hierarchy and to prefer group benefits over the self.[4] Individualist cultures tend to focus on individual interests and value independence, individual goals, uniqueness, privacy, self-knowledge, and direct communication. Notably, most societies worldwide are not individualistic. These cultural differences can shape parenting and decision-making with respect to parenting goals, rules, emotional expression, achievement, identity, and conflict.

Through technology and globalization, the lines between individualistic and collectivist nations have become blurred. Through the internet, cell phones, and social media, people from collective countries are being influenced by individualistic messaging and norms.

CANADIAN CONTEXT

Canada is a particularly interesting mix of individualism and collectivist perspectives. Approximately 30 per cent of the population is foreign-born, meaning they were born abroad and immigrated to Canada.[5] The remaining 70 per cent are Canadian-born, further broken down as 22 per cent second generation and 45 per cent third generation or higher. With a strong focus on immigration, cultures blend, and we now know individuals tend to fall along a spectrum between collectivist and individualist orientations.

For immigrants or children of immigrants, there is a strong emphasis on personal freedom, independence, and individuality in Canadian culture, but they also experience the pressure to balance

loyalties to the culture of origin. It can be arduous to balance the norms of ancestral cultures with the demands of an individualistic culture that is so often promoted as the ideal. Balancing both cultures and determining where one lies on the spectrum can be challenging for parents as well, who often seek to raise children who can succeed in Canada while also maintaining their culture of origin.

For therapists, being culturally competent and approaching care with cultural humility is more than a bonus for clients — rather, it is a necessity. Practitioners must work from a place of cultural humility, which centres around respect rather than judgment. Approaching a session with curiosity can benefit not only practitioners but also clients by dually exploring the context of the client's life.

This exploration can also help individuals better understand their position on various parenting issues. It may be difficult for clients to describe their culture; however, this exercise of discovering where they fall in different parenting categories can be beneficial in processing childhood wounds, establishing a strong sense of self, and informing future decision-making. And while describing their culture can be highly challenging for clients, even more challenging is helping professionals to understand it within the one-hour window of a therapeutic session.

WHY IS IT IMPORTANT TO UNDERSTAND A CLIENT'S CULTURE?

If we want to understand a client's inner world to connect, empathize, and offer appropriate interventions, it is vital that we understand the culture our client is coming from. Most places in the world are not individualistic societies; therefore, when working with someone from a collectivist culture, we must be cautious when applying individualistic concepts or values.[6]

For example, a marker of success when parenting from an individualistic society is independence. In a young toddler, this may manifest as feeding oneself, sleeping alone, and making early decisions. In a collectivist culture, the goal is not independence but interdependence. A marker of success is being deeply connected to the child and responsive to the child, which may manifest as co-sleeping, helping with feeding more often than not, and following the chain of authority in the home.

Through the internet, cell phones, and social media, people from collective countries are being influenced by individualistic messaging and norms.

It is particularly important to be aware of and cautious about applying "general laws of behaviour" that tend to reflect mainstream North American values.[7] Understanding cultural context is important because we cannot, without consideration, apply mainstream North American notions to our clients, which could lead to clients feeling judged or shamed and potentially damage the therapeutic relationship. Applying solutions or interventions without proper consideration from one cultural context to another can be counterproductive. One of the most damaging things a professional can do is further oppress a racialized person while attempting to do good.[8]

Knowing how to work with North American notions versus collectivist cultural lenses can be particularly difficult when working with second-generation and beyond Canadians, because they are constantly pulled in different directions. In addition, this population may not be aware of their positions on certain cultural values.

PARENTING WITH BICULTURAL IDENTITIES

Bicultural identity conflict is a widely experienced phenomenon among racialized populations in Canada.[9] This phenomenon occurs when individuals feel compelled to adopt two different versions of themselves, depending on the setting, because different cultures have different expectations. This can often manifest in parenting, as parents and children may live in the same household but adhere to different cultural norms.

For example, parents from one generation or country of origin may value obedience, family responsibility, respect, and reputation, while the children may value independence, privacy, and the ability to follow their own path. This can create conflicts around dating, clothing, curfews, friendships, and school or career choices.

Furthermore, children may code-switch as a mechanism for survival in two different environments. Split identities can impact family expectations and lead to anxiety, stress, feeling like you do not belong, conflict, and low self-esteem. However, when children with bicultural identities are supported, living with varying levels of inner complexity can also foster strengths such as adaptability, empathy, and greater cultural awareness.

