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The Canadian Counselling and Psychotherapy Association's quarterly newsletter – Printable Version

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President's Message

Ring out, Wild Bells

Ring out the old, ring in the new,
Ring, happy bells, across the snow:
The year is going, let him go;
Ring out the false, ring in the true.

- By Alfred, Lord Tennyson

As another year comes to a close and a new one begins, I want to ask you to consider something that might be new to you. Have you ever considered stepping into a leadership role?

What do I mean by leadership? According to Rosenbach, it is "a process of the leader and followers engaging in reciprocal influence to achieve a shared purpose. It is all about getting people to work together to make things happen that might not otherwise occur, or to prevent things from happening that would ordinarily take place."

Now with more than 5300 members, CCPA is very much in need of volunteers who are willing to take on executive roles in Chapters and committees or to become Directors on our National Board. Many of us shy away from taking on a leadership role believing that leaders are "born to lead." However, leadership is a learned behaviour not a personality trait. Those who lead tend to have initiative and the motivation to take on the role and have a vision of a desired future for the association or organization. As counsellors and psychotherapists we know that people can learn, grow, and change and that learning and personal growth enhance individual effectiveness.
Using the lens of possible selves, our views of the selves that we hope to become, fear we will become, and expect to become can be powerful motivators for our present behaviours. The vividness of our different possible selves, the nature of achieving a possible self or avoiding a negative self all play a role in what we believe is possible for ourselves. In terms of leadership, this would mean that internally, do you have the belief that you have the ability to develop leadership skills? Externally, do you believe the tools are available to perform leadership roles and tasks?

Let me explain some of the supports available for taking on a leadership role with our national association. At the Board level, CCPA has developed a number of tools to help Board Directors ease into their roles (e.g., orientation guide, powerpoints, a webinar etc.). The National Office has recently provided additional supports through a Board Liaison position to assist the Board members, the Standing Committees, and the President in fulfilling their various tasks. Impact Public Affairs trains Directors to speak on behalf of CCPA when meeting with the media or Members of Parliament. Chapter Presidents can ask the National Office for assistance and can bring any concerns about their roles and needs during the Chapter President's regularly scheduled teleconferences. A new leadership initiative is forthcoming through the National Office – stay tuned!

Volunteering in any capacity – as a leader or a member of a Chapter or committee - is an enriching experience and the association benefits from the contribution of its volunteers. Through volunteering, individuals can share their skills, talents, knowledge, and professional expertise and can mentor other volunteers by passing along specific skills and knowledge.

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CCPA values its volunteers and wants to encourage its members to take on leadership roles. As such, CCPA is dedicating organizational and managerial resources to ensure that we remain responsive to the needs of our volunteers. CCPA strives to maintain a receptive culture that values personal growth and respects differences in leadership styles.

Volunteer!

As one of my favourite authors said,
Unless someone like you cares a whole awful lot, nothing is going to get better! Dr. Seuss

Thank you, Merci, Meegwetch!
Blythe Shepard,
President CCPA

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President-Elect's Message

Greetings

Greetings CCPA members,

One of the core dimensions of working on the CCPA Board of Directors is engaging in advocacy and outreach. The ability for CCPA to connect with various strategic partners in mental health services at the local, regional, provincial/territorial, national and international levels provides our Association with opportunities to inform policy and planning decision-making, expand our professional development networks and share learnings on the valuable role that counsellors/ psychotherapists play across the continuum of care in Canada.

In the fall of 2014, on behalf of the CCPA Board of Directors, I participated in the 2014 Canadian Mental Health Association (CMHA) - http://calgary.cmha.ca/public_policy/2014-cmha-conference/#.VJR1gcwHA nation-wide conference held in Calgary, Alberta. This conference gathered CMHA's various provincial/territorial divisions and branches as well as interested parties and key stakeholders for 2.5 days discussing and learning more about the importance of "strengthening our collective voice" – the key theme for this conference. Keynote speakers such as Robb Nash, Amanda Lindhout and Sheldon Kennedy addressed CMHA conference participants and discussed their lived experiences of dealing with mental health issues and being in various stages of recovery from their traumatic incidences:

• Robb Nash shared his lived experience of surviving a car crash with a semi-tractor truck—which included having a fractured skull and being pronounced dead by first responders. Given a second chance in life, Robb Nash and his band set out to make a difference in the lives of others, particularly youth at risk. Robb's focus is on helping youth find their "gifts" and strengths;