THOUGHT EXERCISE

Imagine a therapist working with a young

adult who is deciding what they would like to study at university. The racialized parent is suggesting jobs such as doctor, lawyer, nurse, or teacher, and the young person is not sure what their passion in life is yet. The therapist encourages this young person to "create a boundary," which translates to ignoring her parents' suggestions and refraining from such conversations in the future.

Now, ask yourself, does this seem okay to you? If you adopt an individualistic perspective, this may appear acceptable and, in fact, may be the appropriate way to proceed when working with a young person making decisions about their future, particularly when a parent holds a different perspective. If you are operating from an unchecked western individualistic perspective, then yes, you may entirely agree with this suggestion.

Another perspective is to recognize the value of the client engaging in conversations about decision-making with multigenerational family members who possess wisdom and life experience. Perhaps if the parent were given an opportunity to explain their perspective, they could discuss that these types of jobs typically provide job security, depending on the specialization, consistent hours, along with soft benefits such as respect and social status within the community and opportunities for beneficial networking and connections.

Furthermore, depending on the client's degree of connection to their collectivist culture, the suggestion to establish a hard boundary could create a divide in the room, leaving the client feeling less understood by the practitioner. Additionally, it could exacerbate the disconnection between parent and child, who are already struggling to communicate.

The lesson here is to examine whether you are approaching the topic from your own biases, lenses, and frames of reference. Are you taking this person's situation and interpreting it in a way that best fits your mindset, making it easier for you to proceed in the session and avoid discomfort? If the answer is yes, there are many ways to practise professional sensitivity and cultural humility. The impact can lead to greater effectiveness, a more meaningful session, and a newfound sense of satisfaction from the relationship.[10]

WHAT YOU CAN DO

As a therapist, it is important to examine parenting through the lens of culture because "good parenting" is often defined by a single cultural worldview, and therapy can unintentionally reinforce such definitions. There are things therapists can do inside and outside of the session to become clearer about how to do this work.

If you are working with someone from a collectivist culture, even if they were born in Canada, it is important

The lesson here is to examine whether you are approaching the topic from your own biases, lenses, and frames of reference.

to assess how connected they are to Canadian culture relative to their familial place of origin. It is crucial not to make assumptions; just because you are working with someone who is South Asian, it does not mean that they necessarily hold traditional South Asian values. It is more likely that they have drawn some values from their collective culture and others from Canadian culture; therefore, we cannot make assumptions about their values.

It is beneficial for both the client and the therapist to understand the client's values to fully grasp their perspective, identify the difficulties they are responding to and struggling with, and offer appropriate interventions. If you feel that working with this person is totally beyond your capacity, it is always okay to refer out.

UNDERSTANDING YOUR CLIENTS' VALUES

When working with clients who may be operating from a collective context, it can be helpful to explore their perspective on common collectivist notions in parenting, such as:

- Being directive, i.e. "Do this."
- Hierarchical family structures, i.e. elders lead.
- Being reputation aware, i.e., "What will people think?"
- The family's interest comes first before your own, i.e. "We sacrifice for each other."

Therapists need to remain in the conversation without appearing judgmental. This could look like saying, "Family loyalty is a huge strength in your home. Can I ask you a question about this? When does this help your child thrive, and when does it shut them down?"

It is always important to remain respectful and to approach the situation with cultural humility; otherwise, operating from an unchecked western individualistic perspective risks damaging relationships both inside and outside of the therapeutic space.

CULTURAL MEANING MAKING — NOT ASSUMPTIONS IN SESSION

Instead of interpreting behaviour as healthy or unhealthy, the therapist can ask questions to better understand the cultural context in which the person was raised, the notions they still hold, and those they are ready to release.

- In your family of origin, what did a "good child" look like? What does that look like now in the present day?
- In your community or culture, what does a good child look like?
- When you were young, what did respect look like at home?
- What are the values you want your child to carry into adulthood? On a scale of 1-10, how well do you think you are modelling those?
- What would your parents say good parenting is? Do you agree with those values?
- What would your child say you care about most?
- What were some of the values communicated to you as being important by your family of origin? Which ones do you agree are important, and which ones do you think do not matter as much to you?

These questions illustrate how to determine whether a family prioritizes autonomy, self-expression, independence, belonging, duty, or interdependence. These answers can help the therapist develop goals that align with the client's or family's value system. This exercise should keep therapy away from trying to "westernize" a family and instead work within their cultural values to create family-specific goals.

SELF-WORK OUTSIDE OF THE SESSION

To engage in anti-oppressive practice, it is important to understand your own cultural conditioning and implicit bias. A lack of awareness of this can lead to unintentional microaggressions in interactions with clients or colleagues. Furthermore, it is vital that counsellors learn more than tactics, tips, and specific behaviours; instead, they should develop a shift in consciousness.[11] It is important to understand what you bring into the room in terms of privilege, bias, and self-awareness and to be prepared to work with different cultures if and when you encounter them.

The first step to working with clients from different cultures is to do the work within yourself. Engaging in self-reflective practices lays the foundation for responding appropriately when topics related to other cultures arise. This type of personal work can create discomfort, shame, and uncover unpleasant, deeply rooted childhood messaging. We must examine our messaging and programming to understand our positions regarding different cultures. This work can be both disturbing and enlightening.

ORGANIZATIONS

Organizations that lack culturally competent leaders or policies become breeding grounds for microaggressions and the potential for ruptures in the therapist-client relationship. If organizations are built on unchecked western perspectives as being the correct or only perspective when working with people from different cultures, it can result in poor client engagement, therapists feeling unsupported, increased burnout, greater ethical and legal risks, and a loss of credibility and trust in the community. It is important to assess the levels of education, training, policies, and supervision in place within your organization and to address any gaps.

For more information on engaging in cultural competency training, see the additional resources. ■

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ADDITIONAL RESOURCES

- *The Anxious Generation* by Jonathan Haidt
- *The Body is Not an Apology* by Sonya Renee Taylor
- *The Whole-Brain Child* by Daniel J. Siegel
- www.brenebrown.com: You can find links to podcasts, articles, and resources related to evidence-based research on diversity, equity, and inclusion.
- www.brenebrown.com/resources/dare-to-lead-list-of-values: A list of values you can use for self-discovery, and to bring into sessions to assist clients in naming their values
- www.gurleensangha.ca: The website features additional written work on culture, microaggressions, and anti-oppressive practice. Cultural competency training sessions for organizations and individuals are also available and can be arranged by contacting via email.

HONOURING HERITAGE AND HEALING

Counselling First-Generation Postpartum Moms with Grandmothers in Mind

BY NISHI BANIPAL, RCC

As humans, we go through many transitions in our lives, all of them transformative in some way. Arguably, the most profoundly transformative experience is becoming a mother. The changes are physiological, psychological, emotional, familial, vocational, and the list goes on and on.

These days, we have an app for nearly every aspect of pregnancy and motherhood, a multitude of gadgets, and manuals for every stage of parenting. Capitalism has taken hold of pregnancy and motherhood and created a long list of "must-haves" for anxious first-time moms. How did mothers get by before the internet and Amazon's two-day delivery?

Well, they had the village — you know, the one they say it takes to raise a child. That village consisted of mothers, grandmothers, aunts, sisters, midwives, and village elders. Knowledge was passed down from mother to daughter, and grandmothers were a valuable resource and fountain of wisdom and experience. In the 1800s, the medical world inserted themselves into birthing practices. Midwives were vilified and traditional practices were termed barbaric and uncivilized. Practitioners were subject to legal action for providing the same care they had provided for generations.

THE IMMIGRANT GENERATION GAP

Although there has been a resurgence in traditional healing practices, stigma persists. Traditional practices are often only considered valid when adopted in North America and marketed with a celebrity stamp of approval.

What does this look like when you're the child of an immigrant, growing up between two worlds? For South Asians, it might look like rejecting the Haldi Dudh your grandma made for you but paying $7 for a golden milk latté at a coffee shop. The benefits of turmeric (in both products) are only valid when you read an article or see a favourite influencer raving about it.

Now, you might argue that evidence and research are needed to support benefits that traditional healing practices assert, but how many of us actually look up peer-reviewed studies to validate the claims? Or is this just another tactic to de-legitimize anything outside of the colonial frame of reference?