• Amanda Lindhout shared her lived experience of being a hostage in Somalia—surviving torture and sexual abuse at the hands of her captors. Since her release, she has written a book about her experience (which will now be made into a motion picture)—A House in the Sky and established the Global Enrichment Foundation to empower, educate, and provide aid in Somalia. As part of her healing journey, Amanda chooses compassion and forgiveness and searches for gratitude in life; and

• Sheldon Kennedy shared his lived experience as a former professional hockey player and survivor of childhood sexual abuse at the hands of his junior hockey coach. Sheldon read excerpts from his book, Why I Didn't Say Anything, discussing the depths of the darkness he experienced which included suicide attempts, alcohol and drug addiction. Sober for the last 10 years, Sheldon expressed his determination for educating parents, children, and coaches about safe and respectful sporting environments via The Respect in Sport program and also advancing his work with the Sheldon Kennedy Child Advocacy Centre in Calgary, Alberta. Sheldon advocates for engaging communities to aid in preventing child abuse – "it takes a community to raise a child", and partnering and collaborating between organizations in addressing child abuse.
Peter Coleridge (CEO, CMHA National) provided conference attendees with an overview of the 2015—2017 CMHA Strategic Plan which focuses on strengthening their collective voice, influencing public policy and system planning (e.g., suicide prevention, Bill C-54/Bill C-15 – criminal code, child and youth mental health, and mental health indicators/data sets). Peter presented a video from Newfoundland (CMHA was one of the supporters and partners of said video) - http://thisvideo.ca/.

Louise Bradley (President/CEO, Mental Health Commission of Canada—MHCC) discussed the Mental Health Strategy in Canada outlining that "we all have a role to play" as part of the mental health "community." Louise discussed the importance of bringing together individuals with lived (mental health) experiences, mental health practitioners, and the importance of

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developing emerging leaders and champions in mental health in Canada. Louise referenced the "#308conversations", which involves discussions with Members of Parliament (MPs) in their respective ridings about suicide prevention. Other notable discussion points from Louise's presentation included, but were not limited to, developing a "Mental Health Action Plan", which will involve MHCC engaging in stakeholder focus groups and interviews to set out measurable goals for addressing mental health issues in Canada; building partnerships with other (mental health) stakeholders; and recognizing the need for future funding as MHCC funding ends in 2017.

Through CCPA's participation in events such as the CMHA nation-wide conference, the Association continues its commitment to speaking with a shared voice and being a proactive participant, catalyst, and partner in transformative change for mental health services in Canada. It is through partnerships and collaboration amongst the mental health "community" that we can collectively inform policies, agreements, and related initiatives that can provide citizens with adequate resources (e.g., access to mental

health service providers, practitioners and funding) when they are dealing with various mental health issues. Your voice matters and we truly appreciate your commitment to the counselling and psychotherapy profession in Canada through your involvement with the Canadian Counselling and Psychotherapy Association.

Thank you/Merci/Meegwetch,
Natasha Caverley, PhD, CCC
President-elect, CCPA

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Unlocking Christopher

Submitted by Daniela Krajnjan

I did a fourteen year stint working as an on-contract visual arts instructor for a large government organization. During that time I found three very interesting things: 1) over the fourteen years I saw a rapid spike in the number of children with Autism Spectrum Disorder (ASD) and Pervasive Developmental Disorder-Not Otherwise Specified (PDD-NOS) in my classes; 2) I saw a lot of anger and frustration on the part of the affected children and often their parents, guardians and/ or workers; and 3) I learned that art is an unbelievably powerful tool for reaching these amazing children.

Being a trained therapist, I had a unique perspective on the problems my special needs students were facing but I could not even begin to imagine the powerful tools that my art cupboard would yield in my quest to reach them and make the experience with me enjoyable. Three particular children stand out for me: Christopher, Max and Maddy. Today I would like to introduce you to Christopher.

Christopher was 14 years old and he was placed in a classroom with six to eight year olds. He was tall, aggressive, completely non-verbal except for shrieks, and he was a runner. His male worker continually and forcibly put him back in his seat. The degree of unhappiness this child was experiencing was heartrending and very frightening and disruptive for the other children. I was determined that this young man was going to experience some enjoyment during the course of the week I had him, so I set out to find an art medium that would reach him.

Since tactile sensitivity is often an issue with children with ASD, many art mediums are problematic. That was definitely the case here. Air dry clay is very cold initially and requires the hands to be kept moist while working with it so it was definitely not well received. In fact, it became a projectile. Often when air dry clay does not work, I will try plasticine or Crayola's model magic because they do not need water and they can be warmed up by the instructor before handing the "clay" to the child. Model magic has the additional bonus of not being slimy. Christopher did not take to these either.

Day Two, we tried making a plaster cast of his hand. This is often very successful with children with tactile sensitivity for three reasons: 1) the water can be warmed so it is a pleasant temperature on the skin; and 2) the cast is made by applying wet strips impregnated with plaster and gently rubbing them to release the plaster. The circular motion that is usually recommended for this is very soothing on a visual and tactile level. Most children love to watch their partner apply the plaster and; 3) the weight of the cast material works much like having wrist weights on in helping calm and focus the child. Sadly, Christopher was having a very bad day and was very annoyed with his worker so he did not welcome the idea of having his worker touch his hand for even brief periods of time. So day two was spent battling his worker, screaming and running around the classroom.

Day Three, we were learning to draw by employing the technique of reducing everything to a geometric shape (figure 1). I previously had tremendous success with this activity as long as the child was given thicker pencils, crayons, or pastels to help with the lack of muscle control required in fine motor skill activities.

We discovered that Christopher was quite adept at mimicking what I was drawing but once again, he was annoyed by his worker so the success of the activity was short lived and he once again ran for most of the day. My ability to intervene is

limited when the family has hired a worker. My conversations with the mother didn't help because she believed that her son was out of control and needed a big worker who could force him to comply. Since the worker wasn't actually abusing the child physically my hands were tied but I was determined to help this boy not feel like this art studio was a torture chamber.

Day Four we were building elaborate bowls out of popsicle sticks and tacky glue (Figure 2). Most of the ASD children that I have worked with have demonstrated remarkable ability with repetitive patterns. Christopher was very adept at recognizing a pattern and repeating it but he was tired and could not stay focused on the task for more than 10-15 minutes at a time so I gave him a tennis ball that he could bounce until he could refocus. He did well at the activity but he did not ENJOY the activity. I was becoming disheartened. It was Thursday and I still had not seen that light go on in Christopher's eyes. I only had one day left and it was paint day. Paint day rarely went well with my ASD and PDD-NOS kids because it required fine motor skills and because paint is cold and slimy if you get it on your hands.

I had to modify the paint activity for Christopher because the other children were painting the figurines they had made out of the air dry clay and the plaster casts of their hands. He had been unable to complete those projects. Christopher was also having an "I would rather be playing soccer" day because his brother was at soccer camp that day. I opted to give him a canvas and paintbrushes that had handles of various thicknesses. I also gave him a large paper plate to mix colours on. Then, I did one last thing, I opened the blinds and moved his desk so he faced a beautiful green area with lots of birds and children playing. I gave him warm water to rinse his brushes in and I handed him a brush with a fine tip and thicker handle. Then, I watched. To my absolute amazement and delight, Christopher's face became serene and he stopped hitting his worker. His dipped his brush very methodically into the black paint and he began to make very deliberate strokes on the canvas.

I watched in amazement as I realized that he was painting outer space. He was utterly engrossed and he was enjoying himself! I decided to see how much more he could do. "Christopher, how about some glitter for the stars?" His eyes lit up and he nodded. I handed him a box of assorted colours of glitter, he chose silver and then he began to sprinkle it very methodically into the wet paint to create stars and to add dimension to the Milky way. He created an incredible rendering of this portion of outer space, (Figure 3) and he was content. He had stayed in his seat for over an hour, he had not screamed, he had not hit his worker and he created a beautiful piece of art…and then he gestured for another canvas (Figure 4)… I had finally hit on the correct medium - painting!

That is what I believe all of us should be striving for: We should all be trying to find the key that unlocks their world and let them enjoy the peace for awhile. We are their key to communication. If we can give them effective tools to communicate with, we can help them release some built-up tension and frustration. This may in turn lead to fewer aggressive acts on workers, peers and themselves.

Please open the PDF or YUDU versions of this newsletter to view the figures referred to in the article.

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The Meaning We Make of the Meaning They Make

By Dr. Glen McCabe, CCC, Associate Professor, University of Manitoba

A comparison of Person Centred Therapy (PCT) and Interpretive Qualitative Phenomenological (IQP) research indicates that they have some things in common. Comparing these two professional activities is of interest for at least two reasons. It seems to me as a professional who practices and teaches PCT and IQP that this is not a coincidence, but rather a result of similar or same factors and influences within these two endeavours. Also, this is true of their underlying foundational theoretical principles and foci. Some of these factors and influences make up the central aspects of the following discussion.