Children growing up in Canada in immigrant homes have long struggled to reconcile their home life with their school life, often rejecting their cultural heritage in favour of the dominate culture. Asking their moms to pack them a bologna sandwich for lunch instead ethnic foods and leaving their immigrant mothers perplexed as to how slapping cold meat between two slices of bread is better. The child's preference for western culture is reinforced when no one comments on their lunch or makes a face at the foreign aroma emanating from their lunchbox. Thus starts the rejection of remnants from the motherland, and the immigrant generation gap forms. This gap widens as the child develops and forges their individual identity, an identity they may have to hide from the collectivist nature of their family home.

GENDER DIFFERENCES

A factor that contributes to conflict between parents and their daughters in immigrant homes is that gender differences can be more pronounced compared to their western counterparts. The impact on the female children of immigrants is significant. Mothers often play a vital role in reinforcing patriarchal norms through modelled behaviour and explicit expectations.

The mother-daughter relationship in these homes is complicated, to say the least. The role of the eldest daughter in an immigrant home is widely recognized on social media as a trauma-laden experience. The role often places the child in a parentified position, carrying emotional labour, responsibility for younger siblings, and the added burden of navigating English-speaking systems for parents who are not native speakers.

The rebellious teen years are particularly damaging to this mother-daughter relationship. The teenage daughter longs for freedom, and the conservative immigrant mother fears the repercussions of allowing that freedom. They

enter a complicated dynamic, where the daughter has no choice but to lie, and the mother grapples with the impending loss of control. Their worlds further split when the daughter finds a partner.

The daughter then settles into her role as a wife in a home that doesn't look much like her childhood home but instead looks more like the homes she grew up watching on TV. She doesn't use plastic yogurt containers to store leftovers — she buys glass containers made for the purpose. She doesn't have mismatched dishes in her cupboards, her sofa is not wrapped in plastic, and her shelves are not lined with newspaper. She doesn't see the woman who raised her anywhere in the woman she is today. Instead, she sees a home and woman that look like the ones on her social media channels. She feels like she has finally forged an identity of her own, not realizing that she was simply being influenced to value herself based on her proximity to whiteness and western culture. And why wouldn't she? The main messaging she's received as a child of an immigrant is to fit in, be like the majority, and you will be accepted.

But what happens when this woman becomes a mother herself? So much of how we parent is based on how we were parented. We might do the opposite because we remember how we felt — or we replicate how we were parented because we remember how we felt. How does she reconcile being a mother, when her closest frame of reference is her own mother, a woman that does not align with how she sees herself?

POSTPARTUM TENSIONS

Many of the reproductive mental health clients I see in my practice come from immigrant homes, whether South Asian, Chinese, Filipino, Korean, or Persian. The overwhelming majority express tensions with their immigrant moms during the early postpartum days. These grandmothers are often beyond excited — chomping at the bit — to be involved with their new grandchild. However, the new mom is often apprehensive, unsure about the remedies being suggested — and sometimes forced — for the baby's well-being.

I would like to mention that this tension may also occur in families of European descent, even when the new mothers are third- or fourth-generation Canadians. Differences in childrearing practices across generations can become a source of conflict between any new moms and new grandmas.

However, for children of immigrants, this tension is often rooted in the new mother's preference for the medical model. The ancestral knowledge our mothers and grandmothers carry may not be scientifically validated (yet). When we are raised in a culture that emphasizes science and research, trusting traditional wisdom can feel ridiculous and even

dangerous. This tension can leave the grandmother feeling rejected and unvalued.

This rejection is further cemented when the grandmother sees how much more involved the new fathers are. The spot next to her daughter at the birthing bed is occupied by her son-in-law. Birth was traditionally a time when the women came together, both sets of grandmothers prepared meals together and shared their own stories of birth and early motherhood. It is a chance to reconnect with a life they gave so much to and an opportunity for their children to see the depth of effort, care, and sacrifice that goes into motherhood — a chance to deliver that age-old line: "Now do you understand, now that you have kids of your own?"

> The role of the eldest daughter in an immigrant home is widely recognized on social media as a trauma-laden experience.

HOW TO HELP

As a therapist, helping clients navigate these relationships is multi-layered. For some, it involves dethroning the parent and seeing them as an equal. Asking questions like, how would you feel about this person if she was your classmate? It may involve perspective taking — considering their parent's migration journey and how they would navigate a new country when they have little community and don't understand the language or culture.

Trying to enforce boundaries is not going to benefit either party and will likely lead to further distress. These grandmothers can be the greatest allies in the early trenches of motherhood — a remnant of the village to which we once belonged. Is a boundary even going to be helpful or possible? In most cases, the answer is not likely.

In my experience, most of these grandmothers refuse to go to therapy themselves. They do not want to discuss their traumas and resentments. Instead, the work is done through the new mother clients finding compassion for their mothers but also honouring their own very real hurts and childhood resentments.

For example, a common trope in immigrant households is the parent that doesn't say, "I love you" or "I'm sorry" but instead brings fruit or tries to engage in other ways. We can guide our clients to understand that love is not necessarily expressed in the ways that we want to receive it, but that doesn't mean it's not there. Accepting this can be difficult, because the instinct is to "fix" their parents and make them see their faults, which leads to further frustration.

I often find it helpful to invite the client to reflect on how their grandparents may have raised their parents. This exploration can uncover difficult stories, including experiences of war, forced displacement, loss, violence, oppressive governments, abuse, and other significant traumas. Hearing these narratives can sometimes leave clients feeling guilty for expressing their own struggles or believing that their problems are less significant by comparison. Sitting with this complex mix of emotions is an important part of the healing process. It helps us see how our own stories are woven into generations of experiences that came before us.

At the same time, this web of interconnected stories doesn't exist in a vacuum — it's held together by the broader context of history, sociopolitical forces, economic disparities, and cultural dynamics. So as much as someone may want their parents to "fix" themselves to fit their western perspective, the parents may have a completely different context from which they are operating. The healing lies in finding compassion, taking space when needed, and looking beyond the new mother's story to the stories that lead to a life where you can click three times and have a parcel delivered to your door in two days.

And of course, practising mindfulness when your mom offers you remedy number five that her aunt's sister's friend's grandma from the village back home sent to increase breast milk supply. All the while, acknowledging the irony that mindfulness practices originated in a village in India in the fifth century, but weren't scientifically validated in the West until 1982 (Kabat-Zinn) and that it would take another 30 years for it to be widely accepted as a healing practice.

Perhaps, remedy number five might not be so bad after all. ■

Nishi Banipal, MEd, RCC, is an artist and therapist, who specializes in maternal mental health, adult children of Immigrants and ADHD. She runs a private practice in White Rock and has a special interest in traditional healing methods.

RECOMMENDED READING

- *But What Will People Say? Navigating Mental Health, Identity, Love and Family Between Cultures* by Sahaj Kohli
- *Between Two Worlds: 8 Challenges as a Second-Generation Immigrant —Things About Having Immigrant Parents That No One Talks About* by Imi Low
- *Unfinished Business: Breaking Down the Great Wall Between Adult Child and Immigrant Parents* by Amy Yip
- *Motherhood Journey Through the Eyes of Immigrant Women* — Women's Studies International Forum by Tzu-I Tsai, I-Ju Chen, and Song-Lih Huang
- *The Existential Crisis of Motherhood* by Claire Arnold-Baker

COGNITIVE BEHAVIOURAL THERAPY FOR INSOMNIA

Addressing Underlying Patterns with the First-Line Treatment for Chronic Insomnia

AN INTERVIEW WITH THERESA JACKSON, RCC

Theresa Jackson is the co-founder and clinical director of Gather Clinical Counselling. Her areas of focus include working with couples, supporting individuals through life transitions and self-discovery, helping people navigate perimenopause and menopause, supporting neuro-diverse clients, and helping people navigate anxiety, trauma, and sleep difficulties.

Jackson's therapeutic approach draws from person-centred therapy, CBT, DBT, SFBT, expressive and somatic approaches, and interpersonal neurobiology. She has additional training in the Gottman Method, EFFT, SPACE for parents, and CBT-I. It's work solidly founded in dual master's degrees in counselling psychology and neuroscience.

"I believe neuroscience — learning how our brains function and adapt — is something that everyone should learn about," says Jackson. "Early in my counselling career, I realized I could weave my neuroscience expertise into my counselling work, and that this psychoeducation often helps clients better understand themselves, know change is possible, and develop greater self-compassion."

How is CBT-I different from CBT?