Both PCT and IQP seem to be controversial in the fields of clinical and counselling psychology. Some practitioners have embraced these theories as significant contributions to treatment and research, while others perceive them negatively. PCT, as espoused by Carl Rogers and other humanistic theorists, has been the focus of controversy, it seems, almost since its inception as a clinical intervention model. IQP too has been the subject of controversy and skepticism in the research world from the beginning. These reactions, it seems, are mainly due to the fact that they challenge and contradict the generally accepted knowledge and practices of the day. What is perhaps as significant is that this negativity has persisted, and remains active currently.

PCT and IQP were founded from the 1930s into the 1950s, and were, to some extent, a reaction to the growth and tenacity of the beliefs of the theory of rationality as the pinnacle of human ability. Theorists in both fields assert that PCT and IQP are attempts to wrench dominance in the fields of counselling and psychological research, from the grip of the rationalists. The negative views on PCT and IQP are not surprising since they both are seen as challenges to the dominance of rationality; which psychology bought into very significantly in the 20th century and continues to do so at this time. This helps to explain the pre-occupation in psychology with rational and scientific explanations for all issues faced by humans

In keeping with this notion, the American Psychological Association (APA) and the Canadian Psychological Association (CPA) do not endorse PCT as a supportable method of clinical intervention, due to their assertion that it does not constitute a stepwise intervention process and is not supported adequately by empirical evidence. Cognitive Therapy (CT) and Behavior Therapy (BT) methods are favoured instead. It is interesting that the numbers related to client success from CT and BT have been inflated, whereas PCT success has been typically under estimated. Recidivism and relapse rates in addiction and dependency and in prison populations, treatment areas where cognitive and behavioural treatment techniques have been widely applied, are known to be exceedingly high.

One of the main points about PCT and IQP is that they focus on the feelings of people as the central path to personal development and psychological healing. They do this by providing mechanisms for identifying the implied meaning of a client's or research participant's verbally expressed understanding of his or her lived experience. It is asserted here that the value of PCT and IQP is dependent on how well the therapist or the researcher is able to make useful meaning from the meaning the client or participant makes of his or her own lived experience.

This is a challenging enterprise in that making new meaning from the meaning expressed by another requires skills and self-knowledge at a high level. It requires the development of a profound presence and significant therapeutic or investigative skill on the part of the therapist or the researcher. What also may be difficult for some to accept is that this requires the therapist

to be open in acknowledging that the client is the expert on her/his lived experience. The therapist or the researcher, on the other hand, is expert about the therapeutic or research process.

One of central features of PCT and IQP is the therapist's or researcher's ability to successfully form a professional relational bond with their clients or participants. From this, people seeking help or participating in research are then encouraged to evaluate and explore newly discovered meaning about their lived experience, and to evaluate its accuracy and helpfulness. She/he then accepts or rejects, conditionally or unconditionally, the therapist/researcher offering. Of huge significance in this is the fact that the counsellor or researcher must honestly and deeply accept and understand the decision of the client/participant. Clients and participants go as deeply into their understanding of the meaning of their experience as they are able without pressure from the therapist or the researcher. In PCT and IQP they are not judged for the limits of their understanding. They are encouraged and supported in that process, because it is so difficult to do, and because they are working hard to understand themselves.

An assumption of PCT is that a person would solve their problems on their own if they could, but because they are blocked from reaching into their deepest feelings, they need support and assistance to do this. The therapist helps with this process by offering deeply empathic feedback, showing the client that they are profoundly accepted as valuable and able, and that the therapist is sincere in their caring for the person. In IQP the same principles apply, but with the proviso that the researcher is not doing therapy, but still trying to help the participant express the meaning of their experience to the best of their ability.

As noted above, it is asserted here that the value of psychotherapy, in general, is embodied in how well therapists are able to make additional or new meaning from the meaning others make of their lived experience. The difficulty in this enterprise is that making new meaning from the meaning that our clients make of their lived experience is difficult, and requires the development of a profound presence on the part of the therapist. What may be difficult for some to accept is that this requires the therapist or the researcher to be engaged and open to allowing the client to travel the path he/she sees, not one prescribed by the therapist or the researcher. In the case of PCT the effort is placed in helping the client engage in addressing the deeper feelings that are unavailable to the client.

What is important in PCT and IQP is for the therapist or the researcher to break free from the temptation to control and direct and to take the role of superiority over the client or participant. The therapist and the researcher must engage in a process founded on acceptance and authenticity, rather than control and power to encourage and enable others to explore the realms of their unknown and little understood life experiences.