Cognitive behavioural therapy (CBT) was originally developed by Aaron Beck in the 1960s and 1970s. CBT for insomnia (CBT-I) isn't the work of one single developer; rather, it evolved through the work of several contributors in the 1970s and 1980s, including Dr. Richard Bootzin and Dr. Arthur Spielman. In the late 1990s and early 2000s, Dr. Gregg Jacobs developed a more formalized treatment protocol, much of which is still used today. While CBT is a talk-based therapy applied to a wide range of mental health concerns, CBT-I is more focused and typically shorter term, specifically designed to treat insomnia. Both approaches examine the behavioural and cognitive factors contributing to a concern, but CBT-I also includes a substantial amount of education about how sleep works, specific tracking of sleep, and tailored intervention.

What do you tell clients when they ask how CBT-I works?

Clients often ask how CBT-I works, especially if they feel they've "tried everything." Many people experience bouts of insomnia at some point in their lives, and for those who struggle more chronically, it can be frustrating

and discouraging. By the time they seek support, they've often experimented with numerous home remedies or strategies, sometimes inconsistently, and feel hopeless about the possibility of change. In sleep medicine, once physical health concerns have been ruled out, CBT-I is considered the first-line treatment for chronic insomnia, because it addresses underlying behavioural and cognitive patterns that maintain sleep difficulties.

Sleep is a universal experience crucial to physical and mental health, yet many people don't understand how or why it happens. A fundamental component of CBT-I is education about sleep, because sleep is far more complex than most people realize. In all my years of working with people with insomnia, every single person has learned something about sleep they didn't know. As part of the process, we collect details about what a client's sleep actually looks like. People are often surprised by what we uncover and begin to notice patterns they hadn't been aware of.

CBT-I can feel counterintuitive sometimes. For example, part of the sleep consolidation process may involve temporarily restricting time in bed. The goal is to strengthen the connection between bed and sleep so clients can go to bed and fall asleep within a relatively short period of time, rather than lying awake tossing and turning. I also teach strategies to help people fall asleep more easily. These approaches intentionally calm the body and the mind, reducing physiological arousal and quieting the mental activity that often keeps people awake. When we use strategies grounded in neurobiology, we're not just "trying to relax" — we're deliberately working with the nervous system to shift it out of a state of alertness and into one that supports sleep.

Do your clients come to you specifically for sleep concerns or in addition to other concerns?

I work with people in a variety of ways. As part of my counselling process with all clients, I assess how they're sleeping, because sleep can often shed light on their presenting concerns or highlight an underlying issue. When someone isn't sleeping well, and it's therapeutically appropriate, I'll work with them individually to help improve their sleep.

Throughout the year, we also offer three-week online groups for people who recognize they're struggling with sleep and would like structured support to improve it. One of the strengths of CBT-I is that it can be used alongside other therapeutic work, or someone can choose to focus specifically on their sleep through the program. In either case, I find that many people experience meaningful benefits, and that improving sleep quality often has a positive ripple effect on other areas of their lives.

Do you get many parents of young children in the groups?

Yes, we do see parents of young children in our groups, as this is often a period when adults experience significant sleep disruption. It can be helpful to distinguish between developmentally expected sleep interruptions and insomnia that has become more persistent, and we support parents in understanding that difference.

Our groups are currently open to adults over 18 with sleep concerns. Some people have a long history of insomnia, so it is rewarding to be able to provide support and exciting to hear about the improvements they make. We also see participants across the lifespan, as sleep naturally changes with age. Some individuals begin struggling later in life due to age-related shifts in sleep patterns or other life transitions.

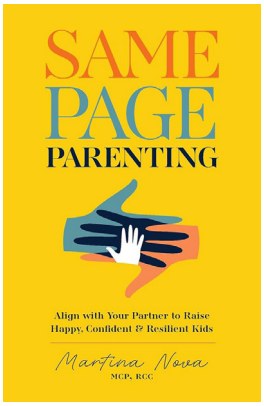
As awareness of our work has grown, we've received increasing interest from specific populations. In response, we plan to offer more targeted groups, including for new parents, teenagers, and first responders, who often face disrupted sleep due to caregiving demands or shift work. We will also be offering groups for individuals experiencing perimenopause and menopause, as hormonal and lifestyle changes during this stage can significantly impact sleep.

Where can RCCs get CBT-I training?

Although CBT-I is a structured and specific protocol, I strongly recommend that RCCs ensure they have a solid foundation in CBT before pursuing training in a specialized approach such as CBT-I. There are a number of reputable online CBT-I trainings available that can support this further development.

I also enjoy offering training and supervision to counsellors at the intersection of neuroscience and counselling, which is particularly relevant when working with clients experiencing sleep difficulties. In addition to recommending existing trainings, I offer my own in-depth course, which includes clinical consultation for therapists who want more applied, practice-focused guidance. While neuroscience terminology is increasingly common in counselling practice, there is not always a clear or practical understanding of how the science translates into ethical, effective therapeutic work. I'm passionate about helping practitioners move beyond jargon and develop a grounded, critical understanding so they can apply it confidently and responsibly in therapy. More information on my course is at www.gathercounselling.ca.

Read



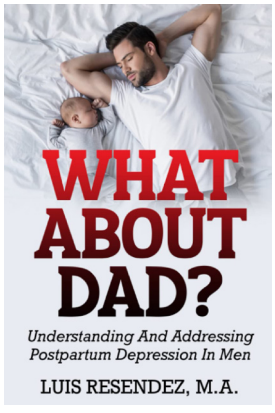
SAME PAGE PARENTING: ALIGN WITH YOUR PARTNER TO RAISE HAPPY, CONFIDENT, AND RESILIENT KIDS

By Martina Nova, MCP, RCC

Overcome parenting challenges and avoid miscommunication with compassionate questions and conversation starters designed for couples and co-parents alike. More than just a parenting book, *Same Page Parenting* helps parents, caregivers, extended family, and co-parents create a shared vision for their unique family unit. Whether preparing for parenthood, in the thick of raising little ones, or co-parenting across different households, this book provides insights that will help parents stay connected and aligned.

The questions and conversation prompts in this book are essential for intentional parenting and to raise children with confidence. Topics include reclaiming your voice as a parent, parenting in the digital age, postpartum mental health for both partners, sharing mental load and emotional labour, rethinking gender roles and family structures, raising socially conscious kids, and trauma-informed parenting.

With a mix of clinical expertise, honest storytelling, and powerful discussion questions for couples, *Same Page Parenting* is an essential resource for anyone looking to approach modern parenting with greater confidence, clarity, and compassion.

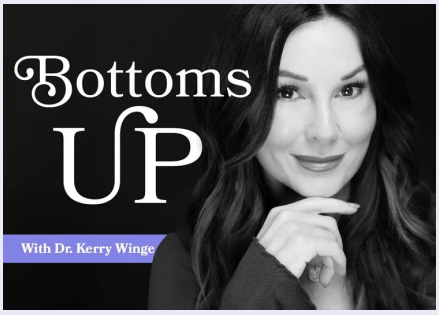


WHAT ABOUT DAD? UNDERSTANDING AND ADDRESSING POSTPARTUM DEPRESSION IN MEN

By Luis Resendez

Many new fathers struggle with postpartum depression (PPD) after the birth of a child, with ongoing clinical research also indicating so. However, due to a prevalence of mental health stigma, men seldom take the initiative to speak up in disclosing their struggles with it and avoid seeking treatment. Psychotherapist Luis Resendez shares his personal struggle with PPD after the birth of his first son to assist readers in obtaining a better understanding of what it is and how to effectively address it. He also offers his thoughts and suggestions about how family, loved ones, and the health care professions can better support men affected by PPD and alleviate the burden of mental health stigma that keep men from connecting with the support they need.

Listen



BOTTOMS UP WITH DR. KERRY WINGE

The journey from survival mode back to sensuality is one almost every new parent faces, yet it's often a silent struggle. For those who wondering how to navigate the exhaustion, hormonal shifts, and emotional distance after having a baby, the episode with **Jo Robertson** is their guide. Sex and relationship therapist Jo Robertson joins Dr. Kerry Winge to tackle the brutal truth about intimacy after childbirth. They cut through the awkwardness and offer real, compassionate advice for new parents, providing a roadmap for not just coping, but truly reconnecting.

7 BEST LGBTQ+ PARENTING PODCASTS TO LISTEN TO IN 2026

Hatch Fertility, Egg Donation and Surrogacy has compiled a list of the best podcasts for LGBTQ+ parents and parents to be. Topics include advice on how to raise children with a same-sex parent, gain visibility into LGBTQ+ parenting culture, learn about the struggles LGBTQ+ parents and individuals face, and more. Daddy Squared, The Proud Parent Club, If These Ovaries Could Talk, Rose and Rosie: Parental Guidance, 2 Birds and a Baby, Some Families, and Pride in Birth can all be accessed from https://www.hatch.us/en/blog/lgbtq-parenting-podcasts

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