Notebook on Ethics, Standards, and Legal issues for Counsellors and Psychotherapists

A Much-Quoted Decision of the Supreme Court of Canada Regarding Medical Records

By Dr. Glenn Sheppard

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The 1992 Supreme Court of Canada decision in the case of **McInerney versus Macdonald** is frequently referenced by those who wish to find a legal basis for their decisions, advice or insight with respect to medical records. This is most likely because the case still stands as the most informative and comprehensive court decision with respect to such critical matters as record ownership and the right of access. It also speaks eloquently about how a fiduciary duty obligates health professionals to follow certain practices with respect to record management, and the maintenance of confidentiality.

This court case had its origins in New Brunswick where Dr. Elizabeth McInerney was practicing medicine as a licensed physician. The respondent was her patient, Mrs. Margaret Macdonald. She had seen a number of doctors over a period of years prior to becoming Dr. McInerney's patient. Apparently some concerns about her health prompted Mrs. Macdonald to visit Dr. McInerney requesting a copy of her complete medical file. Her doctor accommodated her wish by providing her with copies of all the material in the file that she had prepared. However, she refused to provide a copy of reports in the file that she had received from other physicians regarding Mrs. Macdonald. She stated that such material was the property of those doctors and that she did not have the ethical authority to release them unless Mrs. Macdonald sought permission from them for such a release.

Mrs. Macdonald followed up with an application to the Court of Queen's Bench in New Brunswick asking that Dr. McInerney be ordered to provide her complete medical record. This application was successful and a subsequent appeal to the New Brunswick Court of Appeal to have this judgement overturned was dismissed. Dr. McInerney was then granted leave to appeal the decision to the Supreme Court of Canada.

The Supreme Court upheld the decision of the courts in New Brunswick. It concluded that there is an entitlement to a copy of the full medical record, including reports from other professionals, that were used to inform the treatment decisions of the patient's physician. However, it also said that the patient is not entitled to the record itself but rather a copy since the medical records should remain with the physician. Furthermore, patient right of access to medical records is not absolute. The Justices said that a physician may deny access if it was felt that a disclosure could endanger the emotional or physical well-being of the patient. Of course, any such decision could be subject to a court challenge.

Despite the significance of this part of the ruling, it is what the Justices had to say about the nature of the physician/patient relationship, and their elaboration of the commitments that constitute a fiduciary duty that might be even more relevant for counsellors and psychotherapists.
Their views are expressed succinctly in the following statements I have selected from their decision. (Bolds are mine):

- The physician-patient relationship is **fiduciary** in nature and certain duties arise from that special relationship of **trust** and **confidence**. These include the duties of the doctor to act with utmost **good faith** and **loyalty**, to hold information received from or about a patient in confidence, and to make proper disclosure of information to the patient. The doctor also has an obligation to grant access to the information used in administering treatment.

- This **fiduciary duty** is ultimately grounded in the nature of the patient's interest in the medical records. Information about oneself revealed to a doctor acting in a professional capacity remains, in a fundamental sense, one's own.

- While the doctor is the owner of the actual record, the information is held in a fashion somewhat akin to a trust and is to be used by the physician for the benefit of the patient.

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- Further, since the doctor has a duty to act with utmost **good faith and loyalty**, it is also important that the patient have access to the records to ensure the proper functioning of the doctor-patient relationship and to protect the well-being of the patient.

- Disclosure serves to reinforce the patient's faith in her treatment and to enhance the trust inherent in the doctor-patient relationship. As well, the **duty of confidentiality** that arises from the doctor-patient relationship is meant to encourage disclosure of information and communications between doctor and patient.

I expect members will find some reassurance from having fiduciary duty and the ethical nature of the physician-patient relationship expressed as a legal view from our Supreme Court Justices. I have no doubt that these views regarding medical records, including patient access to them, and the nature of the physician-patient relationship, apply equally to counselling records and to our ethical obligations when we enter into counselling relationships. (This decision can be found at the Supreme Court website at http://www.scc-csc.gc.ca)

A Follow-up Note:

On my last notebook, in Cognica Fall 2014, I reported on a number of breaches of privacy by health care personnel regarding health records in Newfoundland and Labrador. In a recent court decision a nurse who had accessed records of 18 patients for whom she did not have treatment responsibilities was fined $1000.00 and had already lost her license to practice nursing.

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Counselling in the Hinterlands: A Rural Perspective on Student Services

By Shawna Hyde

Hello! My name is Shawna and I'd like to welcome you to my e-tour of the Perth campus of Algonquin College…or as the sign on my door reads, "the College of Knowledge in the Ottawa Valley"! We are located an hour west of Ottawa, in beautiful and historic Lanark County.

Our newly renovated campus re-opened in 2011. We have about 260 students enrolled in nine programs. Our Student Services include a Student Success Specialist, a Nurse Practitioner, and me, a psychotherapist extraordinaire. We all have part-time positions, and are located in a tiny crescent off the academic wing, commonly referred to as "the Horseshoe."

Being born in Carleton Place (Lanark County), and growing up in White Lake (Renfrew County), I consider myself to be a true Valley girl (although I have been citified since). Working on a rural campus demands that I be in tune with the surrounding culture and ways of its community, and with the many students who mostly have grown up in areas here or nearby. Some students are attending college with some of the same people who were in their kindergarten class! Some students legitimately hunt for food. Half of the women in one of the helping programs here wear camouflage every day (sometimes in pink!) Some students' families have been here so long they do not know where their family originated.

The mix of ages and backgrounds of the students, combined with a very specific program availability out here, means that as a counsellor I need to "be all things to all people", as much as I can. Drawing on a wide variety of strategies, approaches and techniques is a necessity, as there is no "one-size fits many" approach to counselling on a rural campus, mainly because almost all of my counselling sessions are classified as "Personal" (rather than Career or Academic). As you can imagine, with a selection of only nine programs, I have never been approached by a student in the Heritage Carpentry program who feels that s/he made a terrible mistake with her/his program choice and thinks s/he really belongs in Pastry Arts!

Being the counsellor in a one-room school house (another one of my affectionate names for our campus, although not far from the truth, with one building and two wings to speak of) is a lot like being Norm at Cheers…everybody knows my name! This means that most students equate "Counselling" with a face. As a matter of fact, more often than not students don't introduce themselves to me, assuming that since they know who I am, the knowledge must be mutual.

I try to use my unique position here to model as many life skills to the students as I can. When working with shy students wanting to increase their assertive communication, I explain that I am one of the biggest introverts I know. This usually takes them quite by surprise. They have seen me setting up for events in the cafeteria, surreptitiously commandeering a table cloth to transform me into Superman (or sometimes Zorro, depending on the day). I use this to explain that they can access different parts of themselves (thanks IFS!!) at different times, to help them manage the interpersonal situations that challenge them. It's an amazing opportunity for me to show students ways to develop their professional selves without compromising who they are as people. They can see that it is entirely possible to use what often feels like character flaws as a vehicle to connect with others, and see differences for what they are: gloriously different abilities instead of dysfunctional deficiencies.

Our SSW (Social Service Worker) program is one of the largest offered on campus. It is such a positive experience to be able to model "safe and effective use of self" for these students at the very beginning of their professional development in order to create therapeutic relationships that are honouring and respectful. These students are often actually excited to "go and see Shawna" as many of them have never had an opportunity to access psychotherapy, and haven't had the experience of having

someone attentively listen to them - only them - for a whole hour (that's right, welcome to Perth where this hour really does have 60 minutes!), let alone have someone validate their experiences, truly care about their academic journeys, and still be able to be "real" with them. I can see the relief on their faces as they are learning through me that being excellent in one's profession really has nothing to do with perfection. This is a lesson that is often very hard-won, yet worth its weight in gold.

Of course there are drawbacks to being a rural counsellor; my availability is very limited, there are no male counsellors available for face-to-face sessions, and no alternative counsellors immediately available in case of a personality difference or conflict of interest. I often see students who also happen to be roommates. Some of them negotiate what they will have for supper that evening as they pass each other in my doorway, and this makes me laugh. Others, however, will take great personal delight in watching this introvert mentally squirm when they inform me that I was the topic of last night's dinner conversation! (Goodness…doesn't anybody have homework to do or email to check?!)

So why do I love being a rural counsellor so much? The short answer: Connection.
I love feeling connected to my roots, and I try to inspire that same sense of belonging and pride in our students. At a rural campus, there are many opportunities for students to recognize their community's needs and give back in practical, tangible, and immediate ways; building themselves up in the process.

Ultimately, I love being a rural counsellor because it presents the opportunity for me, just as I am, to connect in so many different ways with students, just as they are, and knowing that we all are changed because of this. Our campus' slogan is: "In Perth, we build futures." What a privilege and blessing it is for me to be a part of this equation in action